

Schizophrenia and Life in the World of Others

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Cet article examine l'impact social et relationnel de la schizophrénie chronique chez 10 adultes atteints de cette maladie et vivant au sein de la société en Nouvelle-Zélande. Les résultats cités dans l'article sont tirés d'une plus grande étude phénoménologique de Heidegger, laquelle répond à la question suivante : *Comment vivent les gens atteints de schizophrénie?* Bien que la schizophrénie touche tous les aspects de la vie d'une personne atteinte, l'article présente six thèmes qui illustrent l'impact de la maladie sur un aspect de la vie des participants – l'interaction avec les autres. Les thèmes sont les suivants : vivre avec les préjugés des autres; avoir peur des autres; se sentir inconfortable en compagnie des autres; demeurer en interaction avec les autres dans le monde; dépendre des autres pour de l'aide; et trouver d'autres personnes qui comprennent. L'article démontre qu'il est possible de comprendre l'expérience des personnes souffrant de schizophrénie et suggère qu'une attention accordée aux dimensions relationnelles de la vie des gens atteints de cette maladie peut favoriser une vie plus saine et heureuse.

This article examines the social and relational impact of chronic schizophrenia on 10 adult sufferers living in the community in New Zealand. The findings reported here are drawn from a larger Heideggerian phenomenological study that set out to answer the question *What is it like to live with schizophrenia?* While schizophrenia affects all dimensions of a person's life, in this article 6 themes are presented to illustrate the impact of their illness on one aspect of the participants' lives — their interactions with others. The themes are: living with the prejudice of others, being fearful of others, feeling uncomfortable in the company of others, staying engaged with others in the world, depending on others for help, and finding others who understand. The article demonstrates that it is possible to understand the experience of those with schizophrenia, and suggests that attention to the relational aspects of the lives of people with this illness can help them to lead healthier and happier lives.

For all of us, to be in the world means encountering others. Meeting with others is an essential and integral part of Being and of world (Steiner, 1978). This meeting others, or being alongside others, is so intimately tied to worldly existence that it is something we often forget to take into account in the conduct of our everyday lives. It is the others amongst whom we live who are the arbiters of social norms and mores, who determine in general how one behaves, the way in which things are done. On a more personal level, it is amongst the others in the

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world that we find our family and our workmates, encounter support or rejection, and choose our friends.

This paper focuses on the effect that chronic schizophrenic illness has had on the social encounters and relationships of 10 adult sufferers. The material from which the paper is drawn was part of a larger phenomenological study examining what life is like for people suffering from schizophrenia who are well and live in the community (Walton, 1995). Aspects of this larger study have been published elsewhere (Walton, 1999). While schizophrenia has a profound effect on all dimensions of a person's life, this article concentrates on one aspect in particular: the way in which the illness has impacted on participants' social interactions and their relations with others.

The devastating nature of schizophrenia is well recognized (e.g., Schultz & Andreasen, 1999). Yet it is also beginning to be acknowledged that once the acute illness is resolved, people with schizophrenia are often able to lead functional and useful lives in the community (Nikkonen, 1995; Walton, 1995, 1999). In this respect some people with schizophrenia may lead lives that are similar to those of non-sufferers, at least in terms of many of their everyday concerns. On the other hand, there is also a growing literature that acknowledges the disability that a schizophrenic illness may bring. For example, Bachrach (1986) says: "Undoubtedly one of the major benefits of deinstitutionalization programming is our growing understanding of the chronically mentally ill as individuals who have disabilities that transcend and complicate their illnesses" (p. 981).

Bachrach (1986) describes three levels of disability typically endured by the mentally ill: firstly, psychiatric impairments or dysfunctions considered symptoms of the illness; secondly, adverse personal reactions that stem from the experience of the illness rather than from the illness itself; and thirdly, social disablements such as stigma, poverty, or unemployment that result from societal responses to illness and disability. So while people's hopes and ambitions, and indeed their achievements, may be similar to those of people without a serious mental illness, their lives are framed against a backdrop of difficulty.

