

Philosophy and Psychiatry

September 2020

INTRODUCTION

Welcome to the latest edition of the Philosophy SIG newsletter. The world has changed beyond recognition since the last newsletter. Nevertheless, we try to bring some “normality” in ensuring the newsletter reaches you and time. We hope some philosophy would bring some variety to the life under lockdown. Unfortunately, most activities have come to a halt. Almost every conference is cancelled, and the remaining have gone online. Nevertheless, technology has enabled us to keep going and a change will surely happen in the way we practice and live. We want to extend our gratitude to the staff at the Royal College of Psychiatrists who have to work during the lockdown to ensure you receive this newsletter. We hope by the next newsletter the pandemic will be under control. In the meantime, we hope you enjoyed the current edition. As usual if you have any book reviews or manuscripts which are suitable for this newsletter please email them to us.

Philosophy SIG Website

For further details concerning the Philosophy SIG, please see our website:
<http://www.rcpsych.ac.uk/college/specialinterestgroups.aspx>

Remember also to check the website of the *International Network for Philosophy and Psychiatry*: <http://www.inpponline.org/>

Philosophy SIG Newsletter

Remember to send us any news about developments in connection with the philosophy of psychiatry in your area. Also, consider sending us reports on conferences or book reviews. Any contributions would be most welcome!!

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UPCOMING EVENTS

Unfortunately, as you know because of the COVID-19 pandemic most of the conferences have been cancelled. The remaining have changed the format into online conferences.

From the INPP website we get these two conferences where phenomenology and psychopathology are coming into dialogue.

The first event called “**Psychopathology and the “scaling up” problem**” is a Zoom conference, free to participate, that runs in the afternoon (15:00-17:30) from 05/10-07/10 organised by Adrian Downey from the University of Sussex. To participate you need to email to a.downey@sussex.ac.uk As the conference organisers say, the main focus will be “upon the extent to which phenomenological and enactive accounts of psychopathology are, or must be, ‘representation hungry’. Whilst explicitly anti-cognitivist phenomenological and enactive accounts of psychopathology are present in the literature, little work has been carried out on discerning the extent to which they require the positing of representation. This is somewhat surprising, because ‘representation hungry’ cognition (thought, imagery, hallucination) plays a prominent role in most psychopathologies. The aim of the conference is to fill this gap by determining whether the concept “representation” is helpful, harmful, or irrelevant to understanding (phenomenological and enactive accounts of) psychopathology”. The following program has been posted:

- **Monday, October 5th**

15:00-16:10 Regina Fabry will talk about “A Non-Representational predictive processing Account of Major Depressive Disorder

16:15-17:25 Adrian Downey will talk about “Grappling with Grip Predictive Processing Schizophrenia and the Problem of Representation Hunger”

- **Tuesday, October 6th**

15:00 – 16:10 Julian Kiverstein will talk about “delusion as a Disturbance of Skilled Intentionality”

16:15-17:25 Annemarie Kalis will talk about “Folk psychological descriptions; what do they describe?”

- **Wednesday, October 7th**

15:00-16:10 Shaun Gallagher will talk about “Scaling up or scaling out? A recipe for explaining psychiatric conditions”

16:15-17:25 Sanneke De Hann will talk about “Embodied, embedded...and existential cognition”

All presentations look very stimulating and we are looking forward to it.

The second event that bring philosophy and psychiatry together will take place during the conference **Encephale 2021** that will take place on **20 - 22 of January 2021 at Palais des Congrès de Paris**. The Encephale Congress will have a special session on philosophy and psychiatry. The session for 2021 will be on phenomenology and psychiatry. It will be in French. The translated English program is:

- **Self-disorders in early schizophrenia**

Michel Cermolacce (Marseille)

<https://pubmed.ncbi.nlm.nih.gov/20142381/>

- **Which tools for a clinical practice inspired by phenomenology?**

- Jérôme Englebert (Belgium)

<https://pubmed.ncbi.nlm.nih.gov/31715612/>

- **Praecox Feeling and diagnostic decision-making**

Tudi Goze (Toulouse)

<https://pubmed.ncbi.nlm.nih.gov/30476340/>

- **In search of the autobiographical self**

Fabrice Berna (Strasbourg)

<https://pubmed.ncbi.nlm.nih.gov/27216589/>

Philosophy in Medical Education

An interesting initiative is advanced by King's College and the Philosophy of Medicine department. Following the recent online conference on Philosophy in Medical Education (see review below), the department organises a series of colloquia on the same topic. Here is a list of the upcoming events that you can access and register via Eventbrite.

