Chapter 2
REVIEW OF LITERATURE

After a meticulous review of literature pertaining to the theories and techniques of communication skills knowledge, attitude, self perceived, and observed practice the literature in this chapter has been mentioned in the following five divisions.

Based on the above search this section is divided into six divisions:
2.1. Theories of communication in nursing.
2.2. Communication frameworks
2.3. Instruments for Assessment of Domains in Communication
2.4. Studies on Communication skills training in Allied Health Professionals
2.5. Studies on Communication skills training program for Nurses.
2.6. Need for the present study.

2.1. THEORIES OF COMMUNICATION IN NURSING:
Based on different definitions provided by several authors, various theories have been formulated. Therapeutic communication theories and techniques have also been studied and elaborated by different scholars. Hildegard Peplau (1952), one of the earliest nursing theorists who explored the nurse-patient relationship and nursing communication has developed the theory of interpersonal relations which emphasizes reciprocity in the interpersonal relationship between the nurse and the patient. Peplau (1952) emphasized on the following concepts: what nurses do to patients, what nurses do with patients, and how to make nursing an interactive and collaborative process between the nurse and the patient. Thus, Peplau (1952) identified four phases of the nurse-patient relationship namely Orientation, Identification, Exploitation and Resolution. The orientation phase includes the rapport building between nurse and patient were they get to know each other. The second phase called as identification phase, the nurse intends to understand the problems of the patient. During the third phase the nurse and the patient get into a mutual understanding in handling the problems thus it is known as exploitation phase. In the final phase known as the resolution phase the goal of solving the problems of the patient is achieved and then the nurse patient relationship is terminated.
Later, Duldt (1985) proposed a theory called Humanizing Nursing Communication Theory (HNCT) which served as a foundation for the specific therapeutic communication required by psychiatric nurses. Duldt (1985) identified three themes in this nursing theory namely, communicating, caring and coaching. The elements of communication include face to face interaction and awareness between the nurse and patient including the nonverbal cues of communication. Duldt (1985) believed that the change occurs through this interaction only. Caring involves valuing and touching with an intention of providing nursing care showing the concern and responsibility of the patient’s health state by the nurse. Coaching refers to the teaching aspect of nursing to provide support and encouragement to the patients in order to achieve the health needs.

Jean Watson’s philosophy of nursing, (1988), comprised ten primary caring factors. The first three factors were from the philosophical foundations of the science of caring and the remaining seven factors sprang from the foundation laid by the first three. Among the ten factors, the fifth one was all about establishing a helping-trust relationship which is characterized by congruence, empathy and warmth.

Watson (1988) explained that the mode of communication was the strongest tool which establishes rapport and caring. According to her, communication essentially included verbal, nonverbal and listening which connotes empathetic understanding. Watson (1988) stated that the first five factors emphasized on communication need between the nurse and patient. They were formation of humanistic-altruistic system of values, installation of faith and hope, cultivation of sensitivity to oneself and others, the development of a helping-trust relationship, and the promotion and acceptance of the expression of positive and negative feelings.

Further, Henderson, (1991), in her “need theory” known as the definition of nursing categorized nursing activities into 14 components based on human needs and three components based on the nurses’ role as substitutive, supplementary and complementary with an aim of helping the person to become as independent as possible. Among the 14 components, she specified communication as the 10th component stating that the nurses should communicate with others in expressing emotions, needs, fears or opinions.
In Transcultural Nursing theory proposed by Madeleine Leininger (Sunrise Model) (1997), the author proposed that cultural competence is an important component of nursing and stated that for a nurse, effective intercultural communication is a must to successfully provide care for a patient who hails from a different cultural ethnic background.

2.2. Communication frameworks:
Realizing the importance of communication in nurse-patient care, several nursing professionals have developed different communication frameworks. Some of them compliment each other whereas some are distinct ones. Some of the important ones are reviewed here.

2.2.1 LEARN: (Berlin & Fowkes, 1983).

2.2.2 Calgary Cambridge Framework: (Kurtz and Silverman, 1996)

2.2.3 SPIKES: (Baile et al., 2000)

2.2.4 SEGUE: (Makoul, 2001)

2.2.5 Kalamazoo’s Essential Elements of Communication: (Brunett, 2001)

2.2.6 COMFORT: (Wittenberg-Lyles et al., 2010).

2.2.7 REDE: (Windover et al., 2013)

2.2.1 LEARN: (Berlin & Fowkes, 1983).

LEARN is the model for teaching communication in cross cultural health care developed by Berlin & Fowkes (1983). Its’ expansion is a mnemonic of L- Listen, E- Explain, A- Acknowledge, R- Recommend, and N- Negotiate. The component Listen describes the skill to listen empathically and understand the patient's perspective of the problem. Explain includes providing explanation about the illness considering the educational level, culture, past experiences, and constantly focusing on a particular topic. Acknowledging is all about accepting the responses that the patient shows back, understanding the problems and integrating the patient’s suggestion if possible. Recommend deals with the process of suggesting the patient, a plan of care that may help her or him in prognosis. Negotiate means conferring the patient on a course of action.
2.2.2 Calgary Cambridge Framework: (Kurtz and Silverman (1996))
The Calgary Cambridge framework is basically a practical teaching tool to enhance the doctor and patient communication. The framework proposes six components to guide the process of communication. They are Initiate the session, Gathering the information, Providing the structure, Building the relationship, Explaining and planning, and close the session. Initiating the Session includes establishing initial rapport and identifying the reasons for the consultation. Gathering information involves exploration of patient’s problems. Providing structure includes organizing the conversation and maintains the flow. Building relationship includes using appropriate verbal and non verbal behavior and involving the patient while communicating. Explanation and planning is where proper information is provided aiding in proper understanding of their condition. Closing the session involves future follow up and coping of the patient.

