Separate and Unequal: The Legacy of Racially Segregated Psychiatric Hospitals
A Cultural Competence Training Tool

Vanessa Jackson, LCSW

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Please contact Vanessa Jackson
P.O. Box 10796, Atlanta, Georgia 30310
healingcircles@hotmail.com

In Celebration of Jennie Fulgham for her passion for mental health
And her willingness to tell a brutal truth when necessary

In Memory of Quincy Boykin, Pearl Johnson and Cookie Gant, fierce and loving
advocates for African American consumers/survivors/ex-patients

I. Introduction

In the preface to the Mental Health: Culture Race and Ethnicity (2001), a supplement to the landmark Mental Health: A Report of the Surgeon General (1999), Surgeon General David Satcher states:

> "This Supplement documents that the science base on racial and ethnic minority mental health is inadequate; the best research, however, indicates that these groups have less access to and availability of care, and tend to receive poorer quality mental health services. These disparities leave minority communities with a greater disability burden from unmet mental health needs.
>
> A hallmark of this Supplement is its emphasis on the role that cultural factors play on mental health. The cultures from which people hail affects all aspects of mental health and illness, including the types of stressors they confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess. Likewise, the cultures of clinicians and service systems influence the nature of mental health services."

The Supplemental report was a long-overdue effort to focus attention on the unique needs and experiences of persons of color within mental health systems. It documents the reality that, 225 years after Charity, a free Black woman in Virginia, was admitted to the first public psychiatric facility in America (Zwelling, 1985), African Americans continue to be disadvantaged in mental health systems. Unfortunately, Dr. Satcher's assertion that "the culture of clinicians and service systems influence the nature of mental health service" is frequently minimized in the development of culturally appropriate services for African American communities. It is critical to understand the cultural values and beliefs that affect how African Americans access mental health services. However, it is equally, if not more, important to explore how mental systems interface with African American communities relative to funding allocations, comprehensiveness of services, availability of African American providers and access to services. These are system-controlled factors and require that the leadership of mental health systems shift their gaze to acknowledge and rectify these impediments to care. Disparities in funding and access to treatment are long-standing challenges for African American communities and it would be beneficial to explore the development of mental health services for African Americans to understand some of the modern day barriers to recovery. This monograph will explore the development of freestanding public psychiatric facilities for African Americans through a review of primary source documents, secondary sources and oral history interviews with former patients, staff and family members at the facilities. The monograph will conclude with recommendations related to legacy of these institutions on current mental health policies and practices. This monograph seeks to highlight the importance of the historical underpinnings of mental health care on the development of truly culturally competent services for African Americans.

It is essential that the evolution of mental health care for African Americans be examined within the context political, social and economic factors that have shaped the lives of African Americans since their forced arrival in Jamestown in 1619. White supremacy or institutional racism is both a historical and current set of attitudes and behaviors that privileges the experiences of European-Americans and negatively impacts opportunities for non –European Americans. Anti–racism activist and author, Paul Kivel (2002) describes the institutionalization of racism as " the uneven and unfair distribution of power, privilege, land and material goods favoring white people." It is beyond the scope of this monograph to provide a detailed overview of the history of Africans in America, and the on-going impact of institutional racism on African American communities. Readers are encouraged to review the resource materials listed in Chapter Four to ensure that they have an adequate historical and political foundation upon which to develop culturally competent mental health services.

II. Institutional Racism and Mental Health Systems

" We cannot build trust and an honest commitment to creating equality in this country if we are denying the injustices of the past. Our good faith efforts to change the system will not be taken seriously if we continue to deny or distort the history of white racism."

Paul Kivel, Uprooting Racism

Godfrey Goffney is listed as the thirteenth patient on the 1870 admissions register for Central State Hospital in Petersburg, Virginia, the first hospital created for the care of "insane Negroes." Mr. Goffney was committed to the facility with a diagnosis of "homicidal mania" and the supposed cause of his lunacy was **freedom.** A more detailed note related to his condition indicated that he "attempts to kill every white man" (Report of Board of Directors of the Central Lunatic Asylum, 1870, appendix). When Mr. Goffney entered Virginia's psychiatric system on December 5, 1868, he was pushed up against a wall of racially biased care that was nearly one hundred years in the making. Under these conditions, it is not surprising that Mr. Goffney would remain in the facility under state control for eighteen years before being released as "restored."

This monograph begins with the story of Mr. Goffney because his life and confinement highlights the complexity of mental illness and race in America. There is little written about the mental health needs of African Americans prior to emancipation and much of what was published focused on positive influence of enslavement on the mental health of African Americans (Cartwright, 1851; Golleher, 1995; Powell, 1895). Several of the 18th century leaders of the mental health movement, which focused primarily on the development of asylums, also worked to bolster the institution of slavery through their pronouncements regarding the underdeveloped natures of African Americans; thereby linking white supremacist values with mental health care for African Americans. In 1847, Dorthea Dix, who led international efforts for lunacy reform, wrote (Dix, 1847):

The Negro and the Indian rarely become subject to the malady of insanity, as neither do the uncivilized tribes and clans of European Russia and Asia. Insanity is the malady of civilized and cultivated life, and sections and communities whose nervous energies are most roused and nourished"

Ms. Dix describes the temperament of "Negroes" but seems to pay little attention to the contexts in which they lived that deprived them of opportunities to have their "nervous energies roused and nourished." Ms. Dix was well aware of the conditions in which enslaved Africans were maintained when on an1831 trip to St. Croix, she had an opportunity to witness slavery up close. In Voice for the Mad: The Life of Dorthea Dix, biographer David Gollaher reports, "In short, Dorthea largely ignored the cruelty, inhumanity and repression of the human spirit essential to any slave system (p.74)." Dorthea Dix's capacity for selective recognition of neglect and brutality was a political asset as she began her lunacy reform activities in the South beginning in 1848.

Thomas Story Kirkbride served as Superintendent of the Pennsylvania Hospital for the insane and was the leading expert on asylum construction. He was a founding member of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), the forerunner of the American Psychiatric Association established in 1844. In 1855 Dr. Kirkbride wrote in the American Journal of Insanity, "The idea of mixing up all colors and classes as seen in one or two institutions in the United States is not what is wanting in our hospitals for the insane" (Vol.12 p. 43). Dr. Francis T. Stribling, Superintendent of the Western Lunatic Asylum in Virginia and another AMSAII founder, was credited with originating the movement for the establishment of separate facilities for Negroes (AJI, Vol.1, 1845-6, p.157). At the inagural meeting of AMSAII, Dr. Stribling was appointed to a committee on asylums for colored persons. Dr. Stribling had successfully repelled all attempts to admit African Americans to his facility, leaving Eastern State Hospital in Williamsburg headed by Dr. John Galt, as the state repository for such patients. Gamewell and Tomes (1995, p.59) indicate that Dr. Galt integrated some of the wards during his tenure (1841-1862) at the facility and was penalized for his commitment to the care of Negro patients by consistently being appropriated less financial support than Dr. Stribling's facility. However, another source indicates that Dr. Galt's interest in racial mixing was limited to training African American patients to care for white patients (AJI, Vol. XXX, 1873-4, p.179).

Gamewell and Tomes (p.56) described the status of institutional care for African Americans in the mid-1800's as follows:

> "Because the number of free Blacks in the North was relatively small, northern asylums had few African American applicants. Some private asylums, including the Friends Asylum [in Philadelphia], simply did not admit Blacks. While other, like the Pennsylvania Hospital for the Insane, discreetly kept quiet about its admissions. State mental hospitals accepted African Americans more openly but placed them in segregated wards or separate buildings where they had fewer amenities than white patients.

Most commonly, public officials assumed that the expense of hospital treatment was wasted on Blacks, who were confined instead in jails and almshouses, where they received decidedly inferior care.

In antebellum South, asylum superintendents had to confront the issue of race more frequently and directly. Laws concerning the care of insane slaves date back to the early 1700's and constitute some of the earliest legislation passed by the colonies."

Working Cures: Healing Health and Power on Southern Slave Plantations, provides extensive documentation of the "harrowing history of medical abuse and neglect of African Americans" from enslavement to the present" (Fett, 2002,introduction p.1). Fett (introduction p.2) notes:

"White physicians and medical students subjected enslaved men and women to experimentation and humiliating displays as medical specimens. By the late nineteenth century, white pundits and scientist alike employed evolutionary theory and population statistics to project the extinction of the 'Negro race.' Twentieth century eugenics, forced sterilization of poor women, nonconsensual experimentation and massive discrimination complete a history of medical abuse built on the legacy of slavery and racism. It is a historical accounting that clearly renders African American distrust of white medical institutions, to borrow sociologist Kirk Johnson's phrase, 'a sensible act.'

In 1851, Dr. Samuel Cartwright, a physician and defender of slavery, described two forms of mental illness that was unique to African Americans (Cartwright, 1851):

Drapetomania, or the disease causing Negroes to run away.
It is unknown to our medical authorities, although its diagnostic symptom, the absconding from service, is well known to our planters and overseers... In noticing a disease not heretofore classed among the long list of maladies that man is subject to, it was necessary to have a new term to express it. The cause in the most of cases, that induces the negro to run away from service, is as much a disease of the mind as any other species of mental alienation, and much more curable, as a general rule. With the advantages of proper medical advice, strictly followed, this troublesome practice that many negroes have of running away, can be almost entirely prevented, although the slaves be located on the borders of a free state, within a stone's throw of the abolitionists.

