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Special Feature Article

Psychiatric Medical Care and Emotional Labor

Fusako ENOKIDO

Taninogozan Hospital

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Abstract

Emotional labor puts lots of stress on workers whose occupations are interpersonal services.

In psychiatric medical care, the addition of human rights issues, legal regulations, and ethical issues increase stress. "Yamayuri-en" is a facility for severe behavioral disorders and is not the same as general psychiatric medical care; however, both are influenced by "emotional labor" and are more likely to encounter patients with traumatic experiences. In this study, I examine my own "emotional labor" and consider the problems of working conditions and the pitfalls of psychiatric medical care, which could not prevent the "Yamayuri-en" incident.

Keywords: emotional labor, psychiatric medical care, consciousness of discrimination and prejudice, "Yamayuri-en" incident, trauma

Introduction

The "Yamayuri-en" incident that occurred in July 2016 had a major impact on various fields. In response to

the incident, the Japanese Society of Psychiatry and Neurology issued "Views on the Incident at the Support Facility for Persons with Disabilities in

Sagamihara City and Subsequent Developments”²²⁾ in August of the same year, and then “Measures to Prevent a Recurrence of the Yamayuri-en incident Based on the ‘Report: Proposals for Recurrence Prevention Measures”²³⁾ in January 2017. In June of the same year, the Japanese Society for Social Psychiatry issued the “Yamayuri-en Incident Special Committee Opinion”,²⁴⁾ which listed four points: 1. the elimination of discrimination and prejudice and the realization of a society of coexistence; 2. support for the patient after discharge, with the patient at the center and taking the initiative; 3. support for supporters; and 4. the expansion of personnel and budgets for psychiatric medical care and mental health and welfare. It also stated that they would continue to hold ongoing discussions with the aim of realizing a society of coexistence.

Psychiatric medical care is closely linked to society, and there are many commentaries that point to the relationship between discrimination, prejudice, and eugenic ideology as the background of this tragedy.¹⁸⁾²⁵⁾²⁷⁾³¹⁾ The year 2016, when the incident occurred, was the year that the United Kingdom voted in a referendum to leave the European Union, the year that Trump was elected president of the United States, and the year that populism and nationalism rose around the world in

response to the acceptance of refugees. The report of the Incident Investigation Committee⁸⁾³²⁾ indicates that the perpetrator of the incident was also influenced by these social conditions.

Measures to prevent a recurrence after the incident¹⁶⁾ include measures to prevent outside intruders and, since the perpetrator was involuntarily hospitalized before the incident, measures to improve support have been implemented after reviewing the period after discharge from compulsory hospitalization.⁵⁾²⁶⁾ However, while it is natural to analyze the psychopathology of the mass murderer and to clarify the social background of the incident, it cannot be said that the circumstances that led the criminal to such a biased ideology, or the fact that there was no deterrent to prejudice and violence within the institution, have been sufficiently discussed. There are situations in psychiatric medical care where ethical judgment is required on a daily basis, but is this judgment logically and clearly organized and presented? In order to console the souls of the victims of the incident and to prevent a recurrence, we must not let the incident fade into the background. In this paper, we will examine the ethical issues facing those involved in psychiatric medical care, using the keyword “emotional labor” to look at

psychiatric medical care from an "emotional labor" perspective.

At the time of submitting the symposium title, I had planned to examine clinical experiences from the perspective of emotional labor, but since it was impossible to obtain the consent of all the people involved, I decided to report only on my own personal experience.

I. Emotional Labor and Healthcare

Emotional labor is a concept proposed by the sociologist A. R. Hochschild in 1983, and defined as "the labor of regulating one's own emotions in order to express, through voice, facial expression, or body movement, emotions deemed appropriate for the purpose of changing or maintaining the emotional state of others."⁶⁾ Until then, work had been divided into two categories: physical labor and mental labor, but with the growth of tertiary industries, such as sales and service, the industrial structure changed and it was pointed out that there was an important aspect of emotional labor. In the tertiary industry, consumer needs and customer satisfaction become major driving forces for consumption, and a way of working that involves controlling (being forced to control) emotions comes at the cost of burnout syndrome, depersonalization, and a sense of being emotionless.

