Writing and Reading Mental Health Records

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Issues and Analysis

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SAGE PUBLICATIONS
International Educational and Professional Publisher
Newbury Park London New Delhi

For information address:

SAGE Publications, Inc.
2455 Teller Road
Newbury Park, California 91320

SAGE Publications Ltd.
6 Bonhill Street
London EC2A 4PU
United Kingdom

SAGE Publications India Pvt. Ltd.
M-32 Market
Greater Kailash I
New Delhi 110 048 India

Printed in the United States of America
Library of Congress Cataloging-in-Publication Data

Reynolds, John Frederick, 1952-
Writing and reading mental health records.

Includes bibliographical references and index.
1. Psychiatric records. 2. Psychiatric hospitals —Records. I. Mair, David Clare, 1949- II. Fisher, Pamela C. (Pamela Correia) III. Title. [DNLM: 1. Medical History Taking—methods. 2. Medical Records. 3. Psychiatry—methods. 4. Psychology—methods. WX 173 R463w]
RC455.2.M38R49 1992 616.89'0751 91-42892
ISBN 0-8039-4079-1 (cl.)
ISBN 0-8039-4098-X (pbk.)

92 93 94 95 10 9 8 7 6 5 4 3 2 1

Sage Production Editor: Diane S. Foster

Writing and Reading Mental Health Records

The truth of everything and all people after Plato is writing: you are, one might say, either what *you* write down, or what somebody else writes down *about* you.

Jasper Neel
Plato, Derrida, and Writing
1988

A Clinician's Foreword

When I was a 3rd-year medical student, during my first experiences in patient care, a wise old medical resident told me that, contrary to what I had been taught, the patient interview and physical examination were *not* the most important parts of patient assessment. He proclaimed that 90% of what we needed to know about a new patient could be found in the old chart. He was often proven right. Despite its critical importance, the role of the patient record in clinical management has remained largely unexamined. This is especially ironic in mental health care, because psychiatrists and other mental health professionals have traditionally placed great emphasis on the value of constructing a narrative account of the patient's history, tracing a life from its prenatal start through key phases of development, major traumas, significant relationships, past and present symptoms, and up to the present illness or problem.

While we mental health professionals read, photocopy, fax, and often obsess over the content of our clinical records, we seldom consider their structure, format, language, or process of construction. Why should that be? *Writing and Reading Mental Health Records* provides us insight because its first two authors are teachers of composition, specialists in technical and professional writing, working in collaboration with a psychologist. For all our uses of language and persuasion, we in the mental health professions are not expert in linguistics or rhetoric. As the authors of this book diplomatically note, we are unaware of many issues regarding our records because we have never been trained to be aware of them.

There are other explanations, however, that can account not only for our inattention to the form and process of our records, but also for a de-

terioration in their focus and quality of content. The authors of *Writing and Reading Mental Health Records* remind us of the increasingly powerful influences of various institutions and social forces on how mental health records are written. Rapidly changing health care delivery systems, third-party payors, the Joint Commission on Accreditation of Hospitals, malpractice suits, federal and state regulations—all have had a tremendous impact on mental health care and how it is recorded. Each has had obvious as well as subtle and occult effects on how the encounter between the mental health professional and the patient is recorded. Unfortunately, the influences do not easily integrate with each other or with our primary purpose, which is treating the patient. No wonder, then, that the mental health record has become a bewildering quilt of different professional jargons and bureaucratic imperatives. No wonder we may even lose sight of the readers for whom our records are written. No wonder that a composition specialist might look on the mental health delivery system as a Tower of Babel.

This book and its authors have raised many questions. To what extent do initial impressions recorded on intake records distort subsequent diagnostic assessment and treatment planning? That is, if the initial impressions are erroneous in some major way, how often are the errors perpetuated by uncritical acceptance? To what extent does record keeping differ between settings (state hospital vs. private hospital, outpatient fee-for-service vs. outpatient HMO, etc.)? What is the relationship between the characteristics of records and reimbursement? Are there differences among the records of Medicare, Medicaid, Blue Cross/Blue Shield, private insurance, and indigent patients? How is reimbursement affected by the structure, content, and process of records? Can we develop meaningful quality standards for records beyond externally mandated standards (e.g., JCAH)? How far have our conscious and unconscious responses to the fear of malpractice suits distorted our record keeping? Reynolds, Mair, and Fischer have brought new light to where we stand in our clinical work. I hope this book stimulates your thinking as much as it has mine.