2.2.3 SPIKES: (Baile et al., 2000)
Baile et al., (2000), developed six step protocol specialized curriculum for delivering bad news that is given the acronym SPIKES. Each letter indicates one step in delivering the bad news to the cancer patients. The first step S indicates the setting up of the interview by considering the privacy, involving others based on the patient’s choice, sitting down, establishing a relationship with the patient and managing time and preventing any interruptions. Step two P includes perception of the patient regarding one’s condition and gathering the information from the patient based on their understanding. Step three involves invitation of the patient, in other words, the readiness of the patient to know about his or her condition and get a clear picture of one’s diagnosis and treatment. The fourth step K indicates imparting the knowledge and information to the patient based on one’s vocabulary by using comprehensive message, using non technical terms, avoiding excess blunt messages, delivering the information slowly one by one and checking for the response and then moving on to the next information. However, technical terms and phrases are avoided in this communication process. The fifth step E - encompasses considers the patient’s emotions and empathic responses. The last step is all about S- summarizing the application and applying various strategies based on the understanding about the patient by the physician.
2.2.4 SEGUE: (Makoul, 2001)

Makoul (2001) developed a framework called SEGUE, which is a communication curriculum. The acronym SEGUE comprises of five stages. The first stage is S - Set the stage that comprises of greeting the patient, establishing reason for the visit, outlining the agenda for the visit, building relationship and maintaining the privacy of the patient. Second stage is E - Elicit information using open ended questions avoiding the use of leading or directive questions, by giving enough time to explain, listen, check and clarify the information given by the patient to understand the patient’s views about one’s problem, to explore the factors associated (physical, emotional and psychological factors), and to discuss the previous treatments and the reflection of the patient’s condition over his daily life and preventive strategies. Third stage is G, which represents Giving information, related to the procedures done to the patient, teaching the patient based on the level of his/her understanding and encouraging one to ask doubts. The last stage is U which represents Understanding the patient’s perspectives by giving respect, expressing care and clear concern showing empathy and by acknowledging the patients progress, and end the encounter by clarifying any doubts of the patient and moving further to the next level.

2.2.5 Kalamazoo’s Essential Elements of Communication: (Brunett et al., 2001)

The Bayer-Fetzer Conference on physician-patient communication in medical education convened a meeting of important stakeholders to review the major theoretical models of physician-patient communication to reach a consensus on the essential elements that characterized physician-patient communication ((Brunett et al., 2001). The report resulting from this conference was termed as the ‘Kalamazoo consensus statement’ and it identified seven key elements of communication in clinical encounters (Brunett et al., 2001). They are as follows: Build the relationship, open the discussion, gather information, understand the patient perspectives, share information, reach agreement, and provide closure (Brunett et al., 2001).

2.2.6 COMFORT: (Wittenberg-Lyles et al., 2010).

While majority of communication models focuses on the physicians’ preparedness, COMFORT is completely a communication based framework that has been developed for the nurses to practice self care and to teach palliative care communication to nurses.
based on narrative approach by Wittenberg-Lyles et al., (2010). It is an acronym where each letter represents a principle for teaching the communication skills framework- C - Communication, O - Orientation and opportunity, M – Mindfulness, F - Family, O - Oversight, R - Reiterative and radically adaptive messages and T - Team.

2.2.7 REDE: (Windover et al., 2013)

Windover et al., (2013) developed a health care communication module called REDE with a purpose to aid teaching and evaluating the relationship centered communication. This module has three phases of relationship. In phase I, is related to establishing the relationship. It include welcoming with value and respect, collaboratively setting the agenda, introducing the computer, if applicable, and demonstrate empathy using the SAVE (S-Support, A-Acknowledge, V- Validate, E – Emotion naming). Phase II comprises Engaging in reflective listening, eliciting the patient narrative and exploring the patient’s perspective, using VIEW (V- Vital activities, I- Ideas, E-Expectations, and W-Worries) and this phase is termed as developing responsibility. Phase III is called engaging in the relationship and it encompasses sharing diagnosis and information, collaboratively developing the plan, providing closure and engaging in dialogue throughout using ARIA (A- Assess what is known, R- Reflect, I – Inform, and A- Assess the understanding and reaction).

2.3. Instruments for Assessment of Domains in Communication:

2.3.1. Knowledge Questionnaire

2.3.1.1. Communication Knowledge Assessment Tool

Goldsmith and Wittenberg-Lyles’ (2010) developed Communication Knowledge Assessment tool which was used to measure the knowledge about communication skills as post evaluation assessing the effectiveness of the COMFORT communication module. This tool consists of eight multiple-choice questions and two open ended questions. Students who scored 75% and above were considered to have adequate knowledge about the communication concepts taught in the module. Students who scored less than 75% were considered to have inadequate knowledge about the concepts taught in the module. One major limitation of this questionnaire is that, it pertains only to COMFORT module (focused on communication in palliative nursing care) and cannot be applied for evaluating other training programs.
Though there were several studies on assessment of knowledge in communication, there is no single standard questionnaire developed for assessing the knowledge on communication skills among student nurses. Hence in the present study, the researcher had attempted to develop on the knowledge questionnaire on communication skill based on the objectives of the research and content of the training module (Arunadevi & Manickam, 2014).

