PORTRAITS FROM THE STATE MENTAL HOSPITALS

by

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A thesis presented to the University of Waterloo in fulfillment of
the thesis requirements for the Degree of Master of Architecture.

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Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

The thesis is a short book of fifty sketches. I felt I threw out a significant amount of other material – plans, sketchup models, physical models, and photographs. Many people I had shown my work to were uninterested in drawing analysis or precedent studies, but reacted strongly to the sketches of patients. People began opening up about aunts, uncles, cousins, and grandparents who suffered through various phases of mental illness. I found that this was the type of discussion I wanted to foster and threw out most of my previous work. The thesis is a challenge to the taboo of mental illness and what we do not say about it.

I travelled to one of the largest and most secluded of the State Hospitals in the American South. I flew to the state of Georgia for two weeks, rented a car and drove two hours east to the small town of Milledgeville. A place has the power to change the way you feel about the world. Central State Hospital, located in the forest south of Milledgeville, had the power to awe. Here was a full city built and deserted in the geographical heart of Georgia. After my travels, I spent time studying the works of photographers who documented State Hospitals across America in the era of long-term institutionalization. Photographs have raw power and truth in their documentation of the human condition. The image pauses a moment of distress, or despair for someone who may not be aware and try to hide it. Photographs are primary documents. They tell what was done to patients, through physical restraints, being force-fed or locked up. The act of redrawing so many photographs leads to a sort of inhabitation of the collective photographs. I imagined myself inside the ward, feeling the raw concrete on the floor and hearing the dry creaks of an overloaded wooden bench. I began to emphasize with the patients. I understood their acts of resistance.

I live with someone who has a mental illness. I feel a sense of horror looking at the cruel restraints and the resigned faces of suffering. As an architect who may decide to branch into healthcare, this work has warned me to take special care in designing for the vulnerable (physically, socially, politically) who are kept in places out of sight from most of the world. I have learned that places where people are sent away from their families and communities, tend to collect these people. These places can grow unchecked through willful neglect, a 'collective amnesia' out of sight (Meskell 2002,566). As architects, we must always keep these institutions for the vulnerable in sight.

Meskell, Lynn. "Negative Heritage and Past Mastering in Archaeology." Anthropological Quarterly 75, no. 3 (2002): 557-74. http://www.jstor.org/stable/3318204.

Acknowledgements

To my supervisor and mentor Robert Jan, for telling me of the horrors that humans can inflict on others, and of our responsibilities to stop them.

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To my advisor Rick, for telling me of the power of the *genius loci,* the spirit of a place which tells its own story.

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Most of all, to my partner Natasha, for being the bravest soul I have the fortune of meeting, and for bringing me into the world of mental health care.

Dedication

For those in despair and suffer alone - know that there are people out there who care, will listen, and with your permission, help.

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THREE ESSAYS

THE PLACES WE BUILD FOR THE PEOPLE WE FEAR.

"THEY would have put me in there, fifty years ago". Natasha, my partner of six years, pointed at the squat brick building on my computer screen. The building was three storeys tall and punctuated with tiny windows spaced evenly apart. Each window had a deep metal frame, with thick bars all painted white. A two-and-a-half-meter high barbed wire fences framed the building, embedded with a patchwork of lighting posts and a chain link 'tunnel' connecting the two areas. This building was just one of over two-hundred buildings on a sprawling campus deep in the heart of a forest in the American South. We were looking at the Central State Hospital, a defunct hospital for over twelve-thousand in the small town of Milledgeville, Georgia.

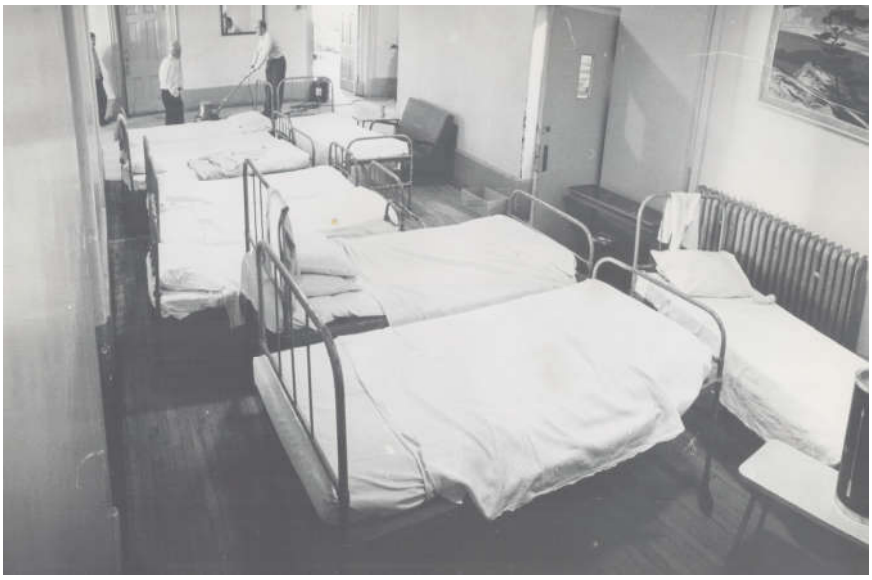
Central State Hospital sits on a site larger than the University of Waterloo. It boasts a train station, mail office, police station, and a theatre. I was impressed at the complexity behind the scenes: as I spent more time on site, I found a truck loading building, a power plant, and a radio tower. It had all the amenities of a small town in rural America. The campus gave the appearance of a homely town. The handsome, brick train station had a beautiful, low roof with deep overhangs and delicate wood detailing. The post office was decorated with proud, brick arches. What the town was missing was any semblance of public life. There were no sidewalks, no benches outside, no places to linger outside. Every building sat well back from the street, with neat, barred windows and a single pathway to the front door. Buildings were spaced far apart with deep lines of sight from buildings to the forest beyond. Tall chain link fences were built where the forest came too close. The campus looked like a welcoming small town.

The sociologist Erving Goffman described the mental hospital as a total institution. A total institution was a permanent place where a large group of people are cut off from the rest of society, and live communally under an external supervision and a regimented schedule.[1] Goffman describes the clear power relationship between the two groups – the larger, managed group (the inmates) and the smaller, supervisory group (the doctors, attendants, and other staff). The staff tend to see the inmates as 'bitter, secretive, and untrustworthy' while the inmates view the staff as mean and condescending.[2] The world of the patient was one of limited contact with the outside world, and living under the total authority of hospital staff. Patients would suffer verbal and mental abuse from staff, who would suffer little or no consequences. It was a terrible place to live, and many patients spent years if not decades in these total institutions. Ken Kesey wrote of his experiences in the fictionalized One Flew Over the Cuckoos Nest. In the story the protagonist McMurphy observes an elderly patient attempt to stand up for himself against the head nurse, "I'm tired. I'm tired out talking and standing up. I been dead fifty-five years."[3] The nurse quickly sedates

him and has the patient-attendants carry him back to his bedroom and locks him in. Saying no to a nurse would verbal beratements, physical abuse, or injections with powerful sedatives. To live in a mental ward was to live in fear – in fear of the nurse, in fear of the doctors who prescribed painful electro-shock therapies and especially in fear of the other patients, strangers who could rat you out for additional punishments from the nurse.

Archival photos show the deplorable conditions that people were forced to live in. Fastened by heavy cloth restraints, patients would amble around rooms or struggle against their restraints. I could only imagine the endless rooms of faces of sorrow and despair. In the 1960s, these anonymous buildings would have housed several hundred patients each. These patients were sent here indiscriminately – troublesome youths, elderly patients with memory loss, patients suffering from any sort of excitable behaviour. These hospitals often became dumping grounds for inconvenient people sent by families, court orders, or the criminal system. How did these places become so large? The Federal Social Security Act of 1935 establishes the first support program for the elderly, who consisted of most of the population of the mental hospital in the early 20th century. After the Depression, Americans increasingly believed that the Federal government should take care of citizens which were going through difficult times. A big change was through changes in the tax system, which increased tax revenue at the federal level, but less so to the State and local level.[4] Prior to this act, many smaller asylums were operated as charitable organizations. After the Second World War and well into the 1950s, State Hospitals began to grow tremendously in size. CSH grew to a peak patient population in 1957, at 11,828 patients.[5]

While the State Hospitals were reaching their peak populations, the cost to house and treat all those patients became a huge burden on State funds. At its peak rate, 0.5% of all Americans were incarcerated in a psychiatric hospital.[6] Another solution had to be found. The answer came from an unexpected place – a chemical used by the French in the Korean war. Chlorpromazine was used as battlefield sedative used to treat excitable patients and calm them down. In 1953, chloropromazine was tested on schizophrenic patients with an astounding ability to sedate most side effects. The drug became immensely popular and profitable. Its success spawned an entire new industry of drugs, now called neuropsychopharmacology.[7] The application of chloropromazine in the psychiatric field mirrored an equally important set of discoveries in the neurological field. In 1955 the neurologist Robert Bowman used a new device called the spectrophotofluorimeter to measure the chemical analysis of compounds in the brain.[8] This research led to conclusive evidence that mental illness was a disease, and that it could be traced to chemical imbalances and neurological damage in the brain. Sixty years after its first introduction, chloropromazine is still heavily prescribed to treat symptoms of schizophrenia. It has been argued that it was only through the introduction of drugs that psychiatrists could truly help their patients.[9]



figures 1.1, 1.2

figures 1.2, 1.3

Pharmacotherapy had grown to become the primary treatment in psychiatry. However, the path to normalcy for patients who were successfully treated with drugs was still a difficult one. Family, friends, and the communities of the patient were often distrustful and afraid of those with the stigma of mental illness. The process of closing down large mental hospitals and sending patients back to their original communities was called deinstitutionalization. This was especially problematic because many patients had lived in these total institutions for decades and had great difficulty adjusting to 'normal' life. It was difficult for these patients to find places to live and work. Many patients ended up returning to another form of similar institution because they had nowhere else to go.[10] Today, many mental health care centres are fully integrated in the communities they serve. Universities are beginning to take mental health much more seriously with the introduction of more on-campus counsellors and session rooms. Private sector and community counsellors are becoming more and more common. Research has shown that those suffering from mental illness do much better when they remain connected with their normal lives.

It is fascinating and horrifying that the State Mental Hospitals grew to incarcerate so many people while the understanding of mental illness was so primitive. These campuses grew into fully functioning cities, with train stations, police forces, and patient labour crews. Patients could be trapped in dilapidated conditions and in isolation for years, or decades. There was a real fear that mental patients were violent and dangerous, whereas it was often found in studies they were as a group much less violent that regular persons. To what end did the hospital administrators think that these camps would end? Did the State Hospitals only stop accepting patients because it was too expensive to house more?

