Difficulties Shared by Visiting Nurses Supporting People with Mental Disorders

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visiting nurse
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difficulties
home-visit nursing station
psychiatric home visiting

ABSTRACT

The purpose of this study was to shed light on difficulties shared by visiting nurses supporting people with mental disorders. Nine nurses serving at two home-visit nursing stations were individually interviewed both formally and informally, and the data obtained were analyzed by the Modified Grounded Theory Approach (M-GTA).

The results of the study reveal that difficulties in supporting people with mental disorders receiving in-home care fall into the following four categories: (a) difficulties in carrying out a contract, (b) difficulties in assisting patients in their homes, (c) difficulties in establishing cooperative relations with the people concerned, and (d) difficulties in mutual support among the nurses. These four categories interact with one another and make the problems even more difficult to solve, resulting in a situation where a visiting nurse feels a sense of isolation.

The study suggests the necessity for (a) education of visting nurses, (b) creating a special management position responsible for the community care of people with mental disorders, and (c) establishing a system that enables the home-visit nursing care service to function fully.

I. Introduction

In Japan healthcare policy toward people with mental disorders was originally centered on hospital treatment, but started to rely on rehabilitation facilities, and to support their community life now. For example, the project for the support to promote the deinstitutionalization of people with mental illness[1] and Assertive Community Treatment (ACT)[2] is being conducted on a trial basis in many communities. Community care is also promoted through the revision of the medical payment system[3].

In spite of these development, home-visit nursing care for peoples with mental disorders has not been widespread yet. This would be because there is not enough cooperation among psychiatric medical institutions and there are few home-visit nurses who have experience of psychiatric nursing, so that many home-visit nurses do not know what to do when they are requested to visit homes of people with mental illness[4] [5]. It is reported that many home-visit nurses who support psychiatric patients feel burdened and stress in Europe and North America[6] [7], but in the case of Japan community care service is insufficient[8] and there are variations of types and roles of community healthcare nurses in Japan[9]. I consider it necessary to clarify the difficulties nurses experience when they support people with mental disorders because it is difficult to conduct effective nursing practice without clarifying it. Therefore, this research attempts to do it.

II. Research Methods

This research employed Modified Grounded Theory Approach (M-GTA) developed by Yasuhito Kinoshita, an approach for looking systematically at qualitative data[10].

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1. Research Participants

Research participants were nine nurses (seven females and two males whose average age was 41 years) who worked for two home-visit nursing stations established together with psychiatric hospitals. Their years of nursing experience (both hospital and home-visit nursing) ranged from four years to 31 years (Table 1).

Table 1. The Outline of Research Participants

Name	Station	Sex	Age	Nursing Experience
Nurse A	X	M	early 50s	about 30 years (psychiatric), 1 year (home-visit)
Nurse B	X	F	mid 20s	2 years (general), about 2 years (home-visit)
Nurse C	X	F	late 40s	several years (general), over 10 years (psychiatric), 4 years (home-visit)
Nurse D	X	F	mid 40s	over 10 years (general), 4 years (home-visit)
Nurse E	X	F	late 40s	2 years (psychiatric), 2 years (home-visit)
Nurse F	Y	M	mid 40s	20 years (psychiatric), 5 years (home-visit)
Nurse G	Y	F	mid 40s	several years (general), 3 years (home-visit)
Nurse H	Y	F	mid 30s	several years (general, psychiatric), 2 years (home-visit)
Nurse I	Y	F	late 50s	over 20 years (general, psychiatric), 1 year (home-visit)

2. Methods of Data Collection

I conducted semi-structured interviews for collecting most data. I also engaged in participant observation for acquiring supplemental data. The content of interviews is mainly as follows: (1) What do you especially care about providing support to people with mental disorders in home-visiting nursing care; (2) What are your worries and difficulties on nursing care; and (3) How do you work with people in other relevant organizations? The average interview time was 90 minutes (ranging from 40 to 180 minutes). The number of interviews were one time (2 subjects), two times (4 subjects), and three times (3 subjects). Verbatim notes (A-4 size) I took

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was composed of 201 pages. I also made informal interviews with them about the things I could not ask, the thoughts about nursing, and the things I want to ask in participant observation during the morning meetings, conferences, and accompanying visits. In addition, I visited the homes of people with mental illness with home-visit nurses and participated in nursing care. I then actively interacted with them, observed what was going on there, and provided feedback to nurses. Data of participant observation and interviews conducted in home-visit nursing stations and during home-visit nursing were composed of 145 pages (A-4 size).

3. The Period of Data Collection

I collected the data of nurses working for X Home-visit Nursing Station from November 2002 to August 2003 and conducted concept generation. I also visited Y Home-visit Nursing Station for collecting additional data from August to October 2005.

4. Methods of Data Analysis

M-GTA sets up an analytical theme and subjects for analysis. The theme of this research is: What kinds of difficulties home-visit nurses experience when they support people with mental disorders in home-visit nursing? The subjects for analysis is home-visit nurses.

Collected data were analyzed based on the following M-GTA methods of analysis: (1) I focused on relevant points of data according to an analytical theme and subjects for analysis, and generated concepts by interpreting them as a concrete example; (2) New concepts were generated through the process of data analysis, and worksheets for analysis were also generated in each concept; (3) I simultaneously looked for concrete examples from the data and added them in the column of concrete examples in the worksheet; and (4) I generated subcategories and categories composing the relationship among a number of concepts, and made a result figure and a storyline.

