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Integration of Buddhist philosophy to Morita therapy and psychiatric nursing
-With dialog, daily activities can be expanded in patients with depression-

HIRAI Toyomi

要旨

うつ病者の看護に精神科看護として「激励」の声掛けは適切ではない。この理由の一つとして，うつ病患者は長期的展望が持てず目先のことにこだわる思考になることが示唆されており，原因として，脳活動の低下（以下，「脳の活性低下」とする）が言われている。ヒルデガード・ペプロウらの精神科看護における先人たちは，看護者の言動の自己洞察や振り返りを行うプロセスレコードを看護教育に導入しており，我が国でも精神科の学生教育に主要な位置を占めている。一般的に，外部からの言語刺激により生じる「快」「不快」の情動賦活の MRI 上の所見は，脳の前部帯状回部分での活性化であり，脳の活性が低下したうつ病患者の治療として「言語刺激」が有効であることが示唆される。これにより，プロセスレコードにより看護師の言動を振り返ることは脳科学的にも妥当性があると考える。本稿では森田療法とロゴテラピー等の治療態度を比較しつつ，うつ病の看護について考察した。

keywords：Cognitive-behavioral therapy, narrative, depression, psychiatric nursing, process recording

INTRODUCTION

Research Background and Purpose

There have been standard tactics in which encouraging speech is not appropriate as psychotherapy in depression care. In psychiatric nursing, students use a process recording to review their own behavior and gain self-insight. The process recording was introduced into nursing education by predecessors such as Hildegard Peplau, when neuroscience research hadn't progressed as it has today. Since the process recording was introduced to psychiatric nursing education, it'd been holding an important position especially in student guidance. Regarding language, frontal gyrus cinguli activity is exacerbated by pleasant/unpleasant meaning of language with the activation of pleasant/unpleasant emotions in an fMRI, which suggests that patient is obsessed with situation at hand and unable to keep a long-term view, so there is validity from a neurological standpoint in reviewing discourse of nurses using process recording.

In in recent years, it has been found that the number of patients with depression has been increased and repeated recurrence of depression causes dementia. It is necessary to nurse while keeping prevention of recurrence of depression symptoms in perspective and there is a need for the nurses working closest with patients to improve their skills in appropriate assessment of patients' cognition.

This report examines nursing for depression while comparing patients' attitudes toward treatments including Morita therapy and logotherapy.

THEORY AND METHOD

We collected information from process recordings, case reports, and practice records. We examine cognitive behavioral therapy through literature from the view of practice records.

As an Ethical Consideration, we explained subjects that their private information would be arranged so that individuals could not be identified, and that withdrawing from participation would not affect treatment, before obtaining both written and oral consent to participate in this research.

Introduce the case, a patient was a female in her 50's who was diagnosed with depression. Her medical history did not include other diseases. Herein, this patient is referred to as Case A.　In October 2011, Case A developed a sense of malaise and fatigability with no clear cause. Although she underwent a health-screening checkup at another hospital, no abnormalities were detected. From November 2011, she developed symptoms of depression including loss of motivation, insomnia and decreased appetite, and she began to seclude herself in her house. She stopped watching television

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and developed suicidal ideation, which led her to visit a local psychosomatic clinic. Prescribed medications did not improve her symptoms. Behaviors that suggested suicide attempt, such as tying a rope around her neck and saying "Kill me" to her family members, were observed, as well as micromania. As a result, she was voluntarily hospitalized in May 2012

Patient's condition while nursing

The patient had a dark expression, no interaction with other patients, spent most of the day in hospital room, and claimed, "This is the god's justice. I can't do anything because I'm possessed by a spirit."

Process of symptoms before hospitalization

In October 2011, Case A developed a sense of malaise and fatigability with no clear cause, and underwent a health-screening checkup at another hospital which did not detect any abnormalities. From November 2011, she developed symptoms of depression including loss of motivation, insomnia and decreased appetite, and began to seclude herself in her house. She stopped watching television and developed suicidal ideation, which led her to visit a local psychosomatic clinic. Prescribed medications did not improve her symptoms. Behaviors that suggested suicide attempt, such as tying a rope around her neck and saying "Kill me" to her family member, were observed, as well as micromania. As the result, she was voluntarily hospitalized in May 2012.

