Klassische Experimente der Psychologie

On Being Sane in Insane Places

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Contents

- Criteria of Normal-Abnormal behaviour
- Rosenhan's biography
- Rosenhan's experiment
- Hypothesis
- Theoritical Propositions
- Method
- Results
- The normal are not detectably sane- Type I and type II errors
- The stickiness of psychodiagnostic labels
- The experience of psychiatric hospitalization
- Powerlessness and Depersonalization
- Recent Applications
- Critique
- Summary-Conclusion
- Bibliography

“Normality and abnormality are not universal. What is viewed as normal in one culture may be seen quite aberrant in another.”

Benedict (1934)

NORMAL ⟷ ABNORMAL

(Effective functioning)

(Mental illness)

“All behaviour can be seen to lie on a continuum with normal at one end, and abnormal at the other”

Distinguishing “normal” from “abnormal” behaviour:

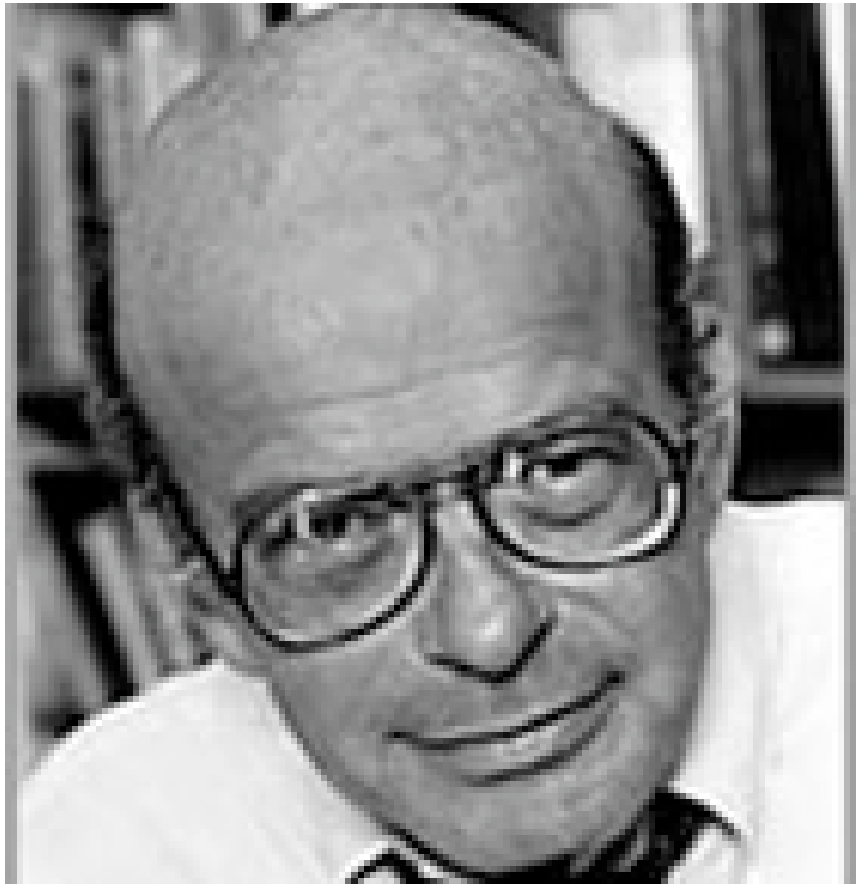
Criteria

- Cortex of Behaviour
- Persistence of Behaviour
- Social Deviance
- Subjective Distress
- Psychological Handicap
- Effect on Functioning

- Are mental health professionals truly able to distinguish between the mentally ill and the mentally healthy?

- What are the consequences of mistakes?

David L. Rosenhan



- received his Bacelor of Arts degree in Yeshina University
- 1953 Master Degree at Columbia University and 5 years later his Ph.D in psychology.
- 1970 joined the Stanford Law School faculty
- 1972 Rosenhan Experiment

ROSENHAN EXPERIMENT

(1972)

Hypothesis

- Do the characteristics that lead to psychological diagnoses reside in the patients themselves or in the environments and cortex in which observers find them?
- If the established criteria and the training mental health professionals have received for diagnosing mental illness are adequate, then would those professionals be able to distinguish between the insane and the sane?

Theoretical Propositions

- Rosenhan proposed to have normal people admitted to psychiatric hospitals and then determining whether they were discovered to be sane and, if so, how?
- If these “pseudopatients” were not discovered to be normal, this would be evidence that diagnoses of the mentally ill are depend more from the situation than from the patient.

