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Development and implementation of VR-simulated experiences to train communication skills

Hoek, K.

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**IMPLEMENTATION AND EVALUATION
OF A THERAPEUTIC COMMUNICATION
EDUCATIONAL PROGRAM FOR NURSES:
PROTOCOL FOR A MIXED METHOD
DESIGN**

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Authors:

Krista Hoek
Louise Suur
Monique van Velzen
Elise Sarton

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ABSTRACT

Background: Admission to a hospital can be a very stressful and anxiety-provoking experience, as patients face many unknowns that can compromise their physical and psychological well-being. Patient-centered care necessitates that healthcare organizations and professionals actively comprehend patients' experiences and values, for which effective training in communication skills is essential. Objective: This study will contribute to this field of research by evaluating a blended therapeutic communication training program.

Methods: The training consists of online e-learning, followed by a virtual reality patient-embodied experience during a 1-day didactic training with experiential small groups. Theory on therapeutic communication is taught, focusing on how to use rapid rapport techniques and hypnotic and suggestive language to facilitate empathy. This is combined with practical exercises, ensuring an active learning process. By integrating these diverse blended learning training methods, the program aims to enhance nurses' communication skills, ultimately improving patient care. Applying the Kirkpatrick model for training evaluation, this prospective study will use a convergent mixed methods study design, integrating both qualitative and quantitative data. Qualitative data will include fieldwork, as well as individual and focus group interviews with the participating nurses. Quantitative data will include questionnaires that include the first two levels of the Kirkpatrick model and that are validated for this purpose.

Results: On February 8, 2024, we received permission from the authorizing body (Institutional Science Committee and NWMO Committee) to start our study. Data collection started in April 2024 and was completed by the end of 2024.

Conclusions: This study will systematically evaluate the effectiveness of therapeutic communication training in the acute admission ward for patients who require emergency treatment. The results will yield insights into the feasibility and acceptance of the implementation of therapeutic communication training among nurses in an acute admission ward in the Netherlands.

INTRODUCTION

Admission to a hospital can be a very stressful and anxiety-provoking experience, as patients face many unknowns that can compromise their physical and psychological well-being. Hospitalization exacerbates patients' emotional reactions and may impede their ability to cope with and adjust to this new environment (1). Especially in the dynamic and acute setting of the acute admission ward, patients are susceptible to anxiety, stress, and pain (1, 2). In the acute admission ward, many medical procedures, such as invasive exams and surgery, are notorious for causing preprocedural anxiety and stress, with a prevalence varying between 11% and 80% of all adult patients undergoing surgery (3, 4). By amplifying the body's stress response and sensitizing the nervous system, preoperative anxiety is associated with more postoperative pain, chronic pain, and lower satisfaction scores (5-9).

Landmark studies on patients' experiences and values describe that anxiety and stress come from the fear of the unknown, the uncertainty of treatments and their side effects, and the loss of control (3, 10). Patient-centered care necessitates that healthcare organizations and their professionals actively comprehend patients' experiences and values (11-14). To establish high-quality and effective communication within this framework, effective training in communication skills is essential. It may assist healthcare providers in managing anxious and painful patients.

Despite its recognized importance, communication skills are not consistently or systematically taught in medical and nursing education. There is no general agreement or regulation in the educational system on how to teach and learn communication skills. Communication skills seem to be acquired 'on the job', greatly depending on implicit contextual factors rather than conventional classes or training (15). The question arises of how to best teach and learn therapeutic communication skills and how to sensitize its importance. We hypothesize that a real lived experience of a patient could be a powerful learning experience, allowing healthcare providers to develop a deeper, more empathetic understanding of the patient's perspective (16, 17). Furthermore, we hypothesize that this understanding fundamentally aids in learning therapeutic communication.

Therapeutic communication can be defined as a way of communicating with awareness of and positive influences on contextual factors (18-20). Spoken words are potent and suggestive tools that can shape future experiences and perceptions. In addition, communication includes paraverbal elements such as voice pitch, pacing, tone, and volume. Nonverbal aspects such as eye contact and body language also play a significant role in shaping perceptions of the receiver. These elements are crucial for establishing rapport between individuals during interactions. *Rapport*, defined as a close and meaningful relationship with mutual understanding, involves both verbal and nonverbal communication

(21, 22). Incorporating elements of therapeutic communication can improve patients' knowledge and understanding, foster trust, enhance self-care skills, increase treatment adherence, provide comfort, and aid in managing emotions, all of which are essential for health and well-being (23, 24).

