Chapter VIII

PSYCHOPATHOLOGY

Reading 29 WHO'S CRAZY HERE, ANYWAY?
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Most people who have never studied psychology have the impression that the field is primarily concerned with analyzing and treating mental illnesses (the branch of psychology called *abnormal psychology).* However, as you may have noticed, nearly all the research discussed in this book has focused on *normal* behavior. Overall, psychologists are more interested in normal behavior than in abnormal behavior because the vast majority of human behavior is not pathological, it is normal. Consequently, we would not know very much about human nature if we only studied the small percentage of it that is abnormal. Nevertheless, mental illness is to many people one of the most fascinating areas of study in all of psychology. A variety of studies essential to the history of psychology are included here.

First is a study that has kept the mental health profession talking for over 30 years. In this study, normally healthy people pretending to be mental patients entered psychiatric hospitals to see if the doctors and staff could distinguish them from those who were actually mentally ill. Second, no book about the history of psychological research would be complete without reference to Sigmund Freud. Therefore, a discussion of his most enduring concept, *ego defense mechanisms,* is discussed through the writings of his daughter, Anna Freud. The third study examined is an experiment with dogs as subjects that demonstrated a phenomenon called *learned helplessness.* This condition relates to psychopathology in that it led to a widely held theory explaining clinical depression in humans. And fourth, an intriguing and well-known experiment is presented involving overcrowded rats and their resulting deviant behavior, which may have offered some important implications for humans.

Reading 29: WHO'S CRAZY HERE, ANYWAY?

Rosenhan, D. L. (1973). On being sane in insane places. *Science, 179,* 250-258.

The task of distinguishing who is "normal" from those whose behavior may be considered "abnormal" is fundamental in psychology. The definition of

abnormality plays a key role in determining whether someone is diagnosed as mentally ill, and the diagnosis largely determines the treatment received by a patient. The line that divides normal from abnormal is not as clear as you may think. Rather, all behavior can be seen to lie on a continuum with normal, or what might be called *effective psychological functioning,* at one end, and abnormal, indicating a psychological disorder, at the other.

It is often up to mental health professionals to determine where on this continuum a particular person's behavior lies. To make this determination, clinical psychologists, psychiatrists, and other behavioral scientists and clinicians may use one or more of the following criteria:

- *Context of the Behavior.* This is a subjective judgment, but you know that some behaviors are clearly bizarre in a given situation, whereas they may be unremarkable in another. For example, nothing is strange about standing outside watering your lawn, unless you are doing it in your pajamas during a pouring rainstorm! Ajudgment about abnormality must carefully consider the context in which a behavior occurs.
- *Persistence of Behavior.* We all have our "crazy" moments. A person may exhibit abnormal behavior on occasion without necessarily demonstrating the presence of mental illness. For instance, you might have just received some great news and, as you are walking along a busy downtown sidewalk, you dance for half a block or so. This behavior, although somewhat abnormal, would not indicate mental illness, unless you began to dance down that sidewalk on, say, a weekly or daily basis. This criterion for mental illness requires that a bizarre, antisocial, or disruptive behavior pattern persist over time.
- *Social Deviance.* When a person's behavior radically violates society's expectations and norms, it may meet the criteria for social deviance. When deviant behavior is extreme and persistent, such as auditory or visual hallucinations, it is evidence of mental illness.
- *Subjective Distress.* Frequently, we are aware of our own psychological difficulties and the suffering they are causing us. When a person is so afraid of enclosed spaces that he or she cannot ride in an elevator, or when someone finds it impossible to form meaningful relationships with others, they often do not need a professional to tell them they are in psychological pain. This subjective distress is an important sign that mental health professionals use in making psyc'.ological diagnoses.
- *Psychological Handicap.* When a person has great difficulty being satisfied with life due to psychological problems, this is considered to be a psychological handicap. A person who fears success, for example, and therefore sabotages each new endeavor in life, is suffering from a psychological handicap.
- *Effect on Functioning.* The extent to which the behaviors in question interfere with a person's ability to live the life that he or she desires, and that society will accept, may be the most important factor in diagnosing

psychological problems. A behavior could be bizarre and persistent, but if it does not impair your ability to function in life, pathology may not be indicated. For example, suppose you have an uncontrollable need to stand on your bed and sing the national anthem every night before going to sleep. This is certainly bizarre and persistent, but unless you are waking up the neighbors, disturbing other household members, or feeling terrible about it, your behavior may have little effect on your general functioning and, therefore, may not be classified as a clinical problem.