The State Hospitals were hospitals in name and intent only – in practice they were State sponsored internment camps for the large-scale housing of different and deviant behaviour. The drawings which follow are an argument for the stripped humanity of those locked inside. More than sixty years later the photographs speak to a suffering which still exists today; in migrant camps, internment camps, and refugee camps. Similar camps are still operated in the United States, and the rest of the world today. Large camps by the U.S.-Mexico border hold groups of Central American refugees fleeing violence and persecution. The U.S. paramilitary organization ICE (Immigration and Customs Enforcement) search out so-called illegal immigrants, before abducting them and separating children from their parents.[11] The South Texas Family Residential Centre in Dilley, Texas houses up to 2,400 migrants. The camp is arranged through multiple barracks, surrounded by networks of high chain link fence. More than half of the detainees are children – their average age is nine. The rest consist of mostly women – their mothers.[12] These are innocent people fleeing violence and persecution. It is our fear of those who are different which cause us to build such horrible camps.

This thesis is an argument that fear built the State Hospital, and that innocent people suffered for it. We build walls around the people we fear, walls which keep people out, or walls which keep people locked in a camp. It is my hope that this thesis speaks against the horrible places we build when we fear people who are simply different.

Endnotes: The Places We Build for the People We Fear.

[1] Erving Goffman, *Asylums; essays on the social situation of mental patients and other inmates.* (Chicago: Doubleday Anchor Original, 1961; reprint, Chicago: Aldine Publishing Company, 1962), 5.

[2] Ibid., 7.

[3] Ken Kesey. *One Flew over the Cuckoo's Nest*. (United States: The Viking Press, 1962; reprint, London: Penguin Classics, 2005), 49.

[4] John Lafond and Mary Durham. *Back to the Asylum: the Future of Mental Health Law and Policy in the United States.* New York: Oxford University Press, 1992, 88.

[5] Central State Hospital. "Report of Examination: Milledgeville State Hospital of the Public Welfare Department." *Georgia State Archives*. 1957, 6.

[6] Margaret Werner Cahalan and Lee Anne Parsons. "Historic Correctional Statistics in the United States, 1850-1984." *U.S. Department of Justice: Bureau of Justice Statistics*, December 1986, 212.

[7] Thomas Ban. "Fifty years chlorpromazine: a historical perspective." *Neuropsychiatric Disease and Treatment*. Vol. 3, No. 4 (2007), 495.

[8] Ibid., 498.

[9] Ibid., 498.

[10] Carla McKague. "Myths of Mental Illness." *Phoenix Rising: The Voice of the Psychiatrized* (1980-1990), Vol. 1 (1980), 8.

[11] Dickerson, Caitlin. "Hundreds of Immigrant Children Have Been Taken from Parents at U.S. Border." *The New York Times.* April 20, 2018.

[12] Preston, Julia. "Women Languish in Texas Immigration Detention Centers." *The New York Times.* June 14, 2015.

THE TOWN AND THE HOSPITAL.

At the beginning of my thesis, I travelled to one of the largest, most secluded, and defunct State Hospitals in the American South. The path to the Central State Hospital was a long one, requiring a flight to from Toronto, Ontario to Atlanta, Georgia. After landing at Atlanta, I rented a car and drove two hours east to the town of Milledgeville. Milledgeville is a small town of eighteen thousand deep in the woods of Georgia. It sits to the west of the Oconee river, which runs through the centre of the state.

Milledgeville felt like an old town, as old as an American town could get. It was a town of handsome brick buildings and deep verandas, garnished in the Greek revival style. From my unscientific observations, it seemed to be a near-even even mix of African-Americans and whites. I thought to myself, how one hundred and fifty years ago, less than three generations, that this town existed as the capital of a slavery-based plantation economy. I kept driving and studied the town around me. Milledgeville was laid out with a rigorous orthogonal plan, oriented towards the river. After the Puritans seized the lands of the native Muskogee people, they imposed a grid on the land. The territory was divided into streets measuring 500 by 500 feet, oriented towards the river. As I drove through the town, I could still see remnants of the rigid grid laid down over two hundred years ago. The wide streets were filled with small houses with large yards. At the centre of the town lay four public squares, each measuring one thousand by one thousand feet.

The first square was called Capitol Square. It contained the government and religious buildings. Two pedestrian paths neatly bisected the square. At the centre sat the old State Capitol building, a two storey stone building which lay on the central axis of the town, facing the Oconee river. Visitors from other towns would have arrived by boat and approached the large State Capitol building down the main street, flanked by churches and other city buildings. It would have been an impressive sight for visitors to the newly founded State of Georgia. The second square held the buildings of discipline and correction. Penitence Square was home to the Georgia Penitentiary complex - consisting of a walled yard, prisoner barracks, a railway station, a courthouse, and a military academy. After the civil war, the compound was used to jail a significant amount of African-Americans, who were then leased out to projects such as the Alabama, Macon, and Brunswick railroads. While emancipation was passed into the South by name, state-sponsored slave labour still prospered in Milledgeville. The third square was a public space facing the town's railroad station. Government Square was located to the west of the town and aligned on Washington Street towards the State Capitol building. The fourth square was a Christian cemetery.

I found it strange that the institution Milledgeville would become famous for – Central State Hospital, formerly the Georgia Lunatic Asylum – was

the only institution located well outside of the city. The institution would grow to be one of the largest State Hospitals in the world, holding twelve thousand patients and employing almost three thousand of Milledgeville's inhabitants.[2]

The Town and the Hospital were linked together through a single road. The road winds south out of the town, and through a dense forest. Tall trees crowded against the shoulders of the road. A large white dome rose behind the trees, in perfect axial alignment with the road. The trees parted suddenly to a wide clearing. The large white dome was sitting on a neoclassical building – a large, squat four storey building painted bone white with the façade of a simplified Greek temple stuck on the front. It looked like the middle sibling of the White House and the U.S. Capitol building. To the left and right were three-storey brick buildings, perfectly symmetrical and axially aligned with each other. One would approach the front of the campus by seeing these three large buildings around a central public square. It was quite the theatrical reveal after driving through the long forest road from Milledgeville.

I drove past the trio of buildings and continued. Past these neoclassical building lay a road. This road wound up and down the hilly landscape. The asphalt looked very dry and had deep scars. Grasses began to erode at the edges of the road. A heavy chain link fence followed the road into the horizon. Driving down this road made my heart beat faster – it did not feel right at all. The two-metre high chain link fences encroached both sides of road, with massive rings of barbed wire on top. Saplings and tallgrasses have grown into the fence. The fences ran two layers deep with a space of a meter in between. Tall towers carried large lamps and multiple security cameras. Pairs of cameras were located on building corners. The site looked abandoned: trees were growing in clusters inside the fenced off areas. The fence ran up to four metres tall near the entrances of the buildings. I counted four sets of windowless metal doors at the perimeter security buildings. The small windows are dirty and cracked in places. A thick set of bars painted white covered each window.

I kept driving on the gravel road. To my right lay a chapel set back behind the same two-metre high chain link fence. A small forest of pine trees had nearly covered the building from the road. There was a small door in the chain link fence. From the gate in the chain link fence led a gravel pathway to the simple wooden door of the chapel. Three crosses stood over the front door – the three Crosses of Calvary. In the Christian stories, Christ was crucified with two common criminals – one refused his help while the other repented, and thus follows Christ into heaven. Behind the cutting teeth of the barbed wire fence lay a promise: madmen - behave well, and God could still save you.

I continued along the scarred road until it wound around a corner into an empty parking lot. The asphalt was deeply wounded here, with gangs

