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## Stigma and Public Education About Mental Illness

**To the Editor:** Thank you for publishing the report by Patrick Corrigan and his colleagues (1) in the May 2004 issue describing how people's attitudes are affected when they are exposed to a mental illness education program that emphasizes violence. At last, advocates can cite research to support a common wisdom that fear fuels prejudice and excessive control.

Although the report refers to "community groups" that emphasize violence to win support, the chief strategists who made public safety the key to new state laws are at the Treatment Advocacy Center in Arlington, Virginia, a creation of psychiatrist E. Fuller Torrey. More than a decade ago, Dr. Torrey and D. J. Jaffe, a Manhattan advertising executive, began to advocate for their legislative agenda by playing on the public's fear of violence and suggesting that others do the same.

Dr. Corrigan's study shows us some possible results of framing mental illnesses as a threat to public safety. His research team tested 161

participants assigned randomly to two types of public education, one linking mental illnesses to violence and the other providing antistigma information. A third group served as a control group. The results showed that participants in the program that highlighted violence favored coercion and separation of people with mental illnesses and avoidance of them. Participants in the program that highlighted antistigma information responded with less fear and more positive attitudes. In a noteworthy finding, the participants in general contradicted a belief that public fears drive funding. In fact, none of the three groups showed significant interest in mandating resources to improve the lives of people with mental illnesses.

Regrettably, Dr. Corrigan's report presented as factual Dr. Torrey's claim that 1,000 homicides are committed annually by people with mental illnesses. That is not a fact. My colleagues and I have seen this number used often, always in Dr. Torrey's articles and media appearances that focus on violence. The figure is meaningless without more details, such as comparisons with the rate in the U.S. general population and the rate among other subgroups. Therefore, we can only assume that the purpose of this figure is to scare clueless audiences. Readers of *Psychiatric Services* may know that the figure is unscientific, but the public does not. It is painful to see new credibility bestowed on it.

**Jean Arnold**

*Ms. Arnold is chair and cofounder of the National Stigma Clearinghouse in New York City.*

## Reference

1. Corrigan PW, Watson AC, Warpinski AC, et al: Implications of educating the public on mental illness, violence, and stigma. *Psychiatric Services* 55:577-580, 2004

**To the Editor:** Dr. Corrigan and his colleagues reported that an antistigma educational presentation lowered several measurements of stigmatizing

beliefs and attitudes among participants, whereas a presentation that focused on the greater propensity for violence among people with mental illnesses had the opposite affect. But what if the goals of groups that address violence among people with mental illnesses are different from the goals of groups that fashion antistigma campaigns? Then the comparison is between the impact on the unilateral objective of one project and the ancillary effects on that objective on another—the approach is akin to comparing the rain-stopping abilities of an umbrella and a T-shirt.

The only entity described by Dr. Corrigan and his colleagues as a proponent of violence education is the Treatment Advocacy Center. Yes, our center does address the heightened propensity for violence to help foment reforms that will, among other objectives, prevent future violence. Although such endeavors may to a small extent heighten stigma by increasing awareness of the problem, the magnitude of the effect should be gauged in a real-world context. To help readers gain perspective: a search of a database of leading newspapers that used both "Treatment Advocacy Center" and "violence" yielded a total of 71 articles, editorials, op-ed commentaries, columns, and other media pieces for the past five years, whereas a search of the same database that used both "mental illness" and "violence" yielded 536 media items from the past month.

The issue of violence emerges in conjunction with campaigns to establish programs such as assisted outpatient treatment, assertive community treatment, crisis intervention teams, and mental health courts that are designed for people who are most acutely and chronically afflicted with severe psychiatric disorders—the small subset of people with mental illnesses most prone to homelessness, hospitalization, incarceration, self-harm, and violence.

For example, the effort to bring assisted outpatient treatment to New York in 1999 was spurred by a succession of tragedies caused by indi-

viduals with untreated psychotic disorders. Inevitably, legislators, media, and the public focused on the incidents and on violence prevention, which may have resulted in increased stigma analogous to Dr. Corrigan's results. New York's legislature adopted assisted outpatient treatment swiftly and overwhelmingly, which may reflect Dr. Corrigan's additional finding that better knowledge of the causes of violence engenders support for treatment interventions. Furthermore, although the Corrigan study found that recognition of a connection between violence and mental illness had no effect on participants' support for increased resources, not only did New York mandate new funding for Kendra's Law but Governor Pataki also dedicated an unanticipated \$125 million to community services three months after signing the legislation.

