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Original Article

Narratives of a patient with chronic multiple psychiatric disorders and status of the patient-nurse relationship : Achievement of rapport through the narrative approach

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Key words

chronic multiple psychiatric disorders, patient-nurse interrelationship, narrative, practical research

Abstract

This practical research aimed to understand and discuss the process by which a patient's narratives and the patient-nurse relationship evolve. The aim was pursued through continuous application of the narrative approach to a patient with chronic multiple psychiatric disorders. Data for analysis were obtained from the narratives of Mr. A who had been in and out of a psychiatric hospital due to chronic multiple psychiatric disorders and from his nurse's (the researcher's) notes on changes in the interrelationship between him and Mr. A that occurred over 12 interview sessions. From the nursing practice undertaken, both Mr. A's narratives and the interrelationship between him and his nurse could be divided into five different stages. Stage 1 [first encounter phase] when [narratives lacking the context of daily life] were told, Stage 2 [co-identification phase] achieved by listening to [narratives full of the patient's personality], Stage 3 [empathy phase] established by listening to [narratives of past traumatic experiences], Stage 4 [sympathy phase] when [narratives of present suffering from living] were told, and Stage 5 [rapport phase] when rapport triggered [narratives about the future]. Through continuous application of the narrative approach, the nurse drew out [narratives full of the patient's personality] and empathized with the patient's [narratives of past traumatic experiences]. By showing sympathy, the nurse enhanced the patient's abilities to deliberate and helped him to express and organize his [present suffering from living], and by building rapport with the patient, the nurse was able to lead the patient to [narratives about the future].

Introduction

Psychiatric disorders often run a chronic course, and some patients do not show positive progression over the long term. In other words, some show little response to treatment and others show a progressive worsening of condition with repeated relapses. The foundations for psychiatric care reform proposed by Japan's Ministry of Health, Labour and Welfare in 2004 set a goal of 70,000 patient discharges. However, many patients are long-term patients or those who have been in and out of psychiatric hospitals. In

2008, from a total of 313,271 inpatients, 210,502 had been hospitalized for more than one year (Ministry of Health, Labour and Welfare), and among them were "the socially hospitalized" who could have been discharged if their family or the community had been ready to accept them. On the other hand, many had been hospitalized or been in and out of hospital because their chronic condition was unstable, making it difficult to treat them.

Among the previous psychiatric nursing care studies on the daily lives of patients with chronic psychiatric disorder are those on the patients' perspectives of in-hospital experiences[1], the suffering of long-term inpatients[2], the life-world of long-term inpatients with chronic psychiatric disorder[3], and the worldview of patients with chronic psychiatric disorder living in the community[4]. These studies revealed that patients and their lives are adversely affected by long-term hospitalization, yet even despite having such a chronic disorder, they can find some small happiness and hope in their daily lives. These studies have also clarified the meaning of the relationship between spirituality and life and death for the patients, and between the patients and others.

As this background shows, the experiences of patients with chronic psychiatric disorder have been gradually revealed. However, the nursing approaches taken to treat them have scarcely been discussed. Hoshino[5] has argued that it is easy to aggravate their condition, making treatment more difficult, and that recovery can be achieved only by them accumulating positive experiences in daily activities over time. In light of this, daily nursing care appears to be critical to the treatment of patients with chronic psychiatric disorder and it warrants the study on such care.

The author had the opportunity to provide nursing care to patients with chronic psychiatric disorder at a psychiatric hospital and encountered promising cases in which the patients rediscovered their liveliness through mutual interaction with him in his role as their nurse and showed signs of recovery. Such changes occurred in a clinical nursing setting through listening repeatedly to the patients' narratives over a prolonged period. While there are reports from both within and outside Japan on the effects of treatment with patients with psychiatric disorder[6–10], the effects specifically of the narrative approach to treat such patients, whose treatment is clinically difficult, have yet to be described.

In efforts to contribute to the development of therapeutic care for patients with chronic psychiatric disorder and a support system for their social reintegration, the researcher has continuously applied the narrative approach as a nursing practice with patients with chronic multiple psychiatric disorders, particularly since the researcher's experience in clinical nursing and his experience with patients with chronic psychiatric disorders was limited. This study aimed to understand the process by which a patient's narratives and the patient-nurse relationship would evolve through the continuous application of this approach, and to examine the therapeutic possibilities of the approach with patients with chronic psychiatric disorders.

Definitions of terms

In this research, patients with chronic psychiatric disorders were defined as "schizophrenic patients who have seen a doctor regularly over a three-year period due to pathology or decreased functioning or patients with multiple disorders including both psychiatric and schizophrenic disorders and whose psychological state has not fluctuated." This definition was established to take into consideration those patients who are likely to be hospitalized for prolonged periods, in order words, more than three to five years after symptom onset[11] .

