

On Being Insane in Sane Places?

The Great Pretender: The Undercover Mission That Changed Our Understanding of Madness

Susannah Cahalan

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Why should readers of the *American Journal of Psychology* read *The Great Pretender*? After all, its author Susannah Cahalan does not publicly identify as a psychologist but as a journalist and former psychiatric patient. As described in her previous book, *Brain on Fire* (Cahalan, 2012), her psychiatric symptoms were eventually determined to be caused by a variant of autoimmune encephalitis, and she was successfully treated. She found that she was afforded much more attention, respect, and compassion when viewed as someone affected by a known biological diagnosis and cause than by a putative biological or psychological cause. This led her to journalistically engage with and investigate how causes and diagnoses were attributed for psychologically aberrant behavior.

Here's what she has found. *The Great Pretender* makes a strong case that one of the most heavily cited articles in the history of psychology with huge negative impact on the credibility of mental health diagnosis among many in the general public and some in the mental health professions (Bartels & Peters, 2017; Blakeslee, 1973), viz., "On Being Sane in Insane Places" (Rosenhan, 1973), was based at best on questionable research practices and more likely outright fraud.

And Rosenhan wasn't just any psychologist but a Stanford University professor emeritus, a fellow of the American Psychological Association, and a visiting fellow at Oxford University. Someone of whom an obituary fragment in the *American Psychologist* reads "The lessons he cared most about offering, in the classroom as in his research, were about human dignity and the need to confront abuse of power and human frailties" (Ross & Kavanagh, 2012). Another fragment from Stanford Law School's obituary (2012) read "leading expert on psychology and the law...pioneer in the application of psychological methods to the practice of trial law process".

Whether one's conception of science is Whiggish with faith in a trajectory of progress (Mayr, 1990), Kuhnian with a respect for the socio-cultural dynamics of paradigms (Kuhn, 1962), Latourian as craft and professional *modus vivendi* (Latour & Woolgar, 1986), founded on Quine's naturalizing (Hoshman & Martin, 1994), or Campbell's (Heyes & Hull, 2001) evolutionary epistemology, or critiqued via Derrida's postmodernism as occluded language with implications for social power (Derrida, 1976), this is strong stuff.

The Great Pretender includes Cahalan's personally searing experiences and critiques by many mental health experts on the reliability and validity of psychodiagnosis. These continue to furnish face validity for Rosenhan's conclusion that at least psychiatrists and their inpatient ward colleagues cannot differentiate people with and without serious psychopathology, viz. schizophrenia. Or as he put it, "It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals. The hospital itself imposes a special environment in which the meaning of behavior can easily be misunderstood. The consequences to patients hospitalized in such an environment -- the powerlessness, the depersonalization, segregation, mortification, and self-labeling -- seem undoubtedly counter-therapeutic" (Rosenhan, 1973).

Rosenhan's perspective was based on his descriptions and analysis of eight so-called normal individuals (called *pseudopatients* by Rosenhan) who were said to gain admission to psychiatric hospitals based on falsely claiming to have experienced a few positive symptoms, e.g., auditory hallucinations, often linked to the diagnosis of schizophrenia. They were then said to have acted normally on the ward and have not admitted any further positive symptoms. They were then said to remain as inpatients for varying lengths of time, and all but one are discharged with a diagnosis of schizophrenia in remission -- the other with manic depressive psychosis in remission. Rosenhan asserts that the experience of these eight pseudopatients demonstrate that psychiatry

should reject categorical diagnoses, e.g., schizophrenia, and instead focus on “behaviors, the stimuli that provoke them, and their correlates” (Rosenhan, p. 257). This was obviously well before significant, contemporary scholarship appeared on the pros and cons of diagnostic categories versus dimensions (Huprich, 2018).

Rosenhan’s article was and has been roundly attacked based on scientific premises (Letters to the editor, 1973). My reading of the attacks suggests that it’s tough enough concluding whether someone might have known right from wrong and could act on this knowledge at the time of some alleged crime. Or detect deception whether faking good or bad (Rogers & Bender, 2018). But how does one validate pre-admission positive symptoms of schizophrenia? And how normal and representative are pseudopatients who willingly remain on a psychiatric ward with constraints on freedom even to further scientific knowledge, because an experimenter suggests it? Is there any analogy to those of Stanley Milgram’s subjects who at an experimenter’s direction intentionally engaged in what they believed to be administering severe shock to another subject who seemingly errs in a learning experiment (Milgram, 1974)? In Rosenhan’s article, “another subject” might be the self as object not subject.

