SELECTED ASPECTS OF NARRATION IN THE INTEGRATED CARE OF PATIENTS DIAGNOSED WITH SCHIZOPHRENIA

Patrycja Zurzycka[A,B,D,E,F], Katarzyna Wojtas[B,D,E,F]

Department of Clinical Nursing, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Medical College, Krakow, Poland

Authors' contribution:
A. Study design/planning • B. Data collection/entry • C. Data analysis/statistics • D. Data interpretation • E. Preparation of manuscript • F. Literature analysis/search • G. Funds collection

Address for correspondence:
Dr. Katarzyna Wojtas
Department of Clinical Nursing
Institute of Nursing and Midwifery
Faculty of Health Sciences
Jagiellonian University Medical College
Krakow, Poland
e-mail: katarzyna.wojtas@uj.edu.pl

SUBMITTED: 14.04.2023
ACCEPTED: 09.05.2023
DOI: https://doi.org/10.5114/ppiel.2023.130712

ABSTRACT

Narrative has found application in medicine and the art of healing. Its particular importance can be shown in the integrated care of patients with mental disorders, practiced by both physicians and nurses. The experience of mental illness resulting in a change of the patient's lifestyle builds an extremely rich human story, heard in the patient's narrative, which allows the patient to be perceived holistically. The resulting respect for the patients' individuality and subjectivity in the narrative, emphasizing their functioning in various dimensions, showing empathy is essential in caring for people who, due to psychopathological symptoms, are unable to interpret and perceive reality on their own, express emotions, or take care of their basic needs. The aim of this paper is to present selected narrative issues in the integrated nursing care of a patient with diagnosed schizophrenia.
Key words: schizophrenia, medicine, narrative.

INTRODUCTION

The progressive development of medical science, especially in the instrumental and technical dimension, often marginalizes the holistic perception of the patient's needs and the recognition of medicine as an art. One of the solutions to prevent this trend is the introduction of narrative into patient care [1-4]. Narrative in medical science is based on recognition of the patient's story, acknowledgement of its uniqueness, and demonstration of care, empathy, and genuine interest [5-8]. Narrative, based on noting non-medical aspects of patients' functioning and experiences situated in a broader social context, allows for the implementation of holistic care [5, 7-10] and emphasizing the patient's subjectivity [3, 4]. Narrative captures information about the patient's condition in relation to the biographical, psycho-social, and cultural background. In addition, it plays an important role in the communication process, data collection, and prevention of professional burnout and allows for the best therapeutic approaches. Other views of narration sensitize to the need for involvement of both the patient and the physician, as well as to the difficulties in its conduction, conditioned by the personality traits of the members of therapeutic team, the intrusion of information from the patient, or orientation of the relationship mainly to psychosocial needs [11]. Narrative has become a subject of increasing interest in qualitative research in various fields of nursing. Narrative methods emphasize the value of the patient's story, the importance of trust in forming a relationship, and are evidence of patient-centred care [11]. Narrative, considered appropriate for nursing research, allows us to study the patient's stories heard and their social functioning in relation to the meaning attributed to life experiences [12].

Nursing care is conditioned by an assessment of the patient's condition. Assessment, the basis of nursing diagnosis, includes collection of data, identification of problems, establishment of care priorities, goal of action, and undertaking and reviewing appropriate interventions [13-15]. A multidimensional assessment that takes into account the narrative aspect is crucial in addressing all patient needs in nursing care [13, 16]. The assessment of the patient's condition in the narrative-based integrated nursing care model includes the biophysical, psychological, socio-relational, and spiritual dimensions of the patient's functioning. An important element in this assessment is dialogue (provision of information) through collaboration between members of the treatment team. Integrated condition assessment combines elements of assessment based on quantitative tools, such as question-

naires, scales, tests, surveys, and qualitative tools, i.e. the patient's interview and narrative. This allows the combination of objective assessment methods with elements of subjective insights [13].

The aim of this study is to present selected narrative issues in the integrated nursing care of a patient with diagnosed schizophrenia.

METHODS

The paper is the result of analysis of literature available in the following databases: Medline, PubMed, and Google Scholar.

RESULTS

Narration in nursing care

Listening to the narrative allows us to find out about the person's functioning in many dimensions, which is often overlooked in the classical bio-medical approach. The narrative approach assumes that the dynamics of life experiences affect a person's being [14], and reactions to life changes (including changes in health) capture the patient, not just through the lens of a disorder and observations of biological parameters [17-20].