2.3.2. Attitude scales

2.3.2.2. Perceived Importance of Medical Communication (Languille et al., 2001).

Languille et al. (2001) developed the Perceptions of the Importance of Medical Communication (PIMC) scale to assess various attitudes towards the importance of communication in a variety of medical situations, including patient-provider interactions and communication among health care workers. This tool contains 12 items and is a five-point scale ranging from strongly disagrees to strongly agree. The reliability coefficient for PIMC has been reported to be 0.79.

2.3.2.3. Communication Skills Attitude Scale (CSAS) (Rees, Sheard, and Davies, 2002).

Rees, Sheard, and Davies (2002), developed the Communication Skills Attitude Scale (CSAS) to assess the attitude towards communication skills learning. It is a 26-item questionnaire that uses a five-point Likert type scale to measure positive and negative attitudes about communication skills training. Two factor scale was adapted for the CSAS. Factor I represented positive attitude towards communication skill’s learning and factor II represented negative attitude. Subscale I had an internal consistency of alpha=0.87 and an intra-class correlation of 0.65 (P < 0.001). Subscale II had an internal consistency of alpha=0.81 and an intra-class correlation of 0.77 (P < 0.001) and possessed moderate test-retest reliability (Rees, Sheard, & Davies, 2002).

2.3.3. Assessment of Communication Skill

In the assessment of the communication skills, various tools have emerged, each with its own advantages and disadvantages. The development of the tool in this field was continuous and abundant. All these tools measure more or else of the same factors, but
in different dimensions and fragments. The following are the few of those used in the studies.

2.3.3.1 Interpersonal Communication Competence (Spitzberg & Cupachs, 1984)

Spitzberg and Cupach's (1984) developed interpersonal communication competence Self-assessment scale, which is a five-point rating scale ranging from 'strongly disagree' to 'strongly agree'. It comprises of 18 items developed based on three factors, namely motivation, knowledge and skill. The combined scoring evaluates the following 6 abilities, namely adaptability, conservation involvement, conversation management, empathy, effectiveness and appropriateness. However this tool focused on the general assessment of interpersonal communication and does not include the communication relevant to the healthcare field.

2.3.3.2 Caring Efficacy Scale (Coates, 1997).

Coates' (1997) Caring Efficacy Scale is a 30 item, six-point Likert type scale that assesses belief in oneself to have the ability to express a caring attitude and develop a caring relationship with patients and caregivers. This scale has two forms titled A & B. It has adopted the Bandura's framework in the Form A and Watsons theory in the Form B assessment. Form A is a self rating scale and the Form B is rated by the faculty or the supervisor. In relation to the reliability, the long form of the caring efficacy scale obtained alpha values of .85 and .88 (Coates, 1997).

2.3.3.3 Interpersonal Communication Assessment Scale (Klakovich & Cruz, 2006)

Klakovich, and Cruz, (2006) developed Interpersonal Communication Assessment Scale (ICAS), which is designed to assess the communication competencies of students in undergraduate and graduate nursing programs. It is a 23-item scale with 4-point rating from seldom to always with three subscales advocacy, therapeutic use of self, and validating. The Cronbach’s alpha of this tool was reported to be 0.96.
2.3.3.4 SEGUE as an Assessment tool (Makoul, 2001)

Makoul (2001) developed a framework called SEGUE, which is a communication curriculum. The SEGUE is an acronym with five domains to be assessed. They are Set the stage, Elicit information with a open question, Giving information, Understanding the patient’s perspectives, and caring with empathy. Originally, there were 3 scaling options: 1. Done well; 2. Needs improvement and 3. Not done, which was later made with a 5-point Likert scale from poor to excellent by Calhoun et al., (2009). They also recommended specific assessment methods to evaluate communication skills, including direct observation with real patients, ratings of simulated encounters with standardized patients, ratings of video or audio taped interactions, patient surveys, and knowledge/skills/attitudes examination. One of the strength of this tool is the ease of its use by multiple raters. However Schirmer et al., (2005) and Joyce, Steenber and Scher (2010) reported that this tool does not require any expertise in rating and even less experienced faculty raters can also follow the instruction and rate effectively.

2.3.3.5 Kalamazoo’s Essential Elements of Communication (Brunett, 2001)

The Kalamazoo’s Essential Elements of Communication checklist serves as an assessment tool for assessing the communication skills of the medical students. The strength of this tool is it was framed after rectifying the drawbacks of previous communication assessment tools by so many experts in a Bayer-Fetzer Conference on Physician-Patient Communication in Medical Education. There are eight domains assessed using the Kalamazoo’s essential elements of communication skills. They are Build the relationship, open the discussion, gather information, understand the patient perspectives, share information, reach agreement, provide closure and manages flow (Brunett et al., 2001). It has five ratings in it namely poor, fair, adequate, very good, and excellent.

2. 4. Studies on Communication skills training in Allied Health Professionals:

Khashab (2006) tried to identify the attitude towards learning communication skills among 470 medical students from 4th and 5th year using communication skills attitude scale. Univariate and multivariate analysis was conducted to find the association between the demographic variables and attitude. The results showed that, 5th year students have a positive attitude towards the learning of communication skills than the
4th year students. It was also found that having ‘father as a doctor’ had enhanced the positive attitude towards learning communication skills.

Wright et al. (2006) in their study compared the knowledge and attitude toward communication skills training between the first year and fourth year medical students. Communication Skills attitude scale (CSAS), perceived confidence, perceived importance of medical communication and knowledge on communication questionnaires were administered to the participants. The correlation results showed a positive relationship between attitude, perceived importance of medical communication, knowledge and communication skills training. Positive relationship were also reported between the perceived importance and the confidence in communication with the patients, but the confidence in communication does not have any relationship with the attitude. Moreover, comparison between first year and fourth year it was also observed that fourth year medical students have a higher positive attitude, perceived confidence towards communication skill training than the first year students, however, the other variables were not reported to be significant. Gender wise comparison revealed that female medical students had higher positive attitudes whereas male medical students had higher confidence.

