Asylum Myth and Material:
A History of the St. Peter Regional Treatment Center
1866-Present

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ABSTRACT

This dissertation investigates the intermingling narrative space between the mythic *Asylum* produced by scholarly and popular discourse and the lived experience of place at the St. Peter Regional Treatment Center (SPRTC). Engaging with psychoanalysis, haunting, and phenomenology—with a deconstructivist eye toward the historiography of mental hospitals—this project focuses on a microhistory of the SPRTC as a means to offer a framework for understanding place in an institutional setting while upsetting the popular narratives that surround mental hospitals.

The SPRTC was founded in the small town of St. Peter, Minnesota in 1866 and conformed to contemporary prescriptions regarding the construction and function of mental hospitals. Based on the theories of alienist Thomas Story Kirkbride and designed by preeminent institutional architect Samuel Sloan, there is nothing remarkable or extraordinary about it. In that regard, it is an excellent example to investigate as a means to understand how these hospitals—as places with a density of meaning produced by use, rather than total or complete and austere institutions—differ from the mythology that surrounds them. This mythology, through the investigation of ruin and aversion in popular culture artifacts such as the video game *Outlast* and specialist discourse such as that put forth by critical theorist Michel Foucault and sociologist Erving Goffman, is contrasted with a close reading of deeply personal engagements with the SPRTC by the residents of St. Peter, patients, and staff from the founding of the hospital to the present.

Complicating the narrative of the *Asylum* and the meaning of place in an institutional setting, this dissertation moves beyond the microhistorical to implicate the desire to clearly identify sanity through the fetishization of its opposite as the driving force behind discourse on mental illness and locations for its treatment. More broadly, this dissertation complicates the notion that the post-asylum era of treatment, or in-community care, is a significant improvement over institutional care. By offering a different perspective on so-called progress and its relationship to institutional places, this dissertation produces new discursive and investigative avenues for the further study of the buildings, landscapes, and place-making that has developed during the evolution of in-community care throughout the United States.

Acknowledgments

I once compared pursuing a doctoral degree and writing a dissertation to the perfect inversion of walking a tightrope: in the latter, one must never look down and in the former, one must never look up. I am extremely fortunate to have had the privilege of knowing and working with a great number of people who have kept me on my inverted tightrope by providing support, assistance, and care when I was too busy to look up. My thanks expressed here can never fully capture the depth of my gratitude.

At the very first, I must thank Betty McGraw, previous director of volunteer services and museum curator at the St. Peter Regional Treatment Center (SPRTC). Without her invitations to visit the hospital, this project would have been impossible. Her curiosity led me explore paths I didn't know existed and to ask questions I never would have formulated on my own. She taught me so much about the SPRTC—about its history, memory, meaning, and depth. Her warmth and caring—not only for the place but for the people—transformed my work from an investigation into bricks and mortar into one concerned primarily with personal meaning. She not only taught me about a mental hospital, she taught me about compassion and an open acceptance of the human condition in all of its forms. It is because of her and our long talks about mental illness, mental health care, movies about mental hospitals, and common myths about asylums, that I knew I had to articulate the difference between a real mental hospital—with all of its flaws and disasters—and a mythological place of horror. If there is any heart in this project, it originated with Betty.

If we begin at this project's origination in the academic realm, I must first thank Craig Eliason and Victoria Young at the University of St. Thomas. Dr. Eliason encouraged me in my master's level work and was willing to withstand the great intensity (one might say single-

mindedness) of my obsession with Batman comics. That obsession, and the belief that it could be investigated with fruitful results, was exactly what led me to research mental hospitals in the first place, under the guidance of Dr. Young. Without her enthusiasm for my work and for the beauty and complexity of architecture, I never would have found myself in the field I am in today. Even years after I left St. Thomas, their personal and professional support has meant the world to me.