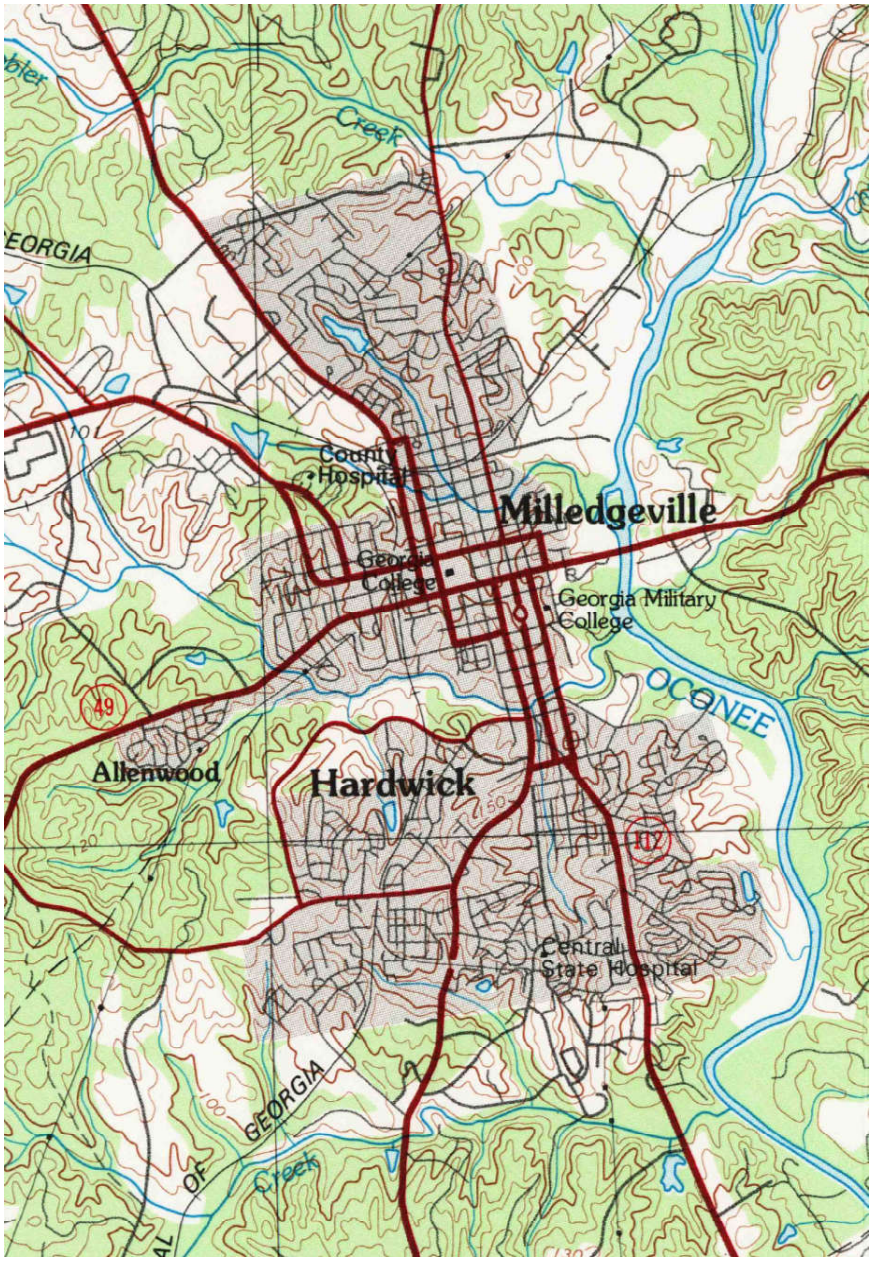


figure 1.5

Milledgeville, c.1981

figure 1.6

Milledgeville, c.1870

figures 1.7, 1.8

figures 1.9, 1.10

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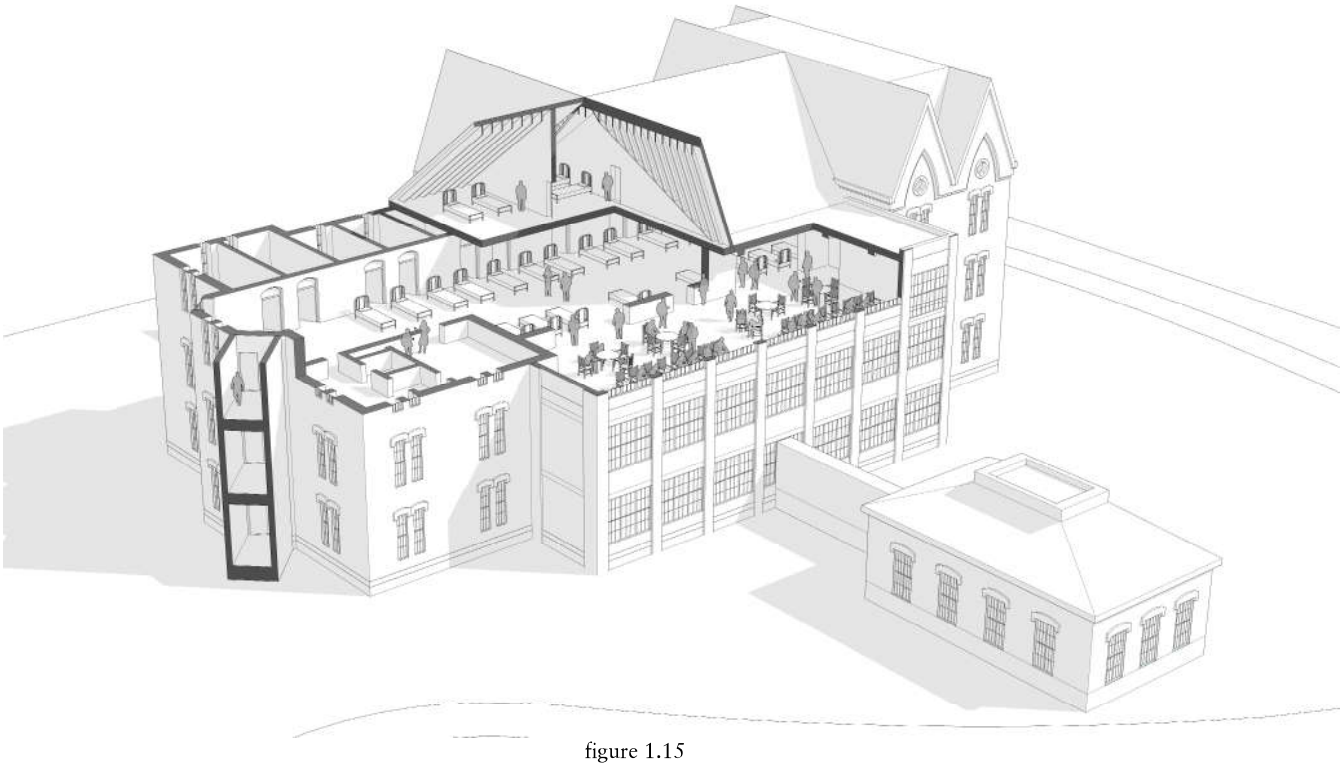

figure 1.15

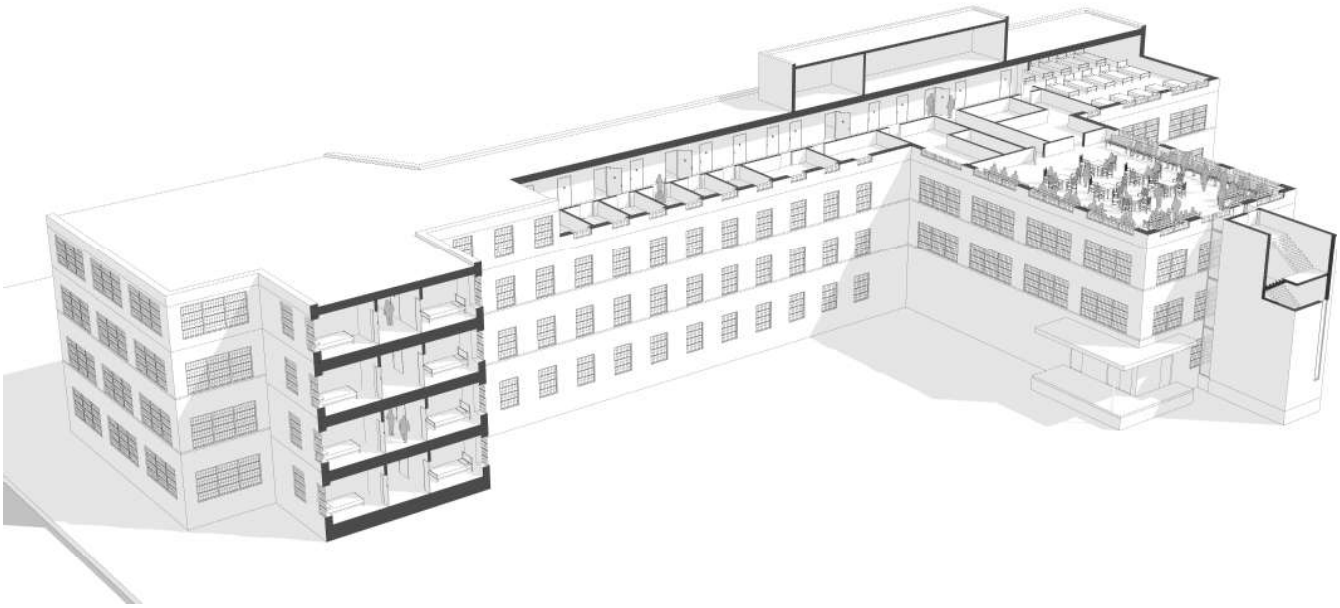

figure 1.16

of weeds punching their way through. Wild grasses leaned in from the edges, barely holding in the forest behind. In the middle of this scarred clearing sat an old white bus. The bus looked like it came off of the set of the post-apocalyptic movie Mad Max: it looked like an greyhound bus with perforated metal plates welded over every window. I could see bars inside the bus. Outside, painted on the bus were the words CORRECTIONS. I parked the car and walked out. A belly, followed by a man, lumbered down the steps of the bus. On his blue shirt, sloppily tucked lay a badge. He looked at me and placed his hands on his hips. "You shouldn't be here," he says, "this is State property."

Here, at the end of the broken road at a forgotten corner of world lay my answer to understanding this horrible strange place. This was not a place of healing or rest. This was prison, a prison city designed with nothing in mind but to hold all of Georgia's delinquent cases in a series of fortified buildings. There were buses to bring patients in from all over the state. There were chain link fences, watchtowers and high walls to prevent patients from escaping. Here lay the fifth square – the place outside the town where the inhabitants sent their unwanted mentally ill. I was there, facing the genius loci of the State Hospital and felt nothing but despair.

I returned to Atlanta and spent my remaining week in the archives. I had felt like Piranesi surveying the ruins of Rome. I was captivated by the monumental scale of the place. The architects had spared no expense in the façades of the buildings in the front of the site. Any family members coming to the site to commit their relatives would have been impressed at the order and precision of the architecture. The incredibly tidy front of the campus would have projected an atmosphere of healing and order. The approach, from the road from Milledgeville to the reveal in the woods to the grand front entrance, was carefully timed to impress. A place has the power to change the way you feel about the world. Central State Hospital had the power to awe. Here was a full city built and deserted deep in the forests of Georgia.

Mental hospitals became convenient grounds to place misbehaving, troublesome or understandable burdensome family members. By the 1960s, the United States held over 600,000 patients in its mental health system. At the peak of mental hospital institutionalization, 1 in 300 Americans was confined to long-term facilities in hospitals across the nation.[2] State Hospitals such as Georgia's Central State Hospital held over twelve thousand patients in sprawling campuses rivalling the size of many contemporary universities. Dr Cranford, a physician at the hospital in 1952, boasted that the campus regarding population was "Georgia's fifteenth town."[3] The campus contained a railroad station, a massive centralised kitchen, a police station, a dentist's office and even a post office. The site sprawls over 2,000 acres and contains over 200 buildings. Today, the hospital only uses several buildings on the campus.

Living conditions were abhorrent. Neglection was especially acute in the racially segregated wards in Milledgeville. The coloured wards were located deep in the campus, behind the wards reserved for whites near the front of the campus.

> In the 64-year old building for Negro females at Milledgeville, hundreds of mental patients like these were huddled on benches that lined the black walls or lay on the dirty pallets strewn on the rotting wooden floors. Once we groped our way into a huge, dank, unlit room. A wave of hysterical screeching from unseen patients warned us that this was the ladies' lavatory. There was not a single graduate nurse in the five-story building at the time of our visit. Here was pandemonium. [4]

These women were collected and abandoned in a dark, rotting building by the hundreds. Men would have been sent to a different but similar building. To call this building a Hospital was an insult to the patients.

The place changed me – there is no doubt. I felt like I had visited the scene of a crime. It was a horrible place, a place built on the idea of intolerance for those who were different. The architectural language of the camp spoke of isolation and despair. Chain link fences, barbed wire, brick buildings with small windows, security towers with cameras and lights. I could only imagine how a place like this would change a person forced to live there every day. For those graduate students reading this essay to better understand the Waterloo thesis process, I have this message to pass on: It is essential to travel to a site and to experience things in person. A place can make you afraid and angry, and will change how you see the world.

Endnotes: The Town and the Hospital.

[1] Central State Hospital. "Report of Examination: Milledgeville State Hospital of the Public Welfare Department." *Georgia State Archives*. 1957, 6.

[2] Margaret Werner Cahalan and Lee Anne Parsons. "Historic Correctional Statistics in the United States, 1850-1984." *U.S. Department of Justice: Bureau of Justice Statistics*, December 1986, 212.

[3] Peter Cranford. *But for the Grace of God: Milledgeville. The Inside Story of the World's Largest Insane Asylum*. 131.

[4] Deutsch, Albert. *The Shame of the States.* 113.

ON DRAWING FROM PHOTOGRAPHS.

The final artefact is a short book of fifty sketches. I felt I threw out a significant amount of other material – plans, sketchup models, physical models, and photographs. I had picked up these tools and habits while working full-time in an architectural office and found they were the wrong apparatuses for crafting my thesis. Many people I had shown my work to were uninterested in drawing analysis or precedent studies but reacted strongly to the design sketches of patients. People began opening up about aunts, uncles, cousins, and grandparents who suffered through various phases of mental illness. I found that this was the type of discussion I wanted to foster and threw out most of my previous work. The thesis is a challenge to the taboo of mental illness and what we do not say about it.