Baerheim et al. (2007) conducted a cross sectional survey with an intervention to rule out the curriculum influences over the knowledge on clinical communication skills by medical students. 1801 medical students participated in this study. Participants were requested to answer a self administered knowledge questionnaire on communication skills. It was found that at the end of the first year, the scores were higher in the schools which provided early patient contact and conducted communication courses to the students. The students from the traditional curriculum scored very low in the end of first year and it was assumed that only towards the end of the third year their scores would increase. This may be due to exposure to the patient contact and to the communication course. On comparing the two groups, only the final year participants of both the curriculum, only a little difference was reported. Thus, it was concluded that there is a great change in the knowledge during their completion of course rather than the early years, which was achieved only when there was an early exposure to communication skills training course as well the patient contact.
Parry (2008) conducted a systemic literature search to evaluate the effectiveness of the interventions to promote the communication practice among the allied health professionals. The researcher also identified the indirect evidences like design that imparted the intervention and its real effects over communication practices were also analyzed. For this purpose, five intervention reports for allied health professionals were reviewed. Nine reviews were added to rule out the indirect evidences among the doctors and nurses. The direct evidences from the five reports suggested significant impact on the communication practice. From the indirect evidences of nine reviews it was concluded that robust design achieved better results. Strong empirical and conceptual foundation for an intervention was found to yield a better outcome and finally performance based training was found to have a better training in improving the communication practice of the participants.

Shama, Meky, Enein, and Mahdy (2009) evaluated the effectiveness of the communication skills training program among the 66 primary health care physicians. It was a 3-day communication training program during which about 18 hours was spent on related theory, applying practically and influencing the attitude change. The result showed significant difference between the knowledge, attitude and self efficacy after the exposure to the communication skills training program.

Lumma-Sellenthin (2012) in a cross sectional survey attempted to find the student's attitude towards learning communication skills among 351 medical students. These students were from first and third term of two traditional and two problem based curriculum. The researcher attempted to find the association between the demographic variables and meta-cognitive variable. For this purpose, ANOVA, univariate and multilinear regressions were used. It was found that there was a positive attitude identified with the students from the problem based curriculum, whereas there was least interest shown by the students from the traditional based curriculum. The associated factors of positive attitude were a better cognition about the patient, female gender, and higher age.

Naghavi et al. (2014) studied the impact of communication skills training on knowledge and attitude of the 77 family physicians using simple random sampling (39 in experimental group and 38 in control group). Knowledge, Physician’ awareness
inventory comprising 12 questions and 10 items physician attitude questionnaire along with the patient satisfaction questionnaire comprising 20 items tools were used before and after the intervention. Two-day educational workshop on communication skills based on the Calgary Cambridge guide was conducted using role play, lectures, team activities, practical assignment and short test over the topic. A gap of two months was given after the intervention and were reassessed for the knowledge, attitude and patient satisfaction. The results showed significant improvement in their knowledge, attitude towards communication skills and patient satisfaction about the care they received from the family physician after the workshop on communication skills training workshop.

Quail, Brundage, Spitalnick, Allen and Beilby (2016) compared third year speech pathology students’ self reported communication skills between the standardized patient, virtual and traditional clinical learning environments. Sixty-two third year speech pathology students were enrolled for the study and were allocated randomly to the three interventional groups. 21 students were allotted to patient in nursing home, 22 were allotted to simulated patient and 19 of them were allotted to virtual patient. They were allowed to engage in a 30-minute interaction with patient in respective group. Before one week of the placement of the six participants each to various intervention groups, they were given a brief information about the expectations and guidance by one clinical instructor. The pre test was conducted before one week of the interaction with the patient and after one week they were allowed for interaction followed with post test by a debriefing session with the clinical instructors. Self reported communication skills, knowledge, and confidence, and Jefferson scale of empathy – health professionals (student version) were used as tools. It was found that all the three interactions were highly significant in increasing the communication skills of the students. On comparison of the three interventions it was found that interaction with the patient in nursing home was more favorable than the other two placements, however standard simulated patient interaction was better than the interaction with the virtual patient. Though the communication skills after the interaction were high it was found to be highly significant in the interaction with the patient at nursing home. Further the knowledge about communication skill was found to be high in the interaction with the standard patient group than the other two groups. Empathy was found to be significant only in the group who had interaction with the patient in nursing home than the other two groups.
2.5 Studies on Communication skills training program for Nurses

Liu, Mok, Wong, Xue and Xu (2007) evaluated the integrated communication skill training program adopting a quasi experimental research design with 129 nurse participants. They were assessed for basic communication skills, communication outcome expectancies, self efficacy in oncology specific communication skills and self perceived support for communication. The intervention group received an intensive learning session along with practice in the clinical setting to create a supportive ward atmosphere. The intervention group was assessed thrice for evaluating the effectiveness pre test, one month after training and six months after the training whereas the control group was assessed only twice, i.e. during pre test and after six months. The results showed a drastic constant significant change in the basic communication skills, communication outcome expectancy, self efficacy in oncology communication skills and self perceived support for communication even after six months of the training.

Ghazavi, Lohrasbi and Mehrabi (2010) evaluated the effectiveness of communication skill training using group psycho education on stress level of the staff nurses in psychiatry ward. Screening tool Holms and Rahe (1967) stress scale was used for screening and those who scored less than 150 were included as participants of the study. The data from 45 participants (23 in experimental and 22 in control group, randomly assigned) were collected at 3 stages- before the training, immediately after the training and finally after a gap of one month of training. The training was conducted in 6 sessions. Each session was about 1 to 1 1/2 hours using group psycho education method. The results showed that the stress level after the training was lowered significantly. Moreover, after one month gap, the stress level was found to be significantly low in the experimental group than that of the control group.

