

## Psychiatric medical directive

### Description

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“It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals. the hospital itself imposes a special environment in which the meanings of behavior can easily be misunderstood. the consequences to patients hospitalized in such an environment-the powerlessness, depersonalization, segregation, mortification, and self-labeling-seem undoubtedly countertherapeutic. i do not, even now, understand this problem well enough to perceive solutions. but two matters seem to have some promise. the first concerns the proliferation of community mental health facilities, of crisis intervention centers, of the human potential movement, and of behavior therapies that, for all of their own problems, tend to avoid psychiatric labels, to focus on specific problems and behaviors, and to retain the individual in a relatively non-pejorative environment. clearly, to the extent that we refrain from sending the distressed to insane places, our impressions of them are less likely to be distorted. (the risk of distorted perceptions, it seems to me, is always present, since we are much more sensitive to an individual’s behaviors and verbalizations than we are to the subtle contextual stimuli that often promote them. at issue here is a matter of magnitude. and, as i have shown, the magnitude of distortion is exceedingly high in the extreme context that is a psychiatric hospital.) the second matter that might prove promising speaks to the need to increase the sensitivity of mental health workers and researchers to the catch 22 position of psychiatric patients. simply reading materials in this area will be of help to some such workers and researchers. for others, directly experiencing the impact of psychiatric hospitalization will be of enormous use. clearly, further research into the social psychology of such total institutions will both facilitate treatment and deepen understanding. i and the other pseudopatients in the psychiatric setting had distinctly negative reactions. we do not pretend to describe the subjective experiences of true patients. theirs may be different from ours, particularly with the passage of time and the necessary process of adaptation to one’s environment. but we can and do speak to the relatively more objective indices of treatment within the hospital. it could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. quite the contrary, our overwhelming i...”

It is clear that we cannot distinguish the sane from the insane in psychiatric hospitals. The hospital itself imposes a special environment in which the meanings of behavior can easily be misunderstood. The consequences to patients hospitalized in such an environment-the powerlessness, depersonalization, segregation, mortification, and self-labeling-seem undoubtedly countertherapeutic. I do not, even now, understand this problem well enough

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to perceive solutions. But two matters seem to have some promise. The first concerns the proliferation of community mental health facilities, of crisis intervention centers, of the human potential movement, and of behavior therapies that, for all of their own problems, tend to avoid psychiatric labels, to focus on specific problems and behaviors, and to retain the individual in a relatively non-pejorative environment. Clearly, to the extent that we refrain from sending the distressed to insane places, our impressions of them are less likely to be distorted. (The risk of distorted perceptions, it seems to me, is always present, since we are much more sensitive to an individual's behaviors and verbalizations than we are to the subtle contextual stimuli that often promote them. At issue here is a matter of magnitude. And, as I have shown, the magnitude of distortion is exceedingly high in the extreme context that is a psychiatric hospital.) The second matter that might prove promising speaks to the need to increase the sensitivity of mental health workers and researchers to the Catch 22 position of psychiatric patients. Simply reading materials in this area will be of help to some such workers and researchers. For others, directly experiencing the impact of psychiatric hospitalization will be of enormous use. Clearly, further research into the social psychology of such total institutions will both facilitate treatment and deepen understanding. I and the other pseudopatients in the psychiatric setting had distinctly negative reactions. We do not pretend to describe the subjective experiences of true patients. Theirs may be different from ours, particularly with the passage of time and the necessary process of adaptation to one's environment. But we can and do speak to the relatively more objective indices of treatment within the hospital. It could be a mistake, and a very unfortunate one, to consider that what happened to us derived from malice or stupidity on the part of the staff. Quite the contrary, our overwhelming impression of them was of people who really cared, who were committed and who were uncommonly intelligent. Where they failed, as they sometimes did painfully, it would be more accurate to attribute those failures to the environment in which they, too, found themselves than to personal callousness. Their perceptions and behavior were controlled by the situation, rather than being motivated by a malicious disposition. In a more benign environment, one that was less attached to global diagnosis, their behaviors and judgments might have been more benign and effective.

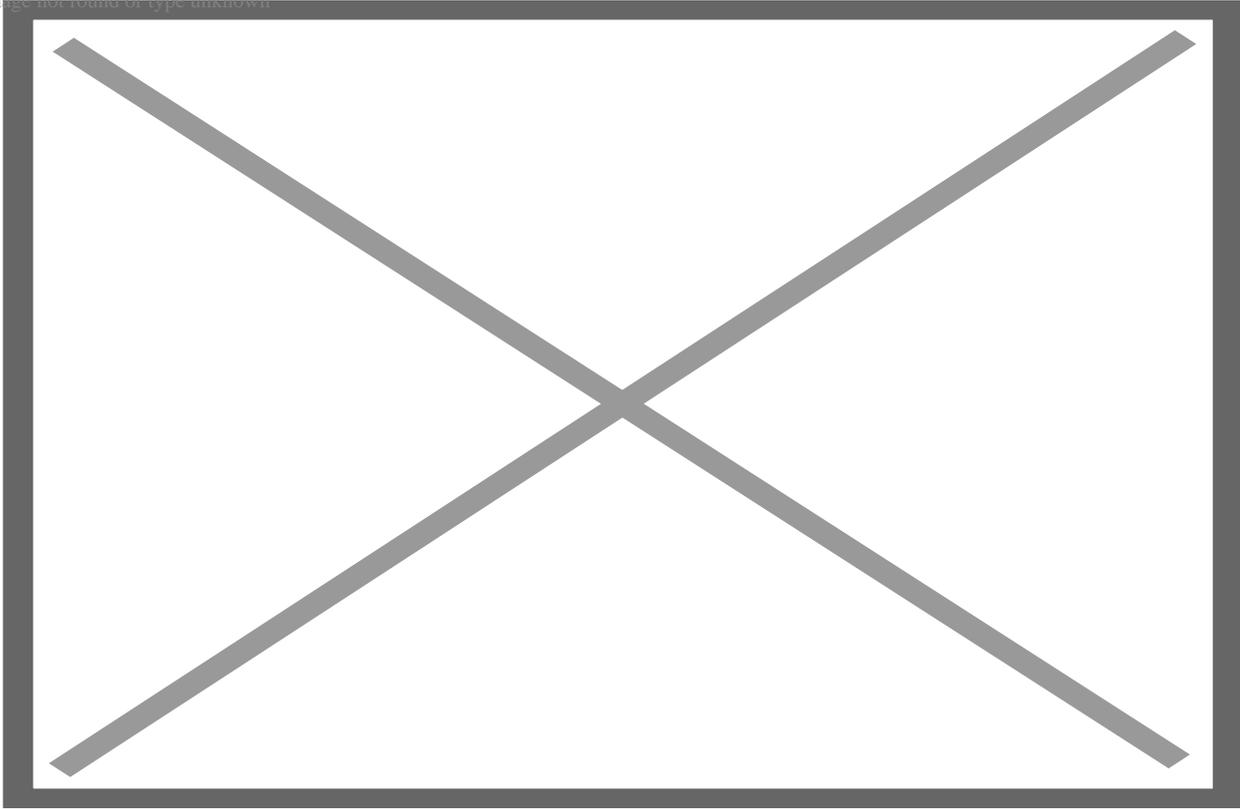
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## Category

1. Psychiatry

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