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Research on changes in the discourses of the depressed elderly through nursing practice based on a narrative approach

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Abstract

This practical research study sought to clarify the treatment effect of, and means of a narrative approach toward, the depressed elderly that could by applied in nursing care with the hope of contributing to the development of a nursing-specific treatment approach that can help to alleviate depression among the elderly. Five hospitalized elderly patients with depression, aged 65 or older, participated in individual interviews based on a narrative approach that were conducted by the nurse researcher. Changes that occurred in the patients' discourses and the researcher's nursing practice over time were recorded and subjected to qualitative inductive analysis. In addition, the process of reciprocal interaction between the patients and researcher were examined with reference to Travelbee's "human-to-human relationship model". In the initial phase of the encounters between the patients and researcher, the patients' discourses focused mainly on their physical suffering. The researcher attempted to build mutual trust by accompanying their mental and physical suffering, and through the mutual trust that developed the researcher prompted them to share their experiences without anxiety. Through this relationship, a coidentity emerged between the two parties. As the interviews progressed, the patients' discourses changed to express their suffering in an intrapsychic world. A deepening of relationship and changes in it occurred between the patients and researcher, and the researcher had "opportunities to reach the heart of the depressed elderly through mutual identification" and listen to their psychological suffering. When their relationship progressed from identification to empathy, the patients told the researcher of their psychological suffering and life history: the discourses now contained previously untold stories, details of the times in which they lived, meaning in their life, and sociality. The discourses finally developed to express self-insights and hopes. This is when the patients and the researcher shared vividly that they now had a connection and rapport was established. The researcher supported the reestablishment of positives in the patients' discourses by "wishing for their recovery and actualizing their hopes", while also accepting their feelings of hopelessness that their depression would never be cured. The continuous narrative approach provided as part of nursing practice enabled the elderly patients who had been experiencing depressive feelings due to physical and intrapsychic suffering to alleviate their depression.

Key words

depressed elderly,　narrative approach,　interaction,　practical research,　treatment effect

Introduction

The elderly population in Japan has been increasing since the 1970s when the emergence of a gray society first became apparent, and as of 2010, 23.1% of the total population is aged 65 and over (White Paper on Aging Society, 2011). The elderly

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often have numerous physical and psychological health issues associated with aging. Their health issues are composed of interrelated physical, psychological, and social problems, and the multiplicity of the causes is emphasized[1-2]. Indeed, geriatric psychiatry came to be widely recognized from the 1980s onwards as the graying of society progressed.

Depression, dementia, and delirium are referred to as the "3Ds" among the psychiatric issues that frequently occur among the elderly, and treatment of these issues is a pressing task for our country. Depressive symptoms among the elderly are non-specific and are frequently overlooked with existing diagnostic criteria. Consequently, it is estimated that many elderly individuals with depressive symptoms are unknown to healthcare facilities, and those who are known are often not treated appropriately[3-4].

It is important, therefore, that the experiences of the depressed elderly are understood through their discourses. In research focusing on the experiences of this population, factors found to influence depression and psychological health included negative memories and aging, difficulties of living and suffering, relationships with others, spirituality, coexisting illness, and self-efficacy[5-8]. In light of this, nursing care that attends to the experiences of the depressed elderly is necessary.

Supportive psychotherapy, cognitive behavioral therapy, interpersonal therapy, short-term psychodynamic psychotherapy, and problem-solving therapy can be effective treatments for the depressed elderly, and these therapies are usually combined with drug therapy[9]. However, insufficient attention has been paid to a nursing-specific approach in which nurses address the discourses of the depressed elderly in efforts to alleviate their depression. Noguchi[10] argues that "illness exists in the form of stories and treatment, and recovery can also be thought to rebuild such stories." While the literature contains some recent studies on the use of narratives in elderly care[11-13], none of these studies have addressed its use in the care of the depressed elderly.

This study implemented a narrative approach with the depressed elderly seeking to identify how their discourses would change with the implementation of this approach and to determine what the treatment effects would be and how the nursing practice of the researcher would contribute to such change. Ultimately, this study hopes to contribute to the development of a nursing-specific treatment approach that can help to alleviate depression among the elderly.

Methods

1. Research design

This practical research recorded and analyzed the experiences of the study participants as expressed in their discourses and the nursing practice of the researcher during such discourses. This study applied social constructivism and used a narrative approach. Social constructivism is an approach in which narratives are believed to shape the world we live in, and in a narrative approach, the fundamental premise is to "tell about oneself" means "to make meaning for oneself" and also to "experience onself"[9]. In addition, through the narrative approach, the process of reciprocal interaction between the participants and the researcher was examined based on Travelbee's human-to-human relationship model[14].

2. Study participants

Patients aged 65 or over who were hospitalized on psychiatric wards for the treatment of depression were put forward as candidates for the study by their attending doctors. Those patients who consented to participate in continuous interviews with the researcher were recruited as study participants.

3. Nursing practice and data collection

In a narrative approach, it is important for participants to build the world they live in through their discourses. For this to happen, the researcher must recognize that that he or she *is ignorant about participants' lives* and weave their *untold stories*, building up the *time in which they lived, meanings* in their life, and *sociality*[10]. In this study, these aspects were used as guidelines for the nursing practice undertaken (i.e., the narrative approach), and each patient was interviewed between four

and ten times in ward interview rooms. Each interview lasted 60 to 90 minutes and audio recordings were made with the patient's consent. The content of interviews with one patient who did not consent to the recordings being made was noted in writing during the interviews.