The goal of narrative approaches as practiced in medical care is to "hear" a person's story and pay attention in daily nursing care to the life experiences and broader needs of patients [17]. The narrative approach plays a key role in achieving quality nursing care [17], ensures safety, and increases patient trust with members of the treatment team [17, 21]. In addition, engaging in narratives can condition professional and personal development of professionals by increasing their ability to reflect [20, 22, 23].

In nursing, despite the dominance of bio-medical-technical aspects in the practice of a profession, there is a tendency to return to the humanistic trend and to recognition of the importance of narrative issues [17], active listening, questioning, taking into account the role of non-verbal communication, noticing the context of statements and the patient's environment [14, 24, 25]. Nurses, due to the nature of their relationship with patients, have the opportunity to listen to their stories, understand their needs more fully, and make appropriate interventions [17]. The opportunity to learn about diverse narratives facilitates the realization of holistic and individualized care, show concern and support [23, 24], and enhances self-development as well as reinforces professional values [23]. The story told by the patient, regardless of the theme addressed, is accompanied by the communication of various emotions, which also build up the way of presenting the experience and subjective perception of the world [17]. Narrative emphasizes patients' individuality, specificity of needs, subjectivity, and positioning at the centre of care process. Storytelling allows us to perceive new or previously marginalized areas and to reformulate our feelings or beliefs (reconstruction of a new identity) in the course of reflection and self-reflection [14]. The stories presented by the patients are a selected (consciously or unconsciously) part of their lives and can therefore take the form of fragmentary statements that do not form a defined plot. Thus, conducting a narrative interview with a patient requires the ability to actively listen, initiate the conversation, and interpret the received message. A narrative-based interview provides increasing insight into the patient's history, experiences of health and illness, and choices made [14, 25, 26]. During the interview, the temporal aspect is crucial, due to the patient's placement of events in the past, present, or future. It is also essential to take in the feelings, desires, values, beliefs of the person, social relations, living conditions, physical environment, or conditions of the health care system. The context of narrative should not be forgotten, which has a significant impact on the experience and thus its representation [14].

Integrated nursing care – analysis

Combining the concept of evidence-based nursing with the narrative-based nursing care model is a major challenge. The factual approach stems from logic, disease focus, rationality, and objective methods of measurement. Reference to narrative takes into account subjective assessment, individuality, and interpersonal relationships with regard to the patient's current health situation. Artioli *et al.* proposed combining these seemingly incompatible models into a single paradigm of integrated and multidimensional narrative nursing (the phrase is given after the author) [16, 27]. This concept is based on positivist, interpretive, and methodological paradigms that integrate quantitative data with subjective information from the patient and family, systemic conditions, and changes caused by pathology or illness. The approach uses both quantitative tools (scales, evidence-based practice) and qualitative tools – narrative, autobiography, broad social context, structural and cultural aspects of the patient's functioning, and ways of coping with the disorder or disease. This holistic view of the patient's enables targeted assessment, formulation of a diagnosis, and appropriate action [16, 27].

Narrative issues constitute part of the comprehensive analysis called Integrated Narrative Nursing Assessment (INNA). This assessment answers the question of who the patients are, what their needs are, and how they subjectively experience the illness (including consideration of reactions and adaptations to illness or disability). The comprehensive (integrated) analysis takes into account the patient's emotions, subjective interpretations, expectations, and

values in relation to their socio-relational situation [13, 27]. The questions posed by the nurse deepen the personalized observation and research conducted [13]. Nursing assessment combining elements of traditional quantitative assessment with qualitative narrative methodology enables holistic cognition of the patient [13, 17, 28] and enhances the patient's sense of being understood [13, 28]. In the above model, the concept of assessment is a multidimensional process of thinking and acting, not only because of the interconnectedness of the patient's functional dimensions, but also the use of a wide area of specific knowledge [14, 17]. Narrative-based care planning involves several steps. The first is the assessment of needs through qualitative data analysis, including the patient's narrative. Narrative diagnosis concerns the interpretation of narrative, conditions associated with it, and non-verbal communication. Through interpretation, the most relevant problems of the patient are identified, including those not directly verbalized by the patient (general condition, nonverbal behaviour, and relational aspects of the patient's intersubjective encounter with the carer). The next stage is the interpretation of the results (measurement scales, assessment scales, tests, or questionnaires) necessary for the overall care process. The final stage of assessment is integrated analysis, i.e. identifying the patient's needs, the individual as well as social resources available to the patient, and the situational context [28]. Narrative is a challenge for nurses, but it is an important element in nursing care and education [29]. It allows for the implementation of personalized education, facilitating the patients' and their families' understanding of the disease, therapeutic recommendations, and building a sense of self-efficacy in managing the disease, as well as developing skills for coping with life's difficulties [14].