In this paper my focus is on the relational aspects of chronic schizophrenia illness as the study participants experienced them. This is an area about which little has been written. While we know a considerable amount about the effect of caring for a family member with a mental illness (e.g., Jeon & Madjar, 1998; Loukissa, 1995; Karp & Tanarugsachock, 2000) and about the importance of social support for those with chronic mental illness (e.g., Bradshaw, 1998; Clinton, Lunney, Edwards,

Weir, & Barr, 1998; Rosenheck et al., 1998), little evidence was found in the literature of research that reports sufferers' own perspective on the relational impact of a schizophrenia illness. Given the widespread acceptance of the need for care focused on the whole person, and the emphasis on the nurse-client relationship in mental health settings, this is an area of real interest to nurses.

A small number of studies have examined the subjective experience of people with schizophrenia who are no longer acutely ill and who are living in the community. From these studies we have some indications of the social impact of the illness.

A group of British researchers conducted a follow-up study of 532 patients discharged from hospital care in Harrow over a 10-year period. Summing up their findings, Johnstone, Frith, Leary, and Owens (1991) comment on the heterogeneous nature of schizophrenia and how this was evident in the lives and characteristics of the people they followed up. While not all the patients had fared badly, unemployment was common, as were social difficulties and a restricted lifestyle.

Leary, Johnstone, and Owens (1991) focused their study on social outcome, and they elaborate on the socially impoverished lives they discovered. In the month prior to their study, 13.8% of the participants had not done any shopping and 44% had not entered a social setting (such as a café, cinema, or church) where they might make contact with others. Even more disturbing, during the same 1-month period over one fifth of the participants (22%) had had no visitors. It is noted that 73% of the people interviewed were inpatients at the time, but the picture of a less than fulfilling existence for all these people is clear. For people with schizophrenia, sometimes it is problems arising from the social dimensions of life that lead to rehospitalization, as was found by Hicks (1989).

While living in the community is often difficult for people with schizophrenia, it is the preferred option for many, including the participants in Norman and Parker's (1990) study and for the 48 discharged long-term psychiatric patients in a quality-of-life study conducted by MacGillp (1991). Living in the community is desirable because it is ordinary (Lorencz, 1991). Lorencz used a grounded theory method to examine the process of leaving a psychiatric hospital as described by four men with schizophrenia. As Lorencz points out, "becoming ordinary" is not a common aspiration amongst adults, but for these men it was a mark of success, signifying their becoming "normal, productive community members" (p. 199).

Barham and Hayward (1991) used semi-structured interviews to ask 24 people about the personal and social consequences of schizophrenic illness. The participants spoke of their experiences of exclusion and of structural constraints that interfered with access to good housing, employment, and social life. They talked of poverty and the difficulties they had in accounting for themselves to others in a climate in which they had to battle against psychiatric ideology, professional expectations, and social prejudice — areas in which others had limited expectations for them.

A phenomenological study that examined mentally ill clients' perceptions of their illness and its effects on their lives is reported by Vellenga and Christenson (1994). The participants had lengthy histories of mental illness (most had a diagnosis of schizophrenia), which both they and the researchers judged to have restricted their ability to function in their environment. Four themes are reported as reflecting the participants' lived experience: stigmatization and alienation, loss, a pervasive feeling of distress, and acceptance — the last entailing self-acceptance and a recognition of the need for acceptance by others.

Study Design and Method

The research on which this paper is based was a Heideggerian phenomenological study that set out to examine the experience of 10 adult schizophrenia sufferers living in the community in New Zealand and well maintained on medication (Walton, 1995). The research question was *What is it like to live with schizophrenia?*

Ethical approval for the study was gained from the university at which the researcher was then working and studying. Because of their mental illness, all of the study participants might be considered to be especially vulnerable. Consequently most participants were sought through a third party, a field worker with the Schizophrenia Fellowship in the area. However, three participants self-selected, volunteering to take part in the research after hearing about it in their local communities. One advantage of using an intermediary was that the participants had someone with whom to discuss their involvement (and who could act as an advocate if they wished), while I had someone with whom I could raise concerns if I were extremely worried about the health of any of the participants.