Burnout syndrome was first proposed by Freudenberger, H.J. in 1974. It is characterized by a loss of motivation, withdrawal from work, and depression caused by emotional exhaustion due to prolonged occupational stress, and is particularly prevalent in jobs that involve working with people.¹⁷⁾

Medicine is a workplace where role and duty are emphasized, and where calm judgment and appropriate treatment are always required; at the same time, it is a typical interpersonal helping profession that requires warm and friendly humanity.⁴⁾³⁵⁾ In recent years, the importance of informed consent, patient-participatory medicine and collaborative decision-making has come to the fore, and communication skills have become a focus of attention. The communication skills of medical professionals are directly related to the life and value of the patient, and they are required to respond in a variety of ways depending on the disease and the characteristics of the people involved. In addition, under the universal health insurance system, they must also ensure convenience and fairness. There are various rules and restrictions in the medical workplace, and medical professionals are forced to make quick decisions and are accountable for their actions. In workplaces where emotional labor is required to such a high degree of interpersonal contact, it is inevitable

that one will experience negative emotions such as conflict, anger, loneliness, and feelings of powerlessness,¹⁹⁾ and there is much pressure on one's self-esteem and sense of self-worth.¹²⁾³⁰⁾³³⁾

The correlation between emotional labor and burnout syndrome has been pointed out,¹⁰⁾ and scales for evaluating emotional labor have also been developed,¹¹⁾²⁹⁾ but the items used in these evaluations are based on research in emergency medicine, general internal medicine, and palliative care wards, and some of the items are not suitable for psychiatric medical care. In the field of psychiatry, there are studies that address issues of abuse and negative emotions targeting nurses, counselors, and welfare workers^{7),19)} and reports of the emotional labor that nurses feel towards doctors.¹³⁾

II. Characteristics of Psychiatric Medical Care and Emotional Labor

In recent years, in response to the growing awareness of patient (consumer) rights, issues such as improving customer service and communication skills in general medical departments have been studied and manuals have been produced.³⁰⁾ However, there are many cases where patients who are the target of psychiatric medical care are unable to communicate, are dominated by

psychotic symptoms, or come to the hospital worried about communication, and things do not always go according to the manual. In recent years, there has been an increase in the number of patients with a variety of life experiences and complex circumstances, including those with depression, dementia, suicide attempts, self-harm, abuse, and trauma-related issues, requiring more consideration in patient care. Furthermore, in psychiatric care, issues become even more complex due to human rights issues, ethical considerations, and legal stipulations, but here we will consider the characteristics of emotional labor in ordinary psychiatric clinical practice.

1. It takes time.

Psychiatric medical care can be long in two ways: the course of treatment can be long, and the time required for consultation and treatment can be long. First and foremost, at the time of consultation, every patient has a unique story that is intricately intertwined with the complexity of human and social diversity, with differences in their upbringing, life history, and environment.³⁾ The psychiatrist must listen to and understand as much as possible about such a complicated situation, and also, while grasping the limitations of the prognosis, which may not be optimistic depending on the

disease, and the scarcity of available treatment options, they must enter into a treatment contract. While making medium-to-long-term plans, psychiatrists seek the best treatment strategy for the "here and now", but there is information that must be kept secret from the patient depending on the situation, and in addition, they must assess the patient's ability to understand, judge, and consent as they talk to them, so the consultation inevitably takes a long time. The time axis of the patient's past life and the world he/she will enter from now on is also long, so the clinical time required for the examination is also longer than in other departments. However, in today's speed-oriented society, anything that takes time is often viewed negatively.

2. Collaboration within the hospital, within the team, and with other professionals is essential.

As humans are physical, psychological, and social beings, the field of psychiatric medical care involved is broad. In hospitals (especially general hospitals), there is much liaison work involved in the treatment and examination of patients, but there are also times when psychiatrists are asked to examine, consult, and mediate with medical staff working in the hospital. There is a

tendency to think of psychiatry as a field that "listens carefully, summarizes well, and gives appropriate advice" (conveniently). It is necessary to calmly analyze the situation without overreacting (over-adapting) to meet expectations.