Selected aspects of narrative in integrated nursing care of patients with mental disorders using the example of schizophrenia

Nurses can provide holistic patient care by fully understanding the patient's situation through narratives that relate to functioning in multiple dimensions. Narrative also allows for a better understanding of all mental disorders [30] and a holistic view of the patient experiencing mental illness, due to the patient's reference to his/her own childhood, disease symptoms, or social support [30]. It is noteworthy that nurses show the ability to reflect on the patient's subjectivity and needs when caring for them [31], but they also need narrative competence in order to help patients find their own story [32]. Narratives of people with mental health problems depicting mental health recovery can address both positive and negative experiences of illness. Positive aspects presented in the narrative include demonstrating hope, empowerment, levelling of stigma and negative aspects include pessimism [33] or feelings of loneliness, disappointment, uncertainty, or rejection [34].

The premise of the narrative model in nursing care is that nurses attempt to take the patient's perspective using communication and active listening to level the experienced negative emotions related to the disease, feeling stigma, or building motivation [35].

The literature points to care approaches in the narrative model. It seems that the scheme of narrative model in care for patients with somatic diseases can also be used in the care of patients with mental disorders. Therefore, an attempt has been made to present an integrated model of care for patients with schizophrenia with a view of selected aspects of the narrative presented by Wang *et al.* [35] preceded by a characterization of the narrative of patients with schizophrenia.

Narrative features of patients diagnosed with schizophrenia indicate incoherence [36] and disintegration "at the pragmatic, semantic, and formal-grammatical levels" [37, p. 14]. The causes of disturbed narrative are psychopathological symptoms shaping the disease picture, present in the form of cognitive disorders and affect disorders, such as delusions, neologisms, splitting symptoms, autism, apathy, and anxiety [38]. The disorganization of cognitive processes [39] experienced by the patients conditions their perception and interpretation of reality [40, 41]. The narrative shaped in this way is extremely difficult to accept by the environment due to the unusualness of content which may arouse fear or even anxiety of the surroundings [36, 40]. Experiencing delusions and their presentation in the patient's view as a narrator is consistent, obvious, and unquestionable, but for those around them, it is evaluated in the context of reality and treated as a disease symptom [41]. Psychotic experiences may not take into account the time frame, the entire context, or the full fact of the event in question, but they are accompanied by a strong emotional charge [42]. Therefore, it is extremely important to use therapeutic behaviours and techniques such as making things real, expressing doubts, ordering events in time, clarifying, or seeking consensual evaluation [43]. It is worth noting that patients' narratives aim to make sense of the experiences they face and often capture ways of coping with psychosis [42]. Analysing the narratives of people showing psychotic disorders can provide information not only on how patients perceive the world, but also on what difficulties they experience [40].

A narrative approach must always include a time and place for direct conversation with the patient, creating a sense of freedom of expression and an atmosphere of confidentiality. The conversation should not be scheduled during mealtimes, rest periods [35],

therapeutic activities, family visits, and other activities on the ward that direct the patient's interest. It is worth pointing out that conducting the narrative by a single nurse can prevent falsification of information, and therefore it is worth planning how many meetings per week and for how long the nurse can work with the patient in this way [35].

In the narrative approach in nursing, special attention is paid to gaining trust from the patient [35]. Contact with a person suffering from a mental disorder sensitizes that the patient very often, for the first time in a conversation with a professional, speaks about their experiences [44]. This stage of narration can use open-ended, non-suggestive questions [35] or statements by the nurse that qualify as therapeutic behaviours such as offering oneself, allowing a wide opening, reflecting or exploring, and encouraging continuity [43]. Building trust requires the nurse to have an attitude of respect towards the patient, avoiding categorizing the patient's problems aimed at diminishing them, for example. Active listening and accompanying the patient requires not only aptly asking questions and not interrupting speech [35], but also conducting targeted observation to assess nonverbal signs indicative of the patient's general condition [43]. Indeed, the psychopathology of schizophrenia may be evident in the expression shown, body movements, or behaviour [45]. The nurse, in contact with the patient using verbal and nonverbal communications, directly confirms empathic understanding of the patient's situation and acceptance of his/her emotional expression. The importance of communicating with the patient has already been emphasized by Nightingale, who pointed out that the nurse, when talking to the patient, should be available to the patient at all times and maintain "face-to-face" contact. Therapeutic communication further proves the consistency of action of all treatment team members and at the same time builds a positive patient experience [46]. Conducting a narrative also requires the nurse to reflect on his/her own emotions, beliefs, and attitudes toward the patient to see if they affect the perception of narrative heard from the patient [35]. The narrative heard can condition different nurses' reactions – direct reactions based, for example, on spontaneous non-verbal expression (smile, nod) or reactions based on the analysis of the patient's narrative; for example, directing the patient's attention to the fact of disease, symptom, which are not identical to the patient and do not define him/her [35]. The use of therapeutic behaviour such as modelling, encouraging comparisons, may be helpful in this case [43]. It is believed that narrative notes may have particular relevance in psychiatric nursing due to the documentation of collected data [47].

