Rosenhan

Sane in Insane Places (1973)
Before we begin……..

- List four behaviours that you consider to be a sign of psychological abnormality
- Write down why you think each of these behaviours is abnormal
True or False

1. In some cultures, depression and schizophrenia are non-existent. **FALSE**

2. About 30% of psychologically disordered people are dangerous; that is, they are more likely than other people to commit a crime. **FALSE**
True or False

4. Research indicates that in the United States there are more prison inmates with severe mental disorders than there are psychiatric inpatients in all the country’s hospitals. **TRUE**

5. Identical twins who have been raised separately sometimes develop the same phobias. **TRUE**
6. In North America, today’s young adults are three times as likely as their grandparents to report having experienced depression. TRUE
8. White Americans commit suicide nearly twice as often as Black Americans do.  TRUE

9. There is strong evidence for a genetic predisposition to schizophrenia.  TRUE

10. About 1 in 4 adult Americans suffer from a diagnosable mental disorder in a given year.  TRUE
Some definitions of abnormality

- Stratton & Hayes (1993)
  Abnormality is
  - behaviour which deviates from the norm
    - most people don’t behave that way
  - behaviour which does not conform to social demands
    - most people don’t like that behaviour
  - behaviour which is maladaptive or painful to the individual
    - it’s not normal to harm yourself
OR…..

• **Different** (deviant)
• **Distressful**
• **Dysfunctional** (disabling)
Look at your examples:

• Did your examples fall into those three categories?

• Can you think of any other useful definitions of abnormality?
"If sanity and insanity exist, how shall we know them?"
In other words…..

• Do the characteristics of abnormality reside in the patients?

or

• In the environments in which they are observed?

– Does madness lie in the eye of the observer?
Background

• A long history of attempting to classify abnormal behaviour.

• Most commonly accepted approach to understanding & classifying abnormal behaviour is the **medical model**.
  – Psychiatry
  – Psychiatrists are medical doctors and regard mental illness as another kind of (physical) illness

• From 1950s the Diagnostic and Statistical Manual of Mental Disorders (DSM) used to classify abnormal behaviour
The Medical Model

- Assumes that psychological disorders are mental illnesses that need to be diagnosed & cured through therapy or medication.
The Diagnostic and Statistical Manual of Mental Disorders provides an authoritative classification scheme. Describes disorders without explaining causes.
Labels

- **Diagnostic labels** may facilitate communication and research.
- But can also **bias our perception** of people’s past and present behaviour.
- Can unfairly **stigmatize**
Background

• 1960s: The anti-psychiatry movement criticize the medical model

• Rosenhan - also a critic of the medical model

• This study attempts to demonstrate that psychiatric classification is unreliable
Background

• Difficulty of judging what is 'normal'
• Varies over time / between societies
• Rosenhan asked "If sanity and insanity exist, how shall we know them?"
• Research Q: if 'normal' people attempt admission will they be detected? / how?
Aim

• Test the hypothesis that psychiatrists cannot reliably tell the difference between people who are sane and those who are insane.
The Researchers

Confederates (not the subjects)

- EIGHT sane people!
- Three women and five men
  - One graduate student
  - Three psychologists
  - One pediatrician
  - A painter
  - A housewife
  - A psychiatrist
Procedures

• Telephoned 12 psychiatric hospitals for urgent appointment (5 US states)

• Arrived at admissions

• Gave false name and address

• Gave other ‘life’ details correctly
Procedures

• Complained that they had been hearing voices
  – Unfamiliar and the same sex as themselves
  – Said 'empty', 'hollow', 'thud'.
  – Symptoms were partly chosen because they were similar to existential symptoms (Who am I? What is it all for?)
  – Also chosen because there is no mention of existential psychosis in the literature.
Findings

- All were admitted to hospital
- All but one were diagnosed as suffering from schizophrenia
- Once admitted the ‘pseudo-patients’ stopped simulating ANY symptoms
- Took part in ward activities
Findings

• The pseudo-patients were never detected

• All pseudo-patients wished to be discharged immediately

• *BUT* - they waited until they were diagnosed as “fit to be discharged”
Findings

How did the staff see them?

• Normal behaviour was misinterpreted

• Writing notes was described as -
  – “The patient engaged in writing behaviour”

• Arriving early for lunch described as
  – “oral acquisitive syndrome”
  – behaviour distorted to ‘fit in’ with theory
Findings

The pseudo-patient’s observations

• If they approached staff with simple requests (NURSES & ATTENDANTS)
  – 88% ignored them (walked away with head averted)
  – 10% made eye contact
  – 2% stopped for a chat
    • (1283 attempts)
Findings

The pseudo-patient’s observations

- If they approached staff with simple requests (PSYCHIATRISTS)
- 71% ignored them (walked away with head averted)
  - 23% made eye contact
  - 2% stopped for a chat
    - (185 attempts)
Findings

How long did they stay?