Since the understanding and cooperation of family members and other concerned parties is important for the social reintegration of patients, it is necessary to ensure that staff members are able to consult each other about anything without reservation, and that they are able to respond appropriately to such consultations, by maintaining close contact with each other on a regular basis regarding their respective professional roles and the latest medical information. Even if physicians have lofty theories or ideal treatment methods, if the staff who put them into practice do not understand them, the staff will feel more burdened and inadequate, and the team will become less cohesive. Information obtained from staff is valuable, so communication within the team is essential for improving team strength.

In addition, because psychiatric medical care is a long-term process, you will encounter people from different professions, of different ages and with different ideas, and the likelihood of conflict and friction will increase. Sometimes you may try to clear up

misunderstandings and end up hurting yourself, or you may end up blaming the lack of understanding of family members or the lack of ability of supporters. Even in such cases, listening to the opinions of staff and patients will give you the chance to question your own preconceived notions, and will give you the chance to expand your understanding of mental illness and the circle of therapeutic alliances.

III. Emotional Labor of Psychiatrists

1. Special characteristics of medical care.

In psychiatric medical care, the interview is not only a means of obtaining information, but also an irreplaceable medical act.³⁹⁾ In psychiatric interviews, the attention, observation, insight and expressive skills of the medical practitioner often play a greater role than objective figures such as clinical test data. For this reason, the interviewer must be aware of the rationality and limitations of their own subjectivity and individuality, and they have the heavy task of renewing their medical knowledge and cultivating their humanity.

Mastering psychotherapy is an essential task for psychiatrists, but psychotherapy is full of charm, with a depth and sharpness of reading and an exquisite communication that cannot be understood from knowledge gained from books alone.⁹⁾²¹⁾ Therefore, some people

may distance themselves from psychotherapy because they feel it is not for them, or they may end up with only superficial imitation. Furthermore, there is a risk of being misunderstood by patients or other people involved, of being the target of misplaced anger, of being betrayed, or of suffering violence.

When treatment stalls or leads to an exacerbation, a change in the content of the prescription can be made by reference to literature searches, but reviewing psychotherapy requires a multifaceted examination of changes in the patient's condition and in the way we interact with them, as well as changes in our own emotions. Ultimately, this is a big task that involves summarizing our understanding of the disease and how we deal with it, and it is not easy to maintain a calm attitude. Psychiatric treatment is not only about digital knowledge, but also involves self-reflection, and is a form of emotional labor that is very demanding.

In Yamagami's³⁴⁾ study of emotional labor among physicians, the 17 respondents were general hospital doctors, and no psychiatrists were included. Hochschild's book⁶⁾ frequently quotes parts of Freud's theories, but there is little mention of psychiatrists performing emotional labor. In the following section, I will provide my own experiences and consider the reality of

emotional labor in psychiatric medical care.

2. Personal History of “Emotional Labor”.

Medical care can be fraught with unexpected obstacles and mistakes. The author has had many dangerous experiences and even thought about quitting the medical profession. Of these, I will look back on my experience of emotional labor and share some of the things I can talk about publicly after more than 30 years.

1) Putting on a (seeming) face, making a face.

The psychiatric ward where the author received training was connected to the main hospital building by a corridor, as was typical of many university hospitals during that period. As I walked down the corridor, mentally planning the day's treatment, I noticed that my face was changing from the natural expression I had just been using to the face of a doctor. Furthermore, when reviewing the treatment to date and reconsidering the treatment plan by collating the points raised in textbooks, specialist books, ward rounds, and case review meetings, I envision myself (my face) examining the patient, not just their response. The image of my face that appears there changes, and I also recognize the self that is causing the change. This is something that makes

sense in terms of the terms “superficial acting” and “deep acting”⁶⁾ in emotional labor.

2) Case A: Conflicts in behavioral restriction and non-consensual medical treatment.

There was an accident in which A, who had suffered from carbon monoxide poisoning and higher brain dysfunction, died of asphyxiation while being physically restrained against psychomotor agitation. The accident occurred at the hospital of a senior colleague whom I respected, and I was A's former attending physician. I felt the limitation of medical treatment based on A's upbringing and living situation, and I remember feeling both relieved and guilty inside that I was able to refer a difficult case to another hospital for treatment. Also while I thought that making a big fuss about improving the system of patrols and nursing would protect the organization, there were still voices of self-deception that questioned whether this was really the right thing to do.