When I made worksheets for analysis based on interviews and participant observation as describe above, specialists of qualitative analysis supervised my research by checking whether the described content was valid and comparing data with my interpretation of them.

5. Ethical Considerations

I explained to administrators and all nurses in home-visit nursing stations the purpose of research, the content of cooperation, and ethical considerations verbally and in written forms. I also gained the consent to participate in the research from people with mental illness and their family members verbally. All data of home-visit nursing stations, their nurses, their users and users' family members were anonymized, and some data were modified without altering their meaning and affecting contexts. This research was approved by the Research Ethics Committee of Japanese Red Cross College of Nursing.

III. Results

In this section I explain the result figure (Figure 1) generated by the M-GTA analysis. Extracted categories, subcategories, and concepts are shown by [ ], 《 》, and <>, respectively. ( ) is a supplementary explanation for clarifying contexts.

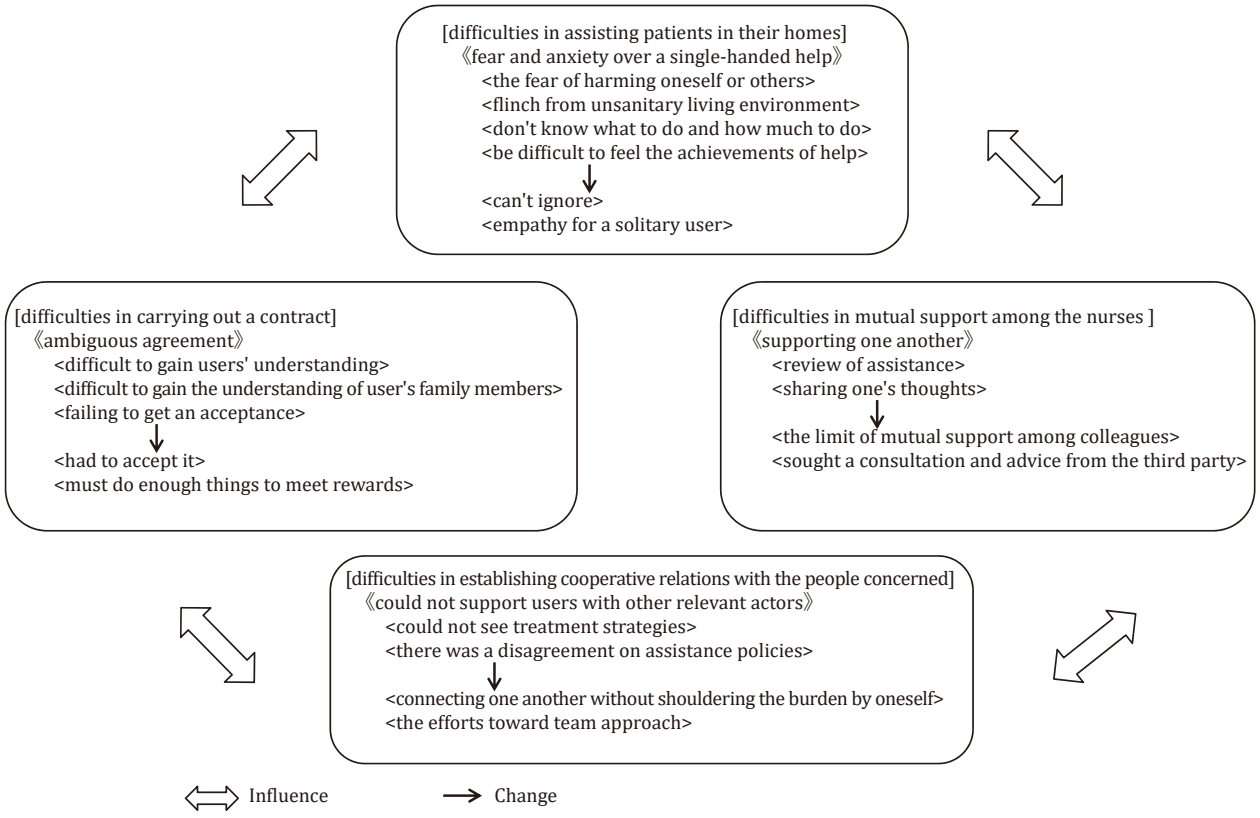

Figure 1. The Structure of Difficulties Nurses Who Support Persons with Mental Disorders Have

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1. Storyline

The difficulties of home-visit nursing for persons with mental disorders were composed of [difficulties in carrying out a contract], [difficulties in assisting patients in their homes], [difficulties in establishing cooperative relations with the people concerned], and [difficulties in mutual support among the nurses].

The first difficulty that arose between nurses and users of a home-visit nursing station was [difficulties in carrying out a contract]. In spite of this difficulty, nurses had to conduct home-visit nursing care because there was a contract relationship between them. They also felt [difficulties in assisting patients in their homes]. There was also [difficulties in establishing cooperative relations with the people concerned] when nurses felt the limit of nursing psychotic patients only by themselves. Even if they tried to cooperate one another for resolving the difficulties, there was [difficulties in mutual support among the nurses]. These four categories showed that nurses could not overcome their difficulties fully by their own efforts, intensifying them by influencing each other reciprocally.

I am going to explain categories, subcategories, and concepts by presenting their variation below.

