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On Being Sane in Insane Places: “If Sanity and Insanity Exist, How Shall We Know Them?”

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

The now famous (some of the 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 individual was immediately admitted to the target psychiatric hospital, 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, the pseudo-patients all acted totally sane, each emphasizing to the hospital staff member 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, hospital stays averaged 19 days, ranging from 7 to 52 days.

The 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 averaged only 6.8 minutes per day (mean 3.9 – 25.1 minutes) and that included the admission interviews, ward meetings, group and individual psychotherapy contacts, case conferences and discharge meetings.

The group observed that attendants only came outside the locked "cage" 11.5 times per 8-hour shift but usually the staff 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 actual patients knew for certain that they were faking. These patients (who were probably actually swallowing their medications) often said things like: "You're not crazy. You're a journalist or a professor. You're checking up on the hospital." The therapeutic 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 jumped to erroneous psychiatric diagnoses in the past.

Because of the controversy, Rosenhan announced that a follow-up study would be done in a certain research and teaching hospital whose staff had heard about the first stu 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

Therefore, definitions of sanity or insanity 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, American psychiatrists diagnosed "schizophrenia" far more often than did British psychiatrists.

3] Bizarre behaviors in people constitute only a small fraction of total behavior

For example, 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 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". Therefore, those unfortunate patients can be permanently labeled (and then permanently over-drugged) as a chronic "schizophrenic of undetermined etiology rather than as an otherwise normal patient with a history of psychological trauma that was having temporary "flashbacks". (Note that combat-traumatized war veterans prior to the 1990s were often mis-diagnosed – and therefore mis-treated – as schizophrenics.).

Hallucinations can normally occur during certain phases of sleep, half-waking states, sleep deprivation, or from drug effects – either because of neurotoxic or psychotoxic effects from brain-altering, psycho-stimulating prescription (or illicit) drugs or from withdrawal from sedating antipsychotic drugs. It is not uncommon for Novartis's *Ritalin*; cocaine; Shire's *Adderall*; speed; or Eli Lilly's *Prozac*; Pfizer's *Zoloft*; Sandoz/Novartis's *Paxil*; Forest Lab's*Lexapro*; Solvay/Abbott's *Luvox*; to cause (drug-induced) psychotic episodes.

It is also 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). But mania can also occur during withdrawal from "minor" tranquilizer drugs (such as the Valium-type benzodiazepines) or "major" tranquilizers (such as antipsychotics like Pfizer's*Geodon*; Smith Kline & French's (GSK) *Thorazin*e; Janssen's (& Johnson) *Haldol*; Janssen/J & J) *Risperdal*;Eli Lilly's *Zyprexa*; Bristol-Myers Squibb's (GSK) *Abilify*; AstraZeneca's *Seroquel*; Sandoz's (Novartis) *Clozaril*; etc.)

One well-done study showed that a significant percentage of patients admitted from one psychiatric hospital emergency room was ultimately discharged with a diagnosis SSRI-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 or tapering-down the offending drug.

Rosenhan rightly points out, reminding readers of Jack Nicholson's and the Chief's characters in "One Flew Over the Cuckoo's Nest":

> "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?"

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 the dosages are cut down or stopped?

Rosenhan's study has far more implications for our society today than in 1973. Back then there was only small numbers of relatively untested psychiatric drugs to be concerned about compared to the hundreds of even more toxic drugs that are being given to more and more people. Both the old "obsolete" drugs and the "modern", over-hyped drugs in the current psychiatrist's armamentaria have been discovered to be brain-damaging and often addictive.

However, today there are scores and scores of what the psychiatric and pharmaceutical industries euphemistically call "second and third generation", "novel" or "atypical" psychostimulants, anti-depressants or anti-psychotics (see lists above) 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 have never been tested for long-term OR short-term safety in the animal labs, much less thoroughly tested in human long-term clinical trials.

All of these psychiatric drugs enter the blood stream and then go everywhere the blood goes, including liver, kidneys, heart, brain, etc. Psych drugs are bio-accumulative substances that are considered hazardous materials by professional waste management crews at manufacturing sites. Such chemicals need to be handled with extreme care – unless, of course, they are prescribed by unaware physicians or nurse practitioners for lifetime use by poorly-informed, obedient patients who may not have adequate liver detoxification capabilities and who might also be taking other prescription drugs with unknown drug-drug interactions. The irony of that reality should give us all pause.

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Choice quotes from Rosenhan's original article entitled "On Being Sane in Insane Places". (Science magazine 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."*

> *"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."*

> *"The view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst."*

"Despite their public 'show' of sanity, the pseudo-patients were never detected, and each was discharged with a diagnosis of schizophrenia 'in remission.'"

"Once labeled schizophrenic, the pseudo-patients (in the study group) were 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."

"It was quite common for fellow patients to 'detect' the pseudo-patient's sanity. The fact that fellow patients could recognize normality when staff did not raises important questions."

"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."

"'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 they 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 within it..."

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

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Dr Kohls practiced holistic mental health care in Duluth for the last decade of his family practice career, primarily helping psychiatric patients who had become addicted to their cocktails of dangerous, addictive psychiatric drugs to safely go through the complex withdrawal process. His Duty to Warn columns often deal with various unappreciated health issues, including those caused by Big Pharma's over-drugging, Big Vaccine's over-vaccinating, Big Medicine's over-prescribing, over-screening, over-diagnosing and over-treating agendas and Big Food's malnourishing and sickness-promoting food industry.

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