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Experiences of a long-term female psychiatric in-patient with psychiatric symptoms in Japan

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This study aimed to clarify the effects of long-term hospitalization of a psychiatric in-patient on her specific psychiatric symptoms and behaviors to provide suggestions regarding nursing support for in-patients. Unstructured interviews were conducted over several months with a long-term female patient (Ms. A) hospitalized in a psychiatric hospital between August 2017 and 2018. Analysis was performed using descriptive and interpretive phenomenological methodology. Four themes emerged from the patient's interviews: (1) Reduced interactions with others and becoming autistic due to a restless life when she was first admitted to the hospital; (2) Persistent psychological resistance due to fear of treatment through medications; (3) Delusion due to missing her family; and (4) Delusion due to longing for a stable, normal life. Our interpretations of the results for the phenomenological study on Ms. A's long-term hospitalized experience indicated that she has been living her life, reconstructing her life story by incorporating her pre-hospitalization life with her family and her longings for a normal life into her current life through delusion. We recommend that nurses should pay more attention to mental symptoms and behaviors, such as delusions, and understand the experiences behind delusions.

Key words: Psychiatric hospital, long-term hospitalized in-patient, mental symptoms, experiences, phenomenology.

INTRODUCTION

Due to numerous reasons, including the protection of human rights for people with mental disabilities, many countries are implementing policies that enable individuals with mental disorders to live in their local communities, following the guidance of the World Health Organization's Mental Health Action Plan for 2013-2020 (WHO, 2013). This is the case in Japan. In response to these global trends, the Japanese government promotes community-based services and daily life support after discharges (Aoki, 2005; Kagawa et al., 2013). Thus, patients with mental illness spend fewer days in hospitals and are readmitted less frequently (Kayama et al., 2005; Watanabe et al., 2000).

The symptoms of schizophrenia include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, and negative symptoms (American Psychiatric Association, 2013). Given these symptoms and characteristics, most people in the public are either

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unfamiliar with, frightened to, or do not sympathize with psychiatric patients, mainly because it is difficult to understand the patient's unexpected behavior (Torrey, 2019; Wong et al., 2009). From a social inclusion viewpoint, it is stressed that individuals with mental disorders should be promoted to live in a community and rebuild their lives by acquiring connections and finding a role in society (Narita and Kobayashi, 2020). Nevertheless, most individuals with mental disorders are, in reality, forced into being in difficult life circumstances in their communities due to pervasive discrimination and a struggle to find work, make reliable friends, or get married in Japan (Heydari et al., 2017; Kanata, 2016; Lasalvia et al., 2013; Seeman et al., 2016; Sekine, 2010; Shimohara, 2012; Tanaka, 2010; Thornicroft et al., 2009).

Consequently, despite the decline in the average length of stay in Japanese psychiatric hospitals, discharging elderly long-term hospitalized patients remains difficult. Therefore, the number of hospitalized patients with mental disorders decreased by only 43,000 from 2002 to 2017 (as of 2017, Japan had approximately 302,000 psychiatric in-patients; Ministry of Health, Labour and Welfare, 2018). According to a survey conducted in 2012, discharging patients hospitalized for more than one year was difficult, as 61% had severe or unstable mental symptoms, 33% lacked housing and daily life support, and the rest required treatment owing to physical complications (Ministry of Health, Labour and Welfare, 2014). Conversely, the psychiatric symptoms that were presented as reasons for the difficulty in discharging patients, such as decreased motivation and obsessions, have been criticized as an institutional syndrome caused by the Japanese psychiatric hospital system through the policy of isolation and detention (Furuya, 2015). It has also been pointed out that deinstitutionalization is likely to lead to enhancements in social functioning for persons with schizophrenia, suggesting that even long-stay patients could achieve better functioning by being discharged (Kunitoh, 2013). In other words, psychiatric symptoms are not only caused by the disease itself, but also by the long-term hospitalization due to the disease. Although many studies discuss the factors that determine the length of stay in a psychotronic hospital (Abe et al., 2012; Nakanishi et al., 2015; Okumura et al., 2019; Shinjo et al., 2017), or the experiences of long-term hospitalized patients (Kataoka et al., 2003; Tanaka, 2010; WHO, 2013), the relationship between the patients' long-term hospitalization and their psychiatric symptoms and peculiar behaviors has not been sufficiently clarified. In general, a psychologically rich life can be contrasted with a boring and monotonous life (Besser and Oishi, 2020; Oishi and Westgate, forthcoming), suggesting that the monotonous long-term hospitalization affects psychiatric patients' symptoms and behaviors. This point has also not been sufficiently discussed in previous studies.