Mohamed and Hammed (2012) identified the effectiveness of communication skills training program in improving the burnout and self esteem among 30 staff nurses in psychiatric hospital. Burnout rating scale, self esteem inventory and communication skills checklist and educational program evaluation sheet along with the structured interview schedule were used to collect the data. The findings showed a significant difference in the burn out, self esteem and communication skills after implementation of communication skills training program. It was also identified that the communication
skills, burnout, and self esteem are interrelated factors showing a strong positive correlation between each variable. Further, the demographic variables like age and domicile showed a significant association with the study variables.

Khodadadi, Ebrahimi, Moghaddasian, and Babapour (2013) conducted a study to find the effect of communication skills training on self efficacy, communication skills rate along with the quality of care and job satisfaction. For this purpose, 73 nurses were selected randomly and 31 were assigned to the control group and 42 nurses to the experimental group. Tools used for this purpose were communication skills questionnaire with 29 questions and 17 item, self efficacy questionnaire. After the pre test, the communication skills training program was conducted for the experimental group nurses alone. Later the post test was conducted from both experimental and control group nurses. The results showed significant increase in the communication skills scores in the experimental group after the training whereas, self efficacy did not have any significant difference.

Shermeh, Amiri, Zarchi, Bahari, and Binesh (2013) using a quasi experimental research design assessed the effectiveness of solution focused communication training (SFCT) on communication skills of 71 staff nurses. The intervention was conducted for 8 hours in one-day workshop. Participants were assessed using the demographic information and a 26 items tool to assess the skills based on the four subscales. The first subscale was on initiation of the session, that included building trust, attention to patients needs, respect, self confidence in communicating. The second sub scale comprises of nurse’s respect to the patient, patience, emphasis on patients’ abilities, active listening and tendency for communication with patient. The third subscale was to assess paying attention to patients, physical and emotional state, explanation of medical interventions, listening and eliminating the patients concern and offering medical information. The fourth subscale was to evaluate the use of facial expressions and body language. A pre test was conducted before conducing the workshop. Later, the instructional module was given for self study under the supervision. Finally, the post test was conducted after two months’ gap. Each participant had completed 3 questionnaires which was evaluated by three persons namely the participant, the head nurse, and a colleague. The results showed a significant improvement in the self perceived communication skills, and the results were same with the head nurse assessment as well as colleagues’ assessment.
Wittenberg-Lyles, Goldsmith, Ferrell and Burchett (2014), assessed the effectiveness of an inter-professional online curriculum for palliative care communication training among 105 nurses, 25 physicians and 47 from other health care disciplines. COMFORT curriculum was adopted for the study and among the seven components of COMFORT curriculum, four modules were selected. The chosen four modules were made available online and the participants were required to complete a pre module survey and entered into the curriculum module and self learn the module. Later, a post curriculum evaluation was done and it showed that there was a significant increase in the mean score of the post curriculum evaluation.

Milic et al. (2015) conducted a workshop of 8-hours duration on communication skills for critical care nurses and explored its effectiveness. They were assessed on their confidence and skill in performing the key tasks in the critical care using 14 items questionnaire that included four factors in it. The factors were 1. assessment of the family, 2. addressing of the family emotional needs and contributing to the family meetings, 3. understanding the prognosis and 4. planning appropriately. The pre-assessment was done before the workshop and post assessment was done immediately after the completion of the workshop and another assessment was done after 3 months. The results showed that the participants had achieved high confidence rate in performing the specific skills after the workshop and it was sustained even after the 3 months of the workshop.

Moss (2015), studied the nurse patient communication skills of novice psychiatric nurses and it was found that the novice nurses who had more than 19 months of experience in the psychiatric setting were found to have better communication skills than those who had less experience in other areas. Further, the results also revealed that the novice nurses had a strong recommendation for a formal communication training program for them in the clinical environment itself rather than a classroom setting.

Sheldon and Hilaire (2015) in their study attempted to elicit the perspectives of newly graduated nurses on their development and implementation of communication skills within six months after graduation. For this purpose, 700 newly graduated nurses were selected from two baccalaureate programs namely, full time undergraduate program and second degree undergraduate accelerate program. Online survey comprising a
demographic data sheet, seven Likert type questions regarding the perception and ability in communicating in the clinical environment, and three open ended questions about their personal experience in the clinical scenario was conducted. The final respondents were only 206 new graduates. The result showed that only 27% of the nurses were confident to communicate with the patient and family members, 23.5% of them were confident in communicating with the interdisciplinary team, 50.8% stated confidence in providing care and 44.5% felt that they always had to ask for help with their colleagues. To conclude, they found that lesser number of nurses were feeling always confident in engaging in communication with the patients and their family members. This is evidence that shows the unpreparedness of the nurses and indicates a threat to the patient safety too. So it strongly endorses that practical communication skill training should be incorporated in the curriculum of nursing course.

Watters et al. (2015) compared the uniprofessionals and inter professionals using simulation in improving the self efficacy of the trainees. For this purpose, 115 nurses and midwives along with 156 doctors were enrolled. The intervention comprised of 21 inter-professional course and 53 uni-professional courses. Each course had one-day intermediate fidelity simulation based course comprising six scenarios namely five acute illness and one associated communication scenario and each scenario lasting for 15 minutes. Unprofessional cohorts were about 12 participants and inter-professional cohorts comprised of doctors, midwives and nurses in a ratio of 1:1 for each course. After the scenario they were involved in debriefing sessions focusing on non technical skills for about 45 minutes. A 10 itemed questionnaire prepared by the researcher was used. Confidence in performing leadership and management skills and confidence in performing communication and teamwork skills were the two factors that emerged. On comparison between the inter-professional and uni-professional training the participants in the inter-professional courses showed a significant improvement than that of uni-professional course in both the factors.

