ABSTRACT

Aim: To synthesise evidence on the concept of reassurance in nursing practice.

Design: Integrative review.

Review method: PubMed, OVID MEDLINE, CINAHL and PsycINFO were searched from their inception to the 30th of May 2020.The search results were screened. We assessed the quality of primary studies using the Mixed Method Appraisal Tool. Included studies were analysed using narrative synthesis. The review protocol was pre-registered (PROSPERO - CRD42020186962).

Results: Thirty-two papers out of the 2771 search results met our inclusion criteria. The synthesis of evidence generated three intricate themes namely "antecedents of reassurance", "defining attributes of reassurance" and "outcomes of reassurance". Emotional distress was the main antecedent of reassurance. The three sub-themes identified under defining attributes of reassurance include self-awareness, emotional connectedness and verbal and non-verbal techniques. Ultimately, reposing the confidence of patients and their families in healthcare professionals and the care delivery process to enable them to overcome their challenges constitutes the outcomes of reassurance.

Keywords: emotional care, conceptual framework, compassion, integrative review, nursing practice, reassurance, therapeutic relationship

Introduction

The emotional challenges experienced by various patient groups in the clinical setting are well-documented (Rückholdt et al., 2017). These challenges often range from uncertainty about the course of disease progression, the potential success or failure of treatment modalities, and more generally, the fear of the unknown (Carleton, 2016). Hospitalization often places patients in new and unfamiliar environment and this serves as a source of anxiety and psychological unrest for patients and their family. Moreover, evidence suggests that patients with chronic pain (Kohrt et al., 2018), long-term conditions (Holmes & Deb, 2003) and those nearing the end of life experience hopelessness and loss of confidence in themselves and their healthcare providers (Virdun et al., 2017).

The prevalence of such emotional issues among the various patient groups requires healthcare providers to make psychological care a central part of their daily care routines. One of such psychological care is "reassurance". Reassurance is vital to a wide-range of patient groups including those with long-term medical conditions and those that require palliative care (Sinclair et al., 2017) as well as users of emergency ambulance services (Togher et al., 2015), and patients with non-specific conditions (Traeger et al., 2017).

Although reassurance as a psychological intervention is widely used in clinical practice, there are some inconsistencies in the characterization of the intervention.

Background

One core duty of the nurse is to provide comfort and allay fears and anxieties of patients and families through therapeutic communication (Pincus et al., 2013). This therapeutic nurse-patient communication often constitutes reassurance. Reassurance in nursing may refer to the totality of non-specific actions that are carried out by the nurse and geared towards restoring confidence and hope and reducing uncertainty in patients. It is also said to be the removal of fears and concerns about illness, and may refer to the behavior of the caregiver or the response of the patient. This nursing intervention is pivotal in carrying out compassionate nursing care (Clarke, 2014).

Nurses provide more hands-on care and spend the most time with patients than other health professionals do. Westbrook and colleagues (2011) indicate that the time spent for hands-on care to patients constitutes more than three-quarters of nurses' time. Majority of this time is spent communicating with patients (Yen et al., 2018). This constant and preponderant nurse-patient interaction presents a unique opportunity for nurses to be at the forefront of identifying and helping distressed patients and relatives. It is thus not surprising that nursing documentation is dominated by at least one variant of the statement: 'patient was reassured'.

However, despite its widespread acceptance and usage in the nursing profession, reassurance remains a poorly defined term (Rolfe & Burton, 2013), and this was noted decades ago (Teasdale, 1989). Its meaning could range from a reassuring presence of health professionals (Lucas et al., 2008; Traeger et al., 2017) to disclosing information that forecasts positive outcomes (Teasdale, 1989). Another query is whether the form and scope of reassurance changes within a particular framework, such as primary care and clinical care, acute and long-term settings, as well as the end-of-life setting. Some questions remain unanswered about reassurance including (a) what exactly do nurses do to reassure patients (how to reassure), and (b) what nursing actions could patients consider reassuring.

Although a reassurance guide for patients with non-specific disease exists (Traeger et al., 2017), there has not been a systematic review that comprehensively addresses how nurses reassure patients and what nursing actions and attributes are considered reassuring by patients.