Dysaethesia Aethiopica, or hebetude of the mind and obtuse sensibility of body- a disease peculiar to Negro-called by overseers, 'Rascality.'
Dysaethesia Aethiopica is a disease peculiar to negroes, affecting both mind and body in a manner as well expressed by Dysaethesia, the name I have given it, as could be by a single term. There is both mind and

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sensibility, but both seem to be difficult to reach by impressions from without. There is a partial insensibility of the skin, and so great a hebetude of the intellectual faculties, as to be like a person half asleep, that is with difficulty aroused and kept awake. It differs from every other species of mental disease, as it is accompanied with physical signs or lesions of the body discoverable to the medical observer, which are always present and sufficient to account for the symptoms. It is much more prevalent among free negroes living in clusters by themselves, than among slaves on our plantations, and attacks only such slaves as live like free negroes in regard to diet, drinks, exercise, etc. It is not my purpose to treat of the complaint as it prevails among free negroes, nearly all of whom are more or less afflicted with it, that have not got some white person to direct and to take care of them. To narrate its symptoms and effects among them would be to write a history of the ruins and dilapidation of Hayti, and every spot of earth they have ever had uncontrolled possession over for any length of time. I propose only to describe its symptoms among slaves.

Dr. Cartwright attempts to pathologize a human instinct for freedom and dignity to support the pro-slavery argument that America's "peculiar institution" was beneficial to the mental and physical well being of African Americans. Dr. Cartwright's medical assessment of the disabling impact of freedom on African Americans came a decade after the 1840 census which fueled concerns regarding the increase in insanity among African Americans, specifically those afflicted with freedom. The clearly fraudulent data included Northern counties in which all Negro residents were listed as insane, was challenged by African American and White physicians and politicians. A congressional investigation was demanded but was effectively undermined by the appointment of John Calhoun, an ardent defender of slavery, to lead the investigation. As the Secretary of State, Mr. Calhoun had overseen the original census survey. Not surprisingly, the 1840 census data was upheld and remained as the official record (Gamwell and Tome p. 1995,102-3).

Clearly, attitudes regarding African American mental health were shaped as much by political and social influences as they were by scientific assessment. In <u>Racism and Psychiatry</u>, Thomas and Sillen (1991) provide an overview of the evolution of psychiatric views on race and the impact of institutional racism on African Americans seeking mental health services. Thomas and Sillen (p.139) state,

> " If he [the psychiatrist] regards black persons as 'naturally' impulsive or emotional, he may not decide that certain modes of behavior are not of psychiatric concern when they in fact reflect a mental illness. Or he may commit the opposite error. If the clinician fails to take into account the special environmental circumstances, he will misjudge normal behavior as pathological. He may label realistic anger as neurotic hostility; or he may mechanically accept an IQ test report that rates the patient as 'mentally retarded,' not recognizing the cultural bias built into the test."

Geoffrey Goffney was a victim of racially-biased mental health care by virtue of his placement in a segregated facility. One hundred and thirty-five years later, concerns about racially biased care persist as reflected in the September 2003 alert from the National Association for the Advancement of Colored People urging its membership to support Child Medication Safety Act (H.R. 1170). It stated, " Children of color, especially African American boys, are much more likely to have these behavior and mind-altering drugs prescribed for them. In fact, a recent study in the state of New York showed that 'minority boys' are eleven times more likely to be on mind-altering medications than in the general student body."

As America moves forward in its efforts to eliminate racial disparities in mental health, it is crucial that a thorough review of African American experiences in mental health systems be conducted, which acknowledges the violations that may dissuade African Americans from seeking services. The development of genuinely culturally competent services is premised on the examination and elimination of the institutional racism that served as the foundation for the development of organized mental health services for African Americans. This monograph explores a core aspect of institutional racism by uncovering the history of freestanding psychiatric facilities for African Americans.

II.   Color Coded Care: Africans American Psychiatric Hospitals

"Restoration is what I need
Someone to scrape and chip until I bleed
And when my picture starts to fade and crack
Paint it all back
Paint it all
Paint it all
Paint it all back"

Restoration, Doria Roberts

The search for historically segregated, freestanding public psychiatric facilities underscores the importance of historical research. When the project began, this author was aware of three state hospitals established exclusively for African-Americans. The official histories of Central State Hospital (Virginia), Goldsboro Hospital for the Colored Insane (North Carolina) and Crownsville State Hospital (Maryland) are easily accessible through a simple Internet search. Other facilities are almost completely lost to memory as facilities for the colored insane. Calls to a national association for state superintendents were a dead end since that information is apparently not part of the organization's historical records. Calls to state departments of mental health were fruitless and time consuming and highlight the danger of a lack of institutional memory. Countless hours were spent on the Internet typing in every conceivable variation of Negro and "insane" to bring forth these historic relics. These disappointments were balanced by the late night excitement of seeing African American hospitals emerge on ghost hunter web pages (Lakin State Hospital in West Virginia) and buried in long-forgotten articles on pellagra (Mount Vernon Hospital for the Colored Insane in Alabama). One facility, State Farm

Division/Palmetto State Hospital was hidden in plain sight in the well-documented history of South Carolina's mental health system (McCandless, 1996). The final known facility, Taft State Hospital (Oklahoma), emerged through vague memories from long-ago orientation sessions at Lakin State Hospital of another hospital for African Americans west of the Mississippi.

As the history of these facilities unfold, there is struggle between the excitement of reclaiming this history and the acknowledgement of their function as places, regardless of the original intent, where many African-Americans spent their entire lives locked on back wards or having their labor exploited in the service of the institution. The uniqueness of the Separate and Unequal Project is that it is first and foremost an oral history project and the history of the facilities is told in multiple voices. Through the voices of former staff, family members and the rare ex-patient interview, this monograph offers powerful gifts that could contribute to the creation of truly healing mental health services for African American communities. Concerns about client confidentiality presented significant barriers to access to former patients. The fact that these facilities drew patients from all over the state made local advertising impractical. Many of these African American elders have passed away or because of the stigma of being labeled with mental illness chose not to come forward.

This humble beginning of recapturing the history of segregated facilities will create an opportunity for reclaiming the stories of African Americans who spent a portion of their lives in these places. African Americans need to call up these lost elders and once again make them visible in our families and communities. Places have memories and it is important to acknowledge these hospitals and the societal values and politics that created them. But more important to African American communities, is the opportunity to re-establish lost connections and offer their experiences in racially segregated care as a cautionary tale for modern day mental health services.

 The Separate and Unequal Project included on-site visits to five of the seven facilities (Maryland, North Carolina, Virginia, West Virginia, South Carolina). Schedule conflicts prevented a trip to Searcy Hospital, formerly Mount Vernon Asylum for the Colored Insane and the author had to rely on the Alabama State Department of Archives for resource material. Taft State Hospital surfaced at the end of the research project and the author was able to secure very limited information regarding the facility. The historical material available at the facilities varied greatly in volume and organization. It is also important to note that South Carolina was the only state to have employed an archivist. However some lover of history always emerged (or simply had it written into their job description) to organize these historical documents. It is notable that the majority of the lay historians were white. This may be a legacy of racial segregation that influenced who secured sufficient status within the facilities to collect and protect these documents. What is certain, especially at facilities in West Virginia, Maryland and Virginia, was that these lay historians understood the historical, political and spiritual value of these materials to African American communities. While the written documents are important in the telling of the history of these facilities, historical information gleaned from the oral histories is at

the center of this monograph because it allows the voices of marginalized persons, those of persons most affected by these facilities, to finally have their say.

Central State Hospital, Petersburg, Virginia (1870-1965)

Central State Hospital in Petersburg, Virginia maintains a storage room filled with historical documents and photographs, including the first admissions log and the Board of Directors meeting minutes. The resource materials include a well-preserved set of the Journal of Insanity dating from 1844 to the early 1900's. The materials indicate that there was a clear commitment at the facility from the beginning to stay abreast of the most current developments in the field. Unfortunately, much of the treatment was more disabling and destructive than the supposed diseases from which a patient suffered as documented in many of the oral history accounts.

Central State Hospital is one of the legacies of the Bureau of Refugees, Freedman and Abandoned Land, commonly referred to as the Freedman's Bureau. The Freedman's Bureau was established in 1865, to aid refugees and freedmen by furnishing supplies and medical services, establishing schools, supervising contracts between freedmen and their employers and managing confiscated or abandoned land (Franklin, 1961, p.36-37). The Howard's Grove Hospital was established in November 1868 as a facility for the care and treatment of homeless and sick Negroes. Dr. Harris, "a Negro doctor," was initially placed in charge of the facility but was soon replaced by Dr. Daniel Brower, a white physician, who remained in the position until January 1869 when he was appointed as the superintendent of Eastern State Hospital in Williamsburg. Dr. Brower would figure prominently in a future scandal that resulted in the removal of one of the three African American members of the Board of Trustees. In December of 1869, Howard's Grove Hospital was designated exclusively for the care of the "colored insane" of the state. Insane and indigent patients who were not resident or "properly a charge of the state" were transferred to the government hospital in Washington, D.C. At that time, control of the facility was transferred to the state of Virginia. "Central Lunatic Asylum" was operated at the Howard's Grove site until a permanent location was established in the city of Petersburg in 1885 (Hurd, Volume III, 1916.)

The quality of care provided to inmates of the facility was questionable from the very beginning. In a devastated economy, poor and "insane" individuals were not a priority. However, the willingness to allocate scarce funds for a separate facility for African Americans may speak to the fears that emerged out of the ashes of the Civil War, that equality for emancipated slaves was the ultimate goal of Reconstruction-era governments. The care of the insane was as good a place to start drawing the line as any other area. Central State Hospital was unique in that the initial Board of Directors included three African American members, Thomas, C. Campbell, James Tyler and Isaac H. Hunter. One wonders how the African- American members felt at the assertions of Hunter Maguire, President of the Board of Directors, that "the disposition, temper and habits of the colored race are so different from those of the white and the management of the two classes so dissimilar, that it would be impossible to keep and successfully treat

them in the same institution" in the first annual report of the institution (Board of Directors report, 1870, p. 6). It is unlikely that Mr. McGuire limited this perception of the peculiar "disposition, tempers, habits" of the race to those African Americans labeled with mental illness.

