Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's telephone and fax numbers and e-mail address. Letters related to material published in *Psychiatric Services* will be sent to the authors for possible reply. Send letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; fax, 202-682-6189; e-mail, psjournal@psych.org.

Stigma and Violence

To the Editor: The special section in the December 2001 issue on stigma as a barrier to recovery included four papers that described how stigma decreases self-esteem and impairs the recovery of individuals with severe psychiatric illnesses (1–4). Like most current publications on stigma, the section opened with a quotation from the Surgeon General's 1999 report on mental health (5), which cited stigma as "the most formidable obstacle to future progress in the arena of mental illness and health."

Remarkably, however, none of the four papers mentioned the most important cause of stigma, which is cited in the Surgeon General's report. As stated in the report: "The answer appears to be fear of violence: people with mental illness, especially those with psychoses, are perceived to be more violent than in the past." The report notes that in the 1950s, when most seriously mentally ill individuals were hospitalized, only 13 percent of the public associated mental illness with violence, while in the 1990s, 31 percent of the public made this association.

It seems clear from the Surgeon General's report, as well as from research studies, that little progress will be made in decreasing stigma until we address the issue of violence. To do so is currently considered politically incorrect by some people, who claim that addressing this issue will cause additional stigma. Yet, if violence is the main cause of the stigma, our failure to address it simply ensures that stigma will continue indefinitely.

E. Fuller Torrey, M.D.

Dr. Torrey is affiliated with the Treatment Advocacy Center in Arlington, Virginia.

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In Reply: In his letter Dr. Torrey critiques the papers included in the special section for not addressing the public's fear of violence, which he cites as the most important cause of stigma. We concur that fear of and misconceptions about violence among persons with mental illness and the potential contribution of these factors to stigmatization are critical topics to address. Some of our colleagues and coauthors of papers in the special section have made contributions to the literature on stigma and violence. They have demonstrated, for example, that the American public believe that persons who have symptoms of mental illness, or who are described as having them, are prone to violence and that this misconception was as prevalent in the 1990s as it was in the 1950s (1–3).

Our section, however, was focused on a different topic: the adverse consequences of stigmatization of people with mental illness as they—and their families—perceive and experience it themselves. In particular, we were concerned with the adverse impact of perceived stigma on key aspects of recovery from mental illness, including its effect on adherence to medication regimens, self-esteem, and social functioning, as well as the impact of stigma on families. Because the impact of stigma on recovery has received little attention and the data reported in the papers in our section suggested that perceived stigma has adverse effects on several areas of recovery, we wanted to draw attention to this little known aspect of stigma.

Deborah A. Perlick, Ph.D.
Robert R. Rosenheck, M.D.

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Closing a State Hospital

To the Editor: Illinois, like many states, would like to shed the burden of caring for persons with mental illness, primarily because it interferes with the state's ability to minister to the needs of people who have more political influence. The article by Nierman and Lyons (1) in the September 2001 issue purports to explain how the authors were able to close an Illinois state hospital for adolescents. However, careful readers will see that the title of the article is misleading. In addition, mental health policy makers in Illinois know that the authors' claims about how the closure was accomplished are misleading.

The hospital closure described by Nierman and Lyons enabled Illinois to end its responsibilities under a class action consent decree protecting the rights of adolescent patients being treated in that hospital. The authors mention the consent decree but fail to point out that the burden of complying with the decree provided an important motive for their actions.

Nierman and Lyons list four reasons for the closure. They are careful not to claim that the closure was intended to improve services. Because improved services was not one of the goals of the closure, the fact that services to adolescents are now worse does not make the closure a failure.

The authors' claim that there was no significant opposition from consumers is incorrect. The Mental Health Association in Illinois (MHAI) objected strenuously to the closure.

Most cynically misleading is the following statement: "The significant concurrent reinvestment in community-based services was a powerful tool for gaining the support of important public advocates." Of course, this is true. But a more honest way of putting it would be "The state's decision to contract with private hospitals and private community mental health providers to serve some—but not all—of the individuals affected by the closure convinced the trade organizations for these entities not to oppose the closure."

The delivery of mental health services requires a coordinated system of inpatient and outpatient care. However, private psychiatric hospitals are rarely part of an integrated system. Thus, in Illinois and elsewhere, persons with mental illness are much more apt to leave private mental health facilities without an adequate discharge plan than are persons who leave public facilities. This was one reason for MHAI's opposition to the transfer of responsibility from state to private hospitals. MHAI predicted an increase in recidivism. Nierman and Lyons are to be credited for reporting that the prediction was correct.

In Illinois, persons in private psychiatric hospitals have fewer rights, and their care is subjected to less scrutiny than that of persons in public hospitals. One of the consequences of closing state hospitals is that less attention is paid to persons with mental illness. They become invisible.

In short, the title of the article by Nierman and Lyons should be "Closing Hospital Saves State Money but Harms Persons With Mental Illness." Unfortunately, many states will view both halves of this equation as worthy goals. Would that Illinois were not one of them.

Jan Holcomb, B.S.N.
Mark Heyrman, J.D.

Ms. Holcomb is chief executive officer of the Mental Health Association in Illinois, and Mr. Heyrman is chair of that organization's public policy committee and a clinical professor at the University of Chicago Law School specializing in mental health law.