Since 1999 more than 5,600 people have either been placed in assisted outpatient treatment or received intensive service enhancements pursuant to Kendra's Law. For a group of 1,407 individuals who completed initial six-month assisted outpatient treatment orders, 63 percent fewer were hospitalized than in the six-month period before the orders (31 percent compared with 84 percent) (personal communication, New York State Office of Mental Health, 2003). Similarly, 55 percent fewer became homeless while in assisted outpatient treatment (5 percent compared with 11 percent). In addition, 75 percent fewer were arrested (6 percent compared with 24 percent) and 69 percent fewer had been incarcerated (4 percent compared with 13 percent). Among the first 2,433 individuals who were placed in assisted outpatient treatment, moreover, the rate of self-harm declined by 45 percent and the rate of harm to others fell by 44 percent (1).

By improving the quality of life of people with mental illnesses, Kendra's Law combats direct sources of stigma. These outcomes equate to fewer stigmatizing beliefs and attitudes among the other citizens of

New York—people can't see what doesn't happen and newspapers can't print it.

**Jonathan Stanley, J.D.**

*Mr. Stanley is assistant director of the Treatment Advocacy Center in Arlington, Virginia.*

#### Reference

1. New York State Office of Mental Health, Kendra's Law: An Interim Report on the Status of Assisted Outpatient Treatment, Jan 2003. Available at [www.omh.state.ny.us/omhweb/Kendra\\_web/interimreport](http://www.omh.state.ny.us/omhweb/Kendra_web/interimreport).

**To the Editor:** Advocacy is the positive representation of an issue. Patrick Corrigan's alleged "research" panders to a negative public stereotype, and thereby reinforces it.

People with mental illnesses—yes, it is plural, not a generic singular—succeed in society at the same rate as any other group of people, and at the same levels. We have won Nobel and Pulitzer prizes, Oscars, Emmy awards, and Obies—whatever awards are available, we have won them. We teach at universities, publish, preach, and represent in government at every level, including the highest. We move through society with the same ease as any other group of people, unhindered by negative stereotypes, recognized simply as people.

Dr. Corrigan's "research" begins with an enculturated bias against a nonexistent stereotype and reimposes it, and while claiming to address it, validates it. This stance is not unusual in the mental health field, where achieving popularity has greater appeal than educating the public.

In 1990 the Robert Wood Johnson Foundation funded a self-serving study by Miles Shore of Harvard University, which argued that the public's main source of information on mental health issues was the media (1). Dr. Shore carefully avoided naming the media's source. Without a doubt that source is people in the mental health professions, whom the media see as expert on the subject and with whom they consult. Until people such as Dr. Corrigan take

their job as educators seriously, misconceptions will continue, journals will continue to publish articles that pander to stereotypes, and the media will promulgate them.

**Harold A. Maio**

*Mr. Maio, who lives in Fort Myers, Florida, is a consulting editor for Psychiatric Rehabilitation Journal.*

#### Reference

1. Shore MF, Cohen MD: Robert Wood Johnson Foundation Program on Chronic Mental Illness: an overview. *Hospital and Community Psychiatry*. 41:1212–1216, 1990

**In Reply:** The diversity and depth of opinion represented in the letters by Ms. Arnold, Mr. Stanley, and Mr. Maio about our article reflect the complexity of stigma and its impact on people with mental illness. The variations in their opinions also support an implied goal of our study—namely, that varied assertions about public attitudes need to be tested in empirical research. The goal in our investigation was to collect evidence on how public education about mental illness and violence affects public opinion.

If we understand Mr. Stanley correctly, he seems to assert that stigma may be a regrettable side effect of programs that focus on violence and mental illness—in other words, that increasing fear and avoidance of people with mental illness is necessary to accurately educate the public about mental illness and increase resources for appropriate treatment. It is up to advocates and policy makers to judge the costs and benefits of this kind of policy.

Mr. Stanley also asserts that violence education has a positive effect on resources for mental health services: "Governor Pataki also dedicated an unanticipated \$125 million to community services three months after signing the legislation." The connection between violence education and the New York governor's decisions are by no means obvious. Our research showed that the public was not likely to increase resources for mental health care after participating

in an educational program that linked mental illness with violence, and actually may have been less likely to support some rehabilitation-based services as a result. Hence, the assertions by D. J. Jaffe (1), Mr. Stanley's colleague at the Treatment Advocacy Center, were not supported in our study: "Laws change for a single reason, in reaction to highly publicized incidences of violence. People care about public safety. I am not saying it is right. I am saying this is the reality."