These symptoms and characteristics of mental illness all involve *judgments* on the part of psychologists, psychiatrists, and other mental health professionals. Therefore, the foregoing guidelines notwithstanding, two questions remain: Are mental health professionals truly able to distinguish between the mentally ill and the mentally healthy? And what are the consequences of mistakes? These are the questions addressed by David Rosenhan in his provocative study of mental hospitals.

THEORETICAL PROPOSITIONS

Rosenhan questioned whether the characteristics that lead to psychological diagnoses reside in the patients themselves or in the situations and contexts in which the observers (those who do the diagnosing) find the patients. He reasoned that if the established criteria and the training mental health professionals have received for diagnosing mental illness are adequate, then those professionals should be able to distinguish between the insane and the sane. (Technically, the words *sane* and *insane are* legal terms and are not usually used in psychological contexts. They are used here because they have a commonly understood meaning and Rosenhan incorporated them into his research.) Rosenhan proposed that one way to test mental health professionals' ability to categorize prospective patients correctly would be to have *normal* people seek admittance to psychiatric facilities to see if those charged with diagnosing them would see that, in reality, they were psychologically healthy. If these "pseudopatients" behaved normally in the hospital, just as they would in their daily lives outside the facility, and if the doctors and staff failed to recognize that they were indeed normal, this would provide evidence that diagnoses of the mentally ill are tied more to the situation than to the patient.

METHOD

Rosenhan recruited eight participants (including himself) to serve as pseudopatients. The eight participants (three women and five men) consisted of one graduate student, three psychologists, one pediatrician, one psychiatrist, one painter, and one homemaker. The participants' mission was to present themselves for admission to twelve psychological hospitals, in five states on both the East and West Coasts of the United States.

All the pseudopatients followed the same instructions. They called the hospital and made an appointment. Upon arrival at the hospital they complained of hearing voices that said "empty," "hollow," and "thud." Other than

this single symptom, all participants acted completely normally and gave truthful information to the interviewer (other than changing their names and occupations to conceal the study's purpose). Upon completion of the intake interview, all the participants were admitted to the hospitals, and all but one was admitted with a diagnosis of *schizophrenia.*

Once inside the hospital, the pseudopatients dropped their pretend symptoms and behaved normally. The participants had no idea when they would be allowed to leave the hospital. It was up to them to gain their release by convincing the hospital staff that they were mentally healthy enough to be discharged. All the participants took notes of their experiences. At first, they tried to conceal this activity, but soon it was clear that this secrecy was unnecessary because hospital staff interpreted their "note-taking behavior" as just another symptom of their illness. The goal of all the pseudopatients was to be released as soon as possible, so they behaved as model patients, cooperating with the staff and accepting all medications (which they did not swallow but rather flushed down the toilet).

RESULTS

The length of the hospital stays for the pseudopatients ranged from 7 days to 52 days, with an average of 19 days. The key finding in this study was that not one of the pseudopatients was detected by anyone on the hospital staff. When they were released, their mental health status was recorded in their files as "schizophrenia in remission." They recorded other interesting findings and observations, as well.

Although the hospitals' staffs of doctors, nurses, and attendants failed to detect the participants, the other patients could not be fooled so easily. In three of the pseudopatients' hospitalizations, 35 out of 118 real patients voiced suspicions that the participants were not actually mentally ill. They would make comments such as these: "You're not crazy!" "You're ajournalist or a reporter." "You're checking up on the hospital!"