Process of the symptoms from admission to commencement of nursing intervention

At the time of admission, lack of energy and diminished ability to think or judge were observed. Case A often showed stunned-looking, and complained strong anxiety, saying; "I'm scared because I feel like I am becoming worthless, even listening to noises is annoying." She also had micromania described as; "I feel like my brain is breaking down. I only have the brain of a mouse so I can only do what mice do." She also indicated suicidal ideation described as; "My body is a wreck. Dying is my only option. It is too hard to go on living." At the beginning of nursing intervention, her expression was gloomy, and she spent most of each day in her room without any interaction with other patients. A diverse range of cognitive distortions and loss of motivation for action were assessed, with comments of the patient such as; "I was judged by God, I have been possessed by a spirit and it stops me doing anything."

Exhaust herself and decreased thinking/judgment ability were found and there were strong scare of anxiety. Delusion of belittlement and suicidal thoughts presented.

Nursing Practice

Nursing diagnosis

Activity intolerance

Nursing objectives

Some comments that demonstrate realization of the importance of a lifestyle that improves activity tolerance.

1. In order to deepen a trusting relationship with patient A, the nurse accepted A's claims and listened to A's feeling of insecurity.
2. Since patient A tends to withdraw into hospital room, the nurse walked the halls daily in the hospital ward with A, taking charge of increasing the amount of A's activities.
3. The nurse colored pictures and did origami with A everyday in the day room. In the final week of nursing practice, A was able to color with other patients.

On the first day of nursing practice, the student greeted Case A, who was walking along the ward halls alone. Case A returned the greeting quietly with staring downwards. She showed stone-like expression and avoided eye contact.

On day 2, the student said to Case A; "If you aren't too tired, would you like to go for a walk together?" hoping to listen to Case A's current feelings and to make her feel refreshed. While walking together, Case A kept looking ahead and did not speak. When the student suggested having a chat in the courtyard, Case A nodded and talked about her anxiety;, "I awake in the middle of night every day. When I am alone in the dark I can't stop thinking about lots of things." She still did not make eye contact and remained a set expression.

On day 3, the student communicated with Case A in the courtyard. The student looked into Case A's eyes, carefully listened and accepted the patient's words. Case A often glimpsed at the student and said that she had the same flowers in her garden as those in the hospital courtyard.

On day 4, the student tried to communicate in the courtyard as with the previous day. On this day, the student attempted to ask about Case A's family, therefore she talked about her own family first; "I have two children. The younger is a boy." Case A widened her eyes with surprise and said; "Oh, do you? I have a son, too." looking into the student's eyes and smiling

for the first time. Subsequently, Case A expressed her feelings that she wanted to die every day and that her life was not worth living. Case A expressed the reason for her suicidal ideation as; "I am cursed by a spirit. The spirit stops me from doing anything. The spirit tells me to die. Dying is my only option." The student was bewildered how to react to the word "spirit", however she demonstrated empathy; "I don't know much about being cursed by spirits but it is how you feel, isn't it? It must be hard for you to feel like you want to die every day." The student also told Case A that she understood Case A's feelings and wanted to help Case A to ease her difficult feelings.

In week 2, Case A started to greet the student with a smile during every visit in the mornings. They had more detailed conversations on their daily walk. The student gained more in-depth information about Case A's family and lifestyle before hospitalization, such as that she used to live in the United States due to her husband's job relocation and that she used to have lots of friends there. Although Case A was unlikely to speak positively, she started asking questions or laughing out loud at a joke around this time.

However, Case A also frequently made self-denying statements such as "I'm a failure as a human," "I am a useless person," and comments such as "When I am doing nothing, the desire to die grows stronger" and "The spirit is stopping me from doing anything." Case A was likely to stay in her room except during occupational therapy and had decreased activity tolerance. Therefore, the student prepared various activities for her such as doing origami and coloring pictures, and spent approximately one hour each day doing these activities with Case A. The student also continued to walk with Case A in the ward before the activities intending to increase the amount of daily activity. They increasingly had active conversations during the activities, and the student gained deeper understandings. It included that Case A, who had reserved and mature personality, had been enduring a lot of things in her life as she described; "My husband always made the rules" and "He only gave me a small amount of money to pay the bills so I couldn't buy anything I wanted." Case A often chose coloring pictures as an activity. The student attempted to make Case A understand that she was not a person who can not do anything, to ensure her self-affirmation, by admiring her beautiful works; "Mrs. A, you color it very beautifully," and "You were able to neatly complete the entire picture." The student also expressed that she was looking forward to spending time with Case A, saying; "What picture shall we color in tomorrow?" and "Let's color in some more pictures with me again tomorrow."