As policy makers and advocates continue to sift through various opinions about public education and attitudes, they will need more research like this to help them distinguish fact from fiction.

**Patrick W. Corrigan, Psy.D.**  
**Amy C. Watson, Ph.D.**

### Reference

1. Jaffe DJ: Assisted outpatient treatment. Presented at the annual conference of the National Alliance for the Mentally Ill, Chicago, June 30–July 3, 1999

## Caring for Young Adults With Mental Illness

**To the Editor:** Services that are clinically and developmentally specific to young adults with mental illness (and chemical dependence) are essential, as noted by Robert Giugliano (1) in the Open Forum in the April issue (1). Although we agree with much of what Dr. Giugliano recommends, we take issue with his advocacy for establishing a bureau for young adults. This idea appears to be the product of an underlying assumption that having a bureau means achieving results. Partitioning off one age group from another can unintentionally splinter and compartmentalize services and funding. In addition, a highly delimited bureau can create transition problems for patients and agencies after the seven years elapse between the ages of 18 and 25 years—and many young adult patients would be in the system for less than seven years before having to make the transition.

Our approach in New York City does not rely on a bureau. Instead, we identify need, engage in effective

planning, and support advocacy for needed services, and on the basis of these efforts we direct funding for populations in need.

**Lloyd I. Sederer, M.D.**

*Dr. Sederer is executive deputy commissioner of the division of mental hygiene services in the New York Department of Mental Health and Hygiene.*

### Reference

1. Giugliano RJ: The systemic neglect of New York's young adults with mental illness. *Psychiatric Services* 55:451–453, 2004

**In Reply:** We appreciate Dr. Sederer's recognition of the long-standing lack of appropriate and adequate housing and clinically and developmentally specific services for young adults with mental illness and co-occurring substance use disorders.

In describing the approach taken by the New York Department of Mental Health and Hygiene (DMHH), Dr. Sederer said, "we identify need, engage in effective planning, and support advocacy for needed services, and on the basis of these efforts we direct funding for populations in need." Who are the "we" in DMHH who are engaged in this approach for young adults? Unless and until there is a "we" for young adults in both DMHH and the New York State Office of Mental Health, this population will continue to be neglected.

The absence of a "we" has resulted in young adults' being worse off now than they were a few years ago when an agency decided to respond to a request for proposals for supportive housing for mentally ill young adults aging out of foster care. The program was poorly designed and underfunded. Not able to manage the young adults and not able to obtain any additional support from DMHH, the agency closed the program and returned the grant to the city. Young adults have less housing and services now than they've ever had.

There are necessary risks involved in change, and the problems of compartmentalization and splintering are

certainly preferable to the complete absence of appropriate and adequate housing and services. The absence of an organized and ongoing approach to dealing with young adults has contributed to the major clinical problems this population presents and the fragmentation of the system. The current adult mental health system does not offer appropriate and adequate housing or services for adolescents when they reach age 18.

At Covenant House about 1,000 homeless mentally ill young adults have participated in our mental health day program since 1996, and we have nowhere to send them. These systemic problems are longstanding, but the time has come to actually do something about them. We look forward to working with Dr. Sederer and with the New York State Office of Mental Health to develop strategies for the solution of these problems.

**Bruce J. Henry, J.D.**  
**Robert J. Giugliano, Ph.D.**

*Mr. Henry is executive director of Covenant House in New York City, where Dr. Giugliano is director of mental health.*

## Should Therapists Give Gifts to Patients?

**To the Editor:** I appreciated the article "Gifts from Physicians to Patients: An Ethical Dilemma" by David Krassner (1) in the May issue. I commend his candor and his attempt to research a "forbidden" subject.

The psychoanalytic aspect of our education urges us to consider multi-layered meanings of any therapist-patient transaction. The dynamic and forensic facets of certain transactions would encourage us to abstain from gift giving in case of misinterpretation by the patient.

In my opinion no blanket rule can realistically be made. The therapist, who has spent time establishing a relationship with the patient, must decide on an individual basis about giving a gift to that singular and unique patient.

Freud wrote about the importance of totems, and Winnicott described transitional objects. Perhaps a gift—