2. [Difficulties in Carrying Out a Contract]

The difficulty nurses have can be explained by the category of [difficulties in carrying out a contract] composed of the time of contracting and the continuation of nursing care to patients after the contract. Nursing care started after an《ambiguous agreement》but nurses considered that they <had to accept it> because they signed a contract, and came to think that they <must do enough things to meet rewards> once nursing care started.

An《ambiguous agreement》refers to the situation in which nurses felt difficulty in conducting nursing care because it starts without the agreement on the perception on home-visit nursing between users of home-visit nursing stations and nurses. Contracts must be implemented after both sides understand and accepted the content of contracts. But home-visit nursing for persons with mental disorders was contracted under an《ambiguous agreement》.

An《ambiguous agreement》includes <difficult to gain users' understanding>, <difficult to gain the understanding of user's family members>, and <failing to get an acceptance>. These three concepts showed the difficulty of nursing care due to the insufficiency of agreements between users of home-visit nursing stations, their family members and nurses.

<Difficult to gain users' understanding> means that nurses feel difficulty in performing nursing care because users of home-visit nursing stations fail to feel and understand the necessity of home-visit nursing even if nurses explain it because they are not fully aware of their own disease.

> *I have continued to visit one user's home since I was asked to see him because he did not visit a hospital. I explained to him about the terms of home-visit nursing, but he did not requested it because it started from the request of our side. Therefore, our relationship has not developed even though I continue to visit his home. It does not sit well, so I'm not sure whether I should continue to conduct home-visit nursing. I think I need to talk to his family doctor once (Nurse F).*

In this way there were many cases in which nursing care started without users' understanding of the necessity to make use of home-visiting nursing although they agreed to its terms. Nurse C said that several users seemed to be told that "you can get out of the hospital if you accept home-visit nursing, or you should receive home-visit nursing because it is cheap by civil servants." She also told that "contract starts after a verbal promise such as 'I visit your home for nursing care,' and 'OK,' that is, it starts without most users' understanding of the meaning of home-visit nursing fully." Nurse D told that "we sometimes hesitate to explain the necessity of home-visit nursing because some users do not like to talk about their diseases." Therefore, nurses told that "we are very careful about the conduct of nursing care when users are unconvinced about its necessity."

There were also many cases in which it was <difficult to gain the understanding of user's family members>. This is the case in which family members do not try to understand user's diseases and troubles occurs when nurses conduct nursing care to patients because they are eager to achieve results. Most nurses said that it was much more difficult to provide help to users who lived with family members than users who lived by himself/herself because they became tired of dealing with users' family members.

> *A user's father talked to Nurse F in an empty room: "His behavior looks childish (user's age was mid-30s). What do you think about his childish attitudes? What is the age limit of the use of home-visit nursing for psychotic patients. The nurse told him that "some patients are over 50 years old." He just said "Is that right?" He continued to say, "I am short-tempered, so I am a bit frustrated that he does not get well at all. (My visit to a patient's home with Nurse F)*

There are some cases of <failing to get an acceptance> in which users refuse to let nurses enter their homes. Nurses are likely to have a sense of helplessness and lose confidence if they fail to make cooperative relationship with patients.

> *Of course, I feel unsure of myself in a situation and sometimes I am rejected by a user, so that staff members also become anxious about what to do (Nurse C).*

In this way there had been a lot of difficulties on nursing care for persons with mental disorders since the start of contracts. But nurses considered that they "can't help but accept" it because of their thought that it is difficult for them to continue to stay at home without their help in a community where there are few other social services for supporting their lives.

Then, once nursing care started, they came to think that they "must do something to deserve a reward." In other words, they think that they must conduct nursing care and show some results because the relationship between them is contractual and users pay the money. Administrators of two home-visit nursing stations told that "we continue to be compelled to think that we must do something."

3. [Difficulties in Assisting Patients in Their Homes]

Once nursing care started, the matter can be explained by the category of [difficulties in assisting patients in their homes]. There was a《fear and anxiety over a single-handed help》. In spite of this difficulty, nursing care was conducted by a sense of responsibility that we <can't ignore> users and <empathy for a solitary user>.

《Fear and anxiety over a single-handed help》refers to the fear for going to help a user by himself/herself and the anxiety and apprehension over a single-handed help. It included four

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concepts: <the fear of harming oneself or others>, <flinch from unsanitary living environment>, <don't know what to do and how much to do>, and <be difficult to feel the achievements of help>. As these concepts show, nurses feel anxiety over doing home-visit nursing by himself/herself.

<The fear of harming oneself or others> refers to nurse's perplexity and fear of doing help due to user's violent and oppressive attitudes and acts. Nurse C told the following story that she could take a user whose symptoms worsened to a hospital in fear of her physical danger.

> *He had stopped consulting a doctor for almost two years, but his conditions was gradually deteriorating, so I talked to his doctor about this situation and brought him to patient's home but he could not examine him. When I visited him, he was upset and took a hoe from a bar, shouting "why do you come here?". His brother then called the police, so the policeman and I persuaded him to go to a hospital. He did not want to be placed in a police car, so I got them to sit in the backseat of my car and drove to the hospital for hospitalizing him (Nurse C).*

The above fear shows that nurses felt awkward about doing home-visit nursing alone partly due to the influence of users' unsanitary living environment. <Flinch from unsanitary living environment> refers to a situation in which user's living environment is so unsanitary that it might not be good for the health of nurses and they might hesitate to conduct nursing care by being intimidated by inconceivable unsanitary living conditions. Nurse H, who were allergic to cats, talked about coughing situations because she had to visit a user's home with cats.