Colloquium on Ethics

22nd October 2020, 17:00 – 18:15 (UK)

Riana Betzler (WUSTL) “Ethics as a Practice in Medical Education”

David Fajardo Chica (UNAM) “Pain, suffering and death: A proposal for philosophy in palliative care education”

Colloquium on Phenomenology

2nd of November 2020, 17 00 18:15 (UK)

Anthony Vincent Fernandes (Oxford) : “Teaching Phenomenology in Clinical Practice: A Conceptual Approach”

Samantha Gallivan (Imperial): “Using Phenomenologically Informed Qualitative Methods to Explore Surgical Practice”

Colloquium on Psychiatry

26th of November 2020, 17:00 – 18:15 (UK)

Benjamin Wilck (Humboldt) and Ivan Nenchev (Charité): “The Value of Philosophy of Language for Psychiatric Diagnostics”

Tania Gergel (KCL): “Teaching philosophy to psychiatrists: a paradigm case of interdisciplinary education?”

Furthermore, KCL organises on the 15th of December 2020 the 2nd Peter Sowerby Interdisciplinary Workshop with the title **Philosophy in Medical Education: Race, Gender and Bias**. Registrations are not yet open. You can find more information in the following link <https://philosophyandmedicine.org/event-series-philosophy-in-medical-education/>

PAST EVENTS

Conference review:

From the patient's point of view: Phenomenological psychopathology in clinical practice

Royal Society of Medicine, Psychiatry Section, 07-09/09/201

Anastasios Dimopoulos

This was a 3-day intensive course organized by Prof Ikkos from the Psychiatry Section of the Royal Society of Medicine and Prof Giovanni Stanghellini, one of the most eminent phenomenological psychopathologists in the world today. The event was organised to celebrate the landmark first edition of the “Oxford Handbook of Phenomenological Psychopathology”, that I hope to review for the following SIG newsletter. Two of the senior editors, Prof Giovanni Stanghellini and Prof Matthew Broome, in collaboration with other national and international experts delivered a rich training experience that left many of the participants, including trainees present, to want more of similar events.

The first day of the course provided a comprehensive overview on the current state of clinical practice in psychiatry and why phenomenological psychopathology can assist in better understanding the subjective experience of the patients. We heard excellent talks by Prof Bill Fulford, Prof Tom Burns and Prof George Ikkos that highlighted the limitations of current descriptive approaches and how there is a need to take in account patient's values and subjective experiences. Prof Stanghellini and Prof Broome then discussed what the contribution of phenomenological philosophy and its application in the exploration of psychopathological phenomena has to offer.

The second day of the conference unpacked a series of detailed phenomenological accounts of principal mental disorders and psychopathological phenomena. Prof Broome discussed in detail neuroscientific research and how it relates with the phenomenological account of the subjective experience in schizophrenia. Prof Stanghellini on his part offered us a series of explorations of the Lifeworld of patients suffering from manic-depressive illness and borderline personality disorder, arguably a difficult task for the latter due to the wide variability in presentation. The concept of Lifeworld as an organizing principle of exploration of psychopathological phenomena is quite central in current phenomenological trends in psychopathology. Having a conversation later on with two of the psychiatric trainees present, they found it quite helpful and wanted to incorporate it in their everyday practice.

The last day of the conference had a very stimulating presentation by Prof Castellani on the phenomenological account of Eating Disorders. Prof Castellani presented research substantiating the limitations of current diagnostic criteria and treatment approaches. In the collaborative research effort with Prof Stanghellini they have identified a psychopathological core that conceptualizes Eating Disorders as Disturbances of Self-Identity. The use of IDEA (Identity and Eating Disorders) questionnaire revealed several relevant experiential patterns in patients with Eds. Common denominator of these experiential patterns was that they facilitate the creation of overvalued thoughts about body weight and shape, eating concerns and dietary restrictions. Some of the strategies implemented by patients with Eds may represent efforts to feel themselves cenesthetically. The last presentation was an exploration by Prof Stanghellini of the value of phenomenological philosophy in psychotherapy, especially in informing psychodynamic psychotherapy.