Ten adults — seven men and three women — took part in the study. Their ages ranged from 21 to 64 years. Some participants were working, either in a paid or voluntary capacity, while others were

unemployed. Occupations included an artist, a writer, an academic, and an educator. All participants had been diagnosed as suffering from schizophrenia at least 2 years before I met them, and all were living in the community, most in their own homes. Four were in supervised or supported accommodation. Most had had several episodes of acute illness and one had lived with his illness for 40 years. All regularly took some kind of antipsychotic medication. No distinction was made concerning diagnostic category other than the broad diagnosis of schizophrenia. What was sought was a range of different stories from people who had lived the experience and were willing and able to talk about it.

Participation in the study was based on informed, written consent. The usual principles of anonymity were outlined, and in reports of the study pseudonyms are used.

Data collection involved unstructured audiotaped interviews. As researcher I quickly learned that the topics of conversation would largely be dictated by the participant rather than by me. I also kept field notes throughout the 16 months of data collection, about my impressions and reflections and the various interactions that the participants and I shared.

I visited participants between three and 10 times each over the course of data collection. In total I collected 57 hours of transcribed interview data and spent approximately 80 additional hours with participants, during which time our conversations were not recorded. Multiple sources of data are used in phenomenological research. While the primary data source was interviews with the study participants, I also collected or was given a variety of art works and written material. Several interviews were held with others (family members or friends) whom the participants had invited to be present. Some participants asked me to drive them somewhere or to walk with them to the shops or out for coffee, and on these occasions I had the opportunity to observe them in other surroundings and to watch how others interacted with them. These supplementary data sources proved particularly useful in stimulating the dialogue with the primary data that is characteristic of phenomenological analysis (Benner, 1985).

As van Manen (1989) explains, phenomenology involves identifying a phenomenon of concern, recasting this concern as a question, and then undertaking various kinds of interrogation of the phenomenon in order to elucidate its nature and meaning. To this end, data analysis involved a lengthy period during which I familiarized myself with the data, asked questions of the data, and wrote and rewrote descriptions

in order to capture the phenomenon of interest. I was guided in this process by van Manen's (1990) work and by Heidegger's (1927/1962) description of the phenomenological project.

Findings

It is clear in the larger study from which this material is drawn that each of the study participants lived with their own history. The facts of having been unwell, being diagnosed as suffering from a schizophrenic illness, and continuing to take medication were part of their lives. As will be shown below, encounters with others during their illness, treatment, and subsequent lives were a significant part of the participants' experience.

The data are presented under six themes: living with the prejudice of others, being fearful of others, feeling uncomfortable in the company of others, staying engaged with others in the world, depending on others for help, and finding others who understand. Limitations of space mean that the phenomenological description cannot be presented in full, but I believe that the description presented here is adequate to illustrate to nurses and other health professionals the importance of the social and relational dimension in this most disturbing illness.

Living with the Prejudice of Others

Each of the participants made reference in some way to the prevailing social climate and the manner in which people with mental illness are perceived by society. Stigma and prejudice were acknowledged to be a part of life for anyone with a history of psychiatric illness. There were instances, however, where the injustice of this situation — of suffering from the prejudice reserved for a particular group — was taken and felt personally. The injustice of being judged or pre-judged without an individual hearing was clearly expressed by Jack:

I've gone out to the mailbox to get mail and two young kids, boys, have been walking down the street...you can't blame the children, they don't know anything about the world, but their parents have been talking, and they took off flat stick down the road: "Look out, the madman's coming." See, that's not helpful. It's ignorance, I know that. Well, it doesn't do me any good 'cause I've never been in trouble with the law, see, I've never broken the law... There's no disgrace in any disability of any kind, the disgrace is in what's done about it, and you could talk for hours about that side of things.