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A Rhetorician's Foreword

Mental health reports? What a strange thing for composition specialists to be concerned with. These reports are filled with a jargon that is inaccessible to composition teachers and that is even misinterpreted by mental health professionals. These reports do not actually constitute a definable genre (the authors of this text caution that their own efforts to define the genre [as reflected in their Taxonomy, Chapter 2] probably cannot be generalized beyond the settings where they did their research). And it is hard to see how understanding these reports would contribute to the teaching of composition—at least to anyone other than mental health professionals. So why mental health reports?

As it happens, *Writing and Reading Mental Health Records* presents a series of rather compelling answers to this question. First, these reports are important because, directly or indirectly, they will touch virtually everyone's life. The authors note that at least one in five Americans will probably, at some point in their lives, seek treatment for a mental disorder. And those who do not seek treatment for themselves will be affected by those who do—friends, family, and significant others, not to mention all sorts of adult and juvenile criminal offenders. For all these persons, the mental health report will be the basis for answering such questions as these: Is this person in fact suffering from a treatable mental disorder? If so, what sort of treatment should the person receive? Will an insurance company have to reimburse him or her for that treatment? Is the treatment succeeding? Should this person be held legally responsible for his or her actions? As a society and as individuals, we have reason to care about answers to these questions.

Second, these reports may present an opportunity for us to do something useful in the world outside our classrooms. This is not to suggest we ought to go barging into mental health organizations advocating features of diction, syntax, or organization that have always served us well in our teaching and in our own writing. Quite the contrary, as this book makes clear, when we enter a particular mental health setting, we are strangers in a land that may be quite different from what we are accustomed to, maybe even different from other mental health settings. As the authors point out, perhaps the most consistent feature of mental health reports is their extreme variability.

But our status as outsiders may stand us in good stead. If we can rein in our teacherly impulse to jump in and propose solutions before we know exactly what the problems are, our lack of understanding can enable mental health professionals to surface their assumptions and tacit knowledge and then subject both knowledge and assumptions to scrutiny or revision. Our lack of knowledge can be an occasion for them to teach us and themselves as well, and it can let us find points at which the things we do know—as writers, as teachers of writing—can be useful. Once we understand the values and goals of a given setting, we can use what we know about diction, syntax, organization, or the composing process to help people achieve these goals.

And finally, mental health reports are important to teachers of writing because they constitute, in the authors' words, "practitioner rhetorics," and, as such, occasions to test and refine our assumptions about the ways meaning gets constructed and conveyed through language. Consider, for example, just one of the several types of writing done in medical mental health settings—the nursing assessment. This assessment, written within 24 hours after a patient has been admitted to a mental health hospital, obliges a nurse to develop a comprehensive understanding of "the patient's physical, mental, and spiritual condition." The nurse has to use that understanding to determine what the patient's problems are, set up goals, and propose "immediate interventions" that will help achieve these goals. This assessment may be read by any number of people—physician, pastoral counselor, social worker, occupational/recreational therapist—and it becomes part of the basis for setting up the patient's "master treatment plan."

By any standard, this is a formidable rhetorical task. It also is an opportunity for us to think through such questions as these: What "ideological biases" (see Chapter 3) are reflected in the language the nurse/rhetorician uses to talk to and talk about the patient? What details do those biases

predispose him or her to see or to ignore? In other words, how does language figure into the process of constructing meaning in this context? What social interactions—with the patient, with other nurses, with physicians—influence the nurse's attempt to construct meaning in this context? And how do readers of the assessment construct their own meanings of the assessment?

These are the kinds of questions this book will help answer, not by addressing them directly but, rather, by providing a map of an extraordinarily complex territory. Particularly valuable in this respect are the authors' discussions of the language of mental health reports and the "ideological biases" that govern the work of mental health professionals. These discussions help us see what kinds of questions can and should be asked. By enabling us to investigate the language and thought of one type of nonacademic setting, this book enables us to consider issues that are fundamental to our field. Why think about mental health reports? *That's* why.

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Preface

> Words were originally magic and to this day have retained much of their ancient magical power. By words one person can make another blissfully happy or drive him to despair . . . convey his knowledge . . . carry his audience with him and determine their judgments and decisions.
>
> Sigmund Freud
> *The Introductory Lectures*

Writing and Reading Mental Health Records is a rhetorical analysis of written communication in the mental health community. It contributes to the body of research being done in composition studies on the nature of writing and reading in highly specialized professional discourse communities.

