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 number and e-mail address. Letters related to material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, MS#4 1906, Arlington, Virginia 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych. org. Letters reporting the results of research should be submitted online for peer review (http://appi.manuscriptcentral.com).

Are Mental Health Professionals Immune to Stigmatizing Beliefs?

To the Editor: The stigma of mental illness is a major obstacle to recovery of persons with severe mental illnesses (1,2). Stigma affects an individual's self-esteem, increases dysfunction, and poses problems to patients with regard to housing and employment (1,3). Stigma is a culturally induced barrier to recovery. Although studies have examined experiences of stigma by users of mental health services and stigmatizing attitudes in the general public, little attention has been paid to the experiences and attitudes of mental health professionals.

To examine this issue we conducted a simple survey at Catawba Hospital in Virginia, a 110-bed state psychiatric facility that provides care for adults and geriatric patients with severe mental illnesses. Permission for the staff survey was obtained from the facility director and chief of staff. Fifty clinical staff, including psychiatrists, psychologists, social workers, adjunctive therapists, and nursing staff, were randomly approached at their work stations over a two-day period. Staff members were chosen on the basis of availability, until a total of 50 respondents were obtained. No staff member refused to participate. A written questionnaire was used to ask two simple yes-or-no questions: "If you were to be diagnosed with schizophrenia, would you be uncomfortable talking about it to a nonprofessional (such as friends or acquaintances)?" "If you answered 'Yes,' is it because of stigma?" The responses were obtained anonymously. Thirty respondents (60 percent) said that they would be uncomfortable talking about it to friends and acquaintances. Seventeen (34 percent) said that it was because of stigma.

This brief survey highlights the feelings of discomfort even professionals experience with a psychiatric diagnosis such as schizophrenia. It is interesting that a third of the respondents would perceive stigma. We may be practicing a double standard—expecting consumers and the public to cast off their stigmatizing beliefs but harboring those beliefs ourselves. Obviously there is a need to conduct more elaborate studies to examine our own attitudes and beliefs as professionals—how they arise and how they might influence our role as care providers. Our educational efforts should not stop at targeting the public and consumers of mental health services; professionals should also be included. Transformation of the mental health system and implementation of a key recommendation of the President's New Freedom Commission (2)—"Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention"—should also address stigmatizing beliefs of mental health professionals.

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Best Friends of People With Mental Illness and Mental Retardation

To the Editor: Research that focuses on the friendships of people with a dual diagnosis of mental illness and mental retardation is not evident in the literature. Virtually all of the friendship literature has focused on people with a single diagnosis of either mental illness or mental retardation. The findings of published studies largely suggest that people with a single diagnosis tend to look to primarily staff members and to other clients with similar diagnoses to be their friends (1). Studies also reveal that people outside the service system are sometimes identified as friends, however challenging these relationships may be (2). Issues related to stigma are among the major obstacles to making friends, according to the reports of people with mental retardation (3).

In an interview study conducted in 2001, a total of 90 people with a dual diagnosis were asked about their friendships. Responses to questions about the person whom they identified as their "best friend" are reported here. Informed consent was obtained from all participants, and the study was approved by the institutional review board of the University of North Carolina at Charlotte. Participants were asked to name the attribute that they like the most about their best friend, what they do together, and what they wish they could do. Responses were compared among four types of friends—other clients, staff members, relatives, and outside friends.

The 90 participants were former

class members of a federal lawsuit in North Carolina (4). Although they had formerly lived in institutional settings, almost all lived in the community when the study was conducted. The sample included 51 men (57 percent) and 39 women (43 percent). They ranged in age from 26 to 74 years (mean age, 47±12 years). Forty-five (50 percent) were white, 44 (49 percent) were African American, and one was a Native American. Information on diagnoses was obtained from case records. Seventy-nine (88 percent) had a psychiatric diagnosis, including schizophrenia (32 participants, or 36 percent), affective disorder (32 participants, or 36 percent), and impulse control disorder (15 participants, or 17 percent). All had a diagnosis of mental retardation, either mild or moderate.

Participants most often identified either another client or a staff member as their best friend (55 participants, or 61 percent). Best friends with whom they had the most frequent contact were also clients or staff members. Best friends who were known the longest were more likely to be family members or outside friends. The preferred attributes of a best friend seemed most varied for outside friends. A few best friends were spouses, were members of the same church, or shared an activity like sports. However, more than a fourth of the outside friendships were inactive.

Participants who identified staff members as their best friends (27 participants, or 30 percent) often indicated that the friendship was mutual, but the staff members who were involved usually did not agree. Also, many who identified staff members as friends expressed no desire for help in finding other friendships. This finding suggests that many staff could focus more on teaching friendship skills and facilitating opportunities to develop other friendships. Several projects across the country have extensive experience in helping people with disabilities build and sustain friendships in the community (5). Agencies that serve people with disabilities could also focus staff training on some of the issues that emerge from this study. Follow-up research might consider such questions as what factors best predict the formation and stability of outside friendships, and how the friendships of people with dual diagnoses are similar and different from those of people with a single diagnosis.

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Acknowledgment

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Closing the Gap in Evaluation Technology for Outcomes Monitoring

To the Editor: Thank you for devoting a major portion of the March 2005 issue of *Psychiatric Services* to the important area of quality of care. Several articles alluded to the pressing need for a way to measure and report the outcomes of mental health services for patients. Although routine collection of information about outcomes is desirable, when change in patient status is measured over time, it is unclear whether changes are attributable to services or to other causes, such as events in the person's life. The near impossibility of mounting controlled research studies in typical service settings to quantify changes caused by services creates a gap between the information that can be collected and the information psychiatrists need to determine the effects of their services on patients. This gap in evaluation technology is now bridged by assessing service productivity (1) or the extent of changes that occur among patients because of services.

