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Development of a Therapeutic Communication Method Using the Delphi Technique

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Abstract

Background and Purpose: In family nursing, therapeutic communication is a method of family assessment/intervention. This study aimed to clarify specific methods for therapeutic communication. **Methods:** A questionnaire was created based on 23 therapeutic communication items identified in a previous study based on a literature review, and opinions were collected through a self-administered questionnaire survey using the Delphi technique. The Delphi technique consisted of two rounds, and the subjects were 112 expert visiting nurses. **Results:** In the first round, 35 participants responded, with a moderate agreement rate (greater than 70%) for 21 items. Based on free comments, items were modified and added at an expert meeting, raising the number of items to 26. In the second round, 32 participants responded, with a moderate agreement rate for 25 items. These 25 consisted of 11 verbal communication items, such as "Provide easy-to-understand explanations to the family"; five non-verbal communication items, such as "Be present with the family holistically"; and nine verbal and non-verbal communication items such as "Listen actively to the family". **Conclusions:** The results of the study revealed that the 25 items are specific therapeutic communication methods that can be used in clinical settings. These results suggest that therapeutic communication is superior to therapeutic conversation, in that it includes not only verbal but also non-verbal interactions.

Keywords

Family Nursing, Therapeutic Communication, Verbal Communication, Non-Verbal Communication, Delphi Technique

1. Introduction

The term "therapeutic communication", which aims to promote patient health

through communication, is said to have been coined by Ruesch in 1961, and has since been practiced as a foundation of psychotherapy [1] [2]. The importance of communication in the medical field is widely recognized, and communication is fundamental to building interpersonal relationships between medical professionals and patients [3]. Medical communication is not simply a medium for exchanging information and conveying feelings; communication itself is endowed with therapeutic meaning, such as providing a sense of security [4]. In family nursing, therapeutic communication has been developed by Hohashi as a method for family assessment/intervention [5]. Family assessment/intervention is practiced through family interviews/meetings conducted by nurses. Therapeutic communication can be an effective and efficient means of alleviating family problems, issues, difficulties or suffering, and for inducing changes in behavior. A related term is therapeutic conversation, which refers only to verbal communication [4]. Therapeutic communication differs from therapeutic conversation in that it refers to both verbal and non-verbal communication.

Therapeutic communication has been shown to improve patient satisfaction, treatment adherence, and patient knowledge [6]; facilitate the transition from active treatment to palliative care [7]; and reduce stress and burnout among healthcare professionals [8]. In healthcare, communication is a fundamental condition for establishing a relationship between patients and healthcare professionals [9], with both verbal and nonverbal communication being essential to care [10]. Therefore, it is important to understand specific methods from the perspective of therapeutic communication in family interviews/meetings.

In a previous study [11], a literature review identified therapeutic communication methods for family interviews/meetings with family members. A total of 23 subcategories were identified: 11 for verbal communication, five for non-verbal communication, and seven for verbal and non-verbal communication. Non-verbal communication refers to gestures, posture, movement (e.g., nodding, behavior), facial expressions, gaze, paralanguage (e.g., intonation, rhythm, voice quality, speed, pauses), interpersonal distance, and physical contact [5]. An example of verbal and non-verbal communication is active listening. Active listening can be verbal (e.g., responding with a nod) or non-verbal (e.g., pauses and silences, seating arrangements), and is inseparable from verbal and non-verbal communication [5]. The next step in research is to ascertain that these methods can be used in clinical settings.

The Delphi technique is a survey method in which a panel of experts is asked to submit a series of questionnaires requesting their opinions, predictions, judgments, etc. Through repeated responses, it is possible to effectively reach a consensus among a diverse group of experts [12]. The Delphi technique can present a consensus-based view as evidence in situations where sufficient evidence does not exist [13]. Therefore, based on the results of previous research [11], it is believed that the Delphi technique can be used to select therapeutic communication methods.

The purpose of this study, then, was to clarify therapeutic communication

methods in family interviews/meetings targeting nurses, using the Delphi technique.