I am forever indebted to the patient support and guidance of my advisor, Anna Vemer Andrzejewski, who has always been able to take apart my work and ask questions in such a way that it improves exponentially… even when I struggle against her. I am also grateful for my committee members, Arijit Sen, Jill Casid, and Katherine Solomonson, who have provided remarkably creative challenges to myself and my work throughout the many years that this project has been in the making. I cannot thank any of them enough for their deep engagement with what has meant so much to me.

I was extraordinarily lucky to have the opportunity to work with the Social Science Research Council through their Dissertation Proposal Development Fellowship. In that context I was able to work with historian of science and technology Stuart W. Leslie and architectural historian Carla Yanni, both of whom helped me clarify and hone my arguments. I am particularly indebted to Dr. Yanni, whose book *The Architecture of Madness* was my bible at the beginning of my journey. Her humor and willingness to help a young upstart in the field (especially one who has such a hard time following direction!) are deeply appreciated.

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I wrote the vast majority of this dissertation by hand, scribbling away with a pen in a book. My particular (and by particular, I mean highly particular), writing process was aided by the wonderful people at Our Kitchen diner and Canteen coffee bar. The former kept me fed when I was too frazzled to feed myself—being sure to ask about my writing on at least a weekly basis, which may or may not have been better incentive for work routine than anything else—and the latter kept me caffeinated and under wide awnings that allowed me to write in the rain.

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Introduction

In early September 2013, Red Barrels production company released the video game *Outlast* for Windows systems. The game was then released for the Xbox One and Playstation 4 video game consoles in the following February. Like all video games, the release of *Outlast* was preceded by a number of trailers, available on-line, to entice gamers into purchasing the game.

The official trailer for the game begins with a flashing series of juxtaposed images and text. The typewriter font text explains the history of the Nazi scientist influenced mind control experiments of the infamous MKULTRA project, conducted by the CIA in the 1950s. These shots of text are punctuated by historical black and white and sepia photographs. The trailer then moves seamlessly into the fictional world of the game, using the same text to tell the viewer that, in 1967, three scientists were murdered by an unknown patient of the Mount Massive Asylum for the Criminally Insane. (Figs. I1 & I2) The implication is that this asylum was used as a testing site for secret MKULTRA experiments, but no more specific information given.

After establishing this connection between secret CIA experiments and Mount Massive, the trailer shifts away from collage style imagery and transitions with a flyover shot that moves in over the Asylum, a hulking mass of stone and turrets set against a cloudy sunset sky (Fig. I3). From there, the viewer joins the protagonist of the game from a first person view, as he moves through the halls of Mount Massive Asylum, surrounded by ruinous clutter and the detritus of a once functioning institutional space. The subway tiled walls are chipped and rotted, wheelchairs sit, upside down, in the hallway, surrounded by boxes and boards and tables and chairs. As the protagonist progresses the ruin becomes progressively more threatening. Blood splatters the

walls and lies on the floor in deep pools. Body parts litter dark corners of the hallways. In a shadowed hospital room filled with softly billowing curtains, the protagonist finds a living man nailed to the wall, bleeding and wheezing (Fig. I4). Figures begin to emerge from the darkness, seen only in periphery as they dart through distant halls. The protagonist slips in a pool of blood, and as he attempts to right himself – his boots leaving red prints on the white floor – one of the shadow figures leaps into view and attacks. The protagonist runs – leaping across tables littered with paper and boxes, squeezing between piles of old mattresses and bedframes that nearly block the hallway – until he slips into a pitch black room and hides beneath a rotted and rusted bedframe. As the protagonist activates his video camera, the darkness is broken by night vision. In the final moments of the trailer, one of the monstrous figures enters the room and violently hauls to protagonist out from under the bed, his disfigured face glowing green in the cameras viewfinder (Fig. I5). Then the screen goes black.