In psychiatric medical care, there are times when difficult decisions have to be made concerning human rights, such as restricting behavior and non-consensual medical treatment. Amid the conflicting thoughts of patients, their families, those involved, and staff, doctors themselves also have to deal with their own internal struggles, and

they have to quickly find practical solutions and points of compromise. There is also the important task of communicating the content of these decisions in a way that is easy to understand, useful, and fair. On the other hand, as people gradually become accustomed to being able to reach smooth and appropriate decisions, the warning bell of emotional labor will ring out, as individuals disappear (dehumanization) as they become role players within an organization.

3) Case B: Dealing with serious cases such as suicide and accidents.

Case B was a patient with attention deficit hyperactivity disorder as listed in the DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised),²⁾ but at the time he was being treated for bipolar disorder. He had a wife and children and was financially well-off, but he was isolated at work and exposed to harassment. As his doctor, I made the mistake of not recommending hospitalization despite seeing signs of suicide, and as a result, I allowed the patient to carry out his plan.

The suicide or serious accident of a patient is a major blow to a psychiatrist, regardless of where the responsibility lies. Psychiatrists listen to the joys and brilliance of their patients' lives, and so they also experience the regret, sorrow and anger that lead to suicide. The

feeling of powerlessness that comes from knowing that you could have saved the patient if he/she had come to the hospital, but now that is impossible, turns into feelings of inability, mercilessness, and remorse, and you are reminded of the importance of life.

4) Case C: Difficulties in Relationships with Patients and Families.

C was hospitalized for a detailed examination of her convulsive seizures, as she had experienced two seizures while using a vacuum cleaner. The examination confirmed that abnormal brain waves appeared only with a certain frequency of sound, so she was diagnosed with reflex epilepsy. She was discharged from hospital after being told to avoid that frequency band and to continue taking her medication. A few days later, her in-laws and other relatives, a total of six people, came to the hospital to ask for an explanation. I explained in detail about the disease called "reflex epilepsy", but the prejudice against the name of the disease "epilepsy" was strong, and at the root of it was a sense of distrust and anger that she had married while hiding her illness, and that they had been deceived by her. I couldn't think of a strategy to ask for support from more experienced colleagues, and I couldn't say that it was wrong to confuse human values with medical disorders. In the end, she got divorced.

Along with the regret of not being able to help, I also felt a lingering sense of frustration at not being able to correct the prejudice against mental disorders, and anger at the prejudice. Prejudices about mental disorders are often based on vague notions of "society" or generalizations of extreme cases, and are strongly influenced by time, culture, and education, so they require a great deal of effort to correct. In addition, they are largely emotional in nature, so there is a limit to what can be achieved by confronting them with logic. Even now, every time I encounter prejudices about mental disorders in society, I am reminded of the difficulty of explaining and overcoming them.

5) Case D: Difficulties in interdepartmental cooperation.

While I was on duty, I received a call from a nurse in another department an hour before lights out, saying, "A patient who was seen by the psychiatric department during the day is acting up in the ward. Please do something". When I went to see him, D, who had been diagnosed with mild mental retardation (note: the diagnosis was from the time of the incident), was wandering around the ward, shouting incoherently and not responding to calls. When I asked the nurse, "What's wrong with him?", she replied, "He's a psychiatric patient, so he can't understand. The nurse said, "You

should go and calm him down or take him away. We have nothing to do with this", and refused to help at all. We quickly asked a psychiatric nurse to help, and the two of us sat D down and persuaded him to take his medicine, and he calmed down completely. D was unable to understand the ward nurse's explanation and had panicked with anxiety about the upcoming surgery, so I thought it was natural for him to react that way.

What shocked me was that there was discrimination and prejudice against mental disorders among the medical staff in the same hospital (and in a medical educational institution), and that this was directed not only at the patients, but also at the medical staff and doctors. Needless to say, the ward in question was given a stern warning, but I doubt that they were able to correct their stereotypical views of mental disorders, rather than just dealing with the problem on the surface.

