


Caring for Clients and Families With Anxiety: Home Care Nurses' Practice Narratives

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Abstract

This study elucidated Japanese home care nurses' experiences of supporting clients and families with anxiety. We interviewed 10 registered nurses working in home care agencies and analyzed the data using grounded theory to derive categories pertaining to the nurses' experiences of providing care. We conceptualized nurses' approaches to caring for anxiety into three categories: First, they attempted to reach out for anxiety even when the client/family did not make it explicit; second, they tried to alter the outlook of the situation; and third, they created comfort in the lives of the client/family. The conceptualizations of nurses' strategies to alleviate client/family anxiety may reflect Japanese/Eastern cultural characteristics in communication and their view of the person and social care system, but these conceptualizations may also inform the practice of Western nurses by increasing awareness of skills they may also have and use.

Keywords

home care, caregivers, caretaking, mental health nursing, nursing, psychology, psychological issues

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Anxiety is a mental state of fear or nervousness about what might happen (Anxiety, 2016) and a very common feeling that many health care professionals encounter on a daily basis among those with various health problems. For example, research indicated that 23% of young adults with cancer in curative-intent therapy were experiencing anxiety (Muffly et al., 2016); 43.6% of family caregivers of patients with Alzheimer's disease experienced anxiety (Sallim, Sayampanathan, Cuttilan, & Chun-Man Ho, 2015); and anxiety was significantly higher among those with Behcet's syndrome than among healthy controls (Ilhan et al., 2016). In addition, anxiety could lead to serious health complications, such as generalized anxiety disorder or increased risk of mortality (Celano et al., 2015; Pratt, Druss, Manderscheid, & Walker, 2015).

Assisting clients and families in coping with anxiety is one of the most common experiences of health care professionals such as home care nurses (Tsuchihashi-Makaya et al., 2013). In the overall Japanese shift from a hospital- to community-based health care system (Arai et al., 2015), the role of home care nurses in assisting persons with disease and accompanying anxiety should be emphasized. However, we have insufficient understanding of how home care nurses provide support (Achury Saldana, Pinilla Alarcón, & Alvarado Romero, 2015) to clients/families in dealing with

anxiety, especially given its very frequent occurrence, and nurses assume they must support clients in this situation.

Nursing is a practice discipline in which multiple modes of knowing are required (Carper, 1978; Chinn & Kramer, 2015; Meleis, 2012). Nurses often accumulate common, everyday tasks, such as alleviating the anxiety of clients/families, as individual and personal practical knowledge. It seems important to try transforming such individual, experiential knowledge into formal knowledge, to enable inexperienced nurses to learn from more experienced nurses and thus improve their practice.

One approach to better understand how nursing care is provided is to ask practicing nurses themselves about their experience of providing care and analyze their narratives. The purpose of each activity performed for the client is often not visible; we may be able to obtain such individual knowledge

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effectively by analyzing nurses' narratives. Extensive interviews and analyzing their narratives with critical care nurses have been used to elucidate the meaning of their practice (Benner, Kyriakidis, & Stannard, 2013). We need further exploration of nursing practice in areas other than critical care.

To date, the few studies investigating nursing practice as a subjective experience have either examined how the caring experience affects the nurse as a person (Bentzen, Harsvik, & Brinchmann, 2013; Johansson & Lindahl, 2012; McGarry, 2010; Patel, Gorawara-Bhat, Levine, & Shega, 2012; Slatyer, Williams, & Michael, 2015; Stoddart, 2012) or focused on the characteristics of the interpersonal relationship between the nurse and the client (Lindahl, Liden, & Lindblad, 2011). This is opposed to investigating how nurses think and perform to best assist clients. Some individual skills for supporting those with anxiety have been conceptualized and named, such as providing empathy or active listening (Maguire & Pitceathly, 2002; Maguire & Pitceathly, 2003), often in the context of therapeutic communication literature (Kluge & Glick, 2006; Leef & Hallas, 2013). More integrated inquiry would be beneficial.

Philosophy and some basic elements in nursing may be universal while there are some elements in nursing practice that are culture-dependent (Betsch et al., 2015); nursing in different cultural contexts may emphasize different elements. Those nursing skills conceptualized and used in Western cultures may be less emphasized in non-Western countries such as Japan, where these conceptualizations of communication skills are largely underdeveloped (Chihara et al., 2007; Ichikawa, Makino, Takemura, Kotake, & Satou, 2014; Matsuo, 2007). Specifically, effective communication that affect client outcomes are dependent on culture (Kreuter & McClure, 2004). Given the increasing aged population and accompanying chronic conditions (Ministry of Health, Labor and Welfare, 2015) anticipated in many Asian countries, accumulating knowledge on nursing care within an Asian cultural context seems important. Studying nursing practice in non-Western cultures may lead to findings overlooked in the Western literature.