Jack's concern with the law was repeated during several of his conversations with me. He went on to point out that, as he saw it, he was vulnerable to the law even when he had not broken it:

If you've got a broken arm, no problem — well, apart from the broken arm. But if you've got schizophrenia, well, you're broken up here [taps his head] but you have the social disability too, because a lot of people don't want to know you. If you're...mental health...they don't want to know you, and then of course the law is a little bit...it's some resemblance to the Dark Ages, isn't it? I mean, they persecute you because you have one particular kind of disability. Schizophrenia or manic depressive or whatever. They do penalize you for it. The police can walk into this house and, say, put me in jail and take me before two doctors and put me in a mental hospital if they are so minded, if they're of the same opinion. That is the law. Not because I've got a broken arm or because I've been down and got a pound of sausages. Because I've got nerve trouble. I've been persecuted because I have a different kind of ability [sic] to what some people have got.

During the period in which data were collected for the study, publicity regarding psychiatric patients was running high. Michael's comments illustrate his concern about statements in the press, a concern that was shared by most of the participants:

When you read about schizophrenia in the newspapers now, there's always something negative attached to it — well, nine times out of ten anyway...this is how people form the impressions in their mind that schizophrenia means something bad and wrong and things like that.

Below, Nick sums up his beliefs about how people see those with schizophrenia. While he does not explicitly relate the inferred prejudice to his own case, he does divorce himself from what he perceives to be the public view:

Oh...they think that they're all nutty and they should be locked up, you know, like at [the hospital] probably...and people think that, oh, they're just losers and all that...they're no good and all that. But it's not true... People with psychiatric problems have feelings too, you know, they live every day...and I think people are just a little bit...they just maybe like to give them a hard time or something...or they can't do anything or all that, you know? I think that people with mental problems have feelings too...they like to be...do well in life...

In this extract Nick uses the word *they* to refer to both people with schizophrenia and the public at large. The public *they* to whom he refers may be equated with Heidegger's *das Man*, translated as one, anyone, or they. *They* are the others who make up the anonymous public understanding, who set the standards for the way one behaves, speaks, and conducts oneself (Frede, 1993).

The stigma and prejudice that colour the general public's understanding of schizophrenia had specific effects on the everyday lives of the participants. Several people spoke of the difficulty in finding suitable housing that is common to people with psychiatric illness. Others had had to face the question of "coming out" — a term I have borrowed from the gay movement — at work or among friends. As large psychiatric hospitals are closed and more people with psychiatric illness are seen in the wider community, it is likely that stigma based on ill-informed notions of what mental illness means will begin to fade. Similarly, and here the parallel with the gay movement is strong, the more people who admit to mental illness, the more visible and thus unremarkable the condition will eventually become. While several participants recognized that being open about their illness would help increase the visibility of mental illness and thus eventually help reduce the stigma, the urge for self-preservation is strong, and participants voiced their concerns and reservations over telling people about their health problems.

Being Fearful of Others

During acute periods of illness several participants had endured extreme difficulties in their Being-with-others-in-the-world. While some of these experiences might be categorized by clinicians as delusional, they were an integral part of the experience of the people concerned and were neither felt nor interpreted as anything other than real. Nick had had to leave an overseas trip and a blossoming romance because he was threatened by a man he did not know and whose actions he did not fully understand. He continued to find people unpredictable and frequently quite threatening, and related several anecdotes regarding the way he had been shouted at in the street, or how strangers had made obscene and frightening gestures towards him, for reasons he did not understand. He had had to alter several aspects of his daily routine such as his cycling route to avoid some of these people. Whatever judgement might be made by others regarding the reality of each of these events, they were real experiences for Nick.

