The Lost Virtues of the Asylum

Oliver Sacks

We tend to think of mental hospitals as snake pits, hells of chaos and misery, squalor and brutality. Most of them, now, are shuttered and abandoned—and we think with a shiver of the terror of those who once found themselves confined in such places. So it is salutary to hear the voice of an inmate, one Anna Agnew, judged insane in 1878 (such decisions, in those days, were made by a judge, not a physician) and "put away" in the Indiana Hospital for the Insane. Anna was admitted to the hospital after she made increasingly distraught attempts to kill herself and tried to kill one of her children with laudanum. She felt profound relief when the institution closed protectively around her, and most especially by having her madness recognized. As she later wrote:

> Before I had been an inmate of the asylum a week, I felt a greater degree of contentment than I had felt for a year previous. Not that I was reconciled to life, but because my unhappy condition of mind was understood, and I was treated accordingly. Besides, I was surrounded by others in like bewildered, discontented mental states in whose miseries…I found myself becoming interested, my sympathies becoming aroused.… And at the same time, I too, was treated as an insane woman, a kindness not hitherto shown to me.
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> Dr. Hester being the first person kind enough to say to me in answer to my question, "Am I insane?" "Yes, madam, and very insane too!"… "But," he continued, "we intend to benefit you all we can and our particular hope for you is the restraint of this place."…I heard him [say] once, in reprimanding a negligent attendant: "I stand pledged to the State of Indiana to protect these unfortunates. I am the father, son, brother and husband of over three hundred women…and I'll see that they are well taken care of!"

Anna also spoke (as Lucy King recounts in her book *From Under the Cloud at Seven Steeples*[1]) of how crucial it was, for the disordered and disturbed, to have the order and predictability of the asylum:

> This place reminds me of a great clock, so perfectly regular and smooth are its workings. The system is perfect, our bill of fare is excellent, and varied, as in any well-regulated family.… We retire at the ringing of the telephone at eight o'clock, and an hour later, there's darkness and silence…all over this vast building.

The old term for a mental hospital was "lunatic asylum," and "asylum," in its original usage, meant refuge, protection, sanctuary—in the words of the *Oxford English Dictionary*, "a benevolent institution according shelter and support to some class of the afflicted, the unfortunate, or destitute." From at least the fourth century AD, monasteries, nunneries, and churches were places of asylum. And to these were added secular asylums, which (so Michel Foucault suggests) emerged with the virtual annihilation of Europe's lepers by the Black Death and the use of the now vacant leprosaria to house the poor, the ill, the insane, and the criminal. Erving Goffman, in his famous book *Asylums*,[2] ranks all these together as "total institutions"—places where there is an unbridgeable gulf between staff and inmates, where rigid rules and roles preclude any sense of fellowship or sympathy, and where inmates are deprived of all autonomy or freedom or dignity or self, reduced to nameless ciphers in the system.

By the 1950s, when Goffman was doing his research at St. Elizabeth's Hospital in Washington, D.C., this was indeed the case, at least in many mental hospitals. But to create such a system was hardly the intent of the high-minded citizens and philanthropists who had been moved to found many of America's lunatic asylums in the early and middle years of the nineteenth century. In the absence of specific medications for mental illness at this time, "moral treatment"—a treatment directed toward whole individuals and their potential for physical and mental health, not just a malfunctioning part of their brain—was considered the only humane alternative.

These first state hospitals were often palatial buildings, with high ceilings, lofty windows, and spacious grounds, providing abundant light, space, and fresh air, along with exercise and a varied diet. Most asylums were largely self-supporting and grew or raised most of their own food. Patients would work in the fields and dairies, work being considered a central form of therapy for them, as well as supporting the hospital. Community and companionship, too, were central—indeed vital—for patients who would otherwise be isolated in their own mental worlds, driven by their obsessions or hallucinations. Also crucial was the recognition and acceptance of their insanity (this, for Anna Agnew, was a great "kindness") by the staff and other inmates around them.

Finally, coming back to the original meaning of "asylum," these hospitals provided control and protection for patients, both from their own (perhaps suicidal or homicidal) impulses and from the ridicule, isolation, aggression, or abuse so often visited upon them in the outside world. Asylums offered a life with its own special protections and limitations, a simplified and narrowed life perhaps, but within this protective structure the freedom to be as mad as one liked and, for some patients at least, to live through their psychoses and emerge from their depths as saner and stabler people.