For practicing nurses to provide even higher quality services, we need a deeper understanding of what constitutes appropriate nursing care for clients with anxiety and how nurses perform it. It is also important to generate knowledge for future nurses to explore the provision of specific services from the standpoint of nurses themselves, with a focus on why they perform their care in particular ways. Therefore, in this study, we investigated how home care nurses in Japan provide care to clients/families with anxiety and chose to do this from their own narratives.

Method

Setting: Home Care Nursing in Japan

Home care nursing was formally started in Japan in 1992, when the home care nursing agency was created (Fukui,

Yamamoto-Mitani, & Fujita, 2014). Home care nursing stations were established to provide nursing care for those requiring it at home, including basic/custodial nursing care (i.e., bathing, toileting), and skilled nursing care (i.e., physical assessment, injection, and dressing changes), including end-of-life care (i.e., home dying; Yamamoto-Mitani et al., 2011). Close collaboration with various professionals is required, such as care managers, family physicians, and home helpers (Yamamoto-Mitani, Igarashi, Noguchi-Watanabe, Takemura, & Suzuki, 2015). On average, Japanese home care nurses stay at each client's home for 51 minutes and visit 5.8 times a month (Ministry of Health, Labor and Welfare, 2014). There is no fixed limit to how long we can provide this nursing service; therefore, many nurses develop long-term, close relationships with their clients and clients' families.

Home care nursing agencies are generally small; the minimum required staff is 2.5 full-time equivalent (FTE) and the average FTE staff is 4.2. Agency directors themselves often provide nursing care to clients, in addition to their administrative work (Ministry of Health, Labor and Welfare, 2014). Other than a registered nursing license (a minority of home care nurses are licensed practical nurses), no specific licenses or qualifications are required to become a home care nurse. The average home care nurse is in his or her 40s and the majority of them have previous experience of working in acute care hospitals (Yamamoto-Mitani et al., 2015).

Participants

The participants in this qualitative exploratory study were 10 registered nurses who worked in various home care agencies throughout Japan. Those agencies belonged to a home care corporation; corporation nursing educators who knew the working nurses very well recommended the participants as competent home care nurses. Because the study investigated high-quality nursing care for clients' anxiety and no other criteria were available to identify nurses with outstanding competency, the authors sought to recruit those nurses who were recognized and recommended by their colleagues as having outstanding nursing expertise.

Data Collection

We conducted 10 semi-structured interviews examining the nurses' experiences of supporting clients/families with anxiety during daily care. We held only one interview with each nurse. In the interview, the nurses chose a single case in which they felt that they paid particular attention to the client/family's anxiety while they cared for them. The central question in the interview was "Could you tell me, in as much detail as possible, your experience of providing care for this person and family with anxiety? How did you know of their anxiety and what did you do?" We tried to collect their narratives as they spoke naturally to capture how they viewed their entire experience providing care for anxiety.

The interviews lasted for 60 to 90 minutes and we conducted them in a room in the nurses' individual agencies. A professional transcriber developed the interview data verbatim. One participant added a long memo regarding his practice experience to provide more information and we included it as data. We also took additional notes during and after the interviews regarding content, possible data analyses, nurses' attitudes, and how they talked in the interview. We used those memos to assist the analyses.

Data Analysis

In this study, we performed qualitative analyses of the narrative data based on constant comparative techniques (Corbin & Strauss, 2014) and constructionist grounded theory (Charmaz, 2014) to derive categories (concepts) pertaining to nursing care, its background, and the context in which the care was provided. We chose grounded theory for several reasons. First, we hoped to capture the experienced nurses' quality care for anxiety by developing categories, so that the findings were easy for other nurses to remember and use in clinical practice. Second, the focus of grounded theory to derive meaning of the experiences for the interviewees in developing categories matched our purpose well. Finally, the authors, especially the first author, were most familiar with this methodology and had extensive training and experience as grounded theorists. Thus, we chose grounded theory as research method.

In the analysis, first, we cut the data into pieces by meaning chunks and assigned tentative names (codes) representing the meaning of each piece. Data pieces were the client/family conditions, how nurses thought of the client/family, client/family contexts, nurses' actions and their intentions, or the responses of client/family. We sorted those codes by its similarities and assigned a more abstract name (tentative category), some of which related to the types of anxiety and others related to caring activities of nurses. In repeating the sorting as we added new data and codes, gradually final categories and subcategories emerged.

