

On Being Sane in Insane Places: A Supplemental Report

The author gives the psychiatric institution a favorable review after spending 19 days as a pseudopatient in the psychiatric ward of a large public hospital. He recommends stressing the positive aspects of existing institutions in future research.

Rosenhan (1973) reported controversial data for eight pseudopatients who deliberately feigned symptoms of psychosis and were admitted to a total of 12 psychiatric institutions. In no case was their simulation detected, despite the fact that on admission the pseudopatients made no attempt to present abnormal symptoms.

This study has, understandably, received widespread attention and has caused consternation in professional circles. Rosenhan concluded that "sanity" and "insanity" cannot be distinguished within the context of the psychiatric hospital. He went on to argue that psychiatric labeling is in itself a pernicious process and should be avoided. He also devoted considerable attention to a subjective description of the institutions studied, a description that tended to be overwhelmingly negative.

Rosenhan pointed to the typical emphasis on maintenance (often through indiscriminate use of drugs) rather

than cure. He presented data to document what he saw as a prevailing pattern of depersonalization of patients. Specifically, he noted that in four hospitals deliberate approaches of pseudopatients to staff were overwhelmingly ignored. He also noted that in the case of six pseudopatients average daily contact with doctoral staff was only 6.8 minutes.

Not surprisingly, the Rosenhan study has been subjected to extensive criticism. Among the grounds for criticism are the allegedly limited data base of the study, the contention that psychiatric institutions could not reasonably be expected to diagnose "researching," and the argument that the behavior of the pseudopatients was not in fact normal.

The Present Investigation

I was the ninth pseudopatient in the Rosenhan study, and my data were not included in the original report. I presented myself for admission to the psychiatric ward of a large public hospital. I complained of hearing voices that said "empty," "thud," and "hollow." I was admitted to an inpatient bed fol-

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lowing a 45-minute psychiatric interview and remained in the hospital for a period of 19 days.

The Physical Environment

Hospital facilities were excellent. Patients were assigned to rooms generally containing either two or four beds. The dayroom was quite large, was attractive, and well lighted; it contained a color television set, and one entire wall was lined with books and magazines. There was also a separate game room equipped with a pool table and a Ping-Pong table as well as with numerous puzzles and board games. The ward, which was never entirely filled during my stay, had a capacity of 18 beds. Both male and female patients were admitted.

At no time was the ward locked, neither staff nor patients wore uniforms, and the staff-patient ratio was virtually 1:1. There were two full-time psychiatrists assigned to the ward, as well as a clinical psychologist, a social worker, a psychiatric technician, and an "assistant social psychologist." There were also seven full-time psychiatric nurses and a head nurse.

Therapy

Therapy tended to take a nondirective milieu-type approach in which both staff and patients took an active role. In

contrast to the Rosenhan figure of 6.8 minutes, average daily contact with doctoral staff was well over 1 hour. This included 45-minute group therapy sessions 4 days a week, attended by both psychiatrists and nurses. For purposes of these sessions, patients were split into two small groups, each of which was led by a psychiatrist. Contact with doctoral staff also took place twice a week in 60-minute community sessions attended by all patients and staff. Additional contact occurred twice weekly, in 60-minute psychodrama sessions.

Patients also attended Saturday morning community meetings led by nurses. Finally, patients were responsible for organizing staff-escorted outings once a week.

Special provisions were made for patients who were felt to be more severely disturbed. Thus one patient who was a clear suicide risk (he had on one occasion slashed both wrists and had jumped out a fourth floor window on another) was constantly kept in sight by staff. He had his own private bed. In addition to regular group therapy, he was seen for individual therapy sessions.

My Role as a Pseudopatient

I initially sought contact with both patients and staff on an individual basis. The limited number of patients made it possible for me to have fairly extensive

contact with all of them. I sought to discover both staff and patient perceptions of my "illness" and to maximize my interaction with both groups. I was particularly interested in examining patient responses to me as a fellow patient free of the staff-patient barrier, as well as in examining the staff-patient barrier itself.

I also attempted to assess the limits of my situation by repeatedly initiating conversations with staff and by making specific suggestions in group therapy sessions, including recommended changes in ward policy. I took extensive notes of my experiences throughout my hospital stay.

The Experience of Psychiatric Hospitalization

Following my admitting interview, I was given a tour of the ward. Hospital policy, including the lifting of ward restriction and the granting of passes, was carefully explained. I was also informed about group therapy sessions and other organized activities.