Case A was previously engaged in activities when encouraged by the student, however; she started to choose the type of activity by herself in week 3. Furthermore, she started engaging in activities with other patients in the day room. Other patients who saw Case A coloring pictures and doing origami every day in the day room said that they wanted to join her. Case A gave other patients some coloring sheets and said; "There you go." For a number of days, they engaged in the activity together. Case A started interacting with other patients, making comments such as "That's lovely," and "You colored it beautifully."

The student and Case A took longer daily walk and Case A voluntarily expressed her anxiety regarding sleeplessness and fear of wakening during the night. When the student said; "I want you to make sure you get some sunlight every day and engage in an active lifestyle," Case A responded; "That's right. It's good to keep active. It would be nice if being active would help me to sleep well, and then I would like to return home as soon as possible." Thus, she began to express the desire to be discharged. During this period, she began to smile and wave at other students as well, not only at her student nurse.

RESULT

1. By conceptualizing anxiety, one of symptoms in depression, patient was able to realize that anxiety is temporary.
2. Regimented activities and lifestyle were able to promote recovery from depression.
3. Improvement of nurses' skills in cognitive behavioral therapy or Morita therapy for patients with depression plays an important role in working with the patient and the recovery process.

DISCUSSION

The origin of Japanese nursing

This paper has thus far covered the overall flow of philosophy spanning from the findings in the sites from around the nascent stage of the Indus civilization, shifting from the perception of water, start of a civilization, samsara, philosophy, and to ethics. Concerning Buddhist nursing in Japan, the Taiho Code was enacted in 701, with the Yoro Code completed in 718. Within these codes, there were the Regulations on Medical Service which served as medical work regulations.

The regulations stipulated medical treatments to be managed by the state, with those who completed a certain amount of education being certified as doctors via a

national examination. These doctors were then assigned to work at locations the state stipulated. Doctors were government officials who received remuneration from the state and did not charge treatment fees from general patients.

The Nursing Law states that (1) "Those aged 80 or suffering from disability (leprosy, insanity, lacking the faculty of both legs, and blind in both eyes) will be assigned an attendee, those aged 90 with two attendees, and those aged 100 with five attendees". Furthermore, it also states that "attendees are selected among one's descendants. If one does not have descendants, they will be selected from relatives. Attendees will be selected outside of family for those who do not have relatives".

Another stipulation is (2) "Widows aged 60, widows aged 50 and above, children under sixteen with no parents, those aged 61 and above with no families, and those with illnesses (those suffering from ague, senility, dwarfism, broken back, or lacking a limb), will be supported by a relative or will be take care of by monks in their villages". "Attendees" here refer to nurses[1].

Designation of nurses started to be seen from 718 A.D, with the ties between monks and nurses becoming developed as a charitable operation built upon moral significance, high in the ethics of Buddhist monks. In the late Edo period, there was even a saying that went, "three-part doctor, seven-part nurses", which is a quip made by the public implying that nurses are what is them. Nightingale, a British nurse who made a great achievement during the Crimean war and modernized nursing, established her first nursing school in 1860. She attention to the environment of the ill to strive to attain *Byoukasuchi,* published by Genryo Hirano in 1830, actually necessary for the treatment of the ill. comfort for has advocated for maintaining good environment for the ill, but Genryo Hirano had already presented in 1830 his belief concerning the environment of the ill and illness prevention.

Moreover, in the field of psychiatry, Dr. Shoma Morita established Morita therapy in 1920 based on his own experience of suffering from panic disorder and his clinical experience as a physician.[2] Morita therapy is based on the principle, "let nature take its course;" thus allowing the patient to break away from the negative cycle of one's thoughts and escape from one's assumptions. The central concept of this principle is to "focus on the present." Morita therapy "encourages spontaneous recovery" while focusing on reality instead of "resignation," which is commonly used in discusses prevention of illnesses. He also discusses early treatment, observation of the general state, and paying psychoanalysis.

(see Table 1)

As shown in Table 1, Hiroshi Suwaki (1969) presented "Research on Naikan therapy." Morita and Naikan therapies are nonreligious types of psychotherapy. Logotherapy by Frankl emphasizes striving to find "the meaning of life." Based on his experience in surviving Auschwitz, he wrote that he "spoke to my wife in my heart," which is consistent with the idea of "narrative" that is currently a popular research method. With regards to "narrative," several Japanese people have a Buddhist or Shinto altar in their homes and engage daily in a "form of narrative" by "praying to their ancestors." This ancestor worship that involves freely speaking to dead ancestors leads to sublimation and insight, which could be the original model for the "narrative" described in research.