An African American Board member, Isaac Hunter was forced to resign in November 1870 following charges of corruption and bribery. Mr. Hunter was alleged to have stated that there were two people who would pay him $500 to be elected to the position of Superintendent of the facility and that he could secure the re-election of the current Superintendent, Dr. Conrad, for a similar amount. Mr. Hunter was reportedly disenchanted with Dr. Conrad for his refusal "to appoint colored men to certain positions in the asylum and that he favored Dr. Brower, a previous superintendent at Howard's Grove, who was currently in charge of the asylum in Williamsburg. Mr. Hunter's chief accusers in the case were Mr. Allard, an area businessman, Dr. Robert Cabell, Assistant physician and Dr. Norborne Page, Hospital Steward. Dr. Cabell's role in the ouster of Mr. Hunter is interesting since he is listed as "colored" in a 1917 annual report. However, no other records indicate that he was African-American. In fact, as the second in command at the facility, his presence would challenge Mr. Hunter's allegation that African Americans were encountering a 19th century glass ceiling at the facility. Mr. Hunter was allowed to speak in his own behalf during the proceedings and offered to produce witnesses, including prominent members of the Richmond City Council, to support his assertion that Mr. Allard approached him and offered a bribe to support Dr. Conrad's re-election. The committee denied Mr. Hunter the right to produce witnesses and moved for a vote on the matter. Mr. Thomas Campbell, a fellow African American member, expressed disappointment that Mr. Hunter had "proven himself unworthy of the trust confided in him by the Governor of the state. Especially as it was the first time that a person of his color has been appointed to a similar responsible positions in the state by the executive." It is notable that a Mr. Allard received contracts in the amount $434 at the next monthly meeting of the board. The Assistant Physician and the Steward were retained in their positions.

The forced resignation of Mr. Hunter was the beginning a series of actions that resulted in the restriction of African American influence on asylum operations. Ms. Sallie Hardiman, a white Matron at the facility, was dismissed after a series of conflicts with Dr. Cabell following her attempts to inform him of the cruelty perpetrated against patients by some of the attendants. Ms. Hardiman's greatest sin may have been her disclosure of the conditions at the facility to the African American legislators during a tour of the hospital. In her testimony before the Board of Trustees on May 1, 1872,

> *"Several colored members of the legislature, while on a visit of inspection to the asylum, questioned me about the reports which had reached them of the cruel treatment and exposure and suffering of the patients and I was forced reluctantly to confess that they had been correctly informed."*

Later that year, the Executive Committee of the Board of Directors authorized the Superintendent to bar colored members of the Richmond City Council from future

inspection visits after one member of the group was reported by the Superintendent to have been intoxicated and talking to patients in an improper manner. While it is possible that the prohibition against inspection visits by African American leaders was instituted out of concern for the mental health of patients, it appears more likely that the measure was taken to reduce the likelihood that the neglect and abuse of African American patients would be documented by outside observers.

White asylums, which opened during the 1800's, possessed at least a passing commitment to moral treatment, which was characterized by exercise, work and amusements. Hard physical labor and custodial care seemed to characterize services for African Americans from the very beginning. Central State Hospital would struggle with overcrowding and second-class status throughout its history. In most of the official reports, more attention was devoted to descriptions of the physical plant and farming operations than the care provided to the patients as was true of many of the early racially segregated psychiatric hospitals**.**

 It appears that African Americans served as physicians in the facility during the earlier days of the facility (Hurd, Vol. III, p.749) Following the collapse of Reconstruction, the facility reverted to white control and African American physicians would be a novelty, if present at all, until the 1970's**.** The superintendent**,** medical personnel and administrative staff were all white for much of the history of the facility. A 1962 picture of the Central State Hospital security staff shows a row of large, solemn white males-not exactly an image that inspires a sense of security for most African-Americans in that era. African American staff where segregated in attendant, food service and laundry positions.

Patients were the undocumented bedrock of the institution's labor force. Patient labor grew and prepared food, dealt with a constant flow of laundry and assisted with care and management on the wards. Patients were also leased out for day work in the homes of hospital staff and community members. It is noted that this peonage system was also implemented in white facilities and continued until labor law changes in the early 1970's required that patients be compensated at minimum wage for their labor. "Occupational therapy" and confinement in overcrowded day rooms were the primary interventions offered to African American patients. Wet packs, needles showers [cold, high pressure showers] Metrozol shock, insulin coma, hydrotherapy, lobotomies and electro convulsive therapy were all utilized by the facility prior to the introduction of Thorazine and other major tranquilizers in the mid to late 1950's. These treatments were fairly consistent with treatments provided to patients in White facilities.

Sandy Stewart was a third generation employee of Central State Hospital who began working at the facility in the early 1960's as a psychiatric attendant after transferring over from the adjoining facility state training school for African Americans. She described the trauma of having to assist in administering ECT to patients. (S. Stewart, personal communication, 2003)

> *"It was terrible to watch. Eventually, I asked for a transfer because I could not*
> *continue to witness what felt like brutality to me. I was in that unit for about a*

> *year and I am sure I saw 500-1000 [shock treatments]. They [patients] would wet*
> *themselves, they would soil themselves, they were incoherent and they could not*
> *feed themselves afterward. It was just so destructive."*

In spite of her intense reaction to participating in ECT, Ms. Stewart stated that there was no discussion among staff or between staff and patients regarding the procedures. Debriefing was not part of the process in the facility. She noted that she received no training specific to ECT prior to being assigned to the unit.

Ms. Stewart also recounted episodes about staff brutality toward patients including wrapping wet towels around the necks of patients and choking them nearly unconscious. Apparently the wet towel would prevent telltale bruising on the patients. She reported that the sexual exploitation of female patients was a constant problem with few consequences for male staff at all professional levels. Ms. Stewart recalled an older male employee who married a fifteen-year old female patient to avoid being arrested for sexually abusing her after it was discovered that she was pregnant. The patient remained in the hospital for four more years but eventually moved into the home with her husband and child. This was no love match and the young woman was buffered from the cruelty of her husband by his extended family. Although she had never seen any written eugenics policy at the facility, Ms. Stewart stated that the accepted standard was that any woman who had two children while in the facility would be sterilized. It is notable that the onus for pregnancy was placed on the vulnerable female patient rather than on predatory male staff.

Jennie Fulgham is a deeply spiritual and passionate African American woman who lives in the small town of Zuni, Virginia. At 80 years old, she lives on a three-acre plot of land that she cleared and landscaped over the past twenty years. She has created a retreat center to promote mental health and has been active in this issue since 1961 in New York and Virginia. The Zuni Federation for Mental Health was her response to the system's focus on "mental illness" and her concern for the <u>mental health</u> of "the victims" who have been held in psychiatric hospitals. Ms. Jennie was admitted to Central State in December 1947 three weeks after she had an intense spiritual experience in church. Her religious experience coincided with marital difficulties and an impeding divorce. She reported that she was admitted for a 30-day evaluation and at the end of that period her husband and siblings refused to allow her to have custody of her two young sons - a decision that held until her sons were adults. Ms. Jennie described leaving the hospital and going to stay with a couple that initially presented themselves to her as supportive friends. After a three-week stay with the couple, which included being forcibly medicated and tied to a bed, she was returned to Central State Hospital. In the interview she described her decision to remain at the hospital (J. Fulgham, personal communication, 2003):

> *"So by April, I had become very friendly with one of the people, he was*
> *probably a social worker. I don't remember his name now but he was*
> *teaching some of the girls how to play the piano and I was one of them. I*

liked it very much and he would take us, a few of us, around the grounds and tell us about different things. I told my oldest sister, Maggie, who was Herbert S____'s wife that I wasn't going to leave there because I did not feel like there was anyplace for me to go. And I am sorry that I didn't stick to that. Right now, fifty-five years later, I'm sorry I didn't stick to that. The way it turned out, I have no family. Anytime your family signs you into a place like that, that's it! You do not exist again. That's the way the society is. Now, if you can do anything about breaking that you're good! Because see, I can't do it. I've tried. I first started in Brooklyn in 1961. Started way back then trying to break this stigma. You know, because someone put you in a mental institution you are no longer recognized or considered in any of the business of the universe. That's the way it is. Because that is how stigmatization is.

Ms. Fulgham highlighted the damage created in families by involuntary hospitalization.

Interviewer: What led to your discharge from Petersburg? What were the circumstances under which you left?

Ms. Fulgham: Well, my sister came and got me as soon as she found out that I didn't care anymore about them. Once I was satisfied to be there. I told her, 'I'm going to stay here.' ' [She said] that ain't no place for you!' Well, why didn't they know that when they were signing me in there? You know what I'm saying?"

Ms. Jennie was long gone from Central State Hospital when the first White patient was admitted on August 27, 1965. In spite of the Civil Rights Act of 1964, which prohibited segregation in public facilities, and the public notice from Hiram Davis, M.D, Commissioner of Virginia's Department of Mental Hygiene and Hospitals in June 1965, the first actual white patient at Central State Hospital arrived with little fanfare. Edrys Rhymes is a white woman who has worked at Central State Hospital in a variety of administrative support positions since 1948. She recalls that the first white admission was a white male for the criminal unit who was delivered by a local sheriff who decided not to drive the additional miles to Southwestern State Hospital in Marion, which housed the white criminal unit. Ms. Rhymes laughed as she recalled the difficulty of convincing a woman in the medical records department that this was not just a fair-skinned African American patient. Ms. Rhymes could not recall how soon after the first admission that other white patients arrived at the facility. Ms. Rhymes spoke about the desegregation of the staff cafeteria and the refusal of some white staff members to eat with African Americans. She did not know what these white staff members did for meals since she continued to patronize the newly integrated staff cafeteria (E. Rhymes, personal communication, 2003).