I received a basic physical examination in a private room, and at that time was also given several parables to interpret. The next day, I was given blood tests and a chest X ray. Within one week of my admission, I had also undergone an electroencephalogram as well as a number of psychological tests, including the Rorschach, the Minnesota Multiphasic Personality Inventory, the Bender-Gestalt, the Human Figures Test, and the Wechsler Adult Intelligence Scale Vocabulary scale.

I participated fully in both group therapy sessions and ward activities. During my 19 days in the hospital, I asked for and received successively a

lifting of ward restriction, daytime passes to leave the hospital grounds, and a weekend pass. Following the weekend pass, I was released from the hospital.

Contact with Staff

My contact, as well as that of the other patients, tended to be much more with nurses and other subdoctoral staff than with psychiatrists. There was an interesting dichotomy with nurses freely available and on a first-name basis, whereas psychiatrists were not. Nurses typically spent several hours a day playing cards or watching television with patients. Psychiatrists, aside from therapy sessions, largely confined themselves to their offices.

Staff showed little tendency to isolate themselves in the nurses' station. Furthermore, the nurses' station was itself usually open to patients.

There were clear differences between staff members, however, in their interactions with patients. Some nurses were far more talkative and more likely to initiate conversations than were others. During my own stay, I engaged in several continuous conversations with staff of more than 1 hour each. At no time was I (or to my knowledge were any of the other patients) ignored by staff.

Patients were strongly encouraged to participate in therapy sessions, and their comments generally received thoughtful attention. However, staff-patient distance seemed greater in the somewhat structured atmosphere of group therapy than it usually did on the ward.

My interaction with psychiatrists was limited almost exclusively to group therapy sessions. The only other con-

tacts came at the admitting interview and at a 10-minute release interview.

Contact with Patients

My contact with patients tended to be very close and emotionally rewarding. I came to know the majority of patients on a friendship basis. Patients sometimes took me into their confidence, as in the case of one person who revealed an earlier "suicide attempt" that was unknown to staff. Interactions with patients included games of cards and pool, trips to the canteen, and lengthy conversations.

Patients appeared to regard me as a leader. In group meetings if I voted for or against a pass request, the majority of patients were likely to follow suit. On one particularly frustrating occasion when I was denied an overnight pass, the majority of patients supported my request despite unanimous opposition from staff.

I succeeded in large measure in organizing group activities after having first established individual friendships. Thus I encouraged a number of patients to take part in informal folk-singing sessions. I was also given the assignment of organizing the weekly outings and was able to induce most patients to take an active part.

I was repeatedly impressed by the insight and concern for others demonstrated by patients. Despite their own problems, they were in many cases capable of close friendships. Their comments in group therapy sessions were usually both constructive and thoughtful. Patients became extremely upset, for example, when a girl turned her chair away from the group during a therapy session. They gently and per-

suasively attempted to convince her that she should participate, that she was not the only one in trouble, and that the function of therapy was to enable her to come to grips with the problems that had caused her to be institutionalized. On another occasion, a woman who professed a belief that she had "been damned by God" threatened suicide. Patients became angry with her, insisted that she should have hope, and quoted to her passages of the Bible to the effect that suicide is unacceptable and that God is all forgiving.

My "Illness" as Seen by Staff and Patients

I was given the diagnosis of "chronic undifferentiated schizophrenia." At no time did staff suggest that my behavior might be normal. My extensive note-taking was viewed as a withdrawal from personal contact, despite the fact that I spent the preponderance of my time interacting with both patients and staff. My concern for other patients was taken as a defense against dealing with my own problems. According to the nurses' notes, I demonstrated "shallow affect" and tended "to interact with others on a superficial level." I was also seen as intellectualizing and as defending against genuine emotional responsiveness.

One nurse in particular was upset by my failure to confront my "problems." She spent hours questioning me on my need to keep detailed written records, assuming that I was somehow using these to maintain a hold upon reality. She questioned my failure to discuss myself at group meetings and worried about what she saw as a lack of affect in my conversations.

Staff did treat me as an intelligent human being. They discussed with me my alleged plans to pursue graduate education. They were also willing to discuss academic subjects, including psychology, without being condescending. On one occasion, I was even asked to read and interpret the MMPI to another patient.

