

## ON BEING SANE IN INSANE PLACES

Katerina Bryant

*\*Content note: this article discusses suicide*

I'VE BEEN THINKING about how my body inhabits place and how it changes – fluctuating between comfort and pain – depending on the state of my illness. While reading Chris Kraus in bed, I'm caught by an obscure reference to a study where people who are not experiencing mental illness are admitted to psychiatric institutions. The idea feels like a transformation I need to seek out, one that unpicks the very conception of mental illness. Could this study answer questions that have been bubbling beneath my skin for months? I spend half an hour searching for it, my body filled with an odd urgency until it is before me: 'On Being Sane in Insane Places', published in 1973. The first line reads: 'If sanity and insanity exist, how shall we know them?' It's a surprise, finding this kind of language in an academic study: I've spent years reading medical journals in search of answers about my own obscure diagnosis, so I'm used to both absolutes and qualifications. But I'm still left with questions: how does place influence our minds? And if sanity and insanity *do* exist, how can we be sane in an insane place?

In 'On Being Sane in Insane Places', psychologist David Rosenhan and seven of his friends and colleagues gained admission into psychiatric institutions across America by saying, falsely, that they had experienced auditory hallucinations. By Rosenhan's instructions, the participants said something along the lines of, 'I am hearing a voice. It is saying *thud!*' The 'pseudopatients', as the study called them, then reported that they felt well, experienced no more hallucinations and behaved in a way that most would consider 'normal'. Nonetheless, each pseudopatient spent an average of nineteen days admitted – the lowest was seven days, the highest fifty-two. Six out of seven were diagnosed with schizophrenia and all agreed to take antipsychotics as a condition of their release.

SOMETIMES I HELP my mother with her work: set up a Twitter account or proof a document. She works as an academic, focused on farmer suicide prevention, and each day, she puts everything into her job. She spends nights and weekends working, even when she is bone tired. One week, I help her write people's stories for a suicide prevention calendar. Each month will feature a farmer who discusses their experience of mental distress and the strategies that have helped them survive. I listen to the audio of their stories as I transcribe them. I notice, afterwards, that when I take my earbuds out, I can still hear them.

Their stories still play in my head.

I READ A piece of my writing at a party. Leaving in the elevator, a man pushes his back onto my front, pressing me to the wall. To feel safe, I have chosen not to take the stairs, where the lights are orange and glow among the shadows. From experience, I know this kind of light can bring on visual hallucinations. So I am in the elevator and he is drunk and his friends are yelling and they won't let the doors close, lest they shut out their friend who is standing outside and talking to them.

I think I may have disappeared: the boundaries of my body feel blurry.

Later, I tell my psychologist it doesn't take a genius to understand the connection between being ignored and feeling as though you're disappearing, and he nods and smiles and I realise all the cognisance in the world won't make these feelings go away.

In 'On Being Sane in Insane Places', I learn that something similar happened to those eight pseudopatients. Ignored by psychiatrists, nurses and attendants, they began to feel a sweeping sense of powerlessness and depersonalisation. In the face of this, they collected their own data. Once a day, they politely asked a staff member a question, to see who would engage in conversation with them. Psychiatrists would 'move on, head averted' 71 per cent of the time. With nurses and attendants, that number rose to 88 per cent. Overall, staff members would pause and chat to a patient about 2 per cent of the time.

I THINK A lot about what 'On Being Sane in Insane Places' would look like today, almost fifty years later and on the other side of the world. In many ways, the differences between now and then are so drastic that it's almost impossible to compare. Our understanding of every kind of illness has changed along with our updated editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) – but stigma and underfunded services remain. I think of one interview my mother wouldn't let me hear: a parent whose adult child was experiencing suicidal thoughts. They were turned away from a hospital, went home and later completed the suicide.

At a conference – the first of its kind on farmer suicide prevention, and one that my mother has spent months organising – I hear a farmer explaining that, even with antidepressants and therapy, healing does not follow a straight line. She talks with such generosity. And as she recounts the story of planning her suicide, I want to pick her up and take her away from the hardness of her own experience. But then I realise – days later in my home, beset by panic attacks and depersonalisation – that I want to take myself away, too.

I find it hard to delineate where isn't an 'insane' place. Unless I'm in the confines of my home – a cup of coffee warming my hands and my dog beside me – it all feels a little murky.