Younis, Mabrouk, and Kamal (2015) conducted a study to assess the effectiveness of planned therapeutic communication program on therapeutic communication skills on pediatric nurses. Using quasi experimental design they had conducted the study among 132 pediatric nurses. Two major tools were used for the study purpose they were tool one includes two sections, first section is Socio demographic data and second section
was a knowledge questionnaire on therapeutic communication. Tool two includes five point likert scale to assess the skills and practice of therapeutic communication. The knowledge and practice pre test was conducted before the commencement of the planned training program. the total samples were divided into three groups and the groups were administered with three sessions of training per week and total of 12 training sessions was conducted for each group. After this training program the post test was conducted for both knowledge and practice of therapeutic communication. The practice of therapeutic communication was assessed with 5 -6 participants per day for about 30 -45 minutes each. The result showed high significance for the knowledge compared with the pre test and post test. As well as, the practice of therapeutic communication skills also showed a great improvement on comparison between the pre and posttest.

Wittenberg, Ferrell, Goldsmith, Ragan, and Paice (2016) conducted a study to evaluate the effectiveness of COMFORT communication curriculum and its longitudinal impact among 28 nurses, 16 social workers, 8 physicians, 5 chaplains, and 1 psychologist. A two-day training program adopting COMFORT curriculum was done. The results were analyzed after six months and nine months. The results revealed that team member training had enhanced the communication and cooperation with the family care givers and overall communication process. Though COMFORT curriculum is an effective online module to teach multiple disciplines on palliative care communication, it focused on palliative care rather than the essential nurse-patient communication.

2.6. Techniques and Methods used in communication skills training:

2.6.1 Simulation Based Training Programs

2.6.2 Modules and Curriculum Based Communication Training Programs.

2.6.3 Recording Based Training Programs

2.6.1 Simulation Based Training Programs

Baxter and Norman (2011) evaluated the senior nursing students’ ability to self assess their performance in responding to the simulated emergency situations among 4th year nursing students. Single group pretest post test design was adopted and the tools were
administered before and after the objective clinical examination with the simulated environment. Apart from self assessment, evaluation under observation was also done. The results showed a significant difference in the performance of the students both in self evaluation as well in the observed evaluation. On self assessment, the students reported that they have gained confidence and competence in handling the emergency situation. Even in observed group they have handled the situation very confidently and gained better skills. However, negative correlation was found between self assessment and observed assessment of the students’ performance.

Cardoza and Hood (2012) carried out a study on the effectiveness of simulation in developing the self efficacy among the senior baccalaureate nursing students for providing family centered care. The data was collected for four times, the first and second data were collected on the first day of the semester before and after the exposure to the simulation and the third and fourth was on the last day of the semester before and after the simulation. Though there was a greater significance in the knowledge and skills after the exposure to the simulation, the self assessed knowledge and practice was unrealistic and inaccurate.

Lewis, Strachan and Smith (2012) in their review on the ‘effectiveness of simulation in developing the non technical skills in nursing along with the communication skills’ reported that high fidelity simulation is safe. They also observed that simulation provides controlled environment that allows the students to have a very wide experience and encounters without the threat to the patient safety. It also helps to enhance the students’ confidence that aid in critical clinical situations.

Liaw, Scherpier, Rethans and Klainin-Yobas (2012) conducted a study to compare and correlate between the knowledge, self reported confidence and observed clinical performance among 31 third year nursing students. They were divided the participants into two groups and the experimental group received simulation of six hours in care of patient with physical deterioration. Pre and post assessment of knowledge, confidence and observation were done immediately before and after the simulation program. The experimental group showed a significant improvement in their knowledge, self reported confidence and observed clinical performance than the control group students. Self confidence was found to be increased and significant in the post test in both the groups.
There was no significance difference found between the self reported confidence and the observed clinical performance or between the knowledge and the observed clinical performance.

Nuraini et al. (2015) conducted a quasi experimental study to find the effectiveness of human patient simulation in shaping the attitude of 2\textsuperscript{nd} year nursing students. The results showed that there was statistical significant improvement in the post test attitude in the experimental group whereas the post test scores got decreased in the control group. This proved that the attitude of the nursing students improves on using human patient simulation learning method.

### 2.6.2 Modules and Curriculum Based Communication Training Programs.

Mullan and Kothe (2010) explored the correlation of the self rated communication skills, with the nurse training course and observed communication skills of 209 first year nursing students before and after the communication skills training program. The results revealed that there was a significant improvement in the self rated ability, satisfaction towards the nursing course and observed communication skills. It was also observed that though there was a significant correlation between the self rated ability and satisfaction towards the nursing course the researchers failed to predict any relationship between the self rated and observed communication skills of the students.

