LETTERS

Letters from readers are welcomed. They will be published at the discretion of the editor as space permits and will be subject to editing. They should be a maximum of 500 words with no more than five references. Address letters to John A. Talbott, M.D., Editor, *Psychiatric Services*, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; e-mail, psjournal@psych.org.

Restricting TV Access by Forensic Patients

To the Editor: In psychiatric hospitals, residents watch many hours of television each day. Because it is so easy and nonchallenging, watching television often becomes a "default" activity (1). Mental health professionals have become concerned about the effects of television on institutionalized individuals (2,3), whose intellectual, psychological, and social handicaps render them particularly vulnerable to the negative effects of television watching (4). We therefore investigated whether keeping television sets off for six hours a day would increase the time that forensic inpatients spend in therapeutic activities.

Twenty-five male patients (23 insanity acquitees and two correctional inmates) in a long-term treatment unit at our maximum-security facility participated in the study. Each week, every patient entered his planned therapeutic activities on a schedule sheet; staff signed the sheets as each activity was completed. All sheets were screened for fraudulent signatures.

After 62 weeks of such recording, all television sets on the unit were kept off from 8:30 to 11:30 a.m. and from 1 to 4 p.m. from Monday through Friday. Staff and patients were informed that the purpose of this intervention was to create some "quiet time" on the ward.

In the 62 weeks before the intervention, patients recorded a mean± SD of 22.8±3.3 hours a week of therapeutic activities. In the next 52 weeks after their exposure to television was reduced, they spent a mean of 23.8±2.1 hours in therapeutic activities, a statistically significant increase ($F=3.48$, $df=1,112$, $p<.05$; Cohen's $d=.37$).

Although the increase of only one hour a week in therapeutic activities appears small, we would argue that it is nonetheless clinically important because it represents a substantial number of hours per year. Even a modest increase in treatment is a worthwhile achievement for these long-term forensic patients, given the importance of inducing change in their behavior and the high cost of their care.

In our view, the benefits of this intervention outweighed any detrimental effects. No increase in violence and no legal action arose as a result of the intervention. While the television was off, patients either participated in therapeutic activities, read in the common rooms, or conversed among themselves and with staff. There was no other obvious explanation for the increase in patients' participation in therapeutic activities.

As far as we have been able to establish, the regulation of television exposure in institutional settings such as psychiatric hospitals has not been based on careful studies of the impact of television on patients. Although inpatients can gain potential benefits from watching television, such as learning, socializing, relief from boredom, and continuity with outside life, these benefits must be weighed against the potential risks.

The public has become increasingly concerned about the negative effects of television on one vulnerable population—children, hence the advent of the "V-chip," a device designed to block objectionable television programs. Forensic and other mental health treaters arguably have a duty to ensure that their patients fully participate in the treatment programs available. We have shown that turning off television sets in a forensic ward is one way to foster increased participation.

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Use of Mental Health Services in Rural Areas

To the Editor: The effect that managed care will have on service access, utilization, and clinical outcome for Medicaid beneficiaries who live in rural areas is unknown. Before statewide implementation of Medicaid managed care in Iowa in March 1995, Medicaid recipients who had used fee-for-service mental health services in fiscal year 1993 were surveyed at the request of the Iowa Department of Human Services (1).

One purpose of the study was to determine if residents of rural counties had less access to the same types of services than their urban counterparts. ("Urban" was defined by the presence of a U.S. Census Bureau metropolitan statistical area within the county.) If rural services were less accessible, then services for vulnerable populations such as rural residents with serious and persistent mental illness would need to be protected or enhanced as the fiscal constraints of managed care began to influence the delivery system.

Out of a total population of 16,579 persons who met criteria for inclusion in the study, survey instruments were

sent to 2,520 persons and were returned by 815, for a response rate of 32 percent. Responses were analyzed by the Cochran-Mantel-Haenszel chi square to test the study hypothesis that persons with residence in rural counties used fewer community-based and inpatient mental health services than persons living in urban counties.

The results showed that Medicaid beneficiaries living in a rural county did not report less overall use of mental health services than beneficiaries living in urban counties; however, they were less likely to use group therapy (22 percent versus 31 percent, $\chi^2=4.75$, df=1, p=.03). Rural Medicaid recipients were more likely to report use of home services than urban residents (36 percent versus 27 percent, $\chi^2=5.64$, df=1, p=.02).

Persons who did not have schizophrenia and who had been hospitalized in fiscal year 1993 were more likely to report a greater lifetime cumulative number of hospital days if they lived in urban versus rural areas ($\chi^2=14.10$, df= 1, p<.001). Cumulative hospitalization of persons with schizophrenia, however, did not differ in rural and urban counties.

From these results, we conclude that rural residents may be less likely to use group therapy because it is less available in rural areas. The lower availability may be a reflection of fewer participants and fewer group facilitators, but it is also possible that rural residents use group therapy less because anonymity in participation is less assured.

One explanation for more frequent use of home services in rural areas is that they are a mechanism for providing outreach to persons who otherwise do not have access to services due to problems with transportation. It is also possible that home services provide a substitute for clinic- or hospital-based providers in rural areas.

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PTSD and Ethnic Violence

To the Editor: Sociopolitical forces may cause, shape, or worsen psychiatric disorders (1). Such disorders are encountered more frequently in refugees and torture victims who seek asylum in the United States. A social climate of intolerance toward ethnic minorities and other socially disenfranchised groups in the U.S. is being increasingly documented (2).

A dramatic example of social intolerance is the incident in River City, California, in which illegal immigrants were beaten by members of the U.S. Border Patrol (3). Such incidents may result in psychiatric morbidity even among those who experienced no direct physical trauma from the event. This report describes and discusses such a case.

Mr. C is a 49-year-old single Mexican-American Vietnam veteran who was admitted to a psychiatric hospital for worsening of his posttraumatic stress disorder (PTSD) symptoms after watching the River City incident on TV. He stated that the violence he witnessed reminded him of experiences in Vietnam and triggered feelings of irritability, resentment, helplessness, and fear. He began to isolate himself and was unable to leave his house for fear that he would be mistaken for an illegal immigrant, taken to jail, and sent to Mexico by the Immigration and Naturalization Service.

Mr. C served in Vietnam in 1968, but he considered himself an outsider because he was never fully accepted by his peers, who frequently reminded him of his physical resemblance to the Vietcong. He witnessed many traumatic events and was wounded by friendly fire.

Mr. C's case illustrates the impact of a sociopolitical event on symptoms of PTSD. His disorder was shaped by the historical context of the Vietnam war, including a military environment that fostered a general mistrust of the government among alienated ethnic minorities. His sense of rejection was further compounded by having been wounded by one of his peers.

Witnessing the River City incident on television triggered Mr. C's decompensation because the violence of the beatings reenacted his conflicts over government as aggressor and himself as victim. To him, the Border Patrol represented the government, a body designed to protect national sovereignty but also an aggressor toward people of Mexican origin. Mr. C also identified with the victims—outsiders with whom he shared a similar ethnicity and physiognomy—and thus felt vulnerable to the attack.

Cases such as Mr. C's may become more prevalent as racist movements grow and violent acts ensue. The impact of these societal developments is likely to be negative. Clinicians need to be attuned to this new reality and to take an active role in recognizing and evaluating the psychiatric effects.

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