Therefore, this study aimed to clarify the effects of the long-term hospitalization of psychiatric in-patients on their specific psychiatric symptoms and behaviors to provide suggestions for nursing support for the patients and promote the deinstitutionalization of long-term hospitalized in-patients. To the best of our knowledge, very few phenomenological studies have paid attention to the delusions of long-term hospitalized psychotic in-patients in Japan. In addition, Murakami (2020) pointed out that because each individual has his/her own experiences, even the detailed phenomenological examination of individual cases can fill in gaps left by larger-scale quantitative research. Therefore, although this study deals with the case of a single in-patient, we believe that the findings provide valuable insight not only for practitioners such as nurses but also policy-makers.

DATA AND METHODODOLOGY

Research design

Our qualitative research study applied an interpretive hermeneutic phenomenological approach developed by Nishimura (2001) and Nishimura and Matsuba (2014), which is based on the philosophy of Merleau-Ponty (1945/1962). Inspired by Husserl's concept of "the event itself," Merleau-Ponty (2013) insisted that our primary experience of the world should not be interpreted from a positivist and scientific viewpoint, but from a singular and personal perspective centered on our actual experience. Merleau-Ponty's phenomenology allows us to view patients as singular entities with their own lives and unique contexts, making it possible to describe their actual lived experiences, including mental states such as delusions and obsessions.

In the phenomenological nursing study, Nishimura and Matsuba (2014: 13) stated that "by examining a case in detail and clarifying the elements within its uniqueness and the connections between the elements, we aim to discover the movements and structures underlying the meaning of the observed symptoms." Therefore, to discover each experience's unique structure, we focused on one patient and analyzed the interviews in detail.

This study was approved by the ethical review committee of the first author's institution (No. 19108-09). Additionally, two private psychiatric hospitals were asked to cooperate in the study, and it was conducted with the approval of the heads of each facility. We conducted this qualitative research regarding the experience of patients admitted to psychiatric hospitals between August 2017 and August 2018. Participants were recruited at the hospitals using the following inclusion criteria: (1) patients hospitalized for more than three years in the psychiatric ward, and (2) Patients able to speak and who could understand the interview questions and research purpose. According to the 2017 Mental Health and Welfare data (Ministry of Health, Labour and Welfare, 2017), 33% of the patients have been in the hospital for five years or more only. We further accounted for the length of stay of in-patients at the hospitals in our research and considered those who had been hospitalized for more than three years. Patients who met the requirements in this study were introduced to the researchers by the head nurse at the ward. Thereafter, the researcher explained the study directly to the patients and then asked them to participate. Six patients, two men and four women in their 50s to 80s, agreed to participate. All were living with schizophrenia, with the length of hospitalization ranging from 10 to 60 years.

This study is part of a larger phenomenological qualitative research on the experiences of chronically mentally ill patients. Of six in-patients, five had been in and out of the hospital repeatedly.

Their experiences in and out of the hospital are intricately intertwined. It is unclear whether their delusions are derived from their experiences in the hospital or during their discharge period. In contrast, the in-patient discussed in this study has been hospitalized for approximately 60 years without ever being discharged. This is considered to be a particularly unique case. Our phenomenological qualitative research intended to clarify the relationship between psychological symptoms and the patients' long-term life experiences in a psychiatric hospital. Thus, this case description focuses on Ms. A, who had lived in the hospital for about 60 years and experienced obsessions and delusions daily.

The field survey and interview survey were conducted by the principal investigator (the first author) who had extensive experience in conducting interviews and phenomenological analysis with psychiatric patients, muscular dystrophy patients, nurses, and occupational therapists. In the field, the investigator was allowed to accompany Ms. A whenever possible and observe her throughout the day during eating sessions, occupation therapy, and so on, in an attempt to describe her daily life from her perspective. Furthermore, we used unstructured data collection, which was suitable for an in-depth exploration of the patient's experiences. As Ms. A's condition fluctuated and, in some instances, she refused to be interviewed or was interrupted, the investigator conducted interviews according to her condition and pace, resulting in 11 interviews, which were audio-recorded with her consent. Each interview lasted approximately 20-60 min; the total interview duration was 253.7 min (4.23 h). In addition to interviews with Ms. A, we occasionally get information regarding her behavior and delusion from the nurses involved in her care. The interview was transcribed verbatim.