I hope that similar events can take place again in the future and possibly become hubs for a continuous exchange between practitioners, allow them to bring forward both strengths and limitations of phenomenological psychopathology.

**Conference review:
Philosophy in Medical Education
King's College, London 15th of September 2020**

This was personally a highly anticipated event by me. It was supposed to be a 3-day conference taking place back in April but as many other events was cancelled due to the pandemic. A reduced version took place online via Zoom on 15th of September and then a series of colloquia, as advertised above, were created by the remaining initial program. I do have a personal interest in exploring ways that philosophy can be integrated in medical education and was curious to see what the experience of similar attempts is abroad and how it can be best conceptualized. It did become evident that there are significant struggles to integrate philosophy in medical education, eve in countries where they form part of the undergraduate curriculum.

Juliette Ferry-Danini brought us an overview of the French experience where philosophy is part of the curriculum. As she pointed out philosophy in France is understood mostly as history of philosophy. Furthermore, there aren't many philosophers that can produce a qualitative training and often philosophy is seen as part of social sciences, somehow losing its methodological rigor. It was quite evident from her presentation that it is quite a challenge scaling similar training at a national level without in the end losing a minimum standard of what is delivered.

Alex Broadbent from South Africa presented his model for philosophy in medical education. As its core role he identified the promotion of the "the inquirer model of medicine". He attempted to debunked some of the common assumptions around the value of philosophy for medicine. He brought forward arguments such as that ethical training is of a dubious value in assisting in practicing medicine, or that philosophy won't necessarily improve the bedside manner of doctors. His core thesis

behind that was that “cure is not the core business of medicine” but rather the “exercise of some skill, ability of competence that the profession generally possessed, but others not”. Following that path, he claimed that medical education should foster the ability of someone to make effective inquiries, practically “turn illness into an inquiry”. It was an interesting presentation and while I did not agree with all said, I was left with the desire to read his book on Philosophy of Medicine.

Rafaella Campanella from Italy made several recommendations on what kind of principles should permeate the integration of philosophy in medical education. The motto used was that of Martyn Evans that “philosophy of medicine asks questions about the questions medicine asks”. The main tenant was to make philosophy part of Continuous Professional Development. She advocated a more specialised approach, recognising that different medical specialties may benefit from different types of philosophical discourse.

Jonathan Fuller was the last presenter of the day but in no way the less interesting. The central proposal of his presentation was that philosophy is the core discipline in developing and learning the “theory of medicine”. Different topics were suggested where philosophical enquiry can become integral in teaching medicine. Debating the concept of disease, using phenomenology for exploring experiences of illness, debating diagnostic categories etc were some of the initial topics identified. He then proceeded with philosophical exploration of different aspects of diagnostic reasoning and how philosophy can help clinicians in developing that skill. He then suggested a case-based and discussion-based educational framework to be used. I really liked the clarity of his presentation and gave me several interesting points to contemplate upon.

Overall, this was a good conference with many interesting points to cherish. Unfortunately, as it happens often in these conferences, not many doctors attend them. We are a practical discipline and that is a significant constrain on how to provide relevant philosophical education to local contexts. The absence of doctors from these events maintains a barrier towards effective transdisciplinary exchange, something that the presenters have highlighted. Bridging this gap and improve the dialogue between philosophy, medicine/psychiatry and medical education is needed. More will follow in this space.

