Rosenhan Revisited

The Scientific Credibility of Lauren Slater's Pseudopatient Diagnosis Study[1]

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Abstract: In a recent and widely publicized book, psychologist Lauren Slater reported an attempt to test David Rosenhan's hypothesis that psychiatric diagnoses are influenced primarily by situational context rather than by patients' signs and symptoms. Slater presented herself to nine psychiatric emergency rooms with the lone complaint of an isolated auditory hallucination (hearing the word "thud"). In almost all cases, she reported receiving the diagnosis of psychotic depression and prescriptions for antidepressants and antipsychotics. Slater concluded that psychiatric diagnoses are largely arbitrary and driven by a "zeal to prescribe." Our goal was to examine the scientific credibility of Slater's findings using a vignette methodology. We presented a sample of emergency room psychiatrists ($N = 74$) with a detailed case vignette derived from the clinical description in Slater's book, and asked them a series of questions regarding diagnosis and treatment recommendations. In sharp contrast to what Slater reported, we found that only three psychiatrists offered a diagnosis of psychotic depression. Moreover, only one third recommended medication. Our study raises questions regarding Slater's results and conclusions, and provides scant support for the claim that psychiatric diagnoses are mostly products of fashion or fad, as claimed by Slater.

Key Words: Psychiatric diagnosis, Slater, Rosenhan.

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How do psychiatrists diagnose patients and prescribe medication? Do they make diagnoses based on an evaluation of the patient's condition and then decide if medication is indicated? Or do psychiatrists first prescribe medication and then make a diagnosis that justifies the medication they have prescribed?

In the third chapter of her recent and widely publicized book, *Opening Skinner's Box*: *Great Psychological Experiments of the Twentieth Century* (2004), author and psychologist Lauren Slater reported the results of her effort to test the hypothesis that psychiatric diagnosis depends largely or entirely on situational context rather than on the psychiatric status of patients. Slater's results seem to show that psychiatrists, when they really do not know what is wrong with patients but want to help them, have a "zeal to prescribe" and then make a psychiatric diagnosis that justifies the prescription. She suggests that the tendency of psychiatrists in the past was to hospitalize patients inappropriately, and that in our culture, this has been replaced by inappropriate use of psychotropic medication. This article describes an attempt to evaluate the validity of Slater's results.

Slater's book is a spirited and engrossing account of 10 key studies in psychology conducted over the last century. The book has been widely acclaimed both by nonmental health reviewers (Isaacson, 2004; Manjoo, 2004; Press, 2004; Singer, 2004; Wargo, 2004) as well as by prominent mental health experts, including psychiatrist Peter Kramer and anthropologist Tanya Luhrman (both of whom wrote endorsements for the book). For all of these reasons, her book is likely to be read widely by the lay public as well as by undergraduate and graduate psychology students.

Many readers will assume that Slater's findings and conclusions are scientifically credible. None of the 25 reviews of Slater's book that we identified (references available upon request), not even Kihlstrom's (2004) very critical *New England Journal of Medicine* review, questioned the validity of her pseudopatient study. Because her findings may lead some individuals in the general public, including psychiatric patients and their family members, to conclude that psychiatric diagnoses and psychotropic medication prescriptions are largely arbitrary, we believe that they merit a closer look.

Slater described her study of psychiatric diagnosis as a test of the hypothesis examined in Rosenhan's (1973) famous study, "On Being Sane in Insane Places," which was published in 1973 in the journal *Science*. Slater and Rosenhan posed the same question: are psychiatric diagnoses based on the evaluation of patient characteristics (symptomatology, history, clinical condition), or are they a function of the context in which the patient is evaluated? To answer this question, Rosenhan enlisted eight "pseudopatients," ostensibly normal people without a history of psychopathology, who had themselves admitted to 12 psychiatric hospitals with the

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lone complaint that they heard a voice that said "empty," "hollow," and "thud." Once admitted, they no longer heard the voice. All but one was diagnosed on admission as having schizophrenia and at discharge as having schizophrenia in remission.

The study was like a sword plunged into the heart of psychiatry. If Rosenhan's interpretation of his findings were correct they would imply that psychiatrists are unable to distinguish the "sane" from the "insane" in psychiatric hospitals. Moreover, they would suggest that psychiatric diagnosis is unreliable, invalid, and potentially harmful to patients. The study was widely acclaimed in the popular news media, and two editorials in *The Journal of the American Medical Association* endorsed its findings (Insane: Sane, 1973; Sane: Insane, 1973).