Data analyses

Following Merleau-Ponty's (1945/1962: 4) concept of "a figure on a background," we considered the overall structure of each of Ms. A's experiences, focusing on their modalities, such as her "unique mode of existing" (p. 20) and "unique manner of behavior towards others and the environment" (p. 20). The data analysis procedures in the phenomenological approach are categorized into seven stages by Colaizzi, four stages by Giorgi Van, and six stages by Kaam (Beck, 1994). Many of these overlap, but the need to progress beyond these stages has been suggested (Holloway and Wheeler, 2006). Therefore, the following steps were taken, with reference to the analysis method used by Nishimura and Matsuba (2014: 148), which was developed specifically for Japanese people, to analyze narratives that use the characteristics of the Japanese language, relying on Merleau-Ponty's phenomenology. This method has already been shown to be effective in the studies conducted by Nishimura (2001), Murakami (2020), and others. The data analysis involved the following steps:

1.Transcripts were created from audio interview data. The participant's gestures and intonation were noted during the interview.
2.Transcripts were read repeatedly to obtain an overall impression. At the same time, we marked any apparent psychological symptoms, such as delusions, obsessions, and so on.
3.Using the perspective of analysis, we analyzed how experiences were recounted and how their context was structured, and we considered the potential themes.
4.Based on the structure, we described how the experience of each theme was structured.
5.We read the transcripts again, re-interpreted them, and searched for themes that persisted throughout.
6.Colleagues and members of the phenomenological study society, who have vast experiences in interpreting interview data phenomenologically, read the statements, and gave us suggestions and comments to improve our interpretation of Ms. A's logic behind her delusion and behaviors. We then considered whether we should incorporate them into the interpretation.

RESULTS

By analyzing what lies behind Ms. A's discourses and behaviors according to the method presented by Nishimura (2001) and Nishimura and Matsuba (2014), four themes emerged in Ms. A's discourses: 1) Reduced interaction with others and becoming autistic due to a restless life when she was first admitted to the hospital; 2) persistent psychological resistance due to fear of treatment; 3) delusion due to missing her family; and 4) delusion due to her longing for a stable normal life.

Ms. A is a woman in her 80s living with schizophrenia. Ms. A was admitted to the hospital when the Health and Welfare Ministry launched a policy on social hospitalization for isolation in the 1960s, and she has remained there for approximately 60 years. To this day, she has reduced interaction with others and experiences hallucinations and delusions and often refuses to take medication; therefore, nurses on her ward regard her as a difficult and troublesome patient.

Reduced interaction with others and becoming autistic due to restless life when she was first admitted to hospital

During the transition of psychiatric medicine in recent years, from hospital-centered to community-centered, Ms. A was considered for discharge from the hospital. However, she said, "I've gotten used to it (living in the hospital), so it's better here." This differs from what she reportedly said when she was first admitted to the hospital 60 years ago: "I wanted to go home." She shared her memories of hospitalization:

A: There's a ward called Ward H... The entrance is over there. Um, over there, and there is the outpatient department. [...] I was admitted to women's Ward H from the outpatient department. [...] From there, I went to Ward F and received ES (electroconvulsive therapy [ECT]). I was scared... then, you know, I went to Ward G, and then Ward I...
I: You went to many places.
A: Then I went to the old Ward I. [...] The Ward H, where did I go? I went to Ward H, yes, Ward H.
I: There were so many wards at that time.
A: Yeah. So, from Ward J to Ward H... [...] Go to Ward H, yeah... It's a little confusing; I've been going around and around.

As Ms. A had not moved wards for some time, we inferred that her experience of relocation was from the distant past. Despite the lapsed time, Ms. A described

her relocation between wards in detail. It is likely that this was an unforgettable and unsettling experience, which must have made her feel restless and uncomfortable. Therefore, she reduced interactions with others and became autistic due to a restless life when she was first admitted to the hospital.

