schizophrenics’ role in diagnosis

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A recent study by Rosenhan (1973) revealed that in the context of a psychiatric residential facility, normal people posing as patients were not detected as sane by the hospital staff. One reason cited by Rosenhan for the failure of staff to identify these pseudopatients was that “once labeled schizophrenic, the pseudopatient was stuck with that label [p. 252].” Furthermore, failure to identify imposters was neither attributable to the quality of the hospitals nor to insufficient time for observing the pseudopatients’ behavior. “Finally, it cannot be said that the failure to recognize the pseudopatients’ sanity was due to the fact that they were not behaving sanely [p. 252].” The really intriguing aspect of Rosenhan’s study is that it contains the germ of an idea to improve our diagnostic tools. How?

Rosenhan’s own words suggest a novel approach to differential diagnosis. For example, a severely autistic child may exhibit many symptoms of the profoundly retarded, and institutionalization in the wrong place occurs. Years later, under strong arousal, he may verbally reveal the diagnostic error—in a sense, “confess” that he is not truly profoundly retarded (Cleland, Altman, and Swartz 1971). In his study, Rosenhan (1973) writes:

It was quite common for the real patients to “detect” the pseudopatients’ sanity. During the first three hospitalizations, when accurate counts were kept, 35 of a total of 118 patients . . . voiced their suspicions, some vigorously. “You’re not crazy. You’re a journalist, or a professor [referring to the continual note-taking]. You’re checking up on the hospital . . . .” The fact that the patients often recognized normality when staff did not raises important questions. [p. 252]

One important question not addressed by Rosenhan, but one that crossed this reader’s mind, was, “Could schizophrenics be experimentally employed as diagnosticians?” In the profoundly retarded (nonverbal) wards of State schools for the mentally retarded, one occasionally and accidentally discovers an autistic “imposter” in retarded clothing (Cleland, Altman, and Swartz 1971). Some patients do get erroneously labeled and may spend years in the wrong company.

Suggested, in recognition of patients’ apparent diagnostic acuity, is that patients be employed as diagnostic aides. If we descend to monkeys in the phyletic order, a related diagnostic phenomenon is noted in Pratt and Sackett’s (1967) study involving a sociometric test with monkeys. Three groups of infant monkeys were subjected to three different rearing conditions. One group was provided full contact and interaction, another received only visual and auditory contact, while a third group was reared in total isolation. Using an ingenious sociometric apparatus, the authors determined that peer preferences were directed toward monkeys similarly reared from infancy; that is, “like seeks like.” From their results, it was clear that socially abnormal monkeys preferred other abnormals, and socially normal monkeys chose not to approach abnormals.

Perhaps the old cliche, “It takes one to know one,” contains a grain of truth. As a test, one could select only those mental patients who have demonstrated a keen knack of spotting imposters, that is, “normals.” Next, these “diagnosticians” could be transported to a school for the mentally retarded. Once there, a visit to a ward housing the profoundly retarded would be arranged and instructions given would be, “Pick out a child (or adult) you’d most like to take back to the hospital.” In the event several known autistic children were “planted,” one would predict from Rosenhan’s and Pratt and Sackett’s work a preference for the autistic children as opposed to the organically profoundly retarded. Should, in fact, the experimental use of patients in diagnostic work be supported, some might be so employed on a paid basis and perhaps hastened on their way to
recovery. Conceivably such an arrangement could be of mutual benefit to both types of patients.

A further hint relative to the experimental approach to differential diagnosis appears in Deane and Ansbacher's (1962) finding of therapy enhancement as a function of attendant-patient commonality of background. The logistics, ethics, and potential gain from such an oblique approach to diagnosis require study. Getting the job done, however, may be accelerated if we inventory our ignorance as Hackerman (1974) suggests.

References


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conference on schizophrenic disorders

The Department of Psychiatry of the University of Rochester School of Medicine and Dentistry has announced the Second Rochester International Conference on Schizophrenic Disorders to be held May 2-5, 1976. The theme of the conference will be "The Origins, Development, and Course of Schizophrenic Disorders." The conference will emphasize fresh research contributions to the understanding of the etiology and pathogenesis of schizophrenic disorders, including predisposing, precipitating, and perpetuating factors. Contributions will take stock of progress in conceptualization, methodology, and new findings since the First Rochester Conference held in 1967. The planning committee for the conference consists of Drs. Lyman C. Wynne and Rue Cromwell (Cochairmen), together with Drs. Norman Garmezy, John Romano, Leonard Salzman, and John Strauss, all faculty of the Department of Psychiatry at Rochester. Further details about registration for the conference will be announced later. Suggestions about contributors who expect to have fresh research data by May 1976 are welcome. Write Dr. Wynne or Dr. Cromwell, Department of Psychiatry, University of Rochester Medical Center, Rochester, N.Y. 14642.
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