This experience made me realize anew the misery, frustration, and suffering that patients go through, and I found myself unexpectedly becoming a party to it. Additionally, when treating victims of abuse and harassment, I realized that if you are not careful with your words and your eyes, you can trigger (stimulate) traumatic experiences.

3. Risks of emotional labor and how to deal with it.

Emotional labor, especially in psychiatric medical care, has the effect of traumatizing not only the person doing the work, but also the patient, family members and other people involved.²⁰⁾ This is because in the medical field, the act of going to the doctor can be a traumatic experience in itself because it means that one's health has been damaged or that one has become ill, and it can also be a double traumatic experience because one has to go through painful and distressing experiences (treatment) in order to get well. For patients, their families and others involved, the realization that treatment is difficult can lead to feelings of disappointment, discouragement, and resentment, and this sense of trauma is compounded by prejudice and discrimination in society.

Moreover, in psychiatric medical care, the relationship with the patient is intimate, and while the trauma, complaints, dissatisfaction and unhappiness of the patients are significant, the problems of frustration, exhaustion, demoralization, reaction formation and slowdown on the part of the medical staff cannot be overlooked. While it is possible to be aware of and objectively evaluate the capabilities and fatigue of physical and mental labor, there is no established evaluation axis

or method for evaluating the effectiveness, risks, and health hazards of emotional labor. The Ministry of Health, Labour and Welfare introduced a stress check system in 2015 and is encouraging both workplaces and workers to be aware of mental health issues.¹⁵⁾ The stress evaluation scale used is meaningful and can be implemented by many people, but it is not specialized for psychiatric medical care. Expressing and evaluating emotions in words tends to be subjective, and it is difficult to put trauma into words,²⁰⁾ so there is probably a lack of research on emotional labor in psychiatric medical care.

The author's "history of emotional labor" also cannot hide excuses for immaturity or physician hubris, and there are many cases where I was relieved to have escaped trouble and was lucky. The reason for my good fortune was that I was blessed with good patients, but I would like to list the origins of my good fortune in avoiding risk and the coping behaviors that were useful. (i) Whenever I encountered difficulties or crises, my staff and friends pointed out my thoughtlessness, gave me advice, and helped me out. (ii) By participating in academic conferences, I was able to train my critical spirit and logical thinking, and I was able to learn many lessons and social etiquette through casual

conversations and consideration. (iii) Participating in case review meetings helped me to develop the habit of carefully and flexibly examining each case from multiple perspectives. (iv) Structuring psychiatric medical care as team-based care and working with local communities and other stakeholders as members of the therapeutic alliance helped to reduce the mental burden and provided many benefits.

IV. “Yamayuri-en” Incident and Emotional Labor

Although support facilities for people with disabilities and general psychiatric hospitals are not the same, the concept of emotional labor as a way of working is an issue that runs through both. However, it cannot be said that the work known as emotional labor has been properly evaluated, or that attention has been paid to the trauma associated with it, or that measures have been considered to prevent and deal with the damage. In addition to the harshness of the physical labor, "Yamayuri-en" also forced its staff to be patient and submissive, and it is likely that the facility is a voice for the negative aspects of emotional labor that cannot be dealt with by idealistic approaches and that is not rewarded financially or psychologically. Furthermore, when we consider whether the perpetrators, the staff who worked there, and the

residents could have shared the same good fortune as the author, it seems that emotional labor is a major risk factor that led to the incident. We know that being forced to see things we don't want to see, such as embarrassing behavior, dirty work, and ugly human relationships, can be traumatic. Perhaps this is why we have not been willing to face the negative aspects of emotional labor.

In addition, while psychotherapy is considered essential for psychiatrists, because it is an important aspect of emotional labor, the narrow approach of trying to understand and communicate psychotherapy in words may have contributed to the distance from supporting people with limited verbal expression. Understanding and being understood is something that comes from real-life interaction and engagement,²⁸⁾ but perhaps we have been too concerned with intellectual understanding and verbal comprehension and have neglected the workings of emotions. Also, perhaps the medical community has been too focused on successful treatment cases and so-called scientific academic research, and has neglected the kind of down-to-earth, gritty clinical research that doesn't have a high impact factor. The same can be said for collaboration with those who work with us and for

educational activities for patients, families and society.

