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The patient-authored medical record: A narrative path to a new tool in psychiatric nursing

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ABSTRACT

This paper describes preliminary research from Japan on developing a new tool for psychiatric nurses, the patient-authored medical record, a "prescription" written in ordinary language by the patient with the assistance of a nurse. The nurse asks the patient how to improve their illness and she types up the patient's story on site in the form of a first-person narrative. The patient checks it for accuracy before taking a copy home. Ten Japanese patients participated in this field-oriented ethnographic study, and the analysis of the qualitative data strongly suggested that the approach had therapeutic effects on each patient. This narrative-based prescription could be used as a tool, specifically by psychiatric nurses, in many cultures, and it is our hope that it contributes to their professional identity.

Introduction

The aim of this study is to examine the effectiveness of the patient-authored medical record, an original tool the authors developed in an attempt to create a suitable method enabling for therapeutic conversation in psychiatric hospitals.

Chronic psychiatric patients in Japan have few opportunities to be heard by their family and medical professionals. Family members may offer continuous care to the patient but often feel awkward listening to the patient's inner feelings and motivations—partly because their relationship is too close to broach family-related issues and partly because the talk might bring out the patient's trauma or previous troubles experienced by them (Fujino et al., 2007).

Psychiatric nurses in Japan working on hospital wards are busy and occupied by their routine work, which involves completing various scheduled tasks. The ward, as a small society (Caudill, 1958), must be well administered, and the control and peace of the ward is a part of the responsibility of the ward nurses (Ogino, 2001). They have little extra time to sit down and listen to individual patients' concerns and anxieties. The nurses working in outpatient services are also busy assisting doctors and monitoring each patient's visit process, checking their vital signs and offering other physical assistance. In such circumstances, nurses have little opportunity to get to know the patient as an individual. Outpatient visits are usually brief, with the doctor checking the dose of psychotropic drugs and the prescription period (Nomura, 1992). The outpatient setting and schedule do not usually permit ample time for conversation that would allow the patient and the doctor to delve into personal and intricate life matters (Jagosh et al., 2011; Kmietowicz, 2000).

Consequently, many chronic psychiatric patients in Japan want to converse with medical staff but are unable to do so. They often have rich life stories (Nomura, 1987) but have not found a good audience who will listen to their stories with genuine curiosity. Patients often have their own unique view of why they developed their disorder and have an accurate understanding of their present mental condition (Nomura, 1998). Once a dialogical relationship with medical staff is established, the patients will willingly talk about their goals and benchmarks for improvement. The patient's untold stories – the "not-yet-said" narratives – may be the treasure box from which the medical staff can devise a therapeutic plan and goals (Anderson & Goolishian, 1988).

In such a medical environment, psychiatric nurses often find themselves in a dilemma in terms of their professional identity, which is somewhere between that of the doctor and other paramedical staff, such as clinical psychologists, psychiatric social workers, or occupational therapists (Kimura & Matsumura, 2010; Sabella & Fay-Hillier, 2014). The professional area and tasks of psychiatric nurses in Japan are

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somewhat ambiguous (Kayama, 2009).

Further, coercion and the use of physical restraint on patients add a further dilemma for mental health nurses, who are caught between ideals and the clinical reality (Jansen et al., 2019; Kono, 2005). Physical restraint often demoralizes nurses because they have to control the situation without talking with the patient. Although nurses are also responsible for managing seclusion rooms, they believe there should be a response that is more medical and therapeutic than keeping someone in custody.

Thus, what seems to be decisively lacking for psychiatric nurses in Japan is an opportunity to sit down with patients and listen to their suffering and life stories. The patients are asked about their *disease* but not their *illness*, i.e., their lived experiences, which supersede the disease in significance (Kleinman, 1988).

This constitutes the background for developing patient-authored medical records (PAMRs), which is designed to provide psychiatric nurses the opportunity to play a significant medical role in the patient's treatment through their own unique contribution. We will briefly outline our theoretical position to situate PAMRs in the history of the theory and recording methods of psychiatric nursing.

The theoretical background of PAMRS

Influenced by H. S. Sullivan's (1947, 1953) interpersonal theory of psychiatry, H. E. Peplau (1952) developed the technique of *process recording* to help her students acquire interpersonal skills in psychiatric nursing. Participant observation, a basic stance in cultural anthropological fieldwork, was the method Peplau adopted. The two main parts of the process record the reactions of the patient and nurse. There are additional sections for the analysis made by the student and the evaluation made by the instructor. I. J. Orlando (1972) refined the *process recording* form, and E. Wiedenbach (1964) introduced the five self-evaluation criteria to enrich students' learning experience.

The PAMR follows the tradition of Peplau, who emphasized the interpersonal aspects of psychiatry and the anthropological approach of participant observation. However, whereas Peplau's *process recording* was influenced by psychodynamic theories, PAMRs are directly descended from communications theory, particularly the interactional view elaborated by G. Bateson (1972). More precisely, based on the interpersonal process of participant observation, PAMRs' unique basic stance is therapeutic "*not-knowing*" (Anderson & Goolishian, 1992) on the part of the psychiatric nurse, which facilitates two-way narrative practice. PAMRs' interactive and collaborative nature is obvious – it is a process of joint record making and scenario writing carried out by the patient but with the assistance of the nurse. It is a dialogue between the patient and the nurse that leads them to write a multivoiced, open-ended prescription (Bakhtin, 1984). Let us now explain this theoretical sketch in more detail.