Resistance due to fear of treatment

Psychiatric treatment is centered on medication; however, many patients refuse to take medication because of side effects and other reasons. Ms. A had also refused to take her medication in several ways, including complaining and hiding it under her tongue. She was observed taking her medication after lunch. Ms. A described her process of taking medication before bed as follows:

A: Bedtime medicine isn't good... Morning, noon, and evening medicine are good.
I: Oh, what's the difference?
A: My stomach is upset. Well, it is a tablet.
I: Oh, but you're taking it patiently.
A: Yes, I do. I take the medicine without complaining... At that time, if I complained before taking the medicine, I would be told to take two bags... If I don't say anything, all I have to do is take just one bag. That's all.
I: I see. You are smart...
A: I've never thrown or let go of my medicine, you know... before. I take medicine without complaining.
Ms. A's current approach of taking medication "without complaining" appears to be a response to the experience of being reproached by nurses in the past. Further, this strategy denies or cancels out her previous tactic of throwing away her medicine.
Ms. A told us about the strong side effects she experienced at the onset of her illness.
A: I went to school... then I was in the hospital... that morning, noon, and night, I was made to take a medicine, named G, whale fat. It's terrible. It's tight.
I: Tight? Do you remember how you felt?
A: Here you are. You know, I thought I'd wash my head, but when I went to the bathroom, I could not wash my hair with my hands. I could not raise my hands. Terrible, G. Medicine, medicine. That's not medicine. If it was medicine, it would help me a lot more... and I asked the nurse to wash my hair.
I: Oh, yeah. Oh, no. Old medicines were tough, weren't they? Not anymore.
A: Actually... when I told them that I don't need any medicine and that I don't want to take it, and I asked them to change it, they said I should receive ES (ECT)…. Well, that medicine is strong. ...I cannot bite. My teeth do not move... That's not the medicine... That can kill my body.

Despite the time elapsed from the beginning of her hospitalization, Ms. A clearly remembered the medicine's name, strong side effects, and statements made by nurses. We reasoned that Ms. A adopted her other acts of refusal—"to throw" or "let go of" her medicine—after being threatened with double doses or ES.
Thus, Ms. A's current method of taking medicine is based on her various past experiences of taking medicine.

Delusion due to missing her family

After Ms. A's hospitalization, her family worried about her and tried to visit the hospital and go out with her to shop and eat as often as possible. However, recently they became too old to visit her. Speaking about her life before admission, Ms. A said:

I went to night school, and after I came back to my house, I had to make dinner for my brother.

At lunchtime one day, I observed Ms. A having lunch in the hall, and in the afternoon, sitting at her bedside; I said:

Today you left some food on your plate, which is rare.
A: I give it to my family…At home, you know, they don't eat... Poor thing. I'm too sad to watch... they are my grandchildren.
I: Oh, grandchildren?
A: Yeah, you know, my brother... B is my grandchild. Another one, my brother C is also my grandchild. They didn't eat it. ... Therefore, they come before dinner to my table…I think they're poor... they are guys and need strength, you know. Yeah. So, they drank juice after the meal.

[After talking about meals and going out for a while, she returned to the topic of her brothers.]

A: My brother B, you know, he came to see me the other day because I'm recovering.
I: Oh, really? Because you're recovering.
A: When my brother took me into this hospital, he asked my doctor to get rid of me if I ran wild in the hospital and could not recover, and then he went home…
I: Oh. Did that happen before?... I see, but now your brothers come to see you.
A: Yes, my siblings come, so I'm relieved, and I'm sleeping and waking up here.

Ms. A maintains her role of providing meals to her brothers in her delusions—which she performed before her hospitalization—by leaving a portion of her hospital meals for them. Furthermore, Ms. A seems to hold onto her brother's words from when he admitted her to the hospital, framing her experience in the hospital by suggesting that she has been there for a long time so that she can "recover."

Ms. A's siblings were no longer able to visit because of old age, and her condition deteriorated as a result. However, through this experience, she could meet her brothers, who were described as "grandsons" in her delirium, and feel a sense of relief. Although the causes of delusion are considered to be diverse and complex, it is possible that the weakening connection with her former family members may have contributed to her delusion.

