# *Rosenhan, D.L. (1973)*
# *On being sane in insane places*

**Background**

There is a long history of attempting to classify what is abnormal behaviour. The most commonly accepted approach to understanding and classifying abnormal behaviour is known as the medical model. This branch of medicine, which is concerned with treating mental illness, is known as psychiatry. Psychiatrists are medical doctors and are trained to regard mental illness as comparable to other kinds of (physical) illnesses. Beginning in the 1950s this medical approach has used the Diagnostic and Statistical Manual of Mental Disorders (DSM) to classify abnormal behaviour.

However, in the 1960s a number of psychiatrists and psychotherapists, known as the anti-psychiatry movement, started to fiercely criticise the medical approach to abnormality. David Rosenhan, a psychiatrist, was also a critic of the medical model and this study can be seen as an attempt to demonstrate that psychiatric classification is unreliable.

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**Aim**

The aim of this study was to test the hypothesis that psychiatrists cannot reliably tell the difference between people who are sane and those who are insane.

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The study actually consisted of two parts.

**Procedure (main study)**

The main study is an example of a field experiment. The manipulation (independent variable) was the made up symptoms of the pseudo patients, and the dependent variable was the psychiatrists' admission and diagnostic label of the pseudo patient. The study also involved participant observation, since, once admitted, the pseudo-patients kept written records of how the ward as a whole operated, as well as how they personally were treated.

The first part of the study involved eight sane people (a psychology graduate student in his 20s, three psychologists, a paediatrician, a psychiatrist, a painter, and a 'housewife') attempting to gain admission to 12 different hospitals, in five different states in the USA. There were three women and five men.

These pseudo-patients telephoned the hospital for an appointment, and arrived at the admissions office complaining that they had been hearing voices. They said the voice, which was unfamiliar and the same sex as themselves, was often unclear but it said 'empty', 'hollow', 'thud'. These symptoms were partly chosen because they were similar to existential symptoms (Who am I? What is it all for?) which arise from concerns about how meaningless your life is. They were also chosen because there is no mention of existential psychosis in the literature.

The pseudo patients gave a false name and job (to protect their future health and employment records), but all other details they gave were true including general ups and downs of life, relationships, events of life history and so on.

After they had been admitted to the psychiatric ward, the pseudo patients stopped simulating any symptoms of abnormality. However, Rosenhan did note that the pseudo patients were nervous, possibly because of fear of being exposure as a fraud, and the novelty of the situation.

The pseudo patients took part in ward activities, speaking to patients and staff as they might ordinarily. When asked how they were feeling by staff they were fine and no longer experienced symptoms. Each pseudo patient had been told they would have to get out by their own devices by convincing staff they were sane.

The pseudo patients spent time writing notes about their observations. Initially this was done secretly although as it became clear that no one was bothered the note taking was done more openly.

In four of the hospitals the pseudo patients carried out an observation of behaviour of staff towards patients that illustrate the experience of being hospitalised on a psychiatric ward. The pseudo patients approached a staff member with a request, which took the following form: 'Pardon me, Mr/Mrs/Dr X, could you tell me when I will be presented at the staff meeting?'. (or '…when am I likely to be discharged?'). See table 1.

In order to compare the results Rosenhan carried out a similar study at Stanford University with students asking university staff a simple question.

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**Results**

All of the pseudo patients disliked the experience and wished to be discharged immediately.

None of the pseudo patients was detected and all but one were admitted with a diagnosis of schizophrenia and were eventually discharged with a diagnosis of '*schizophrenia in remission*' This diagnosis was made without one clear symptom of this disorder. They remained in hospital for 7 to 52 days (average 19 days), Visitors to the pseudo patients observed 'no serious behavioural consequences'. Although they were not detected by the staff, many of the other patients suspected their sanity (35 out of the 118 patients voiced their suspicions). Some patients voiced their suspicions very vigorously for example 'You're not crazy. You're a journalist, or a professor. You're checking up on the hospital'.

The pseudo patients' normal behaviours were often seen as aspects of their supposed illness. For example, nursing records for three of the pseudo patients showed that their writing was seen as an aspect of their pathological behaviour. 'Patient engages in writing behaviour'. Rosenhan notes that there is an enormous overlap in the behaviours of the sane and the insane. We all feel depressed sometimes, have moods, become angry and so forth, but in the context of a psychiatric hospital, these everyday human experiences and behaviours were interpreted as pathological.

Another example of where behaviour was misinterpreted by staff as stemming from within the patient, rather than the environment, was when a psychiatrist pointed to a group of patients waiting outside the cafeteria half an hour before lunchtime. To a group of registrars (trainee psychiatrists) he suggested that such behaviour was characteristic of an oral-acquisitive syndrome. However, a more likely explanation would be that the patients had little to do, and one of the few things to anticipate in a psychiatric hospital is a meal.

In four of the hospitals the pseudo patients carried out an observation of behaviour of staff towards patients that illustrate the experience of being hospitalised on a psychiatric ward. The results were compared with a university study. In the university study, nearly all the requests were acknowledged and responded to unlike the psychiatric hospital where the pseudo patients were treated as if they were *invisible*. See table 1.