2. Methods

2.1. Operational Definition of Terms

Therapeutic communication is defined as being "among verbal and nonverbal communications between the nursing professional and the family, interaction processes, whether intentional or unintentional, that have the effect of family intervention" [5].

Verbal communication is "communication using words" [5]. Non-verbal communication is "communication using means other than words" [5]. Verbal and non-verbal communication are "communication having the effect of both verbal and non-verbal communication" [5].

2.2. Data Collection Method

This study applied a self-administered questionnaire survey using the Delphi technique, conducted in two rounds [14]. To reach consensus on methods for therapeutic communication between nurses and families/family members, we targeted nurses working at visiting nursing stations in the local community, where they have extensive contact with families. Based on Benner's definition of an expert nurse [15], we set the study subjects as nurses with at least five years of clinical experience.

We received information about 16 visiting nursing stations in a certain town through the Japan Visiting Nursing Station Council, and explained the purpose and methods of this study to the facility directors. After receiving consent from all 16 facility directors, we distributed questionnaires to 112 nurses having at least five years of clinical experience.

2.3. Analysis Method

The questionnaire items were based on 23 subcategories from previous research [11]. An expert committee consisting of seven researchers specializing in family nursing reviewed the wording until unanimous agreement was reached, and the questionnaire items were determined.

For each item, participants were asked to check either "very important", "important", "neither important nor not", "not very important", or "not important", and each was scored on a scale of 5 to 1. The percentage of respondents who replied "very important" or "important" was then used as the agreement rate. Regarding consensus building using the Delphi technique, as the numerical value is not clearly defined a wide range of results exists across studies, and no established numerical value has been established for the agreement rate [13]. Because this study was exploratory, the agreement rate indicating consensus was set at greater than 50% [13]. We graded the agreement rates into categories: greater than 50% but 70% or less as low agreement, greater than 70% but 80% or less as medium

agreement, and greater than 80% as high agreement.

In Round 1, a free-text section was provided for each of the 23 items, allowing participants to freely write their opinions on each item. In addition, if therapeutic communication was practiced in addition to the 23 items, a free-text section was provided where participants could write their methods separately for verbal communication, non-verbal communication, and verbal and non-verbal communication. In order to revise or add items, seven researchers specializing in family nursing examined the content of the free-text section and continued to discuss the matter until reaching a unanimous agreement, ensuring the rigor of the analysis [16].

2.4. Ethical Considerations

This study was conducted after being reviewed and approved by the institutional review board of the affiliated university (Approval Number 1201). The study objectives, significance, methods, and duration were explained to the research subjects in writing. A consent form was enclosed with the questionnaire, and participants' filling and returning it constituted their agreement to participate in the study.

3. Results

Table 1 shows the demographics of respondents. Thirty-five individuals (31.3% response rate) responded in Round 1, and 32 (28.6% response rate) in Round 2. The average number of years of clinical experience was 22.2 years in Round 1 and 24.5 years in Round 2. Seven individuals (20.0%) held managerial positions in Round 1 and nine (28.1%) in Round 2.

Table 1. Participant demographics.

		Round 1 (n = 35)		Round 2 (n = 32)	
Sex	Female	28	(80.0)	27	(84.4)
	Male	7	(20.0)	5	(15.6)
Age	30s	7	(20.0)	4	(12.5)
	40s	12	(34.3)	9	(28.1)
	50s	12	(34.3)	16	(50.0)
	60s and over	4	(11.4)	3	(9.4)
Years of clinical experience		22.2 (9.8)	8 - 50	24.5 (10.4)	7 - 50
Years of clinical experience at a visiting nursing station		9.4 (8.3)	1 - 34	10.3 (7.2)	1 - 30
Position	Managerial position	7	(20.0)	9	(28.1)
	Staff member	28	(80.0)	23	(71.9)
Highest education level	University	4	(11.4)	2	(6.3)
	Vocational school	31	(88.6)	30	(93.8)

Note: Sex, age, position, and highest education level are indicated by the number (percentage). Years of clinical experience and years of experience at a visiting nursing station are shown as the mean (standard deviation) and range.