BOOK REVIEWS

Thomas Szasz: an appraisal of his legacy

Edited by: C.V. Haldipur, James L. Knoll IV and Eric V.D Luft

Reviewed by Dr Abdi Sanati

Thomas Szasz played a significant role in the history of psychiatry. His book *The Myth of Mental Illness*, in which he argued against the very existence of mental illness has been widely read by psychiatrists and critics of psychiatry. Throughout his

life, he remained a prolific writer and debater. He has been seen, alongside with Laing and Cooper, one of the main figures of antipsychiatry movement. Interestingly Szasz did not appreciate the company and has been distancing himself from that movement. In his book, *Antipsychiatry: Quackery Squared* he fiercely attacked antipsychiatry and its main figures from Laing and Cooper to Foucault. Much has been written by Szasz and about him. Nevertheless, I think we should welcome this new addition to that collection. The editors have done a momentous job in gathering a wide range of writers and put their writings in a coherent whole. The book consists of three parts. In the first part, the contributors explore the intellectual roots of Szasz's thought. As a colleague once mentioned philosophies do not fall from trees and it is important to investigate how Szasz came up with his ideas. We learn about Szasz's training in psychoanalysis and his work with patients with pain. It is argued that Szasz believed science needed reductionism and working with psychogenic pain led him to believe that pain was of interest to a somatic physician only when it indicated the bodily lesion. How Szasz moved from here to his rejection of mental illness is explored in more detail. Other factors which affected his view of psychiatry included his politics and personal history of escaping holocaust in 1938. Luft discusses the philosophical influences on Szasz which were quite wide. He quoted several philosophers, but it seems that at times the quotes were taken out of the context of the main arguments of the philosopher.

In the second part Szasz's views on the concept of mental illness is examined in more detail. One of the issues that has been given to chapters in this part is suicide. Szasz had strong views about the role of psychiatry in suicide prevention. For him, suicide was an autonomous act and the person should not be interfered by the state in exercising that choice. In one chapter the legal issues regarding physician -assisted suicide and rights to suicide are discussed. Readers in the UK might find this chapter very American centric. Nevertheless, there are interesting learning points. There are some interesting chapters in this part. I enjoyed the synthesis of Szasz and his critics ideas articulated very well by Fulford using value-based practice. In one of the most interesting chapters Jennifer Church applies Szasz's method in deeming mental illness and myth to his own ideas such as autonomy, with interesting results. There are more chapters devoted to Szasz's language of mental illness and his clinical work.

The third part is devoted to Szasz's legacy. Apart from suicide one of the other areas that Szasz was deeply passionate about was insanity defence. His ideas in that area are examined in detail by Neil Pickering. I also enjoyed Allen Frances's chapter on the myth and reality of mental illness. I particularly liked his account of an encounter he had with Szasz. He rightly concluded that the academic perch is quite different from the clinical trench. The chapter by Thomas Schramme and this part on a high note. He eloquently explores the challenges faced by psychiatry.

The book includes scholars who are sympathetic to Szasz and the ones who intellectually oppose him. Nevertheless, the authors who have met him personally

found him to be a sympathetic and genuinely interesting person to know. James Knoll found him to be an icon of independence and intellectual freedom. Another issue that comes out is the fact that Szasz never worked in a psychiatric hospital and how that affected his views. The readers are given sufficient amount of arguments in the book to make of the mind. There are few anecdotes in the book which give a personal touch and allows the reader to also see the person.

Szasz's status among scholars who are critical of psychiatry will remain high. In my years of working on psychiatry I have encountered many colleagues who have been critical of psychiatry. I came to conclusion that any critique of psychiatry has to answer some questions very clearly. One is the question of suicide. Is it going to be allowed, or if it is going to be prevented would it be criminalised again? Another one is the question of mental ill offenders. And the third one, in welfare states, is the status of the mentally ill as to recipients of benefits. So far, the only person I have encountered who has been clear in answering these questions is Thomas Szasz. His stance on the last question got him in friction with a few service-user representatives in the 2010 INPP conference in Manchester. It was at that conference that I met him and was lucky to have dinner with him. I found him a man of good taste (I introduced him to Old Speckled Hen ale) and it was a memorable evening. One author compared Szasz to Socrates. Socrates was described as the gadfly who constantly goaded the political scene in Athens. Many years ago, when I visited Szasz's website there was a statement on how to pronounce his name. Interestingly if his name is uttered the way it should be pronounced, in my mother tongue (Persian) it means bug. While Socrates was the state's gadfly, Szasz is likely to remain psychiatry's bug who will always remind us when we become complacent and sluggish.