When I first began the process, I thought there were two appropriate responses to mental health architecture. The first was to design a contemporary health facility as a counterpoint to the State Hospitals. The second was to create something which questioned them by reexamining how they mistreated the tens of thousands of patients they held. I chose the second option. In my research, I often found the legislative, medical and architectural design briefs written with good intentions. Kirkbride wrote of asylums in the country providing fresh air. Nightingale wrote of dividing patients into groups of twenty to keep the peace in the wards. If I were to design another health facility, I would be accepting many of the same assumptions more talented designers than I had done fifty years ago.

I looked more in-depth at what caused these hospitals to swell to city-sized prisons located in far, secluded areas. The answer was the family. In a period of confusion, I had turned to my partner to ask of her story with mental illness and growing up. In her experiences, the lack of understanding or empathy from the family further exasperated her underlying symptoms. Thus, the thesis became a personal work. There were two parallel strands. First was the research of life in the State Hospitals fifty years ago. The second was my own experience living with someone with mental illness. I had, over six years become her second family and had a first-hand idea of what life transitioning to modern mental health care was like. I realized my thesis wanted to become a critique of mental health care from fifty years ago, from the viewpoint of a bystander who has watched closely how a patient has transitioned through contemporary mental health systems. Thus, I dove into the archival photographs with a sense of how I would have tried to help these patients if they were somehow brought into the present day.

After my travels, I spent time studying the works of photographers who documented State Hospitals in the era of long-term institutionalization. Photographs have raw power and truth in their documentation of the human condition. The image pauses a moment of distress, or despair for someone who may not be aware and try to hide it. Photographs are primary

documents. They tell what was done to patients, through physical restraints, being force-fed or locked up. The act of redrawing so many photographs leads to a sort of inhabitation of the collective photographs. I imagined myself inside the ward, feeling the raw concrete on the floor and hearing the dry creaks of an overloaded wooden bench. I began to emphasize with the patients. I understood their acts of resistance.

The writings of the journalists and images of the photographs changed how I felt about the world. I felt a little despair everywhere I went, knowing that places like this existed to house those I love and still exist today in the psychiatric wards of prisons. I began reading and searching for as many images as I could find documenting life in the State Hospitals. Drawing was how I best understood the world, and I began tracing the gestures of boredom and agony from the images I saw.

When I first started drawing from the photographs, I began taking notes to describe my drawings. I tried to interpret the relationship between the actors in the drawings and what I thought each was feeling. However, during my Thesis Defense I was criticized because some of my descriptions of my drawings were not faithful to how one would describe the photographs. In other words, I was attempting to pass off my personal observations of my drawings as a personal observation of the photographs, which would be untrue. For instance, for figure 3.37, I had originally made the following note: "A woman in a chair scowls as she lifts her arms up for an attendant. The attendant is indifferent to the situation. She lazily makes a note in her log-book." This note was written as a description of my drawing. However, if we returned to the source image, it was clear that the attendant was paying rather close attention. Her eyes were quite attentive, and her writing hand is tensed. The framing of the drawing was also deceiving. In the original photograph, there were two doctors observing the patient as the attendant was taking notes. This framing of the two additional actors greatly changes the atmosphere and power dynamics of the photograph. The doctors held the ultimate authority in the ward – a position feared by both attendant and patient. It would be inappropriate if I tried to pass off the commentary of my drawings without reviewing again the source images.

Photographs tell entire stories on their own; I had forgotten this simple fact. They tell the stories of the photographers and how they see the world. This particular reference photograph was taken by Alfred Eisenstaedt in 1938. Eisenstaedt was a photographer of immense talent and an analysis of his works would be the topic of another thesis. His compositions always seemed to capture the emotion and tension of a scene. It was Eisenstaedt who took the dual photographs of Joseph Goebbels just five years before, one showing a face of joviality and the second, one of hate. There was a precision in Eisenstaedt's work, from the timing of the subjects to the framing of the scene. I returned to the photograph of the patient raising her arm. I had originally believed the patient to be scowling; now I was not so

figures 1.17, 1.18

figures 1.19, 1.20

sure. She appears to hover between discontent and a dissociation from her current situation. A man on the left in a suit, bow-tie and wireframe glasses stands and observes. A second man on the right, with papers in front of him looks onward. A woman in a nurse or attendant's uniform looks on while taking notes. Her posture is straight and she has fine control of her writing instrument. She is closest to the patient and also surrounded by these two men. They are all looking at the patient, who is dressed in an ill-fitting institutional garment. The criticism was fair; if I was to annotate my drawings, I must be as accurate as possible to the subject matter.

In my own defense, I had been reading other sources which tried to elaborate on the complex relationships between patient, attendant, and doctor. A photographer who is given a selectively guided tour will have no option but to take a staged photograph of doctors and attendants at their best behavior. I was interested in these power dynamics – the photographs could only carry me so far. I turned to two authors who experienced life in mental hospitals: Ken Kesey, the institutionalized author of One Flew Over the Cuckoo's Nest, and Ted Conover, the journalist who spent a year undercover writing Newjack: Guarding Sing Sing. Kesey wrote about an attendant who refused to listen to the complaints of an elderly patient and instead, sedates him to keep him quiet.[1] Conover wrote about his experience in the prison's psychiatric unit, where he wrote hourly logs about the conditions of patients. He wrote about the futility of such logs, as he believed nobody ever read them.[2] The experiences of these two authors told a different story than the staged photograph of Eisenstaedt. In both cases, the attendants found the task of listening and observing their patients as a futile task. Although the photograph shows an attendant apt at attention, other sources suggest that attentive patient care was the exception, rather than the norm.

I am deeply indebted to the journalists and photographers who explored and questioned these spaces before me. Their written accounts and photographs provided me a record of the truth. These artefacts told future generations, myself included, of how the State Hospitals mistreated those with mental illnesses. Half a century later, as these hospitals sit in ruin, the writings and photographs still evoke an atmosphere of despair.

The journalist Albert Deutsch toured the United States in 1946-1947 to write about the conditions of the state hospitals. The photographers Herman Seid, Leo Lieb, Joe Rosenthal, Marson Pierce, John Deblase, Charles Lord, and Irving Haberman accompanied him on his tours. Deutsch toured eight hospitals and published his findings in a book titled Shame of the States. He concluded that patients in hospitals across the nation suffered from similar conditions of disrespect, physical abuse, and general neglect.[3] The photographs are clear, direct and focus on the patients themselves. The photographers capture the men and women at various moments of their day, from being tied down to furniture to being spoon-fed by attendants

while confined in straight-jackets. Joe Rosenthal, who photographed for the U.S. Navy in Japan, would comment how some of the scenes in the mental hospitals were more disturbing than those he took at war.[4] The photographers Albert Eisenstadt and Jerry Cooke both toured state hospitals and produced photographic essays for LIFE magazine. Eisenstadt travelled to Pilgrim State Hospital, N.Y. while Cooke travelled to Cleveland State Hospital, O.H. LIFE Magazine Online published Eisenstadt's previously unreleased photographs in a 2016 article titled "Strangers to Reason." LIFE Magazine published Cooke's photographs in a 1946 article titled "Bedlam 1946". The photographs accompanied an article detailing the poor conditions of the Cleveland state hospital.

Despite geographical differences, the photographs of patient life in the state hospitals were very similar. Men and women, many in some form of restraint were packed shoulder to shoulder on wooden benches in day rooms. Some patients would actively resist, as evidenced by the strains in their straight-jackets or the forceful poses against attendants. Others sat resigned, with their heads down or looking out of barred windows. Many others sat alone and afraid in the foetal position or struggling on the floor. It was tough to tell when the photographs of one hospital began and the other ended - it seemed as if they all rendered life from one, big human warehouse. I have made my best efforts to credit the original photographers in my work where possible.

Endnotes: On Drawing from Photographs.

[1] Ken Kesey. *One Flew over the Cuckoo's Nest.* (United States: The Viking Press, 1962; reprint, London: Penguin Classics, 2005), 49.

[2] Ted Conover. *Newjack: Guarding Sing Sing.* (New York: Vintage Press, 2001) 65.

[3] Deutsch, Albert. *The Shame of the States.* 3.

[4] Ibid, 115.