Delusion due to longing

For Ms. A, one pleasure of being in the hospital is reading a newspaper or weekly magazine during occupational therapy.

A: When I get up early in the morning and read the Kanji (Chinese characters) in the newspaper, it's good…it is not good to read only five or six difficult Kanji characters. I have to read a lot of difficult Kanji... A lot of difficult Kanji. …The wedding cake will also be served. It's fun to see…
I: Wedding cake?... Looking forward to it? Wow, that's great. Wow. Can't you see the wedding cake if you will not read a lot? …Sounds good. Comes out like a reward.
A: Yes. [...] You also should read a lot of difficult Kanji.
In this story, for Ms. A, reading a magazine or newspaper involves the challenge of reading many difficult Kanji, and by striving to do this difficult thing, her imagination conjures up a reward for her, which seems to bring her joy.

The sources Ms. A was reading did not mention marriage or wedding cake. However, the head nurse said that many single long-term in-patients long for marriage. This is the case for Ms. A., and she used to read magazines on marriage and child-rearing. Thus, it can be surmised that Ms. A's delirium of "wedding cake" may reflect her longing for marriage and a normal/average life.
The topic of "wedding cake" was common in some of her other narratives, but it was always associated with the act of "reading difficult Kanji."

A: I want to see the wedding cake, but the Chinese characters are difficult to read… When I read difficult Kanji, I look up their meaning in the dictionary... You should study. Really. A shortage of study is not good… After all, if you get only 10 or 20 points at school, when you graduate, you have to go to school for another 2 or 3 years, you know, by the school rules. [...] Poor thing. I got 100 points. Therefore, I was told by everyone that I was excellent and was admitted to the psychiatric department.
I: Oh, really.
A: On the contrary, this disease... I'm not a psychiatric patient. [...] Well, there's another disease. Name, uh, uh, um. …Neurology. ... I am in the neurology department.

Here Ms. A connects reading difficult Kanji with seeing a wedding cake and her previous performance at school. She seems to think that being hospitalized is related to her lack of ability to study. Therefore, she compensates for her past experiences; her successful recollection of difficult Kanji and denial of her status as a psychiatric patient help her to belatedly realize the aspirations that she probably could not achieve in school due to her illness and hospitalization.

DISCUSSION

In this study, we focused on the life of Ms. A, a long-term hospitalized patient, especially her symptoms and characteristics, and described her hospitalization from her perspective. Ms. A spends most of her time in her bed, refuses to take medication, and has delusions; therefore, nurses regard her as a difficult and troublesome patient, as mentioned above (Torrey, 2019; Wong et al., 2009). However, we looked at Ms. A's life from her perspective and made the following observations.

Every day, Ms. A spent much of the day in bed and took the medicine silently and "diligently." She ate her meals with her "brothers" who appeared during her lunchtime. Furthermore, during her daily occupation therapy routine, Ms. A took pleasure in reading difficult Kanji characters in the newspaper using a dictionary and she was rewarded with "wedding cake." However, it should be noted here that her brothers and wedding cake were part of her delusions and hallucination. While recounting her daily life at the hospital, Ms. A described in detail her own experiences in the distant past as if they were recent events. From this, it seems that Ms. A's current life was derived from her past experiences.

Since Ms. A was admitted to the hospital forcefully and suddenly and was repeatedly transferred to various wards at the beginning of her hospitalization, she reduced interactions with others and became autistic due to a restless life when she was first admitted to the hospital. Since she was previously threatened with double doses of medication or ECT when she refused to take her medicine because of the strong side-effects, she often adopted her other acts of refusal-"to throw" or "let go of" her medicine; however, now she takes them diligently. Since she cannot live with her family and misses them, she continues "feeding her older brothers," which is part of her delusion, by leaving some of her lunch for them, instead of preparing supper for them at home as she did before she was hospitalized. Ms. A grants herself the experience of receiving a "wedding cake," which is also part of her delusion, as a reward for reading many difficult Kanji characters, perhaps reflecting her "longing" for marriage and a normal life. By forcing herself to read many difficult Kanji characters, she compensates for her actual experience, whereby she was a student with poor grades, and denies her status as a psychiatric patient.