After treatment during an acute episode of illness, Judith found she was often unwilling to talk to others. She feels different now, but remembers that when she was unwell even shopping became an alarming experience for her:

I can remember that we used to walk down to the supermarket and get our groceries, and this was when I was into the zodiac — I was into spiritual stuff, and I still believe in it, I still believe that there is something

there. But I remember I used to walk around, and I'd know that these people were looking at me. I used to get really paranoid, and they were all dressed in black, and I thought...that's why I used to freak out so much, because I used to think someone was after me, and that's what it was like. Everybody was dressed in black. I thought that there was somebody after me...and I said to David [her husband], "Why do they keep staring at me?" and he said, "Why, what's going on?" and I said, "I feel as if there's a hit after me." That's what it was like. The voices were like that: "We're going to get you."

As Judith indicates here, her experiences of being afraid had ramifications for her relationship with her partner, from whom she could not hide her fears. His supportiveness was something she acknowledged frequently. Judith also mentioned voices. The voices were **of others**. Whenever any of the participants heard voices in the acute stage of their illness they were related to other people. It was not until recovery had begun that voices were recognized as generated by their own thoughts. Thus, if the message given by the voices was a frightening one, other people were interpreted as intent on doing some harm. Participants had reason to fear other people in this circumstance.

Jack had never heard voices but he too expressed a fear of people. In fact this was what his illness was about as he saw it: he was vulnerable to people.

Yeah, I've been diagnosed as that's what's wrong with me. By one psychiatrist. Fear of human beings. You know how you have fear of heights and fear of open spaces... I have fear of people. I hardly ever mix. Well, I do mix if I think a person's Christian and all love, it doesn't worry me too much. But if I...for instance, I don't like going down the supermarket. I hate it. Just hate it. I'm all right at the beach with a special cobbler, all day...I don't mind it. But I don't even like walking... I'm walking up the street...there's people coming, quite often I cross over to the other side. That's what I mean. I've always been like that, even at school, school dances and all that. I was in my element deer stalking way up in the bush...inhabited areas are not my cup of tea.

Roger had recently joined a local church group where, in contrast to many of his other experiences, he felt the people were very kind. As a result he now said of himself, "I'm not as scared to meet people as much as I used to be, which is a good thing. And I want to meet people, I want to help somebody, through the church somehow." I asked him what had helped him overcome his fear. "They're kind. They're kind. The people are kind. They don't look at you like you're a dog because you're mentally ill. What's been and gone or what's going to happen. They're interested in what's happening now." He went on to explain how this had affected his behaviour:

I've only been with the church two months, and I've come from the back row of the church right to the front, sitting at the front of the church...and listening right through the whole session, instead of running out. I mean, that's how I was when I first started. I couldn't sit down at the start there. Frightened of the people, that's what I was...

Roger's fear of others and the success of his own efforts in dealing with his fear have some important implications for nursing. There is a real need for nurses to acknowledge the fear of others experienced by those with schizophrenia and to help people like Roger to deal gradually with their fear and discomfort.

Feeling Uncomfortable in the Company of Others

Less intense than fear of others, yet more common among the participants, was an expressed feeling of being uncomfortable in the company of others. This feeling took a variety of forms. Some participants found it difficult to meet new people, some to establish relationships with the opposite sex, some to sustain friendships or to set limits within them, some to be physically in the company of others in any but a casual way such as that which occurs when shopping or drinking at the pub.

Lucy was a sociable young woman who usually enjoyed the company of friends and family. As she recounts here, however, feelings of paranoia have lasted beyond her acute illness and impact intensely on her feelings of security and self-confidence:

And it's still terrible when you hear people laugh when you walk past. You think, shit, they're doing it to me. That happened all the time. And I don't think it's being paranoid. I really, really don't. If somebody laughs when you walk past, they're not laughing 'cause they're telling a joke — they're laughing 'cause they're laughing at you.