147 years before *Outlast* was released, the first hospital for the insane—the very kind that would later inspire the horror of *Outlast*—was established in Minnesota, in the largely undeveloped town of St. Peter (Fig. I6). The hospital was established in 1866 because the number of indigent insane in the state had finally overwhelmed the procedure of relocating them to a mental hospital in Mount Pleasant, Iowa. Forced to establish its own institution, the state of Minnesota chose a site and constructed a building based entirely on the prescriptions of contemporary alienists, particularly those of Thomas Story Kirkbride, an influential – though young – member of the Association of Medical Superintendents of American Institutions for the Insane (AMSAII).

The primary goal of the institution at St. Peter, which was originally the St. Peter Hospital for the Insane, then the Saint Peter State Hospital, and is today the St. Peter Regional

Treatment Center (SPRTC), was to provide care and treatment for the mentally ill. Unlike asylums, which, strictly speaking, were built for the purpose of containing the insane, mental hospitals were specifically designed to cure insanity. Unfortunately, the Enlightenment dream of a building and landscape capable of effecting such a cure in a time before psychotropic medications existed was untenable. The asylum era mental hospitals were quickly overrun with too many patients – and the SPRTC was no exception. Within ten years two other institutions were built in the state of Minnesota, and treatment still could not keep up with need. The caretaking dream of the mental hospital devolved into a nightmare. By the 1960s, one hundred years after the SPRTC was established and when psychotropics capable of managing severe disorders became available, social critics of the institutional care system began pushing for an integration of mental health care into the community. This deinstitutionalization movement was eager to discredit, discard, and, if they could effect amnesia on a cultural scale, forget the world within the mental hospital.

We are now fifty years out from the deinstitutionalization movement. The majority of care for persons with mental illness is now community based. Most of the toweringly grand buildings that were built to encompass institutional mental health care in the mid-to-late nineteenth century have fallen into disuse and ruin, or have been outright destroyed. The SPRTC specifically has evolved, like a microcosm of greater historical narratives, in step with changing ideas of how best to treat mental illness. Its general population was completely emptied by the 1970s, but the campus remained in use because of its security department. Today, the entire campus is high security and holds only patients who have been found guilty of crimes due to their mental illness. This project as a whole does not engage with the security hospital, as it is essentially a completely different institution, but instead focuses on exploring the original mental

hospital that was dedicated to serving non-criminal populations. The mission of the SPRTC has deviated from the original. The asylum era is long over.

But *The Asylum*, as a mythical place, still haunts our collective imaginings. Cultural productions such as *Outlast* illustrate this point. Their proliferation is, in part, what lends them significance. More importantly, however, is how these artifacts function as simulations of real mental hospitals. The very same prescriptions that shaped the building, the landscape, and the history of the SPRTC and other institutions are what gave rise to the visual and narrative tropes of *Outlast* and other artifacts of its type.

This dissertation explores the complex juxtaposition between fictive representations of *The Asylum* and the reality of mental hospitals. It does this by interrogating the intersectional space between the mythical Asylum and the lived experience of the SPRTC as a microhistory. It approaches an investigation of America's obsession with sanity by juxtaposing large-scale cultural productions, such as *Outlast*, that depict insanity, and a microhistory of the SPRTC, which offers a personal – rather than institutional – vision of life in a mental hospital.

Theories, Methodology, and Literature Review

When I began researching the SPRTC, my only goal as a scholar was to fully understand the original architecture of the main mental hospital building. But the more time I spent on the project, the more difficult it became to distance my personal observations of the place from an objective analysis of its space. I would visit the campus to go through photographic archives, and would end up locked in a room with patients shopping for pants. Or I would be out on the grounds, conducting field work on patient constructed buildings, and I would end up discussing the history of the campus with the physical plant department. Counselors and therapists told me

their stories of working at the SPRTC, escorted patients helped me dig through boxes in the tunnel system. More than once, the SPRTC would offer up some image or affect that was so uncannily like a fictional representation of a mental hospital that it was hard to believe what I was researching was real. Some examples of this experience are the steps in the tunnels below the campus that lead straight into walls where buildings no longer exist, a purple Care Bear taped to a window in the Old Main (there was a problem with a young eagle smashing into the glass day after day) like some crucified monster, and a bucket full of mannequin parts lurking in the dark in the basement of Old Main. Horror movies capitalize on these tropes. What struck me was that, despite the formal similarities between the myths of *The Asylum* that I had encountered all my life and an actual asylum, buried in the intimate personal relationship with the institution was a kind of resigned and absurd humor rather than horror and revulsion.

