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## Is There a Shortage of Psychiatrists?

**To the Editor:** I wish to compliment Dr. Goldman on his column in the December 2001 issue, "Is There a Shortage of Psychiatrists?" (1). In answer to this important question, he found that indeed there is a shortage of psychiatrists in the United States, and a curious one at that. Psychiatrists seem unable to adequately serve patients enrolled in behavioral health carve-outs—that is, most of the privately insured public. Psychiatrists do sign up to participate in the provider networks of carve-outs, as evidenced by a 10 percent increase in the number of psychiatrists in the United Behavioral Health (UBH) network. However, they appear to favor treating privately paying patients over network patients. In his article, Dr. Goldman wondered why and mentioned fees, but then he skipped on to a discussion of the complex demand and supply issues at play in psychiatry.

That discussion, although interesting, may miss the point. Fees are a big issue, and so is micromanagement. If managed behavioral health carve-outs paid psychiatrists at reasonable rates and did not demean them by conducting utilization reviews presided over by lesser-trained clinicians,

the functional problem of access might be resolved. A test of whether there is a true shortage of psychiatrists or a de facto boycott of UBH and other behavioral health carve-outs would be to determine whether Medicare and other non-carve-outs also have problems in getting psychiatrists to see their enrollees. I have never encountered such a complaint about the Medicare system, and I do not find that access to psychiatrists is a problem in our local psychiatrist-friendly health maintenance organization. Also, how is the profession to recruit into a field that is overcontrolled by managed care carve-outs?

Dr. Goldman is right to be pessimistic. However, as senior vice-president for behavioral health services at UBH he is nicely positioned to do something other than bemoan the sad state of psychiatry. How about his pushing UBH to free psychiatrists from case-by-case utilization review, something United Healthcare did for other physicians? I agree with Dr. Goldman that one of the results of the current situation may be an increase in the granting of prescribing privileges to psychologists by state legislatures, with all the dangers this carries for patients.

**Jay M. Pomerantz, M.D.**

*Dr. Pomerantz is assistant clinical professor of psychiatry at Harvard Medical School and codirector of the mental health program of Health New England, a health maintenance organization in western Massachusetts.*

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1. Goldman W: Is there a shortage of psychiatrists? *Psychiatric Services* 52:1587-1589, 2001

## Stigma as a Barrier to Recovery

**To the Editor:** The special section in the December 2001 issue devoted to research about stigma (1) is a must-read for mental health clinicians, program and policy planners, and trainees. In my work with therapy groups of severely ill patients who attend the partial hospital program at the Payne Whitney Clinic, I have been

profoundly moved by the added burden that stigma imposes on the struggle to recover. Several topics arise in group discussions, including how to explain gaps in one's resume, how to obtain medical care without being labeled a "psychiatric patient," how to explain one's depression to family members who oppose the use of medications and insist that one is simply "not trying hard enough," how to manage side effects such as tremor and weight gain that are difficult to conceal, and how to cope with loneliness and isolation from the mainstream culture.

At the 1985 annual meeting of the American Psychiatric Association, Dr. Kenneth Turkelson presented a lecture on the "humiliation" of being mentally ill. Sadly, in 2002 this topic is still relevant. The national leadership provided by the Surgeon General to overcome stigma and improve access to treatment is long overdue. Archaic notions of mental illness persist. Advances in family treatment models have meant a shift away from former interventions in which parents experienced blame and analysis of their personalities toward appreciation of caregiver burden. Nevertheless, parents continue to struggle with shame and grief in a competitive society in which bragging about the accomplishments of one's offspring is commonplace (2,3).

The groundswell of understanding of mental health problems and appreciation for the invaluable role of treatment after September 11 cruelly evaporated soon afterward with the defeat of parity legislation. The failure of national leaders to endorse parity in coverage of psychiatric and physical illnesses highlights the fact that people with serious psychiatric illnesses face a more difficult battle than those with serious physical diseases. Stigma undermines the promise of state-of-the-art treatments that are now available to alleviate suffering and restore functioning. In addition, providing services for this population is especially difficult under managed care, in which treatment can be reduced to symptom manage-

ment and patients can be deprived of longer-term psychotherapeutic and social supports (4,5).