Interaction, verbal and nonverbal, is the two-way, mutual exchange of information. Bateson (1972) placed interaction at the center of the universe and used it as a central explanatory principle. From this epistemology, the double-bind theory on schizophrenia emerged (Bateson et al., 1956). The full merit of the double-bind theory lies not in its hypothesis on schizophrenic etiology but in its confirmation that the phenomena of mental disorders are describable using solely communication language without resorting to psychodynamics. The double-bind theory thus gave family therapists an immense boost with respect to the development of family therapy and the validity of their family work. Subsequent generations of family therapists inherited the theoretical view of Bateson et al. (1956) in developing new methods, such as the recent open dialogue approach (Seikkula & Olson, 2003).

PAMRs can thus be traced to developments in the history of family therapy. When the vigorous family therapy movement reached a sluggish stage in the late 1980s, narrative/collaborative approaches came to the forefront under the popular name of narrative therapy (McNamee & Gergen, 1992; White & Epston, 1990), which later facilitated the narrative-based medicine (NBM) movement (Greenhalgh & Hurwitz, 1998). Out of this *narrative turn*, observing communication not from outside but from within as a conversational partner, Anderson and Goolishian (1988, 1992) introduced the *not-knowing* approach to therapy. While the psychotherapist may have expert knowledge of mental disorders and psychological processes, they may know little about how clients experience the illness and its inconveniences within the context of their personal lives. "*Not-knowing*" entails being curious about the patient's expertise in handling and managing their illness.

This seems to be the dichotomy A. Kleinman (1988) identified in terms of the difference between *disease* and *illness*. That is, *disease* refers to the diagnosis by the doctor, while *illness* is experienced and lived by the patient. Thus, in *not-knowing*, the therapist humbly asks the client to share their "expertise" in the management of illness. Anderson and Goolishian (1992) found that *not-knowing* – the client-as-expert approach – not only facilitated an egalitarian dialogue between patient and therapist but also generated new stories and ideas for resolving the problem through mutual/collaborative striving toward the therapeutic goal. Having such therapeutic goals in *not-knowing* differs from the method of participant observation, whose purpose is to collect information from the insider's viewpoint.

Not-knowing is the theoretical underpinning of PAMRs, based on which the nurse becomes a student being taught by the patient's "expertise." In this scheme, participant observation evolves into a student-teacher relationship. It is a collaborative effort between the two different experts: the expert in medical nursing on the one hand and the expert in personal life management on the other. Dialogue, a two-way egalitarian interactive exchange, brings about something new that would never be attained through a single expert's monologue.

Polyphony is the term coined by the Russian literary theorist and philosopher M. Bakhtin (1963, 1984) to describe the multivoiced character of the dialogical process, that is, a plurality of independent and unmerged voices and consciousness is always present in dialogue. While the doctor's prescription is basically a monologue, that is, a supervoice having authority, PAMRs are a result of dialogue that contains a multiplicity of voices. It contains not only the double voices of the patient and the nurse in interaction but also the multiplicity of voices echoing behind each person during the dialogue, the voices of people who influenced the patient and the nurse in their course of life. Further, the characters appearing in the patient's story have their own voices, adding the degree of polyphony. If someone else reads a PAMR, the reader's dialogical process further enriches and extends the polyphonic worlds. Dialogue itself secures agency (Bakhtin, 1963, 1984). In this way, the contrast between the doctor-authored prescription and the patient-authored prescription in terms of the locus of authority is clear – the PAMR is the restoration to the patient of the authorship of their own life (White & Epston, 1990).

A PAMR is a document jointly written by a psychiatric patient and a nurse describing the patient's medical processes, present concerns, or ideas and personal strategy for addressing the illness. It is a narrated life story, a short biographical account, and a self-authored prescription witnessed by the nurse that may be comparable to the doctor's prescription. The latter is usually written using technical terms in the grammatical person of the third-person observer, and the former is written in the everyday language of the first-person narrator. The patient tells their story in the I-message style in the course of dialogue with the nurse, who types the utterance on site.

A PAMR is not a report but a story. The doctor's prescription objectively describes the patient's condition using medical terms – it is a type of report of the pathological state of the patient at the time of observation. The patient's record, on the other hand, has its own plot narrated based on their inner experience of illness using thicker description (Geertz, 1973). The doctor's document stops time, grammatically using the present tense, with even past events frozen at the present moment of description. In contrast, a PAMR moves in time, going back to the past, looking forward to the future, or providing an overview from the past to

the present to the future, with time moving more freely. While the doctor's record presents observations chronologically in a linear fashion, the patient's record employs narrative time based on the plot (Ricoeur, 1990). More importantly, the former's writing style fixes the patient's state by diagnosis, which makes it difficult for the medical staff to cope with the changes taking place within the patient, causing them to say, for example, "He is schizophrenic, anyway." Changes and transitions, however, become fathomable with PAMRs.