> *Mr. X keeps two cats. I am allergic to cats, so it's difficult to stay his home. I can't stop coughing (in a car) while I go to another user's home. I cannot change a shift time, so I am going to prepare myself for going into his stinky house (Nurse H).*

Nurses went to user's home by motivating themselves to take care of users although they felt awkward to do it alone, but <didn't know what to do and how much to do> there many times. This shows that they were of two minds about nursing care they were conducting. They provided a variety of help such as giving an advice on how to associate with neighbors and preparing a simple nutritional meal with users by making use of their experience as ordinary citizens. But they said, "it is difficult to judge the extent of help as nursing care." and "I worry about the significance of the content of help as nursing care and the usefulness as the contribution of user's independence."

They also think that it <is difficult to feel the achievements of help> because no change of user's attitudes and behaviors was observed, having a feeling of insufficiency. This shows that nurses fail to find meaning of their own doing because users do not change at all in spite of their assistance.

Nurses were unsure of the usefulness of assistance and their roles, feeling marginalized and saying that "they were sometimes at a loss as to what to do." They also told that they did not feel a sense of accomplishment on assistance very much. In this way nurses continued to conduct nursing care on persons with mental disorders with a feeling of incompleteness and helplessness.

Yet, they continued to conduct nursing care in spite of difficult by thinking that they <can't ignore> users with a feeling of anxiety. Nurse F told that "(if I think about users) I feel that I must go to their homes anyway."

Then, by going to the homes of users who are not connected to the outside world, nurses feel that "I must do it" and conduct nursing care for them. While working in a home-visit nursing stations, they talked to users and their family members for consultation by phone.

Nurse H went to came by to see users who lived alone and went along with other nurses even in her holidays.

> *I am mostly worried about Mr. Y. I went to see him in my Bon vacation. I also went along with other nurses to see him. I must go to see him because nobody does it (Nurse H).*

Another factor of inducing assistance was an <empathy for a solitary user>. Many users who discharged from hospital were compelled to live alone because their parents had already died and been estranged from their brothers and sisters. They were not likely to involve themselves with others and stayed up late, making it difficult for them to maintain community disciplines such as the rule of garbage. Nurse H told about Mr. Y who lived at home after 30 years of hospitalization: "If he get hospitalized now, it would be difficult for him to live in the community again." Therefore, she continued to conduct in-home care for him.

4. [Difficulties in Establishing Cooperative Relations with the People Concerned]

Through the engagement with users nurses feel that one person is not enough to support each user, so they considered to work with others, but it was a difficult task. This situation can be explained by the category of [difficulties in establishing cooperative relations with the people concerned].

Nurses felt that they《could not support users with other relevant actors》as [the difficulty of cooperating with relevant actors]. More concretely, they <could not see treatment strategies> of doctors and felt difficulty in cooperating with them because <there was a disagreement on assistance policies> for users between relevant actors and nurses. They encouraged <the efforts toward team approach> for <connecting one another without shouldering the burden by oneself>.

I《could not support users with other relevant actors》included two concepts: <the failure to see treatment strategies> and <a disagreement on assistance policies>. Relevant actors here refer to professionals who conduct assistance, such as doctors and nurses in hospitals and administrators.

<The failure to see treatment strategies> refers to a situation in which nurses do not fully understand or be convinced of doctor's treatment strategies, feeling unsure of the direction of assistance.

> *There was a case in which home-visit nursing started because a user's father told that they need it although the user had not visited a clinic very much. He does not need medical treatment but I visited his home under a doctor's guidance. I asked the doctor to make a house call, but before he visited the user's home, the doctor in charge changed. The new doctor had a policy of providing medical care in a hospital, therefore, no doctor visited his home (Nurse F).*

Some nurses said, "They are often not at home even if I visited them. Sometimes they pretend not be at home." They had this kind of experience many times, so some doctors started to doubt the necessity of home-visit nursing for

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users. They wanted doctors to visit users' homes for knowing users' actual situations and make use of this knowledge for treatment. But there were few doctors who made house calls, and nurses also accepted this situation because doctors were busy taking care of patients in hospitals. They also thought that it was not good for doctors to prescribe a lot of drugs for users. Nurse E appeared to want to question them about it but she could not do it. Nurses said, "doctors are just checking items of drug instructions" and "their instructions were always same." In fact, there was few concrete instructions on the Instruction of Home-visit Nursing for Psychotic Patients. Some doctors were reluctant to write them, so there were some cases in which nurses asked them to do it.

In addition, nurses felt that <there was a disagreement on assistance policies> because the goals of assistance were not fully shared with other professionals. Therefore, they often felt that their assistance to users was not effective. Nurse F said, "There was no enough cooperation with staff members of public health centers, so I am worried about what to do in home-visit nursing." Nurse C also said, "I was just exhausted. Why must only home-visit nurses shoulder the entire burden of the care for people with mental disorders?" She felt a gap in perception on assistance to them with nurses in hospitals, and thought the burden of home-visit nursing was heavy.

Home-visit nurses felt the difficulty of team medical care because they actually failed to cooperate with other relevant actors very much. In order to overcome it, nurses tried to <connect one another without shouldering the burden by oneself>. In other words, they realized the difficulty and limits of home-visit nursing, therefore, it is necessary to work with other relevant actors.

