INTERVENTION INSIGHTS

Writing letters to patients

'One written word is worth a thousand pieces of gold'

—Japanese proverb

Writing letters to general practitioners (GPs) has long been accepted as an integral part of conventional routine psychiatric practice. GPs send their patients along with a referral letter and quite rightly expect a written response. The amount of detail we send back varies, but the standard assessment outlines a formulation of the problem with reference to presenting symptoms, diagnosis, aetiology, treatment and prognosis. This is regarded as a key part of quality clinical management, and is integral to modern models of integrative care and shared care clinical models. Furthermore, during the course of recovery, it is reasonable for GPs to expect regular letters from the psychiatrist keeping them informed of any progress and changes to treatment plan.

Writing letters to patients, however, is less conventional and does not occur routinely in psychiatric practice. The majority of letters that are sent from psychiatrists to patients consist of appointment reminders, cancellations or invoices for service. Although it can be argued that confidential correspondence between professionals is sometimes necessary, it seems strange that patients are often kept out of the correspondence loop. This is particularly discordant with the increasing emphasis on the primacy of the patient in clinical decision-making, and role of the consumer as the central focus in modern health systems development.

In the National Health Service plan, the UK government made a commitment to send patients copies of letters written between clinicians (1):

'The Good Practice Guidelines issued by the Department of Health in (2003) advised that as a general rule (and where patients agreed), letters written by one healthcare professional to another should be copied to the patients concerned' (2).

A significant variation of this principle is the practice of writing letters directly to patients and, with their permission, sending copies to their GPs. The status of psychiatrist-to-patient correspondence then takes on a whole new dimension. The potential benefits that flow from this relatively simple change have yet to be adequately investigated, but this has the potential to be a potent psychoeducational and psychotherapeutic intervention.

As the neurobiological understanding of psychiatric illnesses and treatments expand, psychiatrists face the challenge of integrating a biological bias, fundamental to the medical model, with the systemic and psychological understandings of non-biological paradigms. Michael White and David Epston's narrative therapy may prove to be useful in negotiating this dilemma (3). Narrative therapy encourages the use of all sorts of therapeutic documents, and letters to the patient are often a core component. White's 'externalising the problem' encourages us to separate the 'problem' from the 'person' (4). The patient is no longer the problem. The problem is the problem. This helps free the patient from blame and provides an opportunity for therapeutic change. The patient and the therapist explore the interaction between the person and the problem. In narrative therapy, the story of this interaction is told, evaluated and re-told. What is the patient's attitude to the problem? In what ways is the problem affecting? How they see themselves and how does it influence the way others see them? What is the patient's preferred view of himself or herself? Is there an alternative life story to tell? Are there occasions when the patient is able to defy the problem and take a step towards reclaiming the preferred life story?

The practice of 'externalising the problem' seems to sit easily within a traditional medical model. Sometimes the problem is an illness. This may or may not be apparent to the patient but if this idea fits with how the patient understands things, a conversation follows that encourages the patient to make a stand against the illness. The patient can begin to become the author of a story that describes and indeed directs his or her recovery.

Cognitive analytical therapy (CAT) has incorporated letter writing to patients as an essential part of the therapeutic intervention (5). The initial assessment phase aims to produce a mutually generated cognitive-behavioural 'diagram', and based on this rudimentary map, the therapist writes a detailed formulation in the mode of a letter. This is presented to the patient and the shared understanding from this document provides the foundation for the rest of the therapeutic journey (6). CAT then uses a 'goodbye' letter as part of the of therapy termination process (7).

The relationship that exists between the psychiatrist, the patient and the patient's family in traditional psychiatric practice tends to place the professional in the role of the expert. Associated with this is an assumption of knowledge, power and respect. This in itself is not necessarily a bad thing. Certainly, the paternalistic attitude of traditional psychiatry is useful,

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if not mandatory, for some patients in some situations. When faced with the distressing drama of an acute psychotic illness, patients and their families need someone who can bring some order to the chaos. Indeed research into therapeutic relationships shows that the anticipation of receiving assistance from a qualified experienced professional is one of the key elements of successful psychotherapy (8). It needs to be acknowledged, however, that adopting the expert stance can have other less desirable implications (3,4). Patients and their families may experience disempowerment or even disrespect. They may feel that their story has not been heard or, worse still, it has been devalued or dismissed. In some cases patients may feel pathologised and stereotyped whereas their families may feel excluded or blamed. Both can end up manoeuvred into a passive role or adopt an oppositional response to the professional's authority. Illness itself is disempowering for most individuals and undermines self-efficacy. The patient may subsequently be at increased risk of poor compliance whereas the family becomes alienated or critical when desired outcomes are not immediately apparent. As an 'expert', responsibility to overcome the patient's problem may be perceived to rest solely in the hands of the professional. An active engagement in the treatment process enhances 'buy in' to the therapeutic model, and has the potential to strengthen the therapeutic alliance, increase self-efficacy, confidence and adherence.

