WRITING and READING MENTAL HEALTH RECORDS

Issues and Analysis in Professional Writing and Scientific Rhetoric

SECOND EDITION

John Frederick Reynolds
David C. Mair
Pamela C. Fischer

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Routledge
Taylor & Francis Group
New York London

First published by Lawrence Erlbaum Associates, Inc., Publishers
10 Industrial Avenue
Mahwah, New Jersey 07430

Transferred to digital printing 2010 by Routledge

Routledge

270 Madison Avenue
New York, NY 10016

2 Park Square, Milton Park
Abingdon, Oxon OX14 4RN, UK

Library of Congress Cataloging-in-Publication Data

Reynolds, John Frederick, 1952-
Writing and reading mental health records: issues and analysis in professional writing and scientific rhetoric, second edition / John Frederick Reynolds, David C. Mair, Pamela C. Fischer.
p. cm.
Includes bibliographical references and index.
ISBN 0-8058-2001-9(c : alk paper). -- ISBN 0-8058-2002-7 (alk. paper)
1. Psychiatric records. 2. Psychiatric hospitals--Records.
I. Mair, David Clare, 1949- . II. Fischer, Pamela C. (Pamela Correia) III. Title.
RC455.2.M38R49 1995
616.89'0751--dc20 95-19440
CIP

10 9 8 7 6 5 4 3 2 1

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A Rhetorician's Foreword

Lee Odell
Rensselaer Polytechnic Institute

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 don't really constitute a definable genre (the authors of this text caution that their own efforts to define the genre, as reflected in their Taxonomy in 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. The first is that 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 should go barging in to 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? 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 us answer, not by addressing them directly but 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.

A Clinician's Foreword

James L. Levenson
Medical College of Virginia

When I was a third-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 proved 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.

Although 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.

But there are other explanations, as well, that can account not only for our inattention to the form and process of our records, but also for a deterioration 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 (JCAH), 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, 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 for me. 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 between 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.

Preface to the Second Edition

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, Second Edition, is a rhetorical analysis of written communication in the mental health community. As such, it contributes to the growing body of research being done these days in rhetoric and composition studies on the nature of writing and reading in highly specialized professional discourse communities.

At least since the landmark work of scholars Odell and Goswami (1982, 1985), professional writing in nonacademic settings has been a subject of interest to postsecondary rhetoric and composition studies specialists. As Matalene (1989) observed in her important 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, management, or whatever, it is to some extent the profession of writing.

As a result, writing specialists in university English departments are now often entering into research partnerships with colleagues from other academic disciplines so that various worlds of technical, professional, and scientific writing can be examined from an interdisciplinary perspective. Both editions of *Writing and Reading Mental Health Records* resulted from one such interdisciplinary research partnership, in this particular case an ongoing collaboration between composition

studies specialists and mental health practitioners. This book has always been imagined as being a book by and for both groups, a book that might present research of value not only to writing scholars and teachers, but also to professional clinicians, their teachers, and those who read mental health records in order to make critically important decisions. As Scholes (1991) 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 (we continue to believe that it is, in fact, the most complex world) is the mental health community, a community of professional writers and readers who depend on a plethora of documents full of 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 purposes are to describe, interpret, and analyze the nature of written communication in the mental health community; to bring to life many of the major terms, concepts, and theories currently at the center of postsecondary rhetoric and composition studies; to suggest, at least implicitly, one model for further book-length studies of professional writing communities; and to offer insights that might be used to improve writing and its instruction in the world of mental health. In the case of the latter, 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 do or someday 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, 1989, p. xi). We have always hoped that *Writing and Reading Mental Health Records*, in its various editions, would help to start dialogues that over time might meet some of these needs.

Our work on mental health records had its beginnings in a 1987–1988 research study that we conducted in Oklahoma with the ongoing assistance of 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 the *Journal of Technical Writing and Communication*, and we appreciate Baywood Publishing Company's permission to reprint much of that material here in chapter 2.

