Rosenhan (1973): On Being Sane in Insane Places

The First Study

In the most well-known section of this study, Rosenhan aimed to undermine psychiatric diagnoses by showing that anyone - regardless of their actual mental state - could get themselves diagnosed and institutionalised as mentally ill with very little effort.

In order to make this point, Rosenhan gathered together eight people of a variety of ages, professions and backgrounds who were to become his pseudo-patients. Of these, five were men (Rosenhan was one) and three were women. Each pseudo-patient adopted a fake identity (name and profession), and were dispatched to twelve different hospitals, across five different states in the USA.

Each pseudo-patient telephoned a hospital for an appointment, and on arriving at the admissions office complained of hearing voices. When questioned, they said that the voice - which was unfamiliar, but of the same sex as themselves - was often unclear, but as far as they could tell it said “empty”, “hollow” and “thud”.

Beyond the fake names and occupations and the reports of hearing voices, the pseudo-patients were instructed to tell the truth, and none of their life histories were pathological (abnormal). Rosenhan was interested to see whether these normal people would be admitted to a psychiatric ward. None of them knew how long they would be in the institution - as one of the conditions of the study was that they got themselves discharged - essentially by convincing hospital staff that they were sane!

On the basis of their single discernable symptom, all of the participants were admitted to hospital wards - seven with a diagnosis of schizophrenia. Rosenhan uses this as devastating evidence against the psychiatric profession and - in explaining its occurrence - draws the distinction between the two types of error which it is possible for a doctor to make:

- A type one error is when the researcher diagnoses a sick person as healthy.
- A type two error is when the researcher diagnoses a healthy person as sick.

He argues that when the medical model is applied to any aspect of health and well-being, it is inherently prone to producing the second of these two types of error. In itself, this is not necessarily problematic; however when coupled with the ambiguity surrounding psychiatric diagnosis, the tendency can have human costs.

Work in pairs...
1. Decide on two different behaviours that you consider to be a sign of psychological abnormality.
2. Try to explain why you think they are abnormal.

Background

The first study we will examine in the individual differences unit examines what it means to be psychologically normal or abnormal - and the controversy surrounding both the definition and diagnosis of mental illness. According to Stratton and Hayes (1993), behaviour can be defined as that which,

- Deviates from the norm (most people don't behave that way)
- Does not conform to social demands (most people don't like that behaviour)
- Is maladaptive or painful to the individual (it is not normal to harm yourself).

The most commonly accepted approach to understanding and classifying abnormal behaviour in our society is known as the medical model, as it explains and treats abnormality in terms of “diseases” in the same way that doctors explain and treat physical illness. Consequently, psychiatry is a recognised branch of medicine which specialises in treating psychological disorders. In order to properly apply these treatments, the psychiatric profession has developed the Diagnostic and Statistical Manual of Mental Disorders (DSM) which classifies different types of abnormal behaviour - and prescribes its treatment - based on the symptoms presented by patients.

Aim of the Study

In conducting this study, Rosenhan was aiming to challenge the people’s assumptions about the dependability of diagnosis of abnormality and to illustrate the negative effects of being diagnosed (or labelled) as abnormal and institutionalised on the basis of the diagnosis. Rosenhan spearheaded an anti-psychiatry movement, which argued that diagnosis of abnormality was based less on the internal attributes of the patient (disposition) and more on the external environment and contexts in which they find themselves (situation). Consequently, he aimed to demonstrate that the diagnoses made by psychiatrists lack both validity and reliability.

17. Knowledge Audit! Look over the questions at the end of this handout and tick those which you can now answer.
**“The Sane are not Detectably Sane!”**

Once in the ward, the pseudo-patients were told to cease any abnormal behaviour, and to make notes about their experience. Rosenhan admits that the pseudo-patients may (understandably) have appeared shocked at first, and nervous that they may be discovered as frauds. He argues that this would, however, be tempered by a desire to be discharged - which would lead back to normal behaviour. Visits to the pseudo-patients by observers support this, indicating that no observable abnormalities were present in the pseudo-patients’ behaviour. Furthermore, many of the genuine patients were sceptical about the pseudo-patients. Rosenhan reports that, at one point, a fellow patient declared, “You’re not crazy. You’re a journalist, or a professor...You’re checking up on the hospital”

Despite the ability of fellow patients to correctly diagnose the pseudo-patients, the psychiatric professionals failed to pick up on their normal behaviour. All of the pseudo-patients did eventually manage to get themselves discharged after an average of 18 days (although this ranged from as quickly as week to as much as 52 days). However, they were each discharged with the diagnosis of schizophrenia “in remission”.