Therefore, this review aimed to explore the state of the evidence regarding the meaning and usage of reassurance in nursing practice and possibly arrive at uniformity in the use of reassurance. We also developed a tentative conceptual framework for reassurance as a nursing intervention. We believe that these would be useful for future nursing research and competence training in nursing education.

THE REVIEW

Aims

This integrative review attempted to answer the following 3 questions:

1. What is the concept of reassurance as used in clinical practice by nurses?

2. How do nurses reassure patients?

3. What are the outcomes of reassurance in nursing care?

Design

We conducted an integrative review of the evidence on the concept and use of reassurance in nursing practice. For this study, nurses refer to both qualified nurses and student nurses. We followed Whittemore & Knafl's (2005) updated integrative review methodology, which involves problem identification, literature search, data evaluation, data analysis and presentation. This review is reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher et al., 2009)**.** The study's protocol was registered on the PROSPERO International prospective register for systematic reviews (CRD42020186962).

Search methods

An electronic search was planned and executed on the 30th of May 2020 on PubMed, OVID MEDLINE, CINAHL and PsycINFO. PsycINFO helped to cover the psychological nature of the concept under review, CINAHL provided coverage on nursing-related studies, MEDLINE and PubMed provided wider access to the medical literature. The search was conducted using variants of the search terms: 'reassurance' and 'nurse'. Both index terms and free texts were incorporated into the search strategy to make our search as sensitive as possible. We limited the search to journal articles and studies with human subjects. No date limit was applied to the search.

The search results were imported into Covidence, a systematic review management software. Subsequently, two reviewers independently conducted title and abstract screening; a third reviewer was consulted where there were disagreements. The use of

the three reviewers ensured objectivity in the selection and synthesis of the evidence. The eligibility criteria used were: (1) studies that described reassurance, (2) reassurance delivered by a nurse, (3) patients/relatives as recipients of the reassurance, (4) articles published in English, and (5) studies of all designs. We excluded studies that (1) focused on the use of reassurance by other health professionals, and (2) dissertations, abstracts, conference articles, and journal articles with no available full text. Full texts of tentatively eligible studies were further assessed to determine if they fully met the inclusion and exclusion criteria.

Quality appraisal

Since there is no standardized framework for assessing the quality of reflective essays, editorials and opinion pieces, we only evaluated the quality of primary studies. The methodological quality of the included primary or empirical studies was assessed using the 5-point Mixed Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018). The MMAT has proven useful in the critique of qualitative, randomized controlled trials, quantitative non-randomized, quantitative descriptive and mixed-method reviews. The tool assesses the appropriateness of a study's aim, study design, participant recruitment, data collection, data analysis, presentation of findings, authors' discussions, and conclusions (Hong et al., 2018). Studies were, however, not excluded based on quality as typical of integrative reviews (Whittemore & Knafl, 2005).

Data abstraction and synthesis

The synthesis of relevant studies was guided by Whittemore and Knafl's five-pronged approach to data analysis in integrative review: data reduction, data display, data comparison, verification, and conclusion. In *data reduction*, included studies were divided into two subgroups: empirical and non-empirical studies. For empirical studies, we extracted data on the names of the authors, country, and study objectives. We also carefully summarized the relevant findings of each empirical study. For the other study types (including reflective essays), we summarized the main ideas or themes highlighted by the papers. The reduced data were then put in a table or data matrix during the *data display* stage. This allowed for patterns across the data to emerge. In *data comparison,*

two reviewers inductively coded the data. The codes were then iteratively compared across the studies and categorised into themes. This was done while being mindful of the various patterns and contrasting ideas that are evident in the data. The generated themes were then compared to the reduced data to ensure fidelity to the core meaning of our original data. Conclusions were then drawn regarding the themes that appropriately and wholly answered our research questions. These last bits of the data analysis process constitute *verification and conclusion drawing.*

Results

Search outcomes

Overall, the electronic search produced n=2771 results. After removal of duplicates, n=1903 records remained for the title and abstract screening. N=1782 articles were removed after the title and abstract screenings and n=121 records were subjected to full-text review. Out of these, n=87 studies were excluded with reasons depicted in the PRISMA chart (Figure 1), and n=32 studies that met the inclusion criteria were included in the final analysis.