The first African American superintendent/director was hired in 1985. Olivia Garland's official painting, a tradition among hospital superintendents/directors since its inception, is prominently displayed in the lobby of the administration building. One gets the distinct

impression that she continues to claim space in the hearts of staff when African American and white staff members fondly refer to her as "O.J." or "Olivia." In a recent interview she described an event that clarified to her the historical and emotional importance of her presence at the facility, (O. Garland, personal communication, 2003),

> *"I walked the campus almost everyday to meet with patients, sit on treatment teams and meet employees. One day, a staff member was updating me on a patient and I told her that I did not have much time to talk with her in that moment but asked if she could call my secretary to schedule a time to come to my office. She said, 'To your office?' and I said, 'Yes, just call my secretary and tell her what time would be good for you and just come over.' Well, she came over the next day and she just stood outside my door. When I invited her in, she said 'I have been here 25 years and we weren't allowed to come in this building, let alone the Director's office." I was struck by her comment and I asked her what did she mean. She said, 'we could never come in here and now to have one of us in this office! I am so proud of you!' It was just a moving moment for me frankly. It was then that I realized how important this was to the staff as well. Because 50% to 70% of the staff was African American."*

She described her efforts to restore the dignity and reputation of Central State Hospital. Under her administration, the hospital's accreditation was restored and air conditioning was installed in patient buildings. It was notable that the all-white administration building, still referred to as the "White House," was already air-conditioned at that time.

Central State Hospital holds incredible historical value but has failed to be embraced by African American historians because it was a mental asylum or by mental health or medical historians because it was an African American facility. But it is because of its role as the first African American mental health facility that it has so much to teach us about the care-giving abilities of African Americans providers and the amazing resiliency of African American consumers/survivors.

State Hospital at Goldsboro, North Carolina (1880-1965)

In 1877, the North Carolina legislature allocated $40,000 for the creation of an institution for the care of the colored insane. The facility was built near the town of Goldsboro due to its location near the center of the Negro population. The Goldsboro State Hospital, now known as Cherry Hospital, was completed and the first dozen patients were transferred from their segregated quarters at the state asylum in Raleigh in August 1880. At the end of the month, 60 patients had been admitted to the facility (Hurd, p.285). By 1938, the census of the facility had grown to over 2500 patients with approximately 123 physicians and direct care staff that barely provided custodial care.

The facility maintains a small museum and the majority of the research trip was spent reviewing photographs and other documents. Upon arrival, it is hard to imagine that this museum is connected with a historically African American hospital because the most prominent photographs are of white people- former superintendents and others affiliated

with the facility. The original logbook is on display along with a 1921 photograph of the last two surviving patients who were admitted in 1880. A notation on the photograph indicates that the men spent 53 years of their lives at the facility. Patient #33 was a thirty-two year old farm laborer who was admitted due to "violence." The supposed cause of his "lunacy" was unknown (Admissions Log Book, Colored Insane Asylum of North Carolina, 1888). Looking at the picture of this shrunken, white haired old man staring passively into the camera, one wondered what could have triggered his violence outside of the asylum and whether sacrificing 53 years of his life was adequate payment for his behavior. Violence was listed as the form of disease in a number of these early patients. One wonders about the standards used to determine the violent intent of African American males.

 In <u>Mad in America, the</u> author notes, " After the Civil War ended, Southern Negroes, emancipated from their bonds of slavery, found themselves newly at risk of being locked up in mental asylums. The definition of sanity in Negroes was still tied to behavior that a slave owner likes to see: a docile, hardworking laborer who paid him proper respect. Negroes who strayed too far from this behavioral norm were candidates for being declared insane and put away in asylums, jails and poorhouses." (Whitaker, 2002, p. 171). In 1880, treatment options for Patient #33's violent tendencies would have been extremely limited and would have consisted primarily of confinement on the ward or uncompensated labor at the facility.

The Cherry Hospital museum offers insight into what types of treatments patients would have experienced during certain periods. On the side porch stands a wooden replica of a large iron cage in which violent and manic patients would be placed, along with corn shucks to absorb their waste until they were calm or too exhausted to resist. Clarence Lane was a staff member at the facility in the 1930's and remembers the cage being used during that time (C. Lane, personal communication, 2003). Dr. Mintauts Vault was reportedly appalled when he arrived in 1956 to assume the superintendent post and discovered the iron cage. He crusaded for better conditions and treatment of his patients. Dr. Vault discovered that in 1957-1958, the state spent $886 per patient at Cherry Hospital while per capita expenditures at the all-white facilities ranged from $1477 to $1844 (Wright, 1992, p.1). Wright indicates that real improvement in care did not really occur until the transfer of white patients to the facility in 1965. Cherry Hospital was not unique in inequitable funding based on race. This pattern was replicated at most, if not all, of the racially segregated facilities, according to anecdotal reports from several current and former administrators at historically segregated facilities.

One of the images that stand out most about Cherry Hospital is the picture of African-Americans loaded in large open-bed trucks and working in cotton fields. The museum includes a metal pail with dried cotton bolls. A staff member noted that the facility had an extensive farming operation but did not raise cotton. African-American patients were routinely leased to local white farmers to pick their cotton and other crops. Even if one can accept the therapeutic value of laboring in the fields to produce food for patient consumption, there was absolutely no justification for sending African American patients out to perform painful and backbreaking labor for the benefit of local farmers. It is

notable that the hospital was paid for the labor and the patient leasing fees were reflected in the annual reports of the facility.

African American staff had no point of comparison for the resources that were allocated to Cherry hospital. Even if the disparities could have been documented, African American staff were in no position to challenge the practices. They simply tried to do the best that they could for the patients under their care. Several staff members proudly described, "being able to get the job done" in spite of the lack of resources at the facility. Many staff members lived on the campus in "Happy Hill", as the rows of colored houses were called. They recounted positive memories of life on the campus and of the close knit relationships that developed. A white staff member was near tears as he recalled his anger and frustration at having to go inside restaurants as a fourteen year old boy to purchase the lunches of adult African American men who were barred from the whites only facility. An African American male staff member remembers praying that things would be different when he got older.

African American staff described fairly fluid, yet ethically troublesome, boundaries between staff and patients. As in many facilities, the loaning/leasing of patient laborers was a common practice. However, the long-term nature of these relationships seemed more common at Cherry Hospital. One staff member fondly described her patient caregiver who worked without compensation for the family for fifteen years. She described the patient, Richard, as a loving and attentive caregiver who frequently intervened on the children's behalf when her parents attempted to discipline them. According to the interviewee, Richard would occasionally encounter emotional difficulties reflected in laughing to himself and slamming doors at which point he would be told to go back to the hospital. There was no indication that the family feared for the safety of their children while in Richard's care. During the interview, the family was asked why was Richard capable of handling childrearing and household management responsibilities, but not allowed to go home? What one realizes is that in a place where African American staff were required to stand at attention when a white person entered the ward, this family was not consulted on discharge planning for Richard. A lingering question is how, over time, staff could cease to question such fundamentally oppressive practices, in spite of otherwise loving and respectful connections.

At age eighteen, Robert Kornegey followed his father into service at Cherry Hospital in 1965. He briefly left the facility to pursue a college degree and has spent his entire professional career at the facility. His love for the patients and staff are evident as he described his experiences over the past 38 years. Mr. Kornegey described the work conditions, which he jokingly referred to as an "integrated treatment model." This simply meant that attendants with limited training were responsible for virtually all aspects of patient care. On one shift there might be four to five staff member on a ward of 140 patients. He described the care prior to integration as more like warehousing than any structured programming. In that context, he described his efforts to provide a humane environment for patients (R. Kornegey, personal communication, 2003).

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"We were trained to give shots to patients and do consultative work. Now, nurses are licensed to do that and social workers do that. There were close bonds that I formed with patients here. I was the kind of person that wanted to serve and assist in helping people. When I could relate to them, assist them or just listen to whatever their concerns were-whatever they wanted to talk about. That meant a lot to me. There were patients who had violent outbursts but these same patients would also be there to your rescue"

Doris Artis worked as a nurse at Cherry Hospital for 30 years beginning in late 1960's. She shared the almost universal disgust of African American staff interviewed as part of the Separate and Unequal Project at having to assist with electro-convulsive therapy treatments. She described the racial segregation of staff within the facility, noting that the more desirable positions in maintenance and administration were reserved for white staff. Ms. Artis recalled playing at the facility laundry and on the wards as a child since both of her parents worked at the hospital. She noted that most of the patients she had contact with as a child were not psychotic or dangerous and she wondered if they should have even been in the hospital (Doris Artis, personal communication, 2003).

Robert Kornegay recalled the integration of the facility in July 1965 when a regional system was implemented and white patients were transferred to Cherry Hospital. He noted that the transition went much better than he had anticipated, " They [patients] were making better adjustments internally than outside adjustments [to integration in other areas of community life]". At the time of our interview, as the Director of Personnel, he is the highest-ranking African American administrator at the facility.

Mount Vernon Hospital , Mount Vernon, Alabama
(1902-1969)

Mount Vernon Hospital for the colored insane, now known as Searcy Hospital, was opened in May 1902. Prior to the opening of the Mount Vernon facility, African American patients were maintained in segregated quarters at Bryce State Hospital in Tuscaloosa, which opened in1860. The 1863 annual report reflects an all white patient population. However, by 1868 annual reports indicates a payment of $1900 by the Freedman's Bureau to care for the twenty-six African American patients at the facility. The 1901-1902 biennial reports includes a status report on insanity among African Americans in the state:

"The selfish interests of their masters enforced sanitary, regular and moral habits, and the practice of higher methods of thought, as well as regular muscle exercise, more than and better than the Negroes ever practiced before. The naturally docile disposition of the Negroes, has, as far back as history goes, been the trait which has made them sought for as slaves; they have proved the most suitable people, anywhere in the world, for that purpose, and their docility makes them amenable to disciplinary improvement. The Africans in America came out of their servitude an inherently improved people, mentally and physically. While they were slaves, there was very little deterioration among them and

consequently, little insanity. Since then their rapidly increasing insanity is a result of and an indication that many among them are mentally degenerating. It is very evident , the care of the Negro insane in the south will become more and more a public care and expense. In 1870 there were 33 negroes in our Hospital, in 1880 there were 71, in 1890 there were 241, and in 1900 there were 451."