Table 1: Responses of staff towards pseudo patients requests

| Response | Percentage making contact with patient | |
|---|---|---|
| | Psychiatrists | Nurses |
| Moves on with head averted | 71 | 88 |
| Makes eye contact | 23 | 10 |
| Pauses and chats | 2 | 4 |
| Stops and talks | 4 | 0.5 |

Rosenhan noted that experience of hospitalisation for the pseudo patients was one of ***depersonalisation*** and ***powerlessness***.

Powerlessness and depersonalisation were evident in the ways in which the patients were deprived of many human rights such as freedom of movement and privacy. Medical records were open to al staff members regardless of status or therapeutic relationship with the patient and personal hygiene was monitored and many of the toilets did not have doors. Some of the ward orderlies would be brutal to patients in full view of other patients but would stop as soon as another staff member approached. This indicated that staff were credible witnesses but patients were not.

It was estimated that the pseudo patients were given a total of 2,100 medication tablets, though only two were swallowed. The rest were either pocketed or flushed down the toilet. Often, when the pseudo patients visited the toilets to dispose of their tablets they found the medication of other patients that had already been placed there. As long as the patients were co-operative, then their behaviour went unnoticed.

The records the pseudo patients had made about the amount of time the nurses stayed in the ward offices was about 90 per cent of the time and the number of times medical staff came onto the ward, and the amount of time spent with psychiatrists, psychologists, registrars and so forth was, on average, under seven minutes per day.

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## The Secondary Study

### Procedure/Method

In the secondary study, the staff of a teaching and research hospital, which was aware of the first study, was falsely informed that during the next three months one or more pseudo patients would attempt to be admitted into their hospital. Staff members were asked to rate on a 10-point scale each new patient as to the likelihood of them being a pseudo patient.

This false information was the manipulated independent variable, and the dependent variable was the number of patients which staff subsequently suspected of being pseudo patients.

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### Results/Findings of the Secondary Study

The table shows that many patients of the hospitals regular intake were judged to be pseudo patients. For example, around ten per cent of their regular intake were judged by one psychiatrist and another staff member to be pseudo patients.

Table 2: Judgement of all admissions patients as to the likelihood that they are pseudo patients

| | |
|---|---|
| Number of patients judged | 193 |
| Number of patients confidently judged as pseudo patients by at least one staff member | 41 |
| Number of patients suspected by one psychiatrist | 23 |
| Number of patients suspected by one psychiatrist AND one other staff member | 19 |

## Explanation

Rosenhan claims that the study demonstrates that psychiatrists cannot reliably tell the difference between people who are sane and those who are insane.

The main experiment illustrated a failure to detect sanity, and the secondary study demonstrated a failure to detect insanity.

Rosenhan explains that psychiatric labels tend to stick in a way that medical labels do not and that everything a patient does is interpreted in accordance with the diagnostic label once it has been applied.

He suggested that instead of labelling a person as insane we should focus on the individual's specific problems and behaviours.

## Evaluation of the Procedure

**Strengths**

The participant observation meant that the pseudo patients could experience the ward from the patients' perspective while also maintaining some degree of objectivity.

The study was a type of field experiment and was thus fairly ecologically valid whilst still managing to control many variables such as the pseudo patients' behaviour.

Rosenhan used a range of hospitals. They were in different States, on both coasts, both old/shabby and new, research-orientated and not, well staffed and poorly staffed, one private, federal or university funded. This allows the results to be generalised.

**Weaknesses**

The hospital staff was deceived - this is, of course, unethical. Although Rosenhan did not conceal the names of hospitals or staff and attempted to eliminate any clues which might lead to their identification

Rosenhan did note that the experiences of the pseudo-patients could have differed from that of real patients who did not have the comfort of knowing that the diagnosis was false.

Perhaps Rosenhan was being too hard on psychiatric hospitals, especially when it is important for them to play safe in their diagnosis of abnormality because there is always an outcry when a patient is let out of psychiatric care and gets into trouble. If you were to go to the doctors complaining of stomach aches how would you expect to be treated?

Doctors and psychiatrists are more likely to make a type two error (that is, more likely to call a healthy person sick) than a type one error (that is, diagnosing a sick person as healthy)

When Rosenhan did his study the psychiatric classification in use was DSM-II. However, since then a new classification has been introduced which was to address itself largely to the whole problem of unreliability - especially unclear criteria. It is argued that with the newer classification DSM-III, introduced in the 1980s, psychiatrists would be less likely to make the errors they did. The DSM is currently in its fourth edition (DSM-IV)

## Evaluation of Explanation

The study demonstrates both the limitations of classification and importantly the appalling conditions in many psychiatric hospitals. This has stimulated much further research and has lead to many institutions improving their philosophy of care.

Rosenhan, like other anti-psychiatrists, is arguing that mental illness is a social phenomenon. It is simply a consequence of labelling. This is a very persuasive argument, although many people who suffer from a mental illness might disagree and say that mental illness is a very real problem

**Reference**

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