

Rosenhan (1973) summary linked to reliability and validity of classification and diagnosis of schizophrenia.

Reliability is the extent to which a finding is consistent. It is the extent to which psychiatrists can agree on the same diagnosis when independently assessing patients (**inter-rater reliability**). In order for a classification system to be reliable, the same diagnosis should be made each time. Therefore different psychiatrists should reach the same decision when assessing a patient.

Validity is the extent to which we are measuring what we are intending to measure. In the case of an illness like schizophrenia we have to consider the validity of the diagnostic tools; for example, do different assessment systems arrive at the same diagnosis for the same patient?

Exam Hint: It is important to ensure you understand the distinction between reliability and validity as many students confuse the two concepts.

Key Study: Rosenhan (1973)

Aim: To investigate how situational factors affect a diagnosis of schizophrenia. Sane confederates went into psychiatric hospitals and told medical health professionals they had a hallucination, and observed whether staff would realise that they were sane. If staff did not detect their sanity, it would have implications for methods of diagnosing mental illness and show that situational factors affect diagnosis.

Method: 8 confederates acted as pseudopatients, going to 12 different hospitals. The real participants were the hospital staff who did not know about the experiment. The pseudopatient called the hospital for an appointment. When they arrived they complained of hearing voices saying “empty”, “hollow” and “thud”. They said that the voices were unclear, unfamiliar and of the same sex as the pseudopatient. Pseudopatients gave false names, occupations and symptoms, but gave real life histories. Once on the ward, the pseudopatients stopped pretending symptoms, behaved normally and wrote observations. Pseudopatients were discharged only when they convinced staff that they were sane.

Results: On admission, staff diagnosed 11 pseudopatients with schizophrenia, and one with manic-depression. Staff never detected their sanity. Nurses reported their behaviour as showing “no abnormal indications”, but did interpret their behaviour in the context of their diagnosis (see conclusion). The average hospital stay was 19 days. All pseudopatients were discharged with diagnosis of schizophrenia ‘inremission’. 35 real patients detected sanity (e.g., saying “You’re not crazy”).

Conclusion: Psychiatric staff cannot always distinguish sanity from insanity. Any diagnostic method that makes such errors cannot be very reliable or valid. However, physicians may not identify sanity because it is less risky to diagnose a healthy person as sick than vice versa. So therefore situational factors do affect diagnosis. Normal behaviour was interpreted in the context of illness (e.g., nursing records suggest writing is pathological). Staff reversed some diagnoses due to the situation (expecting pseudopatients). Staff may be more likely to reverse diagnoses when risks are high (e.g., loss of professional esteem). Essentially Rosenhan’s research showed that psychiatrists cannot reliably tell the difference between an insane and sane person, calling into question the reliability of a schizophrenia diagnosis. ‘Normal’ behaviour was misinterpreted as ‘abnormal’ to support their idea that the pseudopatients had a mental illness. This suggests the validity of psychiatric diagnoses was low and the DSM was flawed.