4. Data analysis

Patient-specific experiences and changes in the content of the discourses were derived from the transcripts of the stories that emerged through the series of interviews. Finally, data for each patient were qualitatively aggregated and categorized. In addition, aspects of the researcher's nursing practice that supported the patients to describe their experiences were determined from the transcripts and qualitatively coded and categorized. Moreover, Travelbee's theory[13] was applied to analyze the categories derived from the interview contexts and transcripts to clarify the process in which the interaction between the participants and the researcher developed. The analysis was conducted under the supervision of expert researchers in psychiatric nursing study and experienced in the nursing approach and with Travelbee's theory.

In addition, several psychiatric nursing experts and nurses at the interview site were consulted and discussions were held among them to verify the results of the narrative approach. They judged that hypochondriacal complaints, indefinite complaints, and anxieties expressed by the participants were decreased while their vitality and motivation were increased.

5. Ethical considerations

The study was approved by the ethics committees at Kanazawa University Medical School and the research partner facility. The patients were briefed orally and also in writing on the study purpose, method, privacy protection, their freedom to participate in the study and to discontinue at any time, and the possible risks associated with the study. Only those who provided consent were included in the study and careful consideration was given to the patients' emotional shifts, levels of fatigue and stress, and physical condition. When any changes in their psychological and physical state were observed, the interviews were immediately discontinued. In order that timely and appropriate treatment was provided, the researcher maintained close contact with the patients' attending doctors and nurses.

Results

1. Patients and researcher's summary

Five hospitalized elderly patients (1 man, 4 women; age range 73–87 years) diagnosed with depression in the maintenance or chronic phase (i.e. without acute symptoms) participated in this study. The researcher was a 32-year-old male doctoral student in psychiatric nursing with 9.5 years of clinical experience. Patient characteristics are shown in Table 1.

2. Interview progress and nursing practice

In this study, the case of the Patient A will be discussed as a representative case of the changes (i.e. deepening) that occurred in the discourses and in the reciprocal interaction with the researcher. Below, categories obtained by analysis of the patients' data are denoted《 》and subcategories as〈 〉, and categories extracted for the researcher's

Table 1. Background of study participants

ID	Age	Sex	Diagnosis	Complicating physical disorders & existing conditions	Marital status	No. of interviews
A	76	Female	Depression	High blood pressure, diabetes, cataract, back pain, gastroduodenal ulcer (surgery at 70)	Widow	10
B	87	Female	Depression	Diabetes, severely impaired atrioventricular conduction (pacemaker implanted at 72), knee osteoarthritis	Widow	10
C	79	Female	Depression	Lumbar spinal cord stenosis (surgery at 73), chronic subdural hematoma (surgery at 78)	Married	10
D	80	Female	Depression	After-effects of brain infarction, cataract, glaucoma carcinoma linguae (surgery at 38)	Widow	4
E	73	male	Depression	Spinal canal stenosis, hypothyroidism	Married	6

nursing practice are denoted [[ ]], subcategories as { }, and codes as [ ].

Patient A suffered from severe backache, swelling in the lower legs, and loss of muscle strength, and was confined to a wheelchair. During the first interview, she mainly complained of physical pain and disabilities as illustrated in one of her comments: "Every day, I beg for this (wheelchair) to take care of me." In addition, she told her life story as follows: "I came here to get married, but nothing good happened. My husband passed away quickly and we had three children, but my son also passed away." The researcher felt her pain from outliving her husband and son and quietly said, "You lost your husband and son so early", but since it was the first meeting, the researcher could not touch upon this in detail. The patient herself did not discuss the deaths of her family members any further that session.

In the initial phase of their encounter, Patient A mainly discussed her《physical suffering》, focusing on her sense of grief over her physical state and aging. The researcher interacted with her mainly by {caring about her physical suffering}, such as by putting his hands on the areas that were painful and giving her a shoulder massage. By touching the physical pain and areas of the stiffness, the researcher felt the suffering that she could not fully explain. The researcher also empathized with her feeling that her illness would not be cured due to her age, and attempted to {accompany her grief at having to live with aging and depression}.

In later interviews, Patient A showed concern for the researcher; she was looking forward to meeting and was worried about the researcher's safety when coming to visit, as well as feeling sorry she could not speak well. The researcher attempted to build mutual trust and identify with her by feeling her kindness, cherishing such kindness and her interest in others, and thanking her for consideration of others.

In the third and the later interviews, the researcher continued to {be concerned about the patient's physical suffering} and {accompanying her grief at having to live with aging and depression}. In the fourth interview, the patient said "T-san, you (the researcher) are such a kind person. I wish I had been married to somebody like you." Since it seemed like that she was overlapping the image of her deceased husband with the researcher, he became curious about her husband and asked, "Was your husband kind?" She replied, "No, he was selfish. He drank, drank a lot, and got cancer and then died... Everybody in my family has died, leaving me alone."

She discussed her grief over the losses in her family expressing〈a strong sense of loneliness and depression〉. After the relationship had developed to the empathy phase in the fourth and later interviews, Patient A began to express her《intrapsychic suffering》. The researcher shared her suffering and had {heart-to-heart interactions} with her through {listening to her life story} that she spontaneously told. During the fifth interview, she discussed her〈unintegrated experiences〉such as her having divorced and left her ex-husband behind with her children and that her ex-husband and she were not able to understand each other even when he was dying from cancer.

