SELECTION 39

On Being Sane in Insane Places

David L. Rosenhan (1973)

Mental health workers have devised various classification schemes to help them diagnose abnormal behaviors. Although this may be beneficial in the vast majority of cases, some psychologists worry that misdiagnosis can result in inappropriate treatments or stigmatization and that mental health workers therefore need to be extremely careful about labeling mental patients. David L. Rosenhan is a leading critic of the method in which patients are labeled in mental hospitals.

Rosenhan (b. 1929) earned his Ph.D. from Columbia University in 1958. He is currently a professor emeritus of psychology at Stanford University. Among his books is Abnormal Psychology, coauthored with Martin Seligman (W. W. Norton, 1995).

This selection is from "On being sane in insane places," which was published in *Science* in 1973. In it, Rosenhan describes his and others' experiences as pseudopatients (healthy people who secretly gained admission to mental hospitals as patients), and he discusses the implications of labeling mental patients as insane or as mentally ill. Rosenhan's article encouraged debate among mental health providers on diagnosis in clinical psychology that is still going on today. A readable article, it provides a good inside look at mental institutions as well as the labeling process. Although Rosenhan's research successfully persuaded psychologists to discuss the problems that come with diagnosing mental patients, some people have criticized the study as unethical. As you read this selection, consider what it must be like for mental patients to live in an institution.

Key Concept: labeling and the diagnosis of abnormal behavior

APA Citation: Rosenhan, D. L. (1973). On being sane in insane places. *Science, 179,* 250–258.

If sanity and insanity exist, how shall we know them?

The question is neither capricious nor itself insane. However much we may be personally convinced that we can tell the normal from the abnormal, the evidence is simply not compelling. It is commonplace, for example, to read about murder trials wherein eminent psychiatrists for the defense are contradicted by equally eminent psychiatrists for the prosecution on the matter of the defendant's sanity. More generally, there are a great deal of conflicting data on the reliability, utility, and meaning of such terms as "sanity," "insanity," "mental illness," and "schizophrenia." Finally, as early as 1934, Benedict suggested that normality and abnormality are not universal (*1*). What is viewed as normal in one culture may be seen as quite aberrant in another. Thus, notions of normality and abnormality may not be quite as accurate as people believe they are.

To raise questions regarding normality and abnormality is in no way to question the fact that some behaviors are deviant or odd. Murder is deviant. So, too, are hallucinations. Nor does raising such questions deny the existence of the personal anguish that is often associated with "mental illness." Anxiety and depression exist. Psychological suffering exists. But normality and abnormality, sanity and insanity, and the diagnoses that flow from them may be less substantive than many believe them to be.

At its heart, the question of whether the sane can be distinguished from the insane (and whether degrees of insanity can be distinguished from each other) is a simple matter: do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them? . . . [T]he belief has been strong that patients present symptoms, that those symptoms can be categorized, and, implicitly, that the sane are distinguishable from the insane. More recently, however, this belief has been questioned. Based in part on theoretical and anthropological considerations, but also on philosophical, legal, and therapeutic ones, the view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of the observers

and are not valid summaries of characteristics displayed by the observed.

Gains can be made in deciding which of these is more nearly accurate by getting normal people (that is, people who do not have, and have never suffered, symptoms of serious psychiatric disorders) admitted to psychiatric hospitals and then determining whether they were discovered to be sane and, if so, how. If the sanity of such pseudopatients were always detected, there would be prima facie evidence that a sane individual can be distinguished from the insane context in which he is found. Normality (and presumably abnormality) is distinct enough that it can be recognized wherever it occurs, for it is carried within the person. If, on the other hand, the sanity of the pseudopatients were never discovered, serious difficulties would arise for those who support traditional modes of psychiatric diagnosis. Given that the hospital staff was not incompetent, that the pseudopatient had been behaving as sanely as he had been outside of the hospital, and that it had never been previously suggested that he belonged in a psychiatric hospital, such an unlikely outcome would support the view that psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him.