Table 2 shows the aggregated results for Rounds 1 and 2, as well as the item revision process. Below, therapeutic communication method items are indicated in double quotes, and free-form responses are indicated in single quotes.

Table 2. Therapeutic communication method items using the Delphi technique.

Round 1 items	Agreement rate	Level of agreement rate	Reason for item change	Round 2 items	Agreement rate	Level of agreement rate
Verbal communication						
Provide easy-to-understand explanations to the family.	100.0	High	-	Same as Round 1.	100.0	High
Provide necessary information to the family.	97.1	High	-	Same as Round 1.	96.9	High
Clarify family problems.	82.9	High	-	Same as Round 1.	90.6	High
Encourage independent action by the family.	68.6	Low	Modification	Encourage independent decision-making by the family.	84.4	High
Present topics to the family.	74.3	Medium	Modification	Invoke new topics with the family.	78.1	Medium
Confirm family perceptions and understanding.	100.0	High	-	Same as Round 1.	100.0	High
Elicit family needs.	94.3	High	-	Same as Round 1.	96.9	High
Ask questions to the family.	85.7	High	Modification	Ask questions to confirm what the family has valued up to now.	96.9	High
Use family language.	71.4	Medium	Modification	Use words the family uses daily and that are important to the family.	84.4	High
Elicit family concerns.	85.7	High	-	Same as Round 1.	87.5	High
Summarize family interviews.	77.1	Medium	Modification	Summarize the discussion and review it with the family.	90.6	High
Non-verbal communication						
Be present with the family holistically.	85.7	High	-	Same as Round 1.	78.1	Medium
Allow time for the family to talk.	97.1	High	-	Same as Round 1.	93.8	High
Observe changes in what the family talks about.	94.3	High	Modification	Note changes in the family.	100.0	High
Be supportive of the family.	85.7	High	-	Same as Round 1.	87.5	High
Create an atmosphere where the family feels comfortable talking.	97.1	High	-	Same as Round 1.	100.0	High
-	-	-	Addition	Use touching and massaging with the family.	53.1	Low
Verbal and non-verbal communication						
Make the family aware of their assumptions.	51.4	Low	Modification	Raise awareness of the negative thinking held by the family.	71.9	Medium
Be sincere with the family.	94.3	High	-	Same as Round 1.	96.9	High

Continued

Build trusting relationships with the family.	100.0	High	-	Same as Round 1.	100.0	High
Show empathy to the family.	100.0	High	-	Same as Round 1.	90.6	High
Share the family's strengths.	94.3	High	-	Same as Round 1.	87.5	High
Show interest in the family.	97.1	High	-	Same as Round 1.	93.8	High
Listen actively to the family.	100.0	High	-	Same as Round 1.	100.0	High
-	-	-	Addition	Maintain a neutral stance with each family member.	84.4	High
-	-	-	Addition	Respect the family's style and schedule support.	96.9	High

3.1. Verbal Communication

In Round 1, of the 11 verbal communication items, seven had a high agreement rate, three had a medium agreement rate, and one had a low agreement rate. In Round 2, of the 11 items modified based on the results of Round 1, 10 had a high agreement rate and one had a medium agreement rate.

"Encourage independent action by the family" had a low agreement rate of 68.6% in Round 1. Because previous research has shown that the meaning unit for this category includes participating in decision-making, this item was modified to "Encourage independent decision-making by the family". As a result, in Round 2, the agreement rate changed to high, at 84.4%.

"Present topics to the family" had a medium agreement rate of 74.3% in Round 1. In the free-form responses in Round 1, one participant commented, "I also talk about things and people that are important to the person and their family, even if they are not directly related to their physical condition". Furthermore, because previous research has introduced topics that are difficult to discuss in the meaning unit for this category, the item was modified to "Invoke new topics with the family". As a result, in Round 2 the agreement rate was still 78.1%, a medium agreement rate.