The value of a news report seems to peak at the time of its transmission, and after hearing the same news half a dozen times, people get bored or angry. However, a story is different – it retains its value even after repeated readings, with the reader going back and forth between the text and its interpretation, and the result is the layering of meanings (Benjamin, 1936). Actually, it is interesting to read the patient's PAMR repeatedly, since it is always possible to find something unnoticed in the previous readings. Unlike the doctor's news, re-reading a PAMR gives the reader a chance to expand the interpretive space and its "amplitude," that is, the reader is not coerced to understand the meaning in a certain restricted way defined by the technical terms. Different readers or different contexts permit this free interpretive space, a breadth of interpretation that is not exhausted through re-reading. Unlike the doctor's prescription, the story-based prescription is therefore textually open. The text is also *open* in the sense that the patient can rewrite or correct the previously written record. In creating a PAMR, for example, the patient can change or revise their utterance at each end of the session.

Here, the nurse is more than a participant observer – the nurse attends the narrative exchange with the patient, being present at the site, and becomes a part of the narrative moment. The nurse becomes the patient's "*moral witness*" (Kleinman, 1988), endorsing the patient's story and their view of the world with respect. A PAMR also gives the nurse an opportunity to readjust her view of the patient and of herself due to the dialogue's two-way mutual causality. Change is imperative and mutual in interactive communication, so that as the patient changes – even slightly – through the dialogue, so does the nurse. It is a principle that participants in a dialogue accept the risk of undergoing changes (Anderson & Goolishian, 1988). Therefore, the repeated reading of a PAMR by the nurse reflects her own transition and represents learning anew about the patient – and about the nurse herself.

Method

Setting and sample

The study took place during 2018–2020 in the psychiatric outpatient unit of a large university hospital in central Japan. The research was a field-oriented ethnographic study, and we took PAMRs from 10 outpatients whose diagnoses included schizophrenia or mood disorders such as depression and bipolar disorder. Five patients out of 10 subsequently had follow-up meetings with the researchers and staff with their family members present, and four did so without family participation.

Table 1 shows the interviewed patients' sex, age, diagnosis, major complaint, family composition, hospitalization experience, and the number of times a PAMR was created. The total number of PAMRs used was 48. The data was ultimately somewhat random because of the character of field study.

Participants eligible to participate in the follow-up meeting included the patient, family members, doctors and nurses, although doctors and family were sometimes absent when limited by their work schedules or circumstances. The follow-up meetings always started by reading the previous PAMRs before engaging in free discussion with no previously prepared topics or questions.

Data collection

Permission to conduct this study was obtained from Fujita Health University in Japan (Approved No. HM17-391). Written informed consent was obtained from all the participating patients, who had been referred by the psychiatrists in charge of the patient. One of the psychiatrists in the unit participated in our study as a research team member.

The first author gave an oral presentation explaining the outline of this study, including the ethical considerations, to all the psychiatrists in the psychiatric unit, asking for their cooperation and referrals. She also explained the research plan to the nurses, psychologists, occupational therapists, and psychiatric social workers in the unit and asked for their cooperation.

The following steps were taken to find participants in the study: the psychiatrists introduced the researcher, which made the introduction comfortable for the patients, the researcher met with each patient and explained the research purpose and procedure, and upon the written consent of the patient, the researcher either began creating a PAMR or determined a date to do so.

The typical steps adopted in creating PAMRs were as follows, and the interviewers were two psychiatric nurses, the first and second authors.

① The nurse meets the patient on the day of their visit to the outpatient service, where she secures a private room to talk with the patient. The nurse introduces herself to the patient, and the patient is shown a piece of paper explaining the purpose, method, and significance of this research. The nurse reads it aloud to the patient sentence by sentence and adds further explanations whenever necessary. Only after written permission is obtained does she start her work. The patient and the nurse sit side by side, and the nurse records the patient's narrative on a laptop computer. This ethnographic fieldwork technique may require a bit of practice but is not difficult for most nurses. The walk-in therapy described below adopts this style (Hoyt et al., 2018; Slive & Bobele, 2011).

② The nurse and the patient can start their conversation with any topic. Although she can start out by posing any question to the client as long as she is respectful of the dialogue, the nurse should keep in mind that her key tasks include determining the state of improvement defined by the patient and how to achieve this

Table 1
An overview of the ten patients who produced PAMRs.

Patient	Sex	Age	Diagnosis	Symptom	Living with	Nr of hospitalizations	Nr of PAMRs taken
No.1	M	Early 50s	Schizophrenia	Sleep disorder	Wife, 1 child	None	2
No.2	F	Late 50s	Depression	Fastidious, not motivated	Living alone	None	7
No.3	M	Late 50s	Depression	Insomnia, malaise, anxiety	Wife, 2 children	5 or more	4
No.4	F	Late 50s	Depression	Frustration, anxiety, insomnia	Husband, 1 child	5 or more	8
No.5	F	Late 30s	Schizophrenia	Restless	Parents	2	5
No.6	F	Late 80s	Depression	Anxiety, insomnia, trembling of the lower limbs	Living alone	5 or more	5
No.7	M	Late 40s	Bipolar disorder	Malaise	Living alone	3	10
No.8	F	Early 30s	Schizophrenia	Hallucination, frustration	Mother	2	2
No.9	F	Early 50s	Depression	Melancholy, tiresome	2 children	1	3
No.10	F	Late 50s	Depression	Anxiety, suicidal ideation	Living alone	2	2

improved state, that is, the patient's own prescription. The nurse records what the patient has told her in the form of a first-person narrative. The nurse's questions are recorded in the second person.