The risks associated with emotional labor can undermine trust, lower the morale of medical staff, reduce the quality of medical care, and even lead to accidents. To prevent this, it is necessary to consider countermeasures within a broad framework that includes not only medical staff, but also patients, users, family members, and advocates, and to allow everyone to share their views.

Conclusion

One thing I learned again from the Committee on Medical Ethics of the Japanese Society of Psychiatry and Neurology was the term and concept of “severe behavioral disorder”.¹⁾ I also learned about the families and supporters surrounding these people, the harshness of the working environment for welfare facility staff, the difficulties of supporting severely disabled people, and the problem of staff shortages in welfare facilities.¹⁴⁾ I also reaffirmed that discrimination and prejudice against disabled people is not just a problem for those involved with disabled people, but a problem for society as a whole. For this reason, it is necessary to clearly recognize and properly evaluate the way of working known as emotional labor. In order to prevent emotional labor from becoming

something forced or something that is built on the sacrifice of others, and to ensure that it is rewarded accordingly, we must learn from and share the many innovative attempts and practical examples that already exist, and work to spread them more widely.

Although emotional labor can lead to depersonalization, burnout syndrome, and a backlash, the experience of working through these problems together can be a great source of strength.

In this article, we have examined the impact of the “Yamayuri-en” incident using the keyword “emotional labor”, but the issues are more complex and the challenges are many. As this feature is not intended to reach any conclusions, we would like to leave the deepening of the issue to the ongoing deliberations of the Japanese Society of Psychiatry and Neurology and the Japanese Society for Social Psychiatry's “Yamayuri-en Incident Special Committee”. Finally, we would like to emphasize that psychiatric medical care is a profession that is both profound and endlessly interesting.

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References

- 1) 會田千重: 強度行動障がい理解・治療・支援と今後
(https://www.thanksshare.jp/download?file_id=202366) (参照 2021-12-24)
- 2) American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 3rd ed, Revised (DSM-III-R). American Psychiatric Association, Washington, D. C., 1987 (高橋三郎訳: DSM-III-R 精神障害の診断・統計マニュアル. 医学書院, 東京, 1988)
- 3) 土居健郎: 方法としての面接—臨床家のために—. 医学書院, 東京, 1977
- 4) 福田正治: 看護における共感と感情コミュニケーション. 富山大学看護学会誌, 9 (1); 1-13, 2009
- 5) 平田豊明: 措置入院制度の検証—相模原事件を通して—. 精神経誌, 120 (8); 664-671, 2018
- 6) Hochschild, A. R.: The Managed Heart: Commercialization of Human Feeling. Regents of the University California, Oakland, 1983 (石川 准, 室伏亜希訳: 管理される心・感情が商品になるとき-. 世界思想社, 京都, p.3-86, p.158-185, 2000)
- 7) 今泉 源, 香月富士日: 精神科看護職者の倫理的行動と虐待的行為に関する現状と課題. 日本社会精神医学会雑誌, 29 (4); 271-281, 2020
- 8) 神奈川新聞取材班: やまゆり園事件. 幻冬舎, 東京, p.11-139, 2020
- 9) 神田橋條治: 精神科診断面接のコツ. 岩崎学術出版社, 東京, 1984
- 10) 片山はるみ: 感情労働としての看護労働が職業性ストレスに及ぼす影響. 日本衛生学雑誌, 65 (4); 524-529, 2010
- 11) 片山由加里, 小笠原知枝, 辻 ちえほか: 看護師の感情労働測定尺度の開発. 日本看護科学雑誌, 25 (2); 20-27, 2005
- 12) 加藤宏公: 看護における感情のマネジメント. 精神医学, 61 (11); 1315-1323, 2019
- 13) 木村克典, 松村人志: 精神科入院病棟に勤務する看護師の諸葛藤が示唆する精神科看護の問題点. 日本看護研究学会雑誌, 33 (2); 49-59, 2010
- 14) 厚生労働省: 介護労働の現状. (https://www.mhlw.go.jp/file/05-Shingikai-12602000-Seisakutoukatsukan-Sanjikanshitsu_Roudouseisakutantou/0000071241.pdf) (参照 2022-01-17)
- 15) 厚生労働省: 心理的な負担の程度を把握するための検査及び面接指導の実施並びに面接指導結果に基づき事業者の講

すべき措置に関する指針.

