If sanity and insanity exist, how shall we know them? From as early as 1934, Benedict suggested that normality and abnormality are not universal. What is viewed as normal in one culture may be seen as quite aberrant in another. Thus, notions of normality and abnormality may not be quite as accurate as people believe they are. To raise questions regarding normality and abnormality is in no way to question the fact that some behaviors are deviant or odd. Murder is deviant. So, too, are hallucinations. Anxiety and depression exist. Psychological suffering exists. But normality and abnormality, sanity and insanity, and the diagnoses that flow from them may be less substantive than many believe them to be. At its heart, 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 belief has been strong that patients present symptoms, that those symptoms can be categorized, and, implicitly, that the sane are distinguishable from the insane. More recently, however, this belief has been questioned. The view has grown that psychological categorization of mental illness is useless at best and downright harmful, misleading, and pejorative at worst. Psychiatric diagnoses, in this view, are in the minds of the observers and are not valid summaries of characteristics displayed by the observed.

Gains can be made in deciding which of these is more nearly accurate by getting normal people (that is, people who do not have, and have never suffered, symptoms of serious psychiatric disorders) admitted to psychiatric hospitals and then determining whether they were discovered to be sane and, if so, how. If the sanity of such pseudopatients were always detected, there would be evidence that a sane individual can be distinguished from the insane context in which he is found. If, on the other hand, the sanity of the pseudopatients were never discovered, serious difficulties would arise for those who support traditional modes of psychiatric diagnosis. Given that the hospital staff was not incompetent, that the pseudopatient had been behaving as sanely as he had been outside of the hospital, and that it had never been previously suggested that he belonged in a psychiatric hospital, such an unlikely outcome would support the view that psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him. This article describes such an experiment. Eight sane people gained secret admission to 12 different hospitals. Their diagnostic experiences constitute the data of the first part of this article; the remainder is devoted to a description of their experiences in psychiatric institutions.

**PSEUDOPATIENTS AND THEIR SETTINGS**

The eight pseudopatients were a varied group. One was a psychology graduate student in his 20's. The remaining seven were older and “established.” Among them were three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife. Three pseudopatients were women, five were men. All of them employed pseudonyms, lest their alleged diagnoses embarrass them later. Those who were in mental health professions alleged another occupation in order to avoid the special attentions that might be accorded by staff, as a matter of courtesy or caution, to ailing colleagues. With the exception of myself (I was the first pseudopatient and my presence was known to the hospital administrator and chief psychologist and, so far as I can tell, them alone), the presence of pseudopatients and the nature of the research program was not known to hospital staffs. The settings were similarly varied. In order to generalize the findings, admission into a variety of hospitals was sought. The 12 hospitals in the sample were located in five different states on the East and West coasts. Some were old and shabby, some were quite new. Some were research-oriented, others not. Some had good staff-patient ratios, others were quite understaffed. Only one was a strictly private hospital. All of the others were supported by state or federal funds or, in one instance, by university funds. After calling the hospital for an appointment, the pseudopatient arrived at the admissions office complaining that he had been hearing voices. Asked what the voices said, he replied that they were often unclear, but as far as he could tell they said "empty," "hollow," and "thud." The voices were unfamiliar and were of the same sex as the pseudopatient.

Beyond alleging the symptoms and falsifying name, vocation, and employment, no further alterations of persons' history, or circumstances, were made. The significant events of the pseudopatient's life history were presented as they had actually occurred. Relationships with parents and siblings, with spouse and children, with people at work and in school, consistent with the aforementioned exceptions, were described as they were or had been. Frustrations and upsets were described along with joys and satisfactions. These facts are important to remember. If anything, they strongly biased the subsequent results in favor of detecting sanity, since none of their histories or current behaviors were seriously pathological in any way. Immediately upon admission to the psychiatric ward, the pseudopatient ceased simulating any symptoms of abnormality. In some cases, there was a brief period of mild nervousness and anxiety, since none of the pseudopatients really believed that they would be admitted so easily. Indeed, their shared fear was that they would be immediately exposed as frauds and greatly embarrassed. Moreover, many of them had never visited a psychiatric ward; even those who had, nevertheless had some genuine fears about what might happen to them. Their nervousness, then, was quite appropriate to the novelty of the hospital setting, and it abated rapidly.

Apart from that short-lived nervousness, the pseudopatient behaved on the ward as he "normally" behaved. The pseudopatient spoke to patients and staff as he might ordinarily. Because there is uncommonly little to do on a psychiatric ward, he attempted to engage others in conversation. When asked by staff how he was feeling, he indicated that he was fine, that he no longer experienced symptoms. He responded to instructions from attendants, to calls for medication (which was not swallowed), and to dining-hall instructions. Beyond such activities as were available to him on the admissions ward, he spent his time writing down his observations about the ward, its patients, and the staff. Initially these notes were written "secretly," but as it soon became clear that no one much cared, they were subsequently written on standard tablets of paper in such public places as the dayroom. No secret was made of these activities. The pseudopatient, very much as a true psychiatric patient, entered a hospital with no foreknowledge of when he would be discharged. Each was told that he would have to get out by his own devices, essentially by convincing the staff that he was sane. The psychological stresses associated with hospitalization were considerable, and all but one of the pseudopatients desired to be discharged almost immediately after being admitted. They were, therefore, motivated not only to behave sanely, but to be paragons of cooperation. That their behavior was in no way disruptive is confirmed by nursing reports which have been obtained on most of the patients. These reports uniformly indicate that the patients were "friendly," "cooperative," and "exhibited no abnormal indications."