③ The amount of time required is approximately 40 min, but the nurse asks the patient after 15 min if it is OK to continue.

④ At the end of the session, the patient goes over what has been written and corrects misunderstood parts or inaccurate expressions. Alternatively, after 40 min of dialogue, the patient might change some of the content, and it is perfectly acceptable to revise it. This could reflect a change that occurred during the interaction. When the patient has endorsed the corrected version, the nurse prints a copy out and hands it to the patient to take home. The present study followed the model developed in walk-in therapy in Canada and the U.S. (Hoyt et al., 2018; Slive & Bobele, 2011). In walk-in therapy, the patient can knock on the door at any time and is permitted to talk about their predicament for an hour, after which the patient receives a copy of their words typed up by the therapist who listened to their story. The patient may or may not return to the clinic.

⑤ All the PAMRs provide the (preferred) name of the patient, date, duration of the interview, interview location in the unit, and name of the interviewer. The document is usually 1–2 pages long in the typed format in Japanese.

Analysis

Not-knowing (Anderson & Goolishian, 1992) was our *philosophical stance*, but more significantly, it was our method – for being engaged in conversation and facilitating the patient's narrative. There was no common data collection technique except that the researcher facilitated the conversation so that the patient would feel safe and relaxed enough to express their thoughts. Whenever necessary, the researcher politely asked the patient to explain information in more in depth. Adopting this approach is like being an anthropologist fieldworker who asks the native people how to perform a ritual about which the fieldworker is ignorant. The psychiatric nurse is also the one needing to be taught by the patients how to handle their illness and needing to gain experience. *Not-knowing* is a stance as well as the method for collecting data on the patients' expertise. It is often risky to accept the patient's explanation too quickly – a quick assessment not only truncates the conversation, robbing the interlocutors of the opportunity to extend the conversational space, but also unwittingly leads one to make errors based on premature assumptions. Thus, *not-knowing* requires the therapist to be in the process of understanding, always on the way to understanding. Using this method, the patients and the researchers collaboratively created 48 PAMR documents (see Table 1).

Although these documents are defined as medical records, they can also be viewed as the patient's biographical data. Therefore, the analysis must be based on an anthropological approach to biographical data (Crapanzano, 1980; Langness & Frank, 1981), which has two distinct characteristics. That is, the collaboratively produced biographical story of a PAMR is a conversational record that calls for the following: (a) The observer should be observed, that is, the researcher is also an object of study. The nurse is involved as an observer listening and responding with feedback to the patient by nodding, agreeing, or asking questions. Thus, the presented story is a joint product of those in dialogue, and the patient's story is not presented to a general audience but solely to a particular nurse. (b) There is narrated truth in that relationship that is separate from the empirical truth of factual evidence. That is, the narrated biography, even if produced under the influence of delusion or hallucination, can be more "real" to the patient than the sequence and content of events that are viewed as historically correct. These two characteristics were key analytical stances.

This study defines the term "therapy" as the process of obtaining new ideas and stories that broadens the patient's perspective and contextual premise, since every person in a stuck situation tends to think too narrowly in terms of either/or or of right or wrong (Andersen, 1987). The term "therapeutic" includes a re-writing or re-authoring of one's old story under the influence of a dominant person or dominant value system – the dominant story – of the culture at the time (White & Epston, 1990). The present study adheres to the following definition by Anderson and Goolishian (1988 p. 381): *therapy is a process of expanding and saying the "unsaid" – the development, through dialogue, of new themes and narratives and, actually, the creation of new histories*. Therapy relies on the infinite resources of the "not-yet-said" in the narratives around which we organize ourselves. The realization of change requires communicative action, dialogue, and discourse. Thus, in this study, to be therapeutic is to secure space for dialogical communication and to develop new meanings and ideas within the patient's biographical account, which is continually revised. We ordinarily think that the disappearance of symptoms is a sign of improvement. Such a medical goal may or may not be the patient's goal. Regardless of the presence of symptoms, the situation can be "therapeutic" in this framework when the patient arrives at a new idea or a story about themselves.

The analysis was conducted to examine whether or not the PAMR was effective at meeting the patients' therapeutic goals by contributing the re-authoring of their story. The effectiveness was measured in terms of the extent to which the old story shifted its emphasis, generated new topics, changed its narration mode, or altered the patient's premises and perspectives.

Findings

The PAMRs gave each patient a chance to enter a new type of discourse. The following include some of the comments made by the patients.

"Something unknown came out, which neither I nor others knew before."
(No. 1 in Table 1)
"I saw my own changes through reading them." (No. 2)
"It (the PAMR) gave me a chance to study my own shoes." (No. 2)
"It works as a rough indication for assessing my illness." (No. 2)
"What had been vague and unclear turned into something I could feel sure about." (No. 2)
"I was able to find my own voice that I didn't catch before." (No. 3)
"The methods for improving my illness began to appear." (No. 4)
"My problem was transferred from the abstract (i.e., diagnosis) to something concrete." (No. 4)
"I was able to trace my conditions going up and down through reading them." (No. 6)
"I feel a lot better whenever I am listened to. My one-sided view gets another angle to look at." (No. 8)
Additionally, the female patient (No. 10) who had barely stopped herself from committing suicide later told the nurse, "I want to write another PAMR," adding, "You know, I want you to listen to me – even after your research ends."

