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Institutional Psychiatry—"The Self Inflicted Wound"

David L. Bazelon*

The focus of this conference centers on the human and civil rights of those people who enter at the "gate," pass through, and finally "exit" from the world of institutional psychiatry. The recent APA Psychiatric News has characterized the legal aspects of this phenomenon as an "explosion of mental patients' advocacy litigation" flooding the state and federal dockets. One psychiatric journal recently devoted an entire issue to "Psychiatry Under Siege." One of the contributors described critics of psychiatry as leading the assault with a tract by Tom Szasz in one hand and the latest appellate court opinion in the other. (I wonder which court of appeals he had in mind?)

On closer analysis it is fair to say that the problem is not so much with the mental health disciplines as it is with the mental health professionals. This is especially true in the case of those who no longer serve patients but serve instead as employees of institutions such as the military, state hospitals, penal institutions, schools and industry—to name but a few.

This brings to mind an experience of my dear friend, Dr. Leo Bartemeier, an alumnus of Catholic University and one of this country's most distinguished psychoanalysts. Dr. Bartemeier has occupied a preeminent role in American psychiatry and has influenced the education and training of generations of young American psychiatrists. Beyond that, his intellect, wisdom and indomitable spirit of compassion and gentleness had an important influence on my life and all those who were blessed with his friendship. In 1949, in recognition of his many achievements, he was nominated to the presidency of the International Psychoanalytic Association. Because a prominent American Catholic bishop was severely critical of Freudian analysis as contrary to Catholic dogma and teaching, Dr. Bartemeier sought an audience with Pope Pius XII. As a devout Catholic he decided he could not accept the presidency if the Pope were opposed to psychoanalysis. The Pope granted his request for an audience and, after a lengthy exchange, the Pope concluded the audience with the remark: "The Church's problem is

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not with psychiatry, but with psychiatrists. Go forth, my son, accept the presidency and do honor to the Church.”

I believe I have been uniquely fortunate over the past twenty years to observe the workings of the behavioral science professions from within—as well as from without, as an appellate judge. Based on those experiences, I have become increasingly concerned that institutional psychiatry—especially in the state mental hospitals, the juvenile justice and the correctional systems—has become the “self-inflicted wound” of the profession—a wound which may prove fatal to the credibility of psychiatry.

The birthright of psychiatry won by the moral imperatives of the Pinels and Tukes of the eighteenth century is in danger of being lost in the twentieth to institutional psychiatry—“not with a bang but a whimper.” To paraphrase Rousseau, psychiatry born in a spirit of freedom is becoming shackled in the chains of institutional psychiatry. Let me emphasize that when I speak of institutional psychiatry my remarks are directed to all mental health professionals who work in the institutional setting—the psychologist, social worker, and nurse—to name just a few.

I emphasize psychiatry only because psychiatrists have been in the positions of greatest power and prestige in our society—within and without the institutions.

As a judge of the United States Court of Appeals for the past 24 years, I have been exposed to many of the problems to be addressed at this conference. My involvement is not as an expert in the behavioral sciences, but simply as a monitor of the decisionmaking process. That exposure has for me underscored the lack of both professional and public accountability of institutional psychiatry. My court has confronted such questions as who can be morally responsible for a crime? Who can be ordered into a hospital for compulsory treatment? What kinds of treatment can be imposed involuntarily and for how long? When may a patient be released and under what circumstances? What standards should govern the imposition of solitary confinement and other restrictive measures? What is the child’s right for treatment in the juvenile justice system? These questions present issues of the balance of power between the state and the individual where the stakes are the highest for human and personal rights. I would remind those who suggest that such issues are not for judicial determination, that these questions arise on petitions for redress of grievances. They may *not* properly be avoided or ignored. This is the business—this is the stuff of the judicial enterprise.

