INSTITUTE OF CURRENT WORLD AFFAIRS

JLS-5
Looking for Sanity-2

29 West 17th Street
New York, New York 10011
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Mr. Richard H. Nolte
Institute of Current World Affairs
535 Fifth Avenue
New York, New York 10017

Dear Mr. Nolte,

When David Rosenhan's pseudopatient project was first reported a year ago, it both captured the public imagination and aroused angry comment from many mental health professionals. Much of the criticism was disquietingly off target, for it misconceived the aim of Rosenhan's project and concentrated on the apparent ease with which 8 pseudopatients tricked 12 hospitals into admitting them.

Some critics took the view that the pseudopatients had stumbled upon 12 extraordinarily sloppy hospitals or intake officers. According to this school of thought, it was only the misuse of a valid theory that led to error: "faulty application of concepts does not invalidate those concepts." One critic assured us that there is "not a single psychiatric textbook or journal article on the phenomenology of schizophrenia that suggests that a diagnosis of schizophrenic can

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be made on the basis of auditory hallucinations alone...." Others claimed that none of the pseudopatients would have been admitted to an inpatient bed in their hospitals: so rare a symptom would immediately have given rise to "intense case study" including "urine assays for hallucinogens, neurological consultations, skull x-rays, and electroencephalograms," or interviews with families and friends," lumbar puncture and radioisotope brain scans. Perhaps more went on in the admitting offices than Rosenhan had reported; perhaps the sample of hospitals was skewed.

Others, still focusing on the admissions question, did not deny that it could happen in their hospital or anywhere else. They were willing to concede a "current ignorance of biochemical and physiological parameters." But one mentioned the legal difficulties the hospital or admitting officer might face if a patient with a suspicious symptom were turned away and then committed suicide or homicide. Others took the view that it didn't prove much of anything that 12 hospitals were tricked into admitting the pseudopatients: "...the only accurate conclusion to be drawn is that presumably competent judges cannot distinguish the insane from the sane-feigning-insanity..." And again: "That an illness can be successfully simulated does not make it any less 'real' than one which cannot...."

This is true. Doctors tell me that malingerers can simulate myocardial infarction or lower back pain without a physician's being able to prove that the disorders are not present. Yet no one would claim that therefore these physical illnesses do not exist. The criticism would be lethal if only it were pertinent. But the pseudopatient project was not designed to show how easy it is to simulate a mental disease or

get admitted to a psychiatric ward by simulating one symptom. Trickery was employed instead of collusion with the hospital administrations in getting the pseudopatients admitted chiefly to avoid tipping off the staff members. Rosenhan's point was to see whether sane individuals, once admitted, would be detected as sane by the hospital staffs, and none was.

> The issue is not that the pseudopatient lied. Of course he did. Nor is it that the psychiatrist believed him. Of course he must believe him. Neither is it whether the pseudopatient should have been admitted to the psychiatric hospital in the first place. If there was a bed, admitting the pseudopatient was the only humane thing to do.

Whether or not sanity was detectable would tell us, Rosenhan felt, which of two popular characterizations of mental illness is true: either that patients present objectively observable symptoms from which the existence of an entity called a disease can be inferred and named, or that psychological diagnosis is useless or worse and in the minds of the observers. Rosenhan associates his pseudopatient project with a wide literature on context and perception: "While we may think that in examining a patient we have disembedded him from the context in which he is found, that assumption is open to reasonable question." He points to an experiment in which psychiatrists and psychologists watched videotaped interviews and were asked to rate the degree of adjustment of the persons being interviewed. The result was that raters who were told they were watching job interviews bestowed better adjustment ratings than those who were told they were watching psychiatric interviews. The clinical context had presumably influenced the viewers to discover more pathology than was there, or the employment context had had the opposite effect, or both.

But is context by itself a powerful enough explanation

for the elusiveness of sanity? If it were, the other patients in the wards with the pseudopatients would have been similarly affected by it, but as we know, many of them sensed that the pseudopatients were quite sane. And we recall that when Rosenhan alerted hospital staffs to the possibility of pseudopatients, some were found where actually there were none. This leads one to guess that the point is not context itself, but a more complex combination of the hospital setting, the administrative or professional roles that each person in it has agreed to play, the lack of real contact between patients and staff, and the absence of any careful observation by the staff.

Accordingly, some critics argue that if the distortions Rosenhan has documented do exist, the solution will be found in organizational change within hospitals and social education outside them. But Rosenhan is after bigger game. "The issue," he writes, "is the diagnostic leap that was made between the single presenting symptom, hallucinations, and the diagnosis, schizophrenia...."

> That is the heart of the matter. Had the pseudopatients been diagnosed "hallucinating," there would have been no further need to examine the diagnostic issue. The diagnosis of hallucinations implies only that: no more. The presence of hallucinations does not itself define the presence of "schizophrenia." And schizophrenia may or may not include hallucinations.

A glance at the Diagnostic and Statistical Manual (DSM-II) of the American Psychiatric Association affirms the truth of the last two sentences quoted. But what generalizations about diagnostic labels are we meant to draw from this? Should we object to all systems of labelling human beings or only faulty ones? How do we tell a faulty system? What are the practical consequences of one? Are the current systems in use reliable? These questions will draw our attention repeatedly in the future.