This article describes such an experiment. Eight sane people gained secret admission to 12 different hospitals. Their diagnostic experiences constitute the data of the first part of this article; the remainder is devoted to a description of their experiences in psychiatric institutions. Too few psychiatrists and psychologists, even those who have worked in such hospitals, know what the experience is like. They rarely talk about it with former patients, perhaps because they distrust information coming from the previously insane. Those who have worked in psychiatric hospitals are likely to have adapted so thoroughly to the settings that they are insensitive to the impact of the experience. And while there have been occasional reports of researchers who submitted themselves to psychiatric hospitalization (*3*), these researchers have commonly remained in the hospitals for short periods of time, often with the knowledge of the hospital staff. It is difficult to know the extent to which they were treated like patients or like research colleagues. Nevertheless, their reports about the inside of the psychiatric hospital have been valuable. This article extends those efforts.

PSEUDOPATIENTS AND THEIR SETTINGS

The eight pseudopatients were a varied group. One was a psychology graduate student in his 20's. The remaining seven were older and "established." Among them were three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife. Three pseudopatients were women, five were men. All of them employed pseudonyms, lest their alleged diagnoses embarrass them later. Those who were in mental health professions alleged another occupation in order to avoid the special attentions that might be accorded by staff, as a matter of courtesy or caution, to ailing colleagues. With the exception of myself (I was the first pseudopatient and my presence was known to the hospital administrator and chief psychologist and, so far as I can tell, to them alone), the presence of pseudopatients and the nature of the research program was not known to the hospital staffs.

The settings were similarly varied. In order to generalize the findings, admission into a variety of hospitals was sought. The 12 hospitals in the sample are located in five different states on the East and West coasts. Some were old and shabby, some were quite new. Some were research-oriented, others not. Some had good staff-patient ratios, others were quite understaffed. Only one was a strictly private hospital. All the others were supported by state or federal funds or, in one instance, by university funds.

After calling the hospital for an appointment, the pseudopatient arrived at the admissions office complaining that he had been hearing voices. Asked what the voices said, he replied that they were often unclear, but as far as he could tell they said "empty," "hollow," and "thud." The voices were unfamiliar and were of the same sex as the pseudopatient. The choice of these symptoms was occasioned by their apparent similarity to existential symptoms. Such symptoms were alleged to arise from painful concerns about the perceived meaninglessness of one's life. It is as if the hallucinating person were saying, "My life is empty and hollow." The choice of these symptoms was also determined by the *absence* of a single report of existential psychoses in the literature.

Beyond alleging the symptoms and falsifying name, vocation, and employment, no further alterations of person, history, or circumstances were made. The significant events of the pseudopatient's life history were presented as they had actually occurred. Relationships with parents and siblings, with spouse and children, with people at work and in school, consistent with the aforementioned exceptions, were described as they were or had been. Frustrations and upsets were described along with joys and satisfactions. These facts are important to remember. If anything, they strongly biased the subsequent results in favor of detecting sanity, since none of their histories or current behaviors were seriously pathological in any way.

Immediately upon admission to the psychiatric ward, the pseudopatient ceased simulating *any* symptoms of abnormality. In some cases, there was a brief period of mild nervousness and anxiety, since none of the pseudopatients really believed that they would be admitted so easily. Indeed their shared fear was that they would be immediately exposed as frauds and greatly embarrassed. Moreover, many of them had never visited a psychiatric ward; even those who had, nevertheless, had some genuine fears about what might happen to them. Their nervousness, then, was quite appropriate to the novelty of the hospital setting, and it abated rapidly.

Apart from that short-lived nervousness, the pseudopatient behaved on the ward as he "normally" behaved. The pseudopatient spoke to patients and staff as he might ordinarily. Because there is uncommonly little to do on a psychiatric ward, he attempted to engage others in conversation. When asked by staff how he was feeling, he indicated that he was fine, that he no longer experienced symptoms. He responded to instructions from attendants, to calls for medication (which was not swallowed), and to dining-hall instructions. Beyond such activities as were available to him on the admissions ward, he spent his time writing down his observations about the ward, its patients, and the staff. Initially these notes were written "secretly," but as it soon became clear that no one much cared, they were subsequently written on standard tablets of paper in such public places as the dayroom. No secret was made of these activities.