---

**Sticky Labels**

According to Rosenhan, the failure of doctors to acknowledge the normality of behaviour is a telling symptom of the process of diagnosing psychological abnormality. He argues that diagnosis essentially involves **labelling** people (as, for instance, a “schizophrenic”). These labels are “sticky”, and all further evidence is interpreted in relation to them (so behaviour is interpreted as that of “a schizophrenic”).

Consequently, once the psychiatrist has picked up on a single symptom (hearing voices) and labelled the pseudo-patient as schizophrenic - all other behaviour is interpreted in terms of understanding the behaviour of a schizophrenic. Rosenhan cites many examples from his study of psychiatrists interpretations being distorted by their expectations - for instance, in their initial diagnosis the psychiatrists interpreted the normal backgrounds of their patients as pathological (guided by their expectations of the “typical” background of a schizophrenic). Consequently, rather than using the patients background to inform diagnosis, the opposite is happening - a diagnosis is made by a single symptom, and all other evidence is interpreted in relation to this label. Similar findings were found once pseudo-patients were admitted to the institutions, with normal behaviour consequently interpreted in reference to the label of schizophrenic (see Item B)

In summary, Rosenhan argues that...

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. But the label endured beyond discharge, with the unconfirmed expectation that he will behave as a schizophrenic again. Such labels...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 accepts the diagnosis...and behaves accordingly.

---

**Results of the Second Study**

**Item A - Pseudo-Patient Background**

**Pseudo-Patient’s Actual Background:** He had a close relationship with his mother but was remote from his father during early childhood. During adolescence and beyond, however, his father became a close friend, while his relationship with his mother cooled. His present relationship with his wife was characteristically close and warm. Apart from occasional angry exchanges, friction was minimal.

**Psychiatrist’s Reinterpretation:** He manifests a long history of considerable ambivalence in close relationships, which began 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. Emotional 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.

**Item B - Spotting “Normal” Behaviour**

* A psychiatrist noted “oral-acquisitive” behaviour in a pseudo-patient, noting that he would consistently wait outside the cafeteria half an hour before lunch. The pseudo-patients later revealed that, in fact, he did this because their was little to do on the ward - and the one thing to look forward to was meals!

* Similarly, another pseudo-patient, when spotted pacing up and down by a kindly nurse, was asked if he was anxious. “No,” he replied, “I’m bored”.

* This also occurred with the pseudo-patients note-taking. Initially, the researchers tried to hide this for fear of discovery. However, it quickly emerged that this was a misplaced fear. In fact, the note-taking was interpreted as part of the pseudo-patients' condition - one set of nurses notes stating, “patient engages in writing behaviour”.

---

**Extension Reading: Becker, Cooley and Master Statuses**

The interactionist sociologists Becker and Cooley offer useful concepts in interpreting the kinds of observations made by Rosenhan. Becker, for instance, proposes the concept of **Master Statuses** - arguing that labels can be so strong that they are the primary element of identity for both the individual and those around them. Once a person has been convicted of a crime, for instance, and been labelled as “a criminal” by society; all of their other activity will be interpreted in reference to this master status. They may, consequently, find it difficult to find a job and reintegrate into mainstream society.

In addition, labels can also impact on the self-concept of the individual who is labelled. On this dimension, Cooley’s theory on The Looking Glass Self is particularly useful; stating that a large part of our identity is a product of how others treat us. If, for instance, we are consistently treated as if we are mentally ill, we will gradually incorporate this into our identities - living up to the label which has been applied to us.

---

**The Second Study**

The final two studies conducted by Rosenhan aimed to flesh out some of the issues raised by the first. In this, the second study, the focus was on whether the tendency for psychiatrists to “err on the side of caution” and diagnose healthy patients as insane could be reversed.