Three case examples are presented that illustrate the nature and significance of PAMRs. These ethnographic accounts help explain how PAMRs functioned.

Case examples

(1) Harumi (pseudonym): After Reading it at Home

"When my husband died, I was depressed, but I thought it was natural when facing someone's death. I was basically OK – I led an ordinary life for three to five years. But, when my mother died, it was entirely different – inside my head went round and round, and other strange things, too. This was the first time I noticed something wrong, which was

entirely different from the earlier depressed feelings. I told my sister everything because she can understand me. I felt exhausted but couldn't stop myself. I didn't sleep but worked and moved around a lot. I was strange physically." (Excerpt from Harumi's 1st PAMR).

Harumi (No. 9 in Table 1) was in her early fifties when she was diagnosed with depression. She lived with her two sons, both teenagers, after her husband's untimely death. When her husband, who was five years younger than her, died of complications from an organ transplant, Harumi thought she was responsible for his death due to her misjudgment. Her husband was the only son of a large farming family in a distant rural area, and his family, particularly his mother and elder sister, had an unusually strong attachment to him, sending Harumi money and farm produce even after their son's death. Such deliveries continued despite Harumi's declining to receive the packages, putting enormous pressure on her.

> "I thought I sent my husband to death. He was their only precious son. I was totally confused for about an hour whether I should remove his abdominal dropsy, and finally I asked to remove it. He died soon after that. Someone later told me that they did not remove it because the removal can be fatal. So, I thought I was responsible for my husband's death, and this thought occupied the whole of my mind, endlessly blaming myself. So, I couldn't speak about it to anyone."
>
> (Excerpt from the 1st PAMR)

Harumi read her 1st PAMR after taking it home and realized something different than the reality she had previously believed in.

> "The paper you gave me, I read it after I went home. Before, I didn't think at all that I was sick at the time of my husband's death. But I realized after reading that something was already wrong when I was sitting by his bed. That was only a relapse when my mother died!"
>
> (Excerpt from the 2nd PAMR)

Harumi recognized that she had already been in a state of confusion under the influence of psychosis. She felt relieved of her burden knowing that her misjudgment had not been the sole cause of her husband's death. She was able to revise her old story that she was the one to be blamed. Harumi "re-authored" her story, creating a new version by re-reading the PAMR and through the dialogue with the nurse.

> "Since then, I spoke several times to my sons about their father. And about good memories of the time we spent together. I doubt this kind of thing is helpful for your research, but it was surely good for me, because I think I found out where I was and where I am."
>
> (Excerpt from the 2nd PAMR)

(2) Kyoko (pseudonym): When I Feel Insecure

> "My hands tremble even in normal times. I'm restless. Because I feel ill at ease, I wander around inside my house – it's my problem. My hands have been trembling for several months. I walk around in my house all the time. I cannot sit down and watch TV – can't concentrate. I'm restless during meals, too, but try to manage it. I take baths but can't stay long in the tub. I go to the restroom a lot – it's so frequent. I mainly do housework at home, washing and folding the laundry."
>
> (Excerpts from Kyoko's 1st PAMR)

Kyoko (No. 5 in Table 1) was in her late thirties and lived with her parents and her younger brother, and she also had a dedicated younger sister living within the vicinity. She had been suffering from hand tremors, mainly in her right hand. Kyoko was diagnosed with schizophrenia, and her anxiousness was elusive and unspecific, although her insecure feelings led her to wander around the house and engage in compulsive checking behavior. She had to make sure that the refrigerator door was shut, the toilet was flushed, the front door was locked, etc. With job assistance, she began working at a welfare workshop doing simple handiwork. She heartily wished her anxiety could be relieved.

> "(What do you feel is problematic in daily life?) Strong anxiety, I think, ever since the end of the last year. I felt suffocated, messed up and got panicky, so I wandered around in my room and in the kitchen for about 10-15 minutes. It's mostly because of my work like someone I find it difficult to get along with at the workshop or my poor skills in handiwork. … I have a difficult colleague who I don't get along with – she moves in on everyone's job, including mine."
>
> (Excerpts from the 3rd PAMR)

An obvious difference between the 1st and 3rd PAMR (approximately two months apart) was found in Kyoko's description of her anxiousness. In the 3rd PAMR, the description of her uneasiness was directed toward concrete objects, such as a difficult colleague or her poor handiwork skills. Her vague feelings of anxiety began taking shape – they were no longer abstract shadows. In her 5th PAMR taken 40 days later, her statement was much more lucid.