Contacts among the patients (whether participants or not) and the staff were minimal and often bizarre. One of the tests the pseudopatients initiated in the study was to approach various staff members and attempt to make verbal contact by asking common, normal questions (e.g., "When will I be allowed grounds privileges?" or "When am I likely to be discharged?"). Table 29-1 summarizes the responses they received.

TABLE 29-1 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	.5

Excerpted with permission from Rosenhan, D. L. (1973), "On Being Sane in Insane Places," *Science,* 179:255. Copyright 1973 American Association for the Advancement of Science.

When the pseudopatient received a response from an attending physician, it frequently took the following form:

PSEUDOPATIENT: Pardon me, Dr.________. Could you tell me when I am eligible for grounds privileges?

PSYCHIATRIST: Good morning, Dave. How are you today?

The doctor then moved on without waiting for a response.

In contrast to the severe lack of personal contact in the hospitals studied, the patients received no shortage of medications. The 8 pseudopatients in this study were given a total of 2,100 pills that, as mentioned previously, were not swallowed. The participants noted that many of the real patients also secretly disposed of their pills down the toilet.

Another anecdote from one of the pseudopatients tells of a nurse who unbuttoned her uniform to adjust her bra in front of a dayroom full of male patients. It was not her intention to be provocative, according to the participant's report, but she simply did not consider the patients to be "real people."

DISCUSSION

Rosenhan's study demonstrated that even trained professionals often cannot distinguish the normal from the mentally ill in a hospital setting. According to Rosenhan, this is because of the overwhelming influence of the psychiatric hospital setting on the staff s judgment of an individual's behavior. Once patients are admitted to such a facility, the doctors and staff tend to view them in ways that ignore them as individual people. The attitude created is "If they are here, they must be crazy." More important was what Rosenhan referred to as the "stickiness of the diagnostic label." That is, when a patient is labeled as "schizophrenic," that diagnosis becomes his or her central characteristic or personality trait. From the moment the label is given and the staff knows it, they perceive all the patient's behavior as stemming from the diagnosis—thus, the lack of concern or suspicion over the pseudopatients' note taking, which was perceived as just another behavioral manifestation of the psychological label.

The hospital staff tended to ignore the situational pressures on patients and saw all behavior as relevant to the pathology assigned to the patients. This was demonstrated by the following observation of one of the participants:

> **One psychiatrist pointed to a group of patients who were sitting outside the cafeteria entrance half an hour before lunchtime. To a group of young resident psychiatrists he indicated that such behavior was characteristic of the "oral-acquisitive" nature of the [schizophrenic] syndrome. It seemed not to occur to him that there were simply very few things to do in a psychiauic hospital besides eating, (p. 253)**

Beyond this, the sticky diagnostic label even colored how a pseudopatient's *history* would be interpreted. Remember, all the participants gave honest accounts of their pasts and families. Following is an example from Rosenhan's research of a pseudopatient's stated history, followed by its interpretation by

the staff doctor in a report after the participant was discharged. The participant's *true* history was as follows:

> **The pseudopatient had a close relationship with his mother, but was rather remote with his father during his early childhood. During adolescence and beyond, however, his father became a very 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, (p. 253)**

The doctor's interpretation of this rather normal and innocuous history was as follows:

> **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 [emotional] stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of the children, spankings. And although he says he has several good friends, one senses considerable ambivalence embedded in those relationships also. (p. 253)**

Nothing indicates that any of the doctor's distortions were intentional. He believed in the diagnosis (in this case, schizophrenia) and interpreted a patient's history and behavior in ways that were consistent with that diagnosis.