Although Patient A said, "I felt guilty at first, but I forgot about it in about a week. So it was good in the end", she sometimes also said, "I don't want to have regrets", which the researcher interpreted to mean that for many years she had carried unresolved issues with her husband as deep emotional scars.

At times the researcher was at a loss for words over her psychological suffering; however, he continued to share her suffering by quietly listening to her, to which she responded, "Young man, you should find a nice person. I am praying for you. It is best that you find a nice one and stay with her and your family in peace."

The sixth interview took place on a day when it snowed more than usual. The patient was worried about the researcher having to come to see her at the hospital on snowy roads, and when she saw him she said, "I am glad that you arrived safely." During the interview, she mentioned that she had had the snow on her house's roof removed since she had been worried that the roof might collapse under the weight of the snow and that her son,

who was only six months old when he died, was enshrined in the family alter. The researcher empathized with her for not having forgotten her deceased son and trying to protect him in the continuous snowfalls. The researcher quietly repeated the words that expressed her feelings, "only after six months".

She talked about the day when her son passed away as if it was just the day before. She continued to talk about her beloved family, that her siblings had also passed away, and that she was by herself. She expressed her 〈feelings toward death〉 saying, "I felt sorry for them, but when one's time comes, we all have to go. So, I don't know what to say, but their time had come."

The researcher {faced death} with her by gently touching on her feelings toward death. As shown in these interactions, the relationship between them had developed to the sympathy phase. When the researcher was immersed in her suffering, she said, "Hey, young man, life always has ups and downs. T-san, you are a truly nice person. I'm very happy because I feel like you are my son", and her tone and facial expression brightened. She seemed to be substituting her deceased husband and son with the researcher and they were able to have {heart-to-heart} interactions through [transference of feelings].

During the seventh interview, the researcher shared her《intrapsychic suffering》and said, "It seems like you experienced a lot of difficulties", to which she responded, "Yes, but everyone has some difficulties like that. Everyone suffers, so I can't complain as if it were only me. I try to think this way and have managed to come so far, but my daughter says, 'Mom, you always think you are the only one to suffer'..." In this way, Patient A came to have insight into her way of life. She continued, "In my hometown, we have *meoto-iwa*, loved one and loved one's rocks, and the *abare* festival, the fire and violence festival. They are lots of fun. I want to go and see them again when I feel better. My grandson said he would take me to the mountains to pick grapes. I'm not sure if I can go, but I want to spend time thinking about something fun." As can be seen from this remark, since the relationship had reached the phase of rapport, after the seventh interview the patient expressed《self-insights and hopes》and the researcher engaged in care {wishing for her recovery and actualizing her hopes}.

During the eighth interview, she said, "spring has already come. Please give me one of your pictures when you leave." The researcher sensed that she was getting ready to say good-bye. She added, "After getting married, please stay happily together and take a good care of your parents. By that time, I probably won't be around, so it would be nice if you look at the picture and think of me..." The researcher responded, "I will follow your advice and take good care of my family", which [took on her heart and mind].

Patient A was discussing her painful memories of losing her son and her physical suffering. However, by talking about her reliable attending doctor and her grandson who was the same age as the researcher, she came to say, "If I spend time thinking about the positives, it might not be so difficult every day." In the ninth interview, she even said, "Now that I can spend time and talk with a young man like you, I can say what I want." She was also in a good health and added, "I had the doctor examine me the other day and he found nothing wrong with me."

During the tenth and final interview, she repeatedly said, "Sometimes I will spend time thinking about you, so please keep me in your memory." The researcher thanked her many times and told her numerous times that he wanted her to remain well and that he would not forget her.

3. Patient discourse and nursing practice: reciprocal interactions and development

Discourse analysis for all the patients extracted 9 subcategories and 3 categories (Table 2). Analysis of nursing practice extracted 42 codes, 8 subcategories, and 3 categories (Table 3). In the initial phase of the encounters, the discourses centered around the patients'《physical suffering》such as 〈complaints about physical condition〉and 〈grief over a weakening body and aging〉. The patients' main concern being their physical suffering.