We must continue to address underlying issues that cause stress for patients and their families and that can result only in a tougher journey and a poorer outcome.

**Sue Matorin, M.S., A.C.S.W.**

*Ms. Matorin is treatment coordinator for the affective disorder team at Payne Whitney Clinic of New York Presbyterian Hospital and the Weill Medical College of Cornell University in New York City. She is also adjunct associate professor at Columbia University School of Social Work.*

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**In Reply:** Ms. Matorin draws on her clinical experience to poignantly describe the struggles encountered by patients and families who are coping with stigma in their daily lives. She points out that the efforts of mental health professionals have had only a limited impact on stigmatization, and she implies that the battle against stigma must be waged as much by consumers, families, opinion leaders, and the press as by professionals.

We agree. Autobiographical books such as Andrew Solomon's *The Noonday Demon* (1) and William Styron's *Darkness Visible* (2) are courageous accounts that help promote the idea in the public mind that mental illnesses are like physical illnesses. Popular films such as *Girl, Interrupted* and *Ordinary People* help cut through stereotypes and reduce the fear and mistrust

of people with mental illness that derive in part from ignorance.

As Ms. Matorin suggests, the media played a strong role in helping promote broader recognition of symptoms of mental illness as a normal response to stress and trauma in the portrayal of peoples' responses to the events of September 11. Many of these accounts demonstrated the tremendous potential of the media to help combat stigma.

However, there is still much that mental health professionals can do to help reduce the adverse impact of stigmatization of people with mental illness. First, like others before them, such as Kay Redfield Jamison (3) and Larry Davidson (4), they can be more disclosing about their own illnesses and those of family members. Personal accounts by mental health professionals help foster public acceptance of mental illness, and professionals who are open about their illnesses can serve as role models to patients and colleagues who are struggling with feelings of shame over their illness, leading them to hide it. Personal accounts by mental health professionals may also help minimize the tendency toward what Davidson terms the "us and them" thinking that permeates even the mental health field (4).

Even though the media has enormous influence, any fundamental change in the dichotomous us-and-them thinking that underlies the stigmatization of people with mental illness must start with a shift in the interpersonal dynamic in relationships between persons who have a mental illness and the professionals who treat them.

Second, mental health professionals can support and broaden their involvement with consumer and family advocacy organizations such as the National Alliance for the Mentally Ill and the National Depression and Manic-Depression Association. By openly promoting the interests and entitlements of people with mental illness, such organizations serve to counteract the sense of the disempowerment that frequently accompanies stigmatization.

**Deborah A. Perlick, Ph.D.**  
**Robert A. Rosenheck, M.D.**

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## Assertive Community Treatment in the UK

**To the Editor:** The article by Ms. Phillips and her colleagues, "Moving Assertive Community Treatment Into Standard Practice" (1), is indeed timely. In the United Kingdom we face analogous issues, albeit within a public mental health service that is less fragmented and that has a basic level of coordination despite chronic underinvestment. Our government is strongly committed to the introduction of assertive community treatment, but government authorities are frustrated that European research rarely demonstrates the major reduction in hospitalization seen in the U.S. studies of assertive community treatment. Controversy remains about whether this phenomenon reflects the content of the programs or the context in which they operate.

Like Ms. Phillips and her coauthors, we are interested in identifying the features of assertive community treatment that are most strongly associated with successful outcomes. In our search for these factors, we conducted a systematic review of all studies of home-based care for people with mental health problems. We deliberately avoided too narrow a focus on assertive community treatment, which Ms. Phillips and colleagues suggested may have limited the usefulness of the Lewin Group's findings in this regard (2), and we included any service that aimed to treat patients outside of the hospital. This approach enabled us to look at a wide range of services studied and to examine how the service components provided to the intervention groups

and the control groups were associated with reduction in hospitalization. Our results have been published in detail in a Health Technology Assessment Monograph (3) and are soon to appear in *Psychological Medicine* (4).