> "I was very happy when my colleague at the workshop gave me a candy package – Milky, cough drops, and others, five or six of them in it! Every Tuesday and Thursday are the cooperative cooking days, and a meal costs you only 250 yen (a little over $2). We make lunch together with the workshop staff. The other day, we made Chinese cabbage pork rolls with demi glaze on top and tossed radish and tuna. I did it with about 20 other people. Someone cooked rice for us.
>
> … At the workshop I do the handiwork by myself, so I can work at my own pace in peace. One of the workshop staff told me, "You look so well and relaxed without symptoms!" We start the work at 10 am and take a break at 11:50 am, and then comes lunch break for an hour. The afternoon work is from 1 to 4 pm but with a 10-min break every hour. We sweep and clean the work-site between 3:40 and 4 pm. When the workshop is over, they have a shuttle service that takes us near my home. … My checking behavior still goes on, but my anxious wandering around is less frequent. Before, it took all my effort just to take care of my own problems, but now I can think about people around me. (People around you?) Yes, my family maybe – my mother or my sister. Now, I'm aware exactly when I cannot stop checking something with my family out of my insecure feelings. Before, I had no way of knowing that, so I just wandered around. My family is precious – they do many good things for me. I'm a bit worried about my mother that she cannot move around a lot – she is diabetic and has to go for dialysis treatment perhaps because of it."
>
> (Excerpts from the 5th PAMR)

Kyoko's 5th PAMR is marked by her detailed lively talk, showing consistency. Her story describes not only concrete and tangible episodes, such as those in the collaborative cooking event, but also her "space" for considering her family, particularly her sick mother. Significantly, her elusive anxiety within herself was expressed and *externalized* in the form of a target person or of her job skills. Once *externalized* and identified, the former indefinable anxiety once kept inside could become a topic of conversation with the nurse in the dialogical setting, shining a spotlight on it and making it manageable.

(3) Tatsuo (pseudonym): I Can't Get Through to Them

Tatsuo was in his late 40s when the PAMRs were first taken and had

been treated for bipolar disorder for 20 years. Tatsuo started working at a factory at age 18, but approximately 10 years later, after being harassed by his foreman, he became unable to sleep. He was referred to the psychiatric unit of university hospital and was hospitalized for six months. He was later hospitalized two more times during the course of his treatment but continued working until he had to quit the company a half year before the 1st PAMR. The research team created 10 PAMRs with Tatsuo, more than for any other patient studied. There were two follow-up meetings without his family, one with his psychiatrist and the other without. From the 1st to the 5th PAMR, he mainly talked about his daily routines but emphasized two points: he wanted to work, and he did not feel motivated. In the 6th PAMR, however, Tatsuo came out with his bitter experience at the time he was harassed and became ill.

> "I was in my late 20s. I was assigned to the new line in the factory, and my new supervisor always got angry at me. Whatever he didn't like about me, he jerked me around by saying, 'Come to the line two hours earlier.' I answered him back and said, 'No one comes to work two hours before!' Then he said, 'Do what I told you!' I didn't understand why he demanded such an unreasonable thing. He even came to the line while working and picked at me for a number of things. One time I got one wrong assembly out of 300 pieces while my colleague had 8 out of 300, but he came down on me for the mistake, and not on my colleague. I didn't understand. My colleague said, 'Why didn't I get a talking-to? I don't know.' So, I just put up with him – he was not going to listen to what I said, and if I argued against him, he got angry. After that, I became sick of being involved with others. There were about 20 other workers in our section line, but I was rather new to the place and I had no one really to talk to."
>
> (Excerpts from Tatsuo's 6th PAMR)

Tatsuo took a leave of absence from work several times, including for his three hospitalizations, until he finally had to quit working at the factory in his mid-40s. He was semi-forced out of the company after having meetings with the industrial doctor and his supervisor. He experienced their total unwillingness to listen to his accounts and consequently felt hopeless at relating and communicating with the corporate people. He could not get through to them. Tatsuo came to realize with pain that talk never works. When the PAMR was first taken, his psychological state was more or less at this stage, where he could not help feeling reluctant to disclose himself, overwhelmed by his sense of distrust and social anxiety.

His psychiatrist had been seeing Tatsuo for approximately 20 years ever since his first episode, and the two were able to talk with each other rather naturally but within the context of a routine outpatient setting. Throughout, the psychiatrist encouraged him to exercise and walk at least an hour a day, thinking that he could send Tatsuo to occupational therapy. Perhaps partly due to his social phobia, however, Tatsuo was reluctant to participate in such group therapy, where he would be faced with many unfamiliar people. However, when he had his second follow-up meeting with the two nurses, Tatsuo, being encouraged, went to observe the occupational therapy, and to the nurses' surprise, he participated in the part of the session with ease.

> "Since I started the occupational therapy, I constantly get up around 6 am. Before, I could only get up at 8 or 9. Now, I go to the hospital on Tuesday and Friday, and that may be why I can get up early. I can also even get up early on Saturdays and Sundays. I don't talk much with people doing the ball games at the occupational therapy, but instead I speak to the rehabilitation students. The exercise starts at 9:30 am and ends at 11:30 am… I want the hospital staff to listen to my problem and help me get closer to my goal. My goal is ultimately to find a job and to work."
>
> (Excerpt from the 8th PAMR)

In his last (10th) PAMR, Tatsuo described that he had played table tennis and volleyball but with some sore muscles afterward and that he had taken a cooking class at occupational therapy and began attending it on Wednesday. Although he still complained about his low motivation, he vividly described his progress in the cooking session, learning "the use of teaspoons and tablespoons." He ended his last PAMR saying, "Now, I'm thinking of ways of making myself feel energized and motivated."