Book Review

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

Review by George Dawson, MD, DFAPA

The Great Pretender (1) is written as an exposé of a famous experiment conducted by Rosenhan (2) that purported to discredit psychiatric diagnoses. The original article was published in the journal *Science* in 1973. Whether you are aware of the original article or not, depended on when you were trained and the extent to which you followed that literature. I was just finishing my undergraduate degree at that point and did not complete psychiatric training until 1986. We had a community psychiatry seminar for 6 months during my last year that was taught by some of the innovators in the field. It was common to analyse and discuss controversial papers of the day. A good example would have been the paper that suggested that people with schizophrenia had a much better outcome in the developing countries (3). At no point did we hear about or discuss the Rosenhan paper. In fact, for the next 24 years the

paper never came across my desk. It was only when I started writing a psychiatry blog that I realized it played a major role in psychiatric criticism and antipsychiatry rhetoric. At that point, I read the paper and the associated criticism and concluded independently that the methodology was extremely weak and that pseudopatients were not really a good test of medical or psychiatric diagnoses. I thought it would just fade away on that basis.

I was as surprised as anyone when I heard that investigative reporter Susannah Cahalan had written a book about this experiment, the author, and the methods used. The investigation begins with a visit to one of Rosenhan's former colleagues. This colleague shows her a stack of anti-psychiatry books that he thinks "were the key to his thinking". There is also a file labelled "pseudopatients" that contain the names of all eight pseudopatients and details surrounding their hospitalizations. All the names or aliases and the hospital names had also been changed.

Cahalan's approach is to write about three parallel subjects. The most thorough and objective analysis is about the pseudopatient experiment. She covers everything from the available remaining data and the problems with it, to the likelihood that the experiment actually occurred the way it was described in the *Science* paper. The second broad subject was a character study of Rosenhan. How did people describe him? What was he like? Did people especially his colleagues believe that he conducted the experiment. And finally, the book is a vehicle for Cahalan to comment on psychiatry. She comes to this work with the direct experience of having experienced autoimmune encephalitis and writing about that experience in the book *Brain on Fire*.

Reading the original paper is a good starting point for understanding the book. If you do pull up that article, a few details are immediately evident. The author begins the introduction using the terms "sane" and "insane" as though this is technical language used by psychiatrists. That use of language is interesting because he is listed as a professor of both psychology and law at Stanford. Since the days of my training, insanity is a strictly legal term and it is without meaning in psychiatry. The use of these legal terms allows him to point out the unreliability of the "sane"- "insane" dichotomy based on expert witnesses disagreeing in adversarial court hearings. That has nothing to do with the clinical diagnoses in psychiatry. To what extent were formal diagnoses used in 1973? Rosenhan refers to the Diagnostic and Statistical Manual in the body of his paper. Interestingly, the authors of my community psychiatry paper (3) reported on the 2-year follow-up of patients from the International Pilot Study of Schizophrenia (1973) and concluded that schizophrenia could be reliably diagnosed so that international comparisons and follow up were possible. A sanity metric during the same time frame is crude by comparison. There are many additional examples of a lack of objectivity toward the issue of psychiatric diagnosis in the introductory section of the paper (paragraphs 4-7) and the discussion. Excellent critiques of the scientific merit of the paper were available at the time most notably by Robert Spitzer.

The author describes his pseudopatient experiment as consisting of 8 people – three women and four men of various occupations. Cahalan identifies Rosenhan as

pseudopatient number 1. Twelve hospitals in various locations were chosen. One was a private hospital. Pseudopatients were supposed to call the hospital, present for an intake appointment, and then complain that they were hearing voices. When asked to elaborate they were supposed to say the voices were unclear except for the words “empty”, “hollow”, and “thud”. Rosenhan provides a rationalization for this symptom choice about how on the one hand these symptoms were supposed to have existential meaning and yet there was not a single report of existential psychosis in the literature. Once admitted, the patient was supposed to cease simulating any symptoms and give their actual social history and behave “normally”. They were to take notes and be as cooperative as possible to get discharged. The length of stay was 7-52 days with an average of 19 days.

Rosenhan also claims in the body of this paper that a second experiment occurred at a “research and teaching hospital” where the staff were informed ahead of time that pseudopatients were going to seek admission during a 3-month period. Staff were asked to rate whether a patient was a pseudopatient or not. Of 193 admissions during that time 41 were ranked as likely being a pseudopatient. In this case, Rosenhan did not send any pseudopatients to the facility and claims this false experiment represents “massive errors”.