The administration of the insanity defense is an example of the real problems involved in monitoring the expert decisionmaking in institutional psy-

chiatry. In 1954 I formulated a new test of criminal responsibility in the *Durham* case. That case held that an accused is not criminally responsible if his unlawful act was the product of a mental disease or defect. I hoped that psychiatrists would willingly bring into the courtroom all the information available on the determinants of human behavior. I believed psychiatrists would tell us what is known and (just as importantly) what is *not known* about these factors. *Durham's* purpose was to irrigate a field parched by lack of information and to restore to the jury its traditional function—to apply “our inherited ideas of moral responsibility” to those accused of crime.

I have no doubt that most of you are familiar with the struggle which ensued in countless cases and opinions to fulfill the promise of *Durham*. I am certain you also know that the promise was unfulfilled. The purpose was not achieved. Despite our best efforts psychiatrists adamantly clung to conclusory labels without explaining the origin, development or manifestations of a disease in terms meaningful to the jury. The jury was confronted with a welter of confusing terms such as “personality defect,” “sociopathy,” or “personality disorder” taken—not from a page of Lewis Carroll—but from the APA Diagnostic Manual! What became more and more apparent was that these terms did not rest on facts and reasoning which were the product of disciplined investigation, as required by *Durham*. Rather, they were used to cover up the lack of relevance, knowledge and certainty in the practice of institutional psychiatry—especially in understanding and treating the socially deprived and disadvantaged groups who populate our mental hospitals and penal systems.

Why is it that some experts on examination will invariably characterize the defendant (who, in the District of Columbia, is so often poor and black) as an “anti-social personality”—with no mental disorder? Yet, on occasion, when a psychiatrist independently represents the accused, the same defendant is often diagnosed as suffering from schizophrenia, a mental disorder. Is the conflict of opinion based on the inherent limitations of psychiatric expertise? Is there a more fundamental cultural bias inherent in the discipline in regard to racial minorities and the socially and economically deprived? Is the difference based on the lack of resources, time and facilities to provide the requisite information? The late, distinguished Dr. Winfred Overholser, Superintendent of St. Elizabeth's Hospital, clearly indicated to me that lack of resources prevented the full investigation required by *Durham*.

Do the various diagnostic labels—explaining everything yet making nothing understood—reflect an attempt to cover up the crucial conflicts of interest between patient and institution? Why is it that in the hospi-

tal's written official report to the court of diagnostic conclusions, differing viewpoints within the hospital's staff are not included. Attempts to obtain records or tapes of clinical conferences have consistently been opposed and thwarted by the psychiatric staff at St. Elizabeth's. What effect do *ex parte* communications by the prosecutor, defense attorney, or police have on the ultimate diagnosis? Is the evaluation of the patient affected by the fact that the diagnostic facility is also the treatment facility for the patient held not responsible? To what extent does political rhetoric for law and order affect the decisions of experts relating to the commitment and release of patients? Why instead of the present ad hoc determinations are there no published formal rules, guidelines and procedures to safeguard a fair and just evaluation for every patient?

These are the questions which some courts—unhappily not too many—have tried unsuccessfully to bring out into the open. Until these considerations are adequately explored in the legislature or the courtroom, the insanity defense will remain an empty vessel. Paraphrasing a thought I expressed in the *Browner* case: while we lawyers and judges are designing an inspiring new rule for the insanity standard, the battle is being lost in the trenches of institutional psychiatry.

The problems faced in the administration of the insanity defense also appear in the institutional roles of experts in civil commitment and sexual psychopathy proceedings, in the right to treatment in juvenile and adult institutions and the youthful offender's right to rehabilitation.

These cases starkly reveal the conflicting allegiances of the mental health professional within the institutional setting—and the tendency to put institutional interests above the best interests of the patients. Many of these problems arose in the 1950's and 1960's when psychiatry accepted the task of dealing with the worst problems of our time—crime, poverty, racism, child abuse, sexual psychopathy, alcoholism, drug addiction and others.

I recognize that psychiatry has important information on human behavior and expertise relevant to mental and emotional disabilities of many people. However, the undertaking of psychiatry to alleviate those conditions arising from socio-economic factors was doomed to failure. The conditions were not amenable to its expertise. It was no substitute for an informed public ready to "bear the burden, and pay the price" to alleviate and eradicate the poverty, slums and discrimination which foster such human misery.

