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Edited by Ian Willey



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Nursing English Nexus

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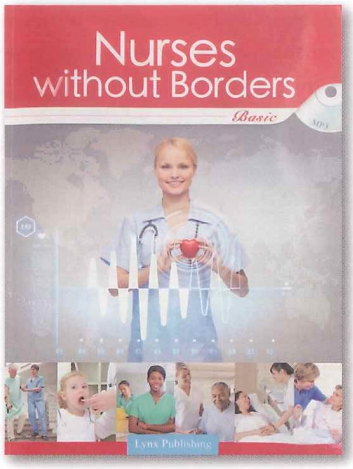
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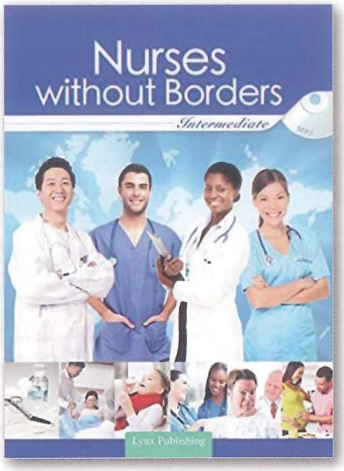
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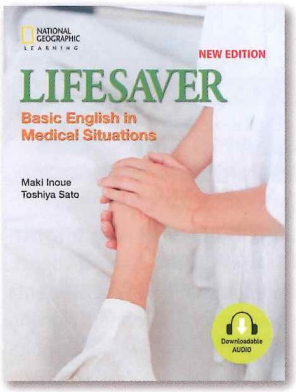
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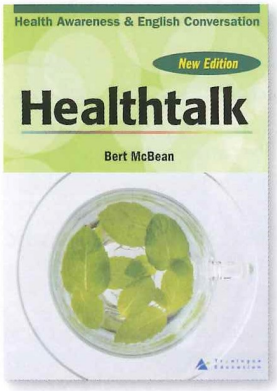
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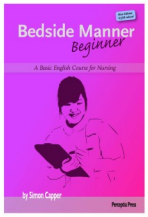
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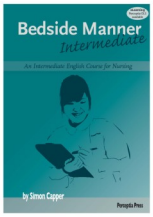


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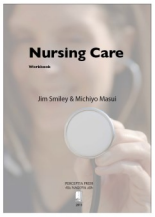


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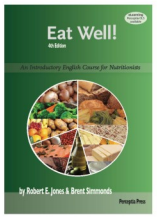


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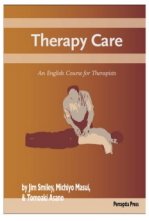


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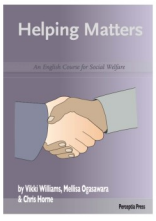


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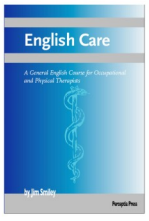


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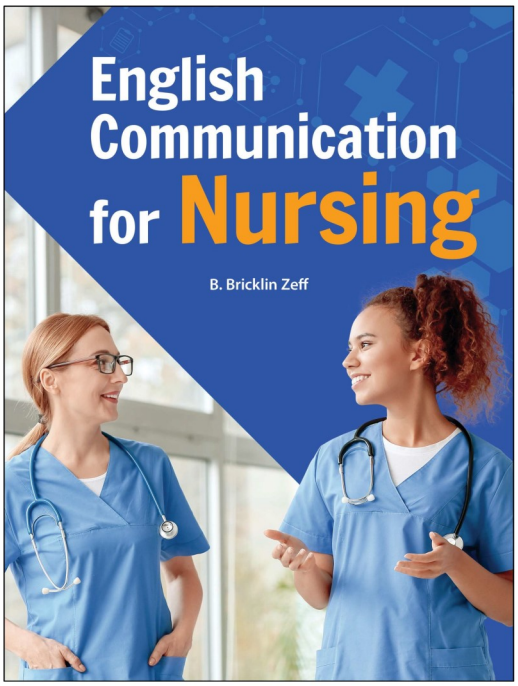
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From the Editor
Ian Willey

When Jeff Huffman asked me to take over as editor of Nursing English Nexus, my first thought was that I could never fill his shoes. I still feel that way, but thanks to Jeff, Mathew, and all the diligent and punctual reviewers, we managed to put together a great issue. We had nine submissions in total, a record for this journal.

First, Ros Wright, the plenary speaker at JANET's 2026 conference, discusses how clinical communication models can provide scaffolding to support nursing learners in developing communication skills. Next, Richard O'Shea and Timothy Williams use the Second Language Writing Anxiety Inventory to assess nursing students' attitudes towards writing.

Following this, Kumi Matsuzaki and Suma Suzuki explore nursing students' perceptions of a rubric to prepare students for study abroad programs. Yasuko Sugiyama, Izumi Dryden, and Lawrence M. Dryden then report on a study investigating how puppet-based dialogues support nursing students' communication skills and emerging professional identity.

Next, Motoko Sando reports on an investigation into stress-related loanwords in Japanese, and how their meanings may differ from the originals. Tsutako Miyazaki, Izumi Dryden, and Lawrence M. Dryden report on a study that examined the narratives of foreign patients in Japan, to highlight the cultural and linguistic challenges faced by these people.

Izumi Dryden and her co-authors then report on a nursing education framework that utilizes films scenes and memory activities to go beyond mere language acquisition, inculcating empathy and patient-centered perspectives as well.

We also have a teaching tip by Su-Jen Lai, who describes how TED Talks can be integrated into nursing English courses. Last, Takahiko Maeda, Izumi Dryden, and Lawrence M. Dryden discuss how nursing English education should be integrated into nursing curricula.

I thank all of the authors for their contributions to Nursing English Nexus. And to JANET members, or anyone reading this, enjoy! Please consider submitting a paper for the April issue. Let's go for ten!

Call for papers: We welcome anyone with an interest in any aspect of nursing English education to submit an article – in English or Japanese – in one of the following formats:

- Research articles (up to 5000 words)
- Reports (up to 2000 words)
- Introduction of current research projects (up to 1500 words)
- Discussion / observations / polemics / opinions (up to 1500 words)
- Short summaries or reviews of books or articles (up to 1500 words)
- Interviews with nursing educators/researchers (up to 1500 words)
- Reviews of nursing English materials and / or technologies (up to 1500 words)
- Short, practical teaching tips (up to 1000 words)

Submissions must be received by January 15 for the April issue and July 15 for the October issue. Information about the submission process and a style guide can be found at <https://www.janetorg.com/nexus>.

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Clinical Communication Models: A Solution to Teaching at Lower Levels?

Ros Wright (ros_wright@hotmail.com)
Clinical Communications Trainer

***Abstract**: Internationally educated nurses with lower levels of English proficiency face a dual challenge: acquiring linguistic competence while simultaneously demonstrating safe, patient-centred communication in complex environments. This paper explores how clinical communication models can provide much-needed scaffolding to support these learners in developing their skills in spoken English. It will outline practical classroom applications for nursing contexts, including escalation of care, consultations, and patient education. It will also address common pitfalls and propose strategies to encourage learners to move from formulaic use to authentic interaction. By integrating clinical communication models, trainers can deliver instruction that is both linguistically accessible and professionally credible, preparing nurses and nursing students for real-world practice. This paper will be of particular interest to teachers of English for healthcare, nursing educators, and trainers working with internationally recruited staff at lower proficiency levels.*

Keywords: clinical communication models; English for healthcare; linguistic competence; nursing educators

About the Author: Ros Wright specialises in English for healthcare. She is (co-)author of several coursebooks including the award-winning *Good Practice* (Cambridge University Press, 2008) and today runs a specialised teacher training course, *How to Teach English to Healthcare Professionals*. Ros is a former General Secretary of EALTHY and IATEFL Trustee (2017-2023).

Japanese nursing students with lower levels of English proficiency face a dual challenge: the need to acquire linguistic competence while simultaneously demonstrating safe, patient-centred communication in complex environments. In response, this paper explores how the use of clinical communication models in the teaching of nursing English might provide a possible solution.

Background

With the steady rise of long-term foreign-born residents (3.5 million in 2024), medical tourism, and the various initiatives to encourage international tourism, the need for healthcare professionals, notably nurses, who can communicate via English is now critical to healthcare provision in Japan. In 2018 this was reflected in the creation of a series of hubs responsible for treating so-called culturally and linguistically diverse (CALD) patients with more serious conditions, as well as the Japan Nursing Association's updated Code of Ethics in 2021, which requires its members to be sensitive to the needs of patients of diverse cultural backgrounds and their families.

Teaching English to Japanese nursing students presents several challenges. Porter et al. (2025) identify large, mixed-ability classes and limited content knowledge as key issues in the university sector. It is often felt that first- and second-year students may not yet be ready to engage fully with the specialised vocabulary and communication strategies of clinical practice, while anxiety around speaking and low motivation can create further barriers (Crosby, 2026; Patterson et al., 2026).

One response might be to prioritise general English until students gain greater clinical knowledge and practical experience. However, Hussin (2011) argues for more "courageous curriculum choices", challenging the assumption that learners with low English proficiency are not able to engage with ESP and emphasising that healthcare is "as much about caring as it is about curing". Introducing this principle early allows it to shape learners' communication from the outset. Using clinical communication models with students who have limited linguistic competence

and clinical knowledge represents one such curriculum choice.

What Are Clinical Communication Models?

Clinical communication models are used extensively in the healthcare setting in the English -speaking world. They are designed to enable healthcare professionals to accomplish a particular function or set of functions safely and effectively. Examples include SPIKES, a model for the delivery of bad news, and ISBAR, used to communicate key patient information during handover and escalation of care.

Kurtz et al. (2006) cite a variety of advantages to employing clinical communication models. Use of such models increases levels of accuracy and efficiency, not only during individual patient encounters, but also in terms of the overall provision of care and the eventual health outcomes for the patient. Clinical communication models increase the level of support provided to the patient and their relatives and help promote a collaborative environment, thus developing a partnership between healthcare professionals and the patient. In other words, clinical communication models go a long way to developing and maintaining a patient-centred approach to care, which in turn increases both patient and professional satisfaction.

Clinical communication models can be transposed easily into the language classroom, making use, as advocated by Dudley-Evans and St John (2005), of the "underlying methodology and activities of the discipline it serves". By incorporating such models into the curriculum, trainers endeavour to employ the methodology used in clinical communication skills training in the English-speaking world; providing a sound, evidence-based approach, which appeals to learners and stakeholders alike. In doing so, English language trainers ensure their credibility, while helping prepare learners for their future workplace.

From a pedagogical perspective, clinical communication models provide a useful framework for designing authentic tasks or even entire syllabuses. Their clear objectives create a structure around which to teach the key language learners need to perform specific clinical functions. As many focus on high-frequency tasks, they provide a relevant and legitimate basis for language input. Models such as SPIKES and ISBAR are also transferable across different scenarios, allowing them to be recycled throughout a course and incorporated into both formative and summative assessments. As a scaffolded approach to spoken communication, they can make learning more relevant, manageable, and motivating, particularly for pre-experience and lower-level learners.

Clinical Communication Models for Japanese Nursing Students

If the goal of healthcare education is to promote patient-centred care, a logical starting point is a model that develops active listening skills. SOLER is particularly suitable for pre-experience learners as it requires neither specialist knowledge nor advanced linguistic competence. Instead, it focuses on the non-verbal behaviours that signal attentiveness: sitting squarely (S), adopting an open posture (O), leaning in (L), maintaining eye contact (E), and relaxing (R). Together, these behaviours can help nurses build trust and encourage patients to express themselves more openly.

Patient-centred care also depends on managing expectations and keeping patients informed. Doing so can build rapport, reduce anxiety, and support a smoother patient journey. Evidence from the Spoken Corpus of Foreign and Immigrant Patient Narratives (2025) highlights how differences in cultural expectations and clinical procedures can disrupt this journey for CALD patients. One Latvian patient, for example, was surprised to be catheterised for a urine

sample with neither prior explanation nor request for consent, while a New Zealand patient was left uncertain as to the decision behind a sudden change from general to local anaesthetic. As the latter observed, even a brief explanation that someone was checking what was happening "would have helped". Such examples underline the important role of nurses in Japan in explaining procedures and decisions, including those involving other healthcare professionals (Porter, 2025).

AIDET offers a simple model for addressing those needs. By smiling and making eye contact, nurses first acknowledge the patient (A) before introducing themselves (I) and stating their role in the patient's care. Next, they offer a realistic duration (D) for the particular test or procedure, etc., and then explain (E) what will happen next and why. With (I), they invite questions from their patient, and finally, thank (T) him or her for their patience or understanding. By making communication more explicit and predictable, AIDET can reduce uncertainty and help prevent the kinds of surprises experienced by the patients above.

Another key nursing role is patient education. Although a South African patient praised the care she received in Japan, she did recall that nurses often had to rely on pointing to printed phrases such as "We're going to give you an injection now" or "We're going to draw your blood" to get their message across. Hussin's (2008) six-stage framework for explaining procedures could have supported clearer, more concise communication and helped facilitate the nurse's role as patient educators.

A slightly adapted version of Hussin's model breaks the explanation into the following stages: (1) explore the patient's prior understanding of the procedure, (2) explain the procedure, (3) ask for cooperation, (4) encourage the patient, (5) offer reassurance, and (6) provide feedback, e.g. on the results of the particular procedure. From there, it is then possible to identify and teach the specific language needed at each stage. This includes going to for explaining what will happen, question forms to check understanding, polite requests to gain cooperation, and simple present and past forms to provide feedback.

As the procedure is familiar and the language requirements relatively low, Hussin's adapted model is well-suited to pre-experience learners in the early stages of their course. It is also transferable to other areas of patient education, including explaining conditions, medications, tests, and investigations, allowing for recycling as the course progresses and content knowledge increases. In addition, and beyond its functional value, the model also serves to reinforce the patient-centred approach, encouraging learners to involve patients more actively in conversations and decisions about their care, and as such respond to the expectations of many CALD patients.

Another model that promotes patient centredness is the CARE protocol. Tsujimura et al. (2016) found that in Japan, nurses were "expected to sense and anticipate the patient's needs" rather than explicitly elicit them. The CARE protocol—Connect, Ask, Respond, Empathise—used during bedside handovers (Chien et al., 2022) provides an opportunity for nurses to elicit and incorporate the patient's perspective at various stages during their hospital journey in a manner that is empathic and non-judgemental. By eliciting as opposed to anticipating needs, the CARE protocol helps to empower patients and ensure they are more directly involved in the handover process.

Differences in workplace culture can negatively affect Japanese nurses working abroad. Hussin (2008) and Ilieva (2020) identified a lack of assertiveness as a particular challenge for Japanese nurses in Australia, often resulting in reluctance to question decisions or escalate care when necessary. This undoubtedly reflects the stronger emphasis on seniority and hierarchical relationships in Japanese healthcare, behaviours

that Australian colleagues may interpret as a lack of clinical reasoning or problem-solving ability (Hussin, 2008), and ones that could potentially lead to adverse health effects and compromised patient safety.

ISBAR offers a practical communication model for addressing this issue. By helping speakers organise and prioritise information, ISBAR (Identification, Situation, Background, Assessment, Recommendation) supports concise, structured communication and reduces ambiguity for the listener. Importantly, it also provides junior staff with a recognised format for voicing concerns and escalating care, enabling them to communicate more confidently, act promptly, and help prevent errors.

Challenges and Pitfalls

While limited clinical knowledge and linguistic competence in the early stages of English language training can be addressed through carefully selected models, other pitfalls remain. One attractive feature of clinical communication models is their accessible, step-by-step structure, which highlights the key expressions and grammatical forms needed to complete a task and makes the process more manageable in English. However, learners should be discouraged from relying too heavily on these models, as this risks reducing communication to a tick-box exercise; a concern that is not unique to language learners. In evaluating the SPIKES model, von Blanckenburg et al. (2020) found that, although the framework supported effective conversations when breaking bad news, communication still needed to reflect individual patient preferences rather than simply follow the six stages.

Clinical communication models therefore provide a useful starting point, regardless of learners' language proficiency, but they should not become scripts. Once learners have mastered the structure, grammar, and lexis associated with a particular function, they should be encouraged to move beyond stock phrases and personalise their language. This means adapting communication to their own style, as well as to the patient, colleague, and clinical situation, therefore avoiding interactions that sound overly formulaic or unnatural.

The Culturally Sensitive Approach

Having argued for the inclusion of clinical communication models in the teaching of entry-level Japanese nursing students, it is useful to consider the culturally sensitive approach (CSA) advocated by Crosby (2026). Central to this approach is the use of linguistic scaffolding to enable learners to participate in communication without becoming overwhelmed by the demands of spontaneous language production. Crosby further argues for a gradual progression in which early-stage tasks are highly structured, narrowly focused, and linguistically manageable.

Clinical communication models fit well within the CSA. By providing learners with a clear structure, limited communicative goals, and the language needed to achieve these goals, models such as SOLER, AIDET, Hussin's six-stage framework, and ISBAR can reduce both the linguistic and cognitive loads while building confidence in clinical interactions. For Japanese nursing students, these models may also provide a bridge between differing cultural expectations toward patient-centred communication, assertiveness, and professional roles.

Conclusion

The value of clinical communication models, however, lies not in their use as fixed scripts, but as scaffolds from which learners can progress. As linguistic competence, clinical knowledge, and confidence develop, support can be gradually withdrawn, and learners can be encouraged to adapt the language to the individual patient, colleague, or situation. As such, clinical communication models offer an accessible entry

point into English for nursing while remaining consistent with a culturally sensitive pedagogy that moves learners from structured practice towards more flexible, autonomous, and patient-centred communication.

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An Investigation of Levels and Subtypes of Second Language Writing Anxiety in Japanese Nursing Students

Richard O'Shea (oshea.richardmichael@nihon-u.ac.jp) & Timothy P. Williams
[1]School of Medicine, Nihon University

***Abstract**: Anxiety has long been recognized as an important affective variable in second language (L2) acquisition. While early research produced inconsistent findings, the development of situation-specific instruments such as the Second Language Writing Anxiety Inventory (SLWAI) has enabled more precise investigation of anxiety within specific language skills. The present study examines the levels and types of foreign language writing anxiety among Japanese second-year nursing students. A total of 34 students enrolled in a compulsory English course completed the SLWAI prior to the start of the 2025 academic year. The instrument measures three dimensions of writing anxiety: cognitive anxiety, avoidance behavior, and somatic anxiety. Descriptive statistics were analyzed using classification criteria proposed by Zhang (2011). Results indicate that 79.4% of participants experienced high levels of L2 writing anxiety, with no students falling into the low-anxiety category. Cognitive anxiety emerged as the most prevalent subtype, followed by avoidance behavior and somatic anxiety. These findings highlight the pedagogical importance of addressing cognitive, behavioral, and physiological dimensions of anxiety in order to support L2 writing development in EFL nursing education contexts.*

Keywords: English as a foreign language; nursing students; second language writing anxiety; SLWAI

About the Authors: Richard O'Shea is an assistant professor at Nihon University School of Medicine. He holds an MA in TESOL and teaches English to medical and nursing students. His research interests include second-language writing anxiety, English for medical purposes, and language education in Japanese healthcare contexts.

Timothy P. Williams is an Assistant Professor in the Office of Medical English Education at Nihon University School of Medicine, Tokyo, Japan. He holds a BA in Philosophy from University College London and an MA in Applied Linguistics from Anglia Ruskin University. His teaching and research interests include medical English education, doctor–patient communication, clinical empathy, and the development of communication skills in medical students.

The role of anxiety in second language (L2) acquisition has been a longstanding focus of research in applied linguistics. Early studies reported inconsistent findings regarding the relationship between anxiety and L2 proficiency or performance (Scovel, 1978). These inconsistencies have been attributed largely to methodological limitations, particularly the use of general anxiety measures such as trait anxiety and test anxiety scales. Such instruments fail to capture learners' affective responses that are specific to the L2 learning context (Horwitz, 1986; Horwitz et al., 1986; MacIntyre, 1999).

In response, researchers reconceptualized second or foreign language anxiety as a distinct, situation-specific construct. This theoretical shift led to the development of specialized instruments designed to assess anxiety within L2 learning environments, including Gardner's (1985) French Class Anxiety Scale and French Use Anxiety Scale, as well as Horwitz et al.'s (1986) Foreign Language Classroom Anxiety Scale (FLCAS). The adoption of these L2-specific measures has substantially advanced understanding of the relationship between anxiety and second language learning.

Empirical studies using these instruments consistently report a negative relationship between L2 anxiety and multiple dimensions of language learning. Elevated anxiety levels have been associated with negative attitudes toward L2 learning (Phillips, 1992), lower self-assessments of proficiency (MacIntyre et al., 1997), impaired language processing (MacIntyre & Gardner, 1994a, 1994b; Steinberg & Horwitz, 1986), and

reduced academic achievement in L2 contexts (Aida, 1994; Horwitz, 1986; Saito & Samimy, 1996). While these findings highlight the pervasive impact of anxiety across language skills, the present study focuses specifically on anxiety related to L2 writing.

Research on writing anxiety as a distinct component of second language learning has been well documented. Previous studies demonstrate that writing anxiety adversely affects both the quality and quantity of learners' written output. Daly (1978) found that highly anxious writers produce compositions of lower quality, characterized by shorter length and simpler syntactic structures. Using writing quality and quantity measures, Hassan (2001) similarly reported that students with lower levels of anxiety produced significantly higher-quality compositions than their more anxious counterparts. Cheng (2002) further observed that learners with high writing anxiety tend to avoid writing-intensive courses and select academic majors that place fewer demands on writing.