We gratefully acknowledge the hundreds of professional writer-clinicians whose names we can never know but whose work has made both book-length expansions of that original study possible. We are enormously indebted to the

dozens of colleagues who have granted us lengthy interviews, answered our follow-up questions, made important suggestions, and/or offered comments, sometimes anonymously, for inclusion in both editions of our book. We appreciate the invaluable help we have received from Dale R. Fuqua, Lodema Correia, and Cindy Gregory, as well as the many hours Warden Jack Cowley has allowed us to spend interviewing staff and observing activities at the Joseph Harp Correctional Center.

I personally want to thank Ann A. Hohmann of the National Institute of Mental Health (NIMH) for her many useful insights, and for putting me in touch with James L. Levenson, who has been enormously helpful to us on more than one occasion over the years. Karen Bourdon, also of NIMH, needs to be acknowledged for her patience in responding to my dumb, no doubt, but critically important questions about the Epidemiologic Catchment Area study. I want to publicly express my appreciation to Marquita Flemming of Sage Publications, and to the many kind reviewers of our first edition—Nancy Comley, Robert McDonald, Carolyn Matalene, and Carol Reeves, in particular—for their support. Also those colleagues who wrote letters nominating our first edition for the NCTE award for Best Book on Technical or Scientific Writing for 1992.

I must once again acknowledge my former department chair, linguist Charles E. Ruhl, a remarkable human being who always understood, as Freud understood, the magical power of words, and who unfailingly used his most magical words to support the early stages of this, and other, work during my years on the faculty of Old Dominion University, where support was often long on talk and short on do. But most of all I want to thank three people: my wacky psychologist father-in-law, Robert Edwards, for introducing me to his fascinating world of work and to my friend and colleague Pamela Fischer; my long-time cohort and collaborator, David Mair, whose words, phrases, clauses, ideas, suggestions, questions, objections, and reactions are, for me, always so incredibly useful and perfectly on-target that I find myself reaching for the phone even when I have no real reason for calling; and my editor at Lawrence Erlbaum Associates, Hollis Heimbouch, who has faithfully and enthusiastically supported not only my work, but the work of many people in rhetoric and composition studies, and with whom I would be proud to work together on anything, anytime, anywhere.

—Fred Reynolds

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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

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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 [sic] 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 some 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 21st 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, increasing numbers of people are writing and reading increasing numbers of mental health records for increasing numbers of purposes, and that trend is likely to continue.

Lewis L. Judd (1990), former director of the National Institute of Mental Health (NIMH), pointed out that mental disorders are much more common than most people realize. They are hardly rare, he explained, and they do not happen only to others. Schizophrenia, for example, one of the less common mental disorders, is 5 times more common than multiple sclerosis, 6 times more common than insulin-dependent diabetes, and 60 times more common than muscular dystrophy.

Overall, NIMH epidemiologic research has suggested that mental health disorders have a prevalence in the general population about 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 (Judd, 1990; Regier, Boyd, Burke, Rae, & Myers, 1988).

Society's thinking, as well as the mental health community's thinking, about what constitutes *mental illness* and *treatment* has changed dramatically during the past two decades. Definitions of both terms have expanded significantly. This has been especially true for alcohol and other drug abuse and dependency, now readily defined as mental disorders and treated as such. A variety of other codependent, addictive, or otherwise dysfunctional human behaviors are now seen as mental disorders as well. To the extent that such things as chemical dependency, eating disorders, domestic violence, and post-traumatic stress disorders (PTSDs), 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 think it is important to note just how fluid and interactive the mental health care "system" is. For example, we believe that the stigma-reducing "treatable disorder" movement during the last two decades has enormous implications which the overall system has only barely begun to realize, especially when that particular movement interacts with insurance carriers' responses to it. Consider the following chain reaction: 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. But as the demand for treatment of that disorder under health insurance coverage begins to increase, insurance companies begin to impose limits on coverage. (We should note here that mental health care is perhaps the easiest health insurance coverage category, politically, in which to cut benefits. As a recent 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 Hospitals," 1991.) In reponding to these constantly changing coverage limits, then, the clinical community feels it has no real choice but to constantly change, as well; that is, to keep developing alternative definitions of illness and approaches to treatment so that clinicians can receive payment for services. Our point here is that the entire situation is remarkably fluid, and likely to become increasingly so. Written documentation plays a key role, of course, in that fluidity. Under current definitions of illness and treatment, mental health records already affect many, many people; and as definitions expand, written records will 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 the mid-1990s—current definitions of *disorder*, *treatment*, and selected current trends and statistics. Although 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