Analysing the patients' social situation or cultural background can help them to understand how these factors condition, e.g., their self-esteem, resources, and opportunities for action or beliefs. This stage of narration should be aimed at pointing out the patient's strengths, his/her determination to take action, or arousing motivation to take action. It is worthwhile, when asking questions, to encourage the patient to identify his/her strengths by using several adjectives [35]. Therapeutic behaviours such as planning, suggesting cooperation, or noticing changes can be used in this area of narration [43]. The narrative process should not be carried out without people from the patient's immediate environment if that is the patient's decision. The presence of significant people can be evidence of support [35].

The implementation of integrated care for a patient with schizophrenia requires involvement of all treatment team members from the moment of first contact with the patient, when the deficits and psychopathological symptoms present will prevent the patient from providing for his/her needs independently, including a sense of security.

Assessment of the patient's condition – the primary intervention by professionals in patient care – includes evaluation of cognitive functions, e.g. disorders of attention, memory, perceptual and thinking disorders due to content, course, and form of speech, as well as disorders of emotion, taking into account dynamics, type, or their saturation. This is complemented by the assessment of psychomotor drive disorders [45, 48], as well as the presence of suicidal thoughts and tendencies [45, 49], outward appearance, behaviour, contact with the environment, attitude to the disease, insight, and criticism [48]. Assessment of the condition is already being undertaken by paramedics, who are often the first to make it, not only during the course of a home visit, but also in a public setting following a call from family or bystanders. Within the scope of their competence, a nurse, for example, within the community care, can also decide on the necessary for hospitalization due to deterioration of the condition. The reasonableness or necessity of a patient's admission to a psychiatric hospital is posed by the examining physician at the time of admission. The nurse also assesses the mental and physical condition due to the gradation of diagnoses and the need to prioritize care. The condition is also assessed using scales: e.g. positive and negative syndrome scale (PANSS) examining the presence of positive, negative and general symptoms in the course of schizophrenia (delusions, hallucinations, thinking disorders, activity, self-esteem, emotions, affect and relationship with the environment, manner of conversation, physical complaints) [45, 50], the Schizophrenia Insight Questionnaire – "My Thoughts and Feelings", used to identify patients with a very low sense of insight into the disease, as well as to intervene during psychoeducation to obtain it by the

patient [51]. According to the authors, the tool can be completed in the presence of a nurse, who calculates the scores and reports the results to the physician [51]. The Brief Sense of Impact on the Course of Illness Scale identifies patients who have a low sense of impact on the course of schizophrenia and may thus have difficulty complying with medical recommendations [52]. The Schizophrenia Quality of Illness Scale (SQLS) examines subjective assessment of quality of life in subscales: psychosocial functioning, motivation and energy, and medication symptoms and side effects [53]. The Cognitive Screening Scale in Schizophrenia (CSSS), identifies cognitive impairments in the course of schizophrenia that reduce overall functioning [54]. The Consumer Experiences of Stigma Questionnaire (CESQ) directs attention to the experience of stigma of mental illness in the patient's daily life and relationships with the environment conditioned by the onset of the illness [55]. The Psychotic Symptom Rating Scale (PSYRATS) allows assessment of delusions and hallucinations; the scale can be used in clinical practice additionally assessing the severity of symptoms with psychological aspects. The scale can also be used in cognitive-behavioural therapy [56]. The Scale for Assessment of Positive Symptoms (SAPS) and Scale for Assessment of Negative Symptoms (SANS) assess positive and negative symptoms, respectively [57, 58]. The Clinical Assessment of Schizophrenic Syndromes (KOSS) scale assesses clinical symptoms of schizophrenia (KOSS) [59]. It is extremely difficult to estimate the risk of suicide in schizophrenia; the Schizophrenia Suicide Risk Scale (SSRS) can be used for this purpose, which is intended to assess short-term risk and does not identify individuals who will commit suicide, but it can identify those at high risk. Another tool is the InterSePT Scale for Suicidal Thinking (ISST), which assesses the severity of suicidal thoughts and tendencies in schizophrenia. Its design allows the assessment of suicide risk due to the presence of psychotic symptoms (hallucinations, delusions) [60].