To systematically examine L2 writing anxiety, Cheng (2004) developed the Second Language Writing Anxiety Inventory (SLWAI), which measures physiological, cognitive, and behavioral dimensions of anxiety related to writing. The SLWAI has since been widely employed in studies involving EFL learners. However, despite its extensive use, research examining L2 writing anxiety among Japanese nursing students remains notably absent.

Recent research has approached second language writing anxiety as a multidimensional phenomenon shaped by learners' perceptions of their competence, their actual writing proficiency, and their previous writing experiences. In particular, perceived writing competence may be more closely associated with L2 writing anxiety than objectively measured writing achievement (Mat Daud et al., 2004). This distinction is important because learners who underestimate their abilities may experience substantial anxiety even when their actual performance is satisfactory. Moreover, the finding that L2 writing anxiety is distinguishable from first-language writing anxiety suggests that it is not simply a general fear of writing. Instead, it may arise from challenges specific to writing in another language, including limited linguistic resources, unfamiliar rhetorical expectations, and concerns about evaluation.

Proficiency nevertheless appears to play an important role. Research guided by the deficit hypothesis has suggested that writing anxiety may develop partly as a consequence of insufficient writing skills, with less proficient learners generally reporting greater anxiety than their more proficient peers (Mat Daud et al., 2004). From this perspective, anxiety is not necessarily the original cause of poor writing performance; it may also be a response to learners' awareness of gaps in their vocabulary, grammar, organization, or writing techniques. Anxiety and performance may therefore have a reciprocal relationship: weaknesses in writing ability can produce anxiety, while anxiety may subsequently interfere with concentration, engagement, and performance.

Studies examining the subtypes and perceived causes of L2 writing anxiety provide further insight into this relationship. For example, research involving Indonesian university students identified cognitive anxiety as the most commonly experienced subtype among both first- and second-year students (Kusumaningputri et al., 2018). Cognitive anxiety includes negative expectations, fear of evaluation, and persistent concern about performing poorly. The principal reported causes included language difficulties, insufficient writing practice, limited knowledge of writing techniques, and time pressure. Although the relative importance of these factors differed slightly by year of study, the results indicate that writing anxiety is influenced by both linguistic limitations and the conditions under which writing is taught and assessed.

Some learner characteristics may also influence anxiety. Female students have been found to report significantly higher L2 writing anxiety than male students in at least one university sample, though differences according to year of study were not statistically significant (Cheng, 2002). Such findings should be interpreted cautiously because gender effects may vary according to educational and cultural context. More broadly, the absence of significant differences between year groups suggests that additional time spent studying a language does not necessarily reduce writing anxiety. Without sufficient writing practice, constructive feedback, and opportunities to develop confidence, anxiety may persist or even increase as learners encounter more demanding academic writing tasks.

Taken together, this research suggests that effective writing instruction should address both writing competence and learners' perceptions of that competence. Explicit instruction in linguistic resources and writing techniques, scaffolded practice, manageable writing conditions, and supportive feedback may help students develop more accurate and positive perceptions of their abilities. However, most existing research has examined general university EFL populations, and comparatively little is known about L2 writing anxiety among nursing students. This is an important omission because nursing students may need to write in English for academic study, professional communication, and engagement with international healthcare literature while completing an already demanding specialist curriculum. The present study therefore examines the levels and subtypes of L2 writing anxiety among Japanese nursing students, extending the literature to an under-investigated disciplinary and educational context.

More recent longitudinal research involving Japanese university students indicates that the different dimensions of L2 writing anxiety may not develop uniformly over time. In a nine-month study of 102 first-year students, cognitive anxiety decreased across all proficiency groups, while somatic anxiety decreased among students with higher English proficiency (Oi, 2003). Avoidance behavior, however, did not decline significantly. These findings suggest that writing instruction and increased experience may reduce negative thoughts and physiological reactions without necessarily overcoming students' tendency to avoid writing. The differences observed among proficiency groups also reinforce the importance of considering learners' English ability and perceptions of academic writing when examining writing anxiety.

In a previous study, O'Shea and Williams (2025) investigated L2 writing anxiety among 111 Japanese medical students using the SLWAI. They found that 83.8% of participants experienced high anxiety, 14.4% experienced moderate anxiety, and 1.8% experienced low anxiety. Cognitive anxiety was the most prominent subtype, followed by avoidance behavior and somatic anxiety. These findings demonstrated the prevalence of L2 writing anxiety among Japanese medical students but also raised the question of whether a similar pattern would be observed among students in other healthcare disciplines. The present study builds on this earlier research by applying the same conceptual framework and instrument to Japanese nursing students.

From a psychological perspective, anxiety is commonly classified into three categories: trait anxiety, which reflects a stable personality disposition; state anxiety, which arises in response to specific situations; and situation-specific anxiety, which recurs in particular contexts. Language anxiety is generally conceptualized as a form of situation-specific anxiety (Horwitz, 2001). Building on this framework, Cheng (2004) proposed a three-dimensional model of writing anxiety consisting of somatic anxiety, cognitive anxiety, and avoidance behavior. These dimensions represent the physiological, cognitive, and

behavioral effects of anxiety on the writing process. Cheng argues that the negative relationship between test anxiety and L2 writing performance is primarily driven by cognitive anxiety rather than somatic symptoms or avoidance behavior. Accordingly, this three-dimensional framework is adopted in the present study to identify and analyze types of writing anxiety among EFL learners.

Writing anxiety is particularly relevant to nursing education, although research involving undergraduate nursing students remains limited. Mitchell et al. (2017) examined first-year baccalaureate nursing students enrolled in a discipline-specific scholarly writing course and found that instructional scaffolding could help reduce writing anxiety. This finding highlights the potential value of explicit guidance, staged writing activities, and discipline-relevant instruction. However, the study examined scholarly writing generally rather than writing specifically in an L2. Nursing students are an important population because, although they resemble medical students in being non-English majors preparing for healthcare careers, their educational experiences, professional roles, and communication needs differ. Nurses may use English when completing patient documentation and case reports, reading research articles, working in international clinical environments, and communicating with patients and other healthcare professionals. English writing anxiety may therefore affect both academic learning and students' willingness to engage in professionally relevant written communication. Nevertheless, nursing students remain underrepresented in research on L2 writing anxiety, particularly in Japan. The present study addresses this gap by investigating the levels of L2 writing anxiety and the prevalence of cognitive anxiety, somatic anxiety, and avoidance behavior among Japanese nursing students.

Accordingly, the present study extends O'Shea and Williams's (2025) investigation of Japanese medical students by examining overall levels and subtypes of L2 writing anxiety among Japanese nursing students. In addition to addressing an under-researched healthcare cohort, the study considers whether the pattern previously identified among medical students is also evident in nursing education.

The study addressed the following research questions:

1. What are the levels of foreign language writing anxiety among Japanese nursing students?
2. What types of foreign language writing anxiety are experienced by Japanese nursing students?

Method

Research Design

This study employed a quantitative, cross-sectional survey design to investigate levels and types of L2 writing anxiety among Japanese nursing students. A quantitative approach was adopted to enable the systematic measurement and statistical analysis of anxiety using a standardized instrument. The cross-sectional design allowed for the collection of data at a single point in time, providing a snapshot of participants' anxiety levels prior to formal instruction in the course.

Survey methodology was selected as it is well suited to examining affective variables such as anxiety across a group of learners in a structured and efficient manner. Data were collected using a self-report questionnaire, specifically the Second Language Writing Anxiety Inventory (SLWAI), which has been widely used in previous research on L2 writing anxiety. This design facilitated the identification of overall anxiety levels as well as differences across the three dimensions of writing anxiety: cognitive anxiety, somatic anxiety, and avoidance behavior.

Participants

A total of 34 second-year Japanese nursing students participated in this study. The participants were enrolled in a compulsory English course at a nursing college during the 2025 academic year and were approximately 19–21 years old. The sample consisted primarily of women, reflecting the gender distribution commonly found in nursing programs in Japan.

The participants were non-English majors enrolled in a general English course designed for healthcare-related communication. No standardized proficiency scores were collected as part of the study; consequently, their proficiency levels were not formally established.

Sampling Method

A convenience sampling method was employed in this study. All students enrolled in the target course were invited to participate, and the final sample consisted of those who voluntarily completed the questionnaire. As the participants were drawn from a single intact class, the sample may not be fully representative of the broader population of Japanese nursing students. However, this approach is consistent with previous classroom-based research in applied linguistics and allows for practical access to a defined learner group.

Instrument

To assess students' second language writing anxiety, the Second Language Writing Anxiety Inventory (SLWAI) was administered in accordance with the host institution's ethical guidelines. Developed by Cheng (2004), the SLWAI is a 22-item self-report questionnaire designed to measure anxiety experienced during second language writing tasks. The English version of the instrument has been extensively validated, demonstrating strong reliability and construct validity through correlational and factor -analytic procedures, with a reported Cronbach's alpha of .89 (Cheng, 2004). The complete SLWAI is shown in the Appendix.

The instrument conceptualizes anxiety across three dimensions. The Somatic Anxiety subscale comprises seven items (Items 2, 6, 8, 11, 13, 15, and 19), the Avoidance Behavior subscale comprises seven items (Items 4, 5, 10, 12, 16, 18, and 22), and the Cognitive Anxiety subscale comprises eight items (Items 1, 3, 7, 9, 14, 17, 20, and 21). Responses were recorded on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree).

Data Analysis

Data were analyzed using descriptive statistical procedures. Responses from the Second Language Writing Anxiety Inventory (SLWAI) were first coded and entered into a spreadsheet for analysis. Negatively worded items (Items 1, 4, 7, 17, 18, 21, and 22) were reverse-scored prior to calculating total and subscale scores, in accordance with the scoring guidelines provided by Cheng (2004).

For each participant, an overall writing anxiety score was computed by summing responses across all 22 items. In addition, subscale scores were calculated for the three dimensions of anxiety: cognitive anxiety, somatic anxiety, and avoidance behavior. Descriptive statistics, including means, standard deviations, and score ranges, were calculated for both the overall scale and each subscale.

To interpret the level of anxiety, mean scores were classified according to the criteria proposed by Zhang (2011), where scores above 65 indicate high anxiety, scores below 50 indicate low anxiety, and scores between 50 and 65 indicate moderate anxiety. Frequency distributions were also calculated to determine the number and proportion of participants falling into each anxiety category (high, moderate, and low).

These analyses enabled the identification of both overall anxiety levels and the relative

prominence of different types of writing anxiety among participants.

Results

Overall Levels of Writing Anxiety

As shown in Table 1, the majority of participants (n = 27) demonstrated high levels of L2 writing anxiety. The remaining participants (n = 7) fell within the moderate anxiety range, while no participants were classified as having low levels of anxiety. These findings indicate that elevated writing anxiety was prevalent across the sample.

Table 1
Distribution of Participants by Level of L2 Writing Anxiety

Anxiety level	n	%
High	27	79.4
Moderate	7	20.6
Low	0	0.0

Types of Writing Anxiety

To examine the second research question, mean scores were calculated for each of the three subcategories of anxiety: cognitive anxiety, avoidance behavior, and somatic anxiety. As presented in Table 2, cognitive anxiety emerged as the most prominent form of anxiety among participants, with a mean score of 82. This was followed by avoidance behavior (*M* = 80), while somatic anxiety recorded the lowest mean score (*M* = 69). Despite these differences, all three subscales fell within the high anxiety range, indicating that participants experienced substantial levels of anxiety across cognitive, behavioral, and physiological dimensions.

Table 2
Mean Scores for the Three Types of L2 Writing Anxiety

Anxiety type	M
Cognitive anxiety	82
Avoidance behavior	80
Somatic anxiety	69

Discussion

Overall Levels of L2 Writing Anxiety

The findings of this study indicate that a substantial majority of participants experienced high levels of L2 writing anxiety, with no students falling into the low-anxiety category. This pattern suggests that writing in English constitutes a significant source of stress for Japanese nursing students. The prevalence of high anxiety levels is consistent with previous research demonstrating that L2 learners, particularly in foreign language contexts, frequently experience elevated anxiety when engaging in productive language skills such as writing.

The prevalence of high anxiety among the nursing students broadly resembles the pattern reported by O'Shea and Williams (2025) among Japanese medical students. In the earlier study, 83.8% of medical students were classified as experiencing high writing anxiety, compared with 79.4% of nursing students in the present study. Moderate anxiety was reported by 14.4% of the medical cohort and 20.6% of the nursing cohort, whereas low anxiety was uncommon in the medical cohort (1.8%) and absent from the nursing cohort. Thus, approximately four out of five students in both studies experienced high L2 writing anxiety.

Table 3
Comparison of Writing Anxiety Levels in Medical and Nursing Students

Anxiety level	Medical students (n = 111)	Nursing students (n = 34)
High	83.8%	79.4%
Moderate	14.4%	20.6%
Low	1.8%	0.0%

These descriptive similarities suggest that high L2 writing anxiety may not be limited to medical students but may be experienced more broadly by Japanese students in healthcare-related programs. Nevertheless, the differences between the cohorts should not be interpreted as evidence that one group is more anxious than the other. The nursing sample was considerably

smaller, the data were collected in different academic years, and no inferential statistical comparison was conducted.

One possible explanation for these findings relates to learners' level of language proficiency. As noted by MacIntyre and Gardner (1989), anxiety tends to decrease as proficiency increases. The participants in the present study were non-English majors enrolled in compulsory English courses. Although proficiency was not measured using a standardized test, the students were generally judged by their experienced English instructors to be at a lower-intermediate to intermediate level. Limited linguistic resources may therefore contribute to heightened anxiety, as learners may struggle to express ideas accurately and fear making errors.

In addition, contextual factors specific to Japan may play an important role. English education in Japan has traditionally emphasized grammar, reading, and examination performance, often at the expense of productive skills such as writing. As a result, learners may have limited experience with extended writing tasks, which can increase uncertainty and anxiety when such tasks are required. Furthermore, sociocultural factors, including sensitivity to evaluation and concern about negative judgment, may intensify anxiety in academic settings.

Types of Writing Anxiety

The results further revealed that cognitive anxiety was the most prominent subtype of L2 writing anxiety among participants, followed by avoidance behavior and somatic anxiety. This pattern is broadly consistent with the theoretical framework proposed by Cheng (2002), who emphasized the central role of cognitive processes in writing anxiety.

The ordering of the three anxiety dimensions was also consistent with the previous medical-student study. In both cohorts, cognitive anxiety was the most prominent subtype, followed by avoidance behavior and somatic anxiety. This consistency suggests that concern about evaluation, negative expectations, and perceived writing performance may be particularly important features of L2 writing anxiety among Japanese healthcare students.

Cognitive anxiety encompasses negative expectations, fear of evaluation, and concerns about performance. The high levels of cognitive anxiety observed in this study suggest that participants are particularly affected by evaluative pressure in writing contexts. This finding aligns with research by Horwitz (2001), which highlights fear of negative evaluation as a core component of foreign language anxiety. Learners who anticipate criticism or failure may experience intrusive thoughts that interfere with concentration and task execution, thereby impairing writing performance.

Avoidance behavior emerged as the second most prevalent type of anxiety. This indicates that a considerable number of students cope with writing-related stress by disengaging from writing tasks or delaying their completion. Such behaviors are problematic in the context of language learning, as writing proficiency develops through sustained practice and feedback. Avoidance may therefore contribute to a negative cycle in which reduced practice leads to lower proficiency, which in turn reinforces anxiety.

Although somatic anxiety was the least prominent subtype, it was nevertheless present at relatively high levels. This suggests that writing anxiety is not solely a cognitive or behavioral phenomenon but also involves physiological responses such as tension and discomfort. The presence of somatic symptoms further underscores the intensity of anxiety experienced by participants and highlights the need for a holistic understanding of L2 writing anxiety.

Pedagogical Implications

The findings of this study have several important

implications for language teaching, particularly in English for Specific Purposes (ESP) contexts such as nursing education. Given the high levels of cognitive anxiety observed, instructors should prioritize strategies that reduce fear of evaluation and create a supportive learning environment. For example, incorporating low-stakes writing activities, formative assessment, and opportunities for revision may help learners develop confidence without the pressure of high-stakes grading.

In addition, process-oriented approaches to writing instruction may be beneficial. By emphasizing drafting, feedback, and revision rather than final products alone, teachers can help students view writing as a developmental process rather than a one-time performance. Peer feedback activities may also reduce anxiety by normalizing errors and fostering collaborative learning.

To address avoidance behavior, it is important to increase students' engagement with writing tasks in a structured and manageable way. Breaking assignments into smaller components and providing clear guidance can make writing tasks feel less overwhelming. Furthermore, integrating discipline-specific writing tasks relevant to nursing—such as case reports or patient documentation—may enhance motivation and perceived relevance.

Finally, given the presence of somatic anxiety, instructors may consider incorporating strategies to help students manage stress, such as brief relaxation techniques or classroom practices that promote a low-anxiety atmosphere. Addressing anxiety from cognitive, behavioral, and physiological perspectives may lead to more effective learning outcomes.

Limitations and Future Research

Several limitations should be acknowledged when interpreting the findings of this study. First, the sample size was relatively small (n = 34) and drawn from a single institution, which limits the generalizability of the results. Future studies with larger and more diverse samples would provide a more comprehensive understanding of L2 writing anxiety among nursing students.

Second, the study relied on self-report data collected using a questionnaire, which may be subject to response bias. Participants' perceptions of their anxiety may not fully reflect their actual experiences in writing tasks. Third, the cross-sectional design captures anxiety at a single point in time and does not account for potential changes over the duration of the course.

Finally, while the questionnaire was provided in both English and Japanese, subtle differences in interpretation may have influenced responses despite efforts to ensure translation accuracy.

Future research could build on the findings of this study by employing longitudinal designs to examine how writing anxiety evolves over time, particularly in response to instructional interventions. Experimental studies investigating the effectiveness of specific pedagogical strategies for reducing writing anxiety would also be valuable.

Conclusion

This study demonstrates that a substantial majority of Japanese nursing students experience elevated levels of L2 writing anxiety. Cognitive anxiety was the most prevalent subtype, followed by avoidance behavior and somatic anxiety. When considered alongside O'Shea and Williams's (2025) findings, the present results suggest that elevated L2 writing anxiety, particularly cognitive anxiety, may be common across different groups of Japanese healthcare students. Replication of the same general pattern in a nursing cohort extends the earlier findings beyond medical education, although the small, single-institution sample means that broader generalization requires further research.

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Appendix

Second Language Writing Anxiety Inventory

1. While writing in English, I am not nervous at all.
英語で書いている間、私はまったく緊張していません。
2. I feel my heart pounding when I write English compositions under time constraints.
限られた時間の中で英作文を書いているとドキドキします。
3. While writing English compositions, I feel worried and uneasy if I know they will be evaluated.
英作文を書いていて、評価されるとわかったら不安や心配です。
4. I often choose to write down my thoughts in English.
私は自分の考えを英語で書き留めることをよく選びます。
5. I usually do my best to avoid writing English compositions.
私は通常、英語の作文を書かないように最善を尽くします。
6. My mind often goes blank when I start to work on an English composition.
英作文を書き始めると頭が真っ白になることがよくあります。
7. I don't worry that my English compositions are a lot worse than others.
私の英語の作文が他の人よりずっと下手だという心配はありません。
8. I tremble or perspire when I write English compositions under time pressure.
時間のプレッシャーの中で英作文を書くと、震えたり汗をかいたりします。
9. If my English composition is to be evaluated, I would worry about getting a very poor grade.
もし私の英語の作文が評価されるなら、私は非常に悪い成績をとることを心配するだろう。
10. I do my best to avoid situations in which I have to write in English.
英語で書かなければならない状況を避けるために最善を尽くします。
11. My thoughts become jumbled when I write English compositions under time constraints.
限られた時間の中で英作文を書くと頭が混乱する。
12. Unless I have no choice, I would not use English to write compositions.
やむを得ない場合を除き、作文に英語を使用することはありません。
13. I often feel fear when I write English compositions under time constraints.
限られた時間で英作文を書くと、恐怖を感じることがよくあります。
14. I am afraid that the other students would laugh at my English composition if they read it.
他の学生が私の英語の作文を読んだら、笑ってしまうのではないかと心配しています。
15. I freeze up when unexpectedly asked to write English compositions.
思いがけず英語の作文を書くように頼まれたとき、私はフリーズします。
16. I would do my best to excuse myself if asked to write English compositions.
英語の作文を書くように頼まれたら、できるだけ言い訳します。
17. I don't worry at all about what other people would think of my English compositions.
自分の英語の作文が他の人にどう思われるか、まったく気にしない。
18. I usually seek every possible chance to write English compositions outside of class.
私は通常、授業以外で英語の作文を書くあらゆる機会を探しています。
19. I usually feel my whole body rigid and tense when I write English compositions.
英作文を書くときは、たいてい全身がこわばり、緊張します。
20. I am afraid of my English composition being chosen as a sample for discussion in class.
クラスでのディスカッションのサンプルとして、私の英語の作文が選ばれるのではないかと心配しています。
21. I am not afraid at all that my English compositions would be rated as very poor.
私の英語の作文が非常に悪いと評価されることをまったく恐れていません。
22. Whenever possible, I would use English to write compositions.
可能な限り英語を使って作文を書いていました。

Identifying Challenges in Applying the AAC&U VALUE Rubrics: A Preliminary Study of Japanese Nursing Students' Perceptions of Short-term Study Abroad Programs

Kumi Matsuzaki (k-matsuzaki@rctoyota.ac.jp) & Suma Suzuki
Japanese Red Cross Toyota College of Nursing

***Abstract**: Fostering intercultural competencies through study abroad programs is increasingly important in nursing education. While the Valid Assessment of Learning in Undergraduate Education (VALUE) Rubric, developed by the Association of American Colleges and Universities (AAC&U), is widely recognized for assessing these outcomes, its applicability to the specific learning context of Japanese nursing education remains unclear. This study explored nursing students' perceptions of the rubric to identify structural and cognitive challenges associated with its use. Semi-structured interviews were conducted with nine nursing students who participated in short-term study abroad programs and completed the rubric. The transcripts were analyzed using an inductive open-coding approach. Meaningful statements were extracted, coded, and grouped into categories. Four categories emerged: (1) Challenges in Rubric Wording and Conceptual Clarity; (2) Structural Challenges of the Rating Scale; (3) Misalignment Between the Program and the Rubric; and (4) Reflective Benefits of Rubric Use. The findings indicated linguistic, structural, and contextual barriers, while also highlighting the rubric's value in promoting reflection. Although the rubric functioned as a reflective catalyst for intercultural learning, linguistic, structural, and contextual barriers limited its effectiveness. These findings suggest that adapting rubrics for nursing education requires contextual translation that enables students to relate evaluation criteria to their experiences and learning contexts, rather than relying solely on direct linguistic translation.*

Keywords: AAC&U; intercultural learning; interviews; study abroad programs; VALUE Rubric

About the Authors: Kumi Matsuzaki is an associate professor at the Japanese Red Cross Toyota College of Nursing. Her research interests include internationalization in higher education and international students' mobility. Suma Suzuki is an associate professor at the Japanese Red Cross Toyota College of Nursing. Her research interests include English education and cooperative learning.