Throughout the interviews, the researcher

Table 2. Patient discourses

Category	Sub-category	Discourses
Discourse centering around physical suffering	Complaints about physical suffering	・Patient B: I don't have much appetite. Nothing tastes that good. I'm diabetic and have kidney issues. (She has edema all over her body.) They even limit how much water I drink. The other day I was dizzy for about a week and I was sleeping with a diaper. My head was spinning and I couldn't get up. ・Patient C: Nobody knows what's wrong with me, so there is no way of treating it. See, my legs are shaking. My legs are numb and it bothers me. They've been numb for a year and a half now. This numbness gives me a bad time. I can tell that it's getting worse. ・Patient D: I hate to imagine that this numbness of my hands and legs will continue until I die. I don't know how to explain it. It feels like as if my hands were twisted. Today while outside, the nurse held my hands to avoid danger. I felt like my hands were thorny and so I felt bad for the nurse because it felt like that I was stinging her.
	Grief over a weakening body and aging	・Patient A: I got faint-hearted as I got older and now I cry easily. Since I got sick, I've not been able to stop crying when I feel only a little lonely or sad. I was not like this before. Now that I'm old, Ican't even cure this illness, and I'm even getting frail. I sometimes wonder if my pain will be relieved if I recover. But I know that I can't get better. ・Patient E: I got my grip strength measured with a dynamometer at the nurse station and it read zero. My grip strength used to be 30 or 40(kg) before, but now it's zero. I woke up at 6 am again this morning and went to bathroom. I sit on a commode. If I sit on it, it usually takes a long time. I have residual urine. It takes about 5 minutes if it's long and about 3 if it's short. Residual urine is really troublesome. My uncle used to have a catheter. He used to say that I would be like him too. I suppose he was right. People have similar issues when they're old.
Expression of intrapsychic suffering	Expressing a strong sense of loneliness and depression	・Patient A: Everyone including my children and relatives have died. I've outlived everyone. No-one is at home. I don't want to be in such a lonely place. ・Patient C: I feel like my body has changed since my operation. But the doctor doesn't understand. He doesn't even touch my bones. You're the only one who does. Hospitals seem to just leave those whose illnesses cannot be cured. My busband cannot help me because he's busy with his job. ・Patient D: The doctor assures me that he will reduce my numbness, but I doubt it. The other day, he came and said "It should have been much better." When I heard that, I was disappointed that he doesn't understand my suffering. ・Patient E: I worked at the townhall until I was 58. I couldn't work until 60 because the municipality didn't have enough money. Towns merged, but even after the merge, the population didn't reach 20,000. And the population is decreasing again now. And since three towns merged, there was a surplus of officials and we were let go. Towns try one thing and another and try to attrcat people, but still people are leaving. It is also convenient in big cities.
	Unintegrated life story	・Patient A: My husband was drinking all the time and I divorced him over that. First I felt guilty, but it was not good for the childrens' education. My classmates were all doing well and I started to hate myself and decided to leave my husband. I got on the train with my kids. When he died, I didn't even go to his funeral because I had been mistreated while young. People were talking behind my back, but after a week or so, they had already forgotten about it. So, it was good that I didn't go... ・Patient B: I wasn't happy at all. I got remarried. When my daughter was five, my first husband died of a cerebral hemorrhage. He collapsed while he was drinking at work and never recovered. He was probably 31. My second marriage didn't work. Since I had a daughter, I should have protected only her ... ・Patient C: I think my illness is due to the operation I had on my lower back. People with spinal cord stenosis usually do not get operations if they are over 70. When I told my Christian friend that I had an operation, he insisted that I had been used as a doctor's guinea pig. And nobody has touched my bones like this. Maybe people don't touch them because I have such big bones in such a small body...
	Expressing feelings about death	・Patient B: It doesn't matter where we die. We will be cremated anyway. So, I feel like there is no point in worrying. Children are usually ready for their parents' death when the parents are over 80. They all know that their parents' days are numbered. They're ready. That's what I think. ・Patient D: Since I retired at 55, I've been thinking that I am about to go to the other side. When I was working, I was busy and didn't have time to think about that. I believed that my life would continue forever. My husband passed away three years ago and since then I've been alone and haven't been able to stop thinking about it. It can't be helped though. Death happens to everyone and in an order. I suppose it's my turn next.
Expression of self-insights and hopes	Self-insights into and affirmation of their way of life	・Patient A: Yes, but everyone has some difficulties like that. Everyone suffers, so I can't complain as if it were only me. I try to think this way and have managed to come so far, but my daughter says, 'Mom, you always think you're the only one to suffer'..." ・Patient B: We should be cheerful when we talk. You know, we say "Laugh and be fat." When we're in this world, we have to be good to others. If we're good, others will talk well about us and that is a plus to us. That's how I think. I want to do something good for others. See, I have knitted three of these. I like doing things like this - I mean giving away things. (Laughs) I can be stubborn, but I'm kind at heart. See, it's funny. I'm gibbering away. Please laugh at me later. Candid people like me talk straight. But I'm refreshingly frank, so I suppose it's OK.

	Hopes for a connection with the next generation	・Patient E: My town happens to encourage children to do kendo. My grandchild will be able to participate in kendo matches in the next national high school athletic meeting. ・Patient A: You [the researcher] have to take good care of your parents. They did their best in raising you. I know that you have to and you will voluntarily do so. Now, I feel happy that I feel as if you were my own child. After getting married, please stay happily together and take good care of your parents. Usually daughters marry out, so sons have to take care of the parents. By that time, I probably won't be around, so it'll be nice if you look at the picture and think of me...
	Insight into the relationship between physical condition and depression	・Patient C: Even though my doctor said I'd recovered, I was skeptical. But this past month, I actually didn't have much pain. It was probably around the time you first came here that I started to feel better. Maybe my worrying about things might have affected my backache. ・Patient D: For the last four or five days, sounds have been echoing through my body. Like the sound when you put dishes down while eating, knocks on the door, and somebody's footsteps. These natural sounds have been echoing through my head and chest. It's hard. I suppose this is the after-effects of my failed operation forty years ago. I had numerous operations in my mouth and I contracted fulminant hepatitis. Back then, I had the same symptom, echoing sounds, and I was depressed. When finally the operation was over, I thought I could finally go home, but then I contracted fulminant hepatitis. I was hospitalized for another two months. I was depressed because my children were small. They were in grades four and six and I was worried. I don't remember how long it took before the echo sounds disappeared. But my worrying about my kids waiting for me at home might have worsened my condition. Now, nobody is waiting for me, so it's interesting. ・Patient D: I was outside for about an hour today. It seems like the more you are mentally disordered, the stronger the numbness becomes. I suppose mind and numbness are connected. When I'm worried about something, the numbness gets stronger. When I feel better, the numbness is a bit better, too.
	Emerging strength to face their mind and body	・Patient A: I can now express what I want to say. I could even say what I had not been able to share with anybody. Since I started talking with you (the researcher), I have been able to share what I want to say. ・Patient E: Yes, my legs. It's hard to walk. Since my body has firmed up, I'm exercising. This morning, too after I woke up, I exercised to the TV, exercised by myself, aerobiked, and went to occupational therapy. I can't ask people to do these things for me, so I am trying to do some exercise by myself. I shouldn't stay in bed for as long as I'll get bed sores.