One of the elements of the paper that is really never discussed is its structure. The primary data points were eight pseudopatients were admitted and discharged from psychiatric hospitals without being discovered. The secondary data points were a series of observations of the staff that is largely unstructured, highly anecdotal, and contrasted with other situations that seem to lack relevance. The bulk of Rosenhan’s discussion is judgmental and there is no discussion of the limitations of the experimental design or data. Instead the author leaps to clear-cut conclusions that are in some cases only peripherally connected to the data.

Cahalan expends a lot of effort to try to identify and find the pseudopatients and ask them what their experience was like. She locates the records of Rosenhan’s own admission as a pseudopatient. The first real sign of a departure from the research protocol described in *Science*, occurs in Rosenhan’s recorded admission interview. He recited the voices script and said the symptoms had been going on for four months. He was admitted on an involuntary commitment and discharged nine days later. The hospitalization ended in 1969 - four years before the article came out. The first major sign that the experiment described in *Science* was not quite the way it was described in the paper occurs when Cahalan looks at the record of the admission interview. In addition to the vague description of hallucinations, Rosenhan states that he believes he can “hear what people are thinking”, that he has tried to “insulate out the noises by putting copper over my ears”, and that he has “suicidal thoughts”. These are all more serious psychiatric symptoms than factitious “existential hallucinations”. Rosenhan also altered his occupational history during one assessment to say that his psychiatric illness led him to give up a job in economics 10 years earlier. At one point he stated that his wife is probably unaware of how useless he felt and that “everyone would be better off if he was not around”. Considering the seriousness of his fake history, I was surprised that he was discharged in 9 days.

What about the other 8 pseudopatients? Cahalan was able to locate two – only one of whom was part of the research protocol and shared Rosenhan’s experience. The second patient started out as a psychologist and co-authored a couple of papers with Rosenhan. The author was surprised at how little preparation went into the pseudopatient role. Patient 2 was taught to cheek medications and spit them out. He was reassured by Rosenhan that he had filed a writ of habeus corpus to get him out of the hospital at any time. When Cahalan tracked down that attorney who said the writs had been discussed but never prepared and that he did not consider himself to be “on call” to get pseudopatients immediately released. Patient 2 was also in the hospital for 9 days and basically released upon his request. There was no reason for discharge given on the official form, but he recalled a psychiatrist approaching him prior to discharge and making remarks to suggest that there was still some concern that he may still be suicidal. Despite that concern there was apparently no discharge plan.

The third pseudopatient discovered by Cahalan was interesting in that he was eliminated from the original protocol and not counted by Rosenhan. Cahalan discovered that the ninth uncounted pseudopatient was a research psychologist named Harry Lando. Dr. Lando is well represented in the smoking cessation literature and had published an article in the *Professional Psychologist* (4) stressing the positive aspects of his pseudopatient experience. His observations were in direct contrast to Rosenhan and he states as much in the observation: “My overall impressions of the hospital are overwhelmingly positive. The powerlessness and depersonalization of patients so strongly emphasized by Rosenhan simply did not exist in this setting.” He goes on to suggest that using better hospitals as models may be a way to improve the quality of care. He also questions the ethics of placing pseudopatients in “already overcrowded and understaffed institutions”. Lando does express a concern about the diagnostic process since all three pseudopatients received diagnoses of schizophrenia. The key question about why the data of the ninth pseudopatient was omitted from the original paper is answered as a footnote number 6 on page 258 of the original paper: “Data from a ninth pseudopatient are not included in this study because although his sanity went undetected, he falsified aspects of his personal history. Including marital status and parental relationships. His experimental behaviours therefore were not identical to the other pseudopatients.”

That footnote is exactly what Rosenhan did when he was admitted as pseudopatient 1 as documented in the existing medical record. Rosenhan’s lapses were discovered and discussed by Cahalan and are included in the following table.