• The shortest stay was 7 days

• The longest stay was 52 days

• The average stay was 19 days
  – They had agreed to stay until they convinced the staff they were sane!!
Findings

They were treated the same as the other patients

- Given total of 2100 medication tablets
  - They flushed them down the toilets
  - They noticed that other patients did the same and that this was ignored as long as patients behaved themselves
Findings

- Nurses stayed in ward offices 90% of time
- Each ‘real patient’ spent less than 7 minutes per day with psychiatric staff
Findings

• 35 out of 118 patients voiced suspicions about the pseudo-patients
Findings

• The pseudo-patients were diagnosed as Schizophrenia “IN REMISSION”
Procedures

- **Field experiment**
- **IV** = the made up symptoms of the pseudo-patients
- **DV** = the psychiatrists' admission and diagnostic label of the pseudo-patient
- **Participant observation** = the pseudo-patients kept records
Responses of staff towards pseudo-patients

<table>
<thead>
<tr>
<th>Response</th>
<th>% Making Contact with Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrists</td>
</tr>
<tr>
<td>Moves on with head averted</td>
<td>71</td>
</tr>
<tr>
<td>Makes eye contact</td>
<td>23</td>
</tr>
<tr>
<td>Pauses &amp; Chats</td>
<td>2</td>
</tr>
<tr>
<td>Stops &amp; Talks</td>
<td>4</td>
</tr>
</tbody>
</table>
Results
Powerlessness & Depersonalization

• Medical records were open to all staff regardless of status or therapeutic relationship w/ the patient
• Personal hygiene monitored
  – Many of the toilets did not have doors
• Some of the ward orderlies brutal to patients in front of other patients ~ would stop when another staff member approached
  – This indicated that staff were credible witnesses but patients were not
"But I don't want to go among mad people," Alice remarked.
"Oh, you can't help that," said the Cat: "we're all mad here. I'm mad. You're mad."
"How do you know I'm mad?" said Alice.
"You must be," said the Cat, "or you wouldn't have come here."

~The Cheshire Cat~
Alice’s Adventures in Wonderland
SO

- Lack of monitoring
- Distortion of behaviour
- Lack of normal interaction
- Powerlessness & depersonalization
The Second Study

• The staff of a teaching and research hospital
  – were aware of the first study
  – were falsely informed that during the next 3 months pseudo-patients would attempt to be admitted into the hospital
  – were asked to rate on a 10-point scale the likelihood that each new patient was a pseudo-patient
The Second Study

- **IV** = The false information
- **DV** = # of patients staff subsequently suspected of being pseudo-patients
Many patients of the hospital’s regular intake were judged to be pseudo-patients

<table>
<thead>
<tr>
<th># of patients judged</th>
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<tbody>
<tr>
<td># of patients judged</td>
<td>193</td>
</tr>
<tr>
<td># of patients confidently judged as being p-p by at least 1 staff member</td>
<td>41</td>
</tr>
<tr>
<td># of patients judged as being p-p by at least 1 psychiatrist</td>
<td>23</td>
</tr>
<tr>
<td># of patients judged as being p-p by at least 1 psychiatrist AND 1 staff member</td>
<td>19</td>
</tr>
</tbody>
</table>
Evaluation of the Procedure

Strengths

• Participant observation meant that the pseudo-patients could experience the ward from the patients’ perspective while also maintaining objectivity.

• A field experiment & so was fairly ecologically valid while still controlling for confounding variables (the pseudo-patients’ behaviour).

• A wide range of hospitals were used.
  – Different States, on both coasts, both old & new, research-orientated & not, well staffed & poorly staffed, one private, federal or university funded.
  – This allows the results to be generalized.
Evaluation of the Procedure

Weaknesses

- **Ethics** - the hospital staff was deceived (Rosenhan did conceal the names of hospitals or staff & attempted to eliminate any clues which might lead to their identification)

- The experiences of the pseudo-patients could have differed from that of real patients who did not have the comfort of knowing that the diagnosis was false

- Doctors and psychiatrists are more likely to make a type 2 error (more likely to call a healthy person sick) than a type 1 error (diagnosing a sick person as healthy)
  - Type 1=false positive
  - Type 2=false negative
Evaluation of the Procedure
Weaknesses

- When Rosenhan did his study the psychiatric classification in use was DSM-II
- Since then a new DSM was introduced which addressed itself largely to the whole problem of unreliability - especially unclear criteria
- Perhaps using the newer classification psychiatrists would be less likely to make the same errors
- The DSM is currently used is the DSM-IV-TR released in 2000
Evaluation of the Procedure
Weaknesses

• Maybe the hospitals were erring on the side of caution
• If they release a patient and s/he hurts himself or someone else-then what?
• If you went to your doctor & complained of chest pains would you rather s/he make a type 1 or type 2 error?
Evaluation of Explanation

Issues for us to consider:

- The study demonstrates both the limitations of classification
- And pointed out the appalling conditions in many psychiatric hospitals
- It stimulated much further research and lead to many institutions improving their philosophy of care (usefulness)
Evaluation of Explanation
Issues for us to consider:

- Rosenhan, like other anti-psychiatrists, is arguing that mental illness is a social phenomenon.
- Rosenhan believes that mental illness is simply a consequence of labeling.
- While interesting, many people who suffer from a mental illness might disagree and say that mental illness is a very real problem.
Vocabulary

- Medical Model
- DSM
- Bio-psycho-social model
- Powerlessness
- Depersonalization
- type 1 error
- type 2 error