Table 3. Nursing practice in the narrative approach based on phenomenological interviews

Category	Sub-category	Code	Examples of Nursing Practice
Building mutual trust by accompanying the physical and psychological suffering of the depressed elderly	Caring about their physical suffering	・Ask about their physical condition ・Listen to the development of their suffering ・Touch the painful areas on their body with hands ・Show interest in their appetite and diet ・Massage the painful areas and stiffness ・Empathize with their physical suffering ・Ask about sleep habits ・Care about the physical debilitation that they care about ・Listen to their physical suffering caused by drug side effects	・Patient B discussed that she had a pacemaker placed and had regularly undergone cardiac testing. Since the researcher noticed she was concerned about her heart condition during one interview,the researcher said to her, "I understand that it is scary to have a heart condition," and assured her that her heart race was stable. ・Patient E had been unable to move his body due to depression and his body was stiff. When the researcher said, "Do you have shoulder stiffness or any body aches?", Patient E said he had both. The researcher massaged his shoulders and neck. The patient then complained of the physical suffering he had been going through since he was diagnosed with spinal cord stenosis two years earlier.
	Accompanying their grief at having to live with aging and depression	・Accompany their sadness and loneliness ・Accept and understand the suffering caused by their inability to do things they want due to physical illness ・Listen to the sadness caused by the loss of many loved ones ・Accept and understand the sadness of aging ・Grasp their anxieties through conversations ・Repeat back their key phrases to them ・Listen to their stories emerging in conversations	・Patient A complained of her physical suffering and said, "I don't think that I will ever get better since I am just getting older." The researcher listened to and acknowledged her double suffering caused by physical pain and sadness over aging. ・Patient C said, "I feel sad that I cannot do anything even though I want to do something nice for others" due to aging and physical suffering. The researcher felt the weight of her lament over the fact that she "cannot do anything". The researcher acknowledged her suffering due to her physical suffering and inability to help others when she wanted to do so.

	Acknowledging their subjective suffering	・Listen to their treatment experiences that they find unreasonable ・Acknowledge the causes of their current suffering ・Accompany their despair that they will not be cured ・Acknowledge their subjective belief that their condition is getting worse ・Empathize with their suffering that nobody understands them	・Patient D had not been admitting that she was hospitalized for depression. While listening to the patient's complaints, the researcher listened to her discuss how she came to be hospitalized. She began to share that her physical suffering and anxiety were growing due to the side effects of the medicine prescribed by her doctor. The researcher acknowledged her suffering by saying, "You have been going through a difficult time due to the medicine."
Reaching the heart of the depressed elderly through mutual identification	Listening to their family stories	・Listen to them talking about their beloved family members ・Assure them that their family cares about them	・Patient B discussed her son's weekly visits. When the researcher said, "A parental presence is a blessing for a child", the patient started to talk about that she always cared about her physically weak son.
	Listening to their life history	・Listen to their suffering from their life history ・Show interest in their memories of their hometown ・Listen to their happy memories ・Show interest in their life-long occupation	・Patient B talked about her husband who had been hospitalized for alcoholism for a long time. The researcher inferred that the patient's family had gone through a lot of troubles, and carefully said, "Were you happy after getting married?" The patient told him that she was not happy at all, that her first husband had passed away when she was still young, and that she had experienced a lot of difficulties with her second husband.
	Having heart-to-heart interactions	・Deal with the transference of feelings ・Disclose about oneself (self disclosure) ・Take on their heart and mind ・Learn from their life experiences ・Be sensitive to the care they provide oneself ・Repeat back their emotionally charged words ・Touch upon their attractive personality traits and values	・Patient A saw shades of her idealized husband and deseased son in the researcher and said, "I am very happy because you are like my son." The researcher admired her as if she was his mother and said to her, "I will follow your advice and take good care of my family." ・The researcher could feel the purity of Patient C's heart and said to her, "Mrs. C, you have a good heart." To this Patient C responded by saying, "Nobody believes this now, but I was a Christian and have lived a good life. So I could not betray anybody." The researcher touched upon her attractive personality and values.
	Facing death	・Touch upon the ways in which they face death ・Listen to their fears of death and worries	・Patient D discussed that whenever she went to a class re-union party, it began with an eulogy on the deseased classmates and ended with a prayer for an uneventful year. The researcher thought that the patient was feeling that death was near and quietly asked about her feelings toward and anxiety about death.
Wishing for their recovery and actualizing their hopes	Wishing for their recovery and actualizing their hopes	・Wish for the actualization of their hopes ・Assure that physical and mental abilities they have cultivated remain while acknowleding their physical suffering ・Assure that they will feel relieved ・Pick up some positives from their discourses ・Wish for their recovery ・Express one's own relief over their recovery	・Patient C complained about her physical suffering in every interview. She had an insight into the relationship between depression and physical suffering and said, "Maybe anxiety has something to do with it." While the researcher acknowledged her suffering, he told her that it seemed like she was getting better and that he hoped that she would get better even a little bit. ・Patient E was depressed about his decreased physical strength. The researcher acknowledged his sadness and observing his large palms and movements of his lower limbs, assured him that his strength that he had developed over years of agricultural work remained with him.

attempted to make it easier for the patients to talk about their own experiences in peace by [[building mutual trust by accompanying the physical and psychological suffering of the depressed elderly]]. The effort to establish mutual trust included {caring about their physical suffering}, {accompanying their grief at having to live with aging and depression}, and {acknowledging their subjective suffering}. Such efforts allowed for coidentity to emerge between each patient and the researcher.