Method

- 8 sane people (3 psychologists, a psychiatrist, a pediatrician, a housewife and a painter) - 3 women & 5 men
- in 12 different hospitals in United States
- called the hospital and made an appointment
- all of them followed the same instructions
- changed their names and occupations
- complained only of hearing voices that said “empty”, “hollow” and “thud”
- all subjects acted normally and gave truthful information

Method

- all except one admitted with the diagnoses of “schizophrenia”
- apart from their nervousness the “pseudopatients“ behaved “normally” and cooperated with the staff and accepted all medications (not swallowed)
- all took notes of their experience
- their aim was to convince the staff that they were healthy enough to be discharged

Results

- length of hospital stay: an average of 19 days (min. 7 max. 52)
- no one of the “pseudopatients” was detected by the hospital staff
- 1 was diagnosed with “schizophrenia”
- 7 were diagnosed with “schizophrenia in remission”
- 35 out of 118 real patients voiced suspicions that 3 of the subjects were not actually mentally ill
- contacts between patients and staff were minimal and often bizarre

The normal are not detectably sane

Rosenhan believed that this happened because of what statisticians call “type error 2”

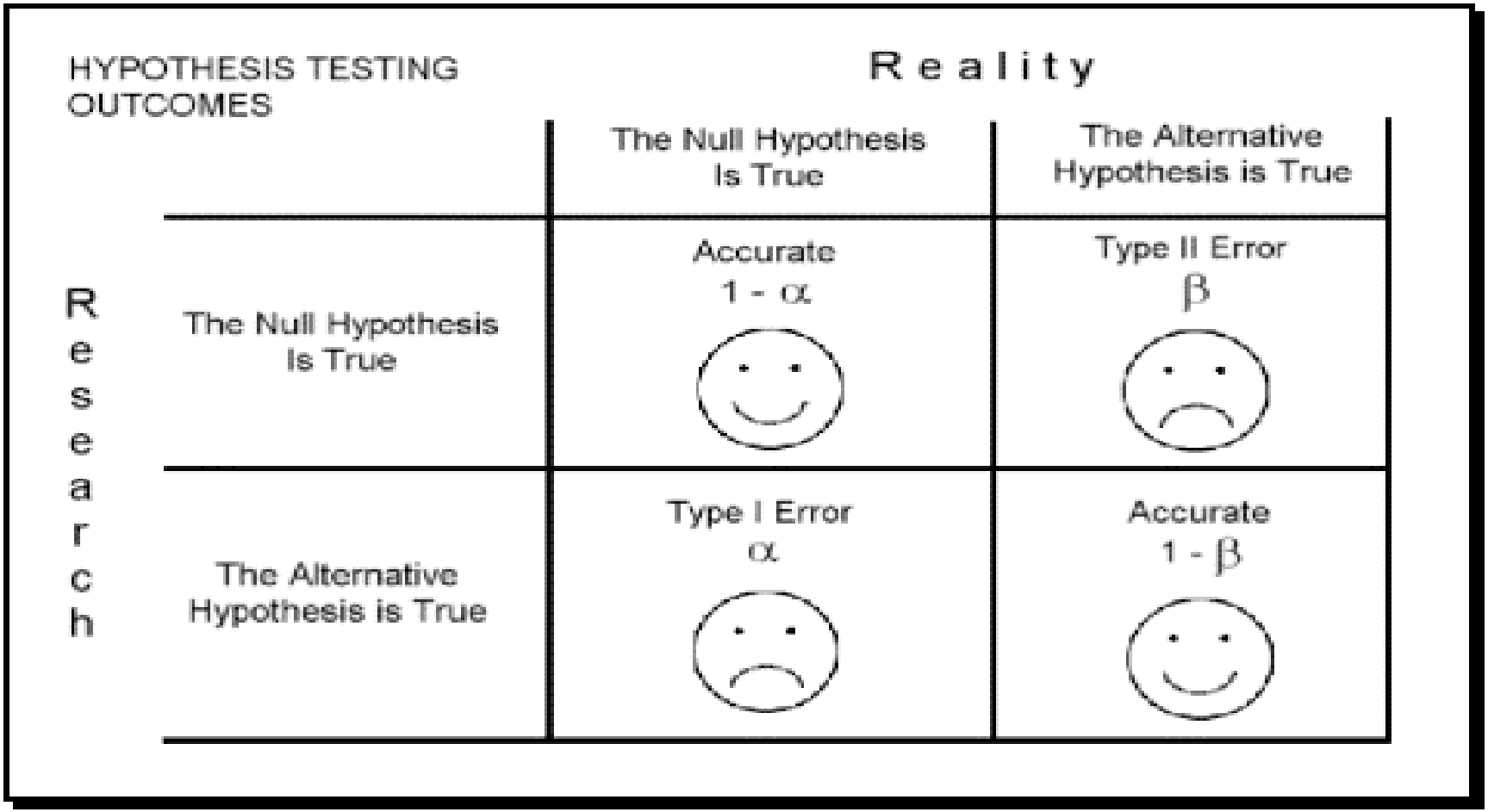
- What is the **“type error 2”** ?