But the experience of the pseudopatients does not, I think, answer them.

The fact that the pseudopatients' sanity was not detected does not, in itself, invalidate the concept of disease. Rosenhan also documented for us the lengths to which hospital staff members went to avoid contact with patients, and most staff are anyway not in the business of hunting down pseudopatients or even, for that matter, continually evaluating whether a given patient has got better. Under an efficient division of labor there are administrative procedures for this, case conferences and the like, and there are staff members designated specially for the job. If sanity were truly elusive, Rosenhan's point could be made more impressively, as one of his critics points out, by taking "obviously insane persons and, by giving them a new name and releasing them to a community where they were not known,successfully pass them off as sane." Nor does it seem illogical for a hospital to define health by a process of exclusion--as the state of being free from certain symptoms for a certain number of days. Many real mental patients, after all, shed their abnormal behavior as soon as they are hospitalized, and some also experience a remission of subjective symptoms. As long as one believes that "abnormal behavior is found in discrete, classifiable patterns," there is a parallel between the behavior of the pseudopatients and that of patients with physical disorders. As one critic puts it, "a patient admitted for bleeding peptic ulcer may 'feel fine' and not be bleeding 24 hours later--he has his ulcer still."

But Rosenhan's critics assume, without arguing the case, that these classifiable patterns truly exist and that current psychiatric diagnoses are highly reliable: "The attack on psychiatric nomenclature as some kind of pernicious 'labelling' comes very close to a denial that any mental disorders

characterized by objectively ascertainable symptoms, behaviors, and tests altogether exist." Some go so far as to blame the "fashionable" denigration of classification for keeping American psychiatry from sharing fully in the achievements of American medicine. To them, it is the mistaken emphasis on the individual and his consciousness that obscures the patterns:

> People accept the fact that they can be guided along highways by traffic policemen who do not know their ultimate destination or motives for traveling, that they can be given money by bank clerks who do not know how they will spend it; but they hate to come up against the fact that in a modern psychiatric hospital they are likely to recover from a psychotic illness without ever telling a psychiatrist about their fears and hopes.

An attack on the current canon of psychiatric categories is even viewed as a stalking horse concealing an attack on the taxonomic method and thence on the scientific enterprise itself: "Measurement is essential to science, but before we can measure, we must know what it is we want to measure. Qualitative or taxonomic discovery must precede quantitative measurement."

But, of course, the rest of us cannot be blamed for asking when the use of classification and the disease entity concept furthers our understanding of mental and spiritual disorder and when it furthers mainly the authority of its advocates. At the least, we require proof that a given system of nomenclature is valid and reliable. And Rosenhan refers us to an extensive literature that questions whether the current system of psychiatric classification satisfies these criteria.

In one study, a list of 35 common presenting symptoms

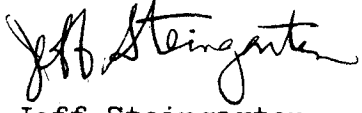
was compiled. Then the records of 793 hospitalized patients were examined to see whether the symptoms reported in each of four diagnostic categories differed significantly from those reported in the other categories. They did not. Among the group of "neurotics," all 35 symptoms were reported in at least one case; the same among "schizophrenics." Among patients with "character disorders" 34 of the symptoms were reported, and among "manic-depressives" 30 were reported. The current methods of classification generally use symptoms instead of etiology, treatment, or prognosis to categorize patients. Given the striking overlap among categories, then, it is natural to wonder whether there is any sense at all in the way patients are assigned to one category or another. Other studies reveal dramatic variation in diagnosis among different hospitals and among different psychiatrists.

Outsiders like us, lawyers and newsletter readers, would have little reason to get involved in an abstract intramural controversy about taxonomy if we did not suspect that the shakiness of the categories into which experts put the rest of us did not contain a potential for great inconvenience, maybe injustice. But the pseudopatient project did not demonstrate that the label schizophrenic had so drastic an effect on the long-term welfare of the pseudopatients. It is true that they flushed the medication given them down the toilet, but so do real patients--as the pseudopatients discovered when they went to the bathroom to get rid of theirs. And when Rosenhan asks "how many people are sane but not recognized as such in our psychiatric institutions?" we might reply, not all that many, at least according to your pseudopatient project. After all, every one was set free in accordance with normal hospital procedures after an average stay of 19 days. Would they have been released so soon if they hadn't been entirely symptom-free or if the prospect of spending a lifetime in a

mental ward had made them anxious, a little irrational, and too eager to gain release? And how many patients learn to confirm the diagnosis they are assigned? For now we lack the information to given an answer.

What the pseudopatients did document is the spell cast by the formula "schizophrenic" in the 12 psychiatric wards to which they had been admitted. Healthy men and women, temporarily labelled schizophrenic, actually looked that way to all the hospital staff, at least for 7 to 52 days. The word itself seemed to trigger a professional reaction--not contagious, therefore, to the other patients--by which plain fact was transformed into fancy. In the presence of pseudo-patients, the mental health professions seemed to engage in self-parody. Pathological meaning was conferred on normal behavior--case histories were distorted to fit theories, boredom was interpreted as symptomatic anxiety, note-taking became writing behavior, and on and on. Sanity may be elusive, but I think I know lunacy when I see it.

Sincerely,



Jeff Steingarten

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