Rosenhan’s Lapses
1. Data was improperly recorded. The two pseudo-patients interviewed by Cahalan pointed out that their durations of stay in the hospital were not correctly recorded.
2. His private notes indicated strong influence by Szasz and Laing. Prior to the

<p>pseudopatient experiment he assigned work to his students describing psychiatric hospitals as “authoritarian”, “degrading”, and “illness-maintaining”.</p>
<p>3. He told a pseudopatient that a writ of habeas corpus was prepared, and an attorney was on call to get them out of the hospital if necessary. That was not true.</p>
<p>4. Professional and possibly “unethical” mistakes (p. 173) about length of stay in pseudopatient number two (7 days versus 8) and pseudopatient number 9 (26 days versus 9 days), patient population in the hospital 8,000 vs 1,510), the specific discharge diagnoses of pseudopatients 2 and 9, and details of staff behavior on the ward.</p>
<p>5. Sending a pseudo-patient into a hospital that was in disarray because it was closing.</p>
<p>6. Rosenhan at one point lied in correspondence to Spitzer about his stay in the hospital and said it was part of a “teaching exercise” that had nothing to do with research (p. 180). Cahalan describes this as “an outright lie”.</p>
<p>7. During his admission Rosenhan “goes off script” and gives far more fabricated symptoms and history than the “empty, hollow, thud” existential hallucinations he described in the protocol. Additional symptoms suggest a significant psychiatric disorder. He describes suicidal ideation and significant conflict with his employer – the same falsification of personal history that led him to eliminate the data of the ninth pseudopatient.</p>
<p>8. Rosenhan fabricated an excerpted portion of the medical record and both the original record and the excerpt are published for A - B comparison on page 190. Cahalan concludes that the facts “were distorted intentionally by Rosenhan himself.”</p>
<p>9. Inadequate preparation of the research subjects. Patient 2 ended up taking a dose of chlorpromazine and patient 9 was given liquid chlorpromazine so it could not be checked as instructed. Pseudopatient 9 estimated the preparation time for hospital admission by Rosenhan was about 15 minutes.</p>
<p>10. When patient 9 was eliminated from the study none of the data about pills dispensed or staff contact time in the paper was changed.</p>
<p>11. In an National Public Radio program that aired before the publication of his paper (December 14, 1972) he misstated his time in the hospital as a pseudopatient (several weeks versus 9 days) and the amount of medications dispensed to pseudopatients (5,000 pills versus 2,000 pills) while building to the conclusion that psychiatric hospitals are non-therapeutic and should be closed (p.234)</p>
<p>12. Pseudopatient 9 commented that what Rosenhan had written about him in the experiment was “total fiction” (p.269)</p>
<p>13. Rosenhan did not complete a book about the pseudopatient experience, despite an advance from the publisher, a subsequent lawsuit from the publisher and what is</p>

described as plenty of publicity around the time the paper came out in *Science*. He also never published on the topic again (p. 295).

Rosenhan did continue to publish a description and discussion of his study in the text *Abnormal Psychology* (5). The discussion emphasized that the simple hallucinations described with nothing else being unusual would have been detected outside of a hospital. In the context dependent setting it was not. In other words – he maintained one of the same themes as in the original paper.

One of the areas that really piqued my interest was why *Science* published this paper in the first place. Cahalan got the opinion from an academic psychologist that the peer review in a non-psychology journal would be less rigorous. When she approached the journal, she was told that records were confidential and that they were not kept back that far. Accessing *Retraction Watch* (6) demonstrated that there has been a total of 120 papers retracted from *Science* since 1963. The reasons for the retractions are given as data errors, errors in methods, result errors, errors in conclusions, errors due to contaminated experiments, falsification/fabrication of data, irreproducible results, misconduct by the author, ethical violations by the author, investigation by a company, institution, or third-party. Only three of these papers had anything to do with psychiatry and those papers were primarily about the neurobiology of the brain. Cahalan's investigation suggests that several of the reasons for retraction have been met.