In higher education, internationalization of the curriculum, defined as the integration of international, intercultural, and global dimensions into program content, learning outcomes, assessment, and student support services (Leask, 2015), is crucial for fostering a global perspective among students. In Japanese nursing education, this need has become increasingly important because nurses are expected to provide culturally responsive care for people from diverse linguistic and cultural backgrounds. Growing international migration, expanding cross-border activities, increasing numbers of international visitors and foreign workers, and global health challenges such as the COVID-19 pandemic, have further highlighted the need to prepare nurses for culturally diverse healthcare settings (Huffman et al., 2020; Okugawa, 2021). The Japan Association of Nursing Programs in Universities (JANPU, 2025) emphasizes the development of competencies to support culturally diverse populations. Its recommended learning outcomes include understanding global health issues as well as the domestic impact of foreign residents' social status—such as language and visa types—on medical practices. Consequently, to address these educational goals, many nursing schools have implemented international learning opportunities, including study abroad programs. Such international exposure has been shown to significantly increase students' understanding of the health challenges faced by foreign residents in Japan (Nishihara et al., 2017).

As international learning opportunities have expanded, various approaches have been used to evaluate their educational effectiveness. Existing

studies have employed a wide range of instruments, including measures of social skills, intercultural understanding, and global competence (Miyazawa et al., 2012; Nakamura et al., 2023). Huffman et al. (2020), for example, identified multiple learning outcomes among Japanese nursing students participating in study abroad programs, including knowledge of nursing practices and health care systems, cultural awareness and sensitivity, English-language proficiency, motivation, and personal and professional development. This diversity of learning outcomes highlights the importance of using assessment approaches that can capture multiple dimensions of students' learning experiences.

Among these assessment approaches, Numazawa et al. (2020) used a modified version of the Intercultural Knowledge and Competence VALUE Rubric developed by the Association of American Colleges and Universities (AAC&U, 2009) to evaluate a short-term study abroad program for nursing students. Their study reported positive outcomes across the domains of knowledge, skills, and attitudes, suggesting the potential usefulness of the rubric for assessing intercultural learning in nursing education.

However, limited information was provided regarding how the original rubric was modified and adapted to the educational context of the program. As a result, it remains unclear whether the modified rubric adequately reflected students' learning experiences and whether students interpreted the assessment criteria as intended. Stevens and Levi (2014) argue that rubrics should be adapted to fit specific educational contexts and purposes. Therefore, examining how students understand and apply rubric criteria is an important step in evaluating the appropriateness of the assessment framework within Japanese nursing education.

Therefore, the purpose of this study was to explore the challenges in the existing AAC&U rubric through interviews with nursing students who participated in short-term study abroad programs. By analyzing students' perceptions and uncertainties during self-evaluation, this study aims to identify the structural and cognitive challenges of the rubric as an assessment tool, providing insights to develop a contextually appropriate rubric optimized for nursing education and its specific institutional philosophies.

Methods

Research Design

This study employed a qualitative exploratory design using semi-structured interviews with nursing students who had participated in short-term study abroad programs. The VALUE rubrics, developed by AAC&U, were adopted as the analytical focus because they are internationally recognized open-source frameworks widely used to assess intercultural knowledge, competence, and global learning outcomes in higher education. Although the VALUE Rubrics encompass 15 domains, it is recommended that they be appropriately modified and contextualized to suit the specific language, academic major, and program. To examine changes in students' attitudes and awareness regarding the understanding of intercultural diversity and global perspectives—which aligns with the objectives of the study abroad programs conducted at our university—this study selected eight specific components from two rubrics. From the Intercultural Knowledge and Competence VALUE Rubric, six components were chosen: (1) Cultural self-awareness (Knowledge), (2) Knowledge of cultural worldview frameworks (Knowledge), (3) Empathy (Skills), (4) Verbal and nonverbal communication (Skills), (5) Curiosity (Attitudes), and (6) Openness (Attitudes). Additionally, two components were selected from the Global Learning VALUE Rubric: (7) Global self-awareness and (8) Perspective taking. Their theoretical

grounding and broad applicability made them an appropriate starting point for examining how such competencies are interpreted and assessed in nursing education in a Japanese study abroad context.

Participants and Setting

Participants were recruited from a nursing college in Japan via purposive sampling. The inclusion criteria specified that nursing students had participated in co-curricular or extra-curricular study abroad programs. The program destinations included Thailand, Cambodia, Korea, and Australia, with each program lasting two weeks or less.

A total of nine students, who joined one or more programs, agreed to participate in the study. The individual semi-structured interviews were conducted face-to-face between May and November 2025, approximately 2 to 8 months after participants completed their respective programs (or their most recent program).

Data Collection and Interview Process

As part of the program evaluation, participating students completed the official Japanese translation of the AAC&U VALUE Rubrics (AAC&U, 2009)—specifically focusing on the eight components selected from the two rubrics mentioned above (see Appendix A)—prior to and/or immediately following their respective study abroad programs.

After completion of the programs, students who agreed to participate in this study were invited to take part in an individual semi-structured interview, lasting 60 to 80 minutes. An interview guide developed by the researchers (see Appendix B) was used to collect interview data. During the interviews, participants were asked to review their previous rubric responses. Each self-evaluation rating was followed by an in-depth inquiry into the rationale behind their choices, the specific impacts affecting their experiences, and their interpretations of the rubric text.

Furthermore, participants were explicitly asked about the clarity and comprehensibility of the descriptions, as well as their overall impressions of the rubric layout and phrasing. With the participants' prior written consent, all interviews were audio-recorded and subsequently transcribed verbatim for analysis.

Data Analysis

The verbatim transcripts were analyzed using an inductive open-coding approach to systematically abstract and categorize the textual data (Graneheim & Lundman, 2004). To ensure trustworthiness, two researchers independently read the transcripts repeatedly to achieve deep familiarization with the data. Meaningful statements reflecting students' struggles, confusion, or perceptions of the rubric were extracted and assigned open codes. These codes were then progressively clustered into subcategories and overarching conceptual categories based on their similarities and homogeneity.

Although participants were prompted with predefined rubric domains during the interviews, the analysis focused on capturing patterns in their interpretations and perceived challenges rather than applying an a priori coding framework. Throughout the analytic process, the researchers held ongoing discussions to resolve discrepancies, enhance reflexivity, and refine the final categorization. The insights gained from this process provide a foundation for revising and contextualizing the rubric to suit the attributes and learning environments of nursing students.

Ethical Considerations

This study was approved by the Institutional Review Board of the Japanese Red Cross Toyota College of Nursing (Approval No. 2433). Prior to data collection, researchers provided both written and verbal explanations regarding the study's purpose, methods, and ethical safeguards to all

potential participants. Written informed consent was obtained from all participants prior to the interviews. Participants were assured that their participation was entirely voluntary, that they could withdraw from the study at any time without penalty, and that all data would be anonymized using linked anonymization to protect their privacy.

Results

Overview of Extracted Categories

The analysis focused primarily on rubric-related challenges identified in participants' responses. All nine participants reported experiencing some form of difficulty or uncertainty when using the rubric for self-assessment. Through the open-coding process, the data were systematically abstracted into four categories, nine subcategories, and 21 representative codes. Table 1 summarizes the categories and subcategories, while the complete coding framework is provided in Appendix C. In the following sections, the findings are presented narratively under each category, with subcategories integrated into the text to illustrate key themes identified in the analysis.

Category 1: Challenges in Rubric Wording and Conceptual Clarity

This category describes participants' difficulties in understanding the wording and concepts used in the rubric. Three subcategories were identified: use of academic and discipline-specific terminology, ambiguity in evaluating broad concepts, and excessive information in rubric wording.

Participants frequently reported difficulty understanding specialized terminology used in the rubric. Terms such as "cultural worldview" and "suspending judgement" were unfamiliar to many participants and made interpretation of the rubric challenging. Some participants also indicated that concepts related to intercultural understanding and global learning were difficult to grasp because they are rarely considered in their everyday life. As a result, participants were often uncertain whether they had interpreted the rubric as intended.

Participants also described challenges in evaluating broad concepts such as empathy and worldview. They explained that these concepts were too abstract to determine what aspects of themselves should be evaluated and what criteria should be applied. Similarly, expressions such as "in historical or contemporary contexts" were viewed as ambiguous, and participants often struggled to relate them to their own experiences.

Finally, participants indicated that some rubric descriptors contained excessive amounts of information. Lengthy statements made it difficult to identify the main point of each performance level and increased the effort required to complete the self-assessment.

Category 2: Structural Challenges of the Rating Scale

This category reflects structural characteristics of the rating scale that made self-assessment difficult. Three subcategories were identified: co-

Table 1
Extracted categories and sub-categories

Category	Subcategory
1. Challenges in Rubric Wording and Conceptual Clarity	1-1. Use of Academic and Discipline-Specific Terminology 1-2. Ambiguity in Evaluating Broad Concepts 1-3. Excessive Information in Rubric Wording
2. Structural Challenges of the Rating Scal	2-1. Co-occurrence of Multiple Evaluation Dimensions Within a Single Performance Level 2-2. Ambiguity in Performance-Level Gradations 2-3. Perceived Discontinuity Between Performance Levels and Need for Finer Gradation
3. Misalignment Between the Program and the Rubric	3-1. Misalignment Between the Rubric and On-Site Experiences
4. Reflective Benefits of Rubric Use	4-1. Facilitation of Reflection and Deepened Self-Understanding. 4-2. Broadened Perspectives and Identification of New Goals

occurrence of multiple evaluation dimensions within a single performance level, ambiguity in performance-level gradations, and perceived discontinuity between performance levels and need for finer gradations.

Participants identified several structural issues, including the fact that a single performance level often encompassed multiple dimensions, such as knowledge, attitudes, and skills. However, participants perceived their level of achievement differently across these dimensions. For example, they might have considered their knowledge to correspond to a higher performance level while perceiving their skills as corresponding to a lower level. As a result, they found it difficult to select a single response option that accurately represented their overall achievement. When their perceived levels differed across dimensions, some participants therefore selected an intermediate level as a compromise.

Category 3: Misalignment Between the Program and the Rubric

This category describes discrepancies between the evaluation criteria and participants' actual learning experiences during the study abroad program.

Many participants perceived a misalignment between some rubric items and the on-site experiences during the program. Several participants felt unable to evaluate themselves on items related to history and religion because they had limited opportunities to engage with these topics during their study abroad experience. Others reported that certain rubric descriptors referred to experiences they had not encountered during the program. These findings suggest that some aspects of the rubric were not fully aligned with the specific content and learning opportunities provided within the study abroad program. As a result, participants occasionally found it difficult to provide meaningful self-assessments for certain items.

Category 4: Reflective Benefits of Rubric Use

Although participants identified various challenges associated with the rubric, they also described several educational benefits that emerged through the self-assessment process. Two subcategories were identified: facilitation of reflection and deepened self-understanding, and broadened perspectives and identification of new goals.

Participants frequently reported that completing the rubric encouraged them to reflect on their experiences more carefully. The self-assessment process prompted them to reconsider what they had learned during the program and to recognize aspects of their personal growth that they had not previously noticed. Many participants described gaining a deeper understanding of themselves and their learning through this reflective process.

Participants also indicated that the rubric broadened their perspectives and encouraged them to think about future development. Reflecting on the rubric helped them become aware of viewpoints different from their own and prompted consideration of areas for further improvement. For some participants, the rubric served as a catalyst for setting new learning goals and aspirations beyond the study abroad experience.

Overall, these findings suggest that, despite certain limitations, the rubric functioned not only as an assessment tool but also as a means of promoting reflection, self-awareness, and future-oriented learning.

Discussion

Linguistic and Structural Challenges in Applying the AAC&U VALUE Rubric

This study explored Japanese nursing students' perceptions of the AAC&U VALUE Rubric following participation in short-term study abroad programs. The findings demonstrated that the challenges experienced by participants were

attributable not only to language translation but also to the conceptual and structural characteristics inherent in the rubric itself.

Participants frequently reported difficulty understanding academic terminology and abstract concepts, such as cultural worldview and suspending judgment. Given that these concepts fall outside students' everyday experiences and the specific learning context of undergraduate nursing education, they were often uncertain whether they had correctly interpreted the criteria before attempting self-assessment. Although these concepts are fundamental to intercultural learning, they were unfamiliar to many students and difficult to relate to students' own experiences. Previous studies have emphasized that existing assessment rubrics require contextual adaptation to ensure meaningful interpretation across educational and cultural settings (Stevens & Levi, 2014). Our findings support this view by demonstrating that students struggled not only with unfamiliar terminology but also with abstract concepts and expressions that were difficult to connect to their own study abroad experiences.

In addition to terminology, participants identified structural problems within the rating scale. Performance-level descriptors often combine multiple dimensions, such as knowledge, attitudes, and skills. This multi-dimensionality makes it difficult for students to determine a single rating when these dimensions develop unevenly. Furthermore, distinctions between adjacent performance levels were frequently perceived as ambiguous, leading many participants to choose intermediate ratings as a compromise rather than as an accurate reflection of their learning. These findings suggest that adapting the AAC&U VALUE Rubric for Japanese nursing education requires not only simplification of terminology and clarification of abstract concepts but also refinement of the rating structure to improve usability and interpretability. Such adaptation may enhance students' ability to engage in meaningful self-assessment and more accurately evaluate their intercultural learning outcomes.

Alignment Between Rubric Expectations and Learning Experiences

Another critical finding was the misalignment between the learning experiences provided by short-term study abroad programs and the competencies assumed by some rubric descriptors. Several participants reported difficulty evaluating criteria related to historical, religious, or broader cultural contexts because these topics had not been addressed explicitly during their programs. Instead, students described intercultural learning as emerging primarily through daily interactions, observations, and communication with local people rather than through structured academic learning. Consequently, some rubric descriptors required students to evaluate competencies that they had limited opportunities to develop.

This finding highlights the importance of aligning assessment criteria with intended learning outcomes and actual learning opportunities. Assessment tools should encourage reflection while remaining grounded in the experiences that students can realistically encounter during short-term study abroad programs. To address this mismatch, literal linguistic translation alone may be insufficient. Rather, contextual translation is needed, whereby evaluation criteria are adapted so that students can relate them to their actual experiences and learning environments. Such contextual translation may help the rubric accurately capture the unique cognitive and non-cognitive outcomes fostered in nursing education.

The Rubric as a Reflective Catalyst

Despite these challenges, participants consistently described the rubric as educationally valuable. Completing the self-assessment encouraged students to revisit their study abroad experiences,

organize their thoughts, recognize personal growth, and identify future learning goals. Several participants also reported that the rubric introduced perspectives they had not previously considered, thereby broadening their understanding of intercultural learning.

These findings suggest that the rubric functions not only as an assessment instrument but also as a catalyst for structured reflection that promotes deeper learning. However, this reflective potential may be limited by linguistic and structural barriers within the rubric. The cognitive effort required to interpret unfamiliar terminology, navigate multidimensional performance-level descriptors, and resolve ambiguous gradations diverts students' attention away from reflection on their learning experience. If these linguistic and structural barriers are addressed through careful customization, the rubric may better support reflective learning and more effectively facilitate intercultural self-assessment.

Implications for Developing a Contextually Appropriate Nursing Rubric

The insights gained from this study offer significant implications for developing a contextually appropriate assessment tool. First, the educational value of the rubric could be further enhanced by introducing it before students participate in study abroad programs. Familiarity with the rubric and its underlying concepts prior to departure may help students consciously observe intercultural experiences throughout the program instead of viewing the rubric solely as a post-program evaluation tool. Rather than functioning as an assessment instrument, the rubric can serve as a learning scaffold that supports students' observation, reflection, and meaning making throughout the learning process.

Furthermore, the customization process should integrate the institution's educational philosophy and the values of the nursing profession. In the context of our college, this may include humanitarian values and respect for human dignity embodied in the Fundamental Principles of the Red Cross, thereby strengthening the connection between intercultural learning and professional identity formation. A value-based, contextually translated rubric may more effectively support the continuous reflective learning and professional development of nursing students.

Conclusion

This study explored the structural and cognitive challenges associated with applying the internationally recognized AAC&U VALUE Rubric to Japanese nursing students participating in short-term study abroad programs. An inductive open-coding analysis of student interviews revealed that, while the rubric demonstrated considerable potential as a reflective catalyst for intercultural learning, its current form presented significant linguistic and structural barriers. The multidimensionality of performance-level descriptors and ambiguous gradations often led students to select intermediate ratings as a compromise, while some rubric criteria were not fully aligned with the learning opportunities available within the study abroad program. These insights suggest that adapting the rubric requires more than direct linguistic translation; it also requires contextual translation that reflects students' educational experiences and learning contexts. The findings provide a foundation for the next phase of our research: the development and validation of a customized, value-based assessment rubric optimized for the unique attributes, clinical contexts, and institutional philosophies of Japanese nursing education.

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Conflicts of Interest

The authors declare no conflicts of interest associated with this manuscript.