"Ask questions to the family" had a high agreement rate of 85.7% in Round 1. Based on the comments in Round 1's free-form responses, such as "It really brings out what the person thinks is important in life" and "It adjusts the family and patient's aspirations and what they value", the item was modified to "Ask questions to confirm what the family has valued up to now". As a result, the high agreement rate in Round 2 rose to 96.9%.

"Use family language" had a medium agreement rate of 71.4% in Round 1. Based on the comments in the free-form responses, such as "Repeat what the family says exactly" and "Speak to family members with an awareness of their developmental challenges", the item was modified to "Use words the family uses daily and that are important to the family". As a result, the agreement rate in Round 2 was high, at 84.4%.

"Summarize family interviews" had a medium agreement rate of 77.1% in

Round 1. In previous research, the meaning unit for this category has included summarizing the content of the interaction, and enabling the establishment of a common meaning of what is expressed. Therefore, this item was modified to "Summarize the discussion and review it with the family". This resulted in a high agreement rate of 90.6% in Round 2.

3.2. Non-Verbal Communication

In Round 1, all five items in the non-verbal communication showed high agreement rates. In Round 2, of the six items that were modified or added based on the results of Round 1, four showed high agreement rates, one showed medium agreement, and one showed low agreement.

"Be present with the family holistically" had a high agreement rate of 85.7% in Round 1 and a medium agreement rate of 78.1% in Round 2.

"Observe changes in what the family talks about" had a high agreement rate of 94.3% in Round 1. However, the free-form responses included "I value changes in the words and facial expressions of the patient and their family" and "I try to create an environment where they feel comfortable talking by noticing subtle changes and communicating them". Therefore, we modified the item to "Note changes in the family", which is not limited solely to family talk. As a result, the agreement rate in Round 2 was even higher, at 100.0%.

In addition, free-form responses included "Depending on the situation, touch the person by placing my hands on their back, etc." and "Provide a massage", so we added "Use touching and massaging with the family". However, in Round 2, the agreement rate was low at 53.1%.

3.3. Verbal and Non-Verbal Communication

In Round 1, six of the seven verbal and non-verbal communication items had high agreement rates, with one having a low agreement rate. In Round 2, of the nine items, which were modified or added based on the results of Round 1, eight had a high agreement rate and one a medium agreement rate.

"Make the family aware of their assumptions" had a low agreement rate of 51.4% in Round 1. In the free-form comments, one comment was, "Conversations that help families become aware of their own problems". Furthermore, because previous research has included raising awareness of negative thinking held by the family as a meaning unit for this category, this item was modified to "Raise awareness of negative thinking held by the family". As a result, in Round 2, a medium agreement rate of 71.9% was realized.

In Round 1, one free-form response read "Acting as a mediator between the patient and family, I build relationships where I can be on both sides", leading to the addition of "Maintain a neutral stance with each family member". As a result, in Round 2, a high agreement rate of 84.4% was realized.

In Round 1, one free-form response read "Even if something feels off, I don't point it out right away, but instead try to build a relationship with them" and an-

other, "For the time being, I do the same thing as the family does, but if it would be better to change the method, I listen to what the family thinks and respond accordingly", leading to addition of "Respect the family's style and schedule support". As a result, in Round 2, a high agreement rate of 96.9% was realized.

4. Discussion

4.1. Study Participants

In this study, visiting nurses with extensive experience working with families in the community served as study participants. Given their years of clinical experience, we believe we were able to gather opinions from visiting nurses who have engaged in a variety of family nursing practices.

The Delphi technique requires a wide range of sample sizes, from 10 to 100 people; however, a sample size of around 20 is acceptable if strict participant criteria are met to ensure participant quality [17]. Good results can be obtained with a sample size of 10 - 15 people, as long as the sample is homogeneous [18]. In this study, 35 participants responded in Round 1 and 32 in Round 2, which we believe were appropriate sample sizes.