Many introductory psychology textbooks cited the study and accepted the results uncritically (Ruscio, 2004). Some recent and widely used psychology textbooks (e.g., Gerrig and Zimbardo, 2005; Nairne, 2000) continue to cite the study uncritically despite extensive critiques of the study (Crown, 1975; Millon, 1975; Spitzer, 1976; Weiner, 1975) showing that a correct interpretation of the results actually disconfirmed Rosenhan's conclusions. For example, at discharge, all of the pseudopatients were diagnosed as being in remission, indicating that the mental health professionals recognized that they were currently free of psychopathology. Contra Rosenhan, these professionals were quite successful at distinguishing psychopathology from normality.

Rosenhan's study had a significant impact on the psychiatric and psychological literature: a Web of Science search conducted by the authors revealed that Rosenhan's study has been cited over 750 times since its publication. In contrast, the critiques of Rosenhan's study have received far less attention (Ruscio, 2004); for example, Spitzer's critique (Spitzer, 1976) has been cited only 36 times.

SLATER'S DESCRIPTION OF HER STUDY

To evaluate adequately Slater's claims as well as the raison d'etre of our methodology, a detailed description of her study is necessary. We present the major facts of her study (pp. 81–91) that are relevant to psychiatric evaluation, diagnosis, and treatment recommendations. (Phrases and sentences in quotes are reprinted from *Opening Skinner's Box: Great Psychological Experiments of the Twentieth Century* by Lauren Slater, copyright © 2004 by Lauren Slater, with permission of the publisher, W.W. Norton & Company, Inc.)

She tells her husband she is going to "repeat the experiment [*Rosenhan's pseudopatient study*] *exactly as Rosenhan and his confederates did." "She kisses her baby good-bye." A friend agrees to let her use her name and then have her, later, with her friend's license, get the records so "I can see just what has been said."*

"I do my preparations. I haven't showered for 5 days. My teeth are smeary. I am wearing paint-splattered black leggings and a T-shirt that says, 'I hate my generation.'"

At the psychiatric emergency room she tells the ER nurse that she is hearing a voice. He asks, "And the voice is saying?" "Thud." "Is that it?" "That's it." "Did the voice start slowly, or did it just come on?" "Out of the blue." "So when did the voice come on?" "Three weeks ago." She is asked whether she is eating and sleeping okay, whether there have been any precipitating life stressors, whether there is a history of trauma. She answers a "definitive no." She says her appetite is good, sleep is normal and her work proceeds as usual. However, she describes having heard about a neighbor drown in his pool when she was in the third grade. "I didn't see it, but it was sort of traumatic to hear about."

The psychiatrist enters the room. "So you're hearing 'thud' . . . What can we do for you about that?" "I came here because I'd like the voice to go away." "Is the voice coming from inside or outside your head?" he asks. "Outside." "Does it ever say anything other than thud, like, maybe, kill someone or yourself?" "I don't want to kill anyone or myself," she says. "But the voice is bothering you." "Sort of, yeah." He says, "So you're experiencing this voice in the absence of ANY OTHER psychiatric symptoms . . . I'm going to give you an antipsychotic. Risperdal." "So you think I'm psychotic?" "I think you have a touch of psychosis," he says. " . . . I get the feeling he has to say this, now that he's prescribing Risperdal. You can't prescribe an antipsychotic unless your diagnosis supports that. It becomes fairly clear to me that medication drives the decisions, and not the other way around. In Rosenhan's day it was preexisting psychoanalytic schema that determined what was wrong; in our days, it's the preexisting pharmacological schema, the pill. Either way, Rosenhan's point that diagnosis does not reside in the person seems to stand."

"But do I appear psychotic?" she asks. "A little," he says. "You're kidding me," she says. "You look," he says, "a little psychotic and quite depressed. And depression can have psychotic features, so I'm going to prescribe you an antidepressant as well."

"So over the next 8 days I do it 8 more times, nearly the number of admissions Rosenhan arranged. Each time I am denied admission—I deny I am a threat and I assure people I am able to do my work and take care of my child . . . I was not given a deferred diagnosis . . . but strangely enough . . . almost every time . . . I am given a diagnosis of depression with psychotic features, even though, I am now sure, after a thorough self-inventory and the solicited opinions of my friends and my physician brother, I am really not depressed. I am prescribed a total of twenty-five antipsychotics and sixty antidepressants. At no point does an interview last longer than twelve and a half minutes." One psychiatrist says, "We want to see you back here in 2 days for a follow-up."