In general, though, patients remained in asylums for long terms. There was little preparation for a return to life outside, and perhaps after years cloistered in an asylum, residents became "institutionalized" to some extent: they no longer desired, or could no longer face, the outside world. Patients often lived in state hospitals for decades, and died in them—every asylum had its own graveyard. (Such lives have been reconstructed with great sensitivity by Darby Penney and Peter Stastny in their book *The Lives They Left Behind*.[3])

It was inevitable, under these circumstances, that the asylum population should grow—and individual asylums, often immense to begin with, came to resemble small towns. Pilgrim State, on Long Island, housed more than 14,000 patients at one time. Inevitable, too, that with these huge numbers of inmates, and inadequate funding, state hospitals fell short of their original ideals. By the latter years of the nineteenth century, they had already become bywords for squalor and negligence, and were often run by inept, corrupt, or sadistic bureaucrats—a situation that persisted through the first half of the twentieth century.

There was a similar evolution, or devolution, at Creedmoor Hospital in Queens, New York, which had been established in 1912, very modestly, as the Farm Colony of Brooklyn State Hospital, holding to the nineteenth-century ideals of providing space, fresh air, and farming for its patients. But Creedmoor's population soared—it reached seven thousand by 1959—and, as Susan Sheehan showed in her 1982 book, *Is There No Place on Earth for Me?*, it became, in many ways, as wretched, overcrowded, and understaffed as any other state hospital. And yet the original gardens and livestock were maintained, providing a crucial resource for some patients, who could care for animals and plants, even though they might be too disturbed, too ambivalent, to maintain relationships with other human beings.

At Creedmoor, there were gymnasia, a swimming pool, and recreation rooms with ping-pong and billiards tables; there was a theater and a television studio, where patients could produce, direct, and act in their own plays—plays that, like de Sade's theater in the eighteenth century, could allow creative expression of their own concerns and predicaments. Music was important—there was a small patient orchestra—and so, too, was visual art. (Even today, with the bulk of the hospital closed down and falling into decay, the remarkable Living Museum at Creedmoor provides patients with the materials and space to work on painting and sculpture. One of the Living Museum's founders, Janos Marton, calls it a

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St. Lawrence State Hospital, Ogdensburg, New York; photographs by Christopher Payne from Asylum: Inside the Closed World of State Mental Hospitals, *published this month by MIT Press*

[1] *From Under the Cloud at Seven Steeples, 1878–1885: The Peculiarly Saddened Life of Anna Agnew at the Indiana Hospital for the Insane* (Guild Press/Emmis, 2002).

[2] *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor, 1961).

[3] *The Lives They Left Behind: Suitcases from a State Hospital Attic* (Bellevue Literary Press, 2008).

"protected space" for the artists.)

There were gigantic kitchens and laundries, and these, like the gardens and livestock, provided work and "work therapy" for many of the patients, along with opportunities for learning some of the skills of daily life, which, with their withdrawal into mental illness, they might never have acquired before. And there were great communal dining rooms, which, at their best, fostered a sense of community and companionship.

Thus, even in the 1950s, when conditions in state hospitals were so dismal, some of the good aspects of an asylum life were still to be found in them. There were often, even in the worst hospitals, pockets of human decency, of real life and kindness.

The 1950s brought the advent of specific antipsychotic drugs, drugs that seemed to promise at least some alleviation or suppression of psychotic symptoms, if not a "cure" for them. The availability of these drugs strengthened the idea that hospitalization need not be custodial or lifelong. If a short stay in the hospital could "break" a psychosis and be followed by patients returning to their own communities, where they could be maintained on medication and monitored in outpatient clinics, then, it was felt, the prognosis, the whole natural history of mental illness, might be transformed, and the vast and hopeless population of asylums drastically reduced.

During the 1960s, a number of new state hospitals dedicated to short-term admissions were built on this premise. Among these was Bronx State Hospital (now Bronx Psychiatric Center). Bronx State had a gifted and visionary director and a handpicked staff when it opened in 1963, but for all its forward-looking orientation, it had to deal with an enormous influx of patients from the older hospitals, which were now starting to be closed down. I began work as a neurologist there in 1966 and, over the years, I was to see hundreds of such patients, many of whom had spent most of their adult lives in hospitals.

