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Psychiatric Hospitals: On Being Sane In 'Insane Places"

If Sanity and Insanity Exist, How Shall We Know Them?

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In 1973, D. L. Rosenhan published a ground-breaking psychiatric study in January 19 issue of Science magazine. The article exposed a serious short-coming in the psychiatric hospitals at the time, and therefore it became very controversial. Dr. Rosenhan, a professor of psychology and law at Stanford University, designed the study to try to answer the title question: ***"If sanity and insanity exist, how shall we know them?"***

The now famous (some offended or embarrassed psychiatrists preferred to call it "infamous") experiment that was carried out involved 12 different psychiatric hospitals and 8 different people, mostly professionals (including the author). Each of the eight were totally and certifiably sane "pseudo-patients".

Each one secretly gained admission to one or two different mental hospitals by falsely complaining to a psychiatrist that they had been hearing voices over the past few weeks. The "voices" in each case were saying only the three words "empty," "hollow," and "thud." No visual hallucinations or other psychological abnormalities were relayed to the examining psychiatrist. Except for the fake "chief complaint", the intake histories relayed by the patients were entirely truthful. Each "patient" was immediately admitted, much to the surprise of most of the pseudo-patients.

All but one of the admitted "patients" were given a diagnosis of "schizophrenia". The other one was labeled "manic-depressive". When they were discharged, the eleven had discharge diagnoses of "schizophrenia, in remission," despite the fact that absolutely no psychotic or manic behaviors had been observed during their stays.

After admission, each pseudo-patient acted totally sane, each emphasizing that the voices had disappeared. When given the chance, each also asked about when they could be discharged. Those questions were largely ignored by staff.

Despite the fact that each one acted totally normally throughout, their hospital stays averaged 19 days, ranging from 7 to 52 days.

The pseudo-patients engaged in all the normal ward activities except for the fact that they never swallowed the variety of antipsychotic pills that had been prescribed for them. The

only obvious difference between the behaviors of the experimental group and the regular patients was that each of them took notes during their hospitalizations. On several occasions, a staff member wrote in the patient's chart: "the patient engages in note-taking behavior". Otherwise none of the staff seemed interested in any of the patient's behaviors.

Although the pseudo-patients planned to secretly smuggle out their daily notes, they eventually stopped trying to hide the fact that they were recording their impressions of their stays, and they soon stopped the smuggling operations – with no consequences.

The average daily contact with the therapeutic staff was only 6.8 minutes per day (mean 3.9 – 25.1 minutes) and that included admissions interviews, ward meetings, group and individual psychotherapy contacts, case conferences and discharge meetings.

The group observed that attendants only came outside the "cage" 11.5 times per 8-hour shift but usually only interacted minimally with the patients when doing so. The staff psychiatrists rarely interacted meaningfully with any patient. If any interaction occurred, it was usually rather patronizing.

None of the professional therapeutic staff ever suspected that any of the 12 were pseudo-patients, whereas many of the "real" patients knew for certain that they were faking. These patients (who were probably actually taking their meds) often said things like: "You're not crazy. You're a journalist or a professor. You're checking up on the hospital." The staff never tumbled to the subterfuge. The only people who recognized normality were those who themselves had been labeled "insane".

Upon the publication of the Rosenhan paper, there arose an enormous uproar from the psychiatric community about the "ethics" of performing such a study. Rosenhan was attacked viciously by those who had been fooled or had themselves hastily jumped to erroneous psychiatric diagnoses in the past.

Because of the controversy, Rosenhan announced that there was to be done a follow-up study in a certain research and teaching hospital whose staff had heard about the first study but doubted that such errors could occur in their own hospital. The staff was led to believe that sometime in the next 3 months there would be one or more pseudo-patients attempting to be admitted. However, by design, no pseudo-patients actually attempted admission.