Our analysis identified a group of features that are common to intervention services: regular visits to the client's home, responsibility for both health and social care, lower caseloads (defined as fewer than 15 clients), multidisciplinary teams, and full integration of the psychiatrist into the work of the team. The first two components were found to be significantly associated with reduced hospitalization.

We found it interesting that services with these features overlap with but are not identical to the services identified in the article by Phillips and colleagues as constituting assertive community treatment. Despite admirable attempts to define assertive community treatment as a model, the danger remains of applying the label without first ensuring that practitioners are actually delivering "assertive community treatment." Phillips and colleagues clearly recognize the problems related to definition in their focus on how best to ensure fidelity to the assertive community treatment model. We would add that the interpretation of evidence from past studies is made difficult by the paucity of detail in many reports about the contents of the "black box."

A surprising finding from our study was that many experimental services had ceased to exist or had changed substantially when we followed them up; a few closed before our study was published (3). In many ways, our approach was the reverse of that used by Ms. Phillips and her colleagues. Although we commend them for seeking to determine the most effective means of implementing assertive community treatment, we would argue that consideration should also be given to whether such services can be sustained—an issue that may be overlooked once studies have become part of the literature and the services they tested are forgotten.

**Tom Burns, M.D.**  
**Jocelyn Catty, D.Phil.**

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## Clinical Experience and Prescribing Practices

**To the Editor:** One objective of the study by Marcia Valenstein and her colleagues, "Delays in Adopting Evidence-Based Dosages of Conventional Antipsychotics" (1), was to upgrade the prescribing practices of American psychiatrists. The study involved the review of prescriptions for 936 veterans in 14 Veterans Affairs facilities. The authors concluded that dosages for 20 percent of the patients were below the recommended range and dosages for 28 percent were above it. Apparently the range was based on information from two sources, one published 13 years ago (2) and the other 14 years ago (3). I suspect that if the authors of these textbooks were quoted in full, they would have allowed variations above and below their recommended ranges, depending on age, plasma drug concentrations, and concurrent medications. In any event, it is hard to imagine that 48 percent of American psychiatrists are doing something wrong.

Patients selected for the study had been hospitalized for at least 150 days or had had five or more admissions during the previous year. One cannot but conclude that the experimental group consisted of patients who were doing poorly. Dosages below the recommended range were described as "suboptimal." Such dosages may have been for patients who had a history of adverse effects with conventional

dosages. What is "suboptimal" for a group may be optimal for an individual. We cannot know whether this is true, because, as the authors acknowledge, their study was cross-sectional and did not include information about past drug trials.

Similarly, patients receiving higher dosages may have had a history of poor response to conventional dosages. Patients with multiple or lengthy hospitalizations may have had relatively intractable illnesses that respond poorly to conventional dosages. The implication of the study is that higher dosages are harmful, which may be true. However, the authors provided no information about the percentage of patients with illnesses that were thought to be intractable but who improved with higher dosages—or with dosages below the recommended range. Such patients were ineligible for the study because they did not have multiple or prolonged hospitalizations. The authors conclude that "a troubling proportion of patients were treated with high dosages—a practice for which there is little supporting evidence." What is really troubling is that the proportion of all patients treated with high dosages is unknown, because good responders were systematically excluded from the study.

The authors noted that younger patients and African-American patients received higher dosages. They did not address the problem of whether African Americans predominated in the younger group, which is important to know. Also, it is clear that geriatric patients constituted a large proportion of the lower-dosage group (36 percent). The authors did not acknowledge that lower dosages for elderly patients may be justified.