As Merleau-Ponty (1945/1962: 484) stated, “time is not a line, but a directional network.” It seems that, during her long hospitalization of about 60 years, Ms. A has relived her experiences at the beginning of her hospitalization as well as her memories of the past when she lived with her family in peace.

How Ms. A’s life in the hospital was influenced by her past experiences is similar to the previous studies of Tanaka (2010) and Kitamura (2004). In this study, it was revealed that Ms. A’s past experiences, especially those before and after her hospitalization, were related to her current delusions and obsessions. In other words, Ms. A has been reconstructing herself and her life story by incorporating her pre-hospitalization life with her family and her longings into her current life through delusions. If a patient is repeatedly admitted and discharged from the hospital, their memories will be overwritten by their life experiences during their discharge. However, except for the frequent movement of wards immediately after admission, Ms. A had spent about 60 years of her life as a monotonous hospital patient. It seems that Ms. A's pre-hospital memories were not significantly overshadowed by her post-hospital monotonous life experiences. As a result, Ms. A's delusion is probably composed of a mixture of her pre-hospital life experience (meals with her brothers) and her current life. In addition to the monotonous life in the hospital, the longing to see her sisters who used to visit her often before it became difficult to do so due to aging, and the longing for marriage and a normal life with her family became stronger. All of these together, may have led to the delusion.

From Ms. A’s experience, which was the focus of this study, it became clear that her current symptoms, such as her refusal to take medication and her delusions, were related to her painful experiences at the beginning of her hospitalization, her thoughts about her family, and her longings. In the past, psychiatric nursing has generally responded to complaints of hallucinations and delusions by “changing the subject when hallucinations are mentioned” and “trying to have realistic experiences” (Kawano, 2015). Based on the results of this study, we recommend that nurses should pay attention to psychiatric symptoms and behaviors such as delusions, especially for long-term hospitalized patients with chronic mental illness, and to elicit their past experiences and thoughts that are difficult to express in words. This will not only help to understand the patients better but also find support for their psychological symptoms.

Additionally, as in the case of Ms. A, a prolonged hospitalization that leads to a disconnection from the life before may lead to delusions; therefore, nurses need to provide nursing care for an early discharge of patients. Generally, psychiatric illnesses in Asian societies, including Japan, were viewed as less socially-acceptable and personal weaknesses (Zhang et al., 2020). Several Japanese studies (Nakamura et al., 2014; Shimotsu et al, 2014) found that group cognitive-behavioral therapy was effective in reducing self-stigma in a situation where self-stigmatization psychopathology is highly stigmatized in Japanese society, probably because self-efficacy has an especially strong and direct impact on their quality of life. It seems that nursing practices that help to reduce self-stigma for hospitalized patients is required so that hospitalization does not result in social isolation. In addition, several studies (Kayama et al., 2020; Niimura et al, 2017) pointed out that psychiatric home visiting nursing services provided by home-visit nursing stations are more likely to prevent prolonged stays in psychiatric hospitals and improve the quality of life for community dwelling people with mental illness. Therefore, outreach service should be more strengthened to help people with mental illnesses live comfortably without being isolated from society.

Conclusion

After describing Ms. A’s experience, it became clear that the mental symptoms and behaviors of long-term hospitalized patients, such as delusion, are not only caused by their illness, but also by their experiences of hospitalization and their longing for their families. In Ms. A’s case, she has been reconstructing herself and her life story by incorporating her pre-hospitalization life with her family and her longings into her current life through delusion. For this reason, we suggest that nurses should pay more attention to mental symptoms and behaviors and find out the experiences and thoughts that are difficult for patients to express in words. Additionally, to prevent cases that are similar to Ms. A’s case, nurses need to collaborate with the community and provide nursing care to discharge patients as early as possible.

This study had limitations. Since we only addressed one patient in her 80s, the conclusions cannot be generalized to the entire population of psychiatric patients. This is a detailed case report of one patient that revealed the complex meaning of the individual’s symptoms and characteristics. We will continue to conduct further phenomenological qualitative research with other cases to highlight other aspects of the meaning of symptoms.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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REFERENCES

Abe T, Moriya M, Ikeda K, Kuroda K, Hagihara A (2012). Psychiatrist characteristics related to patient outcome in Japan. Psychiatric Quarterly Q83:221-239.

American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders: DSM-5. Arlington, VA: American Psychiatric Association.