Among the total of 193 patients that were admitted for psychiatric treatment during the 3-month period, 41 genuine patients (20 % of the total) were suspected, with high confidence, of being pseudo-patients by at least one member of the staff. 23 of the 41 were suspected of being fake patients by a psychiatrist, and 19 were suspected by both a psychiatrist and one other staff member. On the bright side, their heightened vigilance saved 41 normal people from receiving a diagnosis of permanent mental illness and the prescribing of brain-altering drugs.

Among the conclusions the reader can draw from these two experiments are these important and quite logical ones:

1) **The sane are not "sane" all of the time, nor are those labeled "insane" actually insane all of the time.** Definitions of sanity or insanity therefore may often be erroneous.

2) Sanity and insanity have cultural variations. What is viewed as normal in one

culture may be seen as quite aberrant in another. As just one example, there was a famous experiment contrasting American and British psychiatrists and each country's diagnostic differences. The two groups studied identical video-taped interviews of a group of psychiatric patients. In that series of cases, schizophrenia was diagnosed far more often by American psychiatrists than for the British psychiatrists (by a factor of 10, as I recall the article).

3) Bizarre behaviors in people constitute only a small fraction of total behavior. Similarly, violent, even homicidal people are nonviolent most of the time.

4) Psychiatric diagnoses, even those made in error, carry with them personal, legal and social stigmas that can be impossible to shake and which often last a lifetime.

It is a known fact that hallucinations can occur in up to 10% of normal people. Vivid flashbacks in patients with PTSD (posttraumatic stress disorder) have, in the past, been commonly and tragically misdiagnosed as "hallucinations" and therefore that unfortunate patient can be permanently labeled (and then drugged) as a permanent "paranoid schizophrenic" rather than as a patient with PTSD having temporary "flashbacks" (a common error in pre-1990s VA hospitals in combat-traumatized war veterans).

Hallucinations can normally occur during certain phases of sleep, half-waking states, sleep deprivation, or from drug effects – either because of neurotoxic/psychotoxic effects from brain-altering, psycho-stimulating prescription (or illicit) drugs or from withdrawal from sedating antipsychotic drugs. It is not uncommon for Ritalin, cocaine, Adderall or speed to cause (drug-induced) psychotic episodes.

It is well known that drug-induced mania (and thus a false diagnosis of bipolar disorder "of unknown etiology") can occur from even standard doses of most psycho-stimulating antidepressant drugs, especially the SSRIs ("selective" serotonin reuptake inhibitors) or during withdrawal from "minor" tranquilizer drugs such as the Valium-type benzodiazepines or "major tranquilizers" such as antipsychotic drugs like Thorazine, Haldol, Risperdal, Zyprexa, Abilify, Seroquel, Geodon, etc.

One well-done showed that a significant percentage of patients admitted from one psychiatric hospital emergency room were ultimately discharged with a diagnosis SSRI drug-induced mania and not "bipolar disorder of unknown etiology". The cause of those ER visits was not a mental disorder but rather a drug-induced neurological disorder that was self-limited and best treated by stopping the offending drug.

Rosenhan rightly points out: "How many people…are sane but not recognized as such in our psychiatric institutions? How many have been needlessly stripped of their privileges of citizenship, from the right to vote and drive or of handling their own accounts? How many have feigned insanity in order to avoid the consequences of their behavior and, conversely, how many would rather stand trial for a crime than live interminable in a psychiatric hospital because they were wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned, but nevertheless erroneous, diagnoses?" (Ed note: recall the end result of Jack Nicholson's character in "One Flew Over the Cuckoo's Nest"),

To those concerns, I would add, how many patients have suffered the brain-disabling and neurotoxic and neurodegenerative consequences of dangerous, dependency-inducing, and

very powerful psychiatric drugs, that if used long enough can easily produce dementia as well as deadly withdrawal effects when stopped?

Rosenhan's study has significant implications for our society today, and perhaps more so, for in 1973 there was only Elavil, Stelazine, Compazine, Thorazine and a few other psychiatric drugs to be concerned about. Eventually these drugs were discovered to be brain-damaging substances, and we can now justifiably say of them: "good riddance".