Staff in a teaching and research hospital were informed of the results of the first study - and were confident that they would not make the same errors. They were informed that, over the following three months, one or more pseudo-patient would attempt to gain admittance to the hospital. Over this time, judgements of 193 patients were obtained on a 10-point scale from each professional involved with them (psychiatrists, nurses and other staff members). 41 were confidently acknowledged by at least one...
staff member as pseudo-patients, 23 were suspected by at least one psychiatrist, and 19 were suspected by a psychiatrist and one other staff member. Brilliant, except no pseudo-patients were actually sent.

The results of this study suggests that, if the stakes are high enough. However, we cannot be sure of the sanity of the people being turned away - it could be that the psychiatrists simply swung to the other extreme, diagnosing ill people as sane. Rosenhan concludes that "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 Third Study**

Within the original study, Rosenhan also studied how patients were treated by the professionals under whose care they fell - and the effects of this treatment. Four of the pseudo-patients asked staff “Pardon me, Dr [or Mr/Mrs] X, could you tell me when I will be presented at the staff meeting?” or “…when am I likely to be discharged” and then observed their reaction. The table below summarises these responses;

<table>
<thead>
<tr>
<th>Response</th>
<th>Psychiatrists</th>
<th>Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moves on with head averted</td>
<td>71%</td>
<td>88%</td>
</tr>
<tr>
<td>Makes eye contact</td>
<td>23%</td>
<td>10%</td>
</tr>
<tr>
<td>Pauses and chats</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>Stops and talks</td>
<td>4%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Rosenhan argues that “eye contact and verbal contact reflect concern and individuation; their absence, avoidance and depersonalisation”. Consequently, the contempt that staff showed for patients, and the way in which they were treated as invisible, signified their depersonalisation (they were turned into "things").

This argument is supported by the qualitative data generated through the pseudo-patients’ participant observations. Reports were given of a great deal of inhumane treatment, for instance multiple instances of genuine patients being beaten by staff for the sin of having initiated verbal contact. Rosenhan himself reports having seen a patient being beaten for approaching an attendant and telling him, “I like you”. Patients were frequently woken in the morning with a cheery “Come on, you m---f---s, out of bed!”

According to Rosenhan, the depersonalisation of patients can contribute to the probability that the labels attached to them by psychiatrists would lead to a self-fulfilling prophecy. On entering the hospital, the patients existing identity and individuality is taken away, and replaced with an institutional identity - and their treatment as sub-people intensifies this process. Part of this institutional identity is the label of “insane” and this can gradually infest the persons actual behaviour.

**Evaluation**

- One of the core strengths of Rosenhan’s study is its socio-political impact. The study does an impressive job of demonstrating both the limitations of classification by psychiatrists and the appalling conditions in many psychiatric hospitals. This has stimulated further research, and has lead to many institutions improving their philosophy of care.

- In addition, Rosenhan - like other anti-psychiatrists - challenges many of the assumptions surrounding mental health by implicating a social element. This is a very persuasive argument which raises interesting questions about the nature, causes and treatments of mental problems.

- Methodologically, Rosenhan’s use of Participant Observation meant that the pseudo patients could experience the ward from the patients’ perspective while also maintaining some degree of objectivity - thus yielding extremely valid qualitative data.

- Furthermore, the study was a type of field experiment and thus managed to strike a good balance; being fairly ecologically valid whilst still managing to control many variables such as the pseudo patients' behaviour.

- Rosenhan’s sample can also be credited. He used a range of hospitals, in different States, on both coasts, both old/shabby and new, research-orientated and not, well staffed and poorly staffed, and funded by different bodies. This means that Rosenhan can be fairly certain that his results were the product of flaws in the profession of psychiatry - and not other factors such as lack of finances.

- It is, however, possible to criticise Rosenhan. It could be argued that he was 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?

- Furthermore, the study is now dated; when Rosenhan did his study the psychiatric classification in use was DSM-II. However, since then new classifications have been introduced to address 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)

- It could also be argued that Rosenhan is reductionist in his over-emphasis on situational factors. Many people who suffer from a mental illness might say that mental illness is a very real problem - by implying that all psychological illness is socially constructed, Rosenhan denigrates the suffering of a large number of people

- Furthermore, there are also methodological concerns in the study. Most notably, hospital staff and genuine patients were deceived - and this is, of course, unethical. In his defense, we could argue that Rosenhan did not reveal the names of hospitals or staff and attempted to eliminate any clues which might lead to their identification

- Furthermore, 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.