SEVEN DRAWINGS

figure 2.1

figure 2.2

figure 2.3

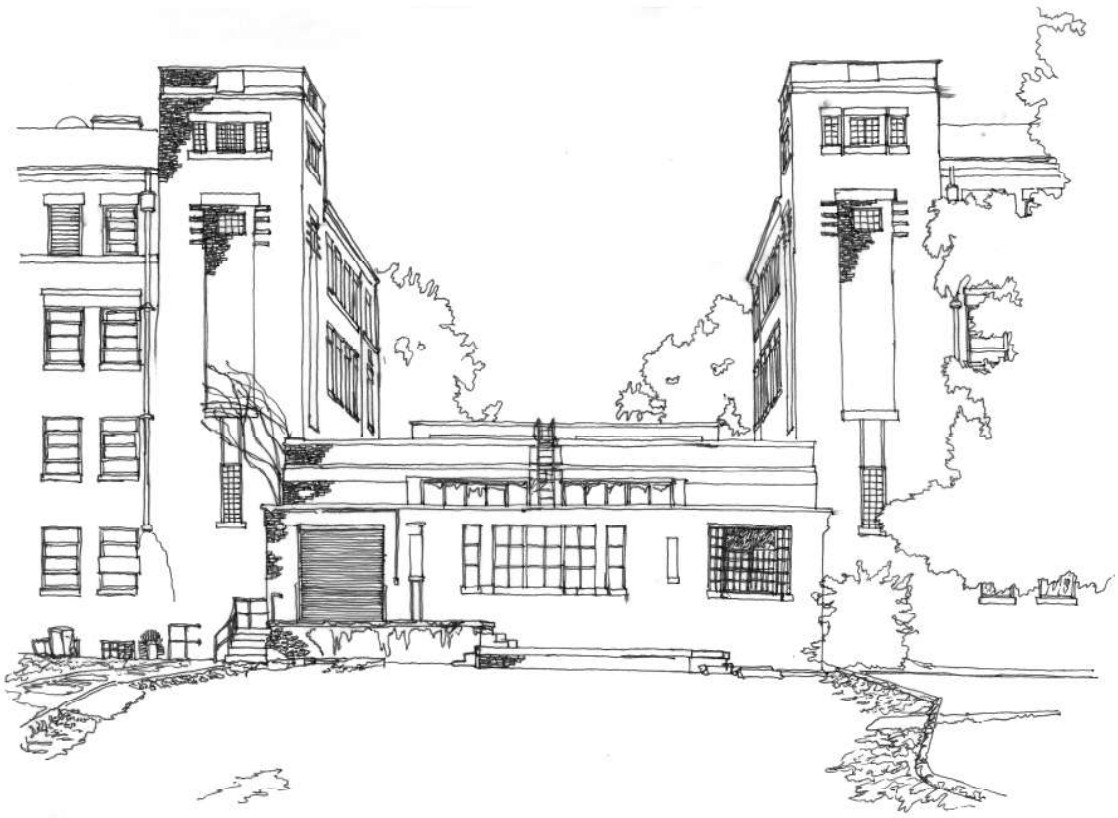

figure 2.4

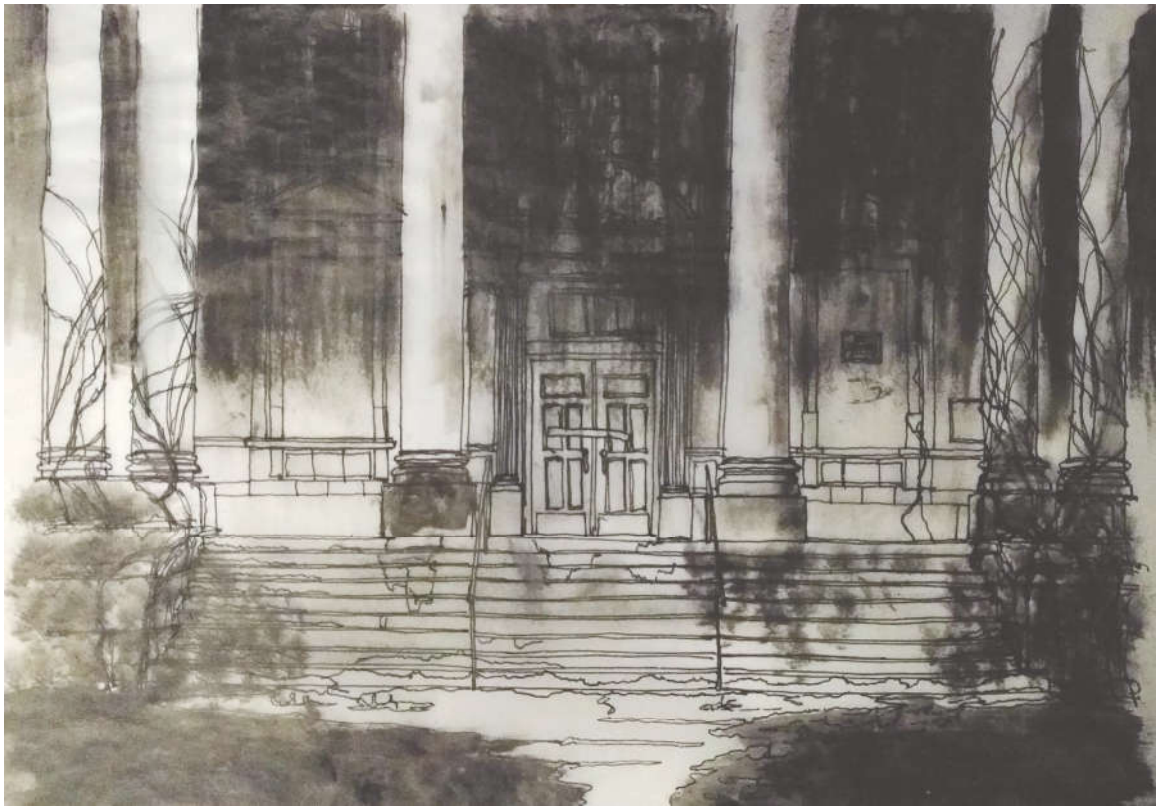

figure 2.5

figure 2.6

figure 2.7

FIFTY PORTRAITS

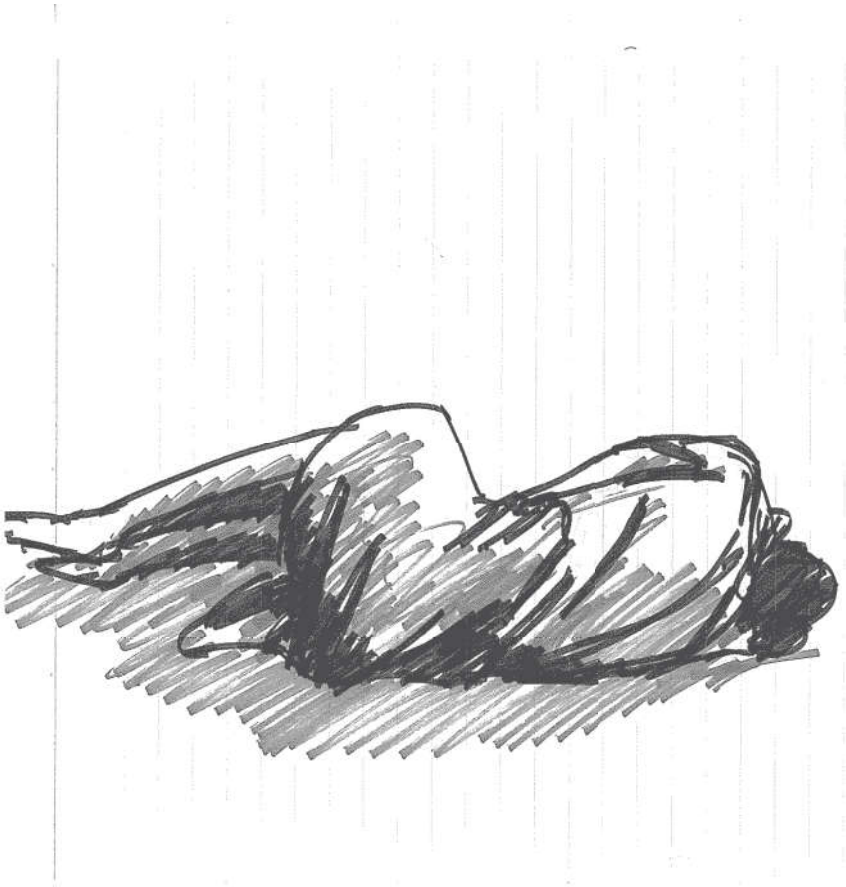

figure 3.1

A woman lies alone on the concrete floor of a day room. She is curled up in the fetal position, with only a thin canvas dress to provide her with warmth. There is nobody around to help her off the floor.

figure 3.2

This woman has been left alone on a wooden bench in another day room. She sits alone, head down, and hair in disarray. Her hands are bound by the fabric dress around her. Her feet are dirty and look as if they have not been washed in weeks. Her slumped posture suggests a private misery.

figure 3.3

A woman sits alone on a wooden bench in a day room. Her head rests on her knees. Her arms are holding her knees tight. She looks like she has been sitting in this same position for hours.

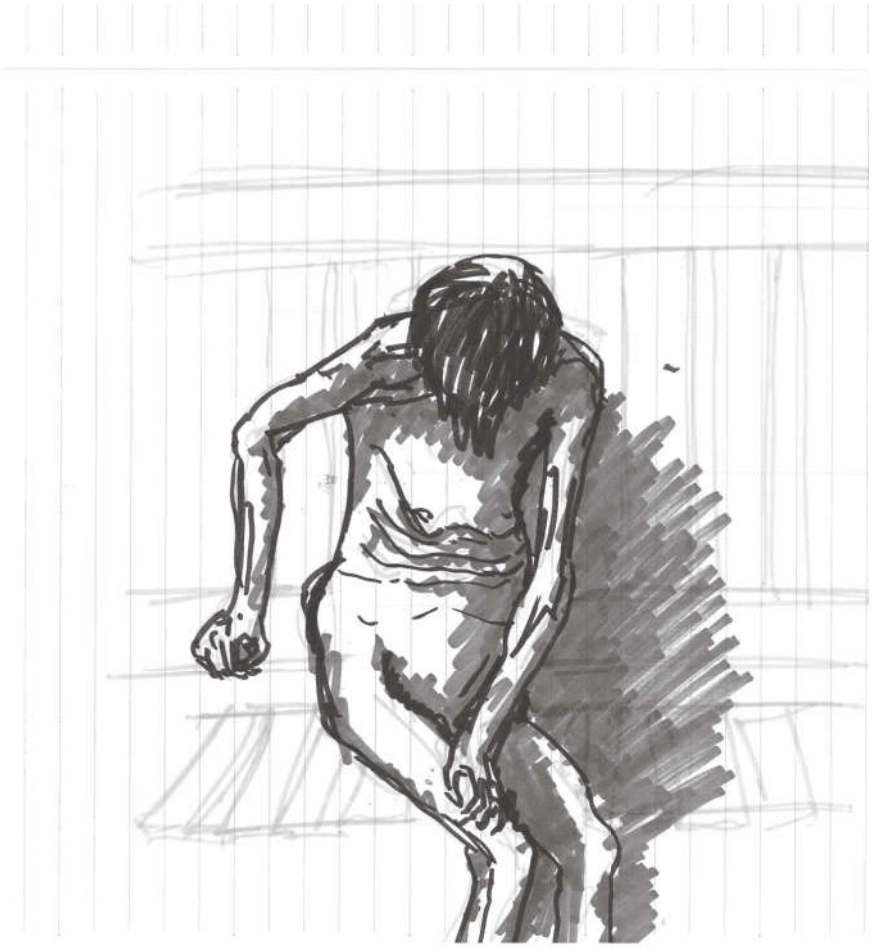

figure 3.4

An elderly woman sits alone on a wooden bench in a day room. Her nakedness and frailty give a sense of extreme vulnerability. It does not look like she has the strength to get up off the bench on her own.

figure 3.5

Two young women huddle in the corner of a day room. The first woman sits with her back against the wall and knees up. She is looking at a spot on the floor. The second woman is curled upright in the fetal position with her head buried in her knees.

figure 3.6

A young woman sits naked and alone in the corner of a dining hall. On the floor lies a tray with a simple meal. She is picking at a meal in a small metal dish.

figure 3.7

Two women sit in a crowded day room. They both have restraints on their upper bodies. The strain of the fabric suggest that they have been resisting against them for some time.

figure 3.8

A woman stares longingly out of a window. Perhaps she has chosen this spot to feel the warmth of sun on her face, but the belt tied between her jacket and bench suggest instead that the spot was chosen for her. Her knees are up against her chest, in some variant of the fetal position. The window is bolted shut and protected with a heavy wire mesh.

figure 3.9

A man sits naked on a rough concrete floor in the upright fetal position. His knees and arms are very close to his core, preserving as much body heat as possible. His hands are covering his face. This is the floor of the incontinent ward. Behind him against the wall sit six other figures in the fetal position, packed together for warmth. These men look like they are huddling together to keep warm in this cold room.

figure 3.10

Another man sits naked next to the first. He also has his arms and knees folded tight against his chest. To his left and right are more figures in similar positions. The scene is ghastly: a tight collections of bodies in distress and agony, bound in a small and windowless concrete basement.