There were, at Bronx State as at all such hospitals, great variations in the quality of patient care: there were good, sometimes exemplary, wards, with decent, thoughtful physicians and attendants, and bad, even hideous ones, marked by negligence and cruelty. I saw both of these in my twenty-five years at Bronx State. But I also have memories of how some patients, no longer violently psychotic or on locked wards, might wander tranquilly around the grounds, or play baseball, or go to concerts or films. Like the patients at Creedmoor, they could produce shows of their own, and at any time, patients could be found reading quietly in the hospital library or looking at newspapers or magazines in the dayrooms.

Sadly and ironically, soon after I arrived in the 1960s, work opportunities for patients virtually disappeared, under the guise of protecting their rights. It was considered that having patients work in the kitchen or laundry or garden, or in sheltered workshops, constituted "exploitation." This outlawing of work—based on legalistic notions of patients' rights and not on their real needs—deprived many patients of an important form of therapy, something that could give them incentives and identities of an economic and social sort. Work could "normalize" and create community, could take patients out of their solipsistic inner worlds, and the effects of stopping it were demoralizing in the extreme. For many patients who had previously enjoyed work and activity, there was now little left but sitting, zombielike, in front of the now-never-turned-off TV.

The movement for deinstitutionalization, starting as a trickle in the 1960s, became a flood by the 1980s, even though it was clear by then that it was creating as many problems as it solved. The enormous homeless population, the "sidewalk psychotics" in every major city, were stark evidence that no city had an adequate network of psychiatric clinics and halfway houses, or the infrastructure to deal with the hundreds of thousands of patients who had been turned away from the remaining state hospitals.

The antipsychotic medications that had ushered in this wave of deinstitutionalization often turned out to be much less miraculous than originally hoped. They might lessen the "positive" symptoms of mental illness—the hallucinations and delusions of schizophrenia. But they did little for the "negative" symptoms—the apathy and passivity, the lack of motivation and ability to relate to others—that were often more disabling than the positive symptoms. Indeed (at least in the manner they were originally used), the antipsychotic drugs tended to lower energy and vitality and produce an apathy of their own. Sometimes there were intolerable side effects, movement disorders like parkinsonism or tardive dyskinesia, which could persist for years after the medication had been stopped. And sometimes patients were unwilling to give up their psychoses, psychoses that gave meaning to their worlds and situated them at the center of these worlds. So it was common for patients to stop taking the antipsychotic medicine they had been prescribed.

Thus many patients who were given antipsychotic drugs and discharged had to be readmitted weeks or months later. I saw scores of such patients, many of whom said to me, in effect, "Bronx State is no picnic, but it is infinitely better than starving, freezing on the streets, or being knifed on the Bowery." The hospital, if nothing else, offered protection and safety—offered, in a word, asylum.

By 1990 it was very clear that the system had overreacted, that the wholesale closings of state hospitals had proceeded far too rapidly, without any adequate alternatives in place. It was not wholesale closure that the state hospitals needed, but fixing: dealing with the overcrowding, the understaffing, the negligences and brutalities. For the chemical approach, while necessary, was not enough. We forgot the benign aspects of asylums, or perhaps we felt we could no longer afford to pay for them: the spaciousness and sense of community, the place for work and play, and for the gradual learning of social and vocational skills—a safe haven that state hospitals were well-equipped to provide.

One must not be too romantic about madness, or the madhouses in which

the insane were confined. There is, under the manias and grandiosities and fantasies and hallucinations, an immeasurably deep sadness about mental illness, a sadness that is reflected in the often grandiose but melancholy architecture of the old state hospitals. As Christopher Payne's photographs attest in his new book *Asylum*,[4] their ruins, desolate today in a different way, offer a mute and heartbreaking testimony both to the pain of those with severe mental illness and to the once-heroic structures that were built to try to assuage that pain.

Payne is a visual poet as well as an architect by training, and he has spent years finding and photographing these buildings—often the pride of their local communities and a powerful symbol of humane caring for those less fortunate. His photographs are beautiful images in their own right, and they also pay tribute to a sort of public architecture that no longer exists. They focus on the monumental and the mundane, the grand façades and the peeling paint.