The pseudopatient, very much as a true psychiatric patient, entered a hospital with no foreknowledge of when he would be discharged. Each was told that he would have to get out by his own devices, essentially by convincing the staff that he was sane. The psychological stresses associated with hospitalization were considerable, and all but one of the pseudopatients desired to be discharged almost immediately after being admitted. They were, therefore, motivated not only to behave sanely, but to be paragons of cooperation. That their behavior was in no way disruptive is confirmed by nursing reports, which have been obtained on most of the patients. These reports uniformly indicate that the patients were "friendly," "cooperative," and "exhibited no abnormal indications."

THE NORMAL ARE NOT DETECTABLY SANE

Despite their public "show" of sanity, the pseudopatients were never detected. Admitted, except in one case, with a diagnosis of schizophrenia, each was discharged with a diagnosis of schizophrenia "in remission." The label "in remission" should in no way be dismissed as a formality, for at no time during any hospitalization had any question been raised about any pseudopatient's simulation. Nor are there any indications in the hospital records that the pseudopatient's status was suspect. Rather, the evidence is strong that, once labeled schizophrenic, the pseudopatient was stuck with that label. If the pseudopatient was to be discharged, he must naturally be "in remission"; but he was not sane, nor, in the institution's view, had he ever been sane.

The uniform failure to recognize sanity cannot be attributed to the quality of the hospitals, for, although there were considerable variations among them, several are considered excellent. Nor can it be alleged that there was simply not enough time to observe the pseudopatients. Length of hospitalization ranged from 7 to 52 days, with an average of 19 days. The pseudopatients were not, in fact, carefully observed, but this failure clearly speaks more to traditions within psychiatric hospitals than to lack of opportunity.

Finally, it cannot be said that the failure to recognize the pseudopatients' sanity was due to the fact that they were not behaving sanely. While there was clearly some tension present in all of them, their daily visitors could detect no serious behavioral consequences—nor, indeed, could other patients. It was quite common for the patients to "detect" the pseudopatients' sanity. During the first three hospitalizations, when accurate counts were kept, 35 of a total of 118 patients on the admissions ward 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." While most of the patients were reassured by the pseudopatient's insistence that he had been sick before he came in but was fine now, some continued to believe that the pseudopatient was sane throughout his hospitalization. The fact that the patients often recognized normality when staff did not raises important questions.

Failure to detect sanity during the course of hospitalization may be due to the fact that physicians operate with a strong bias toward what statisticians call the type 2 error (2). This is to say that physicians are more inclined to call a healthy person sick (a false positive, type 2) than a sick person healthy (a false negative, type 1). The reasons for this are not hard to find: it is clearly more dangerous to misdiagnose illness than health. Better to err on the side of caution, to suspect illness even among the healthy.

But what holds for medicine does not hold equally well for psychiatry. Medical illnesses, while unfortunate, are not commonly pejorative. Psychiatric diagnoses, on the contrary, carry with them personal, legal, and social stigmas (4). . . .

THE STICKINESS OF PSYCHODIAGNOSTIC LABELS

Beyond the tendency to call the healthy sick—a tendency that accounts better for diagnostic behavior on admission than it does for such behavior after a lengthy period of exposure—the data speak to the massive role of labeling in psychiatric assessment. Having once been labeled schizophrenic, there is nothing the pseudopatient can do to overcome this tag. The tag profoundly colors others' perceptions of him and his behavior. . . .

Once a person is designated abnormal, all of his other behaviors and characteristics are colored by that label. Indeed, that label is so powerful that many of the pseudopatients' normal behaviors were overlooked entirely or profoundly misinterpreted. . . .