In coding and categorizing, we tried to use words that pertained to what the nurses intended to achieve in various caring activities. For example, a nurse talked about the comfort of the living room of a client with some breezes. The nurse's activity was "talking about the client's room condition" but she intended to provide "temporary escape" from the daunting thoughts and worry about upcoming death; thus, we chose the latter as the category.

As we continued coding and sorting, we examined the relative relationships among grouped major categories in the context of each case. In the process of analysis, we have drawn multiple diagrams that seemed to depict what was going on (Charmaz, 2014). However, we decided that presenting the categories in a fixed framework did not fit what we saw; rather, the nurses provided those caring activities in a variety of ways in very different contexts of clients/families.

Therefore, we chose to explain each category individually rather than developing a graphical presentation of nurses' caring for client/family anxiety.

We conducted scientific and creative evaluations of the findings based on Charmaz's (2014) criteria: credibility, originality, resonance, and usefulness. We obtained the data from a wide range of locations in Japan to cover various home care nursing topics to enhance credibility. We repeatedly presented the findings to practicing nurses and home care nursing managers to check for resonance and usefulness. In addition, we also conducted extensive literature searches to examine the originality and freshness of the findings. The grounded theory has the notion of theoretical saturation (Corbin & Strauss, 2014) in which no new concepts would emerge; we found that there were no other categories in the acquired data. We are unsure whether additional data from other nurses may yet provide new approaches, although it seemed unlikely. Given financial and time limits, we decided to complete the data collection with 10 interviews.

Ethical Considerations

Prior to the interview, the primary researcher explained the purpose and goal of the study, emphasizing that participation was voluntary although company educators recommended nurses to the researcher. We also informed the participants that we would protect their confidentiality and that we would not disclose data content even to the company educators except for some excerpts. We conducted the interviews after obtaining oral and written consent from the participants, including consent to audio-recording the interview contents. We have had all study procedures examined and approved by the ethics committee of the researchers' university (#10158).

Results

There were 10 participants (only one man) with ages ranging from their 30s to 60s (Table 1). The clients that they described were mostly older adults in their 70s to 80s, suffering from terminal conditions, such as cancer, cirrhosis, or end-stage pneumonia, or chronic conditions, such as amyotrophic lateral sclerosis or senile back pain. Because of their conditions, many of the clients could have not lived at home without the assistance of home care nurses and other home care-related professionals.

Anxiety Among Home Care Clients and Families

To make sense of nurses' experiences in caring for anxious clients, first it was necessary to have some understanding of the nature of the client's anxiety. We summarized the types of anxiety mentioned in the nurses' interviews as threefold: *anxiety about dying*, *anxiety about living with illness*, and *anxiety about receiving care*.

Table 1. Participant Nurses and Their Clients.

Nurse Age	Gender	Major Diagnoses	Client		
			Age	Caregiver	Characteristic Conditions
50s	F	Cirrhosis, liver failure	70s	None	Living alone
50s	M	Amyotrophic lateral sclerosis	80s	Wife	Ventilator
60s	F	Heart failure, renal failure	100s	Daughter	Very old
50s	F	Spinocerebellar degeneration	50s	Son	Son autism
30s	M	Spinal injury	40s	None	Living alone
30s	M	Backache, substance abuse	80s	None	Living alone
40s	M	Pharyngeal cancer	60s	Wife	End-of-life
30s	M	Pneumonia	70s	Wife	Ventilator
40s	F	Liver cancer	70s	Husband	End-of-life
30s	M	Lung cancer	80s	Wife	End-of-life

The most profound anxiety that many clients suggested was, in the nurses' view, anxiety about dying, and it was so profound and intense that clients rarely expressed it directly; rather, they communicated this anxiety subtly by asking about other people dying or expressed it with a hint of humor:

The client (in her 100s) asked me softly one time, "Do you know anybody like me (as old as herself) around you?" "How did she (another client of the nurse who died in her 100s) pass away?" I guess the client was wondering how she should accept her dying.

The client [in her 70s] said to the doctor, "I can't die because I still have a dream." "I have a dream of going to see (a Korean famous singer) in Korea, so Doctor, I can't die." "I am as old as (a famous baseball player). I was once called 'a miracle woman,' so Doctor, please work a miracle by curing my disease. You can be famous." "I will gladly become a guinea pig. So please cure my disease."

Clients also expressed anxiety about living with disease. This anxiety related to the client/family not knowing how the disease would progress and what would happen to them, including whether they would lose mobility, what kind of symptoms they would have, or whether they could continue living in the same house. The client's condition would affect family life as well: "She asked me, like, 'What's gonna happen to me from now?' Kind of anxious feeling. . . . she stated, 'Is there anybody like me?' She said, like, 'My disease won't get well, right?' 'What's gonna happen?'"