[*Slater's conclusion*]: *"I went in with a thud, and from that one word a whole schema was woven and pills were given despite the fact that no one really knows how or why the pills work or really what their safety is . . . The zeal to prescribe drives diagnosis in our day, much like the zeal to pathologize drove diagnosis in Rosenhan's day but either way, it does seem to be more a product of fashion, or fad."*

In summary, Slater reported that she was diagnosed with psychotic depression almost every time she presented to the admitting psychiatrist with the lone symptom of hearing

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the word "thud," despite her denying symptoms of any other psychiatric disorder, including the characteristic symptoms of depression. Slater also reported that she was prescribed large numbers of antidepressants and antipsychotics.

NEED TO EXAMINE THE VALIDITY OF SLATER'S STUDY

Slater's reported findings raise deeply troubling questions. The authors, as well as several colleagues in the mental health field, found Slater's findings extremely surprising for several reasons. First of all, we found it difficult to imagine that many psychiatrists would make a diagnosis of psychotic depression of a patient who (1) denies depressed mood, (2) denies the other characteristic symptoms of a severe depression (e.g., sleep and appetite disturbance), (3) complains only of an isolated auditory hallucination, and (4) appears normal other than seeming not to have showered recently or brushed her teeth. It is also puzzling that "almost every time" the psychiatrists that evaluated Slater gave the same diagnosis, given that the reliability of psychiatric diagnosis in routine clinical settings is at best only fair (Garb, 1998). One would also expect that most, if not all, of the psychiatrists would have realized that there was insufficient information to make a specific diagnosis and would therefore have noted in the case record either "diagnosis deferred" or, because of the auditory hallucinations, "psychotic disorder NOS (not otherwise specified)." According to Slater, none did. One would also expect that with this much diagnostic uncertainty, most if not all of the psychiatrists who evaluated her would have told her of the important need for further evaluation and diagnostic studies. There is no mention of this having happened.

Even more puzzling is Slater's claim that she was prescribed "25 antipsychotics and 60 antidepressants." There is no mention of being prescribed medication other than the nine times she was evaluated in a psychiatric emergency room. When clinicians start a patient on an antidepressant (or an antipsychotic), they almost always prescribe only a single medication. How could so many medications be prescribed on only nine occasions?

To evaluate the validity of Slater's findings, we presented a sample of emergency room psychiatrists with a description of a hypothetical case that matched Slater's description of her appearance and behaviors in her study as closely as possible. The psychiatrists were asked several diagnostic and treatment questions to ascertain the extent to which their answers were similar to the results that Slater reported.

SUBJECTS AND QUESTIONNAIRE

All of the 431 psychiatrist members of the American Association of Emergency Psychiatry were sent an e-mail from the organization's president urging them to participate in a study of psychiatric diagnosis and treatment conducted by unnamed researchers at the New York State Psychiatric Institute. The study was described as taking approximately 5 minutes in which participants would read one brief clinical case vignette and answer a few questions about it. The e-mail noted that explaining the purpose of the study in advance would have potentially biased the answers, but that soon after the study was completed, the purpose of the study and its results would be posted on the American Association of Emergency Psychiatry home page. A link to the study's website and study questionnaire was provided. All responses were anonymous, thereby minimizing the likelihood that participants' responses would be influenced by demand characteristics or evaluation apprehension (i.e., concerns about appearing to be a competent diagnostician in the researchers' eyes). The study was approved by the New York State Psychiatric Institutional Review Board, which waived informed consent.

The questionnaire began as follows:

Consider this case:

A Jewish woman in her thirties, married, and with one child, comes to the emergency room with the complaint that for 3 weeks she has been hearing a voice from outside of her head that says "thud"—nothing else. She describes the voice as having appeared "out of the blue." She wants the voice to go away and says that it "sort of" bothers her. She seemed surprised when another psychiatrist who interviewed her told her he thought she looked "quite depressed." She says that her appetite is good, her sleep is normal, and her work proceeds as usual. She denies all other symptoms of depression about which she is asked. She says that she is able to take care of her child. In response to a question, she states that she does not want to kill herself or anyone else. Her teeth are smeary, as if she had not recently brushed her teeth. It appears that she may not have showered for several days. She wears paint-splattered black leggings and a tee shirt that says, "I hate my generation." When asked to name the day of the week, she responds correctly. She also denies any recent life stressors. When asked about past trauma, she describes having heard about (but not having witnessed) her neighbor drowning in a pool when she was in third grade. She says that this drowning was "sort of traumatic to hear about," but that it "really wasn't a big deal."

Subjects were then asked the following diagnostic and treatment questions:

What diagnosis (or diagnoses) would you write in the chart?

Would you hospitalize the patient?

If No, would you refer the patient to an outpatient clinic?

Would you prescribe medication?

If Yes, medication(s):

Reason for medication(s):

Is there anything else you would do or say?

Subjects were asked if they were familiar with either the Rosenhan or Slater study.