Tatsuo's ten PAMRs, taken in an 18-month period, do not reveal dramatic changes on the surface. However, its impact seemed substantial for him in the area of his social discourse. What seemed altered was his reluctance to enter interpersonal relations despite the psychiatrist's repeated suggestions to go to occupational therapy. Tatsuo's participation became possible through communication with the nurses. His area of discourse expanded to include people in occupational therapy and grew beyond his conversations with his psychiatrist. Encountering a variety of people in the group therapy perhaps mitigated his phobic anxiety toward unknown others. It is possible based on the observable outcomes that the PAMR sessions helped renew his confidence. His unpleasant stress experience, which had long persisted in the form of an inner monologue, now found an audience. The PAMR was also physical proof for him, a thing itself, as a shared historical document.

Despite our desire to include a few more cases, the research had to stop due to the coronavirus pandemic, which consumed most of the capacity of the university hospital. Tatsuo's last PAMR was taken on February 4th, 2020. We have telephoned most of the patients since then, including Tatsuo, for follow-ups. In February 2021, a year after his last PAMR, Tatsuo replied to our follow-up call, giving status updates in a brisk tone of voice. Although his lifestyle had not changed greatly, he seemed to enjoy conversing with the nurse, talking about his automobile and about the coronavirus outbreak that occurred in his town. His replies were unhesitating, and the retarded responses we had often observed before were absent. Just before hanging up, he added, "Ask me again about how I'm doing some time or other."

Discussion

The idea of PAMRs as an *accompaniment* and an *escort runner* is consistent with the traditional role of psychiatric nurses, as reflected in such phrases as just "being with" the patient, sitting quietly beside them, waiting until the patient is ready to reach out to the nurse (Hays, 1962). PAMRs go a step further than the traditional view, showing the nurse's genuine curiosity about the patient as a unique person.

As defined earlier, therapy in this study is a process of unfolding and expanding the domain of the "not-yet-said" (Anderson & Goolishian, 1988). Thus, we will (1) explain the performance of the PAMR according to this definition and (2) discuss more general effects of this tool in the context of psychiatric nursing. The results above were story-based ethnographic accounts, so the evaluation comprises our interpretation of these qualitative data and a succinct presentation of our arguments.

(1) The performance and benefits of PAMRs for Harumi, Kyoko, and Tatsuo

(a) *The re-reading of PAMRs is beneficial for the patients since it creates space for new interpretation.* Harumi read her PAMR at home and discovered a new history of her illness, which eased her suffering. Her initial story was that she had been in a normal psychological state and should therefore have been able to make the right decision at the critical moment for her husband. Her suffering had been embedded in the old story, and the way out of the impasse also existed in the form of a story, albeit an alternative story (Epston et al., 1992; White, 1995). The story-based prescription is textually open and permits different interpretations (Benjamin, 1936).

(b) *It is the not-knowing stance that qualifies the nurse to be an appropriate audience for the patient.* The nurse could not imagine in advance the dramatic result of Harumi's re-reading of her own PAMR. What the nurse did was simply listen to the patient's narrative in good faith based on *not-knowing*, and the patient was *morally witnessed* (Kleinman, 1988).

(c) *PAMRs help the patient externalize their own problem instead of personalizing it, so that the patient can separate themselves from the problem at hand* (White & Epston, 1990). Kyoko was able to put it into words such as "a difficult colleague" or her own "poor skills." Once the problem is *externalized* or expressed, the patient can place the problem within the stream of their own story. Their story changes by re-telling, and so does the problem situated in the story. This occurs because the problem is not substance but is made up of words.

(d) *Unlike the doctor's prescription, PAMRs permit polyphonic voices and multivocality, which is inherently present in a dialogical process* (Bakhtin, 1984). As Kyoko said, "Before, it took all of my effort just to take care of my own problems, but now I can think about people around me (e.g., her sick mother)." Here, noticed is another voice becoming audible, a voice that practically said, "I can think about people around me." Multivocality creates space for the patient, providing an opportunity to write something previously untold. This was something that had been retained in the great reservoir of her "infinity of the unsaid" (Anderson & Goolishian, 1988; Gadamer, 1975).

(e) *PAMRs provide the patient with a safety zone that can promote trust and restore confidence.* In his 6th PAMR, Tatsuo was finally able to examine the traumatic experience that had taken place at his workplace. The story of his social anxiety and related distress had been stuck in the domain of the "unsaid" for a long time. It took six sessions for Tatsuo to reach a place where he could discuss it, but this was a heroic step based on the trustful relations he formed with the nurses. This bears resemblance to narrative exposure therapy – a short-term psychotherapy for posttraumatic stress disorder (PTSD) (Lely et al., 2019; Robjant & Fazel, 2010).

(f) *PAMRs help the patient reclaim authorship over their own story.* Our life is expressed and narrated in the form of story. Tatsuo's agony and social anxiety might have been the result of being completely dominated by the story that someone else had written, which put him down as being incompetent. Someone else, his former supervisor or the industrial doctor, might have written his previous story, depriving Tatsuo of authorship. Tatsuo was able to write another viable story that cast him in a different light and helped him take back authorship from the "fake" authors (Epston et al., 1992).

(g) *PAMRs are useful archives for the patient, an undeniable material proof and record of the patient's life history.* The ten sessions for Tatsuo were not simply ten repetitions – they were *conversations about conversation*, in that each session was a reflection of the previous one (Andersen, 1987). The result was the layering of meanings (Benjamin, 1936) and thick descriptions (Geertz, 1973), which can be considered communicatively equivalent to the relationship that was formed with the nurse.