  the error of accepting a hypothesis that should have been rejected

  This error says that physicians are more incline to call a healthy person sick than a sick person healthy. This is because it is better to err on the side of caution, to suspect illness even among the healthy.

- The difference between medical and psychiatric diagnose is that psychiatric diagnoses carry the personal, legal and social stigma.

Type I and type II errors



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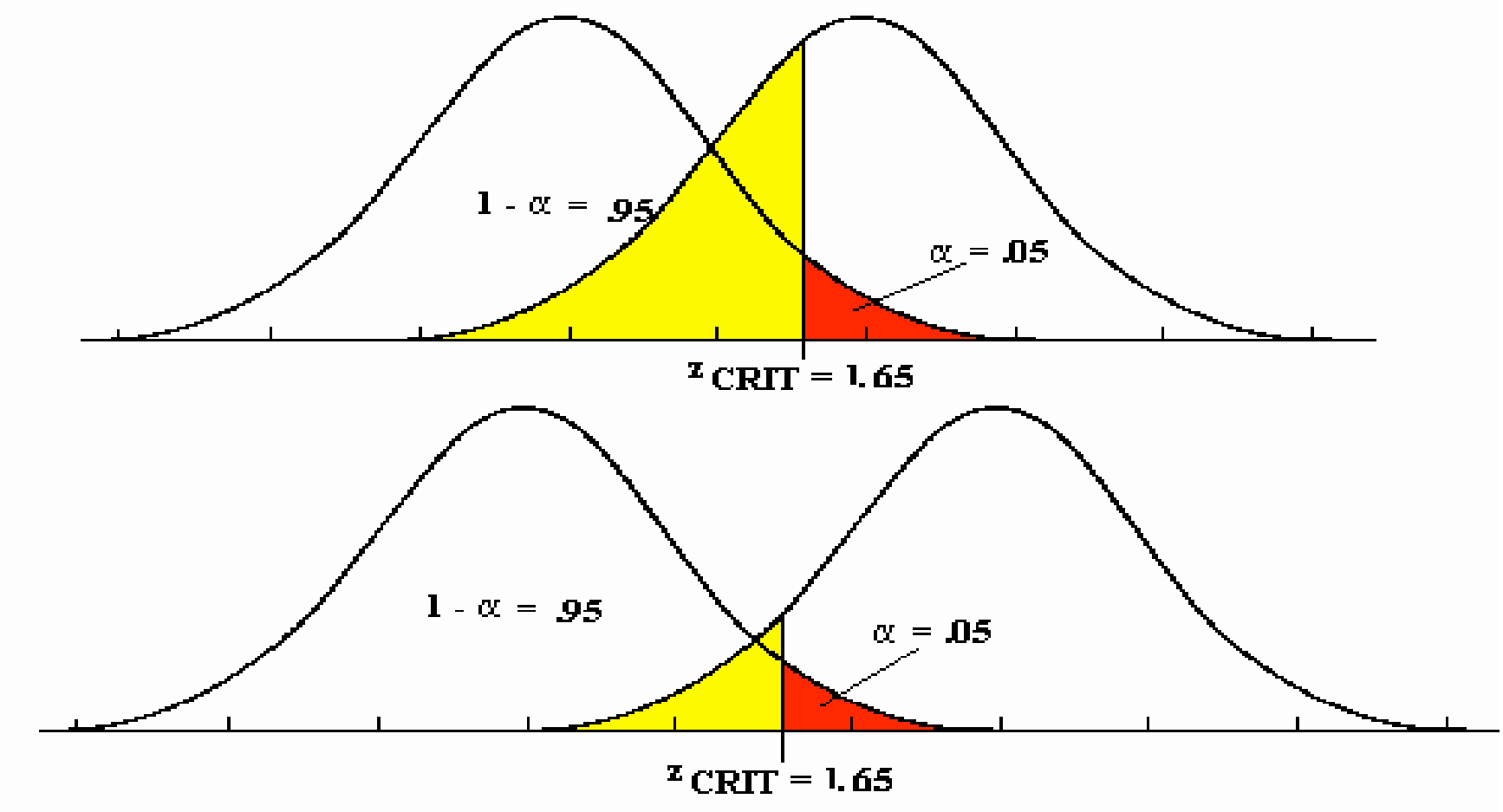

The stickiness of psychodiagnostic labels

When a patient is labeled as schizophrenic it becomes his/her central personality traits and it colours all his/her behavioural characteristics.