All pseudopatients took extensive notes publicly. Under ordinary circumstances, such behavior would have raised questions in the minds of observers, as, in fact, it

did among patients. Indeed, it seemed so certain that the notes would elicit suspicion that elaborate precautions were taken to remove them from the ward each day. But the precautions proved needless. The closest any staff member came to questioning these notes occurred when one pseudopatient asked his physician what kind of medication he was receiving and began to write down the response. "You needn't write it," he was told gently. "If you have trouble remembering, just ask me again."

If no questions were asked of the pseudopatients, how was their writing interpreted? Nursing records for three patients indicate that the writing was seen as an aspect of their pathological behavior. "Patient engages in writing behavior" was the daily nursing comment on one of the pseudopatients who was never questioned about his writing. Given that the patient is in the hospital, he must be psychologically disturbed. And given that he is disturbed, continuous writing must be a behavioral manifestation of that disturbance, perhaps a subset of the compulsive behaviors that are sometimes correlated with schizophrenia. . . .

A psychiatric label has a life and an influence of its own. Once the impression has been formed that the patient is schizophrenic, the expectation is that he will continue to be schizophrenic. When a sufficient amount of time has passed, during which the patient has done nothing bizarre, he is considered to be in remission and available for discharge. But the label endures beyond discharge, with the unconfirmed expectation that he will behave as a schizophrenic again. Such labels, conferred by mental health professionals, are as influential on the patient as they are on his relatives and friends, and it should not surprise anyone that the diagnosis acts on all of them as a self-fulfilling prophecy. Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly (*5*). . . . If it makes no sense to label ourselves permanently depressed on the basis of an occasional depression, then it takes better evidence than is presently available to label all patients insane or schizophrenic on the basis of bizarre behaviors or cognitions. It seems more useful, as Mischel (*5*) has pointed out, to limit our discussions to *behaviors*, the stimuli that provoke them, and their correlates. . . . I may hallucinate because I am sleeping, or I may hallucinate because I have ingested a peculiar drug. These are termed sleep-induced hallucinations, or dreams, and drug-induced hallucinations, respectively. But when the stimuli to my hallucinations are unknown, that is called craziness, or schizophrenia—as if that inference were somehow as illuminating as the others. . . .

SUMMARY AND CONCLUSIONS

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 meanings of behavior can easily be misunderstood. The consequences to patients hospitalized in such an environment—the powerlessness, depersonalization, segregation, mortification, and self-labeling—seem undoubtedly countertherapeutic.

I do not, even now, understand this problem well enough to perceive solutions. But two matters seem to have some promise. The first concerns the proliferation of community mental health facilities, of crisis intervention centers, of the human potential movement, and of behavior therapies that, for all of their own problems, tend to avoid psychiatric labels, to focus on specific problems and behaviors, and to retain the individual in a relatively nonpejorative environment. Clearly, to the extent that we refrain from sending the distressed to insane places, our impressions of them are less likely to be distorted. (The risk of distorted perceptions, it seems to me, is always present, since we are much more sensitive to an individual's behaviors and verbalizations than we are to the subtle contextual stimuli that often promote them. At issue here is a matter of magnitude. And, as I have shown, the magnitude of distortion is exceedingly high in the extreme context that is a psychiatric hospital).

The second matter that might prove promising speaks to the need to increase the sensitivity of mental health workers and researchers to the *Catch 22* position of psychiatric patients. Simply reading materials in this area will be of help to some such workers and researchers. For others, directly experiencing the impact of psychiatric hospitalization will be of enormous use. Clearly, further research into the social psychology of such total institutions will both facilitate treatment and deepen understanding.

NOTES

1. R. Benedict, *J. Gen. Psychol.* **10,** 59 (1934).
2. T. J. Scheff, *Being Mentally Ill: A Sociological Theory* (Aldine, Chicago, 1966).
3. A. Barry, *Bellevue Is a State of Mind* (Harcourt Brace Jovanovich, New York, 1971); . . .
4. J. Cumming and E. Cumming, *Community Ment. Health* **1,** 135 (1965); . . .
5. W. Mischel, *Personality and Assessment* (Wiley, New York, 1968).