There is a larger issue involved with any study that implies that a majority or a substantial minority of American psychiatrists are doing something wrong when they prescribe medications. Psychopharmacology is not an exact science. Psychiatrists and other physicians are strongly influenced by positive results. They gravitate toward whatever dosage works. They tend to avoid any regimen that does not work. A question thus arises about

whether the recommended ranges cited by Valenstein and her colleagues should be reconsidered in view of the practices of 48 percent of American psychiatrists. Perhaps someone should write an article entitled "Delays in Adopting Recommended Dosages of Conventional Antipsychotics on the Basis of Widespread Clinical Experience." To a certain extent that has been done in the Expert Consensus Guideline Series (4).

**Martin Fleishman, M.D.**

*Dr. Fleishman is staff psychiatrist at St. Francis Memorial Hospital in San Francisco.*

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**In Reply:** We appreciate the comments of Dr. Fleishman. As he notes, receiving dosages of antipsychotic medications outside of recommended and generally effective ranges does not in itself indicate poor-quality care. Low dosages of these drugs may have been appropriate for some older patients in this cohort or for patients suffering from side effects.

More suggestive of problematic delays in transferring research findings to clinical practice is the 28 percent of patients in our study who received high dosages of antipsychotics some eight to 15 years after research reports and review articles indicated that this treatment strategy yields little benefit.

As Dr. Fleishman points out, psychiatrists may base their treatments on clinical experience in addition

to—and sometimes instead of—the scientific literature. This strategy may succeed, and some patients may respond to treatments that have little research support.

However, clinicians must be careful when implementing unproven treatments or when continuing treatments that have been demonstrated to be "usually ineffective." Clinical experience, like open-label trials, is subject to biases (1). Both clinicians and patients hope that new treatments will work, and without control groups, random treatment assignment, and blinded ratings, they may have great difficulty separating their hopes and the natural variations in clinical presentation from the effects of treatment.

We suspect that many of the patients in the sample who were receiving high dosages of antipsychotics did not respond but were nonetheless maintained on high dosages. Many were symptomatic. Clinicians may have been misled by the earlier popularity of the high-dosage treatment strategies. They may have misinterpreted minor changes in the patient's presentation as a partial response or may simply have been reluctant to decrease antipsychotic dosages when patients were ill. Unfortunately, high dosages of antipsychotics can cause serious side effects.

Dr. Fleishman states that it is hard to imagine that a substantial minority of psychiatrists would use ineffective or harmful treatments. We agree that psychiatrists are dedicated professionals and have their patients' best interests at heart. Nevertheless, history indicates that psychiatrists may indeed use ineffective and harmful treatments, particularly if patients are severely ill. In the not-too-distant past, patients with schizophrenia were referred for lobotomies, and family members were told that they played an important role in the genesis of the patient's illness (2). Patients who have schizophrenia may have dramatic symptoms, and the pressure to pursue aggressive or new treatments can be immense—even when there is no evidence of substantial benefit.

Psychiatrists and mental health organizations must follow the literature

closely and conduct trials of less studied treatments carefully. The Texas Medication Algorithm Project's guidelines for schizophrenia make treatment recommendations that go beyond the research evidence, but only when evidence-based treatments have been tried and clinicians use a specified timeline and structured method for assessing treatment response (3). Clinicians would do well to adopt such a structured approach with their patients.

We believe our data provide an important cautionary message. As noted in our paper, regular monitoring of the pharmacological treatment of patients with schizophrenia may be important in optimizing care.

**Marcia Valenstein, M.D., M.S.**  
**Laurel Copeland, Ph.D.**  
**Richard Owen, M.D.**  
**Fred Blow, Ph.D.**  
**Stephanie Visnic, M.S.**

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## Evidence-Based Practices and Recovery

**To the Editor:** In "Integrating Evidence-Based Practices and the Recovery Model," which appeared in the November 2001 issue (1), Dr. Frese and his colleagues contend that the benefits of the recovery model do not apply to "the most seriously disabled consumers." They also state that the recovery model is subjective and not based on scientific evidence. Although we are glad to see that the authors acknowledge that people with mental illness can recover, we are dismayed that they marginalized the recovery approach.