Zavertnik, Huff and Munro (2010) assessed the effectiveness of a learner centered simulation intervention in improving the communication skills of the sophomore nursing students. The formal training program for communication was given and a 60-minute practice session with a standardized family member was also arranged. Four domains were evaluated, namely introduction, gathering of information, imparting information and clarifying goals and expectations. The experimental group exhibited better changes in the communication performance than that of the control group. Though there was a significant difference in all the four domains, it was highly significant in the domain of gathering information.
Stecklar (2012) studied the effectiveness of the COMFORT curriculum in improving the communication skills among 12 nursing students using the pretest and post test survey questionnaire, Communication attitude scale (Rees et al., 2002), the modified perceived importance of medical communication (Languille et al., 2001), the caring efficacy scale for nurses (Coates, 1997) and the communication knowledge assessment (Goldsmith & Wittenberg-Lyles, 2010) tools were administered to the participants. The COMFORT curriculum was conducted for 60 minutes as a single session for the students, which included the communication and the role of nurses in end of life care. Later the post test was conducted and it showed that there was a significant improvement in the knowledge on communication. Whereas, there were no significant improvements in the attitude, perceived importance of medical communication and the caring efficacy scale of the nursing students.

Bays et al. (2014) evaluated the effectiveness of an experiential communication skills building workshop (CODE TALK) among 145 participants with the combination of nurse practitioner students and internal medical trainees about breaking bad news and showing empathy to the palliative care patients. The workshop was conducted from five to eight half day sessions in a month. The result showed that there was a significant improvement in the performance of the participants in the workshop. It was also found that the trainee’s characteristic score was also improved from 8 to 11 coded behaviors. It was also made sure that this trainee character did not have any influence on the performance of the participants.

Miligi, Horaim, Anazi and Alateeg (2015) conducted a descriptive cross sectional study to assess the attitudes of nursing students toward learning communication skills among 66 pre-professional undergraduate bachelor course and 120 students from a professional undergraduate bachelor course. For this purpose, the survey questionnaire consisting 25 items on attitude towards learning communication skills was used. The result exhibited positive attitude towards learning communication skills in both the groups. On further comparison, it was found that the attitude towards learning communication skills was high in the professional group than the pre professional undergraduate bachelor group. It was also observed that there was a significant positive correlation between the level of study and the attitude, whereas only limited positive relationship was reported between the age and attitude scores.
Unkuri (2015) conducted a study to explore and appraise the nurse competence of graduating nursing students and to assess the congruence between the self assessment and mentor observed assessment of student nurse competence. There were 154 graduating nursing students and 42 mentors involved in the study process. There were two phases of data collection, the first phase is handling with the descriptive phase by carrying out literature reviews on nurse competence areas for nursing students, and the second phase involved evaluation of the identified nurse competence among the nursing students and to find the similarity of the evaluation by the students themselves as well the assessment by the mentors of the students using cross sectional survey. In the descriptive phase, literature review from MEDLINE and CINAHL were conducted and finally 10 studies and four documents (2 projects, 1 current working paper, and one directive) were included to identify the student nurse competence. In the evaluation phase the data was collected by online and paper survey. Using the three modes of assessment, the first being the generic Nurse Competence Scale (NCS) which consists of 73 items under 7 nurse competence categories, the modified HOTOHA (Hoitotoimintojen hallinta) has 92 items under 12 multidimensional nursing skill categories to assess the nursing skills, Clinical learning environment and supervision plus Nurse teacher to assess the pedagogical atmosphere in the ward and student mentor relationship, they verified their hypotheses. Thematic analysis done on the descriptive phase data identified nine nurse competence areas, namely professional or ethical values and practice, nursing skills and interventions, communication and interpersonal skills, knowledge and cognitive ability, assessment and improving quality in nursing, professional development, leadership management and teamwork, teaching and supervision and research utilization. The self assessed competence of the students manifested a higher nurse competence than that of the mentor’s assessments. It was concluded that the students overestimated their nurse competence both at the group level and mentor level.

2.6.3 Recording Based Training Programs

Nishizawa, Saito, Ogura, Kudo, Saito and Hanaya (2006) compared the non verbal communication skills between the student nurses and experienced nurses. The data for this purpose was collected by making the participants to interact with the two simulated patient each for 5 minute’s duration. This interaction was video taped beginning from the entry of the participant to the simulated patient approximately 3 minutes before nearing
the patient. These video tapes were assessed for the participant’s posture and position, gap between the patient and the nurse, eye contact and position of the face while communicating, facial expression, gestures, head nodding and self contact behavior. Detailed observation revealed that the student nurses had poor eye contact and short duration in usage of hand gestures. Overall results showed that the student nurses demonstrated a very few non verbal communication skills when compared to experienced nurses.

Jones (2007) carried out a study to explore the undergraduate nursing student’s interpersonal skills and to assess the effectiveness of tapes and transcriptions of nurse patient interaction as a teaching, learning resource by using applied conversation analysis and semi structured lecture evaluation forms analysis. Two stage approach of collecting and analyzing both the qualitative and quantitative data was used. The phase 1 included collection and analysis of the data from the student nurses to explore the actual student nurse patient communication. For this purpose, purposive sampling was used and ten student nurses from various wards were allotted and audio recorded. In phase 2, these audio clips and the conversation was made as transcripts and these were utilized for teaching the other slot of about 40 student nurses on communication skills. This was done in three stages, first is a basic lecture for 40 minutes on interpersonal skills and the principles involved in effective communication between the nurse-patient. Then the students were made to listen to the audiotape on the assessment interview along with the transcript of the conversation for about 4 minutes. Later, the student nurses were asked to evaluate the audiotape discussion using the SEGUE framework (Makoul, 2001). The overall performance of the student nurses who were audiotaped found to be unproblematic as per the participants, whereas it was not found to fulfill the policy of teaching in nursing education and also the literature. It was found to be asymmetrical where involvement of the patient was restricted. The second group’s results revealed that the usage of audiotapes and transcriptions had certainly improved the significance in their communication performance. Thus it was concluded that the audiotapes can be best utilized as a resource in teaching about communication skills.