Aoki N (2005). A study of the nursing practice for psychiatric patients during the transition from the hospital to the community. Journal of Japan Academy of Psychiatric and Mental Health Nursing 14:42-52.

Beck CT (1994). Reliability and validity issues in phenomenological research. Western Journal of Nursing Research 16:254-262.

Besser LL, Oishi S (2020). The psychologically rich life. Philosophical Psychology 33(8):1053-1071.

Furuya R (2015). De-Institutionalization Theory of Psychiatric Hospital: The History and Current Situation of Long-Term Hospitalized Patients, and the Philosophy and Issues of Regional Transition Support. Tokyo: Hihyosha.

Heydari A, Saadatian V, Soodmand P (2017). Black shadow of stigma: Lived experiences of patients with psychiatric disorders on the consequences of stigma. Iranian Journal of Psychiatry and Behavioral Science 11:e6201.

Holloway I, Wheeler S. (2006) (trans. Noguchi M). Qualitative Research in Nursing, 2nd Japanese ed. Igaku-Shoin Ltd.: Tokyo pp. 178-179.

Kagawa S, Nagoshi T, Awanou Y, Matuoka M, Minami T (2013). Process of nursing practice among expert nurses in relation to discharge support for long-term patients with schizophrenia. Nihon Kango Kagakkaishi 33:61-70.

Kanata T (2016). Japanese mental health care in historical context: why did Japan become a country with so many psychiatric care beds? Social Work 52(4):471-489.

Kataoka M, Nojima Y, Toyoda K (2003). Lived experience of hospitalized patients with schizophrenia. Journal of Japan Nursing Research 26(5):31-44.

Kawano M (2015). Psychiatric Nursing 2: Psychiatric Clinical Nursing. Tokyo: Nouvelle Hirokawa (in Japanese)

Kayama M, Matushita T, Funakoshi A, Tochii A, Sawada A, Setoya N (2005). Effectiveness of home visits by psychiatric nurses: An empirical study using psychiatric length of stay as an outcome measure. Seishin Igaku 47:647-653.

Kayama M., Setoya N, Doyle C (2020). Expanding use of nurse home visiting for community psychiatric care in Japan. The Psychiatric Quarterly 91(2):571-576. doi: 10.1007/s11126-020-09721-w

Kitamura I (2004). The process in which the person with the mental disease forms the meaning of the illness–Exploration of the factors and structures which prompt the formation of the meaning of illness through the narrative of the person with mental disease. Journal of Japan Academy of Psychiatric and Mental Health Nursing 13(1):34-44.

Kunitoh N (2013). From hospital to the community: The influence of deinstitutionalization on discharged long-stay psychiatric patients. Psychiatry and Clinical Neurosciences 67(6):384-396.

Lasalvia A, Zoppei S, Van Bortel T, Bonetto C, Cristofalo D, Wahlbeck K, Bacle SV, Van Audenhove C, van Weeghel J, Reneses B, Germanavicius A, Economou M Lanfredi M, Ando S, Sartorius N, Lopez-Ibor JJ, Thornicroft G, the ASPEN/INDIGO Study Group (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: A cross-sectional survey. Lancet 381(9860):55-62.

Merleau-Ponty M (1945/1962). Phenomenology of Perception. London and New York: Routledge Classics.

Ministry of Health, Labour and Welfare (2017). Chapter 1: Data and policy in mental health and welfare. Available at https://www.mhlw-houkatsucare-ikou.jp/guide/h30-cccsguideline-p1.pdf; Mental Health Resources, for June 30, [accessed 12 July 2021]

Ministry of Health, Labour and Welfare (2018). Recent trends in mental health and welfare policies. Available at: https://www.mhlw.go.jp/content/12200000/000462293.pdf; [accessed 24 January 2021]

Ministry of Health, Labour, Welfare (2014). The 8th study group on the guidelines for ensuring the provision of medical care for persons with mental disabilities. Current situation of the long-term hospitalized persons with mental disorders. Available at: https://www.mhlw.go.jp/file/05-Shingikai-12201000-Shakaiengokyokushougaihokenfukushibu-Kikakuka/0000046397.pdf; March 28, 2014 [Accessed 27 January 2021].