4.2. Therapeutic Communication

In Round 2, only one item, "Use touching and massaging with the family", had a low agreement rate among the 26 items. Omitting this item, we believe that the remaining 25 items are effective therapeutic communication methods.

In the Calgary Family Assessment and Intervention Model (CFAM/CFIM) [19], therapeutic conversation is defined as intentional verbal communication aimed at relieving the other person's emotions, promoting understanding and aiding in problem-solving. Meanwhile, therapeutic communication as a method of family assessment/intervention is a term coined by Hohashi in the field of family nursing [5]. We believe that therapeutic communication is superior to therapeutic conversation in that it encompasses not only conversation but also nonverbal interactions. The therapeutic communication method items identified in this study have potential as methods for family assessment/intervention. We believe it is important for nurses to conduct family interviews/meetings by maintaining intentions and with each item in mind. To ensure family interviews/meetings become reliable family support techniques, nurses who work with families need to be trained in these skills.

4.2.1. Verbal Communication

"Confirm family perceptions and understanding" indicates the need to interpret the correct meaning of words used by family members. Furthermore, "Use words that the family uses daily and are important to the family" is a reliable way to clarify the specific meaning and image of words used by family members. Words having multiple meanings, referred to as "big words", can lead to misunderstandings, misconceptions, and misinterpretations in communication. When such

words are used, the specific meaning of the word must be confirmed with the other person [20].

"Invoke new topics with the family" is a horizontal question that elicits topics of similar importance and broadens the scope of the topic by changing the topic [21]. One reason for the moderate agreement rate for this item is that although nurses may bring up topics that are difficult to discuss with family members, they first build a relationship with the family before initiating the topic, and therefore rarely bring up or introduce the topic in an abrupt manner.

4.2.2. Non-Verbal Communication

"Be present with the family holistically" refers to a holistic relationship that involves being present rather than doing something. In other words, this involves simply being there for the person and accepting them as they are. It is believed essential for nurses to face families as professionals while also spending time with them as individuals, sharing the same hearts and minds. Furthermore, while family members may feel isolated when communication is lacking [22], it has been shown that the presence of nurses brings peace of mind and leads to family support [23].

"Note changes in the family" is necessary for engaging with families while capturing not only current family phenomena but also anticipated future family phenomena. It is important to capture changing family phenomena. Attention should be paid to facial expressions that reveal the emotions of others, such as whether their facial expressions are softening or whether their brows are furrowing [20]. When sensing someone's anxiety or tension, words can be used to soothe them, and speaking speed, volume, and tone of voice can be changed to make them feel comfortable talking [24].

"Create an atmosphere where the family feels comfortable talking" suggests preparing a quiet environment and creating a comfortable venue for communication, implicitly conveying that this will be a time-consuming opportunity for communication and providing the family with mental preparation and space [24]. Matching the pace of the subject's emotional expression is called pacing, which is a method of speaking by adjusting speaking speed and volume to match the other person's. Mirroring, a method of synchronizing one's movements and facial expressions with other persons, as if reflected in a mirror, is also said to make other persons feel more comfortable and accepted, facilitating discussion [25].

"Use touching and massaging with the family", which was added based on the free-form responses in Round 1, received a low agreement rate in Round 2. Touching and massage are family healing methods [26]. This result revealed that utilizing family healing is not particularly important in therapeutic communication.

4.2.3. Verbal and Non-Verbal Communication

"Raise awareness of negative thinking held by the family" is a belief conversion that transforms negative family beliefs, which are unconstructive, passive, and pessimistic, into positive family beliefs [21]. Drawing out the family's narratives

of distress embedded in negative family beliefs is believed to correct and change family beliefs, leading to a conversion to positive family beliefs.

"Share the family's strengths" praises the family's positive qualities and motivates them to solve problems. Furthermore, focusing on family strengths deepens family bonds and allows family members to view their situation from various perspectives [27]. Identifying family strengths, communicating them to family members, and helping them recognize their own strengths have a positive impact on families [28]. Clarifying family strengths and sharing them with all family members helps nurses build rapport with the family to motivate them and foster their own willingness to solve problems [29].