Anxiety about receiving care was another distinctive type of anxiety that emerged from the data. Entrusting one's physical care to a stranger was frightening to clients with physical disabilities, yet they could not avoid it. Especially when the nurses started caring for a new client, even if they had a long career in nursing, they felt that clients were very anxious and they needed to heed this while providing services. For example, a client in his 40s with spinal cord injury was so tense when a new nurse visited him that he could not move or talk

at all. He was extremely anxious about every aspect of care that the nurse would provide, including shaving or giving him a drink of water. With time, however, he slowly got used to her and the care she provided and gradually became able to talk. Eventually, the nurse found that the client could be extremely talkative.

When the nurses encountered clients/families with anxiety, they provided support to alleviate it. We conceptualized their approaches to managing anxiety into three areas: First, they reached out for anxiety; then they tried to alter the outlook of the situation; finally, they characteristically created comfort for the client/family. In the following section, we will discuss these approaches.

Reaching Out for Anxiety

For effective support, it was essential for the nurses to know the client/family and identify that they were anxious. Asking directly about anxiety, however, often did not work, as the client/family might have been too anxious to discuss the matter. As a result, the nurses needed to identify anxiety through other means. Building a trusting, human-to-human relationship with the client/family was essential; in addition to this, there were numerous strategies to reach out for anxiety. The nurses used these strategies based on careful assessment of the condition of the client/family and their situation.

Listening. It was essential for home care nurses to spend time listening to the client/family. Especially at the beginning of their relationship, the nurses spent a large portion of the visiting time just listening to what the client/family has to say about themselves, what they had experienced so far, and how they viewed their life and illness:

At first, I didn't do anything but listen to their story. I say (nodding), "I see." "I understand." "Oh, I see." "And that was how you came back home from the hospital." I didn't do anything else but this. I start by listening to their story. . . . I don't show whether I agree or not. Just listening to them.

The interviewed nurses reported that novice home care nurses often considered that their role was to do something for the client, such as provide education or handle medical procedures; they started working on them hastily. On the contrary, the interviewed nurses unanimously emphasized the importance of listening to the client/family without negating what they said; they taught novice home care nurses about the importance of just listening.

By listening, nurses gained a deep understanding of the experience of the client/family from their own viewpoint. This understanding became the basis for sensing their anxiety, understanding its nature and characteristics, and assessing what the nurse needs to provide to alleviate it. The client's/family's talk revealed their worldview. By nurses listening to them, the client/family could appreciate that the nurses truly honored their story and perspective and validated them; this in turn helped them feel safer about confiding their inner thoughts and feelings, including their anxiety. Therefore, the nurses might listen not only to gather information but also to gain the trust of the client/family: "I listen to the same story again and again. I would listen even a hundred times." Nurses used listening regardless of the type of anxiety expressed by clients/families, such as thoughts on death and dying, on living with the disease, or on receiving care.

Waiting for the client/family to open up. To be able to alleviate anxiety, nurses first needed to sense it. However, direct confrontation of anxiety was often inappropriate, as issues like anxiety about dying were too difficult to verbalize; talking about them could feel threatening to the client/family:

The client looked exhausted. I could tell "Oh, he doesn't want me to talk about it." . . . He gave me the (non-verbal) sign saying, "Don't talk to me about it now." . . . When I feel such a message from the overall atmosphere of the client, I try not to talk to him.

Rather than directly talking about their concerns, I just wait for the timing. Simply waiting for the occasion when they start talking from their side. There are some clients for whom we directly ask "Are you feeling anxious?" But generally I believe they cannot open their heart to an outsider, even when they ask for suggestions to the outsider. So I wait for timing, or look for simple key words; in an end-of-life case, she might ask, "What would happen to me from now?" This kind of question might come out of an end-of-life case . . .

Even if the client/family would not verbalize their anxiety, the interviewed nurses were highly sensitive to the presence, level, and nature of anxiety, long before the client/family decided to talk about it; for this, they used different skills. For example, they looked into the clients' eyes and evaluated their facial expression or whole body posture to assess their inner anxiety:

The client talks with their eyes. The clients, especially patients themselves. Eyes, they send us signs through the eyes. . . .

(Interviewer: Do you mean even if they do not talk about anxiety, they let you know through their eyes . . .)

Yes, yeah. So I always look into their eyes. When we look in their eyes, they talk (with their eyes). They say they are terrified. They look totally different when they are feeling safe. Yes. Their relaxed smile and smile with anxiety, they are totally different.