Apart from the details of the *Science* paper, Cahalan also does a character study of Rosenhan. We learned that his brother had bipolar disorder and did well on lithium. It was suggested that was why he became interested in psychology. He was described as bright and charismatic. He was clearly influenced by the work of anti-psychiatrists and assigned work to his students that “describe psychiatric hospitals as *authoritarian, degrading, and illness maintaining* among other terms”. (p 73). The title of the book highlights Rosenhan's characteristics as a raconteur who would occasionally pretend to be someone who he was not. His son described an incident in New York City where he introduced himself as a professor of engineering at Stanford in order to get a tour of an interesting construction site with his son. In another scene he is joking about the wig he wore to get into the psychiatric hospital. Cahalan finds the admission photo showing that he is bald without a wig. The people who knew him the best – acknowledge he was difficult to know and just like Rosenhan's arguments about psychiatric diagnoses being context dependent – his personality was as well.

Apart from academic books about the history of psychiatry – most books review sensational history and arguments that by their very nature diminish the field. This book is intermediate in that tone with those arguments interspersed through the investigative journalism about Rosenhan. They touch on the familiar themes of biological reductionism as opposed to a clinical psychiatry where patients are actually listened to with no reference to how clinical psychiatrists really practice every day. Some psychiatrists end up being caricatured and some are acknowledged as being highly motivated and humanistic. I am probably far too invested in clinical psychiatry

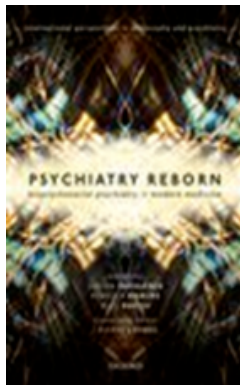
and the good I have seen done to tolerate a journalist's approach to the field. I give Cahalan credit for touching on the current situation that has resulted in severely rationed care and the transinstitutionalization of patients in jails. The overall concept that psychiatrists have little to do with the systems of care that are controlled by businesses and governments is not emphasized even though it was recognized as a problem by two of the pseudopatients. She also points out that the pseudopatient experiment is irrelevant to psychiatric practice today but her resounding theme throughout the book was that it was extremely relevant irrespective of what actually happened. The book also gives Rosenhan too much credit for psychiatric criticism. Like many books of this nature – there is little to no evidence that psychiatrists might be their own best critics or that outrage might be a legitimate reaction to outrageous criticism rather than defensiveness.

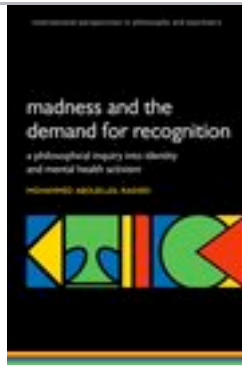
In conclusion *The Great Pretender* identifies extremely specific problems with the original Rosenhan paper that have been listed in the narrative and table in this report. He gained initial celebrity status from the study and signed a book contract. Even though he was given an advance on the book and wrote a manuscript he never produced a book. The author suggests that may have been due to the fact that Robert Spitzer was aware of Rosenhan's nonadherence to the research protocol during his admission. As Rosenhan withdrew from the pseudopatient limelight he also stated that none of his research should lead to the conclusion that psychiatric hospitals were unnecessary and that represented a complete turnaround from earlier statements.

The controversy, the original paper and the book could be the subject of seminars in the history or philosophical aspects of psychiatry. It touches on a number of themes, primarily the ethics of research and how it should be conducted. It also touches on psychiatric criticism and may be useful in discussing how future generations of psychiatrists can prepare to deal with it.

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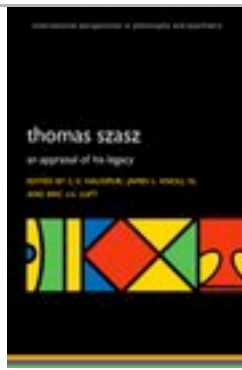
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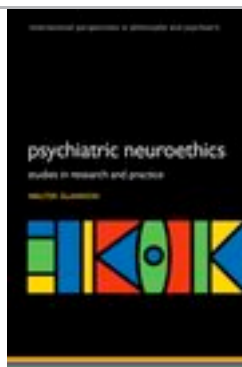
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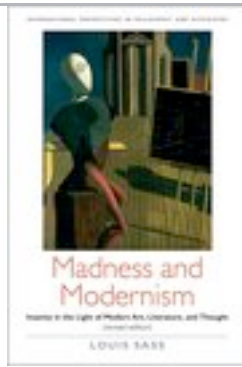
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