(2) The general effects of the PAMR for psychiatric nursing

For the psychiatric patient, PAMRs provide a unique type of discourse, a new conversational opportunity. The patient becomes the protagonist and the main author, assisted by the nurse, and expresses their long-held aspirations. The female patient with suicidal ideation (No. 10) said, "I want to write another PAMR. I want you to listen to me – even after your research ends," indicating the value of her experience with the record making.

By gathering the threads of their own story, the patient becomes more attentive to their own use of words, and the story presentation becomes more cohesive. The patient shifts their literary position from *someone to be read* to *someone who authors*. Authorship means the authority to re-write an alternative story out of the dominant one that has been written by a powerful figure or the dominant culture (White & Epston, 1990; Epston et al., 1992; MCNamee & Gergen, 1992). Anthropologists recognize that the *historical truth* is often different from the *narrative truth*, and native peoples rely most heavily on *narrative truth* for rational guidance (Bruner, 1986 p139-145; Clifford & Marcus, 1986, Eliade, 1956). The psychiatric patients, too, find a home in the story they have written.

The patient is an author but also a reader of their own text. The reading experience helps patients be more objective about their own condition. PAMRs can also be shared outside one's medical circle. A former patient (No. 6) showed her PAMRs to her family when they visited on the weekend, and her son told the patient, "Oh, Mom, you're getting a real good thing! It's good for you to be heard." The reading of one's own text leads to the acquisition of another self as a reader, countering "*the medical gaze*" that confines the patient within the biomedical framework (Foucault, 1975).

For psychiatric nurses, the PAMR could become a symbol of their professional identity. A PAMR is not a prescription for a disorder but is one for an illness, i.e., the suffering person's lived experience. The latter may be the area where psychiatric nurses can play a leadership role in exerting their presence in mental health settings. The nurses become facilitators of a new type of discourse, which uniquely fits within their work scope of caring for and watching over patients. The role ambiguity of nurses in psychiatric units has been noted in terms of their relationship with other medical professionals (Kimura & Matsumura, 2010; Sabella & Fay-Hillier, 2014). The PAMR, as a narrative-based prescription, can be a medical tool used specifically by psychiatric nurses.

Second, the PAMR is a specialized technique of psychiatric nurses. Other neighboring professions would generally experience difficulty in the position of a *not-knowing* fieldworker due to their specified own work domains, such as dispensing medicine or testing. However, it is unnecessary for psychiatric nurses to alter their everyday stance to engage in the PAMR process – they can maintain with their routine demeanor of familiarity, friendliness, and egalitarianism. This does not mean that nurses do not need any training for creating a PAMR – the process involves some learning about the framework with some practice with note taking, but it is nothing difficult.

Third, for the psychiatric nurse as an individual, PAMRs can become a means of life-long learning and cultivation of the dialogical art. Unlike the scripted speech of a counter attendant at a fast-food shop, dialogue does not turn out as planned – it is a novel challenge every single time and is continually unpredictable. As psychiatrists become adept at diagnosing disease, psychiatric nurses can improve their skills in *the art of therapeutic dialogue*. This type of learning inevitably involves substantial training about oneself, since the dialogical process always entails a two-way, circular process where the teacher is taught, or the curer is cured. The writing of collaborative medical records can become the unopposed, exclusive territory of psychiatric nurses.

For psychiatrists, the significant merit of the PAMR may be the binocular vision (Bateson, 1979, p 77–79) that they can obtain by combining the PAMR with their own observation of the patient. The doctor can take *the context of disease*, which is *the illness*, into account.

Conclusion

It seems clear that PAMRs are noticeably effective, helping patients reach their own therapeutic goals. The psychiatrist's prescription and the nurse's PAMR can go hand in hand, being complementary to each other and filling the role that the other cannot. Since the psychiatrist's prescription does not cover *illness*, although it does cover *disease* (Kleinman, 1988), the two can possibly be the warp and weft of the patient's therapy.

Further, PAMRs may encourage psychiatric nurses to establish a professional identity, which has often been obscured in historical

processes. Psychiatric nurses today still ask fundamental questions about "what we do and who we are" (Peplau & Faan, 1994; Barker & Buchanan-Barker, 2011; Sabella & Fay-Hiller, 2014). PAMRs might offer psychiatric nurses a distinct medical practice and help prove their professional identity distinct from that of psychiatrists.

One of the limitations of this study was that the hospitalized patients were not included, as the government-funded research on PAMRs with hospitalized patients is currently under way. Although we could not accomplish it, our initial research plan covered the extended application of the PAMR. That is, the nurse, if the patient desired, would create a computer file within the ordinary hospital record file, making it available to the responsible staff. A dialogue between the patient and the responsible readers would emerge because of the record's first-person character.

The PAMR is our way of making a collaborative medical record, so modifying it to suit the medical environment or culture is quite conceivable and highly encouraged. Its essence, however, is that the PAMR is a joint communiqué, a collectively woven narrative, which the patient and the nurse both try to live up to as a mutual commitment. It is always therapeutic and productive as long as the nurse holds on to the basic stance of *not-knowing*. It is our sincere hope that nurses and psychiatrists across different cultures work collaboratively, mobilizing each specialist skill to help alleviate the suffering of patients with a psychiatric diagnosis.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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