For nurses to sense the client's anxiety, it was necessary for them to know the client very well. Thus, understanding the client by listening also helped nurses to become more sensitive to potential anxiety. When the nurses sensed potential anxiety, rather than asking directly, they tried to create a situation in which clients could easily open up and start talking about their feelings:

Regarding the illness, the clients would tell me from their side what they need to say. . . . So I don't bring it out from me. I bring out something else, such as "It is getting warmer, isn't it? I saw cherry blossoms coming out" . . . I start this way. . . . I would say something such as "How is your foot pain?" I go on this way.

The nurse had to be a good conversationalist so that the client/family could talk extensively. Small talk rather than directly focusing on problematic issues was preferable; some nurses made conscious efforts to obtain clues for conversation to engage the client in an enjoyable chat. Some nurses tried showing interest in the client's daily life and asked questions, searching for the right level of conversation and timing. Nurses sometimes sought topics for conversation from common interests, from health-related topics to flower arrangements, towns of origin, chess, world news, the stock market, and so on. Topics could also be outside of the nurses' own experience; they sometimes went over the daily newspaper to identify potential conversation themes for the next visit. Regardless of the initial topic, the conversation would often move onto something more related to the client's own life and health, and the client could begin to talk about anxiety. Making the client comfortable enough to talk to them was important; the nurses rarely chose to bring out the topic of anxiety themselves.

If their clients started talking about topics of their anxiety, the nurses tried to adopt a listening attitude to show the client that their words were accepted. Once the client started sharing, the nurses tried to take as much time as possible and listened to their clients without interrupting, making judgments, or giving answers. They responded only to let their client know that they were listening and to comfort and encourage them.

Physical comfort as a gate to anxiety. Many nurses mentioned that their clients began talking about their anxiety while they provided physical care to them, such as foot bathing,

massage, or hair washing. Physically feeling good relaxed the client; in receiving some physical care, the client did not need to be face-to-face with the nurse. Thus, providing physical comfort was an effective way to access complex thoughts and feelings that clients often hide deep in their mind.

(Interviewer: How did you start?)

She (client) had already heard that she had an intractable, incurable disease. She said, "What will happen to me?" Such an expression of anxiety.

(Was it also while you provided personal care?)

Yes, everything comes out while providing care. . . . Yes, it was long ago. She started, "Do you know anyone like me?" "What's gonna happen to me?"

Altering the Outlook

When the client communicated his or her inner anxiety, nurses often provided communicative support. In such verbal communications, nurses tried to change how the client/family viewed the situation; we decided to call such verbal support *altering the outlook*. The nurses had not necessarily learned about recent developments in cognitive/behavioral therapy. However, they have learned by experience that the client/family benefited from their attempt to alter the outlook of the situation and used several approaches to do this.

Reminding of support availability. Anxiety often accompanied the feeling of loneliness. Therefore, nurses reminded clients/families that they were neither emotionally nor physically alone, that they had access to nurses and other professionals, and that the people who cared about and for them would surround them. Some nurses emphasized to the client/family that they could reach the professionals at any time, especially in case of emergency; other nurses reminded clients that they could also reach their physicians.

The nurses made sure that they would share details of clients/families and their required medical procedures among all the agency nurses so that clients would not need to repeat this information and informed them about sharing data in this way. The nurses usually made next appointment before they left to let them know that they have some line of connection to outside persons. These approaches worked to reassure the client/family that they were not alone and had access to a network of caring professionals, which seemed to alleviate their anxiety.

(Interviewer: While you talked about the client's son with autism, how would you respond?)

I just couldn't but listen to her. And, I guess we could not have anything to advise, so I just show empathy . . .

(Interviewer: How do you show empathy?)

Well, I say, . . . "There are resources and persons with whom you can talk about your issues." Well, we cannot solve many issues at once. Tons of issues. And clients have anxiety around those issues. . . . I cannot help with everything, although I wish I could. But at least I could say, "There are many people who would help you."

"It is not a dead end." Clients/families often felt immobilized, as if they were at a dead end, which further elevated their anxiety. Therefore, nurses tried to let them know that there were different ways to approach an issue, based on their own experience of having cared for other clients. For instance, a client worried about the progression of her neurological symptoms; her nurse told her that she had seen many variations in those symptoms and different ways to deal with them. Nurses also tried to help clients reframe their views. For example, a nurse transformed concerns about a son who lived far away into a source of motivation to continue rehabilitation, so that the client could visit the son. These approaches helped clients have different perspectives and recognize the possibility of approaching things differently, providing them with hope and decreasing their anxiety:

I heard the client's family live in Tokyo and she is worried about them. She is worried she would not see them again. She said they would not be able to come over quickly enough even if something were to happen to her.