The sentiments expressed in the above passage are very similar to comments made by T.O. Powell, Superintendent of the Georgia State Hospital in 1895. (Powell, 1895**)** Other mental health experts at the turn of the century may have shared these values, however, it was a bit unusual for it to be so blatantly stated in an annual report. This racist philosophy and the resistance to societal changes would continue to influence and reflect Alabama's inability to adapt to the civil rights pressures in the 1960's.

The facility that was to become the Mount Vernon State Hospital was previously used as a military arsenal and it was notable as the barracks where Geronimo and other Apache prisoners of war were incarcerated from 1887 to 1894. The property was transferred to the control of the state of Alabama and designated for use as an asylum for the colored insane. After renovations were made to the property, three hundred and twenty African American patients were moved from the main psychiatric facility in Tuscaloosa in one train in a single day (Hurd, 1916, Vol. II, p. 10). This transfer apparently happened without incident. By the end of 1902, four hundred African American patients were at the Mount Vernon facility. An additional sixty African American patients were maintained at a colony at Bryce State Hospital in Tuscaloosa. There is no explanation in the records for why these patients were retained at the white hospital. However, the most likely explanation is that they were used as laborers at the facility. The Tuscaloosa and the Mount Vernon facility were operated under the same management structure until 1970. The 1903-1904 biennial annual report indicates difficulties encountered in securing sufficient staff at the Mount Vernon facility,

> "*For two years we have worked faithfully to get suitable Negro men and women. We spent considerable money advertising and sending out employees in the Southern part of the state to find colored employees. They so generally prove to be inefficient and untrustworthy, and unstable in their connection with the Hospital, we decided last year to employ white men and women. Considering all the worry and additional expense of obtaining and keeping suitable Negro nurses, the white nurses have proved less expensive, and greatly more efficient. A noticeable change was at once observed in the care of the patients and in their satisfaction. The generally improved efficiency of the management of the wards, is very apparent.*"

 It was reported in 1919, that, "Physicians are freely exchanged from one hospital to the other, as well as employees and patients. The superintendent spends about one-fourth of his time at Mount Vernon. Most of the employees at Mount Vernon are white." (Hurd, Vol. II, p. 4).

A review of state records on mental health in Alabama was most notable for a lack of reference to African Americans. During the period 1964 through 1969, during which the state was engaged in fierce battle with the Federal government regarding compliance with the Civil Rights Act of 1964, there is virtually no mention of African American patients. A June 1965 weekly newsletter from the South Carolina State Hospital notes, "Alabama is sitting tight and awaiting a court challenge." A review of mental health files at the state archives did not turn up any documents related to the desegregation process. However, there have been important changes in Alabama's mental health system over the past few years. Kathy Sawyer, an African American social worker, was appointed Commissioner of the State Department of Mental Health in 1999. In addition to overseeing the settlement of a thirty-year lawsuit against the state regarding conditions at mental health and retardation facilities, Ms. Sawyer implemented a system-wide diversity-training program. Under her administration, the first African American superintendent, Bernice McClain, was appointed at Searcy State Hospital in 2001.

Crownsville State Hospital, Crownsville, Maryland (1911 – 1962)

 In 1910, Crownsville State Hospital was established by legislative act for the "detention and care" of the Negro insane of the state. The act specifically prohibited the facility from being located in Baltimore, which had a significant African American population. Prior to this time, African American patients were maintained in segregated quarters at the existing state facilities and in local almshouses and jails. The facility was eventually located on the site of a former willow plant in Crownsville, Maryland. Temporary quarters were established on the site and on March 13, 1911, the first allotment of 12 patients were transferred from Spring Grove Hospital. Over the next nine months an additional 112 patients were sent to the temporary hospital site to serve as unpaid laborers to excavate and build the permanent structures (Hurd, Vol. 1, p. 546). The white superintendent, Robert P. Winterode provided patients with axes and other tools to accomplish their assigned tasks. By 1913, the hospital census had reached 255.

Crownsville is unique in that all staff was white until 1948. The intersection of a progressive superintendent, Dr. Morgenstern and a focused NAACP chapter resulted in this hiring of an African American psychologist, Vernon Sparks in 1948. Mary Brown, a member of the Crownsville Auxiliary since 1954, was active in the local NAACP chapter and described the concern of many African Americans regarding the all white staff. (Brown, personal communication, 2002) Ms. Brown stated that members of the African American community were aware that integration of the facility would happen at some point and they were concerned about how African American patients would be treated once white patients entered the facility. They strongly believed that African American staff was necessary for the adequate care of Crownsville patients. In addition, there was probably some concern regarding the lack of access to relatively good-paying and stable jobs for African Americans. The mutual needs of African American patients and caregivers were addressed through the political pressure placed on the state office and the hospital superintendent.

Several staff members recounted the story of Mr. Sparks and Mrs. Ellen Stoutenberg, the white administrative assistant of the superintendent, eating lunch alone in the segregated dining area established for the lone African American staff member. Mrs. Stoutenberg reported that they eventually decided to desegregate the doctor's dining hall, apparently without incident. (Stoutenberg, personal communication, 2002) She also noted that as the number of African American staff increased, on-campus housing, a benefit for all staff, briefly was an issue in the integration process. Several white staff complained about living with Negroes and were informed by Dr. Morgenstern that they could live in integrated campus housing or secure outside housing at their own expense. The decision to integrate the staff at the professional level was an astute decision on the part of the NAACP and Dr. Morgenstern. Gwendolyn Lee, an African American social worker, was hired in 1950 as the Supervisor of Social Services. By the 1960's, a significant number of the department heads were African American. The first African American superintendent, Dr. George Philips, was hired in 1966.

Crownsville's African American staff reflected a commitment to patient care that was similar to staff at other African American facilities. In 1952, Sarah Maddox was the first African American aide hired at the facility. She described herself as very curious and assertive and eventually went to school and secured a nursing degree. Upon completion of her degree she returned to Crownsville and remained with the hospital for over thirty years. She noted some of the challenges in helping patients adjust to the new African American staff members (S. Maddox, personal communication, 2002):

> " When I came back [from nursing school], I was a licensed, an LPN, and I had my cap and gown on and everything. A lot of these people [white staff] were not qualified; they wore nursing caps but they were not nurses. I was making rounds on the infirmary and a patient asked for a nurse. So I went over to her and said, 'I'm a nurse'. She said, ' I want a real nurse. Don't you dare put your Black hands on me'."

Patients may have internalized the racist values of the facility, which viewed whites as the only legitimate care givers. Ms. Maddox described one of the innovations initiated by Dr. George McKenzie Philips when he was an intern from Howard University, to help reduce violent behavior on a unit with aggressive female patients,

> "He picked me and three other little women. He told us that "this is a psychiatric hospital and psychiatric nursing is not being given. What they [aides] are doing is fighting the patients. You all cannot fight the patients because you are too small. It [psychiatric nursing] is just understanding and listening'. So he put us all up there on the top floors. I mean my shoes were just too big! Then he took several of the patients out right away and put them into beds [previously held in fenced in dormitory-style ward].

She described other innovations in the facility including music and dance therapy. She also remembered the introduction of Thorazine into the treatment regime in mid-1950.

Ms. Maddox played a key role in the integration of the facility as the nursing supervisor on the newly opened (and integrated) adolescent unit.

Grace Lynis is a 43-year-old African American woman who lives in Brooklyn, NY who responded to an e-mail notice about this project. She wanted to share and further explore the story of her maternal grandmother who was committed to Crownsville State Hospital in 1945. She did not receive much information about her grandmother but she was aware of the profound impact that "motherlessness" had on her own mother. The legacy of Mattie Hughes's hospitalization on the family was secrecy and a strong desire for belonging and this reverberates through her lineage. Mattie Hughes was a 25 year-old African American woman, the mother of a seven year- old daughter and an infant son when she was committed to Crownsville. She remained in the facility until her death in the mid-1960's. Grace keeps the memory of her grandmother alive through her spiritual practice and has been trying to piece together a more complete story of her life. She has heard stories of Mattie being a strong and outspoken woman, "a pistol", and wonders if these qualities contributed to her incarceration. She also wonders if the struggle of negotiating two small children and a possibly challenging relationship during tough economic times may have led to a clinical depression. Grace began a search for her grandmother's record and has initiated conversations in her family about her grandmother's legacy. Grace stressed the importance of honoring ancestors and relatives who have been incarcerated in hospitals or struggled with mental illness. As she notes, "if Grandma Mattie had not come through [lived] my mother would not have been born. Therefore, I would not be here without her" (G. Lynis, personal communication, 2003)

Dr. George McKenzie Philips understood the importance of family and good communication between family members and developed the Family Issue Solving Training (FISTA) program based on Bowenian family systems theory. In his introduction to the manual he briefly outlines his philosophy (Phillips, 1971):

> *"We have all been convinced that the place to start the search for answers to the broadening social issues of modern times is the family unit, and in other sustained interpersonal relationships necessary for survival. My personal task has been to find a way to give the uppermost priority to the kind of grass root level education of people about people."*

The program included training volunteers to work with patients and family members in an evening family therapy program at the facility. It is notable that Crownsville has a solid history of valuing community as evidenced by the creation of the Crownsville Auxiliary in 1954 by Vashti Turley Murphy, the wife of the publisher of the Baltimore Afro-American newspaper. This connection with the newspaper would ensure consistent coverage of issues affecting Crownsville during her lifetime. This volunteer organization was initially composed of middle and upper class African American women from the Baltimore and Annapolis area. From 1954 to 1994, the Auxiliary contributed approximately $600,000 to the facility. Mary Brown was an early member of the Auxiliary and continues to volunteer at the patient canteen established by the Auxiliary

several days a week. This "hidden history" is critical because it again shows that African American communities did not simply shun or abandon their family and friends in psychiatric facilities.

