DOCUMENT SUMMARY This document is the full text of David L. Rosenhan's groundbreaking 1973 study, "On Being Sane in Insane Places." It details an experiment where eight sane individuals, or "**pseudopatients**," gained admission to twelve different psychiatric hospitals by feigning a single symptom. The study found that none of the pseudopatients were ever detected as sane by staff; instead, their normal behaviors were interpreted as pathological and consistent with their initial diagnosis, demonstrating the profound and enduring power of **psychodiagnostic labels** and the contextual nature of psychiatric judgment.

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FORMATTED CONTENT

On Being Sane in Insane Places

By David L. Rosenhan

> 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."[1] Finally, as early as 1934, Benedict suggested that normality and abnormality are not universal.2 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?

From Bleuler, through Kretchmer, through the formulators of the recently revised Diagnostic and Statistical Manual of the American Psychiatric Association, the 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. 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.

PSEUDOPATIENTS AND THEIR SETTINGS

The eight **pseudopatients** were a varied group. One was a psychology graduate student in his 20s. 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. The 12 hospitals in the sample were 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 of 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 are alleged to arise from painful concerns about the perceived meaninglessness of one's life. 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... were described as they were or had been. Frustrations and upsets were described along with joys and satisfactions.

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. 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. 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.

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 that staff that he was sane.

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... 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.

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 notetaking]. You're checking up on the hospital."

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**. 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. 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.

It was therefore important to see whether the tendency toward diagnosing the sane insane could be reversed. The following experiment was arranged at a research and teaching hospital whose staff had heard these findings but doubted that such an error could occur in their hospital. The staff was informed that at some time during the following 3 months, one or more pseudopatients would attempt to be admitted into the psychiatric hospital. Each staff member was asked to rate each patient who presented himself at admissions or on the ward according to the likelihood that the patient was a pseudopatient. Judgments were obtained on 193 patients who were admitted for psychiatric treatment. Forty-one patients were alleged, with high confidence, to be pseudopatients by at least one member of the staff. Twenty-three were considered suspect by at least one psychiatrist. Nineteen were suspected by one psychiatrist and one other staff member. **Actually, no genuine pseudopatient (at least from my group) presented himself during this period.**

> The experiment is instructive. It indicates that the tendency to designate sane people as insane can be reversed when the stakes (in this case, prestige and diagnostic acumen) are high. But what can be said of the 19 people who were suspected of being "sane"...? There is no way of knowing. But one thing is certain: any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one.

THE STICKINESS OF PSYCHODIAGNOSTIC LABELS

Beyond the tendency to call the healthy sick... 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 the 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.

A clear example... is found in the case of a pseudopatient who had had a close relationship with his mother but was rather remote from his father during his early childhood. During adolescence and beyond, however, his father became a close friend, while his relationship with this mother

cooled. His present relationship with his wife was characteristically close and warm. Observe, however, how such a history was translated in the psychopathological context, this from the case summary prepared after the patient was discharged. "This white 39-year-old male... manifests a long history of considerable ambivalence in close relationships, which begins in early childhood. A warm relationship with his mother cools during his adolescence. A distant relationship to his father is described as becoming very intense. Affective stability is absent. His attempts to control emotionality with his wife and children are punctuated by angry outbursts and, in the case of the children, spankings." The facts of the case were unintentionally distorted by the staff to achieve consistency with a popular theory of the dynamics of a schizophrenic reaction.

All pseudopatients took extensive notes publicly. 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.

One tacit characteristic of psychiatric diagnosis is that it locates the sources of aberration within the individual and only rarely within the complex of stimuli that surrounds him. Consequently, behaviors that are stimulated by the environment are commonly misattributed to the patient's disorder.

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. But the label endures beyond discharge, with the unconfirmed expectation that he will behave as a schizophrenic again. Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly.

THE EXPERIENCE OF PSYCHIATRIC HOSPITALIZATION

The term "mental illness" is of recent origin. It was coined by people who were humane in their inclinations and who wanted very much to raise the station of the psychologically disturbed from that of witches and "crazies" to one that was akin to the physically ill. But while treatment has improved, it is doubtful that people really regard the mentally ill in the same way that they view the physically ill. A broken leg is something one recovers from, but mental illness allegedly endures forever. The mentally ill are society's lepers.