I often think about the boundaries of what is thought to be psychosis. Sometimes, I see small Greek women dressed in black and I think they're my *yiayia*, even though she's been dead for over a decade. I've been told this is a common experience. I've also heard that some people feel or see God. My partner told me that as a teenager, lying in his bed one night, he felt God's love envelop him; soon afterwards, he made the switch from atheism to Christianity. Later, when he realised it was not God he needed but support and connection, he returned to atheism. And while they intersect in some ways, God and grief are outside the bounds of psychiatry. Diagnosing them is not as clear-cut as hearing a voice or seeing mixes of colours. Shapes blurring and joining in my vision or sound being dialled up or down in my mind: these remain very much within the realm of 'mental illness'.

IN ONE INTERVIEW, a farmer talks about going to Glenside Health Services, a psychiatric hospital in South Australia. He says that it helped; that it's not a treatment to be feared; that it's a place to heal. I'd walked through that old ward on a tour: is the memory of this experience what makes my body tense, or is it the fear brought on by reading study after study after study where people haven't received the help they so desperately need?

In 1973, David Rosenhan wrote that 'psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him'. We may be ruled by the place in which we find ourselves, but perhaps not as much as we're all ruled by labels, which Rosenhan notes have a certain stickiness: 'Once a person is designated as abnormal, all of his other behaviours and characteristics are coloured by that label.'

But another farmer I spoke to had found another approach to labels, using his own to reach out to others in his rural community – he spoke openly about his experience with suicide ideation and the stress of managing a farm during drought. Now, people in the community call him when they – or a loved one – are unwell. He tells me that after he speaks to them, he puts lists of their names in his phone. He keeps track, making sure to check that they're okay.

I read that the suicide rate for non-Indigenous men in rural areas is 25 to 40 per cent higher than for men living in urban areas. It's 48 per cent higher for male farmers. But there are absences in those numbers; lives that have not been counted. The lives of Indigenous farm workers, of migrant workers: they are not counted in these statistics. And women – who are statistically more likely to attempt but not complete suicide – appear at the margins. As do people who self-harm, or those whose deaths are not officially ruled suicide.

SINCE 1973, ROSENHAN'S study has been replicated in small ways. In 2004, psychotherapist and writer Lauren Slater decided to repeat it using herself as a 'pseudopatient'. In her book *Opening Skinner's Box* (WW Norton, 2004), she recounts an interview with Robert Spitzer – Rosenhan's greatest critic – who, along with various colleagues, worked to transform the DSM II into the DSM III to tighten diagnostic criteria. Speaking to Slater, Spitzer says: 'I'm telling you, with the new diagnostic system in place, Rosenhan's experiment could never happen today. It would never work. You would not be admitted.' Whether it's these tightened criteria or a lack of bed space, Slater was not admitted in the eight instances when she presented at hospital. She was, however, diagnosed with depression with psychotic features. She was prescribed medication, but given little other support.

She writes of those eight visits, where she was given medication each time but not admitted:

I am prescribed a total of twenty-five antipsychotics and sixty antidepressants. At no point does an interview last longer than twelve and a half minutes, although at most places I needed to wait an average of two and a half hours in the waiting rooms.

Reading this, I am not surprised.

AT THE CONFERENCE, I stand with two women whose farmer fathers have suicided. They talk about the experience with such strength and clarity. Yet I worry that I should not stand near; that as a city dweller I'm an outsider, an intruder. My mother tells me later that in rural farming communities, it can often be a family member or friend who first discovers a body.

THE USE OF the word 'thud' in the original experiment was purposeful. Rosenhan chose it because it hinted at something sombre, existential. As a word, it is fitting: the sound of falling, of impact. Like a life with mental illness, it is often dull and repetitive, but painful nonetheless. Rosenhan writes of this semantic choice: 'It is as if the hallucinating person were saying, "My life is empty and hollow."'

Slater describes the use of 'thud' as 'cartoon angst' and, in a conversation with Robert Spitzer, finds that he is also unimpressed with Rosenhan's choice:

This whole business of thud... Rosenhan uses that as proof of how ridiculous psychiatrists are because there had never been any reports before of thud as an auditory hallucination. So what? As I wrote, once I had a patient whose chief presenting complaint was a voice saying, 'It's okay, it's okay.' I know of no such report in the literature. This doesn't mean there isn't real distress.