If not all members of the therapy team can conduct surveys using the above tools, this does not imply that the data obtained in this way is invalid or unobtainable for them. The flow of information within the treatment team ensures that the results obtained are communicated, which can be used to plan interventions by all professionals, and it allows consideration of the patient in a broader context of his/her functioning.

The collected data, based on interviews, narratives, standardized tools, or laboratory as well as physical examinations, allow the patients' problems and needs to be identified, which, due to their condition, may not be expressed by them. The needs of individuals diagnosed with schizophrenia will be conditioned by the course and type of schizophrenia. Patients experience difficulties in communicating with the environment, loss of a sense of security, do not cooperate with the therapeutic team in the treatment process, and express low self-esteem due to the environment's reaction and lack of self-acceptance. They also appear to show aggressive behaviour, withdrawal from social interaction, and a lack of independence in decision-making and coping. Due to their current psychopathology, patients also experience sleep disturbances, activity limitations, and neglect of basic biological needs [38]. A situation of direct coercion in the form of immobilization deprives the patient of a complete opportunity to realize his/her needs, even if his/her resources in the cognitive and motor spheres would be sufficient. This is a situation in which the nurse provides for all the patient's actual and potential needs while preventing complications [38]. Exercising patient care always requires addressing the individual clinical situation, because the severity of symptoms may vary, and thus condition other interventions to provide a sense of security, stabilization, levelling of isolation and social exclusion, and support in emotional, informational and instrumental, spiritual, or other needs [38]. Among the interventions undertaken for people with a diagnosis of schizophrenia, psychoeducation is of particular importance, aimed at learning about the nature of disease, abolishing symptoms of social maladaptation, improving the performance of social roles or taking up new ones, as well as reducing the risk of relapse and improving life competencies and developing an individual concept of active coping [61]. Therapeutic-educational interactions are aimed at making the patient aware of his/her individual experience of schizophrenia symptoms, and at the same time drawing attention to the fact that similar experiences are had by other patients. However, patient participation in psychoeducation can be a difficult experience due to the patients' lack of motivation, lack of criticality, and self-acceptance as a mentally ill person, and because of negative symptoms or a sense of stigma and perceived stigmatization from those around them [61].

Schizophrenia is a chronic illness which has been recognized as one of the most severe mental illnesses [50], and ongoing periods of remission and exacerbation can and do make it difficult to fulfil social roles. The reactions of those around the person can vary due to disclosure of information about the disease by the person and lead to social alienation of the person with a mental disorder, involving withdrawal from contact with the patient due to lack of disease knowledge and to protect one's own emotions [62]. Some studies show that the patient's self-esteem is a basic element in the situation of coping with rejection and stigmatization, which is why it seems so important to support it. A special role in this area can be attributed to therapeutic interactions in the environment and the creation of conditions conducive to the develop-

ment of the skills and abilities of people with mental illness [63].

After discharge from the hospital, under community care, the patient's care in this model can be continued by assessing the physical and psychological condition and basic needs, and by evaluating their psychiatric rehabilitation. Within the psychiatric rehabilitation, it is possible to analyse, for example, the system of professional support, implementation of systematic pharmacotherapy, and the structure of non-professional support, or encourage the patient to participate in psychiatric rehabilitation programs [64]. The development of psychiatric care in Poland is definitely beginning favourably to build the range of various forms of assistance for people with mental disorders. There is a special role for Mental Health Centres providing assistance not only in inpatient day wards, but also in the patient's home environment [65]. Covering the patient with such a form of care is an opportunity for continuous assessment of their mental state by professionals, as well as interventions to prevent hospitalization or the decision to hospitalize due to deterioration, and the flow of information within the therapeutic team, and it provides the patient with a sense of security and stability because the patient's life and disease history are known.