While various communication training programs exist, there is limited research on the effectiveness of short, blended-learning approaches that integrate virtual reality (VR)-based experiential learning to enhance therapeutic communication. This study aims to address this gap by evaluating the impact of a one-day blended-learning therapeutic communication training program. The training combines electronic learning (e-learning), VR patient-embodied experience, and didactic training with experiential small groups, providing an innovative approach to skill acquisition

The main objective of this study is to evaluate the impact of our therapeutic communication training for nurses in the acute admissions ward of a tertiary hospital using Kirkpatrick's 4-level training evaluation model (25, 26) as shown in **Figure 1**. Our research questions are derived from the first two levels:

Level 1: How do participants feel about therapeutic communication training?

Level 2: Did participants learn about therapeutic communication?

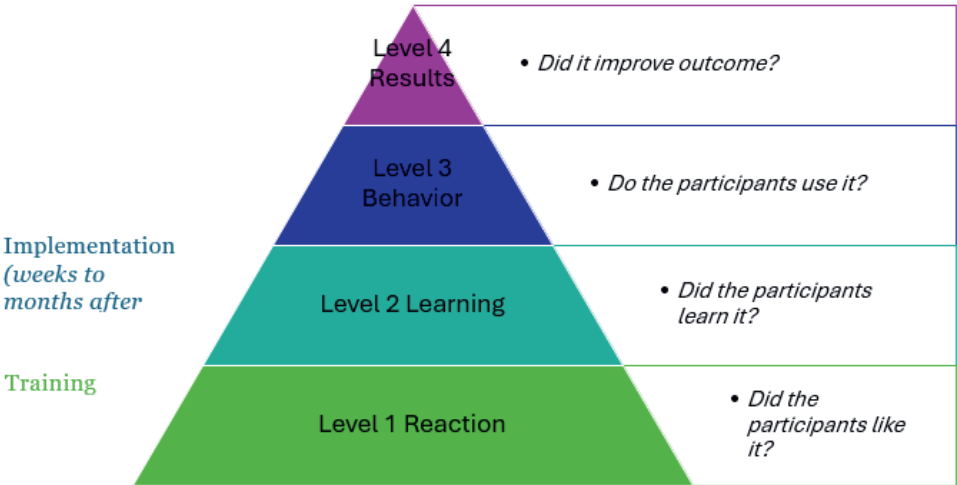


Figure 1. Kirkpatrick four-level training evaluation model

METHODS

Setting and Participants

This prospective study will be conducted at the acute admission ward of the LUMC Hospital, a tertiary teaching hospital in the Netherlands. In the acute admission ward, patients who need emergent care or treatment can be admitted for a short stay. The protocol was approved by the Institutional Science Committee as well as the non-WMO committee and will adhere to Good Clinical Practice (GCP) regulations.

To be eligible for the study, participants must daily communicate with patients or their relatives as part of their daily duties, speak proficient Dutch (local language) to be able to complete the surveys, and participate in an interview. Nurses leaving the ward within a year were excluded. For the quantitative analysis, nurses of a general ward will also be invited enhancing statistical power with a greater number of participants. In both wards, all eligible nurses were invited to participate in the TC training during working hours, and they were invited through email to participate in the study. Participants will not receive any compensation and signed an informed consent form before the start of the study. Pragmatically, the interviews will take place during working hours, inviting nurses on call on the day of the interview. To include broad data, interviews are planned during day and evening shifts on different days of the whole week.

This study will not directly involve patients in the development of the TC training, as it was designed based on established literature on patient stress and anxiety as well as previous research on the development and validation of VR-embodied experiences (16, 17).

The primary objective of this study is to evaluate the effects of the training on nurses, focusing on their perceptions and learning outcomes. Direct patient involvement in this stage would require a substantial shift in study design and ethical considerations, particularly concerning data collection from patients.

Study Design

A convergent unblinded mixed method study design in which qualitative and quantitative data are used in multiple phases and merged and analyzed equally for an interactive approach (27).

Qualitative and quantitative investigations will take place before and after the implementation of the TC training at the acute admission ward. Additional quantitative data is retrieved at a general ward.