Current editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (the *DSM*) 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
- factitious disorders
- impulse control disorders
- adjustment disorders
- other and additional

Current Definitions of Treatment

The following are currently considered to be among the major mental health care treatment settings, at least for purposes of NIMH utilization studies (Shapiro, Skinner, Kessler, Von Korff, & German, 1984):

Specialty Mental Health Resources

- Psychiatrists, psychologists, social workers, other counselors working in private practice or family clinics
- Mental health centers
- Psychiatric hospitals, and psychiatric units of general medical hospitals
- Outpatient clinics at psychiatric hospitals
- Drug treatment clinics
- Alcohol treatment clinics

General Medical Resources

- Medical care practitioners to whom visits are made for emotional or mental problems

Other Resources

- School counseling services
- Prison counseling services
- Church and other pastoral counseling services
- Family service agencies
- Crisis centers, women's centers, etc.

Current Trends and Statistics

At present, the most common mental illnesses are the anxiety disorders (phobias, panic, and obsessive-compulsive disorder) and the affective disorders (depression, manic-depression, and dysthymia; Regier et al., 1988). Men currently have higher rates of diagnosis for the substance abuse and antisocial personality disorders, whereas women currently have higher rates of diagnosis for the affective, anxiety, and somatization disorders (Regier et al., 1988). Higher prevalence rates for most of the disorders are currently found among people below age 45 (Regier et al., 1988). But those rates may change as the population ages: Psychiatric conditions tend to be exacerbated by the stress of chronic and multiple physical illness that accompany aging; and for at least 5% of those over age 65, cognitive deficits or dementia occurs, with associated changes in behavior and affect (Bender, 1990).

Medication decisions are often based upon a written history of the patient's prior responses. Without this history, the selection of one agent over another in its pharmacologic class is more often guided by adverse reaction rates than by a knowledge of which agent will be the most effective for the patient.

—Kenneth J. Bender, PharmD
Psychiatric Pharmacologist

Mental disorders appear to be interrelated. Currently, there is a "general tendency toward co-occurrence, so that the presence of any disorder increase[s] the

odds of having another disorder" (Boyd, Burke, Gruenberg, Holzer, & Rae, 1984, p. 983). In certain cases, the tendency toward co-occurrence is dramatic. NIMH research has shown, for example, "that a pre-existing anxiety disorder or major depressive episode among people 18 to 30 years of age *doubles the risk for future substance abuse and dependence*" (Judd, 1990; italics added). Alcohol and drug abuse/dependency and mental illness appear to be especially interdependent. Up to 53% of drug abusers and 37% of alcoholics have at least one serious mental illness. Similarly, 29% of all mentally ill people have a problem with either alcohol or drug abuse (Bass, 1990). Given the tendency toward interrelationship and co-occurrence of mental illnesses, then, we should consider, at the very least, the current and future systemic significance of the following.

Alcoholism. At present, the magnitude and consequences of alcoholism are enormous. An estimated 10 to 20 million people in the United States are alcoholics (Bender, 1990; McGrath, Kelta, Strickland, & Russo, 1990; Steele & Josephs, 1990). Alcohol consumption contributes to 1 out of every 10 deaths in the United States, approximately 200,000 each year (Bender, 1990). Alcohol abuse is implicated in 70% of fatal automobile accidents, 65% of murders, 88% of knifings, 65% of spouse batterings, 55% of child abuse, 60% of burglaries (Steele & Josephs, 1990), and somewhere between 20% and 37% of suicides (McGrath et al., 1990). No other psychoactive substance is associated with violent crimes, suicide, and automobile accidents more than alcohol (Steele & Josephs, 1990). Alcohol abuse is currently the nation's most costly health problem: "When the costs of lost production, crime, and accidents due to alcohol are totaled and added to the cost of treating alcohol addiction, the bill comes to over $117 billion a year" (Steele & Josephs, 1990, p. 921).