Freud's psychoanalysis involves unconsciously choosing a focus point and promoting consciousness by allowing free association of suppressed thoughts. Freud and Frankl both believed that "patient positivity" was the stance required of patients, whereas in Morita and Naikan therapies, "patient passivity" is emphasized. The past belief of encouraging patients to speak positively about everything was "good psychotherapy" is shown in Table 1 as "positivity." However, it is known that "words" can also negatively act on the formation of the "concept of self" based on the patient's language; thus, this approach does not always lead to treatment.[3]

Studies have shown that debriefing of children traumatized by natural disasters by "securing a safe environment" and "supporting restful sleep" is ineffective. This idea of "promoting spontaneous recovery" underlies Morita therapy. Morita and Naikan therapies were both developed as treatments for neurosis. The "isolation and rest phase" of Morita therapy is an effective approach to psychotherapy for depression, and its application in civilized nations has recently increased. Patients who become depressed upon reaching a stage of exhaustion or fatigue have a superior attitude toward treatment, whereby they "shut off stimulation and wait for their body to recover."

Furthermore, resetting of delayed processes means that the improvement rate for depression is approximately

70%.[4)]

Morita therapy increases the will to become active to "work on the natural healing power of the patient;" thus making it a "passive" and "positive" therapy. Depression involves functional changes within the brain, shifting to decreased retentive power once repeated recurrence leads to contracted hippocampus volume.[5)]

Table 1 (Oda, 1996)

	Psychoanalysis	Logotherapy	Morita therapy	Naikan therapy
Creator	Sigmund Freud	Viktor Frankl	Shoma Morita	Ishin Yoshimoto
Religious or ideological background	Modern Jewish/Christian view of human nature (nonreligious)	Theistic existentialism	Buddhism (Jodo-Shin/ Zen)	Jodo-Shin Buddhism
View of human nature	Humans are sexual and instinctive	Dimensional ontology (resilience of the spirit)	Absolute "other power" ("let nature take its course"	Humans are "evil"
Treatment objectives	Establishment of the Ego "put the Ego where the 'Id' was."			Perception of "evil," perception of "owing" and thankfulness
Techniques	Free association, dream analysis	Paradox intention, dereflexion	Reading therapy, isolation and rest	Reflective journal writing to understand oneself
Attitudinal difference	Active/self-oriented	Positive, existentialist	Passive, natural	Passive, grateful intention

In recent years, advances in diagnostic imaging, such as magnetic resonance imaging (MRI) and functional MRI (fMRI) , have shown that glucocorticoids accumulate and damage hippocampal nerves in the brain.[6)] Analysis of the process codes used in psychiatric nursing and of patients' words in narratives facilitates in understanding specific "stories of the past" and in determining any "immediate benefit" to a patient with depression, which can be simultaneously compared to the hippocampal region nerve injury symptom of "selection of memories of past hippocampal memory function."[7)] Studies have shown that the appropriate timing for pharmacotherapy and sufficient amounts of nutrients, including vitamins and protein, are essential in the treatment of nerve injury of the hippocampus. Prevention of recurrence can decrease the risk of cognitive impairment. In either case, a correct diagnosis and scientific judgment of when to initiate treatment are warranted.

CONCLUSIONS

Illness prompts individuals to undergo purification to reject the illness, pray, and appeal to higher powers.[8)] Psychiatric diseases require an extended amount of recovery time and positive support from family members. Empathy and support are key communication characteristics in psychiatric nursing. Process recording can be used to review whether nurses employ "self-insight" by including empathy and support during interactions with the patient. Process recording can also be used to assess patients' symptoms. Previous studies using word fluency active tasks with fMRI observed a decreased activity in Brodmann area 46 (left prefrontal cortex) in patients with depression.[9)]

Intentional “encouragement” using words should be carefully conducted. This suggests that recurrence of symptoms can be prevented if sufficient recovery of brain function is observed and social recovery is implemented linguistically. The dialog that stimulates realization of the patient can be seen in Buddhism and the Socratic method. In the case in this study, one-on-one care by a skilled nurse expanded activities of the patient, but there is still a deficiency in nurses with psyhciatric nursing skills.

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