Qualitative research, and in our case ethnography, has an important role in better understanding the social factors influencing medical and scientific routines (28). A qualitative

researcher will perform fieldwork and immerse themselves in the research population for an extended period, studying insiders' perspectives, behaviors, and culture. Qualitative outcome measures will include nonparticipatory observations, individual interviews, and focus group interviews with healthcare providers. During fieldwork, we aim to be naturalistic and nondirective, stepping back from action and minimizing interference with regular care (29, 30).

For quantitative data analysis, data saturation will be pursued (31). For quantitative outcomes, our pragmatic feasible objective is to include at least 50% of all nurses, which amounts to 20 nurses of the total 40 nurses working in the acute admission ward, and 20 of the 40 nurses in the general ward.

Intervention

Therapeutic Communication Training

The TC training was developed based on landmark patient-centered studies and included important aspects of lived patient experiences (5-8, 19, 32-35). The trainer is a hypnotherapist and anesthesiologist with extensive teaching experience currently working at the Leiden Universitair Medisch Centrum (LUMC) hospital.

The blended TC training program includes several components, including online and of-line elements, and an overview can be found in **Appendix 1**.

(1) Online e-learning: an online training module covering the basics of therapeutic communication.

(2) VR patient-embodied experience: this immersive experience enables nurses to feel firsthand what it is like to be a patient, enhancing empathy and insight. The VR experience shows the patient journey of a woman who will undergo knee surgery. She was brought into the preoperative holding area, given an IV drip, and driven to the OR. The video ended when the anesthesiologists induced general anesthesia. During the video, the healthcare providers do not apply therapeutic communication practices, show little empathy or personalized care, and give quite a few negative suggestions during the encounters. A more detailed description of the VR experience can be found in our recent work on patient-embodied VR experiences (16, 17).

(3) 1-Day didactic training: this in-person session of a maximum of 10 participants features experiential small-group activities, reinforcing the concepts learned online and in VR. The theoretical foundation of the training focuses on therapeutic communication techniques such as rapid rapport building and strategic word choice using hypnotic language. Techniques such as reframing, mirroring, and positive suggestions are emphasized while

avoiding the nocebo effects of negative language and expectations. Practical exercises ensure an active learning process, enabling nurses to apply these techniques effectively in their interactions with patients.

Quality Assurance

We hypothesized that the implementation of the TC training program would require more than an initial TC training. To facilitate the full implementation process, nurses, researchers, quality advisors, and communication experts will work together to optimize the implementation process, as shown in **Figure 2** and detailed below.

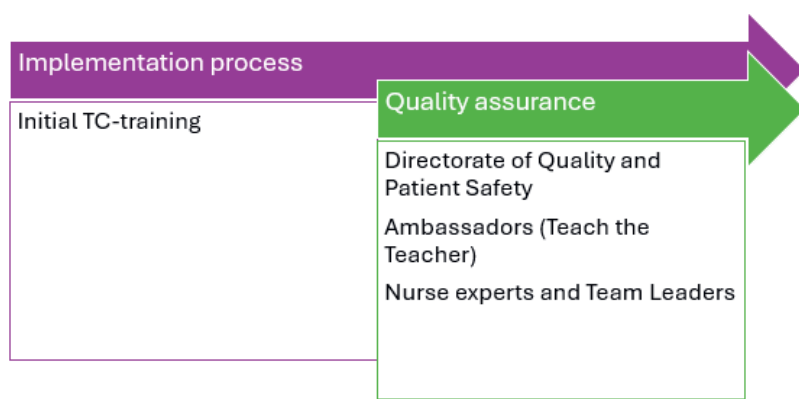


Figure 2. Implementation process

Directorate of Quality and Patient Safety

To ensure the quality of the learned knowledge of TC communication, the Directorate of Quality and Patient Safety and the Communication Department of the Hospital will be involved throughout this research project. They will meet regularly with the nurse experts and team leaders of the ward to evaluate the implementation process.