RESULTS

Seventy-three psychiatrists completed the questionnaire (missing information on some variables two or less). Sex was male, 66%, and female, 33%. Age distribution was <30, 7%; 30

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to 39, 18%; 40 to 49, 41%; 50 to 59, 26%; and 60+, 8%. Years working in an emergency room were less than 10 years, 67%; 10 to 19 years, 21%; and 20 or more, 14%.

We anticipated excluding subjects who indicated familiarity with either the Rosenhan or Slater study because many of those subjects might have been tipped off that the correct diagnosis was malingering. However, although familiarity with the studies was common (Rosenhan, 48%; Slater, 8%), to our surprise, only three subjects noted malingering as a diagnosis that needed to be ruled out. Because familiarity with either study did not often lead to a diagnosis of malingering, none of the 74 subjects was excluded from the analyses.

In answering the question, "What diagnosis (or diagnoses) would you write in the chart?" 80% ($N = 56$) of the subjects avoided a specific DSM-IV diagnosis and instead diagnosed either psychosis not otherwise specified (56%; $N = 39$) or in some way indicated that a specific diagnosis, or any diagnosis, could not be made (24%; $N = 17$). Only 6% ($N = 4$) diagnosed psychotic depression. An additional 6% made another diagnosis but noted that the diagnosis of psychotic depression needed to be ruled out.

The great majority (82%; $N = 63$) noted that they would not hospitalize the patient but would instead refer the patient to an outpatient clinic. Those who would hospitalize the patient indicated that it was for the purpose of further evaluation to make a diagnosis. About a third (34%; $N = 25$) indicated that they would prescribe a medication, which was an antipsychotic in all instances. No psychiatrist recommended an antidepressant.

In response to the question, "Is there anything else you would do or say?" almost all noted the need for additional information to make an informed diagnosis. The following response was typical:

I would search for information that is not provided here—specifically in the mental state examination I would be looking at thought form and not just content. I would ask about any neurological signs or symptoms. I would ask why she decided to come TODAY to the ER. I would ask to speak to her husband or another family member for collaborative data. I would ask for a past psychiatric history. I would want to know her medical history. I would ask her to return to the psychiatric emergency service if the voice intensified, became intolerable or began to command her to hurt herself or others.

Finally, to examine the possibility that the differences between Slater's findings and ours are due to chance fluctuation, we calculated the probability that the difference in the distributions of the diagnosis of psychotic depression (8/9 vs. 4/74) across the two studies was attributable to chance (note that we assumed that Slater had been diagnosed with psychotic depression eight of nine times given her statement on p. 89 that she was given this diagnosis "almost every time"). A Fisher exact test yielded a two-tailed p level of 0.000067, demonstrating that the probability that these two distributions did not differ significantly was less than one in 14,000.

DISCUSSION

Our findings raise serious questions regarding Slater's test of Rosenhan's hypothesis. Although Slater claimed that she received a diagnosis of psychotic depression in almost all cases, we found that emergency room psychiatrists who were presented with a detailed case vignette based directly on the description in Slater's book made this diagnosis only very rarely. Although only 17% of the psychiatrists invited to participate in the study did so, the disparity between our findings and Slater's is sufficiently large to render selection bias an extremely unlikely explanation for the difference.

In our study and in contrast to Slater's, psychiatrists generally appeared to follow the guidelines delineated in the DSM-IV, demonstrating an appropriate reluctance to offer specific diagnoses in the absence of sufficient information. Indeed, 80% of the sample avoided a specific DSM-IV diagnosis. Specifically, slightly more than half made the diagnosis of psychotic disorder not otherwise specified, and about a quarter of the subjects indicated that there was insufficient information to make any DSM-IV diagnosis.

Only three noted the correct diagnosis of malingering as a diagnosis to be ruled out. This finding may indicate that most emergency room psychiatrists are insufficiently cognizant of the possibility of deliberate faking of psychological symptoms, although it should be noted that the base rates of malingering in most emergency room settings are probably quite low. As a consequence, our subjects may have reached a rational judgment that the Type II error risk (the probability that the patient in the vignette did not exhibit genuine psychopathology) was minimal. Finally, in sharp contrast to Slater's study, none of the psychiatrists in our study recommended antidepressant medication.