In this way nurses felt the necessity of teamwork, but other relevant actors did not seem to feel its necessity. Therefore, nurses tried every efforts to improve the quality of home-visit nursing for users by encouraging other relevant actors to cooperate with them.

> *I got in touch with psychiatric social workers in hospitals and public health nurses in Welfare Division for Persons with Disabilities for setting up meetings. I asked them about a variety of things. I called them and got reports, but I said to them, "I think this judgment is not good. I think otherwise." Then, I told that this did not lead to a good decision, and made a new proposal... (Nurse C).*

Nurses considered that they wanted to cooperate with other relevant actors for supporting users. Therefore, they encouraged <the efforts toward team approach> by associating with one another. This implies that nurses make efforts to promote cooperation for assistance with professional teams because assistance by one nurse is not enough to support users. Nurse I talked about how she was making efforts to build a solid relationship with staff members in group homes:

> *When I came to work here, the relationship with group homes were not good. It seemed that we blamed one another. But we have begun to build a good relationship lately. Everyone (in home-visit nursing stations) is making a lot of efforts. I also try to show up frequently and get in touch with them (Nurse I).*

In this way although they worked together to build a cooperative relationship with one another, there is a perception gap on the assistance to users between nurses and other relevant actors.

5. [Difficulties in Mutual Support Among the Nurses]

Nurses try to overcome a variety of difficulties by supporting one another, but their efforts often fail. This situation is explained by the category of [difficulties in mutual support among the nurses the difficulty of mutual cooperation among nurses].

There was an aspect of《supporting one another》among nurses in order to resolve difficulties accompanied by the assistance to users on [the difficulty of mutual cooperation among nurses]. Nurses in a home-visit nursing station tried to cooperate one another for overcoming difficulties, but they were not enough to do them, so that they felt <the limit of mutual support among colleagues>. Therefore, they <sought a consultation and advice from the third party>, but could not get enough of them, so they maintained their assistance to users with difficulty.

《Supporting one another》refers to a situation in which nurses attempt to cooperate one another for overcoming a variety of difficulties on an assistance to users. It includes concepts of <review of assistance> and <sharing one's thoughts>.

<Review of assistance> refers to a situation in which each nurse who visited a user's home alone exchanges information and evaluates his/her works with other nurses. They held a mini conference in home-visit nursing stations quite naturally. They all had a lively conversation about how to assist users, and it sometimes continued even during a break. Nurse C talked about the necessity and significance of intentional reviewing:

> *Especially on home-visit nursing for people with mental disorders I always think about how to work for users effectively. I often say, "We have to review our own works. If not, we can't take an initiative to improve them. More than anyone else, we have to have an opportunity to review our own works. Without it everyday's busyness would make us fail to see what we're doing now (Nurse C).*

Nurses B and F said, "We make it a rule to talk about how to assist users. But we are always not sure how we should do it."

Nurses thought about a variety of things when they engage in <review of assistance>. Therefore, they spontaneously <shared their thoughts> with one another in a home-visit nursing station. This implies that they are trying to stabilize their emotions and accept what they are by expressing their feelings on the assistance to users and sharing their emotions.

In a home-visit nursing station nurses always talked about users whenever they gather. Especially in lunch break they showed a variety of their feelings such as a feeling of insufficiency and helplessness accompanied by assistance, and anger at users.

> *Yet, they did not do what I asked to do. Many persons with mental disorders I take care of in home-visit nursing also have physical disorders. I provide guidance on livelihood support, daily life guidance, and dietary instruction, but they do not try to listen to me. I had a dilemma on it. So I express my displeasure in a home-visit nursing station (Nurse D).*

In particular, administrators in a home-visit nursing station listened to their complaints even if they could not rest quietly during lunch break. We often saw the scenes in which they supported staff nurses when they could not find meaning in

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assistance and became anxious about it in order to encourage them to be involved with users. Administrators engaged in home-visit nursing and psychological support for nursing staff members. Their role as administrators were important, but it seemed that their burdens were too heavy.

《Supporting one another》was not enough to overcome difficulties accompanied by assistance. They had to continue to conduct assistance with difficulty.

As a measure to deal with difficulty, Nurse E said, "It may not be a good thing, but I try not to think that I have to turn for the better." Nurse C told that nurses often talked about users who did not change attitudes and behaviors at all: "What was wrong with us? What goes wrong? Is it better to ask other organizations to take care of them?"

In this way nurses felt <the limit of mutual support among colleagues>. This is a situation in which a group of nurses cannot find out a solution, suffering hardship without overcoming the difficulty of assistance. Nurse C faced a user's suicide and failed to know the reason why such a thing happened, so she was not able to recover from it for a long time. She said she could overcome it only after she could talk to a professor she knew. In this way it was necessary for nurses to get an advice not from other nurses in a home-visit nursing station but from the third party for solving and overcoming difficulties.

> *Life-threatening incidents can occur in psychiatric circles. Who would listen to me when such a thing occurs? For instance, when other nurses in my office experience a similar incidence, I may say, "It can't be helped." But it doesn't touch their heart. Don't you think they would say, "What, but...?" if other home-visiting nurses say, "It can't be helped." If people in other organizations say, "It can't be helped. Such a thing sometimes occur. I know what you went through," I would easily accept it and say, "Yeah." But there was no environment in which we can get an advice from the third party (Nurse C).*

Therefore, nurses could not become confident of the continuation of assistance by themselves, so they <sought a consultation and advice from the third party>. But they usually could not get enough of them.