Consider the structure of the typical psychiatric hospital. Staff and patients are strictly segregated. Staff have their own living space... The glassed quarters that contain the professional staff, which the pseudopatients came to call "the cage," sit out on every dayroom. The staff emerge primarily for caretaking purposes... Otherwise, staff keep to themselves, almost as if the disorder that afflicts their charges is somehow catching.

The average amount of time spent by attendants outside of the cage was 11.3 percent. This figure does not represent only time spent mingling with patients, but also includes time spent on such chores as folding laundry, supervising patients while they shave... On the average, daytime nurses emerged from the cage 11.5 times per shift... Physicians, especially psychiatrists, were even less available. They were rarely seen on the wards. On the average, physicians emerged on the ward 6.7 times per day.

Those with the most power have least to do with patients, and those with the least power are most involved with them.

I turn now to a different set of studies, these dealing with staff response to patient-initiated contact. In four hospitals, the pseudopatient approached the staff member with a request which took the following form: "Pardon me, Mr. [or Dr. or Mrs.] X, could you tell me when I will be eligible for grounds privileges?" By far, their most common response consisted of either a brief response to the question, offered while they were "on the move" and with head averted, or no response at all. The encounter frequently took the following bizarre form: (pseudopatient) "Pardon me, Dr. X. Could you tell me when I'm eligible for grounds privileges?" (physician) "Good morning, Dave. How are you today?" (Moves off without waiting for a response.)

It is instructive to compare these data with data recently obtained at Stanford University. A young lady approached individual faculty members who seemed to be walking purposefully... and asked them... six questions. Without exception, as can be seen in Table 1, all of the questions were answered. No matter how rushed they were, all respondents not only maintained eye contact, but stopped to talk.

Response Metric	Psychiatric Hospitals (Psychiatrists)	Psychiatric Hospitals (Nurses/Attendants)	University Campus (Faculty)	U. Medical Center ("Looking for psychiatrist")	U. Medical Center ("Looking for internist")	U. Medical Center (No comment)
Moves on, head averted (%)	71	88	0	0	0	0
Makes eye contact (%)	23	10	0	11	0	0
Pauses and chats (%)	2	2	0	11	0	10
Stops and talks (%)	4	0.5	100	78	100	90
Mean questions answered (of 6)	Not applicable	Not applicable	6	4.8	3.8	4.5
Respondents (No.)	13	47	14	18	15	10
Attempts (No.)	185	1283	14	18	15	10

POWERLESSNESS AND DEPERSONALIZATION

Eye contact and verbal contact reflect concern and individuation; their absence, avoidance and **depersonalization**.

Neither anecdotal nor "hard" data can convey the overwhelming sense of **powerlessness** which invades the individual as he is continually exposed to the depersonalization of the psychiatric hospital. Powerlessness was evident everywhere. The patient is deprived of many of his legal rights by dint of his psychiatric commitment. He is shorn of credibility by virtue of his psychiatric label. His freedom of movement is restricted. He cannot initiate contact with the staff, but may only respond to such overtures as they make. Personal privacy is minimal.

At times, depersonalization reached such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account. A nurse unbuttoned her uniform to adjust her brassiere in the presence of an entire ward of viewing men. One did not have the sense that she was being seductive. Rather, she didn't notice us.

All told, the pseudopatients were administered nearly 2100 pills... Only two were swallowed. The rest were either pocketed or deposited in the toilet. The pseudopatients were not alone in this... As long as they were cooperative, their behavior... went unnoticed throughout.

THE SOURCES OF DEPERSONALIZATION

What are the origins of depersonalization? I have already mentioned two. First are attitudes held by all of us toward the mentally ill... characterized by fear, distrust, and horrible expectations on the one hand, and benevolent intentions on the other. Our ambivalence leads... to avoidance. Second... the hierarchical structure of the psychiatric hospital facilitates depersonalization. Those who are at the top have least to do with patients, and their behavior inspires the rest of the staff. Average daily contact with psychiatrists, psychologists, residents, and physicians combined ranged from 3.9 to 25.1 minutes, with an overall mean of 6.8.

Heavy reliance upon psychotropic medication tacitly contributes to depersonalization by convincing staff that treatment is indeed being conducted and that further patient contact may not be necessary.

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.

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.

It could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behavior were controlled by the situation, rather than being motivated by a malicious disposition.