Teaching the Teacher

We hypothesized that it would be necessary to have “TC-ambassadors” on the ward to be able to answer questions, plan clinical bedside lessons, and perform practical exercises. Recruitment of the TC ambassadors will start after all nurses in the acute admission ward follow the training. After an initial briefing, an invitation will be sent to participate in “Teach the Teacher training” to become a TC ambassador. Team leaders will have the final choice of selection of these ambassadors. This training will be provided by the Radboud Academy, a partner institution of the Nijmegen Academic Medical Centre. During this course, participants will learn to obtain more in-depth knowledge on therapeutic communication, as well as the didactic competencies needed to become an ambassador of the TC program.

Outcomes and Measures

Qualitative Outcomes and Measures

We have adhered to Consolidated Criteria for Reporting Qualitative Research (COREQ) criteria for our qualitative outcomes including, among others, fieldwork, as well as individual and focus group interviews among the participating nurses before and after the training has taken place (36). The interview guide can be found in **Appendix 3**. Interviews will be audio-recorded, transcribed verbatim, anonymized, and then safely stored.

Focus group interviews are used to interview a small number of demographically similar people in social, psychological, and public health science (37). During the interviews, nurses will be asked about their perceptions, attitudes, opinions, and views regarding therapeutic communication. Group members are free to talk and interact with each other. Instead of a researcher individually asking group members questions, focus groups will be used to observe group interactions to explore and clarify the beliefs, opinions, and views of participants. During these interviews, the interviewer will take notes and record the discussion for subsequent notetaking to learn from the group. The building of the a priori template and analysis was performed by the principal investigator (KH). For practical reasons, if it is not possible to conduct a focus group interview, individual interviews will be held to gather further data.

The interviews were conducted by research interns (NK and CK), and the researchers (MVV and KH), all with extensive experience in qualitative research. Interviews after the intervention will not be performed by KH, as she is the trainer of the TC-trainer, and this might induce biases. All interviewers introduced themselves initially and did not know the participants before the commencement of the study.

Quantitative Outcomes and Measures

Quantitative outcomes include questionnaires on current knowledge of therapeutic communication, as well as validated training analysis questionnaires following the Kirkpatrick analytical model (26), and will be conducted as shown in **Figure 3**.

Kirkpatrick level 1 Reaction: What are Participants' Reactions to TC Training?

This questionnaire will be sent out after the training, including themes such as educational goals, trainees' preparation, the use of new teaching and learning methods, the use of learning tools, teaching environment, teacher assessment, and teacher characteristics on a 5-point Likert scale from very weak to excellent and can be found in **Appendix 4**. (25).

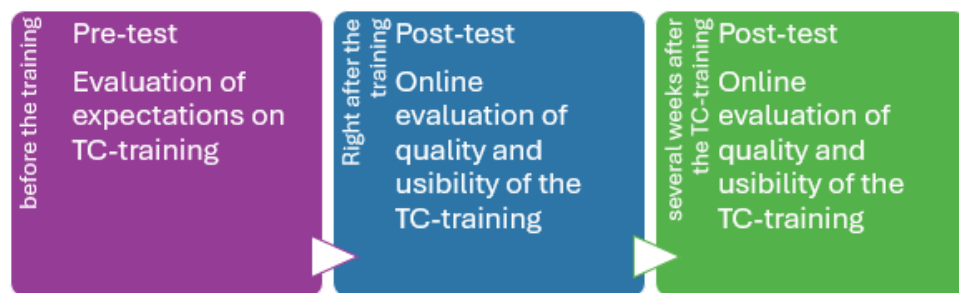


Figure 3. Data collection of quantitative data

Kirkpatrick level 2 Learning: Knowledge of Therapeutic Communication

For the purpose of this study, a standardized Nursing Education Program Implementation and Analysis (NEPIA) questionnaire was developed to evaluate knowledge of therapeutic communication. This questionnaire included five multiple-choice questions, with one or more correct answers, and can be found in Multimedia **Appendix 4**. This questionnaire was conducted and validated by a pilot of ten nurses to evaluate the clarity of the questions. Their responses will not be taken into account in further analysis. This questionnaire aims to respond to Kirkpatrick's second level: "Learning". What is the impact of TC training on participants' self-efficacy regarding therapeutic communication?

Data Analysis

All data will be kept in password-protected files with limited user access on protected hospital network drives and collected in the electronic data capture system Castor EDC. For quantitative data analysis, SPSS 25 (IBM Corp) for Windows will be used. Chi-square tests, independent *t* tests, and Mann–Whitney U tests will be used to test differences before and after training.