CONCLUSIONS

The daily functioning of a person, independent of their state of health, is conditioned by an interaction of biological, psychological, social, cultural and structural factors, as well as life experiences, relationships, and social ties. Members of the treatment team providing care to people with a diagnosis of schizophrenia and other mental disorders are required to be particularly sensitive to the narrative heard, not only because of the complexity of problems contained therein, but also the possible suffering experienced, sense of rejection, sense of ambiguity of the surrounding reality, and the need to function not always in a supportive environment.

Consideration of narrative in nursing care centres around reflective practice and systematic evaluation of actions in the context of care provision. The process of reflective practice leads to improved interventions through an understanding of actions and processes inherent in narrative stories. Narrative practice in nursing requires openness to the other person, and the interview conducted allows for the expression of the patient's individual reflection, which, from a holistic perspective, can prove crucial to actions aimed at improving health. Integrated nursing assessment is based on the premise that assessment is not just a simple collection of information and its transcription, but also refers to the holistic treatment of the patient and the use of multidisciplinary expertise.

Disclosure

The authors declare no conflict of interest.

References

1. Zaharias G. Learning narrative-based medicine skills: Narrative-based medicine 3. Can Fam Physician 2018; 64: 352-356.
2. Liao HC, Wang YH. Storytelling in medical education: Narrative medicine as a resource for interdisciplinary collaboration. Int J Environ Res Public Health 2020; 17: 1135.
3. Pino Andrade R. Narrative medicine in medical diagnosis. Colomb Med (Cali) 2020; 51: e4339.
4. Ahlzén R. Narrativity and medicine: some critical reflections. Philos Ethics Humanit Med 2019; 14: 9.
5. Zaharias G. What is narrative-based medicine? Narrative-based medicine 1. Can Fam Physician 2018; 64: 176-180.
6. Charon R. Narrative medicine as witness for the self-telling body. J Appl Commun Res 2009; 37: 118–131.
7. Charon R. At the membranes of care: stories in narrative medicine. Acad Med 2012; 87: 342-347.
8. Baldwin C. Narrative ethics for narrative care. J Aging Stud 2015; 34: 183-189.
9. Barber S, Moreno-Leguizamon CJ. Can narrative medicine education contribute to the delivery of compassionate care? A review of the literature. Med Humanit 2017; 43: 199-203.
10. Potoniec M, Syzdek H. (Kon)tekst medycyny: o języku medycyny narracyjnej. In: Charon R, DasGupta S, Hermann N, et al. (Eds.). Medycyna narracyjna. Teoria i praktyka. Medycyna Praktyczna, Kraków 2020; 25-37.
11. Wieżel I, Naylor K. Wywiad narracyjny w badaniach pielęgniarskich oraz w opiece pielęgniarskiej – przegląd literatury. In: Wrońska I, Sienkiewicz Z, Wysokiński M, Fidecki W (Eds.). Wyzwania współczesnego pielęgniarstwa. Warszawski Uniwersytet Medyczny, Warszawa 2020; 7-24.
12. Joyce M. Using narrative in nursing research. Nurs Stand 2015; 29: 36-41.
13. Artioli G, Foà C, Cosentino C, et al. Integrated narrative nursing: a new perspective for an advanced assessment. Acta Biomed 2017; 88: 7-17.
14. Artioli G, Cosentino C, Taffurelli C, et al. The narrative interview for the assessment of the assisted person: structure, method and data analysis. Acta Biomed 2019; 90: 7-16.
15. Uchmanowicz I, Rosińczuk J, Kilańska D. Ocenianie sytuacji zdrowotnej pacjenta i jego środowiska. In: Zarzycka D, Ślusarka B (Eds.). Podstawy pielęgniarstwa. Tom 1. Założenia koncepcyjno-empiryczne opieki pielęgniarskiej. PZWL, Warszawa 2017; 272-276.
16. Artioli G, Foà C, Taffurelli C. An integrated narrative nursing model: towards a new healthcare paradigm. Acta Biomed 2016; 87: 13-22.
17. Beuthin RE. Cultivating a narrative sensibility in nursing practice. J Holist Nurs 2015; 33: 98-102.
18. Murphy JW. Primary health care and narrative medicine. Perm J 2015; 19: 90-94.
19. Murphy JW, Franz BA, Schlaerth C. The role of reflection in narrative medicine. J Med Educ Curric Dev 2018; 5: 2382120518785301.
20. Chu SY, Wen CC, Lin CW. A qualitative study of clinical narrative competence of medical personnel. BMC Med Educ 2020; 20: 415.
21. Fioretti C, Mazzocco K, Riva S, et al. Research studies on patients' illness experience using the Narrative Medicine approach: a systematic review. BMJ Open 2016; 6: e011220.
22. Fitzpatrick JJ. Narrative nursing: Applications in practice, education, and research. Appl Nurs Res 2017; 37: 67.