However, today there are scores and scores of "second and third generation", "novel" or "atypical" drugs that were never tested for long-term safety or efficacy before they were granted marketing approval by the FDA. Many of them are commonly used in hugely expensive cocktail combinations which likewise were never tested for long-term safety or efficacy in the animal lab, much less thoroughly tested in human studies.

All of these psychiatric drugs are bio-accumulative substances that are known to be hazardous to the planetary and human environments (essentially HazMat substances). They need to be handled with extreme care – unless, apparently, they are prescribed by a licensed healthcare worker for indefinite periods of time and to be swallowed by obedient patients with unknown liver detoxification capabilities who might be taking other prescription drugs with unknown drug-drug interactions. The irony of that reality should give us all pause.

Below are some choice quotes from Rosenhan's original article which was titled "On Being Sane In Insane Places". (Sciencemagazine 1973, Vol. 179 p. 250 – 258)

> "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.
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> "Psychological suffering exists…but do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them? …Psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him.
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> "The view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst.
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> "Despite their public 'show' of sanity, the pseudopatients were never detected, and each was discharged with a diagnosis of schizophrenia 'in remission.'
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> "Once labeled schizophrenic, the pseudo-patient was stuck with that label. If the pseudo-patient 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.
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> "It was quite common for fellow patients to 'detect' the pseudo-patient's sanity. The fact that the patients often recognized normality when staff did not raises important questions.
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> "Physicians are more inclined to call a healthy person sick (a false positive) than a sick person healthy (a false negative). The reasons for this are not hard to find: it is clearly more dangerous to misdiagnose illness than health. Better to err on the side of caution, to suspect illness even among the healthy.
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> "'Patient engaged in writing behavior' was the daily nursing comment on one

of the pseudo-patients who was never questioned about his writing. Given that the patient is in the hospital, he must be psychologically disturbed. And given that he is disturbed, continuous writing must be a behavioral manifestation of that disturbance, perhaps a subset of the compulsive behaviors that are sometimes correlated with schizophrenia.

"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.

"Often enough, a patient would go 'berserk' because he had, wittingly or unwittingly, been mistreated by, say, an attendant.

"Never were the staff found to assume that one of themselves or the structure of the hospital had anything to do with a patient's behavior.

"A psychiatric label has a life and an influence of its own. Such labels, conferred by mental health professionals, 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 himself accepts the diagnosis, with all of its surplus meanings and expectations and behaves accordingly.

"There is enormous overlap in the behaviors of the sane and the insane. The sane are not 'sane' all of the time. Similarly, the insane are not always insane. It makes no sense to label (anyone as) permanently depressed on the basis of an occasional depression…

"I may hallucinate because I am sleeping, or I may hallucinate because I have ingested a peculiar drug. These are termed sleep-induced hallucinations (or dreams) and drug-induced hallucinations, respectively. But when the stimuli to my hallucinations are unknown, that is called craziness, or schizophrenia.

"The average amount of time spent by attendants outside of the cage was 11.3 percent (range, 3 to 52 percent). It was the relatively rare attendant who spent time talking with patients…

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

"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.

"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.

"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.

"Finally, how many patients might be 'sane' outside the psychiatric hospital but seem insane in it…

"It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals."

***Dr. Kohls** practiced holistic mental health care until his retirement a few years ago. Most of the patients that came asking for his help exhibited a variety of drug-induced, brain-altering, neurological and physical disabilities as well as drug dependencies from the multitude of drugs they had been taking. A number of his columns concerning mental ill health and the dangers of psychiatric drugs can be found at http://duluthreader.com/-articles/categories/200_Duty_to_Warn.*

Dr. Kohls reminds people that they should not try to stop their prescription psychotropic drugs without the help of a physician knowledgeable about basic brain neuroscience, brain nutrition and the intricacies of drug withdrawal syndromes.