Research methods

This practical research study gathered data from the narratives of a patient with chronic psychiatric disorders and from his nurse's (the researcher's) notes on the changes that occurred in the interrelationship between them while undertaking the therapeutic approach. Follow-

ing the ideas of social constructivism, this study employed a narrative approach. Social constructivism holds that words shape our life-world, and the fundamental assumptions of the narrative approach are that "talking about ourselves is to configure ourselves" and such talking also serves "to experience ourselves"[12] .

1. Research participant

A schizophrenic patient in his forties with drug hangover (Mr. A) participated in the study. Mr. A had been treated for multiple psychiatric disorders since his mid-twenties, and he had been hospitalized more than ten times at the time of this research. Schizophrenia is one of the major psychiatric disorders for which over 60% of patients are hospitalized and it often runs a chronic course. Psychiatric disorders are also remarkably more likely to run a chronic course when the patient has an additional disability such as drug hangover or mental disability. Therefore, conducting a case study of a patient with multiple disorders was considered suitable for fulfilling the aims of the present study. In addition, Mr. A had been hospitalized for prolonged periods for multiple disorders, and he often expressed his experiences and way of life through words and drawings. Therefore, the researcher expected that considerable data could be derived from Mr. A's narratives and from changes that would occur in the interrelationship between the patient and his nurse while undertaking the narrative approach.

2. Nursing practice and data collection method

In the narrative approach, it is important for the research participant to construct the world in which he or she lives through dialogues with the researcher. For this, the researcher must "acknowledge his/her own ignorance" and face the participant. The researcher must also weave the participant's "untold stories" and construct "the time in which the participant lived", the "meanings" in the participant's life, and "sociality"[12]. In the present study, these aspects were used as guidelines for the nursing practice to be undertaken (i.e., the narrative approach), and continuous interviews with Mr. A were conducted by the author as his nurse in the hospital ward's interview room. Each interview lasted between 60 to 90 minutes. The interviews were audio taped with Mr. A's consent. Finally the patient began to tell positive stories and stories about the future while still holding onto his suffering. The nurse wished to ease the patient's suffering and, as the result, rapport was established between them, and the patient's suffering was considered to be eased after 12 sessions. At this point, the series of interviews was closed.

3. Data analysis

Patient-specific experiences and changes in the content of the narratives were identified from the transcripts of the stories told during the series of interviews, and a theme was identified for each progressive stage in the development of the patient's narratives. Data were ontologically interpreted; in other words, they were interpreted from the perspective of the time in which the patient live and from the perspectives of others and the world surrounding them. In regards to the researcher's nursing practice, since the researcher was following the practice of the narrative approach, many of his reactions to the patient's narratives were expressed in thoughts and bodily feelings rather than words. Therefore, descriptions of the researcher's nursing practice focused on his being a "listener". Based on changes that occurred in the nurse's inner self and his position as a listener, Travelbee's human-to-human relationship model[13] was applied to understand the evolution of the patient-nurse relationship.

The analysis was conducted under the supervision of experts on qualitative studies and psychiatric nursing care, and expert nurses at the interview site.

4. Ethical considerations

The study was approved by the hospital director, director of nursing, chief nurse, and attending doctor of Mr. A. Prior to the study, Mr. A was informed verbally and in writing of the study purpose, that he was free to discontinue

his participation at any time, that he did not need to talk about anything he did not want to share, that medical care provided at the hospital would be unchanged regardless of whether he participated or not, that the obtained data would not be used for anything other than the research purposes, that data would promptly be discarded after the study, and that his privacy would be protected. After receiving this explanation, Mr. A provided consent to participate. Moreover, since the study was to be conducted over a relatively long period of time, his agreement to participate was confirmed before each interview session in order to take into account changes in his condition and feelings. It should be noted that in order to protect the privacy of the parties involved, specific descriptions were modified without changing the content and individuals were anonymized in the data.

Results

During the period of nursing practice under study, both the narratives of Mr. A and the interrelationship between the patient and the nurse progressed in five stages (Figure 1). Travelbe[13] states that a human-to-human relationship between patient and nurse develops through four interrelated stages, [first encounter phase], [co-identification phase], [empathy phase], and [sympathy phase]. When the interrelationship develops fully, it evolves into the [rapport phase]. Applying Travelbe's concept of the development of human relationships and taking an ontological perspective when examining the five phases between Mr. A and the researcher revealed the following transformations. Qualitative changes were observed in their mutual relationship when it developed from stage 1 to stage 2. During the process where their mutual relationship developed to stage 4, a co-existing relationship was established and deepened. These changes in their relationship in turn transformed Mr. A's narratives in each stage. Finally in stage 5, as the result of the accumulation of the preceding four stages, an additional qualitative transformation occurred in the mutual relationship between Mr. A and the researcher, and Mr. A's sufferings were alleviated and both Mr. A and the researcher grew as people.