22. Is Rosenhan right in using the term “reliable” in this context? Explain your answer carefully.

23. Analyse the general patterns in this data.

24. Comment on the differences in treatment of patients between Psychiatrists and Nurses.

25. What might be the effect of this treatment on patients?

26. Which other study has examined the affect of institutional environments on people’s behaviour.

NOTE: The study was recently repeated by a journalist from The Guardian. She found that, although she was unable to get herself committed to an institution, she was able to be diagnosed as schizophrenic and receive medication. I can’t find my copy of this article or remember the name of the author. If you can find it, you will earn the eternal gratitude of Mr Peace.
Test Your Understanding

Stuff that you MUST know

- Why was it a good idea to use twelve different hospitals in this study?
- What criteria were used to diagnose the pseudo-patients as mentally disturbed?
- Once admitted as patients, the pseudo-patients found their normal behaviour was considered abnormal. Describe one such behaviour.
- What ethical considerations are there in this study?
- This study uses Participant Observation. What are some of the problems with using this method in this study?
- What did the second study demonstrate (where Rosenhan claims that pseudo-patients will be sent to various hospitals but in fact none are sent)?
- Identify the independent and dependent variables in the third study. (Pseudo-patients asking questions to doctors and nurses).
- What did the third experiment demonstrate?

Stuff that you SHOULD know

- Why do you think the pseudo-patients were released with the label of 'schizophrenia in remission'?
- Describe a situation where the label 'schizophrenia in remission' might be a disability to the individual.
- Why might the real patients be more sensitive to the pretence of the pseudo-patients than the medical staff on the wards?
- What does Rosenhan mean by 'the stickiness of labels'?
- Doctors prefer to err on the side of caution. Rosenhan argues that they make type 2 errors. What does he mean by this and why do doctors do it?
- What do you think is meant by the term 'diagnostic reliability'?
- One of the conclusions of this study, that was reported in 1973, is that diagnostic accuracy is not high. Do you think such errors in diagnosis would occur today? Give reasons for your answer.
- Suggest two ways in researcher bias may have appeared in this study.

Past Examination Questions

Methodology

- What was abnormal about the self-reports given by the pseudo patients on arrival at the hospital? [2 Marks]
- What is the difference between the self-reports of the pseudo patients and the self-reports of people with schizophrenia? [2 Marks]
- What is the difference between the abnormal symptoms of the pseudo-patients and the symptoms of a person with a psychotic disturbance such as schizophrenia? [2 Marks]
- The study broke a number of ethical guidelines. Outline one way in which the hospital staff were treated unethically [2 Marks]
- If the study had been ethical, suggest what effect this would have on the results [2 Marks]

Results

- Most of the pseudo-patients were admitted to hospital with the incorrect diagnosis of "schizophrenia". Give two possible explanations why the hospital made these mistakes [4 Marks]
- Give one example of how the hospital interpreted the behaviour of the pseudo-patients [2 Marks]
- How did the real patients interpret the behaviours of the pseudo-patients? [2 Marks]
- Give two features of life on the ward that were recorded by the pseudo patients and, for each feature, briefly outline what they observed [4 Marks]
- The study describes how a hospital rated all admissions over a three-month period on whether they were pseudo patients. What were the results of this study? [2 Marks]
- What conclusions can we draw about psychiatric diagnosis from this study? [2 Marks]
- What symptoms of the pseudo patients were regarded as abnormal? [2 Marks]
- What does Rosenhan mean when he writes about "the stickiness of psychodiagnostic labels"? [2 Marks]
- Give one example of how the label "schizophrenia" affected how hospital staff interpreted the pseudo-patients' behaviour. [2 Marks]
- Give two examples of the powerlessness and depersonalisation experienced by the pseudo-patients. [2 Marks]
- Outline one possible explanation for the behaviour of staff in this study [2 Marks]
- Give one example of how the pseudo-patients' requests for information were dealt with by the staff. [2 Marks]
- Identify the effects that this had on the pseudo patients [2 Marks]