23. Fitzpatrick JJ. Teaching through storytelling: Narrative nursing. Nurs Educ Perspect 2018; 39: 60.
24. Alicea-Planas J. Listening to the narratives of our patients as part of holistic nursing care. J Holist Nurs 2016; 34: 162-166.
25. Artioli G, Foà C, Bertuol M, et al. The impact of a "narrative interview" intervention in oncology. A study protocol for a feasibility study. Acta Biomed 2020; 91: 38-47.
26. Shapiro J. Illness narratives: reliability, authenticity and the empathic witness. Med Humanit 2011; 37: 68-72.
27. Artioli G, Foà C, Cosentino C, et al. Integrated narrative assessment exemplification: a leukaemia case history. Acta Biomed 2017; 88 (Suppl 3): 13-21 [oznaczone jako 2017B].
28. Artioli G, Foà C, Cosentino C, et al. "Could I return to my life?" Integrated Narrative Nursing Model in Education (INNE). Acta Biomed 2018; 89: 5-17.
29. Buckley A, Corless L, Mee S. Patient narratives 1: Using patient stories to reflect on care. Nurs Times 2016; 112: 22-25.
30. Hall JM, Powell J. Understanding the person through narrative. Nurs Res Pract 2011; 2011: 293837.
31. Sebergsen K, Norberg A, Talseth AG. Confirming mental health care in acute psychiatric wards, as narrated by persons experiencing psychotic illness: an interview study. BMC Nurs 2016; 15: 3.
32. Sitvast J. Narrative and meaning of life: How mental health nurses can respond. Med Surg Ophthal Res 2018; 1: PPRS.000503.2018.
33. Rennick-Egglestone S, Ramsay A, McGranahan R, et al. The impact of mental health recovery narratives on recipients experiencing mental health problems: Qualitative analysis and change model. PLoS One 2019; 14: e0226201.
34. Talaei Zadeh S, Panaghi L, Hosseini SMM. The study of self-narration of patients with schizophrenia based on Genette's structural analysis theory. IJPCP 2017; 23: 336-347.
35. Wang L, Wu D, Wu S, et al. The effect of narrative nursing intervention on shame in elderly patients with bladder cancer after ileal bladder replacement: A cohort study. Comput Math Methods Med 2022; 2022: 4299919.
36. Chrzczonowicz A. Narracja a zaburzenia psychotyczne: badania i zastosowanie terapeutyczne. Postępy Psychiatrii i Neurologii 2012; 21: 43-50.
37. Kazimierska-Zając M, Rosińczuk J, Jakubowska L. Komunikacja w schizofrenii. Przyczyny stygmatów i kierunki terapii. Ogrody Nauk i Sztuk 2018; 8: 413-420.
38. Górna K. Opieka nad pacjentem ze schizofrenią. In: Wilczek-Rużyczka E (Ed.). Podstawy pielęgniarstwa psychiatrycznego. PZWL, Warszawa 2019; 152-162.
39. Gebreegziabhere Y, Habatmu K, Mihretu A, et al. Cognitive impairment in people with schizophrenia: an umbrella review. Eur Arch Psychiatry Clin Neurosci 2022; 272: 1139-1155.
40. Chrzczonowicz A. Narracja w psychiatrii – teoria, zastosowanie, związki ze zdrowiem psychicznym. Postępy Psychiatrii i Neurologii 2011; 20: 283-289.
41. Mycek A, Lipski W. Narracja w schizofrenii. Studium przypadku. Biuletyn Logopedyczny 2019; 33: 195-207.
42. Chądzyńska M. Metafory schizofrenii – różnorodność znaczeń i wzorce aktywności w opowieściach o doświadczeniu choroby. Jakościowa analiza narracji. In: Dryll E, Cierpka A, Małek K (Eds.). Psychologia narracyjna: o mądrości, miłości i cierpieniu. Wydawnictwo Liberi Libri, Warszawa 2021; 309-347.
43. Wilczek-Rużyczka E. Komunikowanie się z chorym psychicznie. In: Wilczek-Rużyczka E (Ed.). Podstawy pielęgniarstwa psychiatrycznego. PZWL, Warszawa 2019; 29-50.
44. Kępiński A. Poznanie chorego. Wydawnictwo Literackie, Kraków 2013.