Stage 1 [Narratives lacking the context of daily life] told during the [first encounter phase]

Mr. A told the nurse that he had created a shady world and he himself was Emperor of that

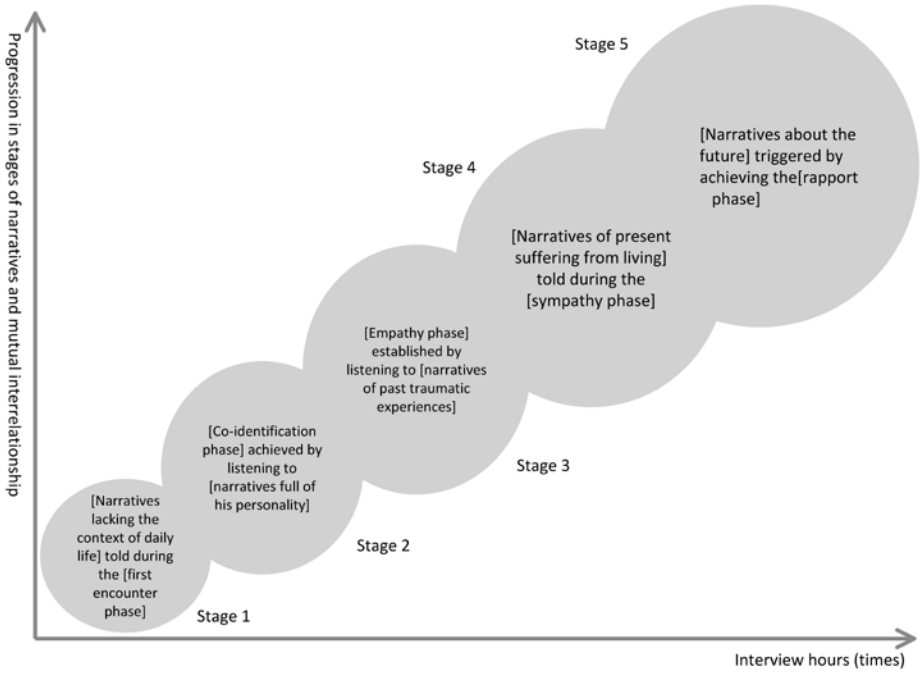

Figure 1. Changes in Patient A's narratives and in the mutual interrelationship between Patient A and the nurse

world. He discussed this shady world and the devils that inhabited it in a desultory manner. It was not clear to the nurse why Mr. A wanted to talk about them, but it did seem that Mr. A wanted him to listen. Accordingly, the nurse just listened to his stories and although at times he became tired of listening to the nonsensical stories, he attempted to devote his entire attention to listening to Mr. A's stories, showing interest in his unique world and worldviews.

As an example, Mr. A said, "I am Emperor of the shady world. When I become a perfect emperor, I can ascend the throne and exert my authority. I cannot tell who actually holds the real power in the shady world, but it is surely a dreadful world for humans. It's my job as Emperor to judge the battle between the gods and devils. The gods are at a standstill and have no chance against the devils. If one emperor of the shady world rises up, the gods will be invincible and will defeat their enemies and can impose sanctions against unnecessary evils. I have many plans as Emperor of the shady world, but the first priority is to increase the number of gods and the lords of the heavens who reflect upon things. That will expand the worldview, and it will capture a lot of attention. The increase in the number of gods and lords of the heavens will lead to the destruction of authority."

As he listened to Mr. A's narratives, the nurse started to be drawn to his world. He gradually came to want to understand who Mr. A was as a person, not in terms of his disorders. Mr. A had been hospitalized for a prolonged period for chronic psychiatric disorders and was rambling about his own world. The researcher became curious as to what kind of life he had been living before he became mentally ill and before he was hospitalized. Therefore, while listening to his narratives, the nurse asked Mr. A to tell him his life story. During Stage 1, both Mr. A and the nurse were living in the "present" state. However, during Stage 2, Mr. A and the nurse moved across time and space to Mr A's childhood.

Stage 2 [Co-identification phase] achieved by listening to [narratives full of his personality]

The nurse asked Mr. A to tell him something he remembered from his childhood or before he was hospitalized. In answering this question, Mr. A's personality and the healthy side to his personality emerged in the narratives, whereas up until that point his narratives had been full of fragmented ramblings. If it had been told during the [initial encounter phase], it would have been an unexpected yet realistic story. This experience served to transform the mutual positions of Mr. A and the researcher. At that time, the researcher was [co-identifying] with Mr. A, regarding him not as his patient, but as an individual.

In answer, first, Mr. A told the nurse that his parents could not raise him due to family matters, so he was entrusted to his aunt in the village soon after birth, and his father passed away when he began to understand things. "When I was a little kid, I believed that people would never die. When my father passed away, I started to wonder why people die. Ever since I started to understand things, everything I see has been a surprise and it has been beautiful. Since I was a child I have often thought, 'For what purpose was I born?'"