On the other hand, how normal and representative are pseudopatients given characterological or other psychological maladaptations they might bring to the ward leading to varying admission stays as differential diagnosis continued? (Rosenhan does not write that pseudopatients were administered a comprehensive psychological assessment a priori). And isn’t an *in remission* diagnosis reasonable, if not correct, once one decides by the pseudopatient’s putatively normal behavior on the ward that malingering or factitious disorder is inappropriate? *In fact*, Rosenhan’s much attacked article significantly facilitated the development of *the Diagnostic and Statistical Manual III* (American Psychiatric Association, 1980) which largely jettisoned

psychoanalytically-imbued constructs for an atheoretical, clinically descriptive nosology.

Psychiatrist Robert Spitzer was both the leader of this effort and the author of an influential critique of Rosenhan (1975).

Although describing some of the main scientific attacks, Cahalan's take on Rosenhan is one of ethics and fraud. She alleges that (1) there were not eight pseudopatients, maybe only three; (2) accounts about even these three were embellished with preliminary work from other studies, maybe even from the accounts of other authors and from Rosenhan's imagination; and (3) Rosenhan had a preconceived conclusion about the problematics of inpatient psychiatry and diagnostic validity which (he thought) merited playing fast and loose with the research details. The foundation for Cahalan's take constitutes (1) interviews with at least one pseudopatient; (2) unflattering intimations of Rosenhan as somewhat of a conniver by famous psychologists such as Kenneth Gergen and Lee Ross; (3) missing paperwork that should have been present, if the study was carried out as originally described in *Science*; (4) paperwork independent of the study that may have been used to embellish it; (5) Rosenhan's never completing a book on the study for which he had signed a contract and received an advance; (6) Rosenhan's never again publishing studies related to what had shook the mental health world; (7) contradictions to Rosenhan's account based on memories of his wife; and (8) inferences that a prior experimental stay on an inpatient ward by Rosenhan colored his account. Since its publication, Cahalan's tale still is and will be news to many in the mental health and social psychology worlds.

The history of psychiatry has been cyclic, or as has been attributed to New York Yankee catcher Yogi Berra, it's déjà vu all over again, especially as to the waxing and waning of biology's etiological primacy. Or the history of psychiatry conforms to a primitive evolutionary theory without an ultimate goal, or as attributed to the winner of the Nobel Prize in Literature

Bob Dylan, 'to be on your own/with no direction home/a complete unknown/like a rolling stone. Or yet again, we might employ Hegel so that the history of psychiatry is some dialectical process whereby through it we come to know ourselves.

However, the title Cahalan' has chosen--*The Great Pretender*—might serve as an epigraph for psychiatry's history. She asserts that Rosenhan may have been a pretender through making up experimental subjects and data. Depending on the experts consulted, her own disorder was a medical problem pretending to be the converse, or the con verse pretending to be medical. Historians and sociologists have long described psychiatry as fending off allegations of being a pretender, play-acting as a medical discipline. Both mental health professionals and patients may be pretenders play-acting via social roles with with murky itarogenic and placebogenic effects. A more malign role of pretender may legitimize appropriation of psychiatric diagnosis and intervention for blatant social control and punishment popularized but not limited to the former Soviet Union (van Voren, 2010) and mental heal professionals who engage I ethical transgression.. In fact, let's modify the old Soviet gallows humor that 'they pretend to pay us and we pretend to work' into 'they pretend to cure us and we pretend to be cured'. Maybe pretending and the mental health professions are yoked together for both healer and patient as in the the Platters' (Ram, 1955) 'The Great Pretender'—"...Yes I'm the great pretender/Pretending that I'm doing well/My need is such/I pretend too much/I'm lonely but no one can tell". Is this the fate of a quest to heal the human heart and soul—one's own or others?

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