(Interviewer: How did you respond to it?)

I said when this wound would heal she could walk and she might want to go visit them. I said, "I guess you have to do the best for what you can control yourself. That is what you can do for your mother." I said, "I am expecting you to go see your mother one day if your wound heals." I talk this way. When we talk about what to do, I say, "Healing the wound is the first thing you have to do. And the second is to practice walking so that you can move around smoothly." . . . "Now I think you have to do the best you can do and it is good for your mother."

(Interviewer: How did she answer to you?)

She said, "OK. I will do my best."

Temporary escape. In working with home care clients/families, nurses encountered many sources of anxiety that had limited fundamental solutions. Clients could be dealing with the anticipation of impending death; others worried about how to continue their lives with an intractable disease. For these clients/families, confronting the issues about which they felt anxious was at times too difficult. Therefore, nurses sometimes used the strategy of providing a *temporary escape* from the issue, so that the client could have some relief, some time off from the matter. In the following example, a client at the end of his life decided to stay alone in his home until his death:

(The client) was living by the canal. The room had a nice breeze. I said, "You have such a nice apartment." "The wind feels good," and he said, "Yeah. That's why I prefer to live here." Or something like that. That way he can talk about the experience of feeling good. . . . Not related to symptoms, I intentionally did not bring about the issues related to illness. . . . I guess it was relaxing to him.

Customizing control. When using communication to alleviate anxiety, how the nurses provided a sense of being in control to the client/family was another key issue. This was especially relevant when the client was anxious regarding receiving care, for instance, when new nurses started providing personal care. Depending on the situation, nurses chose whether to provide a sense of control to the client as we describe below.

There were occasions when having a sense of control alleviated anxiety. For example, a nurse provided personal care to a client with spinal cord injury only after she explained what she was going to do; another nurse gave enough time to clients for them to decide whether they would accept the proposed care. Clients sometimes refused the care offered to them; by accepting the refusal, the nurses seemed to provide a sense of control to the client/family and this seemed to alleviate anxiety.

Conversely, when a client was still new to the use of home care nursing and was unsure about making a decision regarding his care, the nurse took the lead in deciding what to do at each visit. Nurses provided standardized procedures for personal care, such as hair washing, shaving, and bed bathing, without asking; this worked well. Gradually, with time, the client got used to the procedures and spoke up with specific care preferences, which the nurse willingly followed. Having the client/family maintain their sense of control had different meanings depending on the context. The nurses keenly observed what approach was more appropriate for specific clients/families in a given situation.

Empowering through information. Some anxiety was clear and the client/family communicated directly with the nurses; there were some tangible ways to manage the sources of anxiety. When this was the case, the nurses empowered the clients by talking about possible solutions, teaching things, or doing things together. Information provided insight and confidence to the client that could potentially enable him or her to resolve his or her anxiety.

In giving information, the nurses were very careful to respect the client's preferences and gave enough time for clients to think and decide for themselves:

Taking one by one. For example, having her (caregiver) educate how to do this (about handling the gastric tube) so that she could do it without anxiety after they go home. There were many things she had to master while the husband (patient) was still in the hospital. One by one, from today, when the wife could come

visit the hospital, once a day is OK, we asked the ward nurse to teach her, such as setting the g-tube with the nurse . . . when I asked the wife what she was anxious about, she was anxious about the ward staff had done nothing to prepare for discharge after all.

If the issues that caused anxiety in home care clients were difficult to resolve, direct communication and suggestion may be the last resort. One nurse, after some period of attempts to support a client in his end-of-life with anxiety about dying, finally decided that her client needed to confront the fact that he had only himself to the end:

I would say, "You are by yourself even when you fall." He knows that he himself decided staying home alone. I go, "If it is you who decided you want to stay here (to the end), then you should be responsible to organize yourself." That way we tidied up his daily life.

Even if there are possible solutions, the client may not be able to accept the suggestion. The nurses did not force the straightforward solution because just solving the problem was not the goal. It was important that the client truly understand the value and meaning of problem solving and accept the solution to alleviate their anxiety.

Creating Comfort

Many nurses considered that attending to physical issues often worked to decrease anxiety. Even if they did not solve the fundamental problem that caused anxiety, physically feeling good often allowed the client/family to feel less anxious.