The devastation of alcoholism, as with other drug abuse, can also be measured in terms of the destruction of the individual's self-worth, relationships, and the emotional health of associated family, friends, and coworkers (Bender, 1990). Thirty to 50% of the alcoholics in the country today are women, for whom alcoholism leads to increased rates of pancreatitis, cirrhosis, ulcers, and cardiovascular problems. Many women use alcohol to repress traumatic childhood experiences including sexual and physical abuse and incest (McGrath et al., 1990). Although the evidence suggests that some forms of alcoholism have a significant genetic basis, environmentally induced processes have the most powerful influence on the development of alcoholism, and "thus behavioral psychology enters the picture" (Steele & Josephs, 1990, pp. 928–929).

Abuse of Other Drugs. Illicit drug abuse is pervasive in U.S. society. It is widely believed by many experts in the field that the level of drug abuse in the United States is higher than that in any other industrialized nation (National Institute on Drug Abuse [NIDA], 1989). More than one half of U.S. youth try an illicit drug before they finish high school. An estimated 14.5 million Americans used a drug illicitly in the month prior to being surveyed in the 1988 National

Household Survey on Drug Abuse (NIDA, 1989). The number of people admitted to emergency rooms following cocaine use increased more than fivefold since 1990. The number of people who died following cocaine use more than doubled during the same time period (NIDA, 1989).

Drug abuse in the United States is clearly a major public health problem. In addition to medical emergencies and deaths related to drug abuse, other short- and long-term effects have been identified: automobile accidents, workplace accidents, learning disabilities, interference with reproduction, fetal injury, and long-term damage to heart, lungs, and other organs (NIDA, 1989). The U.S. Department of Health and Human Services' (U.S. DHHS) 1990 National Household Survey on Drug Abuse showed declining use of most illicit drugs by Americans. Despite the apparent good news, however, drug abuse remained high among members of key demographic subgroups: young adults ages 18–25, African Americans, individuals in large cities, and the unemployed. According to former Health and Human Services Secretary Louis Sullivan, drug abuse continues to account for a significant portion of the violence, crime, child abuse, and other destructive behaviors in our society (U.S. DHHS, 1990).

Teenage Depression and Suicide. Suicide is correlated with depression in adolescents. Approximately 5,000 young people commit suicide each year, with as many as 300,000 to 400,000 attempts every year in the general population (McGrath et al., 1990). Since the 1960s, the suicide rates for young people have almost tripled. In addition, adolescent suicides are often followed by a "cluster" effect in which one suicide is followed by other attempts (and some completions) from young people in the same community (McGrath et al., 1990).

According to a recent Gallup poll, 6% of U.S. teenagers say that they have tried to commit suicide, and 15% say that they have come close to trying. Three out of five surveyed said that they knew a teenager who had attempted suicide; 15% said that they knew a teenager who had succeeded. Almost 33% of those surveyed said that the suicidal teenager had exhibited warning signs, such as depression or withdrawal, or had talked or written about wanting to die. Of those teens who reported having considered or attempted suicide, 47% blamed family problems, 23% cited depression, 22% cited problems with friends, 18% cited feeling worthless, and 16% cited boy–girl relationships. Some gave more than one reason. The senior analyst for the survey, a former school psychologist, commented that the poll proved that society had not addressed one of its major problems: "The third largest cause of death among adolescents is suicide," he reported, "and yet you don't really see anybody systematically addressing this yet" ("6% of Teens Say, 1991).

According to a study published in the June 1991 issue of *Pediatrics*, a major portion of teen suicides and suicide attempts can be attributed to homosexual and bisexual males. The study reported that nearly one third of all gay male teenagers attempt suicide at least once, suggesting "an urgent public health problem warranting further study" (Majeski, 1991).

Homelessness. Homelessness in the United States continues to increase, and interrelationships between alcoholism, drug abuse, mental illness, and homelessness seem clear (Rossi, 1990). In the mid-1950s, there were more than 550,000 patients in U.S. public mental health hospitals. Now there are about 100,000. Almost one third of the homeless in New York City alone—about 15,000—are mentally ill persons who would have been in hospital-based treatment in the 1960s (Rosenthal, 1990). Estimates of the rates of mental illness among the homeless vary widely, from about 10% to more than 85%, but most studies report rates on the order of 33%, an increase from estimated rates appearing in the literature of the 1950s and 1960s (Rossi, 1990).