In this way home-visit nurses who assist persons with mental disorders faced a challenge from the first stage of developing a contractual relationship with users. When assistance starts, they felt anxious of doing an assistance alone and having a relationship with users by receiving money from them. They had worries and doubts on the assistance relationship with users and its content. Furthermore, they sometimes felt the difficulty in cooperating with other relevant actors. Each nurse tried to overcome these difficulties by cooperating with one another, but without reaching a fundamental solution, they were always compelled to continue assistance with difficulty. Even veteran Nurse I said, "I continue to work while searching for the best way of working, I sometimes suddenly begin to lose my confidence." In this way nurses felt powerlessness, emptiness, and fatigue on the assistance to users.

Nurses could not feel a connection with users and their family members fully and were tired of continuing assistance because they felt the limit of mutual support among nurses and could not also get enough cooperation and support from other relevant actors.

IV. Discussion

1. "Contracts" on Home-Visit Nursing for People with Mental Disorders

In this research service started by contracts of an《ambiguous agreement》between users and home-visit nurses, therefore, it was considered that nurses started to have difficulties at the stage of contracts. They failed to agree on specific points in this contract relationship, and this affected the relationship between users and nurses, nursing care, and cooperation with relevant actors in an adverse way.

First, there were things users must deal with on contract. It seemed that they failed to show what they want on home-visit nursing at the stage of contract and did not know how to make use of home-visit nursing very well. In other words, they were not accustomed to telling nurses their intentions and understanding the content of contracts fully. This is the reason why users failed to make use of home-visit nursing fully.

Next, there were things nurses must deal with on contract. It seemed that they failed to understand users' disease fully and often resisted talking about it, showing that they did not explain the service of home-visit nursing until users were satisfied. In this way it was clarified that nurses needed to be more serious about how to get contracts with users, such as how to explain the necessity of home-visit nursing for them.

Yet, there are many cases in which users fail to understand the necessity of home-visit nursing at the time of contracts, which is often affected by the degree of their disease and handicap. There were also cases in which the agreement became difficult because users failed to face their own disease properly and had problems on their daily lives. In this case it is possible to terminate a contract with psychotic patients, but this has a risk that might stop their treatment and deteriorate their conditions. Therefore, the task of how to continue home-visit nursing become more important in the field of psychiatry than other medical fields[11]. Nurses in this research also recognized it fully.

Third, the tasks of hospitals were clarified. Administrators of hospitals often compelled persons with mental disorders to accept home-visit nursing, and this was done without the attendance of home-visit nurses. It was also suggested that they failed to explain the necessity of home-visit nursing fully to them. It is considered that this affected the relationship between users and home-visit nurses negatively.

2. Nurses' Stress and the Fluctuation of Their Identities Accompanied by Assistance

Among home-visit nursing conducted by intervening in users' daily life, nurses must especially be in close relation to patients in home-visit nursing for persons with mental disorders. For instance, when users are chronic schizophrenic patients, the most typical users in home-visit nursing for psychotic patients, nurses must assist them mainly not only by managing their health and instructing the use of drugs but also by helping them to keep their daily life smoothly. Every assistance is indispensable for users to live their life at home, but nurses had often trouble distinguishing assistance from nursing care. In home-visit nursing nurses engage in assistance alone, so they have a lot of discretion on it. Therefore, they must do it by making use of their own experience of the everyday life. This can be not only the best part of home-visit nursing, but also its difficulty.

In this way many home-visit nurses feel difficulty only after

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they work at hospitals. This suggests the reason why they feel difficulty in converting nursing at a hospital to nursing at a patient's home. Assistance starts when users choose the service of home-visit nursing in home-visit nursing. Therefore, we must confirm users' willingness to receive it before its start, but there were many cases in which this was insufficient at the stage of contract. Home-visit nurses also felt difficulty in taking charge of patients through their judgment with their own responsibility and cooperating with relevant actors who worked in different places. In a hospital ward nurses cooperate with one another to take care of each patient and other professionals work with them by using their professional skills. Yet, in the case of home-visit nursing they are likely to be perplexed by being held responsible for all assistance and being asked to get in touch with relevant actors who belong to other organizations.

The second difficulty lies in the difficulty of finding out the meaning of nursing assistance. Nurses in this study provided assistance to users for making them engage in daily life without trouble by relying on the wisdom of their own life experience. But they <don't know what to do and how much to do>, so that they were compelled to conduct nursing care by trial and error. Takei[12] notes that "the work of assisting patient's daily life is the basic of social therapeutic roles of psychiatric nursing, but its results are usually not noticeable and would not become the focus of attention by others." Even if nurses try their best to assist patients, there is usually no change among them, so that their efforts are not likely to be evaluated positively. This caused their anxiety of assistance and the feeling of undervaluation. Even if they provide a variety of consultation on daily living to them, it was not likely to be noticeable and concrete. Therefore, they reinforced the feeling that "is it OK to continue such an involvement?" In addition, they were told that it is important to reach for the self-reliance of psychotic patients but were often puzzled by the level of assistance to users' daily living which is necessary for their self-reliance and felt difficulty in giving assistance for self-support.