Qualitative analysis will be performed using template analysis (38) in ATLAS.ti (Lumivero).

Initial themes for the interviews can be found in **Appendix 3**. During the initial coding, a critical reflection will be performed (KH, MVV). If needed, themes are modified, or additional themes are added to ensure that the themes fit the data and that the data are not selectively analyzed to fit the themes. The initial analysis provided information for further participant selection and coding. Performing iterative data collection and analysis to guide decisions will improve the dependability of the results (39). The template will be further developed by applying it to the full data set. The building of the a priori template and analysis of the interviews will be performed by the principal investigator (KH). We de-contextualize the data to identify descriptions and cluster them into discrete categories. Overall, we aim to structure these experiences, and additional changes might be made to the template; more interviews might be needed. Qualitative data will be retrieved while

pursuing data saturation; that is, until we are empirically confident, additional data will not lead to any new emergent input (31, 40).

Ethical Considerations

The protocol was approved by the Institutional Science Committee and received a waiver from the institutional review board. The study will adhere to GCP regulations. Written informed consent was obtained from all participants. Participants received no financial compensation. Data will be anonymized.

RESULTS

On February 8, 2024, we received permission from the authorizing authorities (Institutional Science Committee NWMO Commissie divisie 1) to start our study. Data collection started in April 2024 and concluded at the end of 2024. We expect to publish our results in 2025.

DISCUSSION

Overview

This study evaluates the effectiveness of a one-day blended-learning therapeutic communication training for nurses, integrating e-learning, VR patient-embodied experience, and didactic small-group training. Using Kirkpatrick’s evaluation framework, we aim to assess whether this structured format enhances nurses’ communication skills, specifically measuring their reaction (Level 1) and learning outcomes (Level 2). We anticipate that the training will be feasible, well-received, and effective in improving nurses’ understanding and application of therapeutic communication techniques. If successful, this study could demonstrate the value of short, immersive training models in clinical education, particularly in fast-paced hospital environments.

Existing research underscores the importance of therapeutic communication in reducing patient anxiety and pain perception; however, most training programs are time and resource-intensive and often lack immersive experiential components. Our one-day format, enriched with VR-based patient embodiment, addresses these gaps by providing a scalable, high-impact intervention. Previous studies on therapeutic communication training have not consistently incorporated technology-driven experiential learning, making this approach unique in its accessibility and potential for broader hospital-wide adoption.

A key strength of this study is its mixed method design, ensuring a comprehensive evaluation of both subjective participant experiences and measurable learning gains. In

addition, the blended-learning approach, including VR, offers a realistic, patient-centered perspective that may enhance the long-term retention of communication skills.

Another strength of this study is the opportunity to attend the TC training during working hours, enabling all nurses to participate. The team leaders of both wards will make an effort to accommodate this in the scheduling.

A limitation of this study is that only short-term learning outcomes are assessed, leaving a long-term impact on patient care remaining to be evaluated.

Dissemination

We intend to present our results within our hospital and advocate for implementation in other wards, and if possible, hospital-wide. To enhance the dissemination process, we will use social media platforms and in-house press releases. Furthermore, we aim to publish the results of this study in appropriate peer-reviewed, open-access journals to ensure they are accessible to clinicians, researchers, educators, and other relevant stakeholders within healthcare organizations, including patients. Furthermore, dissemination through social media and institutional press will support a wider engagement within healthcare communities.

Future Implications

In the case of proven effectiveness of therapeutic communication training and implementation, future research should be conducted evaluating Kirkpatrick's level 4 training: the improvement of patient outcomes. Finally, our results may be useful for other health care institutions and implementation researchers when planning or implementing therapeutic communication skills training.

CONCLUSION

This study systematically evaluates a short, immersive therapeutic communication training program by using blended-learning methods, including VR-based patient-embodied experiences, we aim to determine its feasibility and effectiveness in improving communication skills. If successful, this training model has the potential to enhance patient care, influence hospital-wide training initiatives, and serve as a blueprint for scalable communication education programs in healthcare settings.

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Data Availability

The datasets used and/or analyzed during this study are available from the corresponding author upon reasonable request. The original audio files were unavailable due to privacy restrictions.

Authors' Contributions

K. Hoek had the original idea for the study and contributed to the conceptualization, investigation, methodology, project administration, supervision, data collection, data curation, and formal analysis.