When people are in the greatest

distress, they experience despair, isolation, hopelessness, and a lack of control. It is at those trying times that they need hope, social connection, and a belief that they can regain control of their life, which are the principles of the evidence-based recovery model. Use of approaches based on the recovery model is crucial at the beginning of the recovery process and throughout it. We know—we recovered from schizophrenia. We were able to begin recovery only when we felt we could connect and borrow someone else's hope until ours returned. Indeed, this is why people move on in their recovery. To wait and apply these principles only later in people's treatment may rob them of their chance to recover.

Research has shown that the principles underlying the recovery model are evidenced based (2). An epidemiological study of a group of seriously disabled persons who were consumers of mental health services in Vermont showed that practices based on the principles of hope, social connection, and self-determination—those of the recovery model—were essential ingredients in the high rate of recovery in this group. A much lower rate of recovery was found in Maine, where treatment was based on maintenance and medication compliance, the essence of the medical model (3).

Another study of the conditions best suited for recovery, the Soteria House study, found that persons experiencing their first episode of schizophrenia achieved more significant recovery when their treatment was provided in the context of relationships characterized by hope, trust, and self-determination rather than in accordance with the principles of the medical model (4). In Falun, Sweden, persons experiencing psychosis who were treated according to the principles of the recovery model had better outcomes than those whose treatment followed the medical model (5).

Currently, the benchmark for evidence-based practice is maintenance: symptom reduction and medication compliance. However, when community integration is used as the outcome measure, the recovery model is

clearly more evidence based than the medical model.

The medical model, which is the underpinning of evidence-based practices, is described in the article by Dr. Frese and coauthors as being "highly paternalistic, emphasizing illness, weakness, and limitations rather than potential for growth." The authors state that people who are in the greatest distress should be treated by a "paternalistic, externally reasoned approach." This is the primary approach used in the mental health system today. When people are told they suffer from a permanent biological brain disorder, they feel they will never recover or regain control over their lives. This treatment approach has ensured that people remain hopeless, helpless patients and has made them indefinitely dependent on the mental health system.

**Daniel B. Fisher, M.D., Ph.D.**  
**Laurie Ahern**

*The authors are codirectors of the National Empowerment Center in Lawrence, Massachusetts.*

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**In Reply:** We appreciate Dr. Fisher and Ms. Ahern's comments. However, we should correct some misunderstandings of our position. First, they claim that we describe the medical model as "highly paternalistic, emphasizing illness . . ." and so forth, but we were referring to an earlier article (1) describing Dr. Fisher's own pub-

lished negative views of the medical model (2). We were not endorsing Dr. Fisher's perspective. We strongly endorse the concept of evidence-based practice, particularly for the most seriously disabled patients, whether critics label it paternalism, the medical model, or something else.

Second, we do not marginalize the recovery approach. We highly value this approach, which we see as becoming increasingly therapeutic as persons recover. Hope, trust, and self-determination should be incorporated into any treatment model.

Dr. Fisher and Ms. Ahern reject the evidence for biochemical correlates of mental illness (3). It is not surprising that this neo-Szaszian denial of the biological basis of mental illness leads them to discount the importance of evidence-based medical treatments engendered by the biological model.

We believe that Dr. Fisher and Ms. Ahern's "recovery-centric" interpretation of studies is a misreading of the results of these studies. We do not believe that the modest evidence supporting the recovery approach outweighs the extensive evidence supporting biological and psychosocial evidence-based treatment, particularly for the most seriously disabled among persons with mental illness.

However, the most important issue raised by their letter is not their creative interpretation. Nor is it their rejection of the value of medical and other evidence-based practices. The most important issue is the plight of neglected mentally ill persons in this country. Hundreds of thousands of abandoned and otherwise underserved seriously mentally ill persons are legally denied treatments from which they can benefit. These individuals are victims of a rights-based ideology gone awry. Nationwide, government officials and rights attorneys continue to argue for the right of cognitively impaired, often anosognosic (4), persons to refuse treatment, including treatment for which there is a solid evidence base. Many of these rights apologists assert that they are arguing on behalf of all consumers, frequently citing the views of the Na-

tional Empowerment Center and similar consumer advocacy entities (5). Claims such as "We know—we recovered from schizophrenia" afford a patina of legitimacy to the arguments of these consumer advocates.