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Appendix A

Selected Components of the AAC&U VALUE Rubrics Used in This Study (Japanese Version)
AAC&UによるVALUEルーブリック

①異文化知識・対応能力について
異文化知識・対応能力とは、「様々な文化的背景を持つ人々との効果的かつ適切な交流・関わりを可能にする一連の認識・情緒的・行動的能力及 び特性」です。以下は、用語の定義です。

文化（Culture） ある集団が共有する知識や価値観のこと。

文化的ルールと偏見（Cultural rules and biases）：社会や集団が共有する価値観に基づき、個人がその社会や集団の一員として帰属意識を持つために守るべき枠組み。

共感（Empathy）：他者の経験に対して、他者の視点を想像しながら、感情的・知的な側面を含めて寄り添うこと。

異文化体験（Intercultural experience）：自分とは異なる文化を持つ個人や集団と交流する経験。

異文化・文化の違い（Intercultural/cultural differences）：
文化的な価値観の違いによって生じる、ルール、行動、コミュニケーション、偏見の違い。
異文化との交流において評価を保留する姿勢（Suspends judgment in valuing their interactions with culturally different others）：自分と異なる文化を持つ人との交流において、すぐに評価（肯定的・否定的）を下さず、一旦判断を保留すること。先入観を避け、異なる視点を考慮する時間を持つ。

世界観（Worldview）：人が自分の経験を理解し、自分の周りの世界を意味づけする際に使用する、認知的・感情的な視点のこと。

*基準１に満たない場合は、０を選択することができる。

	4	3	2	基準　1
知識① 文化的な 自己認識	深い洞察を持ち、自分の文化的ルールや偏見に対処できる（自分の経験がどのように文化的ルールを形成してきたかを理解している。文化的な偏見を認識し、それにどのように対応するかを考えられる。その結果として、自己認識や価値観に変化が生まれることもある。）	自己の文化的ルールや偏見についての新しい視点を認識している（他文化に同じ価値観やルールを求めず、新しい視点によってもたらされた複雑さを受け入れる。）	自分の文化的ルールや偏見を認識する（自分が属する文化の価値観やルールを理解し、それに強い親しみを持っている。他文化にも同じ価値観を求める傾向がある。）	自分の文化的ルールや偏見にほとんど気づいていない（自分の文化的な価値観やルールを意識することが少なく、他の文化との違いを考えることに抵抗がある。）
知識② 文化的世界観の理解	高度な理解（他文化の複雑な要素（歴史、価値観、政治、コミュニケーションスタイル、経済、信念・習慣）を深く理解し、それらがどのように結びついているかを把握している。）	十分な理解（他文化の歴史、価値観、政治、コミュニケーションスタイル、経済、信念・習慣の相互関係を適切に理解している。）	部分的な理解（他文化の歴史、価値観、政治、コミュニケーションスタイル、経済、信念や習慣について、重要な要素をある程度理解しているが、その複雑さや背景まで十分に把握しているわけではない。）	表面的な理解（他文化の歴史、価値観、政治、コミュニケーションスタイル、経済、信念や習慣について、基本的な知識はあるが、深く理解しているわけではない。）

スキル① 共感力	異文化の体験を自分の世界観だけでなく、複数の世界観から理解し、相手の感情を尊重して寄り添う態度で行動する	二つ以上の世界観の知的・感情的な側面を理解し、交流の場で複数の視点を適切に使い分けることができる。	多文化の視点や要素を理解しようとするが、すべての状況で自分の文化的な世界観に基づいて反応する。	他者の経験を自分の文化的世界観で解釈する
スキル② 言語・非言語コミュニケーション	言語的および非言語的コミュニケーションの文化的違い（例：異なる文化での身体的接触の程度、直接的/間接的、明示的/暗示的な意味の使い方）を複雑に理解し、それを基に異文化間で共通理解をうまく調整することができる。	言語的および非言語的コミュニケーションの文化的な違いに気づき、その違いを基に共通理解を模索し始める。	言語的および非言語的コミュニケーションにおけるいくつかの文化的違いを認識し、誤解が生じる可能性に気づくが、共通理解をうまく調整できない。	言語的および非言語的コミュニケーションにおける文化的違いをほとんど理解しておらず、それを基に共通理解を得るように調整できない。
姿勢①他文化への 好奇心	他の文化について、複雑な疑問を持っている。それら疑問に対し、複数の文化的視点を反映する答えを探し、理解したことを明確に述べることができる。	他の文化について深い質問をし、その答えを積極的に求める姿勢を持っている。	他の文化について表面的な質問をする。	他の文化について学ぶことに対して、あまり関心を持たない。

②グローバル・ラーニングについて

グローバル・ラーニングは、学生が自分の行動や視点を広げ、世界規模の問題に対して積極的に取り組む力を育むことを目的としています。

視点の理解（Perspective Taking）とは　異なる視点や経験から学び、自分が世界の中でどのような立場にいるのかを理解する。そして、個人的・社会的・文化的・学問的・環境的・地域的・国際的といった、複数の視点の関連性を理解できるようになることを目標します。

文化的多様性（Cultural Diversity）とは 自己の文化的ルーツやその影響を認識するとともに、それだけでは世界で必要なすべての知識を得るには限界があることを理解する力。これには、他者の文化的多様性について敬意をもって学び、そして個人レベルでは、文化の違いを越えて、協力しながら共通の目標を達成する力が含まれる。また、社会の仕組みとして、文化がどのように分類され、権力構造の中でどのような位置を与えられているのかを比較・分析する力。これは、時代や場所によって変化するものであり、人種・民族・ジェンダー・国籍・宗教・社会階層（クラス）などの理解も含まれる。

	4	3	2	基準　1
視点の獲得	自然や人間社会における複雑な問題に対し、複数の視点（文化的・学問的・倫理的などの観点）を取り入れ、時には対立する意見がある中でも、それらを評価しながら実践的に活用し、問題解決に役立てる。	自然や人間社会の課題を探求する際に、複数の視点（文化的・学問的・倫理的などの観点）を組み合わせて考察する。	自然や人間社会に関する問題を考えるときに、異なる視点（文化的・学問的・倫理的などの観点）を明確にし、それぞれの立場を説明できる。	自己の立場（文化的・学問的・倫理的などの観点）を重視しつつ、複数の視点を認識する。
文化的多様性	様々な世界観、経験、権力構造を深く理解し、それを実践的に活用できる。意義のある異文化交流を積極的に行い、地球規模の課題解決に貢献する。）	複数の文化の価値観、権力構造、経験の重要な関連性を、歴史的に、または現在の状況に照らして詳しく分析できる。他文化と敬意をもって交流する。	歴史的または現代の文脈で、二つ以上の文化のつながりを、権力構造（社会的な格差や影響力の違い）を理解して、説明できる。その結果、異なる文化を尊重しながら交流できる。	自己の文化的視点から、他文化の歴史や現状を説明できる。異なる文化や価値観に対してある程度の関心や受け入れる姿勢を示す。

Selected Components of the AAC&U VALUE Rubrics Used in This Study (English Version)

1. Intercultural Knowledge and Competence

Intercultural Knowledge and Competence refers to *"a set of cognitive, affective, and behavioral skills and characteristics that enable effective and appropriate interaction with individuals from diverse cultural backgrounds."* The following are definitions of the terms used in this rubric.

Culture: All knowledge and values shared by a group.
Cultural rules and biases: Boundaries within which an individual operates in order to feel a sense of belonging to a society or group, based on the values shared by that society or group.
Empathy: "Empathy is the imaginary participation in another person's experience, including emotional and intellectual dimensions, by imagining his or her perspective (not by assuming the person's position)" (Bennett, 1998).
Intercultural experience: The experience of an interaction with an individual or groups of people whose culture is different from your own.
Intercultural/cultural differences: The differences in rules, behaviors, communication, and biases, based on cultural values that are different from one's own culture.
Suspends judgment in valuing their interactions with culturally different others: Postpones assessment or evaluation (positive or negative) of interactions with people
culturally different from oneself. Disconnecting from the process of automatic judgment and taking time to reflect on possibly multiple meanings.
Worldview: Worldview is the cognitive and affective lens through which people construe their experiences and make sense of the world around them.

Note: If your experience does not meet the criteria for Level 1, select 0.

	4	3	2	benchmark 1
Knowledge *Cultural self-awareness*	Articulates insights into own cultural rules and biases (e.g., seeking complexity; aware of how her/his experiences have shaped these rules, and how to recognize and respond to cultural biases, resulting in a shift in self-description).	Recognizes new perspectives about own cultural rules and biases (e.g., not looking for sameness; comfortable with the complexities that new perspectives offer)	Identifies own cultural rules and biases (e.g., with a strong preference for those rules shared with own cultural group and seeks the same in others).	Shows minimal awareness of own cultural rules and biases (even those shared with own cultural group[s]) (e.g., uncomfortable with identifying possible cultural differences with others).

Knowledge *Knowledge of cultural worldview frameworks*	Demonstrates sophisticated understanding of the complexity of elements important to members of another culture in relation to its history, values, politics, communication styles, economy, or beliefs and practices.	Demonstrates adequate understanding of the complexity of elements important to members of another culture in relation to its history, values, politics, communication styles, economy, or beliefs and practices.	Demonstrates partial understanding of the complexity of elements important to members of another culture in relation to its history, values, politics, communication styles, economy, or beliefs and practices.	Demonstrates surface understanding of the complexity of elements important to members of another culture in relation to its history, values, politics, communication styles, economy, or beliefs and practices.
Skills *Empathy*	Interprets intercultural experience from the perspectives of own and more than one worldview and demonstrates ability to act in a supportive manner that recognizes the feelings of another cultural group.	Recognizes intellectual and emotional dimensions of more than one worldview and sometimes uses more than one worldview in interactions.	Identifies components of other cultural perspectives but responds in all situations with own worldview.	Views the experience of others but does so through own cultural worldview.
Skills *Verbal and nonverbal communication*	Articulates a complex understanding of cultural differences in verbal and nonverbal communication (e.g., demonstrates understanding of the degree to which people use physical contact while communicating in different cultures or use direct/indirect and explicit/implicit meanings) and is able to skillfully	Recognizes and participates in cultural differences in verbal and nonverbal communication and begins to negotiate a shared understanding based on those differences.	Identifies some cultural differences in verbal and nonverbal communication and is aware that misunderstandings can occur based on those differences but is still unable to negotiate a shared understanding.	Has a minimal level of understanding of cultural differences in verbal and nonverbal communication; is unable to negotiate a shared understanding.

2. Global Learning

Global Learning aims to foster students' ability to broaden their perspectives and actions, and to actively engage in addressing issues on a global scale.

Perspective taking: The ability to engage and learn from perspectives and experiences different from one's own and to understand how one's place in the world both informs and limits one's knowledge. The goal is to develop the capacity to understand the interrelationships between multiple perspectives, such as personal, social, cultural, disciplinary, environmental, local, and global.

Cultural diversity: The ability to recognize the origins and influences of one's own cultural heritage along with its limitations in providing all that one needs to know in the world.

This includes the curiosity to learn respectfully about the cultural diversity of other people and on an individual level to traverse cultural boundaries to bridge differences and collaboratively reach common goals. On a systems level, the important skill of comparatively analyzing how cultures can be marked and assigned a place within power structures that determine hierarchies, inequalities, and opportunities and which can vary over time and place. This can include, but is not limited to, understanding race, ethnicity, gender, nationhood, religion, and class.

	4	3	2	benchmark 1
Perspective taking	Evaluates and applies diverse perspectives to complex subjects within natural and human systems in the face of multiple and even conflicting positions (i.e., cultural, disciplinary, and ethical.)	Synthesizes other perspectives (such as cultural, disciplinary, and ethical) when investigating subjects within natural and human systems.	Identifies and explains multiple perspectives (such as cultural, disciplinary, and ethical) when exploring subjects within natural and human systems.	Identifies multiple perspectives while maintaining a value preference for own positioning (such as cultural, disciplinary, and ethical).
Cultural diversity	Adapts and applies a deep understanding of multiple worldviews, experiences, and power structures while initiating meaningful interaction with other cultures to address significant global problems.	Analyzes substantial connections between the worldviews, power structures, and experiences of multiple cultures historically or in contemporary contexts, incorporating respectful interactions with other cultures.	Explains and connects two or more cultures historically or in contemporary contexts with some acknowledgement of power structures, demonstrating respectful interaction with varied cultures and worldviews	Describes the experiences of others historically or in contemporary contexts primarily through one cultural perspective, demonstrating some openness to varied cultures and worldviews.

Appendix B

インタビューガイド

インタビュー前の準備

(1) インタビュー日時

研究実施者は、インタビューを行う日時について研究協力者の授業に支障のない、希望される時間帯でインタビュー日時を調整して決定する。

(2) インタビュー場所

対面もしくはオンラインでインタビューを行う。

(3) インタビューに必要な物品と資料の準備

①調査ご協力のお願い

②説明書・同意書

③録音器具

④メモを取る器具

1. インタビュー中に配慮すること

・調査ご協力のお願いに基づいて本インタビュー調査の目的、方法、倫理的配慮を口頭で文書にそって説明し、研究協力者の自由意思に基づいてインタビュー協力に同意が得られるかを伺う。なお、いったん同意が得られている場合でも、中途で辞退できる権利について説明する。

・同意が得られた場合、インタビューを実施するが、インタビューに費やす１時間程度の時間をいただくことを再度お断りする。

・研究協力者にインタビュー内容を録音してよいかどうかを伺い、了解が得られた場合は録音させていただく。録音の目的は大切なインタビュー内容を正確に把握し、調査目的にかなった分析をするためであると伝える。録音された内容は本研究者ら以外が聞くことはないこと、録音内容が研究期間終了後、破棄することを説明する。

・インタビュー設問について聞かせてもらうが、研究協力者ができるだけ自由に自発的に話ができるような配慮を行い、受容的・傾聴的姿勢に徹する。決して質問攻めや強要するようなことはしない。

2. インタビュー（１時間程度）

インタビュー実施日：　　年　　月　　日（　　）

時間：　　：　　～　　：

場所：　対面もしくはオンライン

実施者：　本調査研究チームメンバー

インタビュー１：正課外の海外を拠点とする国際的な活動に参加した学生

本インタビューでは、研究課題「国際的に活動する看護学生育成のための教育活動・評価・ルーブリック開発について―赤十字の理念と建学の精神を中心にー」に関する調査ご協力のお願い」にて説明の通り、以下の質問についてお伺いします。

【質問１】あなたの背景について伺います。

① 氏名、属性

② 過去に留学や日本以外の就業や居住経験があれば教えてください。

【質問２】あなたが本研修に参加するに至った経緯について伺います。研修の参加を決めたきっかけ、動機について教えてください。

【質問３】 AACUによるルーブリックについて伺います。

（別紙ルーブリックの内容を確認しながら質問）

①「・・・」について、研修参加によりどのような影響がありましたか？もしくはなかったのでしょうか？

② これら評価項目において、研修にそぐわない項目、疑問点や不明点などありましたか？

【質問 4】研修を通じた学びについて伺います。

①研修を通じてどのような学びや気づきがありましたか？

②評価項目にはない態度や認知、非認知的な能力の変化について、何かありますか？

③研修全般の評価について伺います。

Interview Guide

<Preparation Before the Interview>

1. Interview Schedule

The researcher will arrange the interview at a date and time that is convenient for the participants and does not interfere with their academic schedule.

2. Interview Modality

The interview will be conducted either face-to-face or online, according to the participants' preferences.

3. Materials Required for the Interview

1) Participant Information Sheet
2) Consent Form
3) Audio-recording device
4) Note-taking materials

<Considerations During the Interview>

1. Based on the Participant Information Sheet, the researcher will explain the purpose, procedures, and ethical considerations of the study and confirm that the participant is willing to participate voluntarily. Participants will also be informed that they may withdraw from the study at any time without penalty.

2. If informed consent is obtained, the interview will proceed. Participants will be reminded that the interview is expected to take approximately one hour.

3. Participants will be asked for permission to audio-record the interview. If permission is granted, the interview will be recorded for the purpose of accurately capturing participants' responses and facilitating data analysis. Participants will be informed that only the research team will have access to the recordings and that all recordings will be securely destroyed after the completion of the study.

4. Throughout the interview, the researcher will encourage participants to speak freely and openly. The interviewer will maintain an accepting and attentive attitude and will avoid pressuring participants or asking questions in an intrusive manner.

Interview (Approximately 60 Minutes)

Date: _____ / _____ / _____

Time: _____ : _____ to _____ : _____

Mode: Face-to-face or Online

Interviewer: Member of the Research Team

Interview 1: Students Who Participated in Extracurricular International Activities Conducted Overseas

In this interview, participants will be asked the following questions as described in the Participant Information Sheet for the study entitled:

"Development of Educational Activities, Assessment, and Rubrics for Fostering Nursing Students Who Can Work Internationally: Focusing on the Red Cross Principles and the Founding Philosophy of the University."

Question 1: Background Information

1. Please tell us your name and current academic status (e.g., year level).

2. Have you previously studied, lived, or worked outside Japan? If so, please describe your experience.

Question 2: Motivation for Participation

Please tell us about the reasons you decided to participate in this program. What motivated you to join the program? What factors influence your decision to participate?

Question 3: AAC&U Rubrics (Using the rubric as a reference during the interview)

In what ways, if any, did participating in the program influence your development in relation to each rubric criterion?

Were there any rubric criteria that you felt did not align with your study abroad experience?

1. Were there any rubric items, terms, or expressions that you found difficult to understand?

2. Were there any rubric items that you found difficult to evaluate yourself against? Please explain why.

Question 4: Learning Outcomes from the Program

1. What did you learn from participating in the program?

2. What new insights or perspectives did you gain through this experience? Did you experience any changes in your attitudes, knowledge, skills, or personal qualities that were not reflected in the rubric items?

3. Overall, how would you evaluate the program?

Appendix C

Coding Framework: Categories, Subcategories, and Representative Codes

Category	Sub-category	Code
1. Challenges in Rubric Wording and Conceptual Clarity	1-1. Use of Academic and Discipline-Specific Terminology	- Difficulty understanding the wording and expressions used in the rubric - Unfamiliarity with rubrics for intercultural understanding and global learning - Difficulty understanding unfamiliar concepts that are rarely considered in everyday life - Uncertainty about whether the rubric wording was interpreted correctly - Difficulty understanding discipline-specific academic terminology (e.g., “cultural worldview” and “suspending judgment”)
	1-2. Ambiguity in Evaluating Broad Concepts	- Difficulty evaluating broad concepts such as “empathy” and “worldview” - Difficulty interpreting expressions such as “in historical or contemporary contexts”
	1-3. Excessive information in Rubric Wording	- Difficulty understanding rubric wording containing excessive information
2. Structural Challenges of the Rating Scale	2-1. Co-occurrence of Multiple Evaluation Dimensions Within a Single Scale Level	- Difficulty selecting a performance level because multiple dimensions were embedded within a single scale level - Selection of intermediate levels due to differences in achievement across dimensions
	2-2. Ambiguity in Performance-Level Gradations	- Difficulty distinguishing between adjacent performance levels - Repeated hesitation when selecting a performance level - Selection of intermediate levels due to unclear distinctions between performance levels
	2-3. Perceived Discontinuity Between Performance Levels and Need for Finer Gradations	- Selection of intermediate levels because the gaps between performance levels were too large - Need for more finely differentiated performance levels, including lower levels
3. Misalignment Between the Program and the Rubric	3-1. Misalignment Between the Rubric and On-Site Experiences	- Inability to respond to rubric items related to history and religion because of limited exposure during the program - Lack of experiences corresponding to the rubric items
4. Reflective Benefits of Rubric Use	4-1. Facilitation of Reflection and Deepened Self-Understanding.	- The rubric served as an opportunity for reflection - The rubric promoted deeper reflection and self-understanding
	4-2. Broadened Perspectives and Identification of New Goals	- The rubric increased awareness of perspectives beyond one’s own - Identification of new goals and aspirations

Developing Empathy, Nursing Communication, and Professional Identity through Puppet-Based Maternity Care Dialogues in a First-Year Nursing English Reading Course: An Interdisciplinary Educational Study

Yasuko Sugiyama[1] (yasuko.sugiyama@mcn.ac.jp), Izumi Dryden[1], & Laurence M. Dryden[2]
[1]Mie Prefectural College of Nursing, [2]independent scholar

Abstract: *Effective nursing communication requires empathy, non-judgmental listening, trust-building, and an understanding of patients' emotional experiences. This qualitative study examined how an interdisciplinary educational intervention integrating nursing English and maternity nursing through puppet-based clinical dialogues supported first-year nursing students' communication learning and emerging professional identity. A 90-minute session was conducted in a first-year nursing English reading course at a Japanese nursing college. Students observed three maternity-care puppet dialogues, collaboratively created continuation stories in English, presented their dialogues, and completed written reflections. Of 97 reflections collected, 96 with written consent were analyzed using qualitative thematic analysis. Five themes emerged: understanding women's emotional experiences (93.8%), learning active listening and non-judgmental communication (41.7%), building trust through empathetic dialogue (58.3%), developing professional identity as future nurses (27.1%), and recognizing English as a tool for patient-centered care (6.3%). The findings suggest that puppet-based clinical narratives combined with collaborative dialogue and reflection can provide first-year nursing students with an accessible form of vicarious clinical experience. Nursing English education may therefore support not only language learning but also empathy, relational competence, and emerging professional identity before substantial clinical placement experience.*

Keywords: empathy; interdisciplinary education; nursing English education; nursing communication; professional identity; puppet-based learning

About the Authors: Yasuko Sugiyama is a Lecturer at Mie Prefectural College of Nursing in Tsu, Japan. She teaches maternal nursing, maternity clinical practicum, and midwifery. Her research focuses on maternal nursing, support for survivors of sexual violence, and maternal and child health.

Izumi Dryden is an Associate Professor at Mie Prefectural College of Nursing in Tsu, Japan. She teaches English reading, literature and medicine, and communication. Her research interests include nursing English education, bibliotherapy, narrative medicine, and the writings and correspondence of Florence Nightingale.

Laurence M. Dryden is a retired university English educator in Suzuka, Japan. He has more than fifty years of teaching and research experience in Japan and the United States. His academic interests include English language education, imaginative literature, world history, and intercultural communication.

Communication is fundamental to nursing practice. Nurses are required not only to assess patients' physical conditions but also to understand their thoughts, emotions, values, family circumstances, and social backgrounds while developing relationships of trust. The ability to communicate empathetically and appropriately is therefore an essential foundation of patient-centered nursing care.

Contemporary nursing education in Japan increasingly reflects these expectations. The Japanese government's revised Model Core Curriculum for Nursing Education emphasizes the importance of developing competencies that enable nurses to understand the diverse backgrounds of patients and other healthcare professionals, establish constructive relationships, and provide high-quality nursing care through effective interaction with patients (Ministry of Education, Culture, Sports, Science and Technology [MEXT], 2025). Communication competence among nursing students has similarly

been identified as an important practical capability supporting patient understanding and the development of therapeutic relationships (Abe, 2025).

For nursing students, however, communication skills cannot be developed simply by memorizing appropriate expressions. Effective nursing communication requires learners to consider what patients may be experiencing, why particular concerns may be difficult to express, how a nurse's response may affect a patient emotionally, and how trust develops within a therapeutic relationship. Empathy, active listening, non-judgmental responses, and the ability to create psychological safety are therefore important components of communication education.

These interpersonal dimensions are increasingly relevant to nursing English education. As healthcare environments become more linguistically and culturally diverse, Japanese nurses may encounter patients and families with whom English serves as an important means of communication—a lingua franca, as it were. Nursing English education consequently needs to extend beyond specialized vocabulary, grammar, and reading comprehension toward opportunities in which students experience how English can function within caring relationships.