His life afterward in the village had a significant impact on Mr. A's character. He lived with his aunt in the village until he was in the fifth grade of elementary school, and he said that he remembered those days as if they were just yesterday, even though more than several decades had passed. "I had a great time in summer. I used to meet with friends at 1 am and we would go catch beetles by a telephone pole on the bridge. Nobody has ever caught more dragonflies, beetles, or stag beetles or was better at spinning a top than me. We used to play with *menko* cards and marbles in autumn and sleds in winter. We used our homemade sleds at the village office. I had a good time playing house with the girls in spring. We went to look for edible plants and ate them."

Looking back, he had a strong sense of loneliness in his boyhood. However, his life in the village surrounded by nature and his facing this sense of loneliness shaped his own sensitivity. "I didn't have what's called 'an education'. The

only treasure in my life is my memory of having played with bugs in the village. I used to catch bugs in the fields and rivers and I would let silkworms crawl on my stomach. So, I still cannot kill bugs. When I was a child, I used to buy Glico candies that had free gifts, and bread filled with red bean paste. I would often lie down talking to myself and laugh at the TV. I also loved to fantasize. For example, I fantasized myself being Superman or Spiderman flying between those buildings... There was nobody close to me that I respected. I couldn't study well, but I liked ethics and art classes."

When he started working in society, he worked as live-in help for four years. Although he had some bitter memories during those four years, he seemed to be proud of that time in his life. "I woke up at 6 in the morning and worked until very late every day. I couldn't wait to have a Mr. Donuts and smoke in the bathroom during work breaks. I made 90,000 yen a month and there was nothing special about me, yet I didn't consider myself dull. After that, I had a chance to go overseas, so I spent about a year abroad. I surprisingly actually made it there by myself without getting lost. I was a half-fledged worker, but I felt superior over my being at least a tradesman. There, one of the things I enjoyed was to eat homemade vanilla [ice cream]. My roommate was American. He was brave and was the kind of person who would succeed. I respected him a lot. He saved me when I was about to get involved in a fight. He used to say 'It's OK.' We didn't understand each other's language, but we knew what the other wanted to say."

The nurse could feel Mr. A's sensitivity and pride, and understood that his personality and the healthy side to it were present, suggesting the possibility for recovery. At the same time, thinking that if Mr. A had not become ill he could have had a much better life, the nurse felt regret, anger, and sadness at the reality that the Mr. A's condition had become chronic and he had been hospitalized for prolonged periods. The nurse continued listening to Mr. A's dialogues with a sense of powerlessness caused by a dilemma between his wish to do something for Mr. A's recovery and his inability to understand what to do.

Stage 3 [Empathy phase] established by listening to [narratives of past traumatic experiences]

Mr. A's narratives gradually deepened and eventually centered around his past traumatic experiences. While listening to the patient's [narratives full of his personality] and [narratives about past traumatic experiences], the researcher began to understand the patient's train of thought in his [narratives lacking the context of daily life] that predominated at the initial stage of the narrative approach.

When Mr. A entered junior high school, he made friends with a student who was good at studying. Mr. A and his friend were bullied by a bad crowd. They fretted over it and went to their teacher about it. Mr. A talked about the unreasonableness of the meeting with the teacher as follows. "I told a teacher in the counseling room that my friend and I were bullied by a bad crowd. We asked him not to tell anybody that we had talked to him. But, when we went to school the following day, the crowd said to us, 'You went to the counseling room. We won't let you get away with it!' and again started bullying us. We went back to the counseling room, only to find the teacher laughing, saying 'I was careful [not to tell anyone].' Even though I didn't cry, my friend fought with the others. My friend acted as my shield and had a hard time."

When he was in the eighth grade, Mr. A started to become friends with those in the bad crowd. He was no longer bullied and instead ended up abusing paint thinner, which he regretted. Mr. A went abroad to improve his work skills, but due to strong feelings of loneliness, he admitted that he used stimulant drugs for the first time there. "For the first time, in a foreign country, I heard of devils of drugs. I had just one friend. Maybe because I was lonely, I got into stimulants. I wanted to be friends with white girls, but I couldn't get close to them. I was always looking at them from a distance thinking how cute they were."

The reason why Mr. A's daily narratives

were lacking the context of daily life seemed to be because the link connecting Mr. A's present and his past and the link connecting his experiences and those of others were unopened. The researcher recognized this disconnection and worked to establish these links by carefully listening to Mr. A's narratives using his own imagination and sensitivity. As a result, during Stage 3, the links were established and the researcher was able to see the connection between the dark world of Mr. A's narratives and his experiences in real life.