Simon felt that the very fact of having experienced an acute schizophrenic illness changed his view of the world and his outlook on life (Walton, 1999). This in turn had an effect on his relationships with others. On a more pragmatic but no less important level, Simon had an ongoing sensitivity to noise. He described how this interfered with his everyday life with others:

I think there has been an enormous cost in terms of personal relationships, which I don't know if I will ever resolve. It's partly because an experience like that [acute illness] puts you on a level of seriousness that frightens most people, I think. And partly it is on-going problems of extreme sensitivity to noise, and too much talking and so on. Most of the circumstances in which you meet people shut me out. So it's a bit of a dilemma about

how to get social fulfilment without getting overwhelmed by too many noises and impressions and so on.

Simon also recognized that schizophrenia often begins during the critical years when people are learning to conduct social relationships, which could mean that young people might be less socially adept than their peers. While no other participant made this observation quite so clearly, several did suggest that they had "lost" periods of their teenage years or their early twenties.

Staying Engaged with Others in the World

Whatever difficulties they encountered in living with others in the world, all the participants made an effort to stay engaged with others on a personal level. Each had a circle of friends, family members, or acquaintances with whom they made regular contact. Staying engaged with others meant making contact with others, sustaining the relationships they found rewarding, and taking a stand on matters of debate when the outcome mattered to them.

The wide range of talents, living circumstances, and ages of the participants was reflected in a correspondingly wide range of personal social circumstances. Those who worked in a paid or voluntary capacity talked of sustaining relationships related to this aspect of their lives. One participant, Adrian, had deliberately chosen work that he could conduct from home in his own time, thus avoiding some of the pressures he had previously felt from co-workers and bosses. Several of the participants who were not employed spoke of pressure from others as one of the factors they could not handle and identified such pressure as a reason for their not working at present.

Family was an important source of social contact for each of the participants. It was from family that they received much of their support and to family that they turned for feelings of usefulness. The everyday relationships of participants with their family members and friends were described in ways that were unremarkable. It seems that, on the whole, these were relationships that just carried on as do the relationships of those who have never suffered from mental illness.

Depending on Others for Help

Each participant had been deeply affected by the experiences that constituted their acute illness. Each had spent time with health professionals when their diagnosis was made and prior to that time, and had

maintained contact with people in the health service ever since. The kind of experiences these contacts turned out to be was dependent to some extent on the age of the participants and the severity of their initial illness.

As the oldest of the participants, Jack had some of the most disturbing stories of hospital life; he was hospitalized in the era of large hospitals and unmodified electro-shock therapy. Jack remained fearful of health professionals until they proved their trustworthiness, and was acutely aware of their potential power over him, which is not surprising given the past with which he lived.

In general, participants appreciated health professionals who were honest, friendly, kind, and helpful, especially when the help was of a practical, problem-solving nature. Actions that were perceived as controlling were not appreciated. As an example of the latter kind of intervention, Liz describes the way she and her boyfriend, while living in a supervised hotel, began to dislike being told what to do or having to ask permission to go out:

We sort of started to pull away from the situation where we were told what to do every day, and could we go out to the dairy [corner shop] and get ourselves a packet of cigarettes, you know, and...generally what time we went to bed and...what we did and where we went and who we were seen with. She [nurse] never really lets go, you know, she sort of always treats you like a patient or something like that and you just...you just want to rebel, or that's how I felt.

One of the important areas in which health professionals were seen as helpful was in encouraging participants to socialize with others. Simon suggested that he would have liked his doctor to model friendship for him, to help him learn what constitutes a successful friendship. Liz acknowledged the help that nurses had provided in teaching her to get on with others while she was in hospital:

We were sort of taught that socializing is very important... I mean, you can just sit there and say nothing and just smoke and drink coffee and just sit in the corner or something, but...once you start asking questions about yourself you start asking questions about other people as well, so you start to take in what's happening around you rather than what's happening in your head all the time. Because it's the easiest thing in the world to go and lie on your bed and just sort of do nothing.