The third difficulty is due to the borderless situation of participants of home-visit nursing because a variety of professionals are involved in it[13]. In this situation many nurses seem to ponder the role of home-visit nurses on home-visit nursing for people with mental disorders. A variety of people engage in assistance for users, so home-visit nurses' roles and functions became ambiguous. It was revealed that they worried about their own assistance and their relationship with users while conducting assistance.

Home-visit nurses felt uncertainty about themselves because they did not have confidence in assistance, doubted about the role of nurses on this job, and failed to have enough ties with users and other relevant actors. In other words, it is said that there was a disturbance of occupational identity as home-visit nurses.

In this way it is considered that home-visit nursing for people with mental disorders is likely to cause dilemma and disturb occupational identities among home-visit nurses. Fujii noted that nurses fail to recognize "what is and what is not" about home-visit nursing by themselves[14]. This shows the necessity of clarifying and organizing the roles of home-visit nursing for assistance not only to psychotic patients but also to other kinds of patients, educating home-visit nurses, and fostering the independence of home-visit nurses through these attempts.

3. The Necessity of Support to Home-Visit Nurses

Home-visit nursing stations became the place where nurses expressed their frustration when they came back from the service of home-visit nursing. Unless they eliminated their anxiety and helplessness, they would not have incentive to visit other users' homes for assistance. Therefore, it is necessary for them to come to terms with their feelings for constructing a good relationship with the next user.

In home-visit nursing nurses must leave the place with a variety of thoughts toward users because they can't leave the place while they are working even if their relationship with users deteriorates. It is also difficult to judge when assistance should be terminated because their relationship with users span longer periods of time than those with patients in hospitals. Medical conditions of psychotic patients are easy to change, which also makes home-visit nursing difficult.

It is important to maintain the close relationship among nurses and peer support among them for overcoming these difficulties. Komatsu[15] noted that she talked to her colleagues about support and the influence of stress on herself and her life through her own practice not by intention but by necessity. Tanifuji[16] also stated that she eliminated anxiety and an uncomfortable feeling by clarifying the basis of care through discussions with other staff members in order to prepare for the next home-visit nursing.

This research also revealed that nurses talked with one another about users, their family members, and other things about troubles and bruises caused by home-visit nursing in a home-visit nursing station. Each nurse talked about one's own feelings at ease freely and listened to other nurses with compassion. It seems to affect nurses' attempt to gain energy for visiting users' homes and the maintenance and recovery of ties and a feeling of trust with other nurses, users, and other relevant actors.

But, nurses often failed to express their own feelings toward other nurses fully and some problems continued to be unresolved. In other words, there was <the limit of mutual support among colleagues> by each nurse in a home-visit nursing station, therefore, they sought the third party's support.

Yet, there are many problems on the treatment of administrators and staff members and working environment in a home-visit nursing station[17]. Home-visit nurses have tried to deal with them, but it has not yet built a framework that support them. Therefore, many home-visit nurses were exhausted and resigned their jobs. This is considered to be a serious social problem now, so it is urgent to develop a system that supports nurses by the third party.

4. Tasks of Community Care System

The analysis clarified several tasks needed to be solved in the home-visit nursing system.

The first is about the home-visit nursing directive. There were few specific and concrete instructions on the home-visit nursing directive for psychotic patients. Hasegawa pointed out the following stresses relevant to doctors' instructions toward home-visit nurses: there was not concrete instructions, the intention of instructions was unclear, and the failure to start nursing due to the delay of the delivery of a directive[18]. The periodic exchange between doctor's instructions and reports from a home-visit nursing stations was mainly done unilaterally by nurses. It seemed that their were frustrated by the failure to exchange information fully with doctors.

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Nurses cannot check doctors' instructions directly if administrators in a home-visit nursing station took them. This also frustrates nurses when they start home-visit nursing. Even worse, they are asked to practice nursing care in accordance with users' needs by their own judgment. In this situation novice home-visit nurses experienced with distress that they <don't know what to do and how much to do> and <are difficult to feel the achievements of help>.

In a hospital ward both doctors and nurses can check patient's conditions although some nurses may feel frustration by disagreements and their relations with doctors. In home-visit nursing, however, only one nurse can check the condition of each user. Nurses requested to make the instructions of home-visit nursing in a manner more consistent with patients' daily living, but they failed to get them. This also contributed to aggravate their anxiety and lack of confidence.

The second is the failure to allow nurses to conduct assistance other than the one at patient's home. Nurses sometimes took users to a hospital in the service of home-visit nursing. Sometimes those who visit users' homes could not conduct home-visit nursing due to their absence or cancellations. They also provided consultation for user's family members and had phone conversations with users and their family members for a prolonged time. These are necessary works but it is not an assistance at users' homes, so the costs for them are not treated as home-visit nursing care expenses. The third is a rule that only one nurse can visit a user's home from a home-visit nursing station. Therefore, nurses had to conduct home-visit nursing alone even if they worry about it.

There was also a task of a "team medical care." This research revealed that nurses tried to cooperate with other relevant actors on the service of home-visit nursing in order to improve it. Yet, fruitful cooperation between them was not materialized. There was a gap in perception between them and administrators of a home-visit nursing station. They also could not expect enough cooperation with administrative organizations in the community.