figure 3.11

Two women sit on a wooden bench in a day room. The woman on the left is wrapped in a canvas straight-jacket top with no bottom. She sits slouched, legs crossed, and staring into the ground. The woman on the right is wearing a simple dress. Its proper fit and design suggests that it is a personal possession, rather than a hospital gown, brought from a world outside the institution.

figure 3.12

An elderly woman sits on the concrete floor of the day room, knees bent up against her chest with her arms wrapped around them. She slouches forward into her knees with a looseness that suggests extreme fatigue or depression. Her dress is carelessly draped over her thighs and ankles. Her white hair, unevenly cut and bushy, hangs over her head and covers most of her face. Her face is pressed against her knees. She is staring blankly into the distance from the gap in her hair.

figure 3.13

An elderly woman sits alone on a hard wooden bench in a day room. She slouches forwards with her knees up against her chest. Her hair is greasy and poorly cut – it does not look well taken care of. She is staring ahead at a spot on the ground. Her arms and legs are very thin and suggest severe nutritional deficiencies.

figure 3.14

A teenage boy sits on a wooden rocking chair, slouching slightly. He is sitting in the children's pavilion. A single teacher travels around the classroom, trying to help the boys read from books on the table. Few of the boys have their books out and ever fewer seem to be paying attention. She is clearly overworked. This patient has lost interest and is rocking in his chair while gazing into the distance. His right elbow sits on the armrest and he is idly playing with his cheek with his hand.

figure 3.15

A woman sits on a wooden bench in the day room. Her outfit is neat and she is alert. She is looking directly at the photographer.

figure 3.16

A woman sits in a ward room, tied to a wooden bench by a leather strap. It seems likely that the same attendant which dressed her and tied the delicate knot on the back of her dress also tied and tightened the leather straps bounding her to a piece of furniture.

figure 3.17

An elderly woman slouches forwards on a ward bench. She is dressed in a loose gown of a coarse canvas-like fabric. She is one of the few patients in this ward with shoes on. She is fidgeting with her hands. She gives the impression of someone in great boredom.

figure 3.18

A woman sits on a wooden bench, arms and legs crossed. Her gown hangs loosely on her body.

figure 3.19

A man sits in front of a table in a nearly empty dining hall, eating a meal alone. The rest of the tables have been cleared. The chairs have been left in total disarray. He is trying to use a piece of bread to scoop a slurry-like meal from a bowl. He has no eating utensils to help him.

figure 3.20

A man in a straight-jacket sits on a simple wooden bench in a lunch room. At attendant to his right has a food on the bench and spoon-feeds him from a bowl.

figure 3.21

An elderly woman sits on a crowded wooden bench in the day room. She is either unaware or indifferent to the commotion around her. Her muscles look frail and atrophied. It seems like she has spent many years at this hospital, passing day after day sitting on the same wooden benches.

figure 3.22

A woman turns towards a minor commotion at the entrance of the hall. Patients in the day room were kept together for most hours of the day.

figure 3.23

An elderly man sits on a simple wooden bench in a ward room. He looks under-fed – his arms and legs are extremely thin and his bones are clearly defined at the elbow and ankles. His loose canvas shirt looks especially large on his wiry frame.

figure 3.24

A man sits on a simple wooden bench, dressed in ill-fitting clothing. His jacket is a few sizes too large while his pants are too short. Patients in this mental hospital seem to be perpetually outfitted with mismatched garments.

figure 3.25

A man on the floor is suffering from an episode. His thin hospital gown offers little protection against the concrete floor. The room is full of other patients minding their own business. There are no attendants or doctors to help him.

figure 3.26

A doctor stands in front of a doorway, of which a woman is facing. The woman has her arms crossed in an act of defiance. Her shoulders are slightly forward and chin out, looking the doctor in the eye. The doctor has his hands on his hips, chest puffed out in a near comical fashion.

figure 3.27

Two men, guests of the hospital, tour a ward for children. A child, bound with a makeshift straight-jacket sits on a bed inside a metal cage. The lid of the cage is locked with a leather strap secured with a padlock. The room is packed and one can easily imagine twenty more children sleeping together in their caged beds.

figure 3.28

An attendant inspects a patient copying an illustration during an occupational therapy class.

figure 3.29

Two women arrive at a courtroom to declare their insanity to a judge. Three men to the right watch the women walk in front of them. They look predatory, lurking in the background with hands in pockets or arms folded. The two women are bound in hospital restraints which impede their movement. An attendant in a pressed uniform stands watch. The two patients amble slowly towards the courtroom door. Some mental hospitals required a confession of insanity before allowing patients to check themselves in. This process was both embarrassing and humiliating – patients would be transported like prisoners in a bus and deposited on the steps of the courthouse like common criminals.

figure 3.30

Four men sitting on a wooden bench in a day room. These men are dressed in overalls and work boots, suggesting that they have just returned from a work shift in the fields.

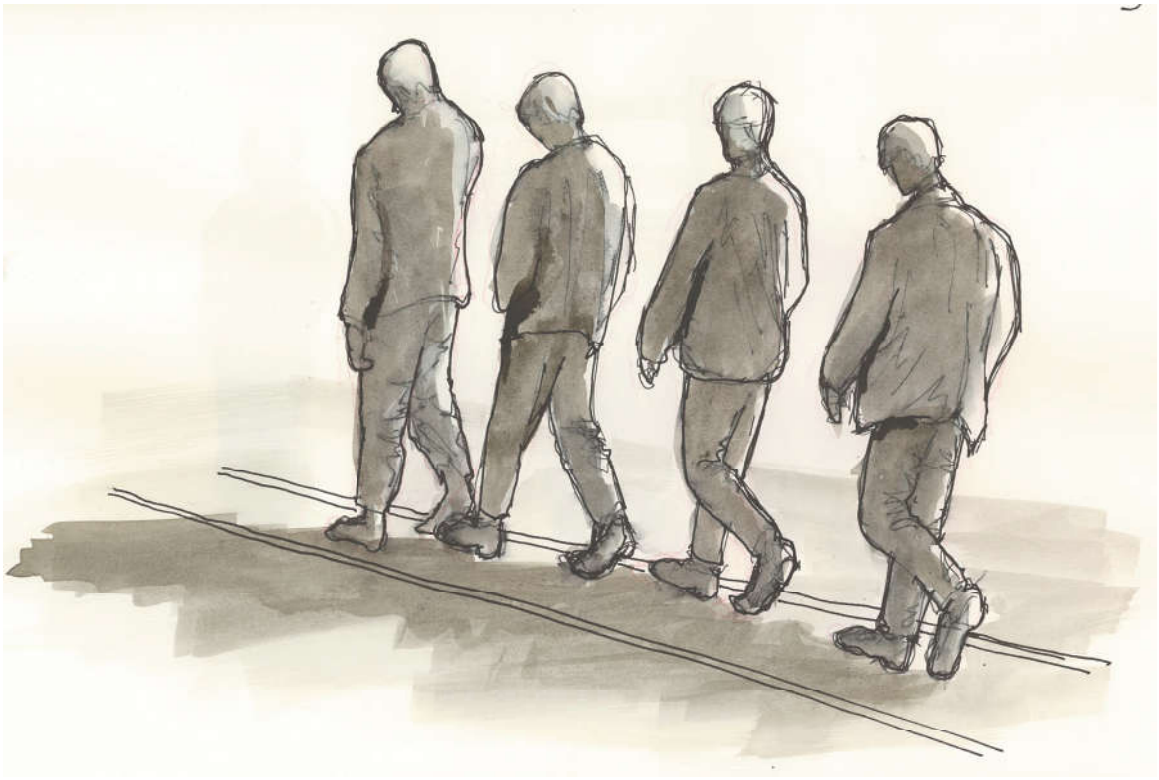

figure 3.31

A group of men walk between two painted lines in a gymnasium. After reaching the end of the path, they look back between another two lines beside the first two. An attendant watches the men walk in circles on the gymnasium floor.

figure 3.32

A wooden obstacle has been added to the end of the course.
Patients must pass under it to continue the course.

figure 3.33

Two children sit in the yard of a hospital. Around them sit another fifteen or so. There are very few children playing here. Most have resigned to sit against the wall, or on benches in the yard. It is a cheerless scene. There is little open space and no playground equipment. The boy on the right is sitting with both hands on his lap, waiting. The boy on the left sits with his against the wall, tired or bored.

figure 3.34

Two children play on the ground of the yard outside the hospital. The child on the right is holding an object on the ground with great care, while the child on the left watches on. Joe Rosenthal (the photographer who captured the image of the U.S. Marines raising the flag at Mt. Suribachi at the battle of Iwo Jima) commented brusquely: "Some of the things here are tougher on the guts than watching our men fight and die in the Pacific."

figure 3.35

A woman sits on a wooden bench in the day room. She is bound by a straight-jacked which is tied to the window. A censor had blacked out her eyes on the source photograph with a black marker.

figure 3.36

A woman in restraints sits in a chair in a busy day room. An attendant sits behind her, making sure she does not wander away. To the left, another group of attendants is performing a physical examination.

figure 3.37

A woman in a chair lifts her arms up for an attendant. The attendant makes a note in her log-book. Outside this scene, two men watch onwards.

figure 3.38

An attendant consoles a patient with a comforting hand while tightening the restraints with the other.

figure 3.39

An elderly woman sits at a table in the day room. She is mending a piece of fabric. A woolen jacket is wrapped around her neck for warmth.

figure 3.40

An elderly man stands in a corridor, looking at his jacket on the ground. It looks like he needs help to picking it up.

figure 3.41

A woman sits in a wooden chair in the day room. The room is sparsely populated with a few tables and chairs, laid out in no particular order. Her elbows rest on the top rail of the back of the chair. Her head is buried in her arms.

figure 3.42

An elderly man sits on a wooden chair at a barred window. He is slouched against the sill, elbow nudged between the bars with a hand holding up his forehead. Some hospitals had outdoor day rooms where patients could be shuffled in for fresh air while still remaining locked up. It looks like he has been slouched up against this window for some time.

figure 3.43

I returned to this source photograph over a year later from the first time I sketched it (figure 20). This time, I felt I understood the scene a little bit better. The scene is of a man in a straight-jacket, being forcefully spoon fed by an attendant standing over him. The attendant stands with one foot on the bench, shoulders forward and lording over the sitting man. The man in the straight-jacket begrudgingly accepts the unappetizing-looking food into his mouth.

figure 3.44

A young woman is dragged kicking and screaming down a corridor. The attendant on the right leads the patient on, her right shoulder pushing on her back and her left arm holding her head down. The corridor is wide, clear of obstruction and made of durable finishes.

figure 3.45

A woman lies in a small bed in a crowded day room. Beds are packed so tight that she would have to crawl over several other patients to go to the bathroom. Bodies are in various stages of tossing and turning around her. She lies wide awake, staring a spot in the ceiling.

figure 3.46

A woman is tied to her bed by restraints on both wrists. She is lying on her side, arms both to one side. She is unable to turn over or move freely in her sleep. The restraints look tight and uncomfortable to sleep with.

figure 3.47

Bed confined patients in a tuberculosis ward wait for attendants to bring them breakfast. This ward was bright and had plenty of natural light and ventilation. Patients who could afford to pay, or had family which paid for their stay could recieve better food, living conditions and more frequent medical attention.

figure 3.48

Patients sleep on thin mattresses on the floor of their day room. Overcrowding at many state hospitals turned many day rooms, corridors and other spaces into makeshift dormitories at night. Patients in this day room had few, if any personal posessions. Privacy was non existant.

figure 3.49

Two patients idle in a cheerless day room. A trio of benches occupy a nearly unfurnished room. Patients are treated to grand views of an outdoors that they have limited, or any access to.