"Listen actively to the family" refers to an attitude of actively listening to family members and trying to understand the details of what they are saying and their feelings [30]. Active listening is optimal communication [31]. It means being supportive to gather detailed information about family members, thereby improving trust in mutual relationships and family adherence [32].

4.3. Limitations of This Study

The questionnaire response rate was low, at 31.3% in Round 1 and 28.6% in Round 2, and the findings must be interpreted with caution when making general conclusions. This study targeted visiting nurses working at visiting nursing stations, and opinions from nurses working in hospitals were not obtained. Expanding the panel would be desirable in the future. Furthermore, since using therapeutic communication methods requires understanding the intent (purpose), context, and expected effects, it would be necessary to investigate each item separately.

5. Conclusion

To clarify therapeutic communication methods in family nursing, we created a questionnaire based on 23 categories of therapeutic communication identified in a literature review of previous studies. A two-round self-administered questionnaire survey using the Delphi technique was conducted. Results showed agreement rates of greater than 70% for 11 verbal communication items, five non-verbal communication items, and nine verbal and non-verbal communication items, for a total of 25 items.

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Conflicts of Interest

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

References

[1] Ruesch, J. (1961) Therapeutic Communication. W. W. Norton & Company.

[2] Arnold, E.C. and Boggs, K.U. (2019) Interpersonal Relationships: Professional Communication Skills for Nurses. Elsevier.

[3] dos Santos, M.R., Szylit, R., Deatrick, J.A., Mooney-Doyle, K. and Wiegand, D.L. (2020) The Evolutionary Nature of Parent-Provider Relationships at Child's End of Life with Cancer. *Journal of Family Nursing*, **26**, 254-268. https://doi.org/10.1177/1074840720938314

[4] Ochoa-Dominguez, C.Y., Banegas, M.P., Miller, K.A., Orellana Garcia, C., Sabater-Minarim, D. and Chan, R.Y. (2024) Healthcare Communication Experiences of Hispanic Caregivers of Childhood Cancer Survivors. *Healthcare*, **12**, Article 1307. https://doi.org/10.3390/healthcare12131307

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

[6] Ong, L.M.L., Visser, M.R.M., Lammes, F.B. and de Haes, J.C.J.M. (2000) Doctor-Patient Communication and Cancer Patients' Quality of Life and Satisfaction. *Patient Education and Counseling*, **41**, 145-156. https://doi.org/10.1016/s0738-3991(99)00108-1

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

[8] Wako, Z., Mengistu, D., Dinegde, N.G., Asefa, T. and Wassie, M. (2021) Adherence to Adjuvant Hormonal Therapy and Associated Factors among Women with Breast Cancer Attending the Tikur Anbessa Specialized Hospital, Addis Ababa Ethiopia, 2019: A Cross-Sectional Study. *Breast Cancer*: *Targets and Therapy*, **13**, 383-392. https://doi.org/10.2147/bctt.s311445

[9] Torres, G.M.C., Figueiredo, I.D.T., Cândido, J.A.B., Pinto, A.G.A., Morais, A.P.P., Araújo, M.F.M., *et al.* (2018) Comunicação terapêutica na interação profissional de saúde e hipertenso na estratégia saúde da família. *Revista Gaúcha de Enfermagem*, **38**, e2016-e2066. https://doi.org/10.1590/1983-1447.2017.04.2016-0066

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

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

[12] Hsu, C. and Sandford, B.A. (2007) The Delphi Technique: Making Sense of Consensus. *Practical Assessment*, *Research*, *and Evaluation*, **12**, 1-8. https://doi.org/10.7275/pdz9-th90

[13] Polit, D.F. and Beck, C.T. (2016) Nursing Research: Generating and Assessing Evidence for Nursing Practice. Lippincott Williams & Wilkins.