In some ways, then, health professionals not only formed part of the participants' social world, but also encouraged them to stay engaged in the world in a wider sense.

Finding Others Who Understand

Although relationships with health professionals were seen as positive on the whole, the majority of the participants had another, perhaps more important, source of comfort and support. It was with others who had undergone similar experiences that they felt most at ease.

It is not surprising that people who have undergone the traumatic experiences that are part of serious mental illness and treatment should get to know each other and become friends. They not only share some common history but also meet each other in hospital, in community treatment, or at group meetings. As Chris said:

We've been laid bare in front of everyone. Our most secret thoughts, we've blurted them out, there's nothing secret any more. And that's another thing about being with other schizophrenics in a club or something...we're all relaxed, we're all relaxed, there's nothing we can do that could be more embarrassing than the things we've already done.

Liz lived with her partner, who also had a schizophrenic illness. She found that many health professionals tried to discourage their relationship, on the basis that they each needed "normal" friends. While she agreed that it was sensible to mix with people who were not unwell when the opportunity arose, her relationship with her partner was important to her and they planned to marry in the next 2 years or so. Liz expressed some exasperation at the way in which people who were in the role of helpers frowned on this relationship. She saw her relationship as comparable to any other.

There were also drawbacks to having friends who suffered from a psychiatric illness. Several participants reported having become very involved in the problems of their friends, sometimes not knowing how best to help them, and several had also experienced the grief that accompanies the suicide of a friend or acquaintance. Also, as Simon pointed out, the fact of a common illness is not a basis for any kind of relationship — each person with a schizophrenia illness is first and foremost an individual.

Conclusion

Being-with-others is an integral part of Being-in-the-world. All participants found some of their relationships with others difficult. Not only did they have to contend with prejudice, of which they were often painfully aware, but often there was fear of other people or accounts of being uncomfortable in their company. Some of the fear or discomfort

felt by participants was related to social attitudes. In other instances it was related to paranoid ideas, reticence, or the ongoing physical or metaphysical effects of the illness.

But in spite of their discomfort, because participants recognized that it was important to stay engaged with others in the world, they worked hard at maintaining relationships they found helpful and sustaining, and actively sought relationships with others who were able to understand their experiences and difficulties. Illness and continuing treatment meant that there were times when the participants depended on others for help, either during an acute episode or on a continuing basis, or both. As all people do, the participants treasured relationships in which they felt understood but worried about, or avoided, those where they were met with unkindness or misunderstanding.

Thus participants struggled with a range of social problems related specifically to their illness and with difficulties that stemmed from the reactions of others towards them. They meanwhile desired, sought, and valued relationships in which they felt safe and understood.

It is important for nurses and other health professionals to recognize that they form part of the relational world of people with chronic mental illness. Their professional focus also enables nurses and others to assist clients in dealing with their other social interactions. This is a privileged position.

The current trend towards health promotion rather than an illness orientation for those with chronic illness is a significant movement in the health-care field, and one of real interest for nurses (e.g., Lindsey, 1996; McWilliam, Stewart, Brown, Desai, & Coderre, 1996; Price, 1996). Understanding the client's experience is fundamental to a shift towards such care. The suggestion by Karp and Tanarugsachock (2000) that the mentally ill "inhabit phenomenological worlds that are inaccessible and incomprehensible to healthy people" (p. 7) simply does not apply when the illness is not acute. Understanding and insight are possible, and it is my firm belief that through these, better helping relationships will be forged and healthier, happier lives enabled.

Nurses who are willing to try to understand the client's experience of illness, to recognize the client's fears and aspirations, and to appreciate the rugged social and relational landscape their clients inhabit are in a position to make a real difference to their clients' lives. Such understanding might allow nurses to help clients better meet the basic human need for satisfying connections with others.

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