They wanted other professionals to help them by using their own professionality, but cooperation between them was always not enough. A variety professionals of medicine and welfare are involved in home-visit nursing but they belong to different organizations whose working system and schedules were also different from one another. Unlike nursing-care insurance system, care management for persons with disabilities fails to be conducted smoothly, compelling nurses to shoulder the main burden of it. It was difficult for different actors to cooperate one another in a team for supporting users because they could not do it based on the system of medical treatment fees.

It seems that the current home-visit nursing as a "team medical care" cannot function well unless nurses make adjustments for other professionals outside duty hours and undertake tasks which are not supposed to be done by nurses. This was apparent as this research showed that nurses visited users' homes and accompanied them to hospitals after work hours and individual efforts of nurses were crucial to cooperate with other relevant actors. They perceived that they were doing them in the form of volunteering, making them think that it is difficult to conduct team medical care[19].

These revealed that nurses fully recognized the importance of team medical care on community care for psychotic patients, but it did not work smoothly. It is necessary to develop a home-visit nursing system by revising medical payment system for helping nurses to conduct home-visit nursing smoothly. There is a limit of assistance by one nurse. This research revealed that it was not clear who were in charge of the conduct of care management on community care for psychotic patients. Its institutional reform is urgent.

V. Implications for Practice

First, we clarified that contracts with users were conducted through an《ambiguous agreement》. We need to induce patients to recognize their own diseases at an early stage of hospitalization and the necessity of home-visit nursing to rectify this problem. It is also necessary for them to have an opportunity to talk with home-visit nurses and medical professionals in a hospital before concluding an agreement. Instructions and reports of home-visit nursing would be in accord with users' wishes by promoting communication on contracts and nursing help among them.

By taking these measures, doctors who provide the guidance of home-visit nursing would write the instruction of home-visit nursing by incorporating necessary information from users and home-visit nurses, and nurses also provide necessary information to doctors more actively. Nurses would be able to offer appropriate nursing care for users by asking users about their necessary help and getting agreements with them repeatedly. It is also necessary to hold a joint meeting involving community care staff before patient's discharge from hospital in order to enhance the awareness of relevant actors on home-visit nursing care for people with mental disorders.

Second, nurses felt a sense of insufficiency and helplessness during their conduct of nursing care. It is important to hold a meeting with other nurses in a home-visit nursing station in order to deal with it. It is significant on two points. First, the sharing of experience among nurses through conversation would enhance a feeling of mutual trust among them. Mutual support among nurses contributes to maintain stable nursing care for users. It would be necessary for them to hold a debriefing session. It would help them to conduct nursing care consciously by thinking about the significance of nursing care they provide. Its reviewing and the sharing of its policies would also help them to conduct an assistance to people with mental disorders with no worry by homogenizing its service and ensuring its proper management. It is also necessary to clarify the tasks of nursing care as home-visit nursing and improve nurses' skills by providing training programs on home-visit nursing for psychotic patients for home-visit nurses.

Third, it was clarified that nurses <sought a consultation and advice from the third party>. It is very important for home-visit nurses to exchange information with other nurses. It is also necessary to keep receiving consultation from the third party such as public health nurses who can perceive their situations and recommend appropriate measures on nursing care. Administrators might be exhausted by listening to staff members' complaints alone. They also need to receive support from the third party. Therefore, we need to construct a support system that can resolve these problems.

Fourth, we revealed that team medical care does not work smoothly. Nurses' conscious efforts to encourage relevant actors to participate in it is indispensable, but it is also important to construct a care system that coordinate

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cooperation with them. They must hold meetings regularly for getting to know each other in order to promote cooperation among them. Administrative agencies such as public health centers must take an initiative for it.

Fifth, nurses engaged in a variety of services other than those defined in contracts for supporting users' daily living. Fundamental institutional measures need to be taken for offering appropriate services to them.

As the fourth and fifth findings show, it is urgent that we should restructure the institution for psychotic patients by constructing a new care system and revising the medical payment system.

VI. The Limits and Tasks of This Study

The purpose of this research was to clarify the difficulties nurses experience when they support people with mental disorders. M-GTA methods of analysis was useful for showing the total picture of the difficulty of nursing help by making the relationship among concepts and categories clear. Yet, we could not collect data on difficulties brought about by nurses' years of experience and the difference of job positions between administrators and staff. In the next study, we need to conduct interviews with other subjects with a consideration of a variety of age groups, career, and job positions, based on concepts generated in this study and continue and a constant comparative analysis for making our analysis more sophisticated.

VII. Conclusion

In order to resolve difficulties nurses had on nursing care for patients, medical professionals in a hospital must encourage them to understand their own diseases and the necessity of home-visit nursing during their hospitalization. Medical professionals in a home-visit nursing station must make a contract with them by forming a consensus with a help of nurses in a hospital and checking the content of contracts with them.

It is necessary to restructure a system that supports home-visit nurses by reviewing working experience with other nurses and receiving consultation from the third party to resolve their anxiety and a feeling of helplessness. It is also necessary to carry out training seminars on home-visit nursing for psychotic patients for making home-visit nurses clarify the goals of nursing care in home-visit nursing and improve their nursing skills.

The analysis also suggested the necessity to improve the system of home-visit nursing through the revision of the medical payment system. We believe that the fundamental problems of home-visit nursing can be reduced by dealing with these defects of the current home-visit nursing system. This is a necessary step we must take for realizing home-visit nurses' "independent" nursing care.

Appendix

This research is a revised and expanded version of my Ph.D dissertation submitted to Japanese Red Cross College of Nursing.

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