The label is so powerful that many of the pseudopatients' normal behaviours were overlooked entirely or profoundly misinterpreted.

Example from the Rosenhan's research of a pseudopatient's stated history

The pseudopatient had had a close relationship with his mother but was rather remote from his father during his early childhood. During adolescence and beyond, however, his father became a close friend while his relationship with his mother cooled. His present relationship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal. The children had rarely been spanked

The director's interpretation of this rather normal history

"This white 39-year-old male manifests a long history of considerable ambivalence in close relationships which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship with his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in case of the children, spankings. And while he says he has several good friends, one sense considerable ambivalence embedded in those relationships also."

The experience of psychiatric hospitalization

- staff and patients are strictly segregated
- those with the most power have least to do with patients and those with the least power are most involve with them
- contacts between patients and staff are often minimal

Pseudopatients test

the “pseudopatients” test to approach staff members and attempt to make a verbal contact by asking common questions

the most common response from the staff was a brief response to the question, offered while they were “on the move” and with head averted or no response at all

pseudopatient: *“Pardon me, Dr…..,could you tell me when I am eligible for ground privileges?”*

psychiatrist: *“Good morning, Dave. How are you today?”*

the doctor moved on without waiting for a response

Responses by Doctors and Staff to Questions Posed by Pseudopatients

RESPONSE	PSYCHIATRISTS (%)	NURSES AND ATTENDANTS (%)
Moves on, head averted	71	88
Makes eye contact	23	10
Pauses and chats	2	2
Stops and talks	4	0.5

Powerlessness and Depersonalization

The absence of eye and verbal contact reflect avoidance and depersonalization

Powerlessness was evident everywhere:

- The freedom of movement is restricted.
- Patients cannot initiate contact with the staff.
- Personal privacy is minimal.
- Patients personal history and anguish is available to any staff member.

The Sources of Depersonalization

- The attitude that all have toward the mentally ill

  (Fear, distrust, horrible expectations and benevolent intentions)

- The hierarchical structure of the psychiatric hospital

  (Patients do not spend much time in interpersonal contact with doctoral staff and this model inspires the rest of the staff)

Recent Applications

Studies that have used Rosenhan's research in challenging the validity of diagnoses made by mental health professionals

- **Thomas Szasz** (early 1970):Mental illness are not diseases, but problems in living that have social and environmental causes.
- **Wahl** (1999): People feel the effects of the stigma surrounding mental illness from various sources.
- **Biosvert & Faust** (1999): The tolerance and understanding of mental illness is incrising.
- **Broughton & Chesterman** (2001): People may fabricate symptoms of mental illness (e.g.criminals)

Critique

Spitzer's belief is that Rosenhan's study did not really invalidate psychological diagnostic systems.(1976)

3 possible ways of detecting the sanity of a "pseudopatient":

- Detecting sanity before admission
- Detecting sanity after admission
- The patient was no longer insane

1. Detecting sanity before admission

The symptom of hallucinations does have diagnostic signification even though there was not in the literature

The clinical picture includes not only the symptom but also the desire to enter a psychiatric hospital.

From that is reasonable to conclude that the symptom is a source of significant distress.

With all the other conditions ruled out there is only one possible diagnoses left: Schizophrenia

2. Detecting sanity after admission

- Diagnostic conditions are not always chronic and unremitting
- Mental illnesses endure forever

  (APA's DSM)
- The diagnoses of schizophrenia does not mean that all the patient's behavior is schizophrenic

3. The patient was no longer insane

The diagnoses “schizophrenic in remission” is extremely unusual because:

a) Patients with the diagnosis of schizophrenia are rarely completely asymptomatic when discharged.

b) The discharged diagnosis associated with the admission to the hospital without any reference to the condition of the patient when discharged

Summary-Conclusion

Rosenhan

> “It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals.(…)In a more benign environment, one that was less attached to global diagnosis, their behaviours and judgments might have been more benign and effective.”

Spitzer

> has argued that psychological diagnostic systems are invalidated.
>
> Such symptom variation in psychiatric disorders is common and does not mean that the staff was incompetent in failing to detect the ruse.

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Thank you for your attention