SIGNIFICANCE OF FINDINGS

Rosenhan's study shook the mental health profession. The results pointed out two crucial factors. First, it appeared that the "sane" could not be distinguished from the "insane" in mental hospital settings. As Rosenhan himself stated in his article, 'The hospital itself imposes a special environment in which the meaning of behavior can be easily misunderstood. The consequences to patients hospitalized in such an environment seem undoubtedly countertherapeutic" (p. 257). Second, Rosenhan demonstrated the danger of diagnostic labels. Once a person is labeled as having a certain psychological condition (such as schizophrenia, depression, etc.), that label eclipses any and all of his or her other characteristics. All behavior and personality characteristics are then seen as stemming from the disorder. The worst part of this sort of treatment is that it can become self-confirming. That is, if a person is treated in a certain way consistently over time, he or she may begin to oehave that way.

Out of Rosenhan's work grew greater care in diagnostic procedures and increased awareness of the dangers of applying labels to patients. The problems this study addressed began to decline with the decrease in patients confined to mental hospitals. This decrease in hospital populations was brought about by the discovery in the 1950s and increased use of antipsychotic medications, which can reduce symptoms in most patients enough for them to live outside a hospital and in many cases lead relatively normal lives. Concurrent to this was the growth of community mental health facilities, crisis intervention

centers, and behavior therapies that focus on specific problems and behaviors and tend to avoid labels altogether.

This does not imply by any means that the mental health profession has eliminated labels. However, largely because of Rosenhan's research and other research in the same vein, psychiatric labels are now used more carefully and treated with the respect their power demands.

QUESTIONS AND CRITICISMS

One research and teaching hospital whose staff had heard about Rosenhan's findings before they were published doubted that such mistakes in diagnosis could be made in their hospital. To test this, Rosenhan informed the hospital staff that during the next 3 months 1 or more pseudopatients would try to be admitted to their psychiatric unit. Each staff member was asked to rate each presenting patient on a 10-point scale as to the likelihood that he or she was a pseudopatient. At the end of 3 months, 193 patients had been admitted. Of those, 41 were considered, with high confidence, to be pseudopatients by at least 1 staff member. At least 1 psychiatrist suspected 23, and 1 psychiatrist and 1 other staff member identified 19. Rosenhan (the tricky devil) had not sent any pseudopatients to the hospital during the 3-month period! 'The experiment is instructive," states Rosenhan:

> **It indicates that the tendency to designate sane people as insane can be reversed when the stakes (in this case prestige and diagnostic ability) are high. But one thing is certain: Any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one. (p. 252)**

Rosenhan replicated this study several times in 12 hospitals between 1973 and 1975. Each time he found similar results (see Greenberg, 1981; Rosenhan, 1975). However, other researchers dispute the conclusions Rosenhan drew from this research. Spitzer (1976) argued that although the methods used by Rosenhan appeared to invalidate psychological diagnostic systems, in reality they did not. For example, it should not be difficult for pseudopatients to lie their way into a mental hospital because many such admissions are based on verbal reports (and who would ever suspect someone of using trickery to get *into* such a place?). The reasoning here is that you could walk into a medical emergency room complaining of severe intestinal pain and you might get yourself admitted to the hospital with a diagnosis of gastritis, appendicitis, or an ulcer. Even though the doctor was tricked, Spitzer contended, the diagnostic methods were not invalid. In addition, Spitzer has pointed out that although the pseudopatients behaved normally once admitted to the hospital, such symptom variation in psychiatric disorders is common and does not mean that the staff was incompetent in failing to detect the deception.

The controversy over the validity of psychological diagnosis that began with Rosenhan's 1973 article continues. Regardless of the ongoing debate, we can have little doubt that Rosenhan's study remains one of the most influential in the history of psychology.

RECENT APPLICATIONS

As an indication of this continuing controversy, we can consider two of many studies that have used Rosenhan's research in challenging the validity of diagnoses made by mental health professionals. One of these was conducted by Thomas Szasz, a psychiatrist who is a well-known critic of the overall concept of mental illness since the early 1970s. His contention is that mental illnesses are not diseases and cannot be properly understood as such but rather must be seen as "problems in living" that have social and environmental causes. In one article, Szasz makes the case that the *crazy talk* exhibited by some who have been diagnosed with a mental illness "is not a valid reason for concluding that a person is insane" simply because one person (the mental health professional) cannot comprehend the other (the patient) (Szasz, 1993, p. 61).