Staff also listened to my suggestions and allowed me considerable freedom in organizing group activities. On one occasion, I advocated a major change in ward policy concerning voting on pass requests. Traditionally, both staff and patients voted, and any two abstentions meant that a pass was denied. I urged that the policy be changed so that only patients voted, with the proviso that staff could have emergency veto power. Surprisingly, the opposition came from patients, many of whom felt that staff should have sole responsibility for deciding passes. However, the proposal received strong staff support and with that support was unanimously adopted.

Patients also appeared to view me as intelligent but did not assign to me the defenses seen by staff. However, they never suggested that I did not belong in the hospital. One patient explained to someone else that I was there because of a sense of insecurity and a need "to get my head back together." On one occasion, a patient angry at my refusal to vote for a pass request accused me of "having more problems than some of the rest of them." Patients did see me as making considerable progress during my stay in the hospital. Toward the end of my stay, when I brought up the question of my release, I received strong support from patients who argued that I was ready to make it on my own.

Conclusions

My overall impressions of the hospital are overwhelmingly positive. The powerlessness and depersonalization of patients so strongly emphasized by Rosenhan simply did not exist in this setting. On no occasion did I observe the approach of a patient ignored by staff. In contrast to his findings, average daily contact with doctoral staff was more than an hour. Contact with nurses and attendants was even more extensive.

The hospital clearly had a benign atmosphere. The extremely favorable staff-patient ratio, the lack of uniforms, and the absence of locks were major contributors to this. Also important was a placing of patients above routine and a genuine caring on the part of the staff. An illustrative example is the treatment of the wife of a patient who traveled 3,000 miles to be with him. Her visit took precedence over an administration of the MMPI. Although visiting hours officially ended at 8:30, she was repeatedly allowed to stay until after 11. Furthermore, one of the nurses took her into her own home because she had no money and no place to stay.

Although my perspective as a pseudopatient was admittedly limited, the hospital appeared to be serving an effective therapeutic function. The average length of stay was only 1 month. During my 19 days in the hospital, eight or nine patients were either released outright or to halfway houses.

My findings would seem to qualify those of Rosenhan. Although the majority of psychiatric institutions appear to be notably lacking in many

respects, there are exceptions. These exceptions should be noted.

In defense of psychiatric institutions, I would agree with a number of critics in arguing that the behavior of the pseudopatients including my own was not in fact normal and could not reasonably be interpreted as such. The extensive note-taking engaged in by all pseudopatients, for example, appears inappropriate when taken out of context. In addition, the very act of seeking admission to the institution must be seen as at least suggestive of underlying disturbance.

My conclusions are not entirely favorable, however. In my own case, despite far more intensive contact with staff than was experienced by the other pseudopatients, my behaviors were consistently viewed as being abnormal. The issue is not that staff failed to overtly detect my simulation, but rather that they actively misinterpreted behaviors that would be viewed as normal in a different context. Thus virtually all of my interactions with both patients and staff, as well as my note taking, were interpreted in the light of the admitting diagnosis.

Psychiatric institutionalization can provide a tremendous learning experience. Debra and a fellow patient in *I Never Promised You a Rose Garden* (Green, 1971) speculate on what it would be like to have staff spend time as patients in their own institutions. Clearly, this could be immensely useful in making professionals more aware of their own subtle biases and in providing insight as to what it is like to be a mental patient. Furthermore, it would allow interactions with patients without the encumbrance of the extensive

staff-patient barriers so cogently described by Goffman (1961). Freedom from such barriers proved to be a tremendous asset in my own contacts with patients.

However, I am not ready to recommend the deliberate feigning of psychosis. Such an act raises serious ethical issues. It is possible that pseudopatient status could minimize distance from patients, but it is likely that invasions of privacy would ensue. Admittedly, the Rosenhan (1973) study has generated a great deal of vitally needed critical discussion and re-examination of psychiatric institutions. Despite this, the legitimacy of nondisturbed people placing themselves in already overcrowded and understaffed institutions must be subject to question.

The present study appears to have a number of implications. Additional evidence was gained concerning the potential harm of psychiatric labeling in leading to misattributions of behavior. More important, however, the study demonstrates that the experience of psychiatric hospitalization is not always one of neglect, abuse, and depersonalization. Future research should focus on the positive aspects of such institutions as the one described herein and perhaps use these as models in upgrading the quality of psychiatric care in this country.

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