Mr. A reported he experienced hallucinations in his mid-twenties, and discussed his suffering while in a relationship dominated by drugs. "One day when I was at home, a god suddenly appeared in front of me. He said *'Genkaku'* (hallucination) with a strange smile and disappeared somewhere. Then I visited temples, but I couldn't find him anywhere. My girlfriend then came home. I thought 'I was dreaming' but it couldn't be a dream as it was so vivid. Then one of my friends showed up with a devil. All of a sudden, three of us were destined to have our blood sucked out of us. But I snapped the devil's tooth (a syringe needle). Then, a blow from Death made me attempt suicide. It could have been karma for my past bad behavior. I thought it was better that I was dead then, that I had no regrets about my life. It was hell to live－I would also go to hell after my death. After my suicide attempt, I was taken to the emergency room and was later admitted to a psychiatric hospital. I was not conscious. I had lost about 1.8 liters of blood. My shower room was covered with blood. The suffering I felt was about thirty times as bad as a motion sickness. A few hours after I tried to kill myself, my mother came home and took me to the emergency room. I heard that I was transfused for 24 hours. When I came back to consciousness, I had been in the protection room at the psychiatric hospital. I don't think the nurses understood how I felt then. I was bleeding and screaming for help, not knowing where I was." Although Mr. A matter-of-factly talked about his [past traumatic experiences] such as hallucinations and his suicide attempt, the researcher was shocked and felt a physical ache in his chest and stomach. The researcher felt physical pain through [empathy], and quietly listened to Mr. A's [past traumatic experiences]. The researcher internalized Mr. A's mind and began to regard Mr. A's sufferings as inter-bodily feelings.

He was in and out of hospital in his late thirties also, and he talked about an incident he felt was unreasonable at a hospital and how it triggered him to become possessed by devils. "A doctor at the hospital sided with a patient who hit me. An understanding nurse suddenly changed his attitude to me and accompanied me to the protection room. Eight or nine people restrained me. I resisted in vain. I was trapped and restrained. Later, I vomited repeatedly and became possessed by devils."

He muttered, "See, I have a sorry life." That comment weighed heavily on the nurse, but it also signified that a human-to-human relationship had been established between Mr. A and the nurse. The nurse empathized with Mr. A and kept listening to him, wishing to ease his suffering.

Stage 4 [Narratives of present suffering from living] told during the [sympathy phase]

As the nurse continued listening to Mr. A, empathizing with his past suffering, Mr. A's narratives changed to those focusing on his present suffering from repeated hospitalization for chronic psychiatric disorders. As the nurse listened to Mr. A's [narratives full of his personality], he became interested in him as a person. Moreover, as he listened to Mr. A's [narratives on past traumatic experiences], he began to see a connection between Mr. A's past and present in his [narratives lacking the context of daily life] at the initial phase of therapy. The researcher accepted Mr. A's suffering, which was conveyed both verbally and non-verbally, as inter-bodily emotional experiences. By doing so, their relationship progressed to the [sympathy phase]. During Stages 2 and 3, both Mr. A and the researcher were placing themselves in the past. However, as the researcher accepted Mr. A's [past traumatic experiences], during Stage 4,

Mr. A's narratives gradually transformed to be about his present suffering. Mr. A and the researcher were back in the present state, where Mr. A stayed in the psychiatric hospital. At that time, the nurse recognized the patient's capacity to deliberate and face his present suffering, and the nurse recognized the possibility of Mr. A's recovery.

Reflecting on his past, Mr. A told the nurse that he was becoming more unsure about the world as he aged. "Looking back, what an eventful life I have had! I am barely surviving. I made a lot of mistakes when I was young. I no longer want to get involved with anybody using stimulants. As I got older, I came to realize that I was the last person that anybody should trust. My teachers give me a route in life. I'm like a ship, always floating. It's as if my ship was floating in a storm. Ever since I grew up, I've felt like I'm in an unstable world. It was only when I was living in the village that I could see the world clearly."

Mr. A also told the researcher that he wished to trust others, while also admitting that he was threatened by agonizing uncertainty and strong pessimism about the world. "I'm used to being betrayed. I want to trust others. On the other hand, I doubt them. I suppose everybody is dissatisfied. No-one is content. There's always something missing, but it's not like that you have to overcome obstacles throughout your life. It reminds me of what my aunt used to say, that life is full of annoyances."

His pessimistic view of the world and the shady world he lived in were influenced by his psychiatrist's comment that he would never be able to cure his disorders. "If you have any other sickness, you'll eventually be cured. But even my doctor told me that I can't be cured. So, it's as if I've been in the dark."

The nurse was able to see Mr. A's narratives in the context of his life. He listened to the patient, sympathizing with the root cause of his suffering, that is, his suffering from living with chronic psychiatric disorders.

Stage 5 [Narratives about the future] triggered by achieving the [rapport phase]

When Mr. A was able to see that the nurse understood and sympathized with him, he began discussing that he was trying to live with an eye to the future by overcoming the suffering caused by uncertainties in his life. Mr. A and the researcher were able to find the link connecting Mr. A's thoughts to the future. As a result, Mr. A began to see himself in the near future. Mr. A and the researcher experienced mutual co-existence and, within such relationship, they both experienced personal growth. At that time, [rapport] was considered to have been built between the two. As the nurse sympathized with Mr. A's sufferings, he could recognize the therapeutic effects of the narrative approach.