At least since the landmark work of Odell and Goswami (1982, 1985), professional writing in nonacademic settings has been a subject of continuing interest to postsecondary composition studies specialists. As Carolyn B. Matalene observed in her important 1989 book *Worlds of Writing: Teaching and Learning in Discourse Communities of Work*, rhetoric and composition specialists in university English departments have increasingly recognized the importance of studying all uses of language, not just literary uses; of offering direction and insight to all users of English, not just to freshmen and poets and literary critics; of building better bridges between the academy and the public; of learning and teaching in the many worlds of writing other than their own. Similarly, professionals from various worlds of work have increasingly begun to realize that to be a white-collar worker today very much means to be a writer; that whether one's actual profession be law, accounting, medicine, engineering, or management, it is to some extent the profession of writing.

As a result, writing specialists are now regularly entering into research partnerships with colleagues from other fields so that various worlds of technical and professional writing can be examined from an interdisciplinary perspective. *Writing and Reading Mental Health Records* resulted from one such interdisciplinary research partnership, in this particular case a collaboration between composition studies specialists and mental health practitioners. This book is by and for both groups. It presents research that we hope will prove to be valuable not only to writing teachers, but also to professional clinicians, their teachers, and those who read mental health records in order to make important decisions. As Robert Scholes (1991) has noted, "Because of the importance and power of [scientific] discourses it is essential for students to learn how they work and what their strengths, costs, and limitations may be" (p. 11).

One of the most complex worlds of writing in our society (if not, in fact, *the* most complex world) is the mental health community, a community of professional writers and readers who depend on careful description, interpretation, and analysis for informed and intelligent decision making. Like those writers and readers, we intend to be both descriptive and interpretive in the rhetorical analysis that follows. Our purpose is to describe, interpret, and analyze the nature of written communication in the mental health community and to offer insights that might be used to improve writing and its instruction. We believe our research indicates that much is at stake. Psychiatrists, psychologists, social workers, nurses, therapists, counselors; lawyers, judges, caseworkers, parole boards, probation officers; classroom teachers, school psychologists, guidance counselors—all of those professionals who for one reason or another currently or in the future will write and/or read mental health records need to do so with the greatest possible caution and care. All need the fullest possible awareness of the complexities and political realities of rhetorical situation(s). The writers need the greatest possible understanding of the tensions and complications that result when almost everything they write will have multiple audiences, purposes, and uses. The readers need the greatest possible consciousness of the fact that almost everything they read probably resulted from complex acts of "discovery, negotiation, compromise, commitment, creation, persuasion, and control" (Matalene, p. xi). We hope that *Writing and Reading Mental Health Records* helps to start dialogues which, over time, will meet some of these needs.

This book had its beginnings in a 1987-1988 pilot study that David Mair and I conducted in Oklahoma with assistance from Robert Edwards, Mark Hayes, Terri Goodman, Daina Baker, John Holter, Judy Norlin, Donna

Johnson, Thomas Miller, the staffs of North Care Center and Bethany Pavilion, and Oklahoma Mental Health Commissioner L. Frank James. Preliminary results from that study were published in 1989 in volume 19, number 3, of the *Journal of Technical Writing and Communication*, and we appreciate Baywood Publishing Company's permission to reprint much of that material in Chapter 2.

We gratefully acknowledge the hundreds of professional writer-clinicians whose names we will never know but whose work made this expansion of that original pilot study possible. We are enormously indebted to the dozens of colleagues who granted us lengthy interviews, answered our follow-up questions, made important suggestions, and/or offered comments, sometimes anonymously, for inclusion in this book. We appreciate the invaluable help we received from Dale R. Fuqua, Lodema Correia, and Cindy Gregory. We especially appreciate the many hours we were allowed to spend interviewing Marcia Haynes, Correctional Health Services Administrator of the Mental Health Unit at Joseph Harp Correctional Center; Ernest Little, Staff Psychologist; and Debbie Huckleberry, Medical Records Supervisor. We also thank Warden Jack Cowley for his cooperation.

I personally want to thank Marquita Flemming and Terry Hendrix of Sage Publications for their interest in our project. I also thank Ann A. Hohmann of the National Institute of Mental Health for her useful insights and for putting me in touch with James L. Levenson, who proved to be enormously helpful to us on more than one occasion. Karen Bourden, also of NIMH, needs to be acknowledged for her patient and critically important responses to my questions about the Epidemiologic Catchment Area study. I thank my former department chair, linguist Charles E. Ruhl, who always understood, as Freud understood, the magical power of words, and who unfailingly used his most magical words to support me and my work. Finally, I thank my psychologist father-in-law for introducing me not only to his fascinating world of work, but also to my friend and colleague Pamela Fischer.