A nursing English reading course can provide one such opportunity. Reading and language learning remain important components of the course, but clinically situated activities can additionally allow students to observe the effects of particular words within nurse–patient interactions. An expression such as "Thank you for telling me," for example, is linguistically simple but interpersonally meaningful because it communicates acceptance rather than judgment. Similarly, "Let's think about this together" can position the nurse not merely as an authority providing information but as a professional accompanying a patient through uncertainty.

Such learning may be especially important during the first year of undergraduate nursing education. First-year nursing students generally have limited direct clinical experience, yet their professional formation has already begun. Classroom experiences may therefore influence how they conceptualize patients, communication, caring, and the kinds of nurses they wish to become.

The present study investigates an interdisciplinary classroom intervention combining nursing English and maternity nursing through puppet-based maternity-care dialogues, collaborative story development, presentation, and written reflection. The fictional pregnant patient in the dialogues was named Chico and is referred to by that name throughout this study. Rather than evaluating the intervention merely as an innovative classroom activity, the study qualitatively examines students' reflections to investigate what the experience revealed about empathy, nursing communication, trust, English learning, and emerging professional identity.

Literature Review

Communication and Empathy in Nursing Education

Nursing communication involves substantially more than transmitting accurate information. Nurses need to listen to what patients say, recognize concerns that may be difficult to articulate, respond appropriately to emotional vulnerability, and create conditions in which patients feel safe enough to communicate openly.

In a review of education for nursing students, Abe (2025) identifies nursing communication (both verbal and non-verbal) as a major pedagogical concern because of students' limited ability to articulate their ideas, emotions, and experiences. Effective communication supports students' understanding of the roles of nurses in helping relationships with patients and colleagues. Communication education therefore properly addresses not only communicative skills

but also the interpersonal and therapeutic purposes for which those skills are used.

Empathy is particularly important in this context. Students need opportunities to move from observing clinical situations externally toward considering how those situations might be experienced by patients. This shift from observation toward understanding another person's experience resonates with Noddings' (2003) relational understanding of caring. As Noddings explains, caring involves, for the one-caring, a "feeling with" the other—a relationship that may be understood as empathy (p. 31). From this perspective, empathy in nursing education involves more than recognizing another person's emotions; it requires students to imaginatively enter the patient's perspective and respond to that experience as relationally meaningful.

The educational value of such perspective-taking can also be understood in relation to reflection and professional development. Schön (1983) emphasizes reflection as an important dimension of professional learning, particularly when practitioners encounter complex situations that cannot be addressed through technical knowledge alone. In nursing, Benner (1984) similarly emphasizes the role of experience in the development of professional expertise, showing how clinical understanding develops through engagement with practice over time. Taken together, these perspectives suggest that students need opportunities not only to acquire knowledge and communication skills but also to interpret situations, consider others' perspectives, and reflect on how they might respond as future nurses. Such opportunities are especially relevant before clinical placement, when students have limited direct experience communicating with patients. Learning environments that encourage students to interpret emotional experience, consider why patients may hesitate to disclose concerns, and reflect on how nurses' responses affect patients can therefore provide an important foundation for subsequent clinical learning.

Simulation and Scenario-Based Nursing Education

Role-play and simulation are widely used in undergraduate nursing education because they allow students to connect theoretical knowledge with representations of clinical situations (Inoue & Sato, 2022). Scenario design is particularly important, as effective simulation requires students to integrate knowledge, skills, attitudes, interpretation, and communication within a meaningful clinical context (Matsuzawa et al., 2017).

Scenario-based learning can provide a preparatory space between classroom knowledge and direct clinical practice. Students can explore alternative responses, discuss interpretations with peers, make decisions without creating risks for actual patients, and reconsider those decisions through reflection. For first-year nursing students, such experiences may be particularly valuable because clinically-situated scenarios allow them to begin thinking from a nursing perspective before they have extensive clinical experience.

Puppet-Based Learning

Interactive puppetry represents a distinctive form of simulation. Tilbrook et al. (2017) endorse the use of interactive puppet simulation in nursing education and children's healthcare. More recently, Abu-Ras et al. (2025) identify puppetry as a potentially useful medium for facilitating emotional expression and social interaction. Puppets may be particularly valuable when education engages with emotionally sensitive situations. Representing another person through a fictional character can create a degree of psychological distance while retaining sufficient narrative and emotional detail to encourage perspective-taking.

In the present study, puppetry was combined with continuing maternity narratives rather than

used simply as a visual or entertaining classroom device. The fictional patient Chico was represented across adolescence, pregnancy, and the postpartum period. This continuity provided students with opportunities to observe not merely isolated clinical problems but changing emotional and interpersonal experiences across time.

Reflection and Professional Identity Formation

Experience alone does not necessarily produce professional learning. Reflection enables learners to reconsider what they have observed or experienced, identify why it matters, connect it with professional values, and consider how they might act in comparable situations. This reflective process is especially relevant to professional identity formation (PIF), through which students gradually develop an understanding of themselves as members of a profession.

Cruess et al. (2014) describe PIF as a developmental process through which individuals come to think, act, and feel like members of a profession. Reflection and social interaction play important roles in this process. Similarly, Dryden et al. (2026) examined professional identity formation through an international nursing exchange involving a Thai nursing student as a visiting student at a Japanese nursing college. Their findings conceptualized PIF as a dynamic and longitudinal process through which nursing students use experiences, social interactions, and reflections to internalize professional values, responsibilities, and ways of understanding themselves.

A particularly relevant finding from Dryden et al. (2026) is that language learning and professional identity formation need not constitute separate educational processes. English communication becomes professionally meaningful when emphasis moves beyond linguistic perfection toward mutual understanding, empathy, psychological safety, and patient-centered interaction. The present study extends this perspective by investigating whether comparable processes may become visible among first-year nursing students before substantial clinical placement experience.

Interdisciplinary Nursing English Education

Collaboration between language and nursing educators may create educational opportunities that neither discipline alone can provide. Nursing educators can contribute clinical authenticity and professional knowledge, while language educators can structure opportunities for dialogue, narrative development, communication, and reflection. Such collaboration may transform the nursing English classroom from a setting in which students primarily learn English about nursing into a learning environment in which they begin to explore, through English, how nurses listen, respond, establish trust, and care for patients.

Despite previous research on simulation, empathy, and interactive puppetry (Tilbrook et al., 2017; Abu-Ras et al., 2025), the authors are not aware of any research that has examined the integration of puppet-based maternity-care scenarios, English dialogue, collaborative narrative construction, reflective writing, and professional identity formation among first-year Japanese nursing students. The present study addresses this gap.

Research Questions

Accordingly, this study seeks to answer the following research questions:

> RQ1. How do first-year nursing students interpret the emotional experiences of women as simulated in puppet-based maternity-care scenarios?
>
> RQ2. What understandings of active listening, non-judgmental communication, empathy, and trust emerge from students' reflections on such simulations?

RQ3. In what ways do students' reflections indicate emerging professional identity formation before substantial clinical placement?

RQ4. How do students understand the role of English in their imagined future patient-centered nursing communication?

Methods

Study Design

The present study employed a qualitative descriptive design to examine first-year nursing students' reflections following an interdisciplinary educational intervention integrating nursing English and maternity nursing. A qualitative approach was selected because the purpose was not to measure improvement in predefined competencies but to investigate how students interpreted and constructed meaning from their educational experiences. Qualitative approaches are appropriate when researchers seek to investigate participants' interpretations of their experiences, feelings, and the meanings they construct from them (Dörnyei, 2007; Holliday, 2015).

The study focused on students' interpretations of simulated interactions between the fictional maternity patient Chico and Nurse Mikan and on how these activities related to their imagined future professional roles. The activities were also intended to prepare students to build trusting relationships with non-Japanese patients in future clinical settings.

Ethical Considerations

Prior to the classroom intervention, students received written and verbal explanations in English concerning the educational activity and the use of their reflections for research and publication. Participation was voluntary, and participation or non-participation had no influence on course grades or academic evaluation. Only reflections from students who provided written informed consent were included in the analysis and in the selection of illustrative quotations.

Participants and Educational Setting

Participants were first-year undergraduate nursing students enrolled in English Reading I, a compulsory Nursing English course at a Japanese nursing college. The intervention was conducted during their first year, before they had accumulated substantial clinical placement experience. This timing was important because the study sought to examine whether clinically meaningful language-learning activities could contribute to patient-centered perspectives and emerging professional self-concepts during an early stage of nursing education.

Ninety-seven students completed an English-language reflection following the session. One student did not provide written informed consent for use of the reflection for research and publication and was therefore excluded. The final qualitative dataset consisted of 96 reflections.

Development of the Educational Intervention

A 90-minute interdisciplinary educational session was collaboratively developed by educators specializing in English education and maternity nursing. Three original scenarios were constructed around the continuing experiences of a woman named Chico and a nurse named Mikan.

In Scenario 1 ("Chico in Adolescence"), Chico visits an obstetrics and gynecology clinic because her period has not occurred for several months and she fears that she might be pregnant. She initially finds it difficult to disclose her concern. Nurse Mikan uses gentle questions, allows time for silence, listens without criticism, and responds, "Thank you for telling me."

Scenario 2 ("Chico Comes to the Hospital for a Prenatal Checkup") is set during pregnancy, when Chico becomes confused and anxious because of contradictory information encountered online

concerning diet, activity, and everyday behavior. Nurse Mikan acknowledges her uncertainty, provides reassurance, and encourages continued communication.

In Scenario 3 ("Chico Becomes a Mother"), during the early postpartum period, Chico is exhausted by her newborn's persistent crying and begins to question whether she can become a good mother. Nurse Mikan acknowledges her distress, reassures her that no one becomes a perfect mother immediately, and supports her in caring for the infant.

The scenarios were deliberately designed to represent different emotional challenges across a maternity trajectory rather than merely different clinical problems. The continuity of Chico as a character allowed students to encounter maternity care as an unfolding human experience.

Learning Activities

The intervention consisted of four interconnected activities. First, students observed puppet-based English dialogues in which movement, pauses, tone of voice, and interaction between the characters conveyed linguistic and emotional meaning. Second, students worked collaboratively to create continuation stories in English. Rather than being given a single correct ending, they discussed how the characters' situations might develop and what kinds of communication might be appropriate. Third, students presented their continuation dialogues to their classmates, enabling multiple interpretations and possible communicative responses to become visible within the classroom. Finally, students completed individual written reflections in English. They considered Chico's emotions, Nurse Mikan's communication, what they had learned from the activity, and how that learning might relate to their future nursing practice.

Data Collection

Written English reflections were collected immediately following the educational intervention. The reflections were treated as qualitative data rather than as course satisfaction evaluations. Analysis focused on how students interpreted the clinical narratives involving Chico and Nurse Mikan in relation to patient emotions, communication, trust, nursing values, English learning, and future professional practice.

Qualitative Thematic Analysis

The 96 reflections were analyzed using qualitative thematic analysis. The researchers first read and reread the complete dataset to become familiar with the students' responses. Meaningful units concerning emotional understanding, listening, non-judgmental communication, empathy, trust, professional self-concept, and English learning were identified.

Initial codes were generated from these units. Related codes were compared and grouped into candidate themes, which were subsequently reviewed against the complete dataset and refined according to their central organizing meanings. Five final themes were identified:

1. Understanding the emotional experiences of pregnant women
2. Learning active listening and non-judgmental communication
3. Building trust through empathetic dialogue
4. Developing professional identity as future nurses
5. Recognizing English as a tool for patient-centered care

Individual reflections could contain evidence relevant to more than one theme; categories were therefore not mutually exclusive. Frequencies were calculated descriptively to indicate the prevalence of each thematic pattern. These frequencies contextualized the qualitative findings rather than functioning as independent quantitative measures of educational effectiveness.

Participants were assigned anonymous

identifiers from S1 to S96 to protect confidentiality while maintaining a clear relationship between interpretations and supporting data. Representative quotations are incorporated into the Results section.

Results

Thematic Analysis

Five interrelated themes were identified from the 96 reflections. Students' responses extended beyond comments concerning enjoyment of the activity or English language difficulty. They interpreted Chico's emotional trajectory, identified relational functions of Nurse Mikan's communication, considered how trust was established, and, in some cases, projected these observations onto their own future professional identities.

Table 1

Mean Major Themes Identified from Students' Reflective Writing (n = 96)

Theme	Number of Students	Percentage (%)
1. Understanding the emotional experiences of pregnant women	90	93.8
2. Learning active listening and non-judgmental communication	40	41.7
3. Building trust through empathetic dialogue	56	58.3
4. Developing professional identity as future nurses	26	27.1
5. Recognizing English as a tool for patient-centered care	6	6.3

Note. Individual reflections could be coded under more than one theme; therefore, combined percentages do not equal 100%.

Understanding the Emotional Experiences of Pregnant Women

The most prevalent theme concerned students' recognition of the patient's emotions and psychological changes. Ninety of the 96 students (93.8%) demonstrated awareness of Chico's emotional experiences across the maternity-care trajectory.

During the adolescent pregnancy phase, students frequently emphasized emotions such as fear, confusion, anxiety, and isolation. One wrote, "Chico felt very scared, confused, and lonely because she could not tell anyone about her pregnancy" (S75). Another observed, "Chico was confused and anxious because of her unexpected pregnancy" (S2). These responses indicate that students recognized not only the clinical possibility of pregnancy but also the emotional difficulty associated with uncertainty and disclosure.

During the prenatal scenario, students identified another form of vulnerability: uncertainty created by excessive and contradictory information. One wrote, "She became overwhelmed by the huge amount of information on the Internet and did not know what to believe" (S89). During the postpartum phase, attention shifted toward exhaustion, self-blame, and diminished maternal confidence: "She blamed herself when her baby would not stop crying" (S89). Students also recognized emotional change resulting from supportive interaction: "Chico gradually became calmer" (S45).

Students therefore followed an emotional trajectory rather than identifying isolated feelings. They recognized that the patient's emotional needs changed across different stages of maternity care.

Learning Active Listening and Non-Judgmental Communication

Forty students (41.7%) explicitly reflected on active listening, acceptance, and non-judgmental communication as important components of nursing care. The simple expression "Thank you for telling me" (S12) was particularly salient. Students interpreted it not merely as an English phrase but as a response communicating acceptance after Chico had struggled to disclose a possible pregnancy.

One participant wrote, "Listening carefully is one of the most important skills for nurses" (S81). Another emphasized, "Mikan did not blame

her" (S71). Students also referred to the importance of accepting patients' feelings and avoiding immediate judgment.

These responses suggest that students recognized a significant distinction between obtaining information from patients and creating an interpersonal environment in which patients feel sufficiently safe to disclose difficult information.

Building Trust through Empathetic Dialogue

Fifty-six students (58.3%) described how empathetic communication contributed to reassurance, psychological safety, and trust. One student wrote, "The nurse listened without judgment and created a safe atmosphere" (S43). Another observed, "Chico continued to trust and rely on her" (S50). Another participant recognized the development of a therapeutic relationship: "This may have helped them build a trusting relationship" (S30). Students also responded to expressions such as "Let's think together," interpreting them as indications that the patient did not need to face uncertainty alone.

Theme 3 was analytically distinct from Theme 2. Theme 2 concerned what the nurse did communicatively, whereas Theme 3 concerned what those actions made possible relationally. Students' reflections therefore suggested a process in which active listening and non-judgmental communication contributed to psychological safety, disclosure, reassurance, and trust.

Developing Professional Identity as Future Nurses

Twenty-six students (27.1%) explicitly connected the activity with their own future identities, values, or responsibilities as nurses. One wrote, "I want to become a nurse like Mikan" (S15). Another stated, "I want to care not only for my patients' bodies but also for their feelings" (S42). Another participant wrote, "I hope to respect every patient's feelings and always provide compassionate, patient-centered care" (S45).

These statements are particularly noteworthy because the participants were first-year students with limited clinical experience. Rather than merely evaluating the behavior of the fictional nurse, these students began to appropriate the values represented by Nurse Mikan and relate them to their own future nursing practice.

Their reflections suggested a developmental movement from observing nursing behavior, to recognizing professional values, to imagining oneself as a nurse, and finally to articulating a desired professional self. This pattern was interpreted as evidence of emerging professional identity formation rather than evidence that professional identity had already been fully established.

Recognizing English as a Tool for Patient-Centered Care

Six students (6.3%) explicitly connected English learning with their future nursing practice. One student wrote, "I need to continue improving my English skills" (S10). Another reflected, "We can talk with patients in easy English" (S21).

Although relatively few students explicitly referred to English, these comments are educationally meaningful. For these students, English began to shift from being understood solely as an academic subject toward being recognized as a practical resource for communicating with patients and supporting patient-centered care.

Discussion

Puppet-Based Maternity Narratives and Patient Understanding

The most prominent finding was students' attention to Chico's changing emotional experiences, thereby addressing RQ1. Ninety of the 96 participants (93.8%) recognized negative emotions or psychological changes across the

scenarios, including fear, confusion, isolation, information overload, uncertainty, exhaustion, self-blame, and reassurance. Importantly, students differentiated these emotions across adolescence, pregnancy, and the postpartum period.

This finding is significant in first-year nursing education because students have limited clinical experience from which to understand how patients may experience healthcare situations. The puppet-based scenarios provided a form of vicarious clinical experience through which students could encounter an unfolding patient narrative before extensive participation in actual clinical care.

The continuity of Chico's experiences across the three scenarios may have strengthened this process. Instead of encountering unrelated cases, students followed one woman through changing life and care situations. They could therefore consider the patient not simply as a clinical problem but as a person whose emotions, needs, and circumstances developed over time.

The puppets themselves may also have supported perspective-taking. Tone of voice, pauses, movement, and interaction enabled emotional meanings to be communicated visually and aurally, while the fictional format provided some psychological distance from sensitive issues such as unexpected pregnancy and postpartum distress. This interpretation is consistent with previous discussions of interactive puppet simulation in nursing education (Tilbrook et al., 2017) and the potential of puppetry to facilitate emotional expression and social interaction (Abu-Ras et al., 2025).

The educational value of puppetry should therefore not be understood solely in terms of novelty or enjoyment. In the present study, it functioned as a narrative medium through which abstract concepts such as vulnerability, hesitation, acceptance, reassurance, and trust became accessible to novice nursing students.

From Communication Techniques to Relational Meaning

A second important finding was that students did not merely identify useful communication techniques; they considered what those techniques accomplished within the nurse–patient relationship. Students recognized the importance of listening, waiting, accepting feelings, avoiding blame, and responding supportively. Expressions such as "Thank you for telling me" and "Let's think together" became particularly meaningful because of their relational contexts. The first followed a difficult disclosure and acknowledged the courage required to speak, while the second communicated that the patient did not have to manage uncertainty alone.

The distinction between Themes 2 and 3 is therefore important. Theme 2 represents communicative behavior—listening, accepting, avoiding judgment, and responding—whereas Theme 3 represents possible relational consequences: feeling safe, disclosing concerns, feeling understood, and developing trust.

This suggests that students were moving beyond a checklist understanding of communication. A clinically appropriate phrase is not valuable simply because it is linguistically or technically correct; its nursing significance depends partly on what it enables within the relationship. The educational question consequently shifts from "What should a nurse say?" toward "What might this way of communicating allow the patient to feel, express, or do?" Such a shift is fundamental to patient-centered nursing communication.

Empathy, Active Learning, and Relational Perspective-Taking

The findings further suggest that students' understanding of empathy extended beyond identifying the patient's emotions. Students considered why Chico was afraid, why she hesitated to speak, why contradictory information caused anxiety, why persistent infant crying could

undermine maternal confidence, and how Nurse Mikan's responses changed the emotional situation. These findings provide answers to RQ2.

This represents a progression from recognizing what a patient feels toward considering why she may feel that way, why communication may be difficult, and how a nurse's response can influence the interaction. Such reasoning reflects relational perspective-taking rather than simple emotion identification.

The collaborative continuation-story activity may have strengthened this process. Students did not remain passive observers of completed model dialogues. They were required to determine what might happen next, imagine the patient's subsequent experience, and construct an appropriate nursing response in English. They therefore had to consider simultaneously what English they could use, what the patient might feel, how the nurse might respond, and how the relationship might develop.

The collaborative nature of the activity also allowed students to negotiate ideas with peers and compare interpretations rather than simply reproduce a predetermined nursing dialogue. Reflection then provided an opportunity to reconsider the meaning of their choices.

The educational mechanism suggested by the findings can therefore be understood as a sequence of narrative encounter, collaborative interpretation, communicative construction, presentation, and individual reflection. Each stage encouraged students to move further from passive observation toward active interpretation of patient-centered care.

From Observing a Nurse to Imagining Becoming One

The professional identity findings constitute an important contribution of the present study. More than one-quarter of participants—26 of 96 students (27.1%)—explicitly articulated characteristics of Nurse Mikan that they hoped to emulate or professional values they wished to carry into their future nursing practice.

These findings address RQ3 in revealing that professional identity formation is not a single educational outcome that can be achieved through one classroom intervention. Rather, it is a dynamic and longitudinal developmental process involving experience, reflection, social interaction, professional values, and increasing participation in professional communities (Cruess et al., 2014). The present findings should therefore not be interpreted as demonstrating that a 90-minute intervention formed students' professional identities. Rather, the intervention appears to have provided an early opportunity for emerging professional identity formation.