As the interviews progressed, the contents of the discourses evolved : the patients first expressed 〈a strong sense of loneliness and depression〉, their 〈unintegrated life experiences〉, and later their 〈feelings toward death〉, which was an《expression of intrapsychic suffering》.

Depending on the situation, the researcher had

{heart-to-heart interactions} with the patients and [[reached the heart of the depressed elderly through mutual identification]]. The researcher did this by {listening to their life story}, {listening to their family stories} and {facing death} and actively listened to their psychological suffering throughout the interviews.

The relationship subsequently developed from the coindentification to empathy phase. In the latter phase, the patients began to discuss their psychological suffering and life story, and disclosed previously untold stories, details about the times they lived, meaning in their life, and sociality. The relationship further developed to allow the researcher to sympathize with them and finally the discourses developed to expressions of《self-insights and hopes》as seen in〈self-insights into and affirmation of their way of life〉,〈hopes for a connection with the next generation〉,〈insights into the relationship between their physical condition and depression〉, and〈the emergence of strength to face their mind and body〉.

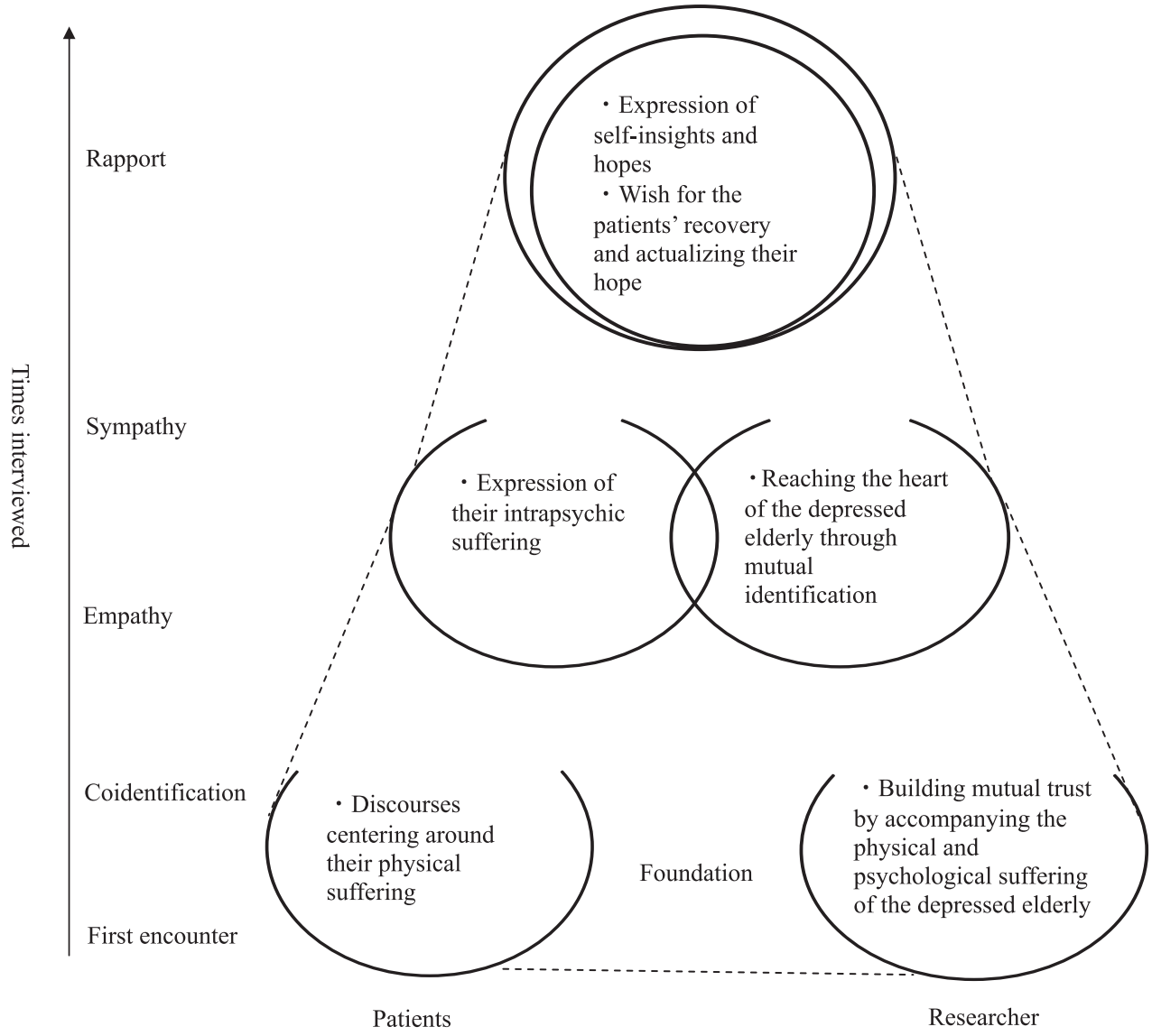

Figure 1. Development of the reciprocal interaction between the patients' discourse and nursing practice

*The vertical axis indicates the passage of time from the bottom up. The categories of derived narratives of the patients and the nursing practice of the researcher were divided into three stages and placed according to their development over time (each category is shown in a half circle or circle). The bottom categories are the foundation of all the other categories above them, and the dashed lines around the circles indicate that categories encompass and cannot develop without the ones below them. This figure is based on Travelbee's human-to-human relationship model and approaching the circles indicates a deepening of the relationship between the patients and the researcher.

