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 e-mail address. Letters commenting on 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, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

"Assisted Outpatient Treatment": An Example of Newspeak?

To the Editor: For years, proponents of involuntary outpatient commitment have put forth the euphemistic term "assisted outpatient treatment" in an apparent effort to render the coercive aspect of the procedure less obvious to the casual observer. Most recently in these pages, Torrey (1) used a book review as a forum to continue promoting this intervention.

According to Webster's online dictionary (www.merriam-webster.com), the verb "assist" used as a transitive verb means "to give usually supplementary support or aid to"; used as an intransitive verb, it means "to give support or aid." The explicit implication of these meanings is that the "assistance" provided is in the furtherance of a goal sought by the receiver of the assistance.

The earliest use of the term "assisted outpatient treatment" in this journal appears to have been in September 2001 (2). In that article, the authors noted that the term was devised by proponents of Kendra's Law in New York, a response to a tragedy in which an individual with serious mental illness killed a woman by pushing her into the path of an oncoming subway train. Here is what the authors of that article wrote: "In many states a take-no-prisoners battle is under way between advocates of outpatient commitment—who call this approach assisted outpatient treatment—and its opponents—who use the term 'leash laws.' " It is clear to me—and appears to have been clear to the authors of that article—that use of the term "assist" in this regard was a deliberate attempt to make the intervention seem less coercive and therefore more palatable.

Somehow, the "assisted outpatient treatment" proponents have been winning the language battle such that the term has replaced the more accurate "involuntary outpatient commitment." This defines Newspeak, the language in Orwell's masterpiece *1984,* in which some terms "meant almost the exact opposite of what they appeared to mean."

If we are honest with ourselves, with our patients, and perhaps most importantly with our policy makers, we ought to recognize and oppose this linguistic sleight of hand. Calling a coercive, court-mandated treatment order "assisted," as if it were a cane or a walker used to assist a person with impaired balance who wants to be able to safely navigate his living room or her sidewalk, is inaccurate and misleading. We are better than this. Whether there is a role for involuntary interventions should be debated honestly and openly and without trying to hide the nature of the interventions that we are proposing. Let's just call it what it is.

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Acknowledgments and disclosures

The opinions expressed are those of the author and do not necessarily reflect those of the Maryland Mental Hygiene Administration or Springfield Hospital Center.

The author reports no competing interests.

References

1. Torrey EF: Against Autonomy: Justifying Coercive Paternalism [book review]. Psychiatric Services (E-pub, August 1, 2013)
2. Monahan J, Bonnie RJ, Appelbaum PS, et al: Mandated community treatment: beyond outpatient commitment. Psychiatric Services 52:1198–1205, 2001

In Reply: Roskes claims that "assisted outpatient treatment" and "involuntary outpatient commitment" are the same and accuses us of making "a deliberate attempt to make the intervention seem less coercive and therefore more palatable." In fact, the term "assisted outpatient treatment" was coined by one of us (JS) in collaboration with the staff of the Treatment Advocacy Center to differentiate it from involuntary outpatient commitment. The difference is subtle but important.

To illustrate: take two people with active tuberculosis who refuse their prescribed antituberculosis medication and are thus potentially dangerous to other people. The first doesn't like the side effects and therefore refuses it. The second has Alzheimer's disease and anosognosia and refuses because he doesn't think he has tuberculosis and believes the nurse is trying to poison him. In many states, public health laws permit the involuntary medication of both individuals.

In the first case, we assume that the man has a normally functioning brain and can make informed choices. Forcing him to take medication is truly involuntary treatment. In the second, we know that the man does not have a normally functioning brain and suspect he cannot make informed choices. Forcing him to take medication is assisting him to make the choice we think he would make if he had a normally functioning brain.

Most individuals with serious mental illness on assisted outpatient treatment have anosognosia. There are now 20 neuroimaging studies showing subtle differences between the brains of individuals with schizophrenia who have anosognosia and those who do not. A recently published study, done on postmortem brains, even shows oligodendrocyte cellular differences between brains of individuals with and without anosognosia (1). Another