In September 1961, three civil rights activists, Wallace Nelson, Juanita Nelson and Rose Robinson, were arrested on trespassing charges at a Route 40 Restaurant near Elkton, Maryland when they attempted to secure a meal. The trio refused legal council and initiated a hunger strike while being held at the Cecil County jail. On the twelfth day of the hunger strike, the judge ordered them transferred to Crownsville State Hospital for evaluation. Sheriff Edgar U. Startt offered his clinical assessment when asked if their behavior suggested any "mental aberration." He responded, "Anybody that will not eat and won't stand up in court and plead acts like a mental case to me-and also to the State's Attorney (Baltimore Sun, 9/19/61). Fortunately, Dr. Charles Ward, the hospital superintendent who personally evaluated the protesters, determined that they showed no signs of mental illness and had informed him that eating would be cooperating in a situation that they thought was wrong and unfair. The civil rights activists were returned to jail and eventually convicted on the trespassing charges. The Elkton Trio was fortunate to encounter a physician with some integrity, along with close press coverage of the situation.

Paul Lurz is a white social worker that came to Crownsville State Hospital as a graduate social work student in 1964. He proudly describes the outpatient clinic established in Baltimore by the hospital in the 1960's when Johns Hopkins Hospital, in practice but not through written policy, failed to provide outpatient mental health services to African American patients. Paul expressed some frustration at the closing of the assisted living program which converted unused wards into little cubby-rooms where long-term patients without community-based housing or too institutionalized to desire to live in the community could reside (P. Lurz, personal communication, 2002). Through the program, these individuals were discharged from the facility and were free to come and go as they pleased but also provided with structured programs and staff support. It was an imperfect option since the patient still lived in an institutional setting. However, it allowed options beyond the right to be homeless or marginally housed in board and care homes at a time when supportive housing in community settings was not a priority.

In October 2003, the Maryland Department of Mental Hygiene recommended the closure of Crownsville Hospital site and the transfer of patients to other state facilities or to community placements.

South Carolina State Hospital-State Farm Division/Palmetto State Hospital (1914- 1966)

The history of South Carolina's mental health system is well-documented in Peter McCandless's Moonlight, Magnolias and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era (1996). African-Americans figure heavily into the history of asylum care in South Carolina. In 1745, the first state legislative act dealing with "insanity" involved a slave woman, Kate, who had killed a Black child. After being placed in the local jail, it was determined that Kate was "out of her Senses" and she was not brought to trial. However, the problem of how to care for Kate was an issue since her owner was too poor to pay for her confinement and South Carolina had made no provision for the public maintenance of slaves. Ultimately, the colonial assembly passed an act that made each parish in the colony responsible for the public maintenance of lunatic slaves whose owners were unable to care for them. (McCandless, p.15) The state spent the next 165 years struggling to find a satisfactory answer to the problem of mentally ill African Americans. McCandless notes that one of the first patients admitted to the South Carolina Lunatic Asylum in 1829 was a fourteen year-old slave named Jefferson. Jefferson's name was not recorded in the admissions book and he was reportedly housed in the yard. The young slave was admitted as a favor to his owner since the facility did not officially receive African Americans until 1848. (p. 76)

 In 1910, after years of legislative debate, South Carolina finally approved funding to purchase land for an annex to house African American patients. Development of the State Park site moved slowly and was plagued with building and funding problems. The first African American patients were moved to the State Park division in 1914. The monthly superintendent's report from 1915 underscores the impact of the niacin deficiency disease, pellagra, on admissions to the state hospital, especially among African American patients. Pellagra was the leading cause of discharge by death for African Americans patients.

South Carolina appears to have instituted social services fairly early in its operations, The June 1924 monthly report provides a summary of the work of field worker, Ethel Sharpe. She provided pre-and post-discharge community visits, special investigations, social histories and follow-up work for clinicians. In that month, she provided these services to 98 patients, of whom only 3 were African American. This racially disparate trend continued for some time. Community visits were a crucial step toward discharge from the hospital, so it is not surprising that it may have been more difficult for African American patients to secure their return to their communities.

As could be expected, conditions at the State Farm site continued to deteriorate with frequent complaints regarding patient care and employee rights. In 1963, the State Park site was reorganized as a separate entity and renamed Palmetto State Hospital. The stated reason for the change was a move toward a decentralized regional system. The primary benefit of the move was to facilitate the improvement of the white facility in order to qualify for Joint Commission on Accreditation of Healthcare Organizations certification and retain its residency program. (Variety, Crafts-Farrow State Hospital Newsletter, July

1968**).** Modjeska Montieth Simkins, African American civil rights activist and founder of the Richland County Citizens Committee, Inc., alternately prodded and publicly challenged the State Commissioner of Mental Health and the Governor to move on the integration of the state hospitals. Ms. Simkins was well known for her incisive and blunt assessment of a situation. Regarding the establishment of Palmetto State Hospital she observed**,** (Richland County Citizens Committee, Inc. Statement, February, 15, 1965).

> *When all of the conditions relative to personnel and services at the Negro asylum are "boiled down", the fundamental outcome of the separation of that section, as conspired by the General Assembly and the Mental Health Commission, was the severing of the umbilical cord and the re-naming of the varmint."*

The Richland County Citizens Committee (RCCC) consistently applied pressure on the state regarding conditions at the facility for African American patients, resulting in a five-hour tour of both facilities by the Governor and key legislators in February 1965. RCCC continued the pressure with formal civil rights complaints and calls for African-American staff to unionize for their protection. The South Carolina Mental Health Commissioner was eventually forced to revise his timetable for complete integration of mental health and mental retardation facilities from five to two years to ensure release of federal funding. In language reminiscent of Francis T. Stribling's arguments for the development of racially segregated facilities, Dr. Hall writes (*William S. Hall in April 8, 1965 letter to James P. Ward):*

> *"Mental hospitals cannot be equated with general hospitals in all respects. A large portion of mental patients are hospitalized for several years, some for life. They are emotionally unstable and many have a low threshold of self-control. Some have unreasoning prejudices and hatreds. A large proportion stem from the lower rungs of the socio-economic ladder where racial antipathies are commonplace.*
> *Long-term mental wards are more like Barracks or dormitories than hospital wards. Most of the patients are ambulatory; a great many are quite able bodied. Massive forced racial mixing very possibly would provoke bloodshed, especially if it were done overnight."*

Dr. Hall's willingness to exploit biases against the poor and persons labeled mentally ill (as if racist attitudes were limited to the patients and that he was somehow hostage to their passions) was one of the low points in the desegregation process. South Carolina eventually developed an acceptable plan, which included the opening of an integrated admissions building at the Columbia facility in February 1966. Palmetto State Hospital was re-named Craft-Farrow State Hospital and transitioned into a geriatric facility.

Lakin State Hospital for Colored Insane (1926- 1954)

Lakin State Hospital was established by the West Virginia legislature in 1919 and was part of a legislative agenda that included the establishment of several African American institutions. The facility received its first patients in 1926 with the transfer of 162 patients from Weston State Hospital. At that time, Lakin was unique in that it was the only state hospital under the management of an African American Superintendent. After an endless parade of white men in hats in the official portraits at all of the other African American facilities, the Lakin official photo looks more like a family portrait with female staff and even a small child present. Based on extensive interviews with staff, this picture appears to reflect what several staff members refer to as the "Lakin Approach." Further research is required to fully understand the politics behind the legislative mandate that the facility be run by African American staff. West Virginia appears to be unique in its creation of a Bureau of Negro Affairs that generated comprehensive biennial reports on the status of African Americans in the state. This indicates that a significant amount of attention and resources where directed toward African American citizens. Lakin was also unique among the African American facilities in that the patient population never exceeded 500 patients. Other African American facilities range in population from 2500 to over 5000 patients.

The facility was built in predominately white Mason County. This placement presented challenges for staff, patients and family members. Family members who had traveled across the state for rare visits were occasionally picked up by the local sheriff and returned to the hospital. It was assumed that any African American walking down the road was an escaped patient (L. Moore, personal communication, 2003). Staff was unable to secure housing in the area since the nearest town was nine miles away with no reliable transportation system and segregated housing patterns. All staff was housed at the facility. In the hospital's early days staff lived in small rooms immediately off the wards and were required to be available for emergency assistance as needed. A separate house for the Superintendent was located across the road from the facility.

Julius McCloud, a retired social work supervisor, was hired at Lakin in December 1954. He described the close relationships that formed among staff and between staff and patients, due in part to the physical proximity (J. McCloud, personal communication, 2003).

> *You knew these people were patients but you really did not see them as patients because you lived with them. When I was there as an aide, I was in a big wide building and there were four dormitories on each floor and some private rooms. These private rooms ended up being employee living quarters. So you literally had to open the main door to get to your room and then you locked your door once you got there. So you literally lived with these guys but you would take your meals at the employee dining room. We had a private bathroom downstairs for employees. But whatever recreation we had…what little television we got [was with patients]… you did not get so much <u>We</u> versus <u>They</u> kind of attitude that you get sometimes in those situations. So you learned to respect these folks and*

*consider the fact that they did have problems. You would laugh and joke with
them but respect was really important. That was one of the things that the people
in charge emphasized. You are supposed to treat these people with respect, they
are human beings-they may be a little bit out of it-but they are still human beings.
So you had that kind of attitude. The patients would have a couple of nights a
week for recreation and you would round up everybody that could participate and
oftentimes there would be quite a bit of staff there. You're living on grounds,
you're ten miles from anyplace and there are only about six to eight cars on
campus. That's your world so you make do with what you've got. So you had that
real sense of oneness and of family."*

He reported that a single staff member would be responsible for three floors of a building
and were very dependent on the assistance of patients to manage and care for patients.