Langewitz et al., (2010) evaluated the effectiveness of communication skills training program for oncology nurses. Using a non randomized trial design data was collected
through video recording before and after the communication skills program between 2003 to 2006. The communication skills training was administered by conducting a seminar for 2 ½ day. Later after 6 months once again a 1 ½ day booster seminar was conducted beginning of which a posttest video was recorded. The data were analysed by three trained raters by using the Roter Interaction Analysis System, by analyzing the length of uninterrupted speech, and by calculating the reciprocities. The result showed that there was significant improvement in using empathy skills, reassurance, optimistic approach and other psychosocial contents.

Norgaard, Ammentorp, Kyvik, and Kofoed (2012) investigated the impact of training course on participant’s self efficacy with a focus on communication with patients and inter-professionals. Among the 181 participants, 21 were doctors, 102 were nurses, 30 were nursing assistants, 17 were secretaries and 11 were other staff members were present. The course was done for 24 hours spread over for 3 days. On day one, the basic elements of interview, was introduced to the participants. On the second day the focus was on psychological reactions of the patients and at the end of this the participants were asked to select a topic to practice and were let to practice for six weeks. During this practice period the participants were asked to videotape the communication session along with the colleagues. After six weeks, the third day training in communication was conducted during which the participants were requested to bring the video recordings for the discussion with their trainers. The training was based on the Calgary Cambridge observation framework (Kurtz & Silverman, 1996), namely initiating the session, gathering information, explanation and planning and closing the session. It was also based on the Maguire’s (2002) work on medical communication which included attentive listening, silence and summarizing skills. The data collection was done in three phases, first pre test was done and then the communication training course and immediately a post test was done. After a gap of six months again the post test was conducted. The comparison of these three data showed that the communication self efficacy was high among nurses followed by the nursing assistants and medical secretaries. With regard to the communication with the colleagues, nursing assistants scored highest followed by doctors, nurses and medical secretaries. Except the doctors the remaining 3 professionals had a significant improvement in the communication skills from the pre test followed by the immediate post test and the six months’ late post test.
2.7 Studies conducted in India on training in communication skills

Imran (2013) had conducted a pre experimental study on evaluating the effectiveness of communication skills training program among student nurses to provide a supportive ward atmosphere for the cancer patients. Using a purposive sampling technique 2\textsuperscript{nd} and 3\textsuperscript{rd} year Bsc nursing students were enrolled for the study. Data were collected using knowledge questionnaire, patient perceived supportive ward atmosphere checklist and communication skills observational checklist. A pre test was conducted and the participants underwent the communication skills training program. After this the post test was conducted. The results showed that the knowledge, perceived ward atmosphere and observational communication skills were be significantly higher in the post test. However this study did not have control group and objective observational data was not collected either using audiotaped interview or videotaped interview.

In one of the studies, Prasad and George (2014) assessed the effectiveness of structured teaching module on therapeutic communication. Using convenient sampling, 50 staff nurses were selected. The communication module had two dimensions, namely knowledge regarding therapeutic communication and knowledge regarding interpersonal relationships. The results showed that there was a significant improvement in the communication skills after the exposure to the module. It was also found that the staff nurses had a better knowledge regarding the therapeutic communication than the interpersonal relationship. However this study was conducted on staff nurses and the focus was on therapeutic communication.

Gandhi, Mythili, and Thirumoorthy (2015) had conducted a study to evaluate the student’s perception on learning mental health assessment and therapeutic communication through traditional and modern teaching strategies. Post test only design was adopted and carried on among 44, Ill year Bsc Nursing students. The students were divided into two groups, 22 in each. For data collection, along with socio-demographic data, Student learning perception scale with 25 items under 5 domains like critical thinking, interpersonal relationship, self directed learning, and learner control and motivation for learning was also used. The reliability of the scale was 0.79. One group was assigned to traditional teaching group on mental health status assessment and therapeutic communication for fifteen hours. Another group was assigned to innovative teaching, they were also taught about the same topics for fifteen hours, but incorporated
with concept mapping, brainstorming session, and problem-based learning for 20 minutes along with the regular classes. The post test was conducted twice, first was after 2 weeks of the classes and later in the 4\textsuperscript{th} week second post test assessment was done. The results showed that on comparison of 14\textsuperscript{th} day (2\textsuperscript{nd} Week) self directed learning level and learning control and motivation of learning the innovative group students were found to have significant difference than the traditional group students. On 28th day (4\textsuperscript{th} week) comparison showed innovative teaching group students had a higher motivation of learning, learning control and self learning perception were having. They had suggested the need for including a control group in order to generalize the findings of the study.

The frameworks mentioned above were mostly meant for the purpose of the assessment of communication skills of medical students. There is no specific module or curriculum developed for the nurses or nursing students specifically. The same frameworks and assessment tools used for the medicine faculty are used even for the nursing. This may be due to non-availability of modules for the nurses and nursing students. The role of the nurse and the physician obviously differs and so as a researcher the attempt to frame a new curriculum for nurses and nursing students were made.

In Indian scenario, nursing is still a growing profession where much emphasis is not given for their upgrading their standard of training. In regard to the communication skills training for the student nurses, there are not many studies conducted in India emphasizing on imparting the skills using curriculum based training in communication skills.

The above set of review gives a clear picture about the present scenario on the communication errors that happens very commonly and leading to drastic complications that endanger the lives of patients. The present health sector remains as a great challenge for the health professionals to participate, especially staff nurses. Among the major reasons for these communication failures, lack of proper preparation of the student nurses appears to be of prime importance. Considering this fact, the researcher planned to conduct a study on the effectiveness of the communication training program for undergraduate student nurses.