Characteristics of included studies

The details of the included studies are shown in Tables 1 and 2. The review included empirical (n=19) and non-empirical studies (n=13). The empirical studies were of qualitative (n=14), quantitative (n=3), mixed-method (n=2) designs. The empirical studies were conducted in the United Kingdom (n=6), North America (n=6), Australia (n=4) and Sweden (n=2). One study, however, was not clear about the country of origin. The primary studies looked at reassurance from the perspectives of nurses, nursing students, patients, and family members. The empirical studies were published between 1976 and 2019, with most studies being published more than a decade ago (n=12). The sample size used across studies varied considerably (ranged from 1 to 431).

The non-empirical studies included conceptual papers and reflective essays that respectively provided in-depth analyses of the concept and the accounts of personal experiences on the application of reassurance in nursing care. Across primary and non-

empirical studies, reassurance was discussed in the context of compassionate nursing care and effective patient-nurse communication.

Results of the data evaluation

The Supplemental Tables summarise the results of the quality appraisal of included studies. Overall, the studies had clear research questions and collected appropriate data. For the qualitative studies, the data analysis and interpretation were rooted in the data as evident by the various verbatim quotes used to support the data interpretation. For one qualitative study, it was unclear whether the findings were adequately derived from the data and whether any interpretation could be substantiated by the data (Jay, 1996). The quantitative studies were of sound methodological rigour except for the high risk for non-response observed in one cross-sectional study (Cossette et al., 2002). One study which used a mixed-method design did not provide any explicit justification for using both quantitative and qualitative methods (Beaver & Luker, 2005). The mixed-method studies did not highlight and explain any divergence in quantitative and qualitative data.

Synthesis of evidence on reassurance

Three themes were generated from the synthesis: antecedents, defining attributes and outcomes of reassurance.

Antecedents of reassurance

The theme describes the events that herald and necessitate reassurance. The presence of emotional distress in patients and their families emerged as a significant event that led to reassurance (Boyd & Munhall, 1989; Fareed, 1996; Gustafsson et al., 2018; Halm, 1992). Emotional distress is associated with hospitalisation (Fareed, 1996; Halm, 1992), unknown intervention or treatment outcomes (Boyd and Munhall, 1989), unknown symptoms (Gustafsson et al., 2018), uncertainty about one's health (Boyd & Munhall, 1989), and patient's perceived inability to execute a treatment plan (Hermann et al., 2019). Emotional distress can manifest either overtly or covertly which triggers a commensurate compassionate response from nurses (Halm, 1992; Price, 2017). Overtly, distress can manifest as crying, altered facial expressions (Boyd & Munhall, 1989; Gregg, 1955) and restlessness (Boyd & Munhall, 1989). Covertly, distress manifestations include the patient asking several questions which may be incongruent with prevailing health needs (Boyd & Munhall, 1989; Gregg, 1955), fear and anxiety (Gustafsson et al., 2018;

Hermann et al., 2019), and non-verbal behaviours of apprehension (French, 1979). The subtleness of these manifestations may suggest that reassurance is an active approach to the identification and resolution of a distressing episode (Boyd & Munhall, 1989; Hermann et al., 2019; Price, 2017).

Defining attributes of reassurance

The theme focuses on the characteristics of the concept. Reassurance is a complex concept characterised by the use of interpersonal skills to intentionally develop and maintain emotional connectedness with the patient and family (Fareed, 1996; Wocial et al., 2014). It requires that the nurse demonstrates self-awareness, emotional connectedness and apply verbal and non-verbal techniques to help restore confidence and empower patients as described below:

Self-awareness

Self-awareness is regarded as preliminary to the actual reassuring actions undertaken by the nurse. Reassurance requires the nurse to be consciously aware of her emotions and the religious and/or cultural context within which he/she operates. Anxious patients may make nurses apprehensive (Chauhan & Long, 2000). Thus, it is likely that the nurse may be reassuring him/herself in an attempt to reassure the patient (Chauhan & Long, 2000). Also, the nervous nurse is at risk for projecting his/her emotions to the patient (Boyd & Munhall, 1989) as well as triggering an exacerbation of the patient's fears (French, 1979). Therefore, the nurse needs to acknowledge or even overcome his/her emotional state, vulnerabilities or humanness and make attempts to make the patient the centre of his/her reassuring efforts (Chauhan & Long, 2000; Easby, 2013). The nurse, in effect, can provide effective patient-centred reassurance if he/she remains true to his/her emotions or self. Also, the choice of reassurance technique depends on the culture (Chauhan & Long, 2000), geographical settings (Cossette et al., 2002; Hicks et al., 2014) and religious affiliation of patients (Diggins, 2012). The nurse provides appropriate, acceptable and effective reassurance by demonstrating cultural and religious sensitivity or awareness (Barr, 1992; Chauhan & Long, 2000; Diggins, 2012). For instance, therapeutic touch may

not be appropriate in certain cultural contexts especially when delivered by the opposite sex (Chauhan & Long, 2000).

Emotional connectedness

This sub-theme discusses the need to establish an emotional connection with patients during reassurance. Through this connectedness, nurses avail themselves emotionally to connect with the patient (Boyd & Munhall, 1989; Gregg, 1955; Jay, 1996; Teasdale & Kent, 1995; Wocial et al., 2014) within an enabling environment (Fareed, 1996). Emotional connectedness and compassion facilitate the sharing of each other's lived experiences through which the nurse can recognize and accept the patient's emotions (Barr, 1992; Wocial et al., 2014). The nurse comes to the level of the patient and shares with the patient personal stories that resonate with him/her (Gustafsson et al., 2018; Usher & Monkley, 2001). This strengthens the nurse-patient bond, allows the patient to freely verbalize his/her concerns and develop trust in the nurse. The emotional connection is also facilitated by the nurse showing genuine interest in the patient's concerns, being honest, respectful, caring, empathetic and non-judgmental (Blackhall et al., 2011; Gregg, 1955; Wocial et al., 2014). These nurse attributes constitute some of the factors that influence the success of reassurance. Aside from the emotional attributes demonstrated by the nurse, physical appearance is also of the essence as it may convey reassurance (Wocial et al., 2014). The relationship that emerges makes the patient and family feel safe (Fareed, 1996), develop trust in the practitioner (Jay, 1996), able to acknowledge their fears or emotional distress (Hermann et al., 2019) and work towards acceptance (Gregg, 1955).

Verbal and non-verbal forms of reassurance

Another key characteristic that emerged from the data reflects the forms of reassurance that enable the patient and family to regain their emotional balance or stability (Fareed, 1996). The forms were broadly categorised as verbal and non-verbal. Non-verbal forms of reassurance included therapeutic touch, maintaining eye contact, active listening, calm voice (Al-Mutair et al., 2014; Barr, 1992; Boyd & Munhall, 1989; Chauhan & Long, 2000; Cossette et al., 2002; Karlsson et al., 2012); being nice (Beaver & Luker, 2005); being

authentically present with the patient and family (Fareed, 1996; Monk, 2019; Usher & Monkley, 2001); and demonstrating respect (Gregg, 1955).

Verbal forms of reassurance noted in the data included offering words of encouragement (Al-Mutair et al., 2014; Barr, 1992; Hermann et al., 2019), and demonstrating professional competence (Gibb & O'Brien, 1990; Gregg, 1955; Hermann et al., 2019; Karlsson et al., 2012). Other forms of reassurance were communicating adequate, clear, honest, and accurate feedback (Al-Mutair et al., 2014; Boyd & Munhall, 1989; Cossette et al., 2002; Gibb & O'Brien, 1990; Gustafsson et al., 2018; Jones et al., 2007; Usher & Monkley, 2001); and keeping the patient and family informed and encouraging them to verbalize their concerns (Blackhall et al., 2011; Fareed, 1996; Wocial et al., 2014). This encouragement should, however, be devoid of deception, as such practices amount to false reassurance which has been shown to be ineffective, and in some cases detrimental to patients' well-being (Chauhan & Long, 2000). Gregg (1955) also noted that the generic and mundane use of certain verbal responses such as "you will be fine" and "it is not that bad" may be regarded as "reassurance noises". The nurse should use such words cautiously (especially before any proper assessment of patient's complaint is done) as it may suggest to patients that their problems are being belittled.