**THE NORMAL ARE NOT DETECTABLY SANE**

In spite their public "show" of sanity, the pseudopatients were never detected. Admitted, except in one case, with a diagnosis of schizophrenia, each was discharged with a diagnosis of schizophrenia "in remission." The in remission should in no way be dismissed as a formality, for at no time during any hospitalization had any question been raised about any pseudopatient's simulation. Nor are there any indications in the hospital records that the pseudopatient's status was
suspect. Rather, the evidence is strong that, once labeled schizophrenic, the pseudopatient was stuck with that label. If the pseudopatient was to be discharged, he must naturally be "in remission" but be was not sane, nor, in the institution's view, had he ever been sane. The uniform failure to recognize sanity cannot be attributed to the quality of the hospitals. Nor can it be alleged that there was simply not enough time to observe the pseudopatients. Length of hospitalization ranged from 7 to 52 days, with an average of 19 days. The pseudopatients were not, in fact, carefully observed, but this failure clearly speaks more to traditions within psychiatric hospitals than to lack of opportunity. Finally, it cannot be said that the failure to recognize the pseudopatients' sanity was due to the fact that they were not behaving sanely. While there was clearly some tension present in all of them, their daily visitors could detect no serious behavioral consequences - nor, indeed, could other patients. It was quite common for the patients to "detect" the pseudopatients' sanity. "You're not crazy. You're a journalist, or a professor [referring to the continual note-taking]. You're checking up on the hospital." While most of the patients were reassured by the pseudopatient's insistence that he had been sick before he came in but was fine now, some continued to believe that the pseudopatient was sane throughout his hospitalization.

The fact that the patients often recognized normality when staff did not raises important questions. Failure to detect sanity during the course of hospitalization may be due to the fact that . . . physicians are more inclined to call a healthy person sick than a sick person healthy. The reasons for this are not hard to find: it is clearly more dangerous to mis-diagnose illness than health. Better to err on the side of caution--to suspect illness even among the healthy. But what holds for medicine does not hold equally well for psychiatry. Medical illnesses, while unfortunate, are not commonly pejorative. Psychiatric diagnoses, on the contrary, carry with them personal, legal, and social stigmas. It was therefore important to see whether the tendency toward diagnosing the sane insane could be reversed.

Powerlessness and Depersonalization Eye contact and verbal contact reflect concern and individuation; their absence, avoidance and depersonalization. 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. The patient is deprived of many of his legal rights by design of his psychiatric commitment. His freedom of movement is restricted. He cannot initiate contact with the staff but may only respond to any overtures as they make. Indeed, privacy is minimal. Patients' quarters and possessions can be entered and examined by any staff member, for whatever reason. The toilet may have no door. At times, depersonalization reaches such proportions that pseudopatients had the sense that they were invisible, or at least unworthy of account. One illuminating instance of depersonalization and invisibility occurred with regard to medications. All told, the pseudopatients were given nearly 2100 pills. Only two were swallowed. As long as they were cooperative, their behavior and the pseudopatients' own in this matter, as in other important matters, went unnoticed throughout. Reactions to such depersonalization among pseudopatients were intense. Although they had come to the hospital as participant observers and were fully aware that they did not "belong," they nevertheless found themselves caught up in and fighting the process of depersonalization.

The consequences of labeling and depersonalization 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 and available for discharge. But the label endured beyond discharge, with the unconfirmed expectation that he will behave as a schizophrenic again. 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. Goffman calls the process of socialization to such institutions "mortification"--an apt metaphor that includes the processes of depersonalization that have been described here. And while it is impossible to know whether the pseudopatients' responses to these processes are characteristic of all inmates-they were, after all, not real patents--is difficult to believe that these processes of socialization to a psychiatric hospital provide useful attitudes or habits of response for living in the "real world."

The Rosenhan experiment was a famous experiment into the validity of psychiatric diagnosis conducted by David Rosenhan in 1972. It was published in the journal Science under the title "On being sane in insane places." "It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals." Impact: Rosenhan published his findings in Science, criticising the validity of psychiatric diagnosis and the disempowering and demeaning nature of patient care experienced by the associates in the study. His article generated an explosion of controversy. Many defended psychiatry, arguing that psychiatric diagnosis must rely heavily on the patient's own report of their experiences. Hence, mis-diagnosis in the presence of fake symptoms no more demonstrates problems with psychiatric diagnosis than would lying about other medical symptoms.

For a Hollywood version of this phenomenon, rent "One Flew Over the Cuckoo’s Nest" (1975 - 3 years after Rosenhan’s experiment)