Measures of service productivity have been field tested and described in the literature (2–4). They focus on the average amount of change patients report on a brief questionnaire, expressed as a percentage of all changes covered. For example, suppose that services are provided in order to produce ten behavioral changes—improved health, adherence to medication regimens, attainment of stable housing and employment, and so forth. A patient indicates that he or she has changed for the better on three items on the ten-item questionnaire because of the services received but has remained the same on the other seven items. This patient receives a score of 30 percent.

There are several key differences between the current approach to measuring service effectiveness and the assessment of service productivity. With the latter approach, no comparison or control group must be studied simultaneously, and scores do not need to be risk adjusted to account for alternative explanations of the outcomes. Data need to be gathered only once, and scoring of the results is straightforward. The results pertain to changes patients have made as a result of the services they received, thus revealing the impacts that clinicians are having. Clear results can be obtained with as few as five questions, because the answers to the questions are averaged to determine the score. The patterns of an-

swers to the questions can be interpreted to discern which aspects of services need revision. Users of the approach control which questions to ask and how often, although enough time must be allowed for changes due to services to be observable. This approach can be applied by service staff with a minimum of evaluation training to provide timely results for practitioners, supervisors, and agency managers.

Although assessments of service productivity cannot replace multistatus assessments of overall change, they are well suited to monitoring patient outcomes in service settings, because the extent to which patients benefit from services can be utilized in an ongoing manner to improve the quality of care. Therefore, adding a measure of service productivity to existing assessments of patient outcomes is recommended.

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Modern Times and Quality of Care

To the Editor: The March 2005 issue of *Psychiatric Services* featured many articles focusing on quality of care, especially care provided in outpatient settings. However, the articles did not address the issue of "time slots" for patients seen by psychiatrists in these settings.

Psychiatric illnesses, like any other medical disorders, used to be reviewed in three different stages—all starting with the letter R: remission (a symptom-free state); recovery (an illness-free state); and rehabilitation (a state free of sociofamilial, educational, and vocational problems). In recent years, we have not been giving much consideration to rehabilitation, although recovery is now receiving some attention.

Nowadays, psychiatrists are expected to see one patient every 15 minutes, which permits time only for a review of symptom remission—an assembly-line approach reminiscent of Chaplin's *Modern Times.* How can we be sure that high-quality care is delivered under these circumstances?'

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Psychotherapy and Eclecticism

To the Editor: In the Practical Psychotherapy column in the March issue Dr. Goin (1) argues for "informed eclecticism . . . a knowledgeable integration of the several available psychotherapy tools." She contrasts this to "eclectic" psychotherapy, which often turns out to be "a potpourri of different activities, fuzzy and unstructured."

Alas, the latter definition doubtless more accurately describes psychotherapeutic eclecticism in practice. There is good reason for this. The evidence base for psychotherapy depends on carefully defined, manualized treatments that are monitored for therapist adherence. Research generally shows that adherence to one specific model yields better results than a muddied, mixed (read "eclectic") approach (2,3). That treatment purity matters makes sense, particularly in the context of short-term treatments. Therapists should equip patients with a kit of finely honed "tools" for handling symptoms and situations, rather than a hodgepodge of responses.

Moreover, no one is really "knowledgeable" about how best to combine differing treatments. Little evidence is available with which to inform eclecticism. Hence, although mixing techniques is a constant temptation in therapy sessions, it is best avoided. The risk inherent in eclecticism is that therapists will fall into idiosyncratic approaches, as they did in the pre-empirical past. It's important that psychiatric residents be trained in carefully defined treatments (psychodynamic, cognitive, and so forth) so that such eclecticism—a euphemism for entropy—is minimized.

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Dr. Markowitz is a research psychiatrist at New York State Psychiatric Institute and clinical professor of psychiatry at Weill Medical College of Cornell University in New York City.

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In Reply: I appreciate Dr. Markowitz's calling attention to the importance of therapists being well informed about the treatments they employ. Adherence to one particular model may be particularly useful when dealing with psychiatric phenomena that respond to short-term therapy. However, the complexity of personalities and psychiatric illnesses often means that what will prove individually most effective demands integrating in a knowledgeable way an amalgam of the methods as currently defined.

As Kendler (1) wrote in a recent article in the *American Journal of Psychiatry,* "Psychiatric disorders are, by their nature complex multilevel phenomena. We need to keep our heads clear about their stunning complexity

and realize, with humility, that their full understanding will require the rigorous integration of multiple disciplines and perspectives."

Marcia Kraft Goin, M.D.

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Missed Monday Appointments

To the Editor: In a brief report in the March issue, Dr. Gallucci and his colleagues (1) reported on the impact of waiting time until appointment on the rate of attendance at the first appointment in an outpatient psychiatric setting. They found that delay had a significant impact on attendance, especially during the first week—each day of delay negatively affected the attendance rate. This result is intuitively and clinically appealing.

We suggest that the authors might further analyze their data. We conducted a one-month survey in four outpatient facilities in Geneva, Switzerland, taking into account not only initial appointments but also follow-up ones (2). The overall rate of missed appointments was 8.1 percent (177 of 2,177 scheduled appointments). We found that delay is probably not the only time-related relevant factor. In our study, comparison of proportions of missed appointments indicated a trend ($p<.052$) for differences across days, with the highest proportion on Mondays (12.6 percent) and the lowest proportion on Wednesdays (6.5 percent). To our knowledge, this aspect has not yet been addressed in the literature. We hypothesize that similar differences might be observed in other behaviours, such as absenteeism at work.

We fully agree with Dr. Gallucci and his colleagues that a better understanding of the motives for missed appointments will contribute to preserving staff and financial resources.

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