Outcomes of reassurance

This theme highlights the outcomes or consequences of reassurance in patients. A common expected outcome of reassurance is the restoration of patients' confidence in their ability to find solutions to their problems (Gregg, 1955). Reassured patients thus feel empowered to take control over their health. One study typified renewal of confidence with statements like 'I was really worried before you told me that, but now I know that I have nothing to fear' (Teasdale, 1989). Reassurance instils hope in patients and offers patients optimistic viewpoints of any emotional or physical challenges they may be facing (Al-Mutair et al., 2014; Fareed, 1996; Teasdale, 1989). Moreover, reassurance helps to keep intact the patient's pre-illness identity, dignity and self-esteem (Barr, 1992).

DISCUSSION

The review sought to synthesise existing studies to understand the application of the term 'reassurance' as used in clinical practice. Reassurance emerged as a complex phenomenon characterised by three interconnected themes: 1) antecedents, 2) defining attributes, and 3) outcomes. Emotional distress across the continuum of care was the main antecedent to the process of reassurance following which a connection between the nurse and the patient facilitated the resolution of the distress using verbal and non-verbal approaches. The review findings highlight the concept of 'reassurance' as an ongoing active process although it may appear latent to the nurse and patient. Our findings should increase awareness of what seems to be a 'taken-for-granted' phenomenon and encourage nurses to reflect on and document their full reassurance episodes to facilitate better mapping of the process to emerging outcomes.

In medical practice, reassurance is often employed when discussing a patient's symptoms or diagnostic results (Kroenke, 2013; Redberg et al., 2011; Spence, 2018). The current review findings, however, suggest that the use of the concept of 'reassurance' by nurses in clinical practice goes beyond these confines to include any episode of actual or potential emotional distress experienced by the patient and family, thereby, highlighting a greater affinity of the concept to nursing practice. Additionally, the review findings suggest that reassurance transcends the physical state of the patient and family to connect emotionally with the nurse. These findings may be related to the core mandate of nursing which is to *care* instead of to *cure* (Watson, 1997). C*aring* endorses the professional identity of nursing which provides avenues to respond to human dimensions of health and illness (Watson, 2007). Interestingly, how this important term (that is, reassurance) is articulated in pre-registration nursing education curricula and taught in nursing schools is rather vague. Although the concept may be resonated in specialist oncology, pain management, palliative and end of life care programmes (Buller et al., 2019; Linton et al., 2008; Wittenberg et al., 2018), the prevalence of emotional distress across patient groups makes it cogent to streamline the concept of 'reassurance' in both undergraduate and graduate nursing curricula to prepare nurses. Perhaps, this may help to increase nurses' self-awareness and sensitivity to any clinical situation requiring reassuring interventions.

Further to the above, the review findings observed that nurses employed a variety of approaches to reassure patients and their families. These include verbal (such as words of encouragement and honest communication) and non-verbal (therapeutic touch and active listening) approaches which are similar to those employed by other practitioners (Giroldi et al., 2014; Pincus et al., 2013). The studies included in this review offer insight into the subjective usage of these approaches albeit how these were objectively carried out remain unclear. The authors agree that some of these approaches, particularly the non-verbal approaches, represent the *art of nursing* which may make it difficult to replicate or standardise. Aesthetic expressions such as empathy or therapeutic touches are often too complex to be reduced to a single definition that may make it difficult to express once the situation is over. However, as Carper asserts, the art of nursing or aesthetics remain one of the major patterns of knowing which cannot be ignored (Carper, 1978). Nurses should, therefore, be encouraged to reflect and document their reassurance experiences to strengthen the evidence-base of these aesthetic expressions. By establishing a plethora of these experiences, common themes may be identified which relate to delivering reassurance. Of note, nursing is a process and interventions are mostly carried out by a team, hence the need to have a standardised way of reporting nuanced interventions such as reassurance (Johansen & Ervik, 2018; Kilner & Sheppard, 2010).