Another study building on Rosenhan's 1973 article examined how, in some real-life situations, people may indeed purposely fabricate symptoms of mental illness (Broughton & Chesterman, 2001). The case study discussed in the article involved a man accused of sexually assaulting a teenage boy. When the perpetrator was evaluated for psychiatric problems, he displayed various psychotic behaviors. Upon further examination, clinicians found that he had faked all his symptoms. The authors point out that mental health professionals traditionally have assumed the accuracy of patient statements in diagnosing psychological disorders (as they did with Rosenhan's pseudopatients). However, they suggest that inventing symptoms "is a fundamental issue for all psychiatrists, especially [when] . . . complicated by external socio-legal issues which could possibly serve as motivation for the fabrication of psychopathology" (p. 407). In other words, we have to be careful that criminals are not able to fake mental illness as a "get-out-of-jail-free card."

How do the people themselves feel who have been given a psychiatric diagnostic label? In a survey of more than 1,300 mental health consumers, Wahl (1999) asked participants about their experiences of being discriminated against and stigmatized. The majority of respondents reported feeling the effects of the stigma surrounding mental illness from various sources, including community members in general, family, church members, coworkers, and even mental health professionals. In addition, the author reported, 'The majority of respondents tended to try to conceal their disorders and worried a great deal that others would find out about their psychiatric status and treat them unfavorably. They reported discouragement, hurt, anger, and lowered self-esteem as a result of their experiences and urged public education as a means for reducing stigma" (p. 467).

The authors of a related study entitled "Listen to My Madness" (Lester & Tritter, 2005) suggested that one possible approach to help us understand the experience of those with mental illness is to interpret their impairment in society similar to our perception of those with other types of defined disabilities. These authors propose that seriously mentally ill individuals' interaction with society is often very similar to people with other disabilities in terms of receiving care. By applying a disability model to the mentally ill, they

will have an easier time gaining access to and receiving the services and help they need.

CONCLUSION

It is hoped that we, as a culture, will increase our tolerance and understanding of mental illness. As we do, our ability to diagnose psychological disorders will continue to improve, although, in many cases, it continues to be as much art as science. Chances are we will never do away with psychiatric labels; they are an important part of effective treatment of psychological disorders, just as names of diseases are part of diagnosing and treating physical illnesses. However, if we are stuck with labels (no pun intended), we must continue to work to take the stigma, embarrassment, and shame out of them.

Broughton, N., & Chesterman, P. (2001). Malingered psychosis. *Journal ofForensic Psychiatry, 12,* 407-422.

Greenberg, J. (1981, June/July). An interview with David Rosenhan. *APA Monitor,* 4-5.

Lester, H. & Tritter, J. (2005) "Listen to my madness": Understanding the experiences of people with serious mental illness. *Sociology of Health & Illness,* 27(5), 649-669.

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Reading 30: YOU'RE GETTING DEFENSIVE AGAIN!

Freud, A. (1946). *The ego and the mechanisms of defense.* New York: International Universities Press.

In a book about the history of research that changed psychology, one imposing figure would be extremely difficult to omit: Sigmund Freud (1856-1939). Psychology as we know it would probably not exist today without Freud's contributions. He was largely responsible for elevating our interpretations of human behavior (especially maladaptive behavior) from irrational superstitions of demonic possession and evil spirits to the rational approaches of reason and science. Without an examination of his work, this book would be incomplete. Now, you may be asking yourself, if Sigmund Freud is so important, why does this discussion focus on a book written by his daughter, Anna Freud (1895-1982)? The answer to that question requires a bit of explanation.

Although Sigmund Freud was integral to psychology's history and, therefore, is a necessary part of this book, the task of including his research here along with all the other researchers is a difficult one because Freud did not reach his discoveries through a clearly defined scientific methodology. It