This is when the patients and researcher shared vividly that they had made a connection and established rapport. The researcher supported the reestablishment of the positives in the patients' discourses by "wishing for their recovery and actualizing their hopes" while accepting their feelings of hopelessness that their "depression would never be cured". The patients who had been experiencing depression due to their physical and intrapsychic suffering began to talk positively; their depression was alleviated and they now accepted the way to live out their natural life (Fig. 1).

Discussion

It is reported that the depressed elderly rarely express their unhappiness. Instead, they make hypochondriac and physical complaints, lament about their debilitating memory loss, and express anxieties[3]. In this study, the patients often made physical complaints, lamented their loss of appetite, and expressed anxieties in early interviews. However, as the interviews progressed and their relationship with the researcher deepened, they began to express their underlying unhappiness and depressive feelings.

It was difficult for the patients to recognize their depressed condition and to verbalize it in early interviews. However, their discourses were found to transform from the ones focusing on their 《physical suffering》 to those expressing their 《intrapsychic suffering》 and later they were able to express their unhappiness and depressive feelings. Such change is believed to have been influenced by the researcher's attempts to understand their physical suffering, which are the main concerns for the depressed elderly, and his caring about them in a careful manner.

Patient A expressed her belief that her illness would not be cured because of aging, and Patients C and D said they had felt despondent over having failed to see any improvement in their condition when their doctors had assured them their illnesses would be cured. Generally speaking, depression is a disorder that is generally curable and it is reported that many patients feel relieved when assured of their recovery[15]. However, the depressed elderly confront the realities of unavoidable strong physical pain and aging; therefore, it is expected that it will be difficult for them to believe their doctors' affirmation that they will get better. Easy affirmation of recovery could lead to hopelessness that even when they complain their suffering, they will not be understood. This in turn will generate feelings of isolation and instead of curing their illness, it could possibly make them cling to their physical suffering.

It is believed that through the researcher [[accompanying the physical and mental suffering of the depressed elderly and building mutual trust]] the patients gained a sense of relief that they were finally understood, and this emancipated them from 〈complaints about their physical condition〉. The researcher achieved this by {accompanying their grief at having to live with aging and depression}, {acknowledging their subjective suffering}, and {caring about their physical suffering} while at the same time acknowledging his own ignorance. Their not focusing on their physical condition seemed to have served as a trigger for the 《expression of intrapsychic suffering》.

In addition, the researcher having [touched the painful areas of their body with his hands] and listened to their physical suffering while [massaging the painful areas and stiffness] were probably effective strategies for facilitating the development of their discourses. As Anzieu[16] stated, "skin allows direct communication and mutual empathy and the establishment of a close heart-to-heart relationship between two people by connecting them." Therefore, touching and massaging the patients seemed to lead to mutual empathy and the establishment of a heart-to-heart relationship between the two parties.

Such physical care through direct communication via the skin deepened their mutual trust and the patients were then able to 《express their intrapsychic suffering》. In other words, nursing practice that shares the physical and mental suffering of the depressed elderly, such as in body-mediated care, can help the transformation of the nurses' view of their patients from being just the

depressed elderly to the patients with individual personalities. Moreover, such care can also help the depressed elderly to view the nurse as a nurse with personality not just merely a nurse providing care. As Travelbee[17] has discussed, the body-mediated care the researcher provided allowed both parties to overcome their roles of "patient" and "nurse" and it formed a human-to-human relationship between them. The relationship evolved from one of coidentification to empathy, from empathy to sympathy, and ultimately to that of rapport.

The depressed elderly's 〈unintegrated life experiences〉 were often associated with emotional trauma and were difficult to overcome even with the passage of time. They also expressed their deep sense of isolation and strong thoughts about death. Such《intrapsychic suffering》shook their existence to its core and they found their suffering difficult to integrate into their life. Erikson[18] has argued that the developmental challenge in late adulthood is the clash between 'integrity' and 'despair'. According to him, through this conflict the elderly face death itself and an informed and detached concern for life – wisdom – emerges.

The depressed patients'《intrapsychic suffering》can lead to "despair", and "despair" that is not verbalized and is contained in the intrapsychic world can cause depression. The researcher {listened to the life story} of each patient and {faced death} with them while acknowledging his own ignorance. Such nursing practice probably constructed new meanings of their traumatic experiences, which were finally integrated. Heidegger[19] has argued that human beings exist as being-in-the-world and can interpret our existence only as embodiments of our relation to the world. He also stated that being-in-the-world faces its inherent possibilities and chooses the inherent self by understanding the certainty of death and being involved in one's own or others' death.

