man suffering will, like it does every day, march on. Now more than ever, we as psychiatrists need to focus on our role as medical doctors diagnosing and treating pathologies that plague and cripple our patients. Our journals should reflect these efforts—not the trials and tribulations of "moving."

Let's take ourselves seriously, and others will follow.

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Satisfaction With eGroups Among Persons With Psychiatric Disorders

To the Editor: Patients with psychiatric disorders may benefit from online groups, often called eGroups. However, few researchers have investigated factors related to the satisfaction of eGroup participants. In March 2000 we established a Web-based self-help psychiatric group (http:// groups.yahoo.com/group/psychpark-friend). Most participants were patients of a virtual psychiatric clinic called PsychPark (1) and had a diagnosis of depression or an anxiety disorder. The virtual clinic, which is operated by members of the Taiwan Association of Mental Health Informatics, has been described in detail elsewhere (2). The eGroup consisted of a discussion forum and mailing list. Posted messages were sent to the forum and to all members anonymously. The authors moderated the group by filtering and deleting unrelated messages and advertisements.

A Web-based interactive yes-no questionnaire based on Yalom's 12 therapeutic factors (3) was designed to evaluate satisfaction with the eGroup; space was included for comments and suggestions. The participants were invited to fill out the online survey form when they logged on to the PsychPark Web site.

Approximately 1,300 members logged on to the Web site during the study period—March through November 2001. On average, 152 messages were posted each month; 281 of the 1,300 members (22 percent) posted messages over the nine-month period. A total of 262 members (19 percent) completed the survey. Their mean±SD age was 25.7±5.5 years. Most were female (194 respondents, or 74 percent). A large proportion were students (113 respondents, or 43 percent), and 131 respondents (50 percent) had at least an undergraduate education.

A total of 198 respondents (76 percent) reported that they were satisfied with the eGroup. Three factors were most commonly endorsed as accounting for satisfaction: 182 respondents (92 percent) cited "imparting information"; 172 (87 percent) cited "universality"; and 168 (85 percent) endorsed "instillation of hope." Only two factors were endorsed by less than 70 percent of respondents: "catharsis" (115 respondents, or 58 percent) and "existential factors" (131 respondents, or 66 percent). From a list of suggestions for improving satisfaction with the eGroup, the most frequently endorsed items were "introduce more professional guidance" (90 respondents, or 34 percent), "provide specific solution methods" (77 respondents, or 29 percent), and "establish specific diagnosis-related groups" (72 respondents, or 27 percent).

To our knowledge, our survey is the first to evaluate the satisfaction of participants in a Web-based group by using Yalom's therapeutic factors. Our results indicate that an anonymous eGroup is useful for clients with psychiatric disorders. Our findings are consistent with those of Davidson (4), who determined that a large group can function effectively on the Internet. Participants in such groups value the information, positive feedback, and encouragement that they receive from other group members, as suggested by the items in our survey that were cited as most related to satisfaction. The factors that were least cited as being related to satisfaction—catharsis and existential factors—may have to do with the virtual nature of our group, whereby members do not meet face to face. However, large groups have some limitations. Weinberg (5) compared a large group to a fishbowl, where only a small number of members participate while the larger membership quietly watches. This phenomenon was apparent in our group. About a fifth of the participants posted messages while the other members observed the online interaction quietly.

The generalizability of our results is limited by the relatively low response rate and possible selection bias related to characteristics of members of our virtual clinic.

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Patient Perspective on Collaborative Treatment

To the Editor: Little is known about patients' understanding of collaborative treatment and the role of professionals involved. We conducted a study among 50 patients at an inner-city academic clinic who were receiving ongoing collaborative treatment from a psychiatrist and a psychologist.

The patients were given a 20-item questionnaire about their opinions of their treatment providers.

All patients believed that psychiatrists can legally prescribe medication; only 6 percent thought therapists could prescribe. Eighty percent understood that all psychiatrists are physicians. Only 16 percent thought psychiatrists and therapists had the same training. Interestingly, 16 percent thought it was illegal for the same psychiatrist to conduct therapy and prescribe medication. Sixty-two percent said the psychiatrist has overall responsibility for treatment; 26 percent, the therapist; and 6 percent, both. Seventy-eight percent said the psychiatrist is legally responsible for treatment; 14 percent, the therapist; and 6 percent, both. Sixty-eight percent thought therapy should be conducted by a therapist; 10 percent, a psychiatrist; 16 percent, both; and 2 percent, neither. However, 68 percent said the psychiatrist is the most qualified to treat them by virtue of training; 18 percent, the therapist; and 12 percent, both.

Ten percent of patients understood that in times of crisis they should call a psychiatrist; 22 percent, a therapist; and 68 percent, either. Yet 26 percent said they would prefer to call a psychiatrist; 32 percent, a therapist; and 40 percent, either. Ten percent said they would call their psychiatrist in case of a problem in their life; 50 percent, their therapist; and 38 percent, either. However, 88 percent said that if the problem were related to medication they would call their psychiatrist; none said they would call their therapist, and 10 percent said they would call either. More patients were likely to disclose a problem to a therapist (58 percent) than to a psychiatrist (34 percent), to both (2 percent), or to either (4 percent). Twenty-four percent said they would conceal their problem from their therapist; 40 percent, their psychiatrist; 14 percent, neither; 2 percent, both; and 2 percent, either. When asked about getting conflicting messages from their psychiatrist and therapist, 72 percent stated that this never happens; 12 percent, that it happens occasionally; 8 percent, sometimes; and 2 percent, most of the time. Ninety-two percent thought it was more appropriate to talk to their psychiatrist if they stopped taking medication because of side effects; 2 percent, their therapist; and 4 percent, both. Eighty percent said they would talk to their psychiatrist when stopping medication because of feeling "dependent" on the medication; 12 percent, their therapist; and 2 percent, both.

Most patients (82 percent) thought getting treatment from two individuals was more helpful; 6 percent, less helpful; and 8 percent, no difference. Thirty-two percent thought getting treatment from two individuals was more cost-effective; 10 percent, less cost-effective; and 52 percent, the same.

This study had several limitations, including the small sample, the inner-city academic clinic setting, use of a simple questionnaire, and the absence of a control group.

In conclusion, it seems that patients receiving collaborative treatment have a good understanding of the roles of the treating parties and a positive appreciation of this treatment model. However, patients seem to be more likely to communicate their everyday problems and crises to their therapist than to their psychiatrist. A well-documented discussion of the treating parties' roles and goals of collaborative treatment should be part of the opening treatment sessions.

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Submissions for Datapoints Invited

Submissions to the journal's Datapoints column are invited. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. National data are preferred. The text ranges from 350 to 500 words, depending on the size and number of figures used. The text should include a short description of the research question, the database and methods, and any limitations of the study.

Inquiries or submissions should be directed to Harold Alan Pincus, M.D., or Terri L. Tanielian, M.S., editors of the column. Contact Ms. Tanielian at RAND, 1200 South Hayes Street, Arlington, Virginia 22202 (terri_tanielian @rand.org).