This juxtaposition, between the mythological Asylum of stories and the real mental hospital that I had the privilege of walking around in, began to haunt me. The amorphously affective space, rather than a building or a campus, became the focus of my work.

This dissertation employs a number of methodologies in an attempt to grapple with this affective space between narrative and reality. It relies most heavily on formal analysis, psychoanalysis, phenomenology, and microhistory. In this case, formal analysis is used to interpret the imagery of cultural representations of *The Asylum* and to understand some of the formal elements of the building and grounds at the SPRTC. Psychoanalysis, focused on abjection and desire, is used to deconstruct the juxtaposition between the mythology and the reality of Asylum spaces/places and to understand the function that mythology serves in the cultural milieu.

Phenomenology is particularly important to this work, as my own experience of investigation plays a large role in informing my scholarly analysis. Because of this dissertation's deep engagement with the everyday, its language performs on both the scholarly and personal level. As its author, I aim to make myself highly visible. Michel deCerteau once critiqued Michel Foucault for failing to position himself in his evaluation of historical archaeology.[1] I would critique past authors on the topic of mental hospitals for erasing their own positions as privileged voices and manufacturing a discourse on sanity through the often fetishized exploration of its opposite. The open usage of my own voice and reflection on my research process also stems from the tradition of microhistory.[2]

I argue that such a specific microhistory of the SPRTC is a valid means to deconstruct the role of the asylum as place in our national discourse on sanity. In this approach, I am following Hayden White's lead in embracing my study's reliance on the literary trope of synecdoche: "By the trope of Synecdoche..." White writes, "it is possible to construe the two parts in the manner of an integration with a whole that is qualitatively different from the sum of the parts and which the parts are but microcosmic replications."[3] Synecdoche is a small part that can speak to a larger whole, in this case, a microhistory of the SPRTC can speak to the larger whole of the culturally constructed and imagined Asylum. Microhistory engages with the large scale – in this case the cultural construction of sanity – by investing in the agency of individuals. One of the foundations of such an approach is the belief that the shape of such cultural discourses and structures is manifested, upheld, and destroyed by individuals.[4]

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[1] Michel deCerteau, *Heterologies: Discourse on the Other*, trans. Brian Massumi (Minneapolis: University of Minnesota Press, 1986), 171-184.
[2] Sigurdur Gylfi Magnusson and Istvan M. Szijarto, eds, *What is Microhistory: Theory and Practice* (New York: Routledge, 2013), 24.
[3] Hayden White, *Metahistory: The Historical Imagination in Nineteenth-Century Europe* (Baltimore: John Hopkins University Press, 1973).
[4] Magnusson and Istvan M. Szijarto, eds, *What is Microhistory: Theory and Practice*.

The Asylum, as a place and an imaginary, is not a benign object to be turned this way and that; it is a fluid ghost winding its way through our culture. To grapple with it, we must begin with admitting our own positions and with the acceptance that the personal is significant. There must be an awareness of this personal stake, wherein haunting and threatening games like *Outlast* and a bucket of mannequin torsos abandoned in a mental hospital basement – which I will discuss in chapter 3 – are of utmost importance. I am not an invisible, innocent, and omnipresent voice, nor are you an innocent and invisible reader. While *The Asylum* and the discourse that surrounds it are haunting us, we are simultaneously haunting it with our desires and our fears. This project is written with that in mind.