This interpretation is particularly meaningful because participants had limited clinical experience. Some students nevertheless identified professional values represented by Nurse Mikan—empathetic listening, non-judgmental communication, respect for patients' feelings, and patient-centered care—and related them to the kinds of nurses they themselves hoped to become. The fictional interaction thus provided a form of vicarious professional experience.

Becoming a nurse involves more than learning what nurses know or what nurses do. Students

Figure 1

The Process of Emerging Professional Identity Formation



also gradually develop understandings of who nurses are and who they themselves wish to become. The present intervention provided an early educational space for this professional self-questioning.

Reflection appears to have been particularly important. After observing Nurse Mikan's interactions with Chico, students were encouraged to relate their learning to their own future practice. Their reflections connected communication, empathy, and professional values with anticipated nursing roles. This interpretation is consistent with Schön's (1983) account of reflection as central to professional learning and with Benner's (1984) understanding of nursing expertise and professional development as grounded in meaningful engagement with practice and experience.

The movement from observing practice toward imagining oneself as a future nurse is also consistent with Cruess et al.'s (2014) conception of professional identity formation as a process through which learners gradually integrate professional values into their sense of self. Although the students had not accumulated substantial clinical experience, the narratives allowed them to encounter clinically meaningful situations indirectly, consider patients' emotional experiences, observe models of nursing communication, and reflect on the professional values represented within those interactions.

This interpretation also extends the findings of Dryden et al. (2026), who showed that professional identity formation through international nursing exchange can develop through experience, reflection, interpersonal interaction, and communication. Whereas that study explored PIF through intercultural and experiential learning, the present findings suggest that related processes may begin considerably earlier, even before extensive clinical placement.

Classroom activities cannot replace direct clinical experience. They can, however, provide preparatory spaces in which students begin developing the values, perspectives, and questions that they later bring to patient encounters. Puppet-based narrative learning and reflection may therefore contribute not only to communication education but also to the early development of students' awareness of themselves as future members of the nursing profession.

Reconceptualizing English—from an Academic Subject to a Caring Resource

Only six students (6.3%) explicitly discussed English as a future nursing resource, and this finding should be interpreted cautiously. The study did not measure English proficiency, and the data do not demonstrate improvement in language ability. Nor should the relatively small number of explicit comments concerning English be overstated.

Nevertheless, the nature of these comments is educationally significant. Statements such as "We can talk with patients in easy English" (R21) suggest that some students were reconsidering what successful nursing English communication might mean. The relevant distinction is not simply between good and poor English but between viewing English solely as an academic subject and recognizing language as a means of reaching another person. This data showed that at least some participants were actively considering the role of English in their future nursing careers (as envisaged by RQ4).

This interpretation is consistent with Dryden et al. (2026), in which communication became professionally meaningful when learners moved away from an exclusive emphasis on linguistic perfection toward mutual understanding and patient-centered interaction. Even linguistically simple expressions can carry considerable professional meaning when they help patients feel accepted, understood, respected, or less alone.

Nursing English education should therefore continue to develop linguistic competence while

also helping students understand the relational purposes for which language is used. From this perspective, English can move from being something students study for nursing toward something they learn to use through nursing relationships.

Interdisciplinary Education as a Professional Learning Space

A distinctive feature of the intervention was the interconnection between English education and maternity nursing. The maternity nursing perspective contributed clinically meaningful situations and knowledge of women's emotional experiences, while the English education perspective created a communicative environment in which students could interpret those situations, construct dialogues, negotiate meanings, and reflect through another language.

The intervention was therefore neither simply an English exercise containing nursing vocabulary nor a maternity nursing simulation translated into English. Its educational value emerged from the intersection of the two disciplines.

This suggests that nursing English can occupy a distinctive curricular position between general education and professional nursing education. Particularly for first-year students, it can provide a bridge from language learning to clinical communication, from understanding a fictional patient to considering actual patient-centered care, and from classroom participation to professional reflection.

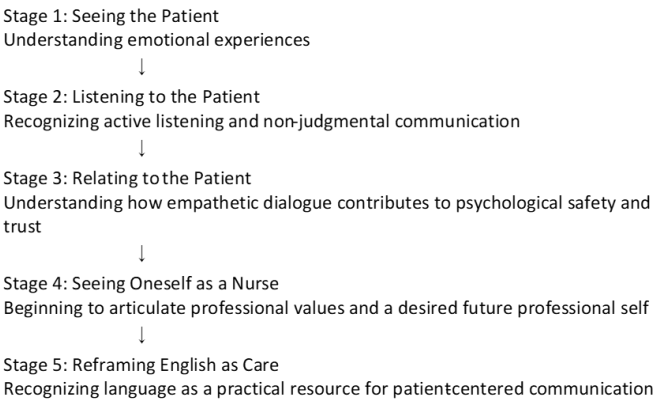
Such interdisciplinary learning also provides an opportunity to connect language with the ethical and relational dimensions of nursing. Students do not simply ask whether an English expression is grammatically correct; they begin to consider whether it communicates acceptance, creates safety, supports disclosure, or contributes to trust.

An Integrated Educational Process

Taken together, the five themes can be understood as interconnected dimensions of an educational process rather than entirely separate outcomes.

Figure 2

Five Stages in an Integrated Educational Process



The sequence shown in Figure 2 should be understood as an interpretive model rather than a demonstrated causal pathway. The five themes overlapped, and the qualitative design cannot establish that one necessarily causes the next. Nevertheless, the model synthesizes the findings and suggests a broader educational trajectory from patient recognition toward professional self-recognition.

Educational Implications

The findings have several implications for Nursing English and first-year nursing education. First, clinically meaningful narratives can be incorporated into language learning from the beginning of undergraduate nursing education. Students do not necessarily require advanced clinical knowledge to begin considering vulnerability, empathy, trust, and patient-centered communication.

Second, communication education should address not only what nurses say but also what their words accomplish relationally. Students can be encouraged to consider whether particular responses create acceptance, psychological safety, reassurance, trust, or willingness to disclose concerns.

Third, reflection should be treated as an

integral component of learning rather than an optional exercise after the main activity. In the present study, reflection provided a bridge between observing Nurse Mikan and considering students' own professional values and future nursing practice.

Fourth, allowing students to construct continuation narratives can encourage active interpretation. Instead of reproducing predetermined expressions, students must consider what a patient might experience and what an appropriate nursing response could be.

Fifth, professional identity formation should not be regarded solely as an outcome of later clinical education. Early classroom experiences may provide opportunities for students to begin considering the nurses they wish to become.

Finally, collaboration between language educators and nursing specialists can create interdisciplinary spaces in which linguistic learning, empathy, communication, professional values, and reflection become interconnected.

Limitations and Future Research

Several limitations should be acknowledged. First, the study was conducted with first-year students at a single Japanese nursing college. The findings therefore cannot be assumed to represent students at other institutions, educational levels, or cultural contexts.

Second, the data consisted of written reflections collected immediately following a single 90-minute intervention. They demonstrate students' interpretations and emerging professional orientations but do not establish sustained changes in empathy, communication behavior, or professional identity.

Third, the intervention included several interconnected components—puppetry, maternity narratives, English dialogue, collaborative story construction, presentation, and reflection. The present design cannot determine the independent contribution of each component.

Fourth, professional identity was interpreted through students' reflective statements rather than measured using a validated professional identity instrument. The findings should therefore be understood as evidence of emerging professional self-concept and professional identity formation rather than proof of an established professional identity.

Fifth, thematic frequencies provide useful descriptive information concerning the prevalence of particular patterns, but this was fundamentally a qualitative study. The percentages should not be interpreted as quantitative measures of intervention effectiveness.

Sixth, the study did not include pre-intervention data or a comparison group. It is therefore impossible to determine the extent to which students' perspectives were generated specifically by the intervention rather than reflecting attitudes they already held.

Future longitudinal research could follow students as they progress into specialist nursing courses and clinical placements and investigate whether early commitments to empathetic and non-judgmental communication are retained, modified, or strengthened through direct patient encounters. Future studies could also compare puppet-based narrative learning with conventional role-play, standardized-patient simulation, video-based cases, or other narrative approaches to clarify which elements are particularly effective in supporting empathy, relational communication, and professional identity formation.

Conclusion

The findings suggest that the educational value of puppet-based learning extends beyond making classroom activities engaging. The maternity-care narratives provided first-year nursing students with an accessible form of vicarious clinical experience through which they could consider patients' emotions, the relational meanings of nurses' words, the development of psychological

safety and trust, and their own future nursing practice.

A particularly important finding was the movement among some students from evaluating the fictional nurse's actions toward articulating their own desired professional selves. Although a single classroom intervention cannot establish professional identity, meaningful patient narratives combined with communication and reflection may create early opportunities for students to recognize professional values and begin imagining the nurses they hope to become.

The findings also support a broader conception of nursing English education. English need not function solely as a subject through which students acquire specialized vocabulary, reading comprehension, or linguistic accuracy. When language learning is integrated with clinically meaningful narratives, empathy, interdisciplinary collaboration, active participation, and reflection, English can become a medium through which students explore the relational and ethical dimensions of nursing.

The educational trajectory suggested by the present study can therefore be summarized as a movement from seeing the patient, to listening to the patient, to building trust with the patient, and ultimately to seeing oneself as a nurse. Within such a process, nursing English may provide students with an opportunity to move from learning English for nursing toward learning, through English, how to become a nurse.

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Four Stress-Related Loanwords in the Disaster Nursing Section of a Fundamental Nursing Textbook

Motoko Sando (msando@wakayama-med.ac.jp)
Wakayama Medical University

Abstract: *The aim of this study was to clarify the meanings of four stress-related loanwords used in disaster nursing and to compile data for inclusion in a nursing loanword glossary. This small-scale, descriptive philological study was based on a comparative analysis of definitions in Japanese and international English dictionaries. The study examined four katakana loanwords: baanauto [burnout], buriifuingu [briefing], defyuujingu [defusing], and deburiifuingu [debriefing]. These terms are associated with Critical Incident Stress Management (CISM), a comprehensive approach to crisis intervention and disaster mental health. The findings indicate that the forms and meanings of these loanwords require careful interpretation when used in Japanese nursing contexts. Because directly equivalent Japanese expressions may not always be available, English-derived terms are often adopted into Japanese katakana form. However, using such terms without a clear understanding of their original meanings and professional contexts may lead to misunderstandings. Nursing students need to understand both the meanings of these loanwords and their appropriate use in English in order to develop accurate professional communication skills.*

Keywords: Critical Incident Stress Management, disaster nursing, English for nursing education, katakana loanwords, nursing terminology

About the Author: Motoko Sando, PhD, is an associate professor of English stylistics and philology at Wakayama Medical University and has been teaching English for 24 years. Her research interests include nursing loanwords as well as a lexicological study of American English.

This paper reports on a descriptive philological study based on a comparative analysis of definitions in Japanese and international English dictionaries, and represents part of an ongoing project to build a nursing loanword glossary (Sando, 2020, 2021, 2022, 2025). I extracted all katakana terms from the 2020–2025 National Nursing Licensure Examination to collect the basic data necessary for creating a glossary. However, due to the standardized nature of the examinations, the katakana terms used were limited and uniform in scope, indicating a need for a more detailed examination of individual nursing areas. Because of the enormous size of the vocabulary required to cover the entire field of nursing simultaneously, I chose to focus exclusively on a fundamental nursing textbook to provide this supplementary examination. Among eight textbooks for first-year nursing students at Wakayama Medical University, I selected Shigeno et al. (2020) for detailed analysis.

Natural disasters can occur anywhere and at any time. Chapter 7 of Shigeno et al. (2020) includes a section titled *Saigaiji ni okeru kango* [Disaster Nursing] which notes that disasters can have a profound effect on healthcare professionals who are likely to be overworked in unfamiliar and demanding environments. Because high-stress situations can lead to mental and physical health problems, there is also a growing need to provide care and support for healthcare professionals themselves.

In light of this context, the aim of this research was to focus on stress-related disaster nursing loanwords, categorize them into typical loanword types, and compile data for inclusion in a nursing loanword glossary.

Methods

I extracted a total of 107 katakana terms from the 20-page disaster nursing section of the textbook (Shigeno et al., 2020) through a page-by-page

examination, and identified 63 katakana terms that had not appeared in the National Nursing Licensure Examination during the previous six years. Seven of the 63 terms were listed as academic terms in disaster nursing by the Japan Society of Disaster Nursing (n.d.), and three—*baanauto*, *buriifuingu*, and *defyuujingu*—were stress-related. Since *deburiifuingu* seemed to be closely related to these three terms, I decided to focus on all four stress-related terms.

First, I examined the definitions of the four terms in several Japanese dictionaries (Expert Nurse Editorial Department, 2016; Ibe and Minowa, 2017; Iida, 2015; Mito et al., 2011; Wada et al., 2010). I also examined the definitions of the corresponding English terms in several major international English dictionaries (McFerran, 2021; Merriam-Webster, n.d.; O'Toole, 2017; Taylor, 2019; Venes, 2025). In addition, I consulted a disaster-related glossary (Everly, 2025) and other references as necessary. Next, I compared the definitions given in the chosen sources and determined working definitions for the four terms for the glossary. Finally, I categorized the terms and compiled the findings into a table. Based on my earlier studies, nursing katakana terms can be broadly categorized into the following loanword types: Type I, terms borrowed from languages other than English; Type II, English-derived terms adopted into Japanese without abbreviation or semantic modification; Type III, terms coined in Japan using existing foreign-language elements; Type IV, terms used in Japanese with meanings that differ from those of the corresponding source-language terms; and Type V, abbreviated or shortened forms of source-language terms (Sando, 2021, 2022, 2025).

Results

Baanauto [Burnout]

Two Japanese dictionaries include *baanauto* [burnout] (Expert Nurse Editorial Department, 2016; Iida, 2015). Three others include *moetsuki-shokogun* [burnout syndrome] (Ibe & Minowa, 2017; Mito et al., 2011; Wada et al., 2010). Four international English dictionaries include burnout (McFerran, 2021; O'Toole, 2017; Taylor, 2019; Venes, 2025). After Freudenberger (1974) introduced the concept of burnout to the healthcare field, the term burnout became widely used in interpersonal and helping professions. The World Health Organization (2025) classifies burnout as an occupational phenomenon and defines it as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed."

In summary, *baanauto* [burnout] can be categorized as a Type II loanword and defined by the author of this paper as mental or physical exhaustion, often in relation to prolonged occupational stress. In a medical context, burnout also has a dental meaning related to casting, defined as "in dentistry eliminating by heat to prepare the mold to receive casting metal" (Stedman, 2013, Definition 1), while, in a more general sense, it has been defined as "rendering unserviceable by excessive heat" (Venes, 2025, Definition 1). Table 1 shows the multiple meanings of *baanauto*, as well as the meanings of the other three loanwords discussed in the following subsections.

Buriifuingu [Briefing]

No Japanese dictionaries include *buriifuingu* [briefing] and only Venes (2025) defines briefing, as "a short session of instruction or preparation for a person, crew, or staff on how to accomplish an upcoming operation." Everly (2025, p.22) lists crisis management briefing as "an information-based group crisis intervention, the goal of which is to provide a forum and formulaic structure for the provision of information."

Based on these definitions, buriifuingu was categorized as Type II and defined by the author as an information-based session that provides instructions or preparation before an upcoming

mission or operation.

Defyuujingu [Defusing]

Among the Japanese and international English dictionaries examined, only Venes (2025c) lists critical incident stress defusing, defining it as "communication after a stressful care episode such as the death of a partner or patient, a serious injury to a child, a mass casualty incident, or other disaster." Everly (2025, p.25) defines defusing as "a 3-phase, 20–30-minute small group interactional crisis intervention for emergency services personnel" consisting of introduction, exploration, and information.

In summary, *defyuujingu* [defusing] was characterized as Type II and defined here as "a brief, structured intervention conducted shortly after a stressful or critical incident to address immediate reactions and provide information and support" (Everly, 2025, p.25).

Deburiifuingu [Debriefing]

Expert Nurse Editorial Department (2016) agrees with Mito et al. (2011) who state that *deburiifuingu* [debriefing] has its origin in the military and refers to "a report after the mission as one of the crisis intervention methods in a group session." Moreover, Venes (2025c) includes critical incident stress debriefing (CISD) and gives the same definition as that for critical incident stress defusing. According to Everly (2025, p.23), CISD is "a 7-phase psychological crisis intervention conducted in small interactional groups after some highly stressful event," consisting of introduction, fact, thought, reactions, physical symptoms, teaching and summary.

In summary, *deburiifuingu* [debriefing] can be categorized as Type V and defined here as "a structured, multi-phase group intervention conducted after a highly stressful or critical incident to review participants' experiences and reactions and provide information and support." *Deburiifuingu* was categorized as Type V because debriefing is used here as a shortened form of critical incident stress debriefing (Everly, 2025, p.23).

Discussion

Healthcare professionals need to recognize their limits and protect their own lives while carrying out rescue missions. Everly (2022) recommends using a system called Critical Incident Stress Management (CISM), a combined approach to emotional crisis and disaster mental health intervention. CISM includes briefing, defusing, and debriefing as interventions intended to manage healthcare professionals' stress and reduce the risk of burnout.

As with many disaster nursing loanwords, numerous healthcare concepts and techniques originated outside Japan and were subsequently introduced into Japanese healthcare contexts. It is

Headword	Japanese meaning	English equivalent	Type*	Part of Speech	Definition & Usage Example
ﾊﾞｰﾝｱｳﾄ (*baanauto*)	1. 燃え尽き症候群 2. 焼却 3. -	burnout	II	noun	1. Mental or physical exhaustion, often in relation to prolonged occupational stress e.g., Healthcare professionals may be at increased risk of burnout following prolonged exposure to stressful working conditions. 2. In dentistry, elimination by heat to prepare a mold to receive casting metal. 3. Rendering something unserviceable by excessive heat.
ﾌﾞﾘｰﾌｨﾝｸﾞ (*buriifuingu*)	打ち合わせ	briefing	II	noun	An information-based session that provides instructions or preparation before an upcoming mission or operation. e.g., Healthcare professionals may attend a briefing before providing care in a disaster-affected area.
ﾃﾞﾌｭｰｼﾞﾝｸﾞ (*defyuujingu*)	息抜き[1]	(critical incident stress) defusing	II	noun	A brief, structured intervention conducted shortly after a stressful or critical incident to address immediate reactions and provide information and support. e.g., A defusing session may be conducted shortly after a critical incident.
ﾃﾞﾌﾞﾘｰﾌｨﾝｸﾞ (*deburiifuingu*)	振り返り[2]	critical incident stress debriefing (CISD)	V	compound noun	A structured, multi-phase group intervention conducted after a highly stressful or critical incident to review participants' experiences and reactions and provide information and support. e.g., Healthcare professionals may participate in a debriefing session following a critical incident.

often difficult to translate these terms into Japanese, especially when there are not any directly equivalent Japanese expressions. Therefore, the four terms examined in this report may be adopted into Japanese in borrowed or shortened forms. However, using such terms without fully understanding their origins, meanings, and professional contexts may cause misunderstandings. Nursing students, as future healthcare professionals, need to understand how these terms are used in English.

Conclusion

This report has focused on stress-related loanwords and found that three of the four terms can be categorized as Type II and one as Type V, and that *baanauto* [burnout] has multiple meanings. Although katakana terms may be convenient for Japanese speakers, they can create ambiguity when the corresponding source-language words have multiple meanings. To improve their English proficiency and professional communication skills, nursing students need to understand the meanings of these loanwords and learn how to use the corresponding terms accurately in English.

Because of space limitations, this report dealt with only four terms, while many other terms are used in the fundamental nursing textbook. As part of the adult nursing curriculum, Wakayama Medical University offers a required class called *Saigai kangoron* [Disaster Nursing Theory] for second-year nursing students. From the perspective of English for nursing education, I plan to examine other katakana nursing terms across a broader range of nursing fields and eventually develop a nursing loanword glossary.

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Supporting Foreign Patients and Families in Japanese Healthcare Settings: Reframing Nursing English Education as Professional Communication for Culturally Responsive Care

Tsutako Miyazaki[1] (tsutako.miyazaki@mcn.ac.jp), Izumi Dryden[1], & Laurence M. Dryden[2]
[1]Mie Prefectural College of Nursing, [2]independent scholar

***Abstract**: As Japan's foreign resident population continues to increase, nurses require communication skills that extend beyond English proficiency. The present study is a qualitative descriptive report that explores the healthcare experiences of foreign women and families in Japan and examines the implications for nursing English education. Interview narratives and relevant literature were analyzed using qualitative descriptive analysis. Three themes emerged: communication barriers related to language and health literacy, reliance on family members as interpreters, and cultural differences in health beliefs and family practices. These findings indicate that effective nursing communication depends not only on language ability but also on "cultural humility," patient-centered communication, and collaboration with professional interpreters. Accordingly, nursing English should be reconceptualized as professional communication education rather than as language instruction alone. Educational programs should foster communication competence through plain-language communication, teach-back strategies, culturally responsive care, and reflective learning to prepare future nurses for increasingly multicultural healthcare environments.*

Keywords: cultural humility; foreign residents; intercultural communication; nursing English; patient-centered care

About the Authors: Tsutako Miyazaki is a professor at Mie Prefectural College of Nursing, where she teaches pediatric nursing and related courses. She also serves on the college's executive board and as Director of the Regional Community Center, working with local residents, students, and faculty to address the social and ethical challenges faced by children with disabilities and children in need of social care.