Once having entered this public thicket, psychiatrists should have recognized that their "sacred trust" to the patient was being undermined by serving as institutional gatekeepers for society. The sign over the gates may

well have read "Abandon all hope ye who enter here!" Psychiatrists did not ask the crucial questions about the basis and relevance of their expertise in this "brave new world" of institutional psychiatry. Nor did psychiatrists acknowledge the inherent conflicts of interest between the patients and the institution. Instead, psychiatrists ignored, repressed or covered up these conflicts—really serving institutional goals under the guise of fulfilling their obligations to their patients.

What is very disturbing about these situations is not that psychiatric motives are venal, or that conflicting societal interests may dictate different results—we are used to that in the law. But it is frightening that psychiatrists as well as other mental health professionals have yet to confront these conflicts out in the open. Failure to do so fatally infects the decisional process. The ethics of the medical model governed by the Hippocratic Oath were abandoned and replaced by the new situational ethics of the institution where extraneous social, political and economic factors came into play. Case after case makes clear that there are hidden agendas at work behind a facade of expertise. The predictable result has been public confusion about what is the expertise of psychiatry and the role of the psychiatrist. This confusion impairs the trust and confidence which are essential to the doctor and patient relationship. Unless a patient trusts the psychiatrist, whatever hopes there may be for the therapeutic process are diminished if not demolished. There can be no hope for treatment and recovery when the psychiatrist's allegiance is either in doubt, or, worse still, identified with one who is seen as an oppressor.

Until psychiatry and other mental health professions address the dilemmas of institutional psychiatry, legal challenges will continue unabated and public mistrust will grow. I fully recognize that reliance on the law and courts to bring about significant reform is reliance on a slim reed indeed. Courts such as in the *Wyatt* case in Alabama can do little more than mitigate horrendous conditions which violate our basic sense of decency. The real hope lies in the mental health professions taking on the challenge themselves. Each must scrutinize its expertise, fashion standards, rules and guidelines, and provide mechanisms of review. Each must monitor the decisionmaking process in order to maximize patient freedom and dignity.

A good example was a recent NIMH panel on which I served that considered the broad moral, legal and ethical issues involved in psychosurgery. Questions focused on models of the behavioral sciences and their applicability to understand and treat violent behavior. Is violence a brain disease to be treated with drugs, hormones or surgery? Is violence a learned phenomenon to be treated with Skinnerian techniques of operant conditioning? Is vio-

lence a psychological malady to be dealt with in psychotherapy? Is violence a socio-cultural phenomenon to be dealt with by confronting the conditions which foster violence? Which models, if any, fit which people and why? Is psychosurgery a proven therapy or is it still an experimental procedure? How do such models affect the practice of psychiatry and the human and civil rights of people within mental and penal institutions? These were some of the hard questions asked and debated. These are the kinds of questions mental health professionals in institutions should be asking of themselves concerning every patient. These considerations should be openly aired. Records should be kept, files opened. Only then can criteria and standards emerge to ensure what Tom Szasz would call "psychiatric" justice—not tyranny.

None of us can afford to allow society the great cop-out of relegating tough social problems to the experts. Society must understand there is no magic pill, no medical prescription. The mental health professional has an enormous responsibility to blow the whistle on the charade that institutional psychiatry is alive and well and performing effectively the tasks assigned to it by society.

It is no secret that I strain not to hide the raw facts of life behind legal niceties and neutral rules. Whether intended or not, the law seems to screen out the hard cruel facts on the rationale that they are irrelevant. I am really getting to believe that irrelevancy is the cop-out rationale—a service of the law, if you will—something we need to save us all from feelings of very painful guilt and helplessness.

But we cannot, we must not, succumb to the temptation. To do so violates the ethical, moral and educational values we all share. As George Bernard Shaw wrote, "The worst sin towards our fellow creatures is not to hate them but to be indifferent to them: that is the essence of inhumanity."