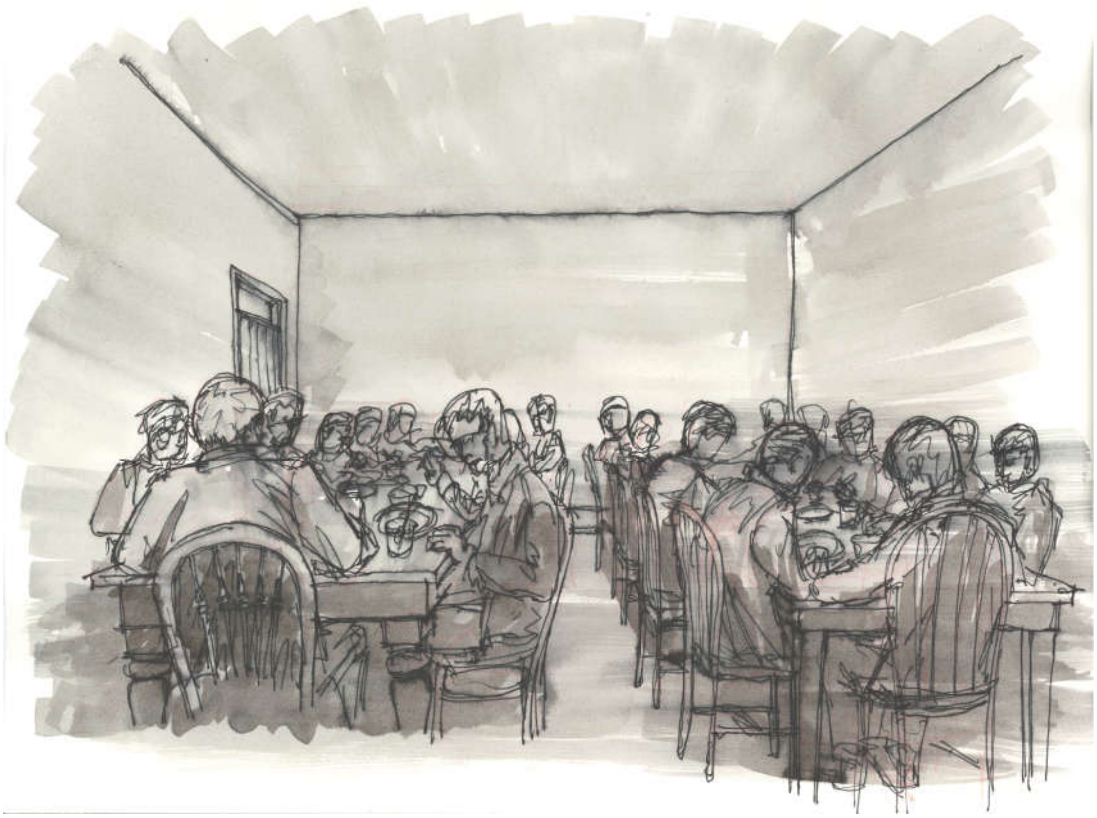

figure 3.50

Patients have lunch in a crowded, windowless dining room. There is hardly enough space to pass between chairs. The dishes consist of simple tin plates and bowls. Food is served from communal pots passed around the table. There are sometimes shortages of cutlery: some patients have brought their own spoons.

EPILOGUE / THE THESIS PROCESS

"They would have locked me up in this place fifty years ago" commented Natasha, my partner of six years. We were surveying Central State Hospital through Google Maps before my trip in person. I could not disagree with her - I had seen her episodes before medication and could imagine family or officials locking her away for life. I saw the cruel architectures of barbed wire and bars welded on windows and imagined a life inside waiting for death.

Natasha is the love of my life. I feel joy in my heart when she has a good day. I feel sadness when she tells me stories of the injustices in the world. I feel empty when she tells me she feels like nothing at all. The times where she feels like nothing at all can last for days, or weeks. These weeks are punctured with moments of despair - hours spent crying with no way to stop. She is a brave woman, and there is no doubt about it. I feel helpless because there is nothing I can do except comfort her. I have no idea when these next episodes will come. Some days I will return home and find her curled on the couch, in the same spot from the morning, a half-box worth of tissues spent wiping tears strewn about the floor. How does it feel to spend the equivalent of a whole work day crying? I know that even as I sit with her and give her all the support I can, that she is alone against the thing in her head.

After the episodes, she explains to me it is instead the lack of a thing which causes her such grief. There is an inability of her nervous system to properly release and regulate serotonin, the chemical which signals happiness in our nervous system. There are drugs to manage symptoms, but this particular discipline of pharmacy is very much in its infancy. She is in many ways unable to feel the same happiness and joy as others around us.

Natasha grew up in a home that did not believe in mental illness. Her parents would tell her "stop being so miserable." As a profoundly religious immigrant family, she said they were much more concerned with the salvation of her soul rather than the health of her mind. Or perhaps, they did not believe her and thought she was using her episodes to excuse herself from religious events.

Natasha would not get mental health help from her parents. It would not be until she left the household and attended university in a different city that she sought counselling and medication services. It was a combination of factors, leaving the controlling atmosphere of home and the availability of social and health services at the university which made help possible. Our health insurance plans with the university made it possible to pay for the series of counselling sessions, therapy sessions and psychiatric drugs necessary to treat her symptoms. Without these social security nets, we would have been in serious trouble. There is no doubt how expensive mental illness can be - both treatment as well as time lost from employment or school.

I hope these drawings give life to reader's impressions of the State Hospitals, or Asylums. These were not places filled with dangerous psychopath killers. Instead, these were institutional spaces which were designed to confine patients and let them both degrade mentally and physically. The question at the centre of my thesis was to ask what patient life was like inside the state hospitals. After living half a decade with a patient and spending a year reading and looking through photographs, I have taken the position that these spaces were places of despair, neglect, and loneliness. These spaces accepted unwanted people from broad geographic areas, segregated them into discrete groups and left them to rot, both physically and mentally. My work aims to express my understanding of these photographs - both to tell a story and to warn future architects of the horrors that they can create inside these secluded institutions.

I have learned that places where people are sent away from their families and communities, tend to collect these people. These places can grow unchecked through willful neglect, a 'collective amnesia' out of sight. Many architects and designers have had good intentions in designing for the patient. As architects, we must always keep these institutions for the vulnerable in sight.

ANNOTATED BIBLIOGRAPHY

Conover, Ted. *Newjack: Guarding Sing Sing.* (2000; reprint, New York: Vintage Press, 2001)

Ted Conover spends nearly a full year as a New York State Corrections Officer. Newjack is his non-fiction book about the unforgiving nature of prison life and the often-humiliating things experienced by both prisoner and guard. Conover wrote of an interview with a prison psychiatrist – the psychiatrist told him that life in prison was an incredible stressor, and that many people had their first breakdown in the penal institution. It was prison, the psychiatrist said, that made many people 'crazy' and further exacerbated those with pre-existing mental health condition. From his experiences, Conover was convinced that the prison environment did not help those with mental health issues, but only made them worse. Conover wrote his book from the perspective of a working prison guard – we do not understand the paths of the inmates which had led them to prison, or the psychiatric unit located inside. Conover acts as an agent caught between two forces: a brutal militaristic administration determined to keep order, using physical punishments and psychological tortures, and an incredibly stressed body of inmates with lots of idle time and no love of the brutal techniques used by the guards. His story is fraught with instances where he felt his own person was in physical danger from the inmates, whether it be being outnumbered by a mob armed with makeshift weapons, or having human excrement thrown at him from behind the bars. There are many instances where Conover, already on edge admits to using excessive force in fear of his life. The book is important in providing the perspective of a person employed by the prison-psychiatric system, and the real lack of emphasis on care at the guard and attendant level. This was the story of a man who worked in a human warehouse and spent most of his day keeping them locked up, under order, and keeping himself alive.

Cranford, Peter. *But for the Grace of God: Milledgeville. The Inside Story of the World's Largest Insane Asylum.* Augusta, Georgia: Great Pyramid Press, 1981.

Peter Cranford was a clinical psychologist at the Central State Hospital in Milledgeville. But for the Grace of God is a book written about his experiences in the hospital as well as excerpts from his diaries. The diaries are of specific interest – they capture the inner thoughts and stories of a doctor who oversaw several hundred, if not thousands of patients. The diaries are intimate - they tell the story of a man who has just arrived from Texas to this strange town of fifteen thousand and is trying to understand the place. They are peppered of stories of patients and families using the guise of 'mentally ill' to check themselves,

or others into the institution. He recounts a story where a man was registered as being paranoid and issuing homicidal threats. The man claimed that he and his wife cooked up his charges as they could not afford private care so that he would be sent to Milledgeville instead. The other patients pooled funds to send their attendant home to talk to his wife – the wife tells the attendant that she doesn't want the man out; he was so violent with her that she wanted him to stay locked up. The stories are colloquial, at times casually racist, revealing a fondness for young attendants, and ultimately showing his inner doubt at the effectiveness of some of the treatments being provided in the institution. At times Cranson writes as a travel writer, marveling at the subculture of the superlarge institution. He is incredulous at the smaller patient run institutions. He notes the Opera at Milledgeville, where patients could choose to watch in a field on the hospital grounds. The book is not particularly analytical, and functions more as a primary document then a retrospective.