Izumi Dryden is an associate professor at Mie Prefectural College of Nursing in Tsu, Japan. She teaches English reading, literature and medicine, and communication. Her research interests include nursing English education, bibliotherapy, narrative medicine, and the writings and correspondence of Florence Nightingale.

Laurence M. Dryden is a retired university English educator in Suzuka, Japan. He has more than fifty years of teaching and research experience in Japan and the United States. His academic interests include English language education, imaginative literature, world history, and intercultural communication.

Japan has become an increasingly multicultural society, with the number of foreign residents exceeding 4.12 million in 2025, the highest level on record (Immigration Services Agency, 2026). As the population of foreign residents of childbearing age continues to grow, nurses are increasingly providing maternity, pediatric, and family care for patients from diverse linguistic and cultural backgrounds.

Effective communication is fundamental to safe, patient-centered nursing. However, communication in multicultural healthcare extends beyond language proficiency. Patients' understanding of health information is influenced by health literacy, cultural beliefs, family roles, religious values, and previous healthcare experiences (Nonaka & Higuchi, 2010; Watanabe, 2024). Consequently, accurate translation alone does not guarantee mutual understanding or informed participation in healthcare decisions.

Although healthcare institutions in Japan are caring for an increasing number of foreign patients, culturally and linguistically responsive support remains insufficient. A nationwide survey by the Ministry of Health, Labour and Welfare (2024) reported that many hospitals continue to

lack comprehensive systems for multilingual communication, professional medical interpretation, and coordinated support for culturally diverse patients. Previous and subsequent studies have similarly identified communication difficulties between Japanese healthcare providers and foreign residents during pregnancy, childbirth, child-rearing, and pediatric care (Gomi & Ota, 2023; Hashimoto & Satoh, 2023; Nishioka et al., 2025).

These challenges have important implications for nursing English education. Traditionally, nursing English has focused on medical terminology and routine clinical communication. While linguistic competence remains essential, contemporary nursing practice increasingly requires communication that promotes cultural responsiveness, shared understanding, and collaborative partnerships with patients and families. Nursing English might therefore be viewed as professional communication education rather than language instruction alone.

This paper reports on a small-scale study that explored the healthcare experiences of foreign women and families in Japan and examined how these experiences can inform the future development of nursing English education. By integrating perspectives from family nursing, intercultural communication, and nursing education, the authors propose educational approaches that foster communication competence and culturally responsive nursing practice.

Methods

Report Design

The study reported on here employed a qualitative descriptive design to explore healthcare experiences of foreign patients and families in Japan and examine their implications for nursing English education. Qualitative description is well suited to generating practical knowledge that informs healthcare practice and educational development (Sandelowski, 2000). In qualitative descriptive research, data are examined with the aim of staying close to participants' accounts and presenting experiences in clear, practice-oriented language rather than developing highly abstract theoretical explanations. Accordingly, in the present study, interview narratives were read repeatedly, compared across cases, and organized according to recurring communication-related patterns. These patterns were then considered alongside relevant Japanese -language literature to clarify their practical significance. This approach is particularly appropriate to the present topic because the study sought to describe how communication difficulties are experienced in actual healthcare encounters and to translate those experiences into concrete implications for nursing English education.

Data Sources

Data were obtained from two complementary sources. First, interview narratives from 13 foreign patients, family members, and Japanese school teachers were examined to identify communication challenges during pregnancy, childbirth, child-rearing, and general healthcare encounters. These interviews were conducted by the first author of this paper over multiple years. From these interview narratives, three cases were selected that provided particularly illustrative perspectives from three different positions—a mother, an individual with lived experience as a child interpreter, and a schoolteacher.

Then, Japanese-language literature addressing maternity care, pediatric nursing, maternal and child health, and the healthcare experiences of foreign residents was reviewed to contextualize and support the interpretation of the interview findings (Gomi & Ota, 2023; Hashimoto & Satoh, 2023; Kawasaki, 2014; Nishioka et al., 2025; Nishimura et al., 2023; Toda, 2019; Watanabe, 2024).

Data Analysis

Data were analyzed using qualitative descriptive analysis. Through iterative reading and comparison of interview narratives and published evidence, recurring patterns were identified and organized into three themes: (1) communication barriers associated with language and health literacy; (2) challenges related to interpretation and language support; and (3) the influence of cultural beliefs and family health practices on healthcare experiences. These themes were interpreted in light of the perspectives of family nursing, intercultural communication, and nursing English education, with the aim of identifying educational strategies for strengthening culturally responsive communication.

Findings

Analysis of the interview narratives and supporting literature identified three interconnected themes affecting healthcare communication for foreign patients and families in Japan: (1) communication barriers related to health literacy; (2) reliance on family members as interpreters; and (3) cultural differences in health beliefs and family practices. Together, these findings indicate that effective nursing communication depends on understanding patients' linguistic, cultural, and social contexts rather than relying on language proficiency alone.

Communication Barriers Related to Health Literacy

One participant who developed pregnancy-induced hypertension was advised to reduce salt intake. Although she followed the instruction by avoiding table salt, she was unaware that many processed foods and seasonings commonly consumed in Japan also contain high levels of sodium. Because the explanation did not sufficiently connect the general instruction to the specific foods, seasonings, and meal patterns in her everyday life, she was unable to recognize all of the dietary sources of sodium that were relevant to her condition. She subsequently delivered a very low-birth-weight infant prematurely. Despite this outcome, she expressed gratitude for the care she received, believing her infant might not have survived in her home country. This case illustrates that patients may appear to understand health guidance while important misunderstandings remain undetected because of information gaps caused by unaddressed cultural and language differences. This case also demonstrates the importance of confirming not simply whether patients understand the words used in an explanation, but how they typically interpret and apply health information within their everyday lives.

Reliance on Family Members as Interpreters

Another participant relied on her school-age child to interpret during a medical consultation because professional interpretation was unavailable. The child struggled both to explain symptoms accurately and to convey the healthcare provider's recommendations, resulting in misunderstandings that delayed treatment. Similar difficulties were reported when adult family members acted as interpreters despite having only conversational Japanese skills. These findings suggest that family interpretation may compromise communication accuracy and place unnecessary emotional responsibility on relatives, particularly children.

Cultural Differences in Family Health Practices

A third example involved oral health education in an elementary school attended by children from multicultural families. Some children repeatedly arrived without toothbrushes, prompting school staff to explore the reasons with their families. Through communication with the families, staff learned that the issue was not simply that the children had forgotten to bring toothbrushes to school. Rather, regular toothbrushing had not been established as a routine health practice in some of the children's households. As a result,

bringing a toothbrush to school and participating in school-based toothbrushing activities were not yet understood as part of the children's everyday health routine. Importantly, school staff did not immediately interpret this situation as parental indifference or neglect. Instead, they sought to understand the families' existing health practices and the circumstances underlying the children's behavior and adapted their oral health education accordingly. This case demonstrates that practices which healthcare and educational professionals may regard as basic or self-evident cannot always be assumed to be shared across families. Effective health education therefore requires respectful dialogue to identify existing health practices and knowledge, followed by support that helps families understand the purpose of unfamiliar preventive health behaviors without stigmatizing or judging them.

Discussion

The findings indicate that communication challenges experienced by foreign patients and families in Japan extend beyond language differences. Effective healthcare communication is shaped by the interaction of language proficiency, health literacy, cultural beliefs, family practices, and access to appropriate support. Consistent with previous research (Gomi & Ota, 2023; Hashimoto & Satoh, 2023; Watanabe, 2024), these results suggest that misunderstandings often arise because patients and healthcare professionals interpret health information through different cultural and social frameworks.

A key finding is the distinction between language proficiency and health literacy. Patients who communicate adequately in everyday Japanese may still struggle to understand medical concepts or apply health advice appropriately. The case of pregnancy-induced hypertension illustrates the need for effective communication in which nurses impart health information that is clearly tied to patients' daily lives, dietary habits, and cultural contexts. Communication could therefore be viewed as a collaborative process of developing shared understanding rather than simply transmitting information with minimal context.

The findings also highlight the limitations of relying on family members, particularly children, as interpreters. Although relatives often provide valuable support, they may lack the linguistic and clinical knowledge needed for accurate medical interpretation. Their involvement may also increase emotional burdens that lead to communication errors. Whenever possible, it would be best for healthcare professionals to collaborate with qualified medical interpreters while using multilingual resources, visual materials, and plain-language communication to enhance patient safety and understanding.

The previously-mentioned oral health example further illustrates that culturally responsive care does not mean attributing every difference to culture. Rather, such situations require professionals to suspend immediate judgment, explore the practices and assumptions operating within a particular family, and determine collaboratively what kind of explanation or support is needed. In this case, recognizing that regular toothbrushing had not been established as a household routine allowed school staff to respond educationally rather than judgmentally. This distinction is particularly important in nursing, where behaviors that appear to indicate noncompliance may instead reflect differences in prior health education, health literacy, family routines, or understandings of preventive care.

Such perspectives and practices align with the concept of cultural humility (Foronda et al., 2016), which emphasizes continuous self-reflection, respectful partnerships, and openness to patients' perspectives. Cultural humility does not require nurses to possess detailed knowledge about every cultural group. Rather, it encourages them to recognize the limits of their own assumptions, ask

respectful questions, listen carefully to patients and families, and develop care collaboratively according to individual circumstances. Such an approach helps prevent cultural difference from being interpreted through stereotypes while still recognizing that cultural and social experiences may influence health practices.

The findings presented here have significant implications for nursing English education. Nursing students need more than the ability to reproduce appropriate medical terminology or standardized clinical expressions. They need to learn how to discover what patients and families already know, how they understand a health issue, what practices are part of their everyday lives, and what may prevent them from following healthcare recommendations.

For nursing English education, therefore, scenario-based learning would require students to negotiate meaning rather than merely produce correct English. Students could practice explaining health information in plain language, checking understanding through teach-back, working appropriately with professional interpreters, and responding to culturally unfamiliar perspectives without making premature assumptions. For example, instead of simply instructing a family to follow a particular health behavior, students might learn to begin with open questions such as, "Could you tell me about your usual oral-care routine at home?" Such questions transform English from a tool for giving instructions into a means of understanding the patient or family before deciding how best to communicate health information.

Reflection following these activities can further help students examine how their own cultural and professional expectations influence communication. Students can be encouraged to consider why they regard particular health practices as obvious, how a patient or family member might understand the same practice differently, and how they can communicate recommendations without stigmatizing unfamiliar behaviors.

In such ways, nursing English education can function as a bridge between language learning and professional nursing judgment. Its contribution lies not only in expanding students' vocabulary but also in helping students decide what needs to be explained, what needs to be asked, how understanding ought to be checked, and when additional linguistic or cultural support is required. Developing these capacities may enable future nurses to recognize hidden misunderstandings earlier and respond more effectively in increasingly diverse clinical settings.

Conclusion

Japan's increasingly multicultural healthcare environment requires nurses to provide communication that is both linguistically accessible and culturally responsive. This preliminary report demonstrates that communication challenges experienced by foreign patients and families extend beyond language barriers to include differences in health literacy, cultural beliefs, family practices, and healthcare expectations.

The three cases presented in this report demonstrate a common educational lesson: communication difficulties may remain hidden when healthcare professionals assume that patients and families share the same meanings, knowledge, and everyday practices. The educational priorities for nursing English would be optimally served not by the addition of more English expressions alone, but by the development of students' abilities to discover, prevent, and repair misunderstandings through listening, questioning, explanation, and verification of understanding.

Nursing English education can provide students with repeated opportunities to explain health information in accessible language, explore patients' everyday practices without premature judgment, collaborate appropriately with

interpreters, use teach-back, and reflect critically on their own assumptions. In this sense, English communication becomes inseparable from patient-centered nursing judgment.

Future research and teaching practices could develop and evaluate nursing English learning activities based on authentic multicultural healthcare cases such as those presented here. Examining how students respond to these cases—and whether they become better able to identify health-literacy needs, use interpretation support appropriately, explore family practices respectfully, and adapt communication to individual patients and families—would provide a strong evidence base for integrating intercultural communication into nursing English curricula in Japan.

Ultimately, preparing nurses for multicultural healthcare is not simply a matter of teaching students what to say in English. It is a matter of teaching them how to listen, how to identify what has not yet been understood, and how to build shared understanding with patients and families whose experiences and assumptions may differ from their own.

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Incorporating Psychological Inference and Characterization into Nursing English Classes

Izumi Dryden[1] (idumi.doraiden@mcn.ac.jp), Tsutako Miyazaki[1], Atsushi Koike[1], Megumi Tanahashi[1], & Laurence M. Dryden[2]

[1]Mie Prefectural College of Nursing, [2]independent scholar

***Abstract**: Children often express their emotions indirectly through behavior, facial expressions, play, or silence rather than through explicit verbal communication. Consequently, pediatric nurses require the ability to interpret children's psychological states as well as communicate effectively. The present report describes a nursing English educational framework presented at the 2026 conference of the Japan Association for Nursing English Teaching (JANET). The framework integrates literature, films, memory activities, and English role-play to stimulate psychological inference and characterization skills in undergraduate nursing students. Watching such feature films as the Harry Potter series, Maleficent, and Home Alone, students explored emotional neglect, attachment, resilience, family relationships, and alternative caregiving while practicing English communication. Memory activities encouraged students to recognize the importance of understanding each child as an individual, and English role-plays integrated pediatric communication with basic cognitive assessment. Rather than focusing solely on language acquisition, the educational activities cultivated empathy, reflective thinking, and patient-centered perspectives. The present report suggests that integrating familiar stories from films and books with reflective learning activities provides an engaging educational approach for developing psychological inference skills that are essential for communication with pediatric patients.*

Keywords: characterization; empathy; narrative medicine; pediatric nursing; psychological inference

About the Authors: Izumi Dryden is an associate professor at Mie Prefectural College of Nursing (MCN). She teaches liberal arts courses in English reading, literature and medicine, and communication.

Tsutako Miyazaki is a professor at MCN, where she teaches pediatric nursing and related courses.

Atsushi Koike is a professor of psychology at MCN. His research focuses on how international and Japanese nursing students develop verbal communication skills.

Megumi Tanahashi is a second-year student at MCN. She holds a PhD in medicine and is a clinical psychologist.

Laurence M. Dryden is a retired university English educator in Suzuka, Japan. He has more than 50 years of teaching and research experience in Japan and the United States.

Communication is a fundamental component of pediatric nursing, but children do not always express their feelings, fears, or concerns directly. Depending on their developmental stage, personality, health condition, or emotional state, they may communicate through behavior, facial expressions, play, or silence rather than through explicit verbal explanations. Nurses therefore need to interpret these indirect forms of communication while building trusting relationships with children and their families (Hockenberry et al., 2019, pp. 86–87). Understanding children's emotional experiences is particularly important for providing compassionate and patient-centered care.

As reflected in commonly used nursing English textbooks (e.g., Inoue & Sato, 2022), nursing English education often focuses on areas such as medical terminology, reading comprehension, and spoken communication in healthcare settings. These areas provide an essential foundation for developing the English language skills that nursing students may need in their future professional practice. At the same time, nursing English classes can also provide opportunities to connect language learning with broader aspects of psychology, interpersonal communication, and human relationships.

This possibility may be particularly valuable in pediatric nursing, where effective communication involves understanding not only what children say but also what they may be feeling, thinking, or unable to express directly. English does not necessarily need to be taught as an isolated subject; it can provide a meaningful context in which students engage with these interpersonal dimensions while developing their language skills. This is not to say that English classes should be required to incorporate the teaching of psychological or clinical skills, but that nursing English can be viewed as a potentially valuable interdisciplinary space in which students observe characters, infer emotions and intentions, consider different perspectives, and communicate with sensitivity.

Narrative medicine provides a useful perspective for considering this possibility. Charon (2006, p. 11) describes narrative competence as the ability to recognize, absorb, interpret, and respond to the stories of others. In pediatric nursing, children's personal stories may be conveyed through actions and relationships as well as words. Imaginative literature and films can therefore provide opportunities for students to practice interpreting emotions, motivations, and interpersonal relationships before encountering comparable situations in clinical practice (Greenhalgh & Hurwitz, 1999, p. 50).

However, the integration of psychological inference and characterization into nursing English education remains relatively under-explored, particularly in relation to pediatric nursing. There is therefore scope to consider how English classes might incorporate these interdisciplinary elements without shifting their primary focus away from language learning, and how such approaches might connect English communication with empathy, perspective-taking, and patient-centered understanding.

Educational Framework: Developing Psychological Inference through Literature, Films, and Reflective Learning

The educational framework presented here encourages nursing students to consider the interpersonal meanings underlying communication with children. Throughout the English course, students were guided by three fundamental questions: "What might this child be feeling?"; "What evidence supports this interpretation?"; and "How should a nurse respond?" These questions provided a basis for psychological inference and guided the classroom activities.

Familiar literary works and films were incorporated to support this process. The Harry Potter series, Home Alone, and Maleficent were selected because they are familiar and engaging films for students and, more importantly, because each offers opportunities to examine children's emotions, relationships, family backgrounds, and responses to challenging life experiences. Analyzing fictional characters allows students to maintain a degree of analytical distance while considering how children's behavior and communication may reflect underlying emotions and psychological needs. The films therefore provided accessible contexts for examining children's experiences from multiple perspectives.

Classroom discussions were conducted in English, allowing students to use the target language while expressing and exchanging their interpretations of the characters' emotions, motivations, and relationships. Rather than viewing only selected clips, students watched each film in its entirety over several class sessions. This gradual viewing process gave students opportunities to follow the development of the child characters and their relationships over time and to consider how emotions, behavior, and psychological needs changed in response to different experiences and interactions.

The Harry Potter series (Columbus et al., 2001–2011) was used to explore childhood neglect,

resilience, and supportive relationships. Students considered Harry's experiences of growing up without his biological parents and living in an emotionally unsupportive environment. Questions such as "What kinds of people did Harry need?" and "Why were Harry's relationships with Ron, Hermione, Hagrid, and Dumbledore so important?" directed attention away from the fantasy elements and toward emotional development and interpersonal relationships. Students considered how a child's behavior might be better understood in the context of personal history and relationships, and how nurses might communicate with children experiencing isolation or insecurity.

Maleficent (Stromberg, 2014) offered a different perspective on attachment and caregiving. Aurora develops a trusting relationship with Maleficent despite being separated from her biological parents. Students considered themes of belonging, identity, foster care, adoption, and alternative caregiving. Discussion focused on how emotional security can develop through consistent care, protection, and acceptance rather than through biological relationships alone. This set of concerns also provided an opportunity to consider how nurses may encounter children from diverse family backgrounds and why each child's individual circumstances need to be understood sensitively.

A different learning activity was developed using Home Alone (Columbus, 1990). Students were shown photographs of 10 children appearing in the film, together with a separate list of their names, and were asked to match each child with the correct name. Although the exercise appeared straightforward, many students found remembering all the names difficult. This experience led to discussion about pediatric nursing, where nurses encounter many children with different personalities, developmental stages, family circumstances, and emotional needs. Remembering a patient's name was presented as only the first step toward recognizing the child as a unique individual.

Following these activities, students participated in English-language role-plays based on pediatric nursing scenarios. They assumed the roles of nurses, parents, children, and siblings while practicing communication that might occur in pediatric settings. The role-plays progressed from basic orientation questions to conversations exploring children's feelings and concerns. Students were encouraged to consider how anxiety, trust, fear, and emotional security might influence a child's responses and to adapt their English communication accordingly. Attention was also directed toward non-verbal cues and what a child might be unable or unwilling to express directly.

In such ways, imaginative literature and films provided material for observation and interpretation; the memory activity focused attention on children as individuals; and role-play offered opportunities to translate these insights into interpersonal communication. The activities were not intended to turn an English course into a series of psychology experiments or clinical training exercises, but rather to explore how language learning could be enriched through attention to the intricate dynamics of people, emotions, experiences, and relationships involved in communication.

Educational Implications

There are considerable advantages to using familiar works of fiction for reflective learning. The selected films allowed students to discuss such emotionally complex issues as neglect, attachment, resilience, loneliness, and family diversity in a psychologically safe English classroom environment. Because the characters were fictional, students could examine sensitive topics with some analytical and emotional distance while considering how similar situations might arise in pediatric nursing practice.

The gradual, sequential viewing of complete

films over several class meetings may also have educational advantages. Short clips can illustrate specific language or situations efficiently, but following the arc of an entire narrative over several sessions lets students observe how characters and relationships develop and change. Students can reconsider their earlier interpretations as new information becomes available, providing opportunities to recognize that understanding another person is an ongoing process rather than an immediate judgment based on a single behavior or interaction.

The memory activity similarly drew attention to the process of individualization. Identifying children by name is but one step toward understanding them as individuals with distinctive personalities, developmental stages, family backgrounds, and emotional experiences. When combined with role-play, the memory activity encouraged students to consider how communication might need to change according to the individual and the situation rather than relying only on predetermined questions or expressions.

These activities also put aspects of narrative medicine into practice within nursing English education. Charon (2006) emphasizes the importance of recognizing and interpreting patients' stories. By exploring children's experiences through fiction and film, students can attend to perspective, context, relationships, and meaning while simultaneously using English for discussion and interpersonal communication. In this respect, English becomes not only the object of learning but also a medium through which students can explore human experiences relevant to nursing.