Narrative therapy challenges therapists to give up the monopoly on expertise by trying to explore and negotiate a shared understanding (4). This is quite a challenge in those clinical scenarios when patient insight is lacking. Some would suggest that a clear statement of the different opinions of patient, family and the psychiatrist at least puts the patient's dilemma on the table. The realities of mandated authority and subsequent professional responsibility could then be made overt. Reasonable negotiation hopefully proceeds.

Some styles of correspondence about the patient might aggravate any unhelpful complications of a power imbalance in the psychiatrist-patient-family system. Careful consideration of what we write as professionals is becoming a mandatory part of routine clinical practice (9). Patients who do not frequently seek access to hospital files are indeed presented with copies of their discharge summaries as a matter of hospital protocol (1). With this in mind, a formal letter to the patient, written with empathy and respect for the reader, can go long way to consolidating the therapeutic relationship. The practice of thinking about and documenting the patient's dilemma in an objective, non-judgemental and perhaps a more compassionate style not only can influence the self-perceptions of patients and attitudes of family members but may also positively influence the writer's own evolving perspective. This contributes to the process of self-efficacy. It also increases the sense of ownership of the joint treatment plan, and boosts autonomy and control, that is so frequently undermined by illness.

Patients can share this written information with families or whomever they please, thus potentially addressing a family's lack of knowledge or indeed challenging residual shame or secrets within the family. Of course a possible complication of third parties reading private and potentially inflammatory information needs to be kept in mind by the letter writer. This should be discussed with the patient prior to sending any sensitive letters.

Narrative therapy encourages the writer to use the patient's own words as much as possible and as a consequence psychiatric jargon tends to be kept at a minimum (3,4). The written word can be a powerful validation of the patient's experience and an undeniable proof that their story has been heard. The letter may be a record of the decisions and plans that have been negotiated in the session or a clear statement of the patient's progress. The patient is given a concrete resource personalised and specific to their clinical condition and circumstances. The written record of joint treatment decisions, for example regarding lifestyle interventions or behavioural strategies, serves as a written behavioural prescription, with the person as dispenser of his or her own treatment. Core psychoeducational messages can be conveyed in such communications, and can be honed to the individual's specific issues. Some patients report that they subsequently carry this document with them like a valued transitional object (5,7). Research shows that up to 97% of patients who received copies of referral letters and summaries said they would like to receive copies in the future (10). Written records would be especially appreciated by those patients whose memory is impaired, whether because of organic or psychological influences.

The use of emails and phone texts to patients as further therapeutic tools is a relatively new innovation that needs to be considered and evaluated (11). Writing to the patient, when done well, fosters a more knowledgeable, empowered and respected population for psychiatrists to serve in the provision of quality health care. Writing letters to patients should be considered as a component of routine care rather than the exception used only in particular models such as cognitive analytic therapy. Clinicians will need to give careful consideration as to what information is appropriate and safe to send in a letter. The letter needs to be drafted in a manner that reduces potential sources of ambiguity. Sometimes the technical details that might be important to send to a colleague could be omitted or summarised in the letter to the patient. There will be occasions when patients request no correspondence. Yet the principle remains that if an individual seeks an opinion or treatment from a professional, a written confirmation of the contract could be a useful part of the treatment package.

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References

1. Department of Health. The NHS plan. London: Stationery Office, 2000.
2. Marzanski M, Munsuri P, Coupe T. Copying letters to patients: a study of patients' views. Psychiatr Bull 2005;**29**:56–58.

3. Monk G, Winslade J, Crocket K et al. Narrative therapy in practice. The archaelogy of Hope. San Francisco: Jossey-Bass, 1997:121–157.
4. White M, Epston D. Narrative means to therapeutic ends. New York, London: W.W. Norton, 1990:38–75.
5. Ryle A, Kerr IB. Introducing cognitive analytic therapy: principles and practice. Chirnside: John Wiley, 2002.
6. Bennett D, Parry G. A measure of psychotherapeutic competence derived from cognitive analytic therapy (CCAT) Psychother Res 2004;**14**:176–192.
7. Kerr I. Cognitive analytic therapy. Psychiatry 2005;**4**:28–33.
8. Hubble M, Duncan B, Miller S. The heart & soul of change. What works in therapy. Washington: American Psychological Association, 1999:259–264.
9. Bloch S, Riddell CE, Sleep TJ. Can patients safely read their psychiatric records? Implications of freedom of information legislation. Med J Aust 1994;**161**:665–666.
10. Jelley D, van Zwanenberg T, Walker C. Copying letters to patients. Concerns of clinicians and patients need to be addressed first. Br Med J 2002;**325**:1359.
11. Seeman MV Seeman B. E-psychiatry: the patient-psychiatrist relationship in the electronic age. Can Med Assoc J 1999;**161**:1147–1149.

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