[14] Hasson, F., Keeney, S. and McKenna, H. (2000) Research Guidelines for the Delphi Survey Technique. *Journal of Advanced Nursing*, **32**, 1008-1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

[15] Benner, P. (1984) From Novice to Expert Excellence and Power in Clinical Nursing Practice. Addison Wesley Publishing Company.

[16] Powell, C. (2003) The Delphi Technique: Myths and Realities. *Journal of Advanced Nursing*, **41**, 376-382. https://doi.org/10.1046/j.1365-2648.2003.02537.x

[17] Fujita, Y., Ueki, S., Kitao, M., Maeda, Y. and Fujiwara, C. (2018) Delphi Method Study with Nurse Participants: Survey of the Japanese Literature. *Nursing Journal of Mukogawa Women's University*, **3**, 35-42. https://doi.org/10.14993/00001212

[18] Keeney, S., Hasson, F. and McKenna, H. (2010) The Delphi Technique in Nursing and Health Research. Wiley. https://doi.org/10.1002/9781444392029

[19] Shajani, Z and Snell, D. (2023) Wright & Leahy's Nurses and Families: A Guide to Family Assessment and Intervention. F.A. Davis Company.

[20] Ambo, H. and Muto, T. (2010) Concordance: 21 Practical Skills for Empathizing with Patients. Igaku-Shoin.

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

[22] Rothausen, C.S., Clausen, A.M., Voltelen, B. and Dieperink, K.B. (2023) Protective Buffering: Nurses Facilitating Communication between Adults with Cancer and Their Adult Family Caregivers Who Overprotect One Another—An Integrative Review. *Journal of Family Nursing*, **29**, 417-436. https://doi.org/10.1177/10748407231156454

[23] Benson, J.J., Washington, K.T., Landon, O.J., Chakurian, D.E., Demiris, G. and Parker Oliver, D. (2023) When Family Life Contributes to Cancer Caregiver Burden in Palliative Care. *Journal of Family Nursing*, **29**, 275-287. https://doi.org/10.1177/10748407231167545

[24] Back, A.L., Arnold, R.M., Baile, W.F., Tulsky, J.A. and Fryer-Edwards, K. (2005) Approaching Difficult Communication Tasks in Oncology. *CA*: *A Cancer Journal for Clinicians*, **55**, 164-177. https://doi.org/10.3322/canjclin.55.3.164

[25] Ishikawa, H. (2020) An Introduction to Health Communication for Health Professionals. Taishukan Publishing.

[26] Hohashi, N. (2023) Understanding Family Health Care Nursing through Applicable Terminology: Family Transcendence Theory (Ver. 2.1). Editex.

[27] Azcárate-Cenoz, N., Canga-Armayor, A., Alfaro-Díaz, C., Canga-Armayor, N., Pueyo-Garrigues, M. and Esandi, N. (2024) Family-Oriented Therapeutic Conversations: A Systematic Scoping Review. *Journal of Family Nursing*, **30**, 145-173. https://doi.org/10.1177/10748407241235141

[28] Murray, C., Bain, L., Drake, P. and Avery, D. (2022) Stepping up and Stepping in: Exploring the Role of Nurses in Supporting Grandparents Raising Grandchildren. *Journal of Family Nursing*, **28**, 341-352. https://doi.org/10.1177/10748407221124854

[29] Martín-Martín, J., Pérez-Díez-del-Corral, M., Olano-Lizarraga, M., Valencia-Gil, S. and Saracíbar-Razquin, M.I. (2021) Family Narratives about Providing End-Of-Life Care at Home. *Journal of Family Nursing*, **28**, 17-30. https://doi.org/10.1177/10748407211025579

[30] Hohashi, N. (2023) Understanding Family Health Care Nursing through Applicable Terminology: Theory of and Introduction to Practice of Family Health Care Nursing (Ver. 3.5). Editex.

[31] Tracy, M.F., O'Grady, E.T. and Phillips, S.J. (2022) Hamric & Hanson's Advanced Practice Nursing: An Integrative Approach. Elsevier.

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