But we, too, are in recovery from schizophrenia or other psychotic disorders. Some very recovered—even "fully recovered"—consumer-survivor advocates oppose evidence-based assisted treatment for persons who are too impaired to understand its value. But, increasingly, recovering persons realize that we have serious biologically based conditions that at times prevent us from appreciating or understanding that treatments for which there is a solid evidence base can and must be made available to all those suffering from these disorders.

Many consumer advocates are now recognizing that the right to refuse treatment, even when cloaked in the mantle of the recovery model, should no longer be allowed to trump the delivery of evidence-based treatment for those who are most seriously disabled. Whether the negative experiences of consumer-survivors such as Dr. Fisher and Ms. Ahern or our more positive experiences with evidence-based treatments are more generalizable is itself an issue for evidence-based research.

**Frederick J. Frese III, Ph.D.**

**Jonathan Stanley, J.D.**

**Ken Kress, J.D., Ph.D.**

**Suzanne Vogel-Scibilia, M.D.**

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## Trauma and PTSD Among Substance-Abusing Patients

**To the Editor:** Exposure to a traumatic event and posttraumatic stress disorder (PTSD) are more prevalent among persons with substance use disorders than in the general population (1). Early diagnosis of this dual problem—PTSD and a substance use disorder—may lead to better treatment outcomes because both conditions can then be treated concurrently (2). We sought to determine whether the use of a structured psychiatric interview would significantly improve the identification of a history of trauma and the diagnosis of PTSD in a chronically substance-abusing population.

Patients in the study were visitors to a psychiatric emergency department in December 2000. A total of 172 patients who had at least one diagnosis of a substance use disorder were evaluated with the Mini International Neuropsychiatric Interview (MINI) (3). The mean±SD age of patients in this group was 34.8±10 years. A total of 115 patients (67 percent) were male, and 101 (59 percent) were Caucasian. The control group consisted of 150 patients with at least one diagnosis of a substance use disorder. Their mean age was 37.5±10.8. One hundred of the patients in the control group (67 percent) were male, and 85 (57 percent) were Caucasian. Patients in the control group were randomly selected not to receive a structured interview as part of their clinical evaluation. Patients in both groups had a history of chronic substance abuse or dependence (a mean of 17±4 years of use) and extensive substance abuse treatment (a mean of 3±1 previous treatment episodes). A total of 215 patients (67 percent of the total sample) had at least one co-occurring psychiatric disorder.

Major differences were found between groups in self-reports of traumatic experiences as defined by *DSM-IV* criteria. Forty-two patients in the group that was evaluated with the MINI reported a significant trauma, compared with 11 patients in the control group (24 percent versus 7

percent;  $\chi^2=16.8$ ,  $df=1$ ,  $p<.001$ ). Among the patients who reported a traumatic experience, 24 in the study group (57 percent) reported symptoms of PTSD, compared with five in the control group (45 percent). This difference was not significant. A review of the medical records of all patients found only five diagnoses of PTSD on axis I in the study group and three in the control group.

Use of a structured interview in an acute psychiatric setting during the evaluation of patients with substance use disorders led to more frequent identification of a history of trauma and elicited more reports of symptoms related to PTSD. For patients with a substance use disorder, early identification of PTSD may guide the subsequent referral and treatment process (4). This study supports the use of a structured interview during routine evaluations in this setting. The results of a structured assessment should be considered to be as important as the results of any test, such as an electrocardiogram, a blood test, or the Beck Depression Inventory.

**Leo Bastiaens, M.D.**

**Jacob Kendrick, B.S.**

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