L. Suur contributed to conceptualization and recruitment project administration and management.

M. van Velzen assisted with conceptualization, data curation, formal analysis, investigation, resources, software, supervision and participated in data validation and review & editing.

E.Y. Sarton has evolved around education in medical training. She contributed to conceptualization, project administration, supervision, visualization, data validation and review& editing

Conflicts of Interest

K. Hoek is the trainer and developer of the TC training.

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APPENDIX 1

TC-training

The training will take place between April and August 2025, one to three times per month. Two additional training days will be scheduled for any participant who was not able to follow the training on the planned date.

The TC-training will consist of the following:

->E-learning: this e-learning will be available with a personalised link 2 weeks prior to the physical training. It takes about 30-45 minutes to complete the e-learning. The e-learning deploys key insights of therapeutic communication. It encompasses the explanation of important terminology such as placebo, nocebo, negative and positive suggestions, reframing, and *rapport*.

->VR-embodied experiences. There will be 2 VR-embodied experiences available and shown on the day of physical training. The description and validation of these VR-experiences can also be found in our earlier published work (16, 17).

->physical training with a first part of theoretical knowledge and frameworks, landmark research. This is followed with hands-on training using mirroring rapport techniques and applying therapeutic communication skills with reframing in small groups.

Timeline:

E-learning: 30-45 minutes

Physical training: 5.5 hours (with 45 minutes pause included), and two VR-experiences (each around 12 minutes).

APPENDIX 2

The NEPIA questionnaire, Kirkpatrick's level 2:

Question 1: Which statement is correct?

- a. Pain leads to an increase in inflammatory markers in the blood.
- b. The brain can open or close pain gates and thus modulate pain.
- c. A high degree of stress leads to the suppression of the entorhinal cortex, thereby reducing pain perception.
- d. Shifting attention can increase pain perception.

Correct: A, B

The brain can open or close pain gates and thus modulate pain. An increase in inflammatory markers is a consequence of stress, not pain. These are very closely related. However, not every (minor) pain prick will cause increased inflammatory markers. How the brain recognizes and interprets pain depends on various factors and complex mechanisms. Pleasant stimuli (e.g., a gentle touch) can close pain gates (gate control), and the brain can also open pain gates, as seen in the feeling of a 'broken heart.' A high degree of fear and stress leads to the activation of certain areas in the brain (entorhinal cortex, insula, and anterior cingulate gyrus), enhancing pain perception. Studies using functional MRI have shown that visual and somatosensory stimuli have pain-modulating functions. Simply put shifting attention results in less pain.

Question 2: You are administering a painkiller. Which action will ensure the medication works best? Choose the best answer.

- a) Administer the medication without providing any additional information.
- b) Say that this is a very effective medication and the patient will likely feel better.
- c) Say that you see the patient is in pain and this will help.
- d) Say that you don't think this medication will work well against the pain.

Correct: B

Say that this is a very effective medication, and the patient will likely feel better. Here, you are giving two positive suggestions: you trust the medication, and you indicate that the patient will feel better. The third answer is less effective because it focuses on the patient's pain, emphasizing a negative feeling, which is unnecessary.

Question 3: What promotes coping-stimulating behaviour? Choose the best answer.

Coping: the way someone deals with problems and stress

- a. Distraction techniques
- b. Lots of empathy
- c. Commentary
- d. Apology

Correct: A

Distraction techniques. Distraction techniques promote coping-stimulating behaviour. Conversely, too much empathy, commentary, or an apology reduces coping-stimulating behaviour because these focus on negative feelings.

Question 4: Which statement is correct? Choose the best answer.

- a. Empathy always has a positive effect on a patient's comfort.
- b. Implicit factors, such as the colour or temperature of the environment, affect a patient's experience.
- c. Anxiety is a detrimental mechanism that activates limbic structures.
- d. I should always give a warning before inserting an IV.

Correct: B

Implicit factors, such as the colour or temperature of the environment, affect a patient's experience. Atmosphere can be influenced unnoticed by background noises, smells, and colours. The third answer is incorrect because anxiety is not always detrimental. Although anxiety activates limbic structures and triggers the sympathetic autonomic nervous system, causing physiological effects like tachycardia and tachypnoea, these are stress responses. The last answer is incorrect because a warning can cause anticipatory stress and increased pain. For example, when inserting an IV, it is better to ask the patient to keep their arm still or consider distracting them by asking a question at the moment of insertion (e.g., what did you have for dinner last night?).