According to Mr. McLeod, occupational (arts and crafts), industrial (work assignments),
and recreational therapy were the major treatment modalities in the early to mid fifties
before the advent of anti-psychotic medication. He remembered several female patients
who were in "permanent lock-up " and remained in seclusion most of the time because
they reportedly could not adjust to the general population. Insulin therapy, hydrotherapy,
pre-frontal lobotomies, needle showers and wet packs were all utilized in patients'
treatment. Lakin staff prided themselves on their willingness to utilize innovative
treatments. Milieu therapy, or the creation of a therapeutic community in which patients
could develop more appropriate social skills was a core component of the program. Due
to limited opportunities for African American professionals, the facility was able to
attract quality staff from throughout the nation. From its inception, Lakin required that all
non-professional staff have at least a high school diploma. This was not the standard in
other West Virginia hospitals at that time as Dr. Mildred Bateman, an African American
psychiatrist, discovered when she was appointed as the state Director of Mental Health
(M. Batemen personal communication).

Lakin established a formalized aide-training program and all aides had to complete a
nine-month course. The training included observation of medical procedures including
lobotomies and electro-convulsive therapy. Mr. McLeod and Helen Culmer, a psychiatric
nurse, both described the brutality of the procedure, which included the administration of
a rapid series of ECT treatments to "sedate" the patient for the procedure*.* Ms. Culmer
reported that she observed lobotomies performed by Dr. Walter Freeman, the American
Expert on psychosurgery, that resulted in two fatalities and left two patients permanently
blinded (H. Culmer, personal communication, 2002).

When the medical center was opened in 1953**,** paying patients were accepted and this
group was predominately white. African American staff provided all psychiatric care. In
fact, the positive reputation of the Superintendent, Dr. S.O. Johnson drew white patients
to the facility (L. Moore, personal communication, 2003). Dr. Mildred Mitchell Bateman
was the Menninger-trained staff psychiatrist under Johnson who assumed the
superintendent position in 1958. Dr. Bateman was appointed as the first and only state

Director of the Department of Mental Health in 1962 and served in that position until 1977. She continues in active psychiatric practice as of 2003.

Elopements from the facility were rare due to its isolated location and the high visibility of African Americans in a nearly all-white county. Sterilizations did occur at the facility but staff generally perceived that as a last resort. The diagnostic staff including the superintendent, staff psychiatrist and psychologist, met to review all requests for sterilizations (M. Bateman, personal communication, 2003).

Other Lakin innovations included:

- Establishment of an adult family care program in collaboration with the state welfare department, which provided financial support for the care of former patients. County welfare workers assisted in monitoring people in these community placements. Patients were not required to work in these family home placements.
- Training white county health nurses at Lakin to provide outpatient support to patients to ensure medication monitoring.
- Active participation of psychiatric aides in the treatment team meetings. Aides were expected to submit summary reports on patients prior to discharge since they were most familiar with the patients. Staff noted that this validation of the perspective of the aides probably contributed to better patient care due to improved morale among aide staff. It would be unlikely that an African American aide would ever be allowed to function in such a role in other facilities prior to integration or until African Americans assumed professional level staff positions.

The integration of the facility began in 1954 with the admission of white patients to the medical center. At that time, the name of the facility was changed to Lakin State Hospital. Larry Moore, a white social worker that joined the Lakin staff in 1969 reflected on the changes at the facility:

> *" The medical center was put in at the lower end of the property that had major and minor surgery and offices. It also became the place where the first white admissions went if they had money. If you did not have money and you were what they called county billing, you went to buildings A and B- the two original buildings. These were white folks. This would be somebody from the local community. This would have been the mid-fifties. Med center opened in 1953 but I am not sure when the first white admissions were. I always wondered what the reaction was when the first whites went onto the floors in Buildings A and B."*

In 1979, the facility transitioned into a state-operated nursing home as the state's mental health program shifted to community-based services. Mr. Moore is one of the few remaining staff members who worked at the facility when it was a psychiatric hospital

> *"What I knew as Lakin lives on. The vast majority of the folks out here don't know where it [the values] came from. They don't know the source. The Lakin approach*

- the family attitude of 'what do I want for my brothers and my sisters.'' We are not good at professional detachment. We care. We do it with love. People need to know where this comes from.

A significant number of former employees of Lakin State Hospital remain in the immediate area and they have retained the family spirit, which was the hallmark of the hospital. The need for them to document the history of the facility and to tell the stories of the patients who lived there become more critical as the hospital becomes a relic on ghost-hunter web pages. The historic marker outside the facility has been removed and the once all-African American facility now boasts a total of three African American staff members.

Taft State Hospital (1933 –1954)

This author began to hear about "another all Black hospital west of the Mississippi" during interviews with staff members at Lakin State Hospital. Confirmation of the Oklahoma facility came in a chance review of a legal book on state's laws and race. (Murray, 1995, p. 370) Unfortunately, this discovery occurred near the deadline for submission of this monograph. A former employee of the facility confirmed that the hospital was opened in 1933 with an all African-American staff. She reported that the facility was already integrated when she arrived in the mid-1950's. The facility was closed in 1970 and re-opened as a state prison, which continues to operate on that site. It is notable that the facility was opened during the administration of the flamboyant and outspoken segregationist Governor William Henry Murray. Future research on this facility could focus on the impact of the facility's location in a historic all-black town on the philosophy and practices of mental health care for African Americans. Since the facility closed over thirty years ago, it is essential that the collection of oral histories occur as soon as possible or the stories of former patients and staff could be lost forever.

Future Research

It is possible that other freestanding psychiatric facilities for African Americans may emerge. There also is need to explore the conditions in psychiatric facilities that maintained segregated wards and buildings and what factors influenced states like Louisiana, Mississippi and Georgia to forgo segregated facilities. It is notable that Texas did initiate development of a freestanding facility (Rusk State Hospital) in 1919. It shifted to a segregated ward system prior to the hospital's opening when the need for beds for white patients exceeded the desire for a completely separate facility for African Americans (Rusk Cherokeean, 1919). It would also be valuable to identify any facilities that provided truly integrated care prior to the Civil Rights Act of 1964 and to better understand the political and philosophical underpinnings of inclusive care for persons labeled with mental illness. The history of segregated institutional care has much to teach current and future mental health consumer, providers and advocates about what heals and what hurts and how to create a system of care that maximizes opportunities for all Americans to experience recovery.

III.   <u>Lessons From the Past</u>

> *Love is profoundly political. Our deepest revolution will come when we understand this truth. Only love can give us strength to go forward in the midst of heartbreak and misery. Only love can give us the power to reconcile, to redeem, the power to renew weary spirits and save lost souls. The transformative power of love is the foundation of all meaningful social change. Without love our lives are without meaning. Love is the heart of the matter. When all else has fallen away, love sustains.*
>
> *bell hooks, Salvation: Black People and Love*

Uncovering the history of "colored hospitals" is about coming to terms with the incarceration of significant African Americans for "behavior unbecoming Negroes" hidden behind medical terms like, "homicidal mania" and "paranoia." This exploitation of the mental health system was a double-edged sword because it <u>created</u> a paranoia that keeps the worried well **and** the emotionally overwhelmed out the system. The end result is that many African Americans are left without healing and slapped with non-compliant labels. If there has been no acknowledgement of previous harm done, whether by individuals or institutions, then the only reasonable response is to approach the next contact with some degree of caution. bell hooks, a Black feminist social critic and author, describes the impact of this invalidation in <u>Rock My Soul: Black People and Self Esteem</u> (2002, p.76):

> *When black folks address the issue of everyday racism, naming how it impinges upon our day-to-day well being only to be accused of exaggerating, individuals whose self-esteem is fragile come to fear naming what hurts. And yet this repression itself is dangerous, because it promotes psychological implosion. Time and time again black folks talk about feeling "crazy" when they name racism and its impact only to have their stories discounted. This discounting is a form of psychological terrorism that has been used to silence antiracist protest. And it supports racist backlash by encouraging the masses of white folks, and other non-black groups, to see black people as insane when they discuss their victimization.*

There are many people in African American communities that could benefit from mental health care, including medication. However, these options need to be freely chosen, accessible and offered in a culturally conscious manner. How have mental health systems explored the coping strategies of significant numbers of people who struggle daily with symptoms of mental illness yet are functional and well-loved members of their communities? Andrea Canaan offers a perspective from the experience of a family that protected a family member from contact with the mental health system due to realistic concerns that she would be damaged by the experience. She articulates the African American value that allows the community to embrace and negotiate behaviors that might

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be consistent with symptoms of a mental illness (A. Canaan, personal communication 2003):

> "There is a myth that the mentally ill are vacant and that they cannot do anything. My grandmother was mentally ill and she cooked three meals every day for us. She washed our hands and made our clothes by hand. She was always doing something. She taught us to read. My grandmother was literate, smart and she knew stuff. She was a functional part of the family. My work ethic, cleanliness, and honesty- these things came from my grandmother. Yes, she was mentally ill <u>and</u> she was not her mental illness. That's not the only thing she was by far. She was also the family historian."

These community-generated care strategies are not a rejection of science but a demand that science be more flexible in how it views healing. Dr. Ronald Forbes is psychiatrist at Central State Hospital (VA) and he offered this wisdom in his approach to the blending of science and caring (R.Forbes, personal communication, 2003).