Deutsch, Albert. *The Shame of the States.* (New York: Harcourt, Brace and Company, 1948, reprint, New York: Arno Press, 1973)

Albert Deutsch toured State Mental Hospitals across America in the 1940s with a team of photographers. The Shame of the States his report on the deplorable conditions of the hospitals he found. Deutsch believed that it was only through public exposure of the poor treatment of human beings would legislators be forced to react. Deutsch described in vivid detail the hospital wards in words a layman could understand. The photographs are framed in a way that the patients occupy the space of the viewer – one can see how tight a patient is grasping her legs as she hides under a rough, wooden bench. The Shame of the States tours thirteen hospitals across the United States. Deutsch's work is one of the best documents which describe the overall condition of State Mental Hospitals all across America, from the West coast to the East coast, and including both urban and rural areas. The sample size large enough to dispel excuses of these poor conditions being confined to single hospitals. Deutsch wrote not as a doctor nor psychiatrist, but as an observer of the social conditions around him. In the hospital in Milledgeville, Deutsch describes walking in a four-storey rotting wood building, through a dimly lit hall, and being startled by the wails of women as they flailed on the floor and on dirty mattresses. This work was key to my thesis as the photographs just made me so uncomfortable. These were powerless people in despair, left in anonymous rooms by the thousands. The photographs are an accusation to the viewer, which questions how one can live while city-sized warehouses for the so called insane house people in truly abhorrent conditions.

Kirkbride, Thomas Story. *On the Construction, Organization, and General Arrangements of Hospitals for the Insane, second edition.* (Philadephia: J.B. Lippencott and Company, 1880; reprint, New York: Arno Press, 1973)

Thomas Kirkbride was the Physician-In-Chief and the Superintendent of the Pennsylvania Hospital for the Insane. On the construction, organization, and general arrangements of hospitals for the insane is written as a guide on how to design an ideal Asylum based upon Kirkbride's experiences as both a doctor and administrator. He was concerned about the medical side of managing an asylum, but also about the economics of care. The work was widely circulated and accepted in the late 19th century, and led to a generation of "Kirkbride Buildings" which were close iterations of Kirkbride's formulaic hospital layout. Kirkbride is thorough and descriptive of his idea hospital. In his view, the ideal hospital was a three storey symmetrical building, dividing patient populations by gender, then by afflictions in wards connected by a single long corridor. He was prescriptive in how many patients would reside in a ward, as well as the organizations of day rooms, occupational therapy rooms, and dining rooms. He also made the distinction between the types of insanity which he believed were curable, and those which were not. He recommended that patients be sorted by curability, as well as other methods of management such as excitability. Kirkbride's work is key to understanding American State Mental Hospitals. Hospitals constructed almost a century later still follow many of the basic tenents set out in Kirkbride's work. It is arguable that many of the hospital buildings constructed in Milledgeville in 1940 and 1950 follow his original layout very closely. My work examines State Mental Hospitals all across America – Kirkbride is a good starting point.

McKague, Carla. "Myths of Mental Illness." *Phoenix Rising: The Voice of the Psychiatrized* (1980-1990), Vol. 1 (1980): 1-14.

Carla McKague was a former psychiatric patient and later became an advocate for patients in the mental health care system. In 1979, as a third-year law student, she delivered a speech to the Kingston chapter of the Canadian Mental Health Association. McKague's thesis is that mental hospitals and their array of medicalized treatments and drug therapies are ultimately harmful for people – rather, patients are looking for friendship and understanding, and people who can understand that some people are just a little different than the rest. In McKague's experience, one of the main reasons that patients returned to hospitals was that they had such difficulty finding places to live and work that they had nowhere else to turn to. The transcript of McKague's speech was a short seven pages, yet very effective. For her, the entire existence of the mental hospital did more harm, and often caused side effects worse than the original symptoms. She argued that patients needed more legal protection, and that it should be much more difficult to force

someone to receive treatment or to be forcibly hospitalized. The text is an elegant and accusatory rebuke at the idea of the mental hospital, and by extension forced confinement. In terms of my research, McKague's speech brings to light the right to refuse treatment. My drawings often showed patients physically resisting attendants or struggling against their restraints. What the drawings don't and can't show are the legal relationships; the limits on what a patient could say no to and their rights within the authoritative institution of the mental hospital.

Meskell, Lynn. "Negative Heritage and Past Mastering in Archaeology." *Anthropological Quarterly*, Vol. 75, No. 3 (Summer, 2002): 557-574.

Lynn Meskell, Associate Professor of Anthropology at Columbia University, tackles the topic of what to do with architecture embodied with a negative history. Meskell wrote the paper Negative Heritage and Past Mastering in Archaeology half a year after the events of 9/11, during a time of discussion of what the memorial should look like. Meskell's thesis is that is critical to shift the definition of the 9/11 memorial, in its future form, from being a memorialization in shape of the 'current nationalist fervor'. She argues that it would be more appropriate to recognize the layered and multicultural agendas, and thus frame the memorial as a didactic tool explaining cultural differences and intolerance. Meskell brings up two examples of architectures being incompatible with contemporary orders – first, the integration of Nazi architectures in a post-war Germany, and second, the destruction of the Bamiyan Buddhas by the Taliban in Afghanistan. She brings up the duality of negative heritage in the case of the Buddhas destruction. For the Taliban, the existence of such religious iconography was anathema and a site of negative heritage, one that had to be erased as a part of their definition of a new national identity. For much of the rest of the world, that erasure became the site of a new negative heritage, one where cultural artefacts were destroyed as an act of intolerance of others. Meskell's essay framed a very difficult question I was having in the beginning of my thesis – the question of if, and how much we should preserve mental hospitals. Patients show an almost universal hatred of these buildings, as the sight of any of them will bring back painful memories of electroshock therapy, solitary confinement, and other inhumane treatments. However, erasure of the buildings – whether by adaptation to other uses (the adaptation of Buffalo's Insane Asylum into a high-end boutique hotel, an example of erasure by whitewashing) or neglect – may contribute to our willingness to forget such a painful period in our collective memory.

Nelson, Jack. "Unapproved Drugs Given Mental Cases." *The Atlanta Constitution* (1946-1984), March 5, 1959.
Nelson, Jack. "Doctor Quits Milledgeville On 'Demand'." *The Atlanta Constitution* (1946-1984), March 17, 1959.
Nelson, Jack. "Transfer Hospital, Investigators Urge." *The Atlanta Constitution* (1946-1984), April 24, 1959.
Nelson, Jack. "Vandiver Finds Hospital 'Worse Than I Thought'." *The Atlanta Constitution* (1946-1984), July 10, 1959.
Nelson, Jack. "9 Mental Centers Proposed for State." *The Atlanta Constitution* (1946-1984), August 27, 1959.
Nelson, Jack. "'Why Am I in Here?' Plead Fulton's Jailed Mental Cases." *The Atlanta Constitution* (1946-1984), October 23, 1959.
Nelson, Jack. "Jolted Legislators Vow Hospital Aid." *The Atlanta Constitution* (1946-1984), November 3, 1959.
Nelson, Jack. "Tour of Milledgeville Ends; Rep. Kidd Asks Budget Rise." *The Atlanta Constitution* (1946-1984), November 25, 1959.

Jack Nelson of The Atlanta Constitution won a Pulitzer Prize in 1960 for his breaking news reporting of the abysmal conditions at Central State Hospital, Milledgeville. Over the span of almost a year, Nelson convinced doctors and administrators to let him tour the hospital. His work included publicizing a multitude of disciplinary actions against doctors, and interviewing patients who were erroneously placed in the institution but could not get out. He wrote vividly of the dangerous conditions in the overcrowded and poorly designed wards. He also wrote of unethical drug trials being performed on patients without their knowledge, or consent. These articles were the main body of work for his accusation against both Hospital administrators and the State for allowing conditions to deteriorate so far. These articles ultimately coincided with the Governor of Georgia touring the Hospital and declaring it a hazard to human life. Nelson's work is historically significant because it was the first chance that many Georgians had to understand life behind the high walls of the elusive and secluded Central State Hospital. For my research, Nelson's reporting gave day-to-day details of life inside the institution which would not have been recorded anywhere else. For instance, Nelson reported that Governor Vandivier commented that one of the wards, a fifty-eight-year-old building converted from a prison was a 'fire trap'. The patients had been employed in the fields for labour, and unappetizing meals had been left on some tables on the lunch rooms inside. Vandivier commented 'I don't see how a dog could have eaten it." Nelson's reporting gave me a better understanding of the atmosphere of the Hospital that may not have come through in the photographs.

Rosenhan, David. "Being Sane in Insane Places." *Science*, Vol. 179 (January, 1973): 250-258.

David Rosenhan, an American Psychologist, wrote his most famous paper "Being Sane in Insane Places" in 1973, at a time where many mental hospitals were being shut down. Rosenhan and seven other colleagues posed as pseudo-patients to gain access into various mental hospitals. The pseudo-patients claimed to hear voices during their intake examinations, but after admission acted in a perfectly 'normal' for the rest of their stay. None of the patients were registered as fully sane, and always kept the tag of 'schizophrenic' or 'schizophrenic in remission'. Rosenhan's thesis is that diagnosed labels are grossly inaccurate, and that these labels are very harmful in how doctors, friends, and family view the patient. It was rather the hospital setting which caused the most harm to one's mental wellbeing. The data taken from this experiment is both quantitative and qualitative. Although Rosenhan notes that none of the pseudo-patients were ultimately detected, it was the qualitative observations of how they were treated which alarmed him the most. Rosenhan speaks of attendants physically and verbally abusing patients for the most minor of things. For him, it was the state of being powerless and the act of depersonalization which halted any process of healing. As a student studying the Mental Hospital almost fifty years after depersonalization, I had a difficult time imagining myself walking through the institution. I am lucky enough to not suffer from mental illness, and often wondered how many misdiagnosed patients received a designation and then were not permitted to leave. Rosenhan's description of these hospital's basic failure to detect 'sanity' paints a tarrying picture of the unchecked rules of incarceration in these institutions.

Steadman, Henry, John Monahan, Barbara Duffee, Eliot Hartstone, and Pamela Robbins. "The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978." *The Journal of Criminal Law & Criminology*, Vol. 75, No. 2. (1984): 474-490.

Steadman et al. published their retrospective paper on the relationship between the populations of the State Mental Hospitals and the populations of the State Prison systems. Their hypothesis was that many patients who were released from State Hospitals were eventually picked up through each State's criminal justice system. They looked at data from six states: New York, California, Arizona, Texas, Iowa, and Massachusetts. They found that there was no strong correlation between the two systems during the period of deinstitutionalization. However, they suggested that it was rather the buffer institutions, such as care homes, community residences, men's shelters, and local prisons which take on the largest portion of released patients. Steadman et al. found that State Prisons only took on a relatively small portion versus

significant increases in the other institutions. The paper is important in debunking one of the prevalent myths in the 1980s that State Prisons were experiencing an explosion in population directly because of the release of mental patients from State Hospitals. In terms of my research, Steadman et al.'s paper suggests that many patients would not experience a coherent deinstitutionalization process. They argued that in sum, the use of these institutions is a measure of society's general tolerance of deviance with a direct correlation to incarceration rates. Many local and community institutions would struggle to manage a large flow of patients, many of which who would have difficulty readjusting to regular life after many years in confinement. Although the bulk of my research focused on life inside the institution, it is important to understand the life that patients would live after leaving the State Hospitals. Many would not have sufficient financial or transitional support, and would end up in smaller, local community institutions.

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