Our findings paint a considerably more sanguine picture of psychiatric diagnostic practices than implied by Slater, who drew sweepingly negative inferences from her results: "Rosenhan's point that diagnosis does not reside in the person seems to stand" (p. 87) and "the doctors who are giving these [diagnostic] labels are still doing so with perhaps too little regard for the DSM criteria the field dictates" (p. 91). Slater further contended that her findings indicate that "the zeal to prescribe drives diagnosis in our day" (p. 90). Our findings suggest that these conclusions, which were reported widely in the popular press following the publication of Slater's book, are dubious. When presented with the same clinical picture described by Slater, the substantial majority of psychiatrists in our study based their diagnoses on the patient's signs and symptoms, not on the situational context, and they adhered reasonably closely to the DSM-IV criteria. Nor do our findings provide any evidence for a "zeal to prescribe" given that two thirds of the psychiatrists did not recommend medication.

Of course, our study differs from Slater's in one obvious respect: whereas we presented psychiatrists with a detailed case vignette, Slater presented herself in person to psychiatrists. Nevertheless, given that (a) our case vignette was based directly, and in many cases verbatim, on Slater's presenting signs and symptoms, (b) the vignette included details regarding Slater's physical appearance, and (c) the magnitude of the difference in the distribution of psychiatric

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diagnoses across the two studies was enormous, it strains credulity to contend that Slater's physical appearance alone was sufficient to account for the discrepancy across studies. Indeed, if this were the case, it would raise deeply troubling questions of its own given the widespread use of vignette methodologies in studies of gender and race bias on psychiatric diagnoses (Garb, 1998).

Some readers may harbor the view that our findings are much ado about nothing. After all, they might contend, Slater's results were not peer-reviewed and can safely be ignored by the scientific community. In our view, this response would be misguided. Because Slater's book was undoubtedly read by thousands of individuals in the general public, it is probably more likely to shape the laypersons' impressions of diagnostic and prescription practices of psychiatrists than are peer-reviewed publications. Mental health researchers ignore popular perceptions of psychiatry and psychology at their peril (Lilienfeld, 1999) and must remain vigilant about correcting potential distortions and misrepresentations of scientific findings that are promulgated to the general public.

Finally, our findings underscore the hazards of uncritically accepting and disseminating findings that have not undergone peer review. Indeed, Slater's findings are exceedingly difficult to interpret given the apparent absence of objective documentation of her observations, which is traditionally regarded as a prerequisite for placing trust in published scientific findings. For example, it is unknown how, if at all, Slater verified that she was diagnosed with psychotic depression, as she did not report whether she examined any of the chart diagnoses upon discharge. Nor is it possible to verify the medications she received. Nor can we exclude the possibility that she provided psychiatrists with diagnostically relevant information that she omitted from her description or that her observed affect and behavior were considerably more disturbed than indicated in her description. In an effort to corroborate Slater's assertions, the authors of this article, along with other prominent mental health professionals, contacted her repeatedly to request copies of records from her hospital encounters. Nevertheless, she refused to supply us with any documentation such as case records (with identification deleted) or hospital bills or to explain puzzling details about her reported experiences, such as how she was prescribed 85 medications on only nine occasions.

We leave it to readers to draw their own conclusions regarding the striking disparity between Slater's results and our own. Nevertheless, our failure to corroborate Slater's findings, conjoined with her unwillingness to supply us with any objective documentation, raise troubling questions about the credibility of her study's findings.

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END NOTE

[1]Is it appropriate for a scientific journal to publish a paper inspired by a book apparently intended for popular consumption? In this instance, the paper's senior author, Robert P. Spitzer, MD, a leading architect of the contemporary psychiatric diagnostic system, and his coauthors answer the question in the affirmative, underscoring the importance of "correcting potential distortions and misrepresentations of scientific findings that are promulgated to the general public" (p. 738). The book under scrutiny, *Opening Skinner's Box,* is subtitled *Great Psychological Experiments of the Twentieth Century*, and the author, Lauren Slater, EdD, is presented on her book's cover as a psychologist. She has declared its aim to be the translation of these experiments "into narrative form," capturing some of their drama so as to make them more accessible to general readers. The chapter on Rosenhan's experiment offers a specific example of the challenges inherent in the translation of such research.

This seemed to us to be a potentially useful case study regarding the question posed, one which offers an opportu-

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nity for dialogue about some significant issues in the field of mental health and psychiatry. They include the impact of popular literature on public attitudes toward emotionally distressed persons, their well-being and search for relief; the role of social context in identifying people as mentally ill; and the ways in which psychopharmacological products can be used by psychiatrists charged with the rapid diagnosis and disposition of help-seekers.

With our usual reliance upon the opinions of external referees, we decided to accept the paper by Spitzer et al., and invited Slater to contribute a commentary. Another commentary is contributed by Mark Zimmerman, MD, who reviewed the original paper and is a member of our Editorial Board. A final commentary comes from Spitzer and colleagues with Scott Lilienfeld, PhD, as lead author.

Editors

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