Mr. A said that he was currently pessimistic about the world and felt despondent yet also had some hopes for the future in the uncertain world. On the other hand, he also admitted that he wished to cure his disorders and live a normal life, living at home and working. "I know that I have to do something about my life. I'm inferior to others because I can't work. I can't do something that others do routinely. I'm living off the taxpayer's money, so I really have to cure my disorders. Once I'm cured, I don't care at what, I just want to work."

Mr. A also said that he wished to draw some pictures and manga which he loved to do, and to volunteer in the field of public welfare and get involved with others in the future. "The best way to leave a trace of your existence as a human is to have offspring. That's troublesome if you become Emperor of the shady world like me. [...] I want to spend my time drawing pictures and manga from now on. I want to leave good work through drawing, and spend time with kids in the neighborhood doing things together like cleaning rivers in the community. I hope that discrimination against anyone will disappear and education, medical care, and welfare will be accessible to everyone."

Finally, he talked about what he hoped from nurses through his prolonged hospitalization. Comparing nurses to angels with lights, he talked as he drew a nurse shedding light on pa-

tients. "A hospital is a breeding ground for sickness, so I can't help but draw dark pictures in the hospital. I suppose I am starving for beautiful scenery. Hospital is darkness. I want nurses to shine light into the darkness. Hospital is also like a small society, a small society that can't be accepted by others. So, I want the nurses to accept each patient as a human being."

Through continuous application of the narrative approach, Mr. A was enabled to think about ways to live a realistic life, how to live in the future, and to examine the demands for psychiatric care and society. This continuous application drew [narratives full of the patient's personality] from Mr. A, and the nurse empathized with Mr. A's [narratives on past traumatic experiences] in the process of [co-identification]. In the process of establishing [rapport], this increased Mr. A's capacity to deliberate and helped him express and organize his [present suffering from living], leading him to have [narratives about the future]. Following the series of 12 interviews, Mr. A has still been in and out of the hospital; however, the numbers of hospital days has reduced and he now spends more time in the community. He has not stayed longer than one year in the hospital at one time.

Discussion

1. Establishing the context of narratives

Patients with psychiatric disorder have symptoms such as hallucination and thought disorder. Due to their psychiatric symptoms, patients tend to have difficulty in reasoning and their narratives tend to be incoherent when their symptoms are fully developed. Hoshino[5] argues that difficulties in relationships that develop during treatment often lead to worsening of the patients' condition and difficulty with treatment. Moreover, as their condition becomes chronic and difficult to treat, they are more likely to present with hallucination and their thought disorder is more likely to stay with them, which in turn reduces the nurses' keen interest in the patients[14]. All of these aspects make it difficult for patients to talk about their own experiences, and when they do, their narratives tend to be incoherent. Indeed, in the present study, Stage 1 consisted of Mr. A's [narratives lacking the context of daily life] and the nurse was unable to make anything out of them. However, as the nurse continued listening to the patient, he began to pay attention to Mr. A's personality and became able to see his train of thought. In other words, in order to understand the logical flow of the narratives of patients with chronic psychiatric disorder, we need to pay attention to the [narratives full of their personality] and the [narratives on past traumatic experiences] as well as to their medical condition, and find the connection between their present [narratives lacking the context of daily life] and their humanity and existential experiences. Nakai[15] argues that "it is important for care providers to show interest in listening to the patient's healthy daily life stories, like he went to a cafe or the theater with friends or played baseball, even when he shares surprising pathological experiences and some phenomenon that nobody has ever reported before. Most patients can be cured because their care providers do pay attention to their healthy side of their lives." Accordingly, it can be argued that for the treatment of patients with chronic psychiatric disorders, first and foremost, it is important to focus on the [narratives full of their personality], which the patients tend to forget during their prolonged hospitalization. During this process, we need to create an environment in which the patients' narratives deepen and they can spontaneously talk about their [past traumatic experiences] and their [present suffering from living]. By doing this, patients will be able to organize their train of thought.

2. The meaning of the constructed narratives

The ontological interpretation of Mr. A's narratives that were spun by the application of the narrative approach shows that Mr. A was suffering from grief over living, with his existential foundation being threatened. In the [narratives full of the patient's personality], Mr. A expressed his childhood as the time when he was shining. On the other hand, his life history and the narrative that started with "The only treasure in