Post-Traumatic Stress Disorders. Post-traumatic stress disorder (PTSD), what Menninger once described as a "whiplash of the soul," was originally associated primarily with military combat and was not officially recognized as a bonafide mental disorder until 1980, long enough after the Vietnam War had ended that most Vietnam-related cases of PTSD likely saw delayed treatment or no treatment at all. Today, however, combat-related PTSD may loom large on the mental health horizon. It is feared by some, for example, that an especially large number of the more than 500,000 troops sent to the Persian Gulf in 1990–1991 (as well as many of their parents, spouses, and children) will enter into mental health care-delivery systems over the next few years for treatment of nightmares, depression, substance abuse, and relationship troubles that may have resulted from stresses associated with their military service (Pate, 1991).

Furthermore, PTSD diagnoses are no longer being linked solely to military or combat-related experiences. The physical, cognitive, and behavioral responses of female sexual abuse and assault victims, for example, are now seen as as being consistent with *DSM* criteria for PTSD (Koss, 1990). In fact, some experts consider female sexual abuse and assault victims to be the largest single group of PTSD sufferers, and believe the size of that group is huge and likely to increase. When epidemiologic methods have been applied to the study of violence against women, the results suggest that sexual abuse and assault have been experienced by 38% to 67% of adult women recalling the period before age 18, 12% of adolescent girls, 15% of college women, and approximately 20% of adult women. In addition, violence in the recent relationships is reported by 31% of married women. Alarmingly, "all of the studies document levels of violence that far outdistance office estimates. They suggest a scourge of violence against women in the United States" (Koss, 1990, p. 375).

Clinical recognition of PTSD and other mental disorders in adult female victims of violence is thus on the rise. Even when evaluated many years after an assault, victims are significantly more likely than nonvictims to qualify for psychiatric diagnoses of major depression, alcohol and/or drug abuse or dependence, generalized anxiety, obsessive-compulsive disorder, and PTSD (Koss, 1990). Increasingly, victimization in general is being recognized as a significant etiology in eating disorders, multiple personality, and borderline syndrome. It is now "abundantly

clear that a history of victimization is a strong risk factor for development of lifetime mental health problems" (Koss, 1990, p. 376).

Other "New Mental Health Disorders." Just as chemical dependency and PTSD only recently received widespread acknowledgment as mental disorders, as bonafide mental illnesses, other "new mental health disorders" are constantly in the process of being identified, recognized, and accepted by both the public and mental health community. Some are quite technical (e.g., Late Luteal Phase Dyspheric Disorder), whereas others are simply faddish. One regional magazine, for example, recently published a special issue exploring

> some mental health disorders [*sic*] just now coming out of the closet and being recognized as warranting specialized treatment: difficult children, problems with intimacy, co-addictive behavior, adults molested as children, looking for father, toilet training, facing infertility, talking man to man, family trauma, addictive relapse. (*Fourth Annual Guide*, 1990, p. 1)

These, and others, may soon come to be seen as mental health disorders, prompting large numbers of people to seek treatment.

CONCLUSION

The long-term U.S. mental health picture, then, is likely to be one of rising incidence and prevalence of a growing number of disorders and associated disorders, leading to an increasing number of patients entering into an increasing number of care-delivery systems, where more mental health records will be written, read, kept, and utilized. From a records point of view, the mental health picture resonates with paradox. Given the enormously destructive social and economic effects of mental illness, it is critical that more of the mentally ill seek treatment, that more be diagnosed and treated effectively in as many settings as necessary, and that (if necessary) more be covered by insurance and other third-party payment sources so that care can be made available to them. However, as more people are treated for mental health problems, more become dependent on and vulnerable to mental health records. Records play a critical systemic role, and the larger the system, the larger the role of the records.

Compared to other mental health issues, however, the records are a largely unexplored aspect of the mental health care picture in the United States, despite their obvious importance both now and in the future to the increasing numbers of patients, practioners, and third parties who collectively comprise the mental health care system.

For patients, written records facilitate the delivery and, perhaps, determine the quality of mental health care services. They certainly facilitate and determine levels of reimbursement when insurance coverage is involved. And because they become part of patients' life histories, mental health records can come back to save and, as well, to haunt.

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