It is likely that the depressed elderly in the present study were confronting the idea of death, reviewed their unintegrated experiences with the researcher, and attached time and meanings to their life history, becoming able to express their《self-insights and hopes》by constructing wisdom and interpreting themselves through this wisdom. This occurred during the later interviews and likely reflects the effects of the continuous narrative approach. In other words, through the process of listening to their《physical suffering》, a human-to-human relationship was constructed between the patient and researcher, with the relationship finally reaching rapport. Throughout the process, the discourses of the depressed elderly evolved to be more positive: their《intrapsychic suffering》became integrated into their life, they showed 〈self-insights into and affirmation of their own way of life〉, 〈hopes for a connection to the next generation〉, 〈insights into the relationship between their physical condition and depression〉, and 〈the strength to face their mind and body〉. This in turn contributed to the alleviation of their depression.

Yoshimura and Naito[11] used a three-time narrative approach with hospitalized elderly patients with physical disorders and concluded that the approach led to the construction of a relationship between each patient and researcher and it triggered the patients to begin talking. In their study, the patients were given opportunities to seek the real causes of their anxieties and time to find clues to resolving them. Moreover, they argue that by the elderly talking about their emotions swaying toward aging-related physical and life circumstances complemented a decline in their abilities. A similar process was observed in the present study involving the depressed elderly. In short, it is important to attend to patients' swaying emotions when in a depressive state. On the other hand, their swaying emotions of the present patients were not caused solely by their aging-related physical and life circumstances, but also by their《intrapsychic suffering》such as seen in 〈expressing a strong sense of loneliness and depression〉, discussing their 〈unintegrated life story〉, and 〈their feelings toward death〉.

In order to get closer to the past, present, and future experiences of the depressed elderly, it is necessary to have {heart-to-heart interactions}

with them while building a relationship with them. In short, [dealing with transference of feelings], [taking on their heart and mind] and [learning from their life experiences] are critical.

Takenaka[2] has argued from a geriatric psychiatry standpoint that emotional factors play a major role in the patient-nurse relationship in elderly care. According to him, the elderly rarely voluntarily discuss their inner struggles and failures, tend to deny the relationship between changes in their mind and body and depression, and believe that their unintegrated life stories will not be understood by younger generations. Put simply, the techniques that share their《intrapsychic suffering》through {heart-to-heart interactions} are more important in nursing practice for the depressed elderly than in nursing practice for the elderly with physical disorders.

Takenaka[2] has stated that in the psychological treatment of the elderly, nurse should keep in mind that first of all, the patients are older than them and that they have not experienced aging yet. This indicates the importance of caring for elderly patients while acknowledging nurse's own ignorance. Moreover, the present study confirmed the importance of the narrative approach as a nursing practice for sharing the experiences of the depressed elderly.

In the past, a combination of medication and supportive psychotherapy, cognitive behavioral therapy, interpersonal therapy, short-term psychodynamic psychotherapy, and problem-solving therapy have been found to be effective in treating the depressed elderly[9]. This study highlights the effectiveness of the narrative approach, which supports《expressing self-insights and hopes》.

Limitations and challenges for the future

The number of patients included in this study was only five and the participants were limited to patients hospitalized on a clinical psychiatry ward. The number of interviews varied from four to ten and the researcher's interview and analysis ability might have influenced the outcomes of the study. For more robust results, and the number of cases to be included in the study need to be increased and the ability of the researcher to interview and analyze data evaluated. More clinical studies are also required.

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ナラティヴアプローチを基盤とした看護実践による うつ病高齢者の語りの変化に関する研究

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要　　旨

本研究は、うつ病高齢者に対するナラティヴアプローチの治療的効果とその実践方法について明らかにすることを目的とした実践研究である。

入院治療を受けているうつ病高齢者5名に対して、ナラティヴアプローチを行い、研究参加者の語りの変化と研究者の看護実践をデータとして質的帰納的に分析を行った。また、ナラティヴアプローチの実践によって、参加者と研究者の相互作用が進展していくプロセスをTravelbee[13]の理論に則って捉えた。

研究参加者の語りは、初期の出会いの位相では《身体の苦悩を基軸とした語り》が中心であった。研究者は、『うつ病高齢者の心身のつらさに添いながら相互信頼を構築する』かかわりを基盤とし、参加者が研究者とともに安心して自己の体験を語ることができるように配慮していた。そのようなかかわりによって、両者の間に同一性が出現した。面接の経過を経るに従い語りの内容は変化し、参加者は《精神内界の苦悩を表出》するようになった。研究者は、参加者との関係性の深まりや変化をみながら、状況に応じて『相互に一体感をもちうつ病高齢者の琴線に触れる』かかわりを行い、精神的な苦悩を傾聴していた。参加者と研究者の相互関係は同一化から共感の位相に進展したことによって、精神的な苦悩や生活史が語られるようになり、そこには各参加者のいまだ語られていなかった物語や生きられた時間、意味性、社会性が表現されていた。そして、同感の位相を経て、最終的に参加者の語りは《自己洞察と希望の表出》という形に展開した。ここには、参加者と研究者の間に、お互いが結ばれているという生き生きとした体験が基盤にあり、ラポールが構築された。研究者は、参加者の抑うつ感情や「病気が治ることはない」という絶望感に添い、受容しながらも、『回復や希望の実現を願う』ことで参加者の語りがポジティブに再構築されるように支援していた。これまで、身体の苦悩や抱え込んでいた精神内界の苦悩によって抑うつを体験していた参加者は、継続したナラティヴアプローチによって、抑うつを緩和することができていた。