my life is my memory of having played with bugs in the village" which reflect his own life history show that he was also experiencing a strong sense of alienation and loneliness in relationships. Moreover, during the [narratives of past traumatic experiences], he talked about his experience of being bullied, drug use, and suffering from a life taken over drug abuse, and his suicide attempt. As just described, Mr. A seems to have repeatedly had extraordinary experiences. According to Heidegger[16], the ordinary is the present existence's way of living day to day safely without extraordinary happenings, and the ordinary is the foundation that supports our present existence. However, since Mr. A had repeatedly experienced extraordinary happenings in his life history, the foundation that Heidegger suggests to support the present existence was threatened. Mr. A repeatedly experienced such extraordinary happenings during the period when fundamental trust toward life and the world are supposedly established. Therefore, Mr. A may have suffered from continuous questioning of his own existence and feelings of denial about his existence. This was shown in his own reflection when he said "I often questioned for what purpose I was born." Moreover, his sufferings from the instability of his existential foundation became even more pronounced with the development of schizophrenic disorder and with the effects of drug hangover, and these seem to have led Mr. A's experiences to become unshareable with others. Laing[17] asserts that when a person's own experiences are unshareable with others, external events can greatly affect him and they could become persistent lethal threats. Applying this to the case of Mr. A, his unshareable experiences seem to have led him to be threatened by hallucinations and an uncontrollable impulsive desire for death. When the present existence recognizes the certainty of death and when the person has experienced someone dying first-hand, the present existence is confronted with his own natural capabilities, and as a result, he chooses to be his natural self[16]. As Mr. A said that he had often questioned for what purpose he had been born, remembering the deaths in his family and his own near death experience seemed to have offer Mr. A the opportunity to reflect on his own natural self and the meaning of life and death. However, since Mr. A has had few experiences since adolescence that could teach him the meaning of his existence, he had trouble finding the answer to the self-asked question about the purpose of life. The more he confronted questions about the meaning of his existence, the more he suffered, and that was probably why he began to seek his place in "the dark world".

Through this context of his suffering, meanings were attached to the [narratives lacking the context of daily life], and Mr. A and the researcher could organize their thoughts once the narratives' context were established. Although the thoughts were organized, Mr. A's suffering was not alleviated. By examining the reality, Mr. A and the researcher confronted his existential suffering, such as his suffering reflected in the [narratives of the present suffering from living].

3. The nature of the patient-nurse relationship to establish the context of the narratives and the mutual effects produced in this relationship

In the [narratives full of the patient's personality] seen in Stage 2 and in the [narratives of past traumatic experiences] seen in Stage 3, Mr. A discussed matters as if he was back in his adolescence. The researcher was also drawn into the reality of such narratives and felt as if he had been across time and space in Mr. A's adolescence. In other words, while stories were told by Mr. A, the "narrator", to the researcher, the "listener", in the interview room of the hospital ward in the present world during Stage 1, during Stages 2 and 3 Mr. A and the researcher moved across time and space to the past that Mr. A had lived. According to Heidegger[16], the foundation of the present existence is mutual coexistence in temporality. Therefore, in order to establish the context of the narratives of the narrator, it is important for both the narrator and listener to exist in the time when the narrator lived, and that they are in a mutual-coexistential relationship that would verify the meaning of

the existence of the narrator. The nature of this presence of the listener is imperative to connect the past and the present of a narrator who has [narratives lacking the context of daily life] and to activate the link that has formed between the narrator and listener.

To establish the link between the narrator and listener, the nurse must face the patient as a human being and establish a human-to-human relationships with him or her. Emotional experiences[13] such as co-identification, empathy, and sympathy between the patients and their nurses are established during this process. In fact, in the present research, the nurse "wished to do something" to help Mr. A's recovery and felt helpless, not knowing what actually he should do. He also felt frustrated with the reality that Mr. A had been hospitalized for a prolonged period. These emotional experiences were the driving force behind continuing the narrative approach and helped him draw from Mr. A [narratives full of the patient's personality] and face Mr. A's [narratives of past traumatic experiences] and [narratives of present suffering from living]. At the time, the researcher was sharing Mr. A's suffering as inter-bodily feelings and he was felt moved. The patient-nurse relationship established with this driving force for care became solidified as the nurse helped the patient organize his train of thought, and this experience provided the nurse with confidence about his own ability to establish a therapeutic relationship with Mr. A and to keep using the narrative approach. In other words, the nurse was able to practice a continuous narrative approach due to his own driving force for Mr. A's care which was generated by empathy in this patient-nurse relationship. The change in Mr. A's narratives from incoherent ones to the ones on his [present suffering from living] and [about the future] reassured the nurse of the positive effects of narrative approach. Mr. A and the researcher placed themselves in Mr. A's past and then moved themselves across time and space back to the present time. By doing so, they were able to move themselves even closer to the near future and successfully transformed Mr. A's narratives. Travelbee[13] argues that nurses strongly wish to appease patients' sufferings when in the [sympathy phase]. In addition, by reaching the rapport, the patients' sufferings are eased and both the patients and nurses mature as people. In the present study, the fact that the nurse held this wish and Mr. A's narratives changed over time suggests that their relationship had developed rapport backed up by sympathy. This in turn suggests that sympathy and rapport are imperative in human-to-human relationships to help patients organize their train of thought. In addition, Searles[18] states that everyone is a psychotherapist at the unconscious level, and we need to define the symbiotic relationship in which care providers also are treated by their patients as "therapeutic symbiosis" which promotes positive developments on both sides. In relation to the present study, this reflects the nurse being supported by Mr. A through the narrative approach, which enabled him to draw narratives from Mr. A, face his suffering, and reach the [rapport phase] where he became convinced of the approach's therapeutic effects.