Question 5: Which statement about the placebo effect is correct?

- a. The placebo effect only works mentally.
- b. Placebo effects can be harmful.
- c. In a randomized study, there are no placebo effects.
- d. Placebo effects can be unconscious.

Correct: D

Placebo effects can be unconscious. There are implicit or explicit placebo effects, with implicit effects being unconscious. Placebo effects can have biochemical and physiological impacts. Even in randomized studies, there can be (implicit) placebo effects.

Course evaluation Kirkpatrick level 1:

Improving the quality of continuing education requires your constructive and insightful comments and recommendations. Please help us provide effective training conditions by answering the following questions accurately.

Name of the training course: Basic Therapeutic Communication Training (TC-training)

Date of the course: [Enter the date here]

Please fill in your answer by choosing between:

- 1: very poor/little
- 2: somewhat poor/little
- 3: sufficient
- 4: somewhat good/much
- 5: very good/much

Instructor Assessment	excellent	Very good	Intermediate	weak	Extremely weak
Academic proficiency of the instructor					
Lecturing method and the ability to transfer the concepts to learners					
Ability of the instructor in class management					
Use of active teaching methods and engaging the learners					
Ability to respond to the ambiguities and questions of learners					
Frequency of using practical examples during teaching					
Course content assessment	excellent	Very good	Intermediate	weak	Extremely weak
Effectiveness of the contents of the course in increasing your knowledge					
Relationship between training course and your organizational needs					
Up-to-datedness of the contents of the course					
Quality of teaching in the training course					
Course support assessment	excellent	Very good	Intermediate	weak	Extremely weak
Your satisfaction with the duration of the course					
Desirability of educational location and environment					
Brightness and light in the classes					

Course support assessment	excellent	Very good	Intermediate	weak	Extremely weak
Ventilation and adequacy of cooling/heating system					
Catering and reception					
Treatment of authorities toward you					
Overall satisfaction	excellent	Very good	Intermediate	weak	Extremely weak
Satisfaction of the quality of workshops					
Satisfaction of the way of conducting workshops					

APPENDIX 3

Interview guide

Topic List for Before the Training (set to take between 15-45 minutes)

Topic	Question
Demographics (Round of questions - all at once)	- What is your name? - How old are you? - How long have you been a nurse/medical professional?
Pain	- What do you typically use to evaluate a patient's pain? How do you 'see' that a patient is in pain? - Is this a standard at LUMC? - Follow-up: What do you think about this? - What do you think are the most effective methods to assess pain? - What is the role of doctors in assessing/treating pain? Do they do things differently? - What are your experiences with the Central Pain Team?
Registration	It happens that the registration of NRS scores is not filled in, especially for the second measurement after a high NRS score. Why is this? Does it ever happen that a pain score does not match how a patient seems to experience the pain? How do you handle this?
Anxiety	- What do you typically use to assess a patient's anxiety? How do you 'see' that a patient is anxious? - Is there a standard at LUMC (similar to pain scores, but for anxiety)? What do you think about this? - How do you deal with an anxious patient? - What do you think are the most effective methods to assess (to 'see') anxiety? - What is your role in assessing/treating anxiety? What is the role of the doctor? Is there a difference?
TC (Not yet completed)	- What do you already know about the TC course? - Do you know why the TC course is being introduced? - What are your expectations of this course? - What would you like to learn during the course?

Topic List after the Training (set to take between 15-45 minutes)

Topic	Question
Demographics (Round of questions - all at once)	- What is your name? - How old are you? - How long have you been a nurse/medical professional? - Have you completed the TC training?
TC Training	- What did you think of the TC training? - To what extent do you think you can apply TC communication? Do you have an example? - Did the training meet your expectations? (Explain why/why not) - Do you need additional training at this time?
Pain	- During the TC training, it was discussed to evaluate pain and anxiety with a comfort score (NRS comfort), with a checkbox does the patient need more pain relief. Do you agree with this? - Do you have any other suggestions to improve pain registration?
Free	- Do you have any other points regarding pain, anxiety, and therapeutic communication that you would like to discuss?