THE FUTURE ROLE OF STATE MENTAL INSTITUTIONS
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We are told that a few moments before she died Gertrude Stein spoke her final words. "What is the answer?" she asked and then after a short pause, "What is the question?" Over the years, most of us have grown suspicious of "answers" and especially of those which offer tidily packaged solutions to any but the simplest problems. Qualifications and reservations and exceptions begin to crowd in, and we are soon caught up in a net of "maybes," "yes, buts" and "provided thats."

The present discussion is not a search for pat answers. Rather it is an attempt to isolate the pertinent dimensions of the problem and to formulate at least a few of the relevant questions. One of the truly fundamental characteristics of all hospitals, and particularly of those administered by the State, is the fact that they exist as social instrumentalities. And in precisely the same fashion as the public school, the Supreme Court and the Department of Highways, they are concretizations of society’s viewpoint and intention. In this context the state mental hospital, then, is an institution established by the collectivity, to endure at its pleasure, and accountable for the discharge of a mission.

And what is this mission? It has, of course, varied as society’s viewpoints and intentions have taken now one direction, now another. For something in the neighborhood of a century, this mission, at least within the United States, has been reasonably clear. One component was to provide for the sick a refuge, a sanctuary, an asylum; and as a corollary, to set up for the non-institutionalized populace safeguards against the unacceptable or dangerous acts of those who were ill. The second component of the hospital’s mission was to provide the sick with treatment in the hope that they could be cured of their malady or so improved that their discharge from the hospital could be effected and their resumption of a productive social role achieved.

Until a couple of decades ago the core questions tended to stop at about this point and we began to think about tactics: procedural techniques, budgeting strategies, recruitment and deployment of personnel, therapeutic modalities, administrative procedures, and so forth. Yet in a nation which has begun to inquire into the
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adequacy of its Constitution, into the obligation of its citizens to obey some but not all of its laws, into the desirability of a guaranteed annual income for all non-workers—and among whose theologians are to be found those who assert that God is dead—in such a nation there is little occasion for surprise when another question is asked. “Who are the sick?”

It is with one of the answers to this question and with its implications that we now must deal. Stripped of certain purposeful ambiguities, the answer we sometimes hear is simply that there are no sick, none that is in whom demonstrable organic pathology is lacking. That segment of sick humanity in whose disorders psychiatry has heretofore claimed to specialize is divided into two subgroups: those whose illness is causatively related to demonstrable organic factors, for example, neurologic, toxic or vascular; and the remainder whose disorders, once called functional by the psychiatrist, are now more commonly described by proponents of the new look as aberrations of behavior. A new continuum is thus conceptualized which includes delinquency, learning defects, homosexuality, the psychoneuroses, criminality, anomie, eylothymia, drug dependency, schizophrenia, marital conflict, infantile autism, character disorders, adolescent rebellion—in short all socially undesirable behavior for which there is no demonstrated organic etiology.

The last official revision of the Diagnostic and Statistical Manual of the American Psychiatric Association was published in 1951. Excluding the brief section on mental deficiency, it is of some interest that three qualifying words are used throughout: “Syndrome,” “Reaction,” and “Disturbance”—syndrome for those disabilities in which there is an organic factor, reaction for the functional psychoses, the psychoneuroses and the psychosomatic conditions, and disturbance for the personality disorders.

The ends to be served by this taxonomy were at the time, and remain, somewhat uncertain. For many psychiatrists no doubt the change in nomenclature was a transitory irritant rapidly forgotten as appropriate translations were made from the older to the newer language. Other psychiatrists welcomed the change, feeling, I believe, that a more honest statement could now be made regarding their patients’ state; that such diagnoses as Hypochondriasis or Schizophrenia, Paranoid Type carried unwarranted implications that the disorders were alike in kind if not in form with Glomerular...