This does not mean that psychological inference or characterization ought to become required components of nursing English education. Rather, this is one example of how teachers can connect language learning with the teaching of other aspects of interpersonal communication that are relevant to nursing. It illustrates how educators can create meaningful contexts for English communication that relate to students' future professional practice.

Conclusion

The key takeaway from the educational framework presented here is that nursing English classes can provide opportunities to connect language learning with the interpersonal dimensions of nursing practice. Literature, films, reflection, memory activities, and role-play can create an interdisciplinary space in which students use English while considering how children may think, feel, behave, and communicate. Psychological inference and characterization are therefore not proposed as additional competencies that English teachers are required to teach, but as potentially valuable skill sets through which language learning can be connected with empathy, perspective-taking, and patient-centered communication.

Future research might identify optimal combinations of literature, film, memory work, and role-play that improve English communication skills in ways that also develop psychological inference skills and deepen understanding of pediatric patients. The mechanics of such research could include student reflections, pre- and post-course evaluations, and longer-term follow-up in current and wider arenas. Research might also explore how the classroom framework proposed here could be adapted to other areas of nursing in which understanding patients' perspectives, backgrounds, and unspoken concerns is particularly important.

Integrating language learning with the exploration of human experiences thus represents one possible way to widen the scope of nursing English education while retaining the core focus on language learning.

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Using TED Talks to Enhance Listening Comprehension in a Nursing English Course

Su-Jen Lai (janelai@mail.cgu.edu.tw)
Chang Gung University, Taiwan

About the Author: Su-Jen Lai is an Assistant Professor at Chang Gung University, Taiwan, specializing in English for Specific Purposes. She earned a Ph.D. in Linguistics from Lancaster University, UK, and has published research on EFL and ESP teaching in such journals as the Journal of Asia TEFL, Asian ESP Journal, and Nursing English Nexus.

Introduction

TED (Technology, Entertainment, and Design) Talks have emerged as a leading global platform for concise and engaging presentations on a wide range of topics. In language education, they are widely used as sources of authentic language input and are often accompanied by comprehension exercises and discussion activities that promote active learning. Previous research has shown that TED Talks can significantly enhance learners' listening comprehension, vocabulary acquisition, and critical thinking skills. However, their application in English for Specific Purposes (ESP) contexts remains relatively underexplored (Al-Jarf, 2021; Humeniuk et al., 2021; Nurhidayat & Syarifah, 2022; Wu, 2020). This gap is particularly evident in English for Nursing Purposes (ENP) in EFL settings, where access to authentic, discipline-specific language input is essential but often limited (Hillier et al., 2020). This paper aims to provide practical teaching tips for integrating TED Talks into university-level Nursing English listening instruction in Taiwan.

The Nursing English Course

The Nursing English course is a required component of the School of Nursing curriculum. Designed for third-year undergraduate EFL students, the course aims to develop learners' listening and speaking skills in professional nursing contexts. Students enrolled in the course possess foundational knowledge of nursing and healthcare, and their English proficiency ranges from CEFR B1 to B2. The course is offered over a 16-week semester, with an additional two weeks reserved for flexible scheduling, and includes two hours of instruction per week.

The primary instructional material for the course is the commercially published textbook English Communication for Nursing (CEFR B2 level), which covers a range of topics, including general medicine, surgery, medication administration, pediatrics, pain management, orthopedics, gastroenterology, and cardiology (Zeff, 2024). To enrich the curriculum, supplemental materials were incorporated, including adapted content from nursing-related publications (Cheng, 2019; Putlack, 2017) and selected TED Talks. Classroom activities included listening practice, group discussions, dialogue exercises, and role-plays, all of which were designed to cultivate practical communication skills relevant to professional nursing practice.

Instructional Procedures for TED Talks

TED Talks were integrated into the Nursing English course to enhance students' listening comprehension and increase their exposure to authentic spoken English. The following criteria guided the selection of the videos:

1. Topic Relevance: Videos were selected based on their relevance to major medical fields, including general medicine, surgery, pediatrics, pain management, orthopedics, gastroenterology, and cardiology.
2. Language Level: Videos were appropriate for high-intermediate EFL learners.

3. Length: Each video was 5-10 minutes long to maintain student engagement while ensuring a manageable cognitive load.

The instructional procedures consisted of the following five steps:

Step 1. Activating Background Knowledge

Before viewing the selected TED Talk, the instructor provided a brief overview of the topic to activate students' background knowledge. Key vocabulary and medical terminology were introduced, and guiding questions were presented to direct students' attention to the main ideas.

Step 2. First Viewing: Understanding the Main Idea

Students watched the TED Talk with English subtitles while taking notes in response to the guiding questions. At this stage, the primary objective was for students to understand the main idea and the speaker's overall message.

Step 3. Second Viewing: Focused Listening

Students watched the TED Talk a second time while completing targeted listening tasks, such as answering comprehension questions, identifying supporting details, and noting key medical terminology. Chinese subtitles were provided during this viewing to scaffold comprehension and strengthen form–meaning connections.

Step 4. Comprehension Check and Discussion

The instructor conducted a brief comprehension check through whole-class discussion or small-group sharing. Students discussed the content, clarified misunderstandings, and connected the ideas presented in the talk to authentic nursing contexts, such as patient communication and interprofessional collaboration.

Step 5. Transcript-based Mini-Lecture

Following the group discussions and class sharing, the instructor delivered a transcript-based mini-lecture to clarify key concepts, language use, and useful expressions. This activity further enhanced students' comprehension, promoted critical reflection, and facilitated the development of professional listening strategies applicable to future clinical communication.

Student Feedback

At the end of the semester, the 21 nursing students enrolled in the Spring 2026 Nursing English course completed a three-item student questionnaire, one item of which assessed the extent to which TED Talk videos had improved their English listening comprehension. The results are presented in Table 1.

Table 1 summarizes students' perceptions of the extent to which TED Talk videos supported their English listening comprehension. Among the 21 respondents, the majority (57.14%, n = 12) reported that the videos were very helpful, indicating a strong positive impact on their listening development. An additional 23.81% (n = 5) considered the videos somewhat helpful, indicating a moderate benefit. In contrast, 19.05% (n = 4) reported that the videos were not helpful.

Overall, the findings indicate that more than four-fifths of the students (80.95%) perceived at least some improvement in their listening comprehension as a result of using TED Talk videos. These results suggest that TED Talks may serve as an effective supplementary resource for

Table 1

Student Responses to the Questionnaire

To what extent did TED Talk videos help you improve your English listening comprehension? (N=21)		
Response Category	**Frequency**	**Percentage**
Very helpful	12	57.14%
Somewhat helpful	5	23.81%
Not helpful	4	19.05%

enhancing listening skills in EFL nursing education contexts.

Pedagogical Implications

Integrating TED Talks into a Nursing English course offers valuable opportunities for language development. Previous research has shown that TED Talks can enhance learners' listening comprehension, pronunciation awareness, vocabulary acquisition, and speaking confidence when appropriately selected and adapted to learners' proficiency levels (Al-Jarf, 2021; Nurhidayat & Syarifah, 2022; Wu, 2020).

Carefully selected TED Talks expose students to authentic spoken English in medically relevant contexts, helping them develop listening skills, become familiar with professional discourse, and expand their medical vocabulary. A structured sequence of activities before, during, and after listening further supports comprehension by activating background knowledge, guiding active listening, and encouraging reflection and application.

Subtitles can also be used strategically to scaffold learning. For Chinese-speaking learners, English subtitles strengthen connections between spoken and written language, while Chinese subtitles support comprehension of specialized medical terminology. In addition, discussion-based activities and transcript analysis reinforce both language and content learning by promoting critical reflection, highlighting useful expressions, and increasing awareness of effective listening strategies.

Overall, the scaffolded integration of TED Talks can enhance students' listening proficiency while preparing them for English-mediated healthcare communication. This paper provides practical guidance for integrating TED Talks into English for Nursing Purposes (ENP) courses, with implications for Nursing English education in Taiwan, Japan, and other EFL contexts across Asia.

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Building Nursing Knowledge Before Using Nursing English: Integrating Foundational Nursing Education and Nursing English

Takahiko Maeda[1] (takahiko.maeda@mcn.ac.jp), Izumi Dryden[1], & Laurence M. Dryden[2]
[1]Mie Prefectural College of Nursing, [2]independent scholar

Abstract: *As healthcare becomes increasingly globalized, nursing students require English communication skills as part of their professional preparation. However, the timing and positioning of nursing English within the broader nursing curriculum deserve greater attention. Students may encounter specialized English terminology before they have developed sufficient conceptual understanding of nursing in their first language, requiring them to learn unfamiliar professional concepts and their English expressions simultaneously. This Observation/Opinion article argues that nursing English may be most educationally meaningful when it reinforces, extends, and applies nursing knowledge that students have already begun to acquire. Drawing on nursing theory, meaningful learning, cognitive load theory, Content and Language Integrated Learning (CLIL), and recent literature on nursing curriculum alignment and redesign, we propose a concept-first, English-next, professional-application approach. Rather than requiring individual English teachers to assess or teach specialized nursing knowledge, curriculum-level collaboration can determine where nursing English could most effectively reinforce professional learning. Practical recommendations include curriculum mapping, identifying appropriate points for English reinforcement, reconsidering course sequencing, using authentic clinical contexts, and conducting collaborative curriculum evaluation. Such alignment may help transform nursing English from isolated vocabulary instruction into a meaningful component of professional nursing education.*

Keywords: concept-based learning; curriculum alignment; curriculum design; nursing education; nursing English; nursing knowledge

About the Authors: Takahiko Maeda is a professor of pediatric nursing at Mie Prefectural College of Nursing in Japan. Although his primary area of expertise is pediatric nursing, he has also conducted research on the experiences and roles of male nursing students and male nurses, recognizing the growing importance of male nurses within the healthcare profession.

Izumi Dryden is an associate professor at Mie Prefectural College of Nursing in Tsu, Japan. She teaches English reading, literature and medicine, and communication. Her research interests include nursing English education, bibliotherapy, narrative medicine, and the writings and correspondence of Florence Nightingale.

Laurence M. Dryden is a retired university English educator in Suzuka, Japan. He has more than fifty years of teaching and research experience in Japan and the United States. His academic interests include English language education, imaginative literature, world history, and intercultural communication.

As healthcare becomes increasingly globalized and linguistically diverse, English has an important role in preparing future nurses. Nursing students may need English to access international literature, communicate with healthcare professionals, participate in international professional communities, and interact with patients and families from different linguistic and cultural backgrounds.

Yet an important curriculum question precedes the question of how nursing English can be taught: When and how can students best encounter professional nursing concepts in English?

In many programs, nursing English is introduced while students are still developing foundational knowledge in nursing. Students may therefore encounter expressions such as "aseptic technique," "activities of daily living," "patient assessment," or "infection prevention" before they have developed a secure conceptual understanding of these ideas in their first

language. The resulting task involves more than learning vocabulary. Students are simultaneously being asked to construct professional knowledge and learn how that knowledge is represented in another language.

This distinction is particularly important because nursing knowledge is conceptual rather than merely terminological. McKenna (1997) describes nursing theories as being composed of "concepts and the propositional statements connecting these concepts in a systematic way" as part of the continuing "theoretical journey" of nursing (p. 85). McKenna (1997) further observes that nursing was historically influenced by theories and models from other disciplines, particularly the medical model.

Professional nursing education therefore involves learning to understand relationships among concepts—not simply remembering technical terms. Nursing English can be considered within this larger process of conceptual and professional development.

From Cognitive Load to Meaningful Learning

The demands of learning to see relationships in conceptual terms can be understood partly through cognitive load analysis. Working memory has limited capacity, and learning may become less effective when students must process multiple unfamiliar elements simultaneously (Sweller, 1988). Asking beginning nursing students to understand a new professional concept while also processing unfamiliar English terminology may therefore impose demands that do not necessarily contribute to the intended learning outcome.

Meaningful learning provides a complementary perspective. Ausubel (1968) emphasized the importance of connecting new knowledge with what learners already know. This model of learning arose from constructivist learning theory, which was developed in the twentieth century by learning theorists such as Vygotsky, Piaget, and Bruner. These thinkers agreed that optimal learners do not passively absorb information; instead, they construct new knowledge by activating prior knowledge and experience, then apply it reflectively in novel contexts. Constructivism has guided progressive education in the U.S. over the past 80 years and, internationally, has been introduced in nursing education (Epp et al., 2021; Yang et al., 2026). For example, an English term is more meaningful when students can connect it to an established or developing nursing concept rather than memorize it as an isolated lexical item.

This is not to suggest that English can simply be removed from the early nursing curriculum. Nor does it mean that every nursing concept must be completely mastered in Japanese before it appears in English. Instead, we propose a general curriculum principle: Concept first; English next; professional application thereafter. Under this principle, English becomes a means of revisiting, extending, communicating, and applying developing professional knowledge rather than the principal medium in which specialized nursing concepts are initially taught.

This distinction in the place also addresses an important boundary in nursing English education. Determining whether a student possesses sufficient specialist nursing knowledge would not be the responsibility of an English instructor, particularly when, as is typically the case, the instructor is not a licensed nurse. Responsibility for foundational nursing knowledge properly belongs to nursing faculty and the professional curriculum. The role of nursing English is different but complementary: to provide linguistic and communicative contexts through which established or developing nursing knowledge can be revisited and applied.

Curriculum Alignment: Moving Beyond the Individual Classroom

The questions of when and what students learn in nursing English need therefore to be approached

as matters of curriculum alignment, rather than as problems for individual English teachers to solve. Khan et al. (2015) define curriculum alignment in terms of congruence and sequencing among what is planned, taught, learned, assessed, and evaluated. They argue that alignment connects teaching, learning, and evaluation and is particularly important in nursing education, where professional training integrates many disciplines—basic and applied sciences, psychology, sociology, humanities, communication, and clinical practice.

Importantly, curriculum alignment is not achieved simply by asking an English teacher to coordinate each week's lesson with a nursing course. Such synchronization may be difficult because timetabling, course sequencing, faculty assignments, and curriculum requirements are usually determined at the institutional level. Khan et al. (2015) identify time, differing educational philosophies, faculty workload, and the integration of theory and practice as challenges to alignment. They recommend institutional support, collaboration among stakeholders, adequate time for curriculum revision, and continuing evaluation.

More recent nursing education literature strengthens this argument. The Ottawa Model for Nursing Curriculum Renewal emerged from an integrative review of nursing curriculum renewal and conceptualizes curriculum change as a systems-level process involving context, preparation, active curriculum development, outcomes, and evaluation (Jager et al., 2020). Curriculum renewal was found to require a shared vision, faculty commitment, collaboration, and attention to both internal and external educational contexts.

Similarly, Dormire et al. (2025) describe undergraduate nursing curriculum redesign as a structured, faculty-led, and data-informed process rather than a series of isolated course modifications. Such articulated design is well suited for nursing English because it indicates that the proper location and purpose of English learning need to be discussed as part of program-level curriculum design.

From Content Coverage to Competency Development

Recent curriculum literature also demonstrates a broader movement away from content accumulation and toward competency development. Naguszewski et al. (2025) apply backward-oriented course design to undergraduate nursing education, asserting that competency-based education could be outcome-driven rather than content-driven. In backward design, a process adapted to nursing education in Naguszewski et al. (2025), educators first identify desired outcomes, then determine appropriate evidence of learning, and finally develop learning activities aligned with those outcomes. This design model offers a useful way to reconsider nursing English.

In such an approach, planning does not begin with questions about which English nursing terms first-year students need to learn. Instead, curriculum designers might start by asking what nursing students ultimately need to be able to do professionally in English. Possible outcomes might include using clear English to perform tasks such as explaining a familiar nursing procedure, obtaining basic patient information, providing reassurance, recognizing key information in international nursing literature, or interacting effectively in an intercultural healthcare setting. The English curriculum can then be sequenced backward from these desired professional outcomes.

This approach is also consistent with content and language integrated learning (CLIL). Accordingly, Coyle et al. (2010) conceptualize content and language learning as mutually supportive rather than as entirely separate educational processes. Meaningful integration, however, does not require every English lesson to introduce new disciplinary concepts. In nursing English, integration may instead involve using English to reactivate and apply disciplinary

knowledge that students have already encountered.

The Japanese Nursing Curriculum Context

Discussion of program-wide reform is particularly timely in Japan. The recently revised national Model Core Curriculum for Nursing Education emphasizes competency-based education and identifies learning objectives and expected levels of achievement across nursing education (Ministry of Education, Culture, Sports, Science and Technology [MEXT], 2025).

An integrated approach to curriculum design encourages educators to consider the nursing program as a developmental sequence rather than a collection of independent subjects. Nursing English can likewise be conceived in relation to students' progression across that sequence.

For example, introductory English courses may properly focus on general healthcare communication and accessible professional language. After students have studied foundational nursing concepts and procedures, later nursing English instruction can introduce increasingly authentic clinical contexts. Students who have already studied vital signs, for instance, do not need the English teacher to reteach the clinical principles of measurement. Instead, students might be asked to use English to interpret a brief patient scenario, explain the procedure, identify relevant patient information, or practice an appropriate nurse-patient interaction.

The distinction is subtle but important: the nursing course develops the professional concept; nursing English provides another context in which that concept can be communicated and applied.

Context, Reflection, and Professional Development

Authentic context is particularly important in a reformed model of nursing English. Bosher and Smalkoski (2002), in developing a healthcare communication course, demonstrated the value of designing language instruction around learners' communicative needs rather than isolated linguistic content.

Accordingly, rather than memorizing blood pressure, pulse, respiration, and temperature as four independent vocabulary items, students who already understand vital-sign assessment can encounter these terms during a short clinical interaction. Students' attention can then move from remembering definitions toward understanding how professional knowledge functions communicatively.

Reflection can extend this learning further. In nursing English, a common professional vocabulary can serve as a bridge between language learning and nursing reflection.

Students might ask:

- "How would I explain this procedure to a patient in simple English?"
- "Which information is essential?"
- "What might be misunderstood?"
- "How could I communicate this concept respectfully to someone from another linguistic background?"

The learning sequence therefore becomes: concept → context → English communication → reflection → professional application. This sequence is preferable to simply adding more bilingual information to a lesson. It also avoids assuming that greater quantities of Japanese and English terminology necessarily improve learning.

A Practical Model for Incorporating Nursing English

If nursing English is treated as part of curriculum design, institutions could consider a four-stage process.

1. Map the nursing curriculum.
   Nursing faculty and language educators can identify when major recurring concepts—such as safety, infection, assessment, pain, mobility, communication,

nutrition, and patient-centered care—are introduced, developed, practiced, and assessed.

2. Identify appropriate points for English reinforcement.

   Rather than attempting to synchronize every nursing and English lesson, faculty can select a manageable number of concepts for which English provides meaningful professional application.

3. Review the timing and progression of nursing English.

   If professionally specialized nursing English is taught before students have sufficient foundational knowledge of nursing, curriculum committees could consider moving part of the course to a later year or distributing nursing English across multiple years. This does not necessarily mean "English later"; rather, it may mean general communication earlier and increasingly specialized professional communication later.

4. Evaluate collaboratively.

   Nursing faculty, English educators, students, curriculum committees, and educational leaders can examine whether the sequence supports the intended competencies and periodically revise it. This model places responsibility where it belongs: at the curriculum level rather than on an individual English instructor.

Recent research on nursing curriculum renewal supports precisely this kind of collaborative process. The Ottawa Model emphasizes preparation, stakeholder engagement, active curriculum renewal, and evaluation (Jager et al., 2020). Similarly, Dormire et al. (2025) demonstrate the value of structured faculty-led redesign. Backward design further provides a practical mechanism for aligning learning outcomes, assessment, and educational activities (Naguszewski et al., 2025).

Nursing English and the Development of a Nurse

Ultimately, nursing English education cannot be evaluated solely by how many specialized words students remember. Competent use of professional language demonstrates solid professional knowledge. In McKenna (1997), the account of nursing as a discipline organized through interconnected concepts helps explain why sequencing matters. Students gradually learn not only what nurses say, but how nurses conceptualize patients, health, safety, care, and professional responsibility.

Nursing English can contribute to this process when it enables students to encounter familiar professional concepts from another linguistic and communicative perspective. The goal is therefore not to transform English teachers into nursing instructors, nor to make nursing faculty responsible for language teaching. Instead, the goal is to create a curriculum in which different areas of faculty expertise contribute at proper stages toward shared educational outcomes.

Conclusion

The central question for nursing English education can properly shift from "What nursing vocabulary should we teach?" to "Where in students' professional development can English most meaningfully reinforce and extend nursing knowledge?" We propose a concept-first, English-next pedagogical principle. Foundational nursing concepts can primarily be developed through appropriate professional nursing courses. Nursing English could then revisit those concepts through authentic linguistic and clinical contexts, helping students communicate and reflect upon knowledge that is becoming professionally meaningful.

Achieving such goals requires more than classroom-level teaching tips. It requires

curriculum mapping, thoughtful sequencing, collaboration between nursing and language faculty, support from curriculum committees and administration, and periodic evaluation. In this sense, nursing English need not stand beside the nursing curriculum as an isolated language subject. When properly articulated with the rest of the academic program, nursing English can become part of students' broader developmental journey—from acquiring nursing knowledge to thinking, communicating, and ultimately acting as well-prepared members of the nursing profession.

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