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 Blvd., Suite 1825, Arlington, VA 22209-3901; fax, 703-907-1095; e-mail, psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Reducing Barriers to Care by Looking Closely at Stigma

To the Editor: I read with interest the article "Perceived Stigma and Mental Health Care Seeking" (1) by Golberstein and colleagues in the April issue. This is a timely study in light of recent recommendations from a midcourse review of the Healthy People 2010 initiative to address barriers to mental health care (2). I agree with the authors' recognition that their study is unique in its focus on a specific population—namely, students from one public university. I propose that this level of focus may be what we need in order to examine the social and personal factors that might influence the decision to seek mental health care. The continued call to reduce disparities in mental health care requires us to more closely examine individual subpopulations, including those defined by ethnic groups. We must look at service utilization by population subgroups in order to advance the nation's efforts in improving access to high-quality mental health care.

One of the major findings of the study by Golberstein and colleagues is that Asians were less likely to perceive a need for mental health care, as measured by self-reported claims of needing help for mental health problems. It is not uncommon for Asians to express symptoms of depression through somatic means that may be better understood within their social environment (3). Although recognizing that the choice of independent variables may have been limited to items contained in the survey, I suspect that the study would have produced much different findings had the authors been able to use more than one indicator for perceived need, such as how frequently poor mental health affected the respondents' ability to perform in everyday life functions, such as work and recreation. I also suspect that the results for service use would have been much different had the authors been able to use multiple measures to describe persons from ethnically diverse populations. Some of these measures may include the respondents' nativity or generational status, length of time in the United States, age at which they arrived in the United States, and cultural identity.

The next challenge is to interpret these findings so that they become meaningful to program administrators and policy makers.

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Mr. Lee is an independent researcher who is also affiliated with the California Department of Public Health, Sacramento. The views expressed are those of the author and may not necessarily represent the policies of the California Department of Public Health.

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In Reply: We thank Mr. Lee for his thoughtful letter and his interest in our work. He raises several important points. We agree that the mental health services literature benefits from exploring alternative measures of perceived need for mental health services, particularly to capture help-seeking sentiments in diverse ethnic populations. We also agree that understanding differences across ethnic groups requires looking more deeply at factors such as nativity and length of time since immigration, as Mr. Lee suggests.

Regarding Asian students in our sample, we can note a few additional findings that were not in our article. First, international Asian students (that is, those who were not U.S. citizens or residents) had higher levels of perceived stigma and lower levels of perceived need than Asian Americans, although the latter group was still significantly different from other student groups on these measures. Second, Asian students—both international students and Asian Americans—were less likely than other students to report that their mental health affected their academic performance. However, as Mr. Lee hypothesized, this difference was smaller and less robust than that for the measure of perceived need that we reported in our article.

These findings and the points raised by Mr. Lee all point to the complexity of stigma's role in help seeking for mental health problems. As several scholars have noted, the concept of stigma has many dimensions and potential consequences (1,2). On this point, we believe that future studies of stigma should include multiple measures of stigma and test for differences across subpopulations in the relative importance of perceived public stigma versus one's own stigmatizing attitudes toward mental illness and mental health services use. It is quite possible that different facets of stigma matter more or less in different subpopulations. Understanding the extent to which that is true may be valuable for designing opti-

mal interventions to reduce barriers to mental health services use.

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Heterogeneity in the Assessment of the At-Risk Mental State for Psychosis

To the Editor: Over the past decade interest has increased in the potential benefit of early intervention in schizophrenia, including the initiation of treatment before the first episode. This interest parallels the growing focus on prevention in other areas of medicine. However, the literature shows that samples of persons with prodromal symptoms of psychosis present a wide range of risk of developing a psychotic disorder, depending on the criteria used to define an at-risk state for psychosis (that is, clinical versus genetic). Furthermore, within the same sample, prodromal symptoms may vary greatly. Individuals who present with negative psychotic symptoms, such as social isolation, decreased expression of emotions, decreased experience of self, and schizotypal traits, are more likely than individuals without these symptoms to be excluded from current studies of high-risk populations.

Multisite studies are urgently needed to provide sufficient statistical power to reach reliable results. However, such studies are difficult to conduct because they entail standardization of well-defined diagnostic criteria across different sites. The field of psychopathological assessment instruments is currently dominated by two main approaches. One derives from the traditional approach of using the Positive and Negative Syndrome Scale and focusing on attenuated positive symptoms. This approach includes the Comprehensive Assessment of At-Risk Mental States (CAARMS) (1), the Structured Interview for Prodromal Syndromes (2), and the Basel Screening Instrument for Psychosis (3). Conversely, the basic-symptoms approach is based on a detailed phenomenological way of describing disturbances before onset of psychosis. This approach includes the Bonn Scale for the Assessment of Basic Symptoms (4) and the Schizophrenia Prediction Instrument–Adult Version (SPI-A) (5). Some authors presume that the basic-symptoms approach characterizes the early prodromal phase whereas the focus on attenuated positive symptoms characterizes the late prodromal phase.

Outreach and Support in South London (OASIS), a community mental health team for people with an at-risk mental state, has just introduced an experimental version of the CAARMS, with the aim of clinically integrating these two approaches. According to the traditional CAARMS, an individual can meet inclusion criteria for a prodromal state of psychosis in one of three ways: a recent decline in function, coupled with either schizotypal personality disorder or a first-degree relative with psychosis; attenuated positive symptoms; or a brief psychotic episode of less than one week's duration that resolves without antipsychotic medication. The new version of CAARMS includes a fourth "cognitive at-risk group," which is grounded in the SPI-A questionnaire. The aim of including this group is to increase the sensitivity of CAARMS to the subtle neurocognitive disturbances evident during the prepsychotic phases: inability to divide attention, thought interferences, thought pressure, thought blockages, disturbance of receptive speech, disturbance of expressive speech, disturbances in abstract thinking, unstable ideas of reference, and captivation of attention by details of the visual field.

Although this is only a pilot study, preliminary results and clinical audits have confirmed that it is possible to combine the two approaches in a clinical setting such as the OASIS service. An international consensus conference is urgently needed to ensure the introduction of a standardized taxonomy for the at-risk phases of psychosis in order to sustain ongoing research on prepsychotic phases, inform clinical services, and help overcome methodological heterogeneity across studies.

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