Payne's photographs are powerfully elegiac, perhaps especially so for someone who has worked and lived in such places and seen them full of people, full of life. The desolate spaces evoke the lives that once filled them, so that, in our imaginations, the empty dining rooms are once more thronged with people, and the spacious dayrooms with their high windows again contain, as they once did, patients quietly reading or sleeping on sofas or (as was perfectly permissible) just staring into space. They evoke for me not only the tumultuous life of such places, but the protected and special atmosphere they offered when, as Anna Agnew noted in her diary, they were places where one could be both mad and safe, places where one's madness could be assured of finding, if not a cure, at least recognition and respect, and a vital sense of companionship and community.

What is the situation now? The state hospitals that still exist are almost empty and contain only a tiny fraction of the numbers they once had. The remaining inmates consist for the most part of chronically ill patients who do not respond to medication, or incorrigibly violent patients who cannot be safely allowed outside. The vast majority of mentally ill people therefore live outside mental hospitals. Some live alone or with their families and visit outpatient clinics, and some stay in "halfway houses," residencies that provide a room, one or more meals, and the medications that have been prescribed.

Such residences vary greatly in quality—but even in the best of them (as brought out by Tim Parks in his review of Jay Neugeboren's book about his schizophrenic brother, *Imagining Robert*,[5] and by Neugeboren himself, in his recent review of *The Center Cannot Hold*, Elyn Saks's autobiographical account of her own schizophrenia[6]), patients may feel isolated and, worst of all, scarcely able to get the psychiatric advice and counseling they may need. The last fifteen years or so have seen a new generation of antipsychotic drugs, with better therapeutic effects and fewer side effects, but the too exclusive an emphasis on "chemical" models of schizophrenia, and on purely pharmacological approaches to treatment, may leave the central human and social experience of being mentally ill untouched.

Particularly important in New York City—especially since deinstitutionalization—is Fountain House, which was established sixty years ago, and provides a clubhouse on West 47th Street for mentally ill people from all over the city. Here they can come and go freely, meet others, eat communally, and, most importantly, be helped to secure jobs and fill out tax forms and tricky paperwork of one sort or another. Similar clubhouses have now been established in many cities. There are dedicated staff members and volunteers at these clubhouses, but they are crucially dependent on private funds, and these have been less forthcoming during the current recession.

There are also, intriguingly, certain residential communities that derive, historically, both from the asylums and the therapeutic farm communities of the nineteenth century, and these provide, for the fortunate few who can go to them, comprehensive programs for the mentally ill. I have visited some of these—Gould Farm in Massachusetts, Cooper Riis in North Carolina—and seen in them much of what was admirable in the life of the old state hospitals: community, companionship, opportunities for work and creativity, and respect for the individuality of everyone there, now coupled with the best of psychotherapy and whatever medication is needed.

Often it is rather modest medication in these ideal circumstances. Many of the patients in such places (though they may remain schizophrenic or bipolar for the rest of their lives, in the sense that a diabetic remains a diabetic) may graduate after several months or perhaps a year or two, and be able to lead full and satisfying lives with no relapses, no recidivism, no looking back.

Christopher Payne

A patient-made game, Cherokee State Hospital, Cherokee, Iowa

But there are only a handful of comparable facilities in the US—they can accommodate no more than a few hundred patients out of the millions that exist. These patients must depend on their families to help pay the very considerable costs of staying there—more than $100,000 a year—and on whatever can be raised from private sources.

The remainder—the 99 percent of the mentally ill who have insufficient resources of their own—must face inadequate treatment and lives that cannot reach their potential. The National Alliance for the Mentally Ill does what it can, but the millions of mentally ill remain the least supported, the most disenfranchised, and the most excluded people in our society today. And yet it is clear—from the experiences of places like Cooper Riis and Gould Farm, and of individuals like Elyn Saks—that schizophrenia is not necessarily a relentlessly deteriorating illness (although it can be); and that, in ideal circumstances, and when resources are available, even the most deeply ill people—who have been relegated to a "hopeless" prognosis—may be enabled to live satisfying and productive lives. □

[4]To be published by MIT Press at the end of September. This essay will appear in somewhat different form as the introduction.

[5]*Imagining Robert: My Brother, Madness, and Survival* (Morrow, 1997); see Tim Parks's review in these pages, "In the Locked Ward," February 24, 2000.

[6]*The Center Cannot Hold: My Journey Through Madness* (Hyperion, 2007); see Jay Neugeboren's review in these pages, "Infiltrating the Enemy of the Mind," April 12, 2008.