Reassurance is a complex intervention that can lead to varied outcomes (Giroldi et al., 2014), including ensuring the dignity of the patients (Sailian et al., 2021).The more complex psychological and emotional care needs of a patient, the more the need for reassurance. Reassurance is at the heart of effective communication that ensures respectful and compassionate care as well as shared decision-making in palliative and end of life care (Virdun et al., 2017). In the current review, patient empowerment and instilling hope emerged as outcomes associated with reassurance. Only one study used an objective measure to ascertain reassurance among persons with chest pains (Hicks et al., 2014). Outcome measures exist to evaluate anxiety, but as noted in this review, the concept of 'reassurance' goes beyond anxiety which warrants the development of more situation-specific outcome measures. Therefore, 'outcome' in this context is part of the resource process rather than a stand-alone step as illustrated in figure 2.

A conceptual framework for reassurance in clinical care

Figure 2 illustrates the interconnectedness of the three themes that constitute the reassurance process. Nurses as health professionals should actively look out for signs that suggest that the patient is emotionally and psychologically unstable (*antecedents of reassurance*). Some patients may not verbalise what their worry is, while others will do. Therefore, the nurse should be approachable and be ready to listen to patients' concerns and actively look for both actual and potential sources of distress. This can be achieved by being self-aware of the antecedents that warrant reassurance, by adopting empathetic connection with the patient through both expressed words and non-verbal gestures (*defining attributes of reassurance*). The nurse should complete the reassurance process by evaluating the consequences of the act of reassurance (the *outcome of the reassurance*). If the evaluation indicates that the reassurance was not fully achieved, then the process is repeated. Therefore, reassurance is a *cyclical process* of problem identification, intervention and evaluation.

Strengths and Limitations

This review presents a framework for reassurance in clinical care, and this could guide future research focusing on developing a tool for reassurance. The unique integration of evidence from reflective essays, theoretical papers and primary studies allowed us to present more nuanced and granular details on the use of reassurance in nursing practice. Moreover, the use of a highly sensitive search strategy, multiple electronic databases and no date filters reduced the likelihood of missing relevant papers.

However, an important limitation of the current review was the exclusion of non-English papers, conference presentations and dissertations. This exclusion is likely to have resulted in the potential loss of some evidence.

Recommendations

Most reassurance interventions do not follow any evidence-based framework, and therefore, there is a lack of consistency in reporting what was done and in evaluating the effectiveness of the nurse's reassuring actions. We recommend the development of an evaluation tool for reassurance. Whilst we acknowledge that there are tools that currently assess the psychological state of distressed patients (anxious, stressed, depressed, among others), we believe that the perfunctory nature and use of reassurance requires a shorter validated assessment tool that could be rapidly used by nurses within the context of their busy work schedules. As suggested by Forbes (2009), documentation of nursing interventions should be characterized by the highest level of granularity. Future research should consider creating a checklist of items to report when documenting reassurance for both clinical and research purposes. Moreover, future studies should evaluate the various verbal and non-verbal reassurance techniques in clinical trials to determine the best technique (or combination of techniques) and the factors that are likely to influence the success of specific reassurance techniques. This would help nurses adopt a more evidence-based approach to reassurance.

Conclusion

This study reviewed the concept of reassurance as used in clinical practice and found three major themes: antecedents to, defining attributes of and outcomes of reassurance. Overall, this review reveals a stark lack of evidence about the standardisation of the concept of reassurance for patients and their families in the clinical setting. Specifically, looking at what reassurance means from different perspectives (for example, patients, family caregivers, healthcare professionals), settings (acute and long term facilities), type of disease (acute episode, chronic conditions, and end of life), among others will harness the development of a standardised evidence-based framework for reassurance that will be applicable in most context, and situations. This framework for reassurance could provide a guide for nursing education and practice, offering a flexible approach to the provision of compassionate and context-appropriate reassurance to patients and families. Creating a checklist of items to report when documenting reassurance for both clinical and research purposes could be a consideration for future research.

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