(<https://www.mhlw.go.jp/content/11300000/000346613.pdf>) (参照 2022-08-01)

16) 厚生労働省相模原市の障害者支援施設における事件の検証及び再発防止策検討チーム: 報告書—再発防止策の提言—. 2016 (<https://www.mhlw.go.jp/file/05-Shingikai-12201000-Shakaiengokyokushougaihokenfukushibu-Kikakuka/0000145258pdf>) (参照 2021-12-24)

17) 久保真人: バーンアウト(燃え尽き症候群)—ヒューマンサービス職のストレス—. 日本労働研究雑誌, 558; 54-64, 2007

18) 熊谷晋一郎, 雨宮処凜: 「生産性」よりも「必要性」を胸を張って語ろう. この国の不寛容の果てに—相模原事件と私たちの時代— (雨宮処凜編). 大月書店, 東京, p.77-118, 2019

19) 松浦利江子: 患者に対して陰性感情をもつ体験に付随する倫理的葛藤. 日本看護管理学会誌, 14 (1); 77-84, 2010

20) 宮地尚子: 環状島=トラウマの地政学, 新装版. みすず書房, 東京, 2018

21) 村瀬嘉代子: 心理療法—統合的アプローチの視点から考える—. 臨床精神医学, 41 (増刊); 45-50, 2012

22) 日本精神神経学会法委員会: 相模原市の障害者支援施設における事件とその

後の動向に対する見解. 2016

(https://www.jspn.or.jp/modules/advocacy/index.php?content_id=35) (参照 2021-12-24)

23) 日本精神神経学会法委員会委員長 富田三樹生: 「報告書—再発防止策の提言—」をふまえた"相模原事件の再発防止策"について. 2017

(https://www.jspn.or.jp/uploads/uploads/files/activity/sagamiharajiken_houiinkaienkai.pdf) (参照 2021-12-24)

24) 日本社会精神医学会: 相模原事件特別委員会 見解. 2017

(<http://www.jssp.info/pdf/sagamihara.pdf>) (参照 2021-12-24)

25) 大澤真幸: この不安をどうしたら取り除くことができるのか. 現代思想, 2016 (10); 38-43, 2016

26) 太田順一郎, 井原 裕, 平田豊明ほか: 相模原事件が私たちに問うもの(太田順一郎, 中島 直編, メンタルヘルス・ライブラリー—38). 批評社, 東京, p.14-60, 2018

27) 斎藤 環: 「日本教」的 NIMBYSM から遠く離れて. 現代思想, 2016 (10); 44-55, 2016

28) Sechehaye, M. A.: Introduction à une Psychothérapie des Schizophrènes. Presses Universitaires de France, Paris, 1954 (三好暁光訳: 分裂病の精神

療法—象徴的実現への道—。みすず書房，
東京，1974)

29) 関谷大輝，湯川進太郎：感情労働尺
度日本語版（ELS—J）の作成。感情心理
学研究，21（3）；169-180，2014

30) 武井麻子：ひと相手の仕事はなぜ疲れ
るのか—感情労働の時代—。大和書房，東
京，p.50-122，2006

31) 富田三樹生：美しい日本—相模原事件
について—。相模原事件が私たちに問うも
の(太田順一郎，中島直編，メンタルヘル
ス・ライブラリー38)。批評社，東京，p.92-
107，2018

32) 津久井やまゆり園事件検証委員会：津
久井やまゆり園事件検証報告書。2016
([www.pref.kanagawa.jp/documents/675
97/852956.pdf](http://www.pref.kanagawa.jp/documents/67597/852956.pdf))(参照 2021-12-24)

33) 山田陽子：働く人のための感情資本論
—パワハラ・メンタルヘルス・ライフハックの
社会学—。青土社，東京，2019

34) 山上実紀：医師の感情労働—日本の
総合診療医を対象とした調査より—。一橋
大学大学院社会学研究科修士課程論文。
2011

35) 山上実紀：感情と労働—医師の感情に
焦点をあてる意義—。日本プライマリ・ケア
連合学会誌，35（4）；306-310，2012