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1. Nierman P, Lyons J: Shifting resources to the community: closing the Illinois state psychiatric hospital for adolescents in Chicago. Psychiatric Services 52:1157–1159, 2001

In Reply: The State of Illinois remains steadfast in its desire to address the needs of mentally ill children. The funding for the state-operated hospital was transferred in whole to community mental health providers and to private hospital partners. The total amount transferred would now be greater than $50 million over the past five years, and the number of children served would tally in the thousands.

Ms. Holcomb, on behalf of the Mental Health Association of Illinois, makes a good point that private hospitals were rarely integrated into a coordinated system of care. One of the significant benefits of the experience in the Chicago area has been to greatly increase the participation of private-sector hospitals in a coordinated system of care. These hospitals, through increased collaboration with community mental health partners, have gained clinical experience and system management skills that greatly enhance their crafting of appropriate aftercare plans.

A cascading effect has been the improvement in private-sector hospital services to children who are wards of the state, forensic clients, and Medicaid clients not covered under the contract with the office of mental health of the Illinois Department of Human Services (DHS). The role of the office of the inspector general of the Illinois DHS has been expanded, and these private hospitals are now required to follow the same procedures as state-operated hospitals with respect to incidents of potential abuse and neglect and violations of patients' rights.

The office of mental health of the Illinois DHS has provided ample evidence that Metropolitan Child and Adolescent Services has implemented a model that is efficient, consistent with the principles of the Child and Adolescent Service System Program, and fully within the tenets of the *Olmstead* decision. With the help of consumer organizations and advocacy groups like the Mental Health Association of Illinois, we will continue to be held to the highest standards.

Peter Nierman, M.D.
John Lyons, Ph.D.

Patients' Attitudes Toward Antidepressants

To the Editor: The efficacy and tolerability of an antidepressant medication are not determined solely by the drug's pharmacological potency. An intricate interaction of factors, including the doctor-patient relationship and the patient's attitude toward his or her illness and toward prescription medications, influences outcome.

In the study reported here, stable depressed patients who were adherent to medication regimens and who were attending the outpatient clinic of a psychiatric hospital in the Netherlands in 1999 were asked to complete a questionnaire about their attitudes toward taking medications and to give the questionnaire to their therapist or return it by mail. Items in the questionnaire were based on studies of factors involved in treatment compliance (1,2). The decision to prescribe antidepressant medication was made by each patient's therapist. Written informed consent was

obtained from all patients before they completed the questionnaire.

Of the 301 patients who were given the questionnaire, 233 (77 percent) returned it. The sociodemographic and diagnostic characteristics of the respondents did not differ from those of nonrespondents. The respondents' mean±SD age was 49.4±22.6 years. Seventy-eight of the respondents (33 percent) were male, and 155 were female. The primary diagnoses of the respondents were major depression (126 patients, or 54 percent), dysthymia (23 patients, or 10 percent), bipolar disorder (16 patients, or 7 percent), anxiety (37 patients, or 16 percent), and other diagnoses (22 patients, or 13 percent).

A total of 192 patients (82 percent) had been taking an antidepressant medication for more than six months. These patients were asked whether they agreed with 12 statements about antidepressants. Seventy patients (30 percent) said they believe that antidepressants are addictive. A total of 99 (43 percent) said they believe that taking them makes people dependent on their doctor. Seventy patients (30 percent) expressed a belief that a person who starts taking antidepressants can never stop using them. Sixty-eight patients (29 percent) said that taking an antidepressant prevents people from doing the things that they could do to feel better on their own. Forty patients (17 percent) said they believe that taking antidepressants is a sign of weakness. A total of 174 (75 percent) said that the medication gives them courage.

A total of 162 of the respondents (70 percent) said they believe that antidepressant medications do not really solve a person's problems, whereas 203 patients (87 percent) agreed with the statement "They help me, because as I feel better, they help me to tackle my problems." Forty-one (18 percent) expressed a belief that the medication suppresses their problems. Sixty-one patients (27 percent) endorsed the item "It is better to solve your own problems than to use antidepressants." Sixty-six (28 percent) said that taking a medication makes them feel like a psychiatric patient. A total of 174 patients (75 percent) said they believe that using an antidepressant is similar to using a medication for diabetes.

A total of 184 patients (79 percent) reported that they received information about antidepressants before beginning treatment. Eighty-two (35 percent) stated that their partner was present when the information was provided, and 135 (58 percent) said they believe that it is very important that a partner be present when such information is provided. Fifteen patients (6 percent) reported that they did not feel supported by their partner in their decision to use an antidepressant. Sixty-four (27 percent) reported a lack of such support from their family, and 71 (31 percent) from their friends.

A total of 152 patients (65 percent) said that they knew other people who were using antidepressants. However, only 17 (7 percent) thought that this was a reason to use medication themselves.

Limitations of the study are that the severity of each patient's disorder was not assessed and that medication compliance was not examined. However, the results show that even in a group of long-term users of antidepressants, negative attitudes toward these medications persist. Some respondents' beliefs raise particular concerns: that antidepressants are addictive, that taking them leads to dependence on the clinician, that once people begin using antidepressants they can never stop, that taking these medications prevents people from taking steps to get better on their own, and that taking them does not really solve problems. Further research is needed to identify negative attitudes toward antidepressants that contribute to noncompliance.

Clinicians who prescribe antidepressants and those who develop psychoeducational programs may find the results of this survey useful. Involvement of a patient's partner may be an important factor in ensuring treatment compliance. Clinicians should explore a patient's perceptions of the extent of support provided by significant others and the role that such support plays in the patient's acceptance of antidepressants.

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