> *" As difficult as it is, the science is the easy part. If somebody is depressed there is a medicine that helps. If someone is psychotic there is a medicine that helps. If someone is alcoholic there is a treatment that helps. To stay well is something else. It's softer…It's right brain…its contact and its healing. Part of healing is assessment and evaluation, coming to a rational treatment plan and giving the proper medicine. That's part of it. But another part of it is heart to heart. I come from a Pentecostal background and the concept that healing is more than just symptom relief. Healing is contact and acknowledgement of a problem. It's realizing that it's not just you but you and some others-the energies of others including some higher powers that we talked about. Healing is not just getting rid of disease but it is function. Over and over again after Jesus healed someone he said, 'Get out of here…go back to your work or your family…go wash or go do something [laughing].' My sense is that a lot of people are here because of broken relationships and part of treatment is repairing relationships. Part of what we have to do individually is to start by making some contact and healing the ability for people to relate. You then use those relationships to move on- to continue to progress. Healing is not just getting rid of the symptoms but it is regaining some experiences and regaining some abilities and then using that to move forward."*

As America moves to implement the recovery values embodied in the Surgeon General's Report on Mental Health and the President's New Freedom Commission on Mental Health (2003), stakeholders are encouraged to examine some of the healing practices which emerged from historically segregated psychiatric facilities and the African American care givers who found ways to offer healing in the shadow of oppression.

Hopefully, this monograph offers a small step toward healing by publicly acknowledging the state-sponsored abuses perpetrated against African Americans within the American

mental health systems. At the same time, African American communities will be able to receive validation for their resiliency and capacity for care-giving in the face of oppression. The author offers these initial recommendations on healing steps based on the issues raised during the research process:

- Initiation of dialogue within African American communities regarding the preservation of some or all of these historically segregated facilities. Mental health consumers/survivors must have a leading role in these dialogues since they have been the most directly affected by these institutions. The Hugh Young Building at Crownsville State Hospital has a unit filled with floor to ceiling murals that were created by patient/artists. They are at risk for simply decaying and being lost forever. The original patient logs and other documents at other facilities are an irreplaceable part of African American history. I would recommend that a research center on African American mental health and wellness be established at one of these facilities. These facilities have been virtually ignored by mental health historians because they were African American. African American historians have also discounted these historically segregated facilities because they are psychiatric facilities. Preservation of photographs and documents at all of the historically segregated facilities is essential.

- Increased dialogue between African American consumers/survivors and mental health professionals regarding a vision of culturally conscious mental health services for their communities. African American mental health providers will need to accept responsibility for their role in marginalizing the voices and experiences of consumers/survivors. However, it must also be acknowledged that institutional racism limited the influence of African American mental health providers by concentrating them in low-level positions. These steps will allow for the possibility of reclaiming the values of respect and partnership, which characterized the philosophy of the Lakin community. We can look to the strategies utilized by Modjeska M. Simkins, which demonstrated the power of linking the needs of African American patients and staff to bring about system change.

- Increase involvement of African American communities in the restoration of cemeteries at these historically segregated facilities to ensure that African American patients are given dignity in death that they did not receive in life.

- Conduct a 'historical fiscal audit" of the historically segregated facilities to assess the fiscal legacy of segregation. There was a strong perception, borne out by the data at Cherry Hospital, that these facilities were significantly under funded. Stakeholders need to assess to what, if any extent, this has carried over into the present day funding of community-based organizations.

- Conduct a research project, which incorporates a strong oral history component, on the mental health implications of trauma resulting from violence perpetrated

against civil rights and Black liberation activist. The research could focus on the protective factors that contributed to the emotional resiliency of many activists. It could also document the massive emotional toll on individuals, families and communities in the struggle for social justice and civil rights.

- Investigate the attitudes and organizational cultures that fostered the development of effective White allies who were able to embrace African American leadership and practice culturally conscious engagement with African American patients. These partnerships were most evident at facilities in Maryland and West Virginia where African American leadership was well established prior to the passage of the Civil Rights Act of 1964.

- National, state and local mental health departments/organizations should take the "Kodak Cultural Competency Test" [take a photograph of the agency staff] and assess how closely their leadership reflects the populations served. At present, many of these organizations would look all too similar to the portraits of all-white medical staffs at the segregated hospitals of the early 1900's.

- Conduct research on the impact of eugenics programs on the sterilization of African American mental health patients. Several states have issued formal apologies regarding their sterilization programs and data in any racial disparities should be easily accessible due to documentation generated in support of the official apologies.

This monograph deliberately does not focus on funding for services. African American communities need to be able to move forward on creating healing space for persons labeled with mental illness whether or not formal mental health systems choose to move forward with them. As African American communities clarify their agendas based on an authentic partnership between consumers/survivors, family members and mental health professionals, they can make more effective decisions regarding resource allocation. These decisions do not have to result in segments of the community being pitted against each other for scarce resources. African Americans have a rich and complex history of caring and healing. Communities, in partnership with formal mental health systems, can draw on that legacy to create healing space for future generations.

Resource Materials

The Color of Fear (video). Stir Fry Productions. 154 Santa Clara Avenue, Oakland, CA 94610. www.stirfryseminars.com.

hooks, bell. Salvation: Black People and Love. New York: William Morrow, 2001.

_____. Rock My Soul: Black People and Self-Esteem. New York: Atria Books, 2003.

Kivel, Paul, Uprooting Racism: How White People Can Work for Racial Justice. British Columbia: New Society Publisher, 2002.

Jones, Reginald L, ed. Black Psychology (3rd Edition). Berkeley, CA: Cobb and Henry Publishers, 1991.

Jones, Charise and Kumea Shorter-Gooden. Shifting: The Double Lives of Black Women in America. New York: Harper Collins Publishers, 2003.

Loewen, James W. Lies My Teacher Told Me. New York: The New Press, 1995.

McGoldrick, Monica, ed. Re-Envisioning Family Therapy: Race, Culture and Gender in Clinical Practice. New York: The Guilford Press, 1998.

Pinderhughes, Elaine. Understanding Race, Ethnicity and Power: The Key to Efficacy in Clinical Practice. New York: The Free Press, 1989.

Poussaint, Alvin and Amy Alexander. Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis among African Americans. Boston: Beacon Press, 2000.

Smith, Susan L. Sick and Tired of Being Sick and Tired: Black Women's Health Activism, 1890-1950. Philadelphia: University of Pennsylvania Press, 1995.

Thomas, Alexander and Samuel Sillen. Racism and Psychiatry. New York: Carol Publishing Group, 1991.

Citations

Baltimore Sun, *Mental Illness Not Found In Fasters.* September 19, 1961.

Cartwright, S. *Diseases and Peculiarities of the Negro Race. Africans in America online citation. Retrieved March 14, 2001from* http://www.pbs.org/wgbh/aia/part4/4h3106t.html.

Colored Insane Asylum of North Carolina, Admissions Log, 1880.

Fett, C. Working Cures: Healing, Health and Power on Southern Slave Plantations. Chapel Hill: University of North Carolina Press, 2002.

Franklin, J. H.. Reconstruction After the Civil War. Chicago: University of Chicago Press, 1961.

Gamwell, L. and N. Tomes. Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914. Ithaca, NY: Cornell University Press, 1995.

Gollaher, D. Voice for the Mad: The Life of Dorthea Dix. New York: The Free Press, 1995.

hooks, bell. Salvation: Black People and Love. New York: William Morrow, 2001.

_____. Rock My Soul: Black People and Self-Esteem. New York: Atria Books, 2003.

Hurd, H. M., ed. The Institutional Care of the Insane in the United States and Canada Volumes I, II, III. Baltimore: John Hopkins Press, 1916.

McCandless, P.. Moonlight, Magnolias and Madness: Insanity in South Carolina From the Colonial Period to the Progressive Area. Chapel Hill: The University of North Carolina Press, 1996.

New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. DHHS Pub. No. SMA003-3831. Rockville, MD, 2003.

Officers of the New York State Lunatic Asylum, Utica. The American Journal of Insanity, Volume I. Utica, NY: Bennett, Backus and Hawley, 1944-5.

_____. American Journal of Insanity, Vol. XXX. Utica, NY: State Lunatic Asylum, 1873-4.

Poussaint, A. F. and A. Alexander. Lay My Burden Down: Unraveling Suicide and the Mental Health Crisis Among African Americans. Boston: Beacon Press, 2000.

Powell, T.O. The Increase of Insanity and Tuberculosis in the Southern Negro Since 1860: Their Alliance and Some of the Supposed Causes. Augusta, GA: Richard and Shavers Printers, 1895.

Richland County Citizens Committee, Inc., Statement, Columbia, South Carolina, February 15, 1965.

Rusk Cherokeean. *Take All Colors at Rusk.* July 11, 1919.

Thomas, Alexander and Samuel Sillen. Racism and Psychiatry. New York: Carol Publishing Group, 1991.

U.S. Department of Health and Human Services. (2001) Mental Health: Race, Culture and Ethnicity – A Supplement to Mental Health: Report of the Surgeon General. Rockville, Maryland: U.S. Department of Health and Human Service, Office of the Surgeon General.

Variety, Crafts-Farrow State Hospital Newsletter, July 1968.

Whitaker, Robert. Mad in American: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill. Cambridge, MA: Perseus Press, 2002.

Wright, Gary L. "*It was like Going Back to the Last Century". The Charlotte Observer, 1992.Reprinted on http://www.uncc.edu/thomass/last.htm. Retrieved 6/2/03).*

Zwelling, Shomer S. Quest for a Cure: The Public Hospital in Williamsburg, Virginia, 1773-1885. Williamsburg, VA: The Colonial Williamsburg Foundation, 1985.