Physical comfort to alleviate anxiety. Many home care nurses managed physical aspects of the life of clients/families. Alleviating physical symptoms such as pain or fatigue, as well as assisting with activities of daily living, was an essential part of the home care nurses role; these tasks had the additional effect of alleviating anxiety. They achieved providing comfort not only through additional services, such as massage, but they could also plan regular bathing or hair washing as a strategy to alleviate anxiety:

(To alleviate anxiety) I guess I try providing some physical care that I myself would enjoy receiving. Like massage. Not only talking, I would do something related to cleansing (that would be helpful to alleviate anxiety). It (cleaning body or shampooing) feels good, doesn't it?

Severe physical symptoms seemed to limit clients' attention to the present moment, shutting out the future, and thus leading to the feeling of being in a dead end. Therefore, competency in custodial and skilled nursing care to alleviate symptoms and provide comfort was important to alleviate anxiety.

Making everyday life possible and comfortable. Nurses also made daily life possible and comfortable to alleviate anxiety. Nurses emphasized that simply organizing daily life and the client's schedule, rather than doing something special, was important. This approach was effective for clients to regain their emotional equilibrium and stability and enjoy the comfort of being alive, while also diverting his or her attention from the anxiety. The reported practices were very simple, such as making sure that the oxygen tube was in place or the room temperature was appropriate. Taking care of daily life is a mundane, common nursing practice; here the point is that the nurses consciously and strategically did so as one of the limited strategies to alleviate anxiety about dying.

It is true that he is dying soon, . . . to me it seemed important for him to feel strongly that he is alive now to alleviate the fear and anxiety of dying, or even if it (alleviating anxiety of dying) is not possible, I would want to divert his attention away from the fact "I am dying, I am dying." I think it is important that he enjoys the reality of being alive. To make it possible, I guess, it is important to arrange for a comfortable everyday life . . . I think it is really important that we pay attention to details so as for him to have a comfortable daily life.

As shown above, nurses used a variety of approaches in their efforts to alleviate clients' anxiety. Specific interventions characteristically entailed multiple purposes or goals, for example, providing physical comfort also aimed to reduce anxiety. Thus, our results tangibly reflect the holistic nature of nursing care.

Discussion

This study focused on the daily ordinary practices of home care nurses that we often overlook and yet make a difference in the lives of clients/families. Nurses took various approaches to alleviate the anxiety of their clients and families. Some of these approaches are similar to those taught in therapeutic communication; some are more rooted in the characteristic context of nursing but have not been documented in detail. Others may be more characteristic cultural communication patterns in Japan. There is no standardized nursing education in Japan regarding communication with clients with anxiety. In other cultures where therapeutic communication is taught, it may not cover all the channels nursing practice characteristically owns. Nurses may often overlook some approaches identified here. Therefore, the approaches elucidated in this article might help both novice and experienced nurses, domestically and internationally, develop their own repertoire of effective methods to deal with clients/families with anxiety.

In this article, we grouped the types of anxiety identified by home care nurses into three categories: anxiety about dying, anxiety about living with illness, and anxiety about receiving care. These types are by no means exhaustive but

the interviewed nurses commonly experienced them. The identification of commonly seen anxiety types might help nurses better understand their clients and their situation. In the interviews, we did not get a clear picture of the association between the specific types of approaches and the anxiety categories; this correspondence might depend on the specific context of the encounter between the nurse and the client/family. In the future, a closer, more detailed examination of nursing practice may help elucidate which approaches nurses should take to manage specific types of anxiety.

In this study, we conceptualized three major categories that pertained to the nurses' approaches for clients' anxiety. This nursing care took place in the context of home care nursing in the social care system in today's Japan, in which interventions are mostly on a long-term basis with relatively ample time for communication between the nurse and client/family. Such conditions of care provision may not be available in home care nursing in other countries. However, similar communications and approaches may take place, even in part, in other countries and thus they may not be completely specific in Japan.

Most nurses discussed approaches in *reaching out for anxiety* as an important part of their practice. First, the nurses emphasized the importance of carefully listening to clients/families. In the Western literature on professional communication, they seem to emphasize more prompt and efficient approaches (Hudson et al., 2006; Maguire & Pitceathly, 2002), although careful listening to the client is emphasized as a basic approach in nursing regardless of country and how much time is actually used would depend on specific contexts. Under the long-term care insurance system, Japanese home care nurses tend to have long-term relationships with clients; this may influence how much time they could initially spend for just listening to their clients.

The nurses in our study were very sensitive to the client's anxiety without eliciting direct disclosure. This seems characteristically different from the findings described in the Western literature, where eliciting questions, directly exploring concerns, and verbalizing the anxiety were encouraged for health care professionals (Maguire & Pitceathly, 2002; Maguire & Pitceathly, 2003). For example, verbalizing the unspoken but implied message is one of the desired therapeutic responses (van Servellen, 2009). This does not mean that Japanese health care professionals never communicate about the client's concerns directly or Westerners always prioritize verbalizing unspoken messages. However, among other strategies to deal with anxiety, Japanese may emphasize a less direct approach; especially when approaching anxiety, direct verbal communication may be difficult. Strengthening nonverbal communication skills, such as appreciating the client's eye expression, can help nurses better assist Japanese clients with anxiety.