Murakami Y (2020). Phenomenological analysis of a Japanese professional caregiver specialized in patients with amyotrophic lateral sclerosis. Neuroethics 13(2):181-191.

Nakamura H, Watanabe N, Matsushima E (2014). Structural equation model of factors related to quality of life for community-dwelling schizophrenic patients in Japan. International Journal of Mental Health Systems 8:32.

Nakanishi M, Niimura J, Tanoue M, Yamamura M, Hirata T, Asukai N (2015). Association between length of hospital stay and implementation of discharge planning in acute psychiatric inpatients in Japan. International Journal of Mental Health Systems 9:23.

Narita T, Kobayashi K (2020). Rebuilding of life in local communities by males living with schizophrenia who had experienced long-term hospitalization, and currently daycare services-developing connection in loss and loneliness. Japan Academy of Nursing Science 40:205-213.

Niimura J, Nakanishi M, Yamasaki S, Nishida A (2017). Regional supply of outreach service and length of stay in psychiatric hospital among patients with schizophrenia: national case mix data analysis in Japan. Psychiatry Research 258:295-298.

Nishimura Y (2001). Narrating the Body: Phenomenology of Nursing Care. Yumiru Shuppan (in Japanese).

Nishimura Y, Matsuba S (2014). Phenomenological nursing study: Theory and its practice. Tokyo: Igaku-shoin (in Japanese).

Oishi S, Westgate EC (forthcoming). A psychologically rich life: Beyond happiness and meaning. Psychological Review.

Okumura Y, Sugiyama N, Noda T, Tachimori H (2019). Psychiatric admissions and length of stay during fiscal years 2014 and 2015 in Japan: A retrospective cohort study using a nationwide claims database. Journal of Epidemiology 29(8):288-294.

Seeman N, Tang S, Brown A, Ing A (2016). World survey of mental illness stigma. Journal of Affective Disorders 190:115-121.

Sekine T (2010). The meanings of having a prolonged stay in a psychiatric hospital and the processes to provide “Stigmata” in there. Journal of Gunma Prefect College of Health Science 5:29-41.

Shimohara Y (2012). Correlation between home-visit psychiatric nursing care and the self-reported QOL status of schizophrenic patients living in the community. Journal of Japan Academy of Psychiatric and Mental Health Nursing 21:1-11.

Shimotsu S, Horikawa N, Emura R, Ishikawa S, Nagao A, Ogata A, Hiejima S, Hosomi J (2014). Effectiveness of group cognitive-behavioral therapy in reducing self-stigma in Japanese psychiatric patients. Asian Journal of Psychiatry 10:39-44.

Shinjo D, Tachimori H, Sakurai K, Ohnuma T, Fujimori K and Fushimi, K (2017). Factors affecting prolonged length of stay in psychiatric patients in Japan: A retrospective observational study. Psychiatry and Clinical Neurosciences 71(8):542-553.

Tanaka K (2010). The lifeworld of the long term hospitalized psychiatric patients. Journal of Japan Academy of Psychiatric and Mental Health Nursing 19:33-42.

Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M and INDIGO Study Group. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. Lancet 373(9661):408-415.

Torrey EF (2019). Surviving Schizophrenia: A Family Manual. 7th ed. New York: Harper Perennial pp. 30-31.

Watanabe M, Kawano K, Noshiura K, Miyata K, Nakaya H, Kawamura K (2000). Factors affecting rehospitalization of mental disorder patients receiving home-visit nursing at psychiatry. Journal of Health

and Welfare Statistics 47:21-27.
Wong C, Davidson L, Anglin D, Link B, Gerson R, Malaspina D, McGlashan T, Corcoran C (2009). Stigma in families of individuals in early stages of psychotic illness: Family stigma and early psychosis. Early Intervention in Psychiatry 3(2):108-115.
World Health Organization (WHO) (2013). Mental health action plan 2013-2020. World Health Organization. Available at https://www.who.int/mental_health/publications/action_plan/en/. [Accessed 25 April, 2020]
Zhang Z, Sun K, Jatchavala C, Koh J, Chia Y, Bose J, Li Z, Tan W, Wang S, Chu W, Wang J, Tran B, Ho R (2020). Overview of stigma against psychiatric illnesses and advancements of anti-stigma activities in six Asian societies. International Journal of Environmental Research and Public Health 17(1):280.