Despite repeating this key detail from what had proven to be an influential study, Slater's version of the experiment implies that the study itself is neither memorable nor entirely well known. Preparing to enter the emergency room, she writes: 'At any moment someone might recognize my gig. As soon as I say, "Thud," any well-read psychiatrist could say, "You're a trickster. I know the experiment." I pray the psychiatrists are not well read. I am banking on this.'

And for the eight times Slater presents herself at the hospital saying she hears a voice saying 'thud', she is never called out. Either that, or a psychiatrist says nothing, unable to place the memory of 'thud' from some reading at medical school or perhaps unsure why someone would want to repeat a controversial experiment thirty years after it was first performed.

I LISTEN TO a recording of farmers speaking about coping strategies, survival techniques. One woman walks her property and uncovers what it holds. I imagine old car parts, aged wood, wildflowers. I think about the landscape's capacity to heal, and through this I wonder if – for a moment – farmers can ever forget about the hardships of drought that lace these interviews. The lack of feed, the hungry animals.

I think of dusty boots and wide stretches of sky and am reminded of the first time I found peace in landscape. I was a teenager and my mother and I would walk from Henley Beach to Somerton and back, watching the water swell. Each time she would tell me that the light reflecting off the ocean was good for us. I remember her voice some days, as light as the sea air: 'Let's soak up the serotonin.'

IN 2011, OVER thirty-five years after Rosenhan's work, Dr Murray J Goddard revisited that first study. He did not feign symptoms and, when admitted to a 'US psychiatric institution', he described himself as 'agitated from several life stressors'. Unlike Rosenhan, Goddard found that staff both spent time with patients and considered their requests. However, Goddard too experiences the stickiness of a psychiatric label:

I was not sleeping well initially, which the staff considered evidence consistent with my disorder. Later, though, I discovered that the thermostat in my room was set above 80-degrees Fahrenheit, and when it was properly adjusted, my sleep improved. Of course, a lowered temperature was confounded with delayed drug onset (the explanation favoured by my psychiatrist), and at that point I decided that 'good patients' do not point out the design flaws common in applied research.

Goddard's words remind me of complaining to my GP of overwhelming migraines and lethargy as a side effect of medication prescribed by my psychiatrist. Her reply was, 'No, that can't be. Side effects only occur in 1 per cent of cases.'

We did not speak about it further.

I FINISH THE calendar entries and my mother debriefs me. She says she does this with everyone who works for her and even though I am donating my time, why would she do things any differently for her own daughter? She says it's normal to feel unsettled, even without mental ill health – and I am not a 'pseudopatient', by any means. I try to understand that this new ripping feeling that tints my purposefully quiet and routine-led life is natural.

In late 2018 I write an article for *The Guardian*. One paragraph, drawing together the data I've pored over, explains:

The combination of drought and the resulting economic malaise in farming has led to a crisis of farmer distress and suicide. The suicide rate for Australia's farming men is about double the general male population, sitting at 32.2 compared with 16.6 per 10,000. This is a difference that has been documented since the 1980s, but with little change to rates of suicide. While research often focuses on farm owner-operators, farm labourers account for 46.9 per cent of farmer suicides. Eighty-seven per cent are men. While male farmers are reluctant to seek professional help, it is now being shown that ongoing lack of health services – including in some cases access to a GP – in rural areas compounds their despair.

Writing is the only skill I have, but it does little to help communities reeling from loss.

ROSEHAN'S STUDY IS only seven pages, but it has filled me up and inhabited my mind. I think about community and I think about sanity and insanity. In rural areas in Australia, there are often no psychiatrists or psychologists. There *may* be a GP. A lack of medical services may mean that, in the aftermath of suicide, community will make the most palpable impact in offering support to family, friends, one another. These community-run prevention networks care for people; they're groups that exist on a shoestring. It's hard work, caring for a community in distress; the ongoing drought in Australia has caused economic hardship and a peak in life stressors for farmers and farm workers.

But suicide prevention networks – the people behind them – are making an impact. In those interviews, I hear farmers voice this again and again. Sitting at that conference, too, I witness women building community from their own conviction that care can bring about change. Watching people in a community helping one another, I start to understand place as something that can be built upon care – as something that can exist as both a stressor and a salve, oscillating between help and harm.

One day, my mother drops by my home with a couple of takeaway coffees. She talks to me about her day. She talks about the never-ending fight for funding, but she talks more about her frustration with people who cast their eyes down when she tells them about what she does. Who sigh and say, 'How depressing.'

I tell her that, if anything, her work is about hope. It's about belief in the power of care, whether or not sanity and insanity exist.

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