My research builds on the work of Carla Yanni in her 2007 book *The Architecture of Madness: Insane Asylums in the United States*, which established the history of the form of mental hospitals throughout the United States in the nineteenth century. Yanni's book is a study in mental hospital typology and outlines debates concerning architecture's therapeutic role in the psychiatric community, specifically following the evolution of linear plan hospitals.[5] Although the book examines the way in which psychiatric discourse concerning architecture influenced hospital design - in particular the discussions among members of the AMSAII (a precursor to the American Psychiatric Association) – It does not include analyses of cultural discourse concerning mental illness. It also does not examine representations of mental hospitals or material objects used within mental hospitals. My dissertation will build on Yanni's work by exploring the architecture from the perspective of usage, in addition to its broader typologies.

Annmarie Adams's 2008 book, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943*, meanwhile, uses the case study of the Royal Victoria hospital in Montreal

[5] Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007).

to interrogate the relationship between architecture and medical practice. She examines the complex interrelations between the architecture of hospitals, patient and staff usage of space, and contextual signifiers of meaning such as postcards and newspaper articles to support her argument that architecture is not passive in the evolution of medicine, but rather instigates change in medical practice.[6] My dissertation will build on this idea of architecture's influence on treatment, but will expand on it by engaging with place as both a physical landscape and a series of representations that influence how that place is perceived. From this perspective, I argue that culture as a whole plays as significant a role in shaping institutional architecture as medical or expert knowledge. Books, videogames, movies, and other cultural productions that focus on mental hospitals influence non-specialist understanding of these places, and that in turn shapes the discourse on their meaning and even efficacy. My dissertation also argues for the centrality of place in shaping the cultural history of the perception of mental illness in America. As such, theoretical studies of place in extant literature is vital to my project.

The significance of place, as a marker of cultural understanding, can be seen in the work by Pierre Bourdieu (particularly his concept of *habitus*), in the analysis of memory given by philosopher Edward S. Casey in his book *Remembering*, and in the articles and books concerning the concept of haunting by Steve Pile, Gordon Avery, and Michael Mayerfeld Bell. Bourdieu's *habitus* is summarized in his introduction to *Habitus: A Sense of Place*, in which he states that *habitus* is not only a place, but a series of dispositions. These dispositions are not natural, but are culturally produced. In turn, we produce their structure. Place, as a marker of *habitus*, shapes the way we perceive and generate our own culture.[7]

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[6] Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893-1945* (Minneapolis: University of Minnesota Press, 2008).
[7] Pierre Bourdieu, "Habitus," in *Habitus: A Sense of Place* ed. Jean Hillier and Emma Rooksby (Burlington: Ashgate Publishing, 2005).

Edward S. Casey's analysis of memory, in his book *Remembering: The Phenomenology of Memory*, puts a particular emphasis on place. According to Casey, there is no such thing as a place-less memory.[8] Because memory is required for an individual's understanding of themselves and their world, its root in place implies the significance of place in shaping individual identities and cultural perceptions. In conjunction with Bourdieu's *habitus*, this would mean that place – as both a physical location and a representation – can alter the way individuals generate their culture. I build off of this concept by asserting that the physical landscape of mental hospitals and the representations that depict them alter the way people engage with the concept of mental illness.

Haunting, as outlined by Pile, Avery, and Bell, incorporates place, memory, and the psychoanalytical concept of trauma to examine how we make sense of our world.[9] Not only are places haunted by memories, but people are haunted by places that embody particular memories. Gordon Avery expands upon this by suggesting that we can examine sociological experiences as hauntings, explaining that particular types of repressions, such as those found surrounding issues of 'otherness,' can be explored through the metaphor of haunting.[10] This dissertation asserts that the landscape of the mental hospital haunts the collective imagination and memory of Americans, shaping the way they perceive the 'otherness' of persons with mental illness and impacting cultural narratives of sanity and insanity.

Haunting is particularly powerful in the context of ruin. To analyze the affective impact of ruin, this dissertation turns to philosopher Edmund Burke's concept of the sublime as

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[8] Edward S. Casey, *Remembering: A Phenomenological Study* (Bloomington: Indiana University Press, 2000).
[9] Steve Pile, "Spectral Cities: Where the Repressed Returns and Other Short Stories," in *Habitus: A Sense of