Rosenhan (1973)

There is a long history of attempting to classify what is abnormal behaviour. Beginning in the 1950s the medical approach 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.

Rosenhan stated, 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?**

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. The study consisted of two investigations, the main experiment and the follow-up.

Along with himself, Rosenhan recruited seven other people to act as pseudopatients in this investigation. One was a Psychology graduate student in his 20s, three were qualified psychologists, one was a paediatrician, another a psychiatrist, another a painter, and a housewife. Three of the pseudopatients were women and five were men. All of them employed pseudonyms to avoid detection.

A **field** study was conducted using **participant observation**. Rosenhan manipulated the false symptoms described by the pseudopatients and asked them all to record the psychiatrists' admission and diagnostic label given to them.

The **12 hospitals** in the sample were located in **five different states** on the East and West coasts of America.

The first part of the study involved the eight sane people (including Rosenhan) attempt to gain admission to the 12 different hospitals. These pseudopatients 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 pseudopatients 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. Once admitted, the pseudopatients were asked to behave normally and keep written records of how the ward as a whole operated, as well as how they personally were treated. However, Rosenhan did note that the pseudopatients were nervous, possibly because of fear of being exposed as a fraud, and the novelty of the situation.

Once inside the hospital, the pseudopatients took part in ward activities, speaking to patients and staff as they might ordinarily. When asked how they were feeling by staff they said they were fine and no longer experienced symptoms. Each pseudopatient had been told they would have to get out by their own devices by convincing staff they were sane. This proved quite difficult for some of them. The psychological stresses associated with hospitalisation were consider able, and all but one of the pseudopatients desired to be discharged almost immediately after being admitted. They were therefore motivated to cooperate and behave sanely.

The pseudopatients 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 pseudopatients 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?').

Despite their public "show" of sanity, the pseudopatients were never 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. This highlighted the poor reliability of the diagnosis process.

Pseudopatients remained in hospital for 7 to 52 days (average **19 days**). 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 pseudopatients' normal behaviours were often seen as aspects of their supposed illness. For example, nursing records for three of the pseudopatients showed that their writing was seen as an aspect of their pathological behaviour. **'Patient engages in writing behaviour'**. Rosenhan noted 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 pseudopatients 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 pseudopatients were treated as if they were invisible.

Responses of staff towards pseudopatients 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 pseudopatients 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.

Powerlessness was evident everywhere. The patients were deprived of many of their legal rights and instead given a psychiatric label. Their freedom of movement is restricted and they cannot initiate contact with staff and instead may only respond to such overtures as they make. Personal privacy is minimal. Medical records were open to all 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 pseudopatients 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 pseudopatients 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 pseudopatients made about the amount of time the nurses stayed in the ward offices was about **90% 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**.

This initial investigation highlighted (i) the unreliable diagnosis process upon admission, (ii) the failure to 'treat' patients once hospitalised, given the minimal contact with medical professionals. Rosenhan stated that "the facts of the matter are that we have known for a long time that diagnoses are often not useful or reliable, but we have nevertheless continued to use them".

Follow-Up Study

Here 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 pseudopatients 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 pseudopatient.

The results found that many patients of the hospitals regular intake were judged to be pseudopatients. For example, around 10% of their regular intake were judged by one psychiatrist and another staff member to be pseudopatients.

Judgement of all admissions patients as to the likelihood that they are pseudopatients

Number of patients judged	193
Number of patients confidently judged as pseudopatients 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

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 (type one error), and the secondary study demonstrated a failure to detect insanity (type two error). The study also demonstrates both the limitations of **classification** and importantly the appalling **conditions** in many psychiatric hospitals. This has stimulated much further research and has led to many institutions improving their philosophy of care.

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. Rosenhan, like other anti-psychiatrists, is arguing that mental illness is a social phenomenon. It is simply a consequence of **labelling.**

Reference:
D. L. Rosenhan, "On Being Sane in Insane Places," Science, Vol. 179, January 1973, pp. 250-258