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Contents

Introduction

The Growing Importance of Mental Health Records

> We should never forget that John Tower was denied the chance to be George Bush's Secretary of State because there were records of his alcoholism, or that Thomas Eagleton was denied the chance to be George McGovern's running mate because there were records of his shock therapy, or that Richard Nixon was denied the chance to be President because there were some psychiatric records he wanted from a safe in an office at the Watergate Hotel.
>
> Anonymous Psychiatrist in Private Practice

Problems associated with writing and reading mental health records are well worth our attention. Large and ever-increasing numbers of people are going to be affected by the writing and reading of these records sometime during their lifetimes. As we approach the twenty-first century, more and more people are entering into an increasing number of mental health care delivery systems. At the same time, growing numbers of problems are coming to be defined as mental disorders. Consequently, an increasing number of people are writing and reading mental health records for an increasing number of purposes.

Lewis L. Judd, former director of the National Institute of Mental Health (NIMH), has pointed out that mental disorders are much more common than most people realize. They are not rare, he has explained; they do not happen only to others. Schizophrenia, for example, one of the less common mental disorders, is five times more common than multiple sclerosis, six times more common than insulin-dependent diabetes, and 60 times more common than muscular dystrophy (Judd, 1990).

Overall, NIMH epidemiologic research has suggested, mental health disorders have a prevalence in the general population about the same as

that of hypertension, and thus significant numbers of people are at risk for mild to severe impairments (Freedman, 1984). In fact, *one in every five Americans will have a mental disorder at some time in life* (according to one study, the number may be as high as *one in three*), and *one in five will seek treatment* (Regier, Boyd, Burke, Rae, & Myers, et al., 1988; Judd, 1990).

Society's as well as the mental health community's thinking about mental illness and treatment has changed dramatically during the past two decades. Definitions of both have expanded significantly. This has been especially true for alcohol and drug abuse and dependency, now readily defined as mental disorders and treated as such. It is becoming increasingly true for a variety of other co-dependent, addictive, or otherwise dysfunctional human behaviors. To the extent that chemical dependency, eating disorders, domestic violence, and post-traumatic stress disorders, for example, have only relatively recently come to be thought of by large segments of the public and the clinical community as mental disorders rather than weaknesses of will, the already-dramatic mental illness statistics and trends may reveal only the tip of an iceberg of mental illness in our society at the turn of the century.

Before we look at some of those statistics and trends, we believe it is important to note that the stigma-reducing "treatable disorder" movement during the last two decades has enormous implications that the system has only barely begun to realize. Once a given problem comes to be seen as a treatable disorder, more people begin to seek treatment for that disorder, causing more documents to be generated. More people begin to be documented, in writing, as having had that disorder, as having been treated for it, successfully or unsuccessfully. Experience has shown that as the demand for treatment under health insurance coverage increases, insurance companies begin to impose limits on coverage. Mental health care is perhaps the easiest coverage category, politically, in which to cut benefits.

As one recent (and obviously biased) article on psychiatric hospital insurance problems noted, "Because of the relative imprecision of mental illness diagnosis, it is easier for insurers to challenge psychiatric admissions than admissions for other ailments. In many cases, insurers are simply decreasing the limits on psychiatric inpatient stays, no matter what a doctor prescribes" ("Psychiatric," 1991, p. 17).

The clinical community has no real choice, then, but to develop alternative definitions of illness and approaches to treatment so that clinicians can receive payment for services. The situation is therefore fluid and likely to become increasingly so. Written documentation will play a key role in

that fluidity. Under current definitions of illness and treatment, mental health records affect many people; as definitions expand, written records begin to affect even more.

The Mental Health Picture Today: A Thumbnail Sketch

The following is a thumbnail sketch of the national mental health picture as of this writing—the current definitions of "disorder," the current definitions of "treatment," and selected current trends and statistics. While the latter are not complete in their coverage, not a mental health status report per se, they do suggest the growing importance of mental health records in our society.

CURRENT DEFINITIONS OF "DISORDER"

The current editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*, 1980, and *DSM-III-R*, 1987) officially recognize, name, define, and describe more than 40 mental illnesses, 15 of them major, according to the following general categories:

- infant, childhood, or adolescent disorders
- organic mental disorders
- substance-abuse disorders
  alcohol
  drugs
- schizophrenic disorders
- paranoid disorders
- psychotic disorders
- affective disorders
  mania
  depression
  dysthymia
- anxiety disorders
  phobias
  panic
  obsessive-compulsive disorders
- somatoform disorders
- dissociative disorders
- psychosexual disorders