There were many strategies for alleviating anxiety categorized as *altering the outlook* of the situation. The sources of anxiety are often not changeable or treatable, but nurses try

to change clients' views by offering different perspectives. They may add to the picture the presence of various sources of support, suggest different possibilities to deal with an issue, or even provide a temporary escape. Such attempts to modify the cognitive response to the situation are more than mere therapeutic communication skills and rather similar to the principles of cognitive therapy (Beck & Haigh, 2014), although the nurses' communication is not aimed to treat specific psychological disorders. Regardless of culture, strategies such as temporary escape may be useful and nurses could use it intentionally in various clinical settings.

It is noteworthy that some nurses reported taking care of physical aspects of the client's life as a part of attending to anxiety. Not only by altering the outlook, but also by *creating comfort*, nurses took care of their clients' anxiety. This may reflect the universal nursing characteristic perspective on the person which assumes a mind-body unity regardless of culture (Benner, Tanner, & Chesla, 2009; Watson, 2012) and is emphasized in Eastern views of a person (Nakao & Ohara, 2014). It is unclear whether the interviewed nurses were conscious of this philosophy and intentionally used it; providing physical care for those with anxiety seemed to be a rather experiential knowledge for those nurses. A more detailed examination of the actual daily practice of nurses across different countries may lead us to a better understanding of this mind-body unity view inherent in nursing care. A variety of skills for alleviating anxiety should be part of the basic knowledge for nursing practice.

There are several limitations to this study. First, it is largely an exploratory study because we obtained data from only 10 nurses from agencies owned by a single company. Therefore, we need a deeper examination with a broader background regarding the practice of home care nurses. Second, we relied on the subjective evaluation of practicing nurses themselves regarding the effectiveness of those approaches, not including evaluations by other nurses or clients. Therefore, there is a possibility that these practices were in fact not effective. Nursing practice is largely embedded into the long sustained process of caring for the client; an objective evaluation of the effectiveness of specific approaches to alleviate anxiety may be difficult. The participating nurses had extensive experience; in this study, we assumed that there would be some reality in their subjective selection of what was effective in their practice.

Third, this study focused on home care nursing in Japan; we examined the data in the context of the Japanese cultural and social system. Although most of the caring activities by the interviewed nurses may be observed in other countries and thus universal, the levels of emphasis on each of the activities may vary depending on the cultural and social contexts. For example, nursing in other countries may emphasize technical aspects of care more or they may not focus on psycho-emotional aspects of client/family as much as Japanese nurses typically do. Yet many clients experience the feelings of anxiety that we examined in this study and

thus we consider them universal; nurses would do care for those clients and attend to their anxiety. Some findings, such as the multiple meanings of nursing care practices, may well be applicable to nursing care in other countries as well.

In spite of the several limitations, this article may be useful because it is one of the few studies that attempted to capture and conceptualize daily mundane nursing practices to care for clients/family with anxiety. The skillful practice presented in this study could help nurses in Japan and other countries improve their practice and broaden their skills to manage clients and families with anxiety. To date, nursing philosophy and research paradigms are largely influenced by Western philosophical and cultural traditions. Some conceptualizations in this article may help us to be more aware of practices that may be emphasized in Eastern cultural characteristics, such as *waiting for the client/family to share*. Such awareness to Eastern cultural views of person and its positive influence on caring activities may assist both Western and Eastern nurses to consciously improve their care for client/family with anxiety. All of these practices are more or less easily observable, regardless of cultural traditions. Thus, nursing skills described in this article may be helpful for nurses universally, in obtaining a different perspective on their own practice, and/or further improving their skills. Anxiety is a universal phenomenon and the findings would be relevant for all nurses caring for those in need of help.

Conclusion

This article reported Japanese home care nurses' experiences of how they provide support to clients/families with anxiety. We interviewed 10 home care nurses and analyzed data qualitatively to conceptualize the skills and attitudes that they utilized in assisting those clients. The nurses typically made efforts to carefully reach out for the anxiety of clients/families, attempted to alter the outlook of the situation, and created comfort as a way to alleviate anxiety. These strategies may partly reflect Japanese/Eastern cultural characteristics in communication and the view of the person, but they may also inform the practice of Western nurses and increase their awareness of skills that they may already have and use.

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