45. Gałecki P, Szulc A. Psychiatria. Edra Urban & Partner, Wrocław 2018.
46. Sharma N, Gupta V. Therapeutic communication. In: StatPearls [Internet]. StatPearls Publishing, Treasure Island (FL) 2022. Available from: https://www.ncbi.nlm.nih.gov/books/NBK567775/ (access: 25.02.2023).
47. Abu-El-Rub N, Urbain J, Kowalski G, et al. Natural language processing for enterprise-scale de-identification of protected health information in clinical notes. AMIA Annu Symp Proc 2022; 2022: 92-101.
48. Kotlicka-Antczak M, Pawełczyk A. Psychopatologia. In: Jarema M (Ed.). Psychiatria. PZWL, Warszawa 2016; 35-72.
49. Grabski B. Podstawy badania psychiatrycznego. Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2015.
50. Wojciechowska K, Walęcka M, Szmyd J, et al. Simplified Interview for Negative and Positive Symptoms (SNAPSI) and the PANSS-6 scale – Polish language adaptation and application. Adv Psychiatry Neurol 2020; 29: 215-223.
51. Kokoszka A, Telichowska-Leśna A, Radzio R. Kwestionariusz wglądu w schizofrenię – „Moje myśli i odczucia". Psychiatr Pol 2008; 42: 491-502.
52. Kokoszka A, Telichowska-Leśna A, Radzio R. Krótka skala poczucia wpływu na przebieg choroby – wersja dla schizofrenii. Psychiatr Pol 2008; 42: 503-514.
53. Klamka A, Mazurowski K, Gezela M, et al. Czynniki związane z jakością życia pacjentów ze schizofrenią – badanie przy zastosowaniu skali SQLS. Nowiny Lekarskie 2006; 75: 564-567.
54. Mosiołek A, Gierus J, Koweszko T, et al. Przesiewowa Skala Funkcji Poznawczych w Schizofrenii (CSSS). Część 1. Konstrukcja i struktura skali. Psychiatr Pol 2018; 52: 227-239.
55. Świtaj P, Wciórka J, Grygiel P, et al. Częstość doświadczeń stygmatyzacji u chorych na schizofrenię w porównaniu do pacjentów z innymi problemami zdrowotnymi. Postępy Psychiatrii i Neurologii 2010; 19: 269-274.
56. Gawęda Ł. Polska wersja Skal Oceny Objawów Psychotycznych (PSYRATS). Akademia Psychiatrii 2012; 9: 100-107.
57. Andreasen NC. The Scale for the Assessment of Positive Symptoms (SAPS). The University of Iowa, Iowa City 1984.
58. Andreasen NC. The Scale for the Assessment of Negative Symptoms (SANS). The University of Iowa, Iowa City 1984.
59. Wciórka J. KOSS. Kliniczna ocena syndromów schizofrenii. Wersja 6. IPiN, Warszawa 2002.
60. Młodożeniec A, Jarema M. Ryzyko samobójstwa szacowane na podstawie skal oceny stanu psychicznego. Przegląd ważniejszych narzędzi badawczych. Psychiatria po Dyplomie 2010; 7: 54-59.
61. Körter K, Schmidt F. Psychoedukacja na przykładzie schizofrenią. In: Neu P (Ed.). Stany nagłe w psychiatrii. Podręcznik psychiatrii ratunkowej. PZWL, Warszawa 2013; 204-230.
62. Wilczek-Rużyczka E, Wojtas K. Wsparcie społeczne w chorobach przewlekłych i psychicznych. In: Wilczek-Rużyczka E, Czupryna A (Eds.). Wybrane zagadnienia z pielęgniarstwa specjalistycznego. PZWL, Warszawa 2010; 71-80.
63. Frączek K, Hintze B. Zasoby jako predyktor poczucia piętna wśród uczestników środowiskowych systemów wsparcia. Resocjalizacja Polska 2020; 19: 229-243.
64. Skorupska-Król A. Rehabilitacja w psychiatrii. In: Wilczek-Rużyczka E (Ed.). Podstawy pielęgniarstwa psychiatrycznego. PZWL, Warszawa 2019; 229-250.
65. Rozporządzenie Rady Ministrów z dnia 8 lutego 2017 r. w sprawie Narodowego Programu Ochrony Zdrowia Psychicznego na lata 2017–2022, Dz.U. 2017, poz. 458, Załącznik z 2 marca 2017 r. Available from: https://www.gov.pl/web/rpp/narodowy-program-ochrony-zdrowia-psychicznego (access: 14.02.2023).