4. Importance of the narrative approach for patients with chronic psychiatric disorder and its potential therapeutic effects

Helping patients with chronic psychiatric disorder organize their train of thought refers to the process whereby care providers, by drawing out [narratives full of the patient's personality], face the patient's existential suffering expressed in the [narratives of past traumatic experiences] and the [narratives of present suffering from living]. The present study showed that it is important that nurses face their patients as human beings through the narrative approach, "acknowledging their own ignorance" and helping the patients to transform their narratives to those [about the future]. As was the case for Mr. A, patients with chronic psychiatric disorder repeatedly experience suffering such as loneliness, alienation, and traumatic events that can threaten the underpinnings of their existence in their lives full of disorder. Due to such experiences, their narratives can become those [lacking the

context of daily life] and as Mr. A expressed, they can often live suffering from living in an uncertain world. Patients who have traumatic experiences and suffering in their life history tend to wish to trust others, yet find it difficult to do so, as did Mr. A. Therefore, for therapeutic intervention to be effective, it needs to be practiced in a fully developed mutual relationship, developed through the process of co-identification, empathy, and sympathy. In other words, it requires the application of a narrative approach in which the nurse and patient have a human-to-human relationship. As it has been shown, it is important during the narrative approach for the nurse to naturally weave together what patients want to say while reassuring them that it is safe to talk and of the solid relationship that has been established between them as their interrelationship developed. This approach differs from that of exposure therapy, which has already-proven effects on patients with traumatic stress disorders and depression, in which the care provider directly approaches the patient's trauma[6) 7)].

The effectiveness of the narrative approach for patients hospitalized for prolonged periods for chronic psychiatric disorder and who have difficulty in logical verbalization can said to lie in its ability to relax them, enhance their capacity to deliberate, help them to express and organize their [present suffering from living], and draw from them [narratives about the future]. The narrative approach may not be applicable to some patients with chronic psychiatric disorders who are experiencing a sudden relapse or those who have reduced ego functioning and suffer from the actual event of relating their experiences. However, the transformation of Mr. A's narratives from being incoherent to more logical suggests that the narrative approach had positive effects. This research suggests that continuous application of the narrative approach can enable care providers to draw from their patients [narratives full of personality] which will help them to empathize with their patients during the [co-identification phase] and in the [rapport phase] draw from them [narratives about the future]. The narrative approach has clear potential as a therapeutic approach for the patients with chronic psychiatric disorder.

Limitations of the study

The research focused on one patient with chronic multiple psychiatric disorders and a narrative approach was continuously practiced, with the patient's narratives and aspects of the mutual interrelationship between the nurse and patient recorded and analyzed in detail. If we follow Sandelowski[19)], we could assume idiographic generalization, namely, interpreting the characteristics of the general case from the context of the present case. However, due to the nature of the methodology used, it cannot be denied that the results could have been influenced by the ability of the nurse (researcher) to approach the phenomena and interpret the data. Future studies based on more cases and conducted by more experienced nursing practitioners are warranted.

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慢性精神疾患をもつ患者の語りと患者看護師間の相互関係の様相
― ナラティヴアプローチの実践によるラポートへの到達 ―

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キーワード
慢性精神疾患，患者看護師関係，語り，実践研究

要　旨

本研究は、慢性精神疾患をもつ患者に対して継続的なナラティヴアプローチを実践することにより、患者の語りと患者看護師間の相互関係が変化していく様相を解釈し、その治療的効果について言及することを目的とした実践研究である。慢性精神疾患を抱え、精神科病院に入退院を繰り返しているＡさんを研究協力者とし、12回のナラティヴアプローチを実践し、Ａさんの語りおよびＡさんと研究者の相互関係の様相をデータとした。

研究者の看護実践によって、研究協力者であるＡさんの語りおよびＡさんと研究者の相互関係の様相は以下の５つのステップに分類された。ステップ１【出会いの位相】の中で聴いた【生活の脈絡を欠いた語り】、ステップ２【その人らしさに満ちた語り】を聴くことで構築された【同一性の位相】、ステップ３【過去の外傷体験の語り】を聴く中で構築された【共感の位相】、ステップ４【同感の位相】の中で語られた【現在の生きる苦悩の語り】、ステップ５【ラポートの位相】で発動した【未来に向けた語り】。

継続的なナラティヴアプローチは、慢性精神疾患をもつ患者の【その人らしさに満ちた語り】を紡ぎ出し、研究者は患者との同一性の中で【過去の外傷体験の語り】に共感し、同感の中で患者の現実検討力を高め【現在の生きる苦悩】を表出し整理することや、ラポールという関係性の中で【未来に向けた語り】を導き出すために効果的であることが示唆された。