

year, 3,000 individuals with schizophrenia kill themselves every year, more than 30,700 individuals with serious neurobiological disorders serve time in our jails every year, and 150,000 individuals with serious neurobiological disorders live on the streets or in shelters.

It is hoped that after reading Dr. Torrey's commentary, the leadership of the Center for Mental Health Services and state departments of mental health will focus their efforts on those who need treatment, rather than those who need to prevent it.

D. J. Jaffe

Mr. Jaffe is a spokesperson for the Alliance for the Mentally Ill/Friends and Advocates of the Mentally Ill in New York City.

To the Editor: The testimony of psychiatric "survivors" reaffirms the disappointing limitations of our current science: our diagnostic categories are imperfect, our treatments are not always effective, and powerful treatments always carry some risk of adverse effects. Clinical practice is a lesson in humility.

Scientific medicine progresses by examining averages—the experience of large numbers of patients. Over the last 30 years, we have accumulated overwhelming evidence that modern psychiatric treatments, are, on average, remarkably effective. Clinical practice, however, teaches us that averages do not always apply to individuals. No responsible clinician would claim that any treatment is always safe or never harmful.

While we are cautious not to mechanically apply averages to the individual, the "survivors" make an even more dangerous leap: applying the experiences of individuals to the entire population. It is certainly true that some individuals have fared better after rejecting conventional psychiatric treatment. Their experience, however, does not negate the experience of a much larger number who have obtained dramatic and enduring benefit.

Gregory Simon, M.D., M.P.H.

Dr. Simon is associated with the Center for Health Studies/Mental Health Services of the Group Health Cooperative in Seattle.

To the Editor: To hold Jay Mahler and civil liberties lawyers responsible for making it "virtually impossible to treat [people] with no insight into their illness or their need for treatment" is to truly miss the point of the last 30 years of experience with deinstitutionalization. The real culprit is the unwillingness of society to support adequate care for the mentally ill, or perhaps the failure of mental health advocates to justify such care to legislators and their constituents.

While I personally support civil commitment in the circumstances described by Torrey and know consumer-survivors who do also, that is not the issue. There are currently few viable treatment options other than involuntary commitment. Many involuntary detentions could be avoided with adequate alternatives. But because of the lack of alternatives, people are often forced to trade their liberty for care. In fact, many persons come to psychiatric emergency services today begging for civil commitment because that is the only way to get any help. Although civil commitment saves lives, for many it results in a learned helplessness that ensures their revolving-door participation in the system. Some patients avoid all treatment because of fear of civil commitment.

The lack of alternatives to hospitalization remains a key issue in psychiatric care, and the problem will only be exacerbated with the coming of managed care.

Steven P. Segal, Ph.D.

Dr. Segal is professor and director of the Mental Health and Social Welfare Research Group in the School of Social Welfare at the University of California, Berkeley.

To the Editor: Like the thousands of nonsurvivors Dr. Torrey identified, my brother died last year because of his schizophrenia, perhaps because it was so difficult for us to get him treatment. For nine torturous years my parents and I were forced into inaction due to the current laws, and all the while the delusions and voices overwhelmed my brother's life. It was only after his condition degenerated to the point where he was destroying the house that we could finally get him to the hospital.

Then, as is so often the case, catching a person during that very small window of time when he or she is "a danger to himself or others"—and before he or others are dead—is an overwhelming task with a disease that can fluctuate dramatically in a matter of hours. In our case, my parents were taking their first real vacation in years, and we just couldn't respond to my brother quickly enough. How many people can be prepared for their worst nightmare 100 percent of the time?

Sadly, because the many who don't get treatment are usually outside the system, they rarely get counted in unnatural death statistics. I applaud Dr. Torrey for his efforts in helping the mentally ill. Finally, someone is counting, and speaking out for the people who no longer have a voice—the huge population of nonsurvivors.

Brian Chiko

Mr. Chiko is webmaster for www.schizophrenia.com in San Jose, California.

To the Editor: I've benefited immensely from psychiatric care over the years. The label I use for myself in relation to psychiatric care is "consumer" or "client." I find the labels "psychiatric survivor" and "patient" to be inaccurate and undesirable.

Larry McCleery

Mr. McCleery lives in Salt Lake City, Utah.

To the Editor: The consumers-survivors who are the subjects of Dr. Torrey's commentary appear to have adopted the philosophy of Dr. Thomas Szasz (1), who has written that the concept of mental illness is erroneous, and that practices based on the concept are an "immoral ideology of intolerance."

Psychiatrists as ethical physicians have practiced their profession in keeping with the science and social standards of the time. Thirty years ago, Dr. David Vail (2), among others, pointed out the need for humanistic practices in caring for people with mental illness. Psychiatrists have made huge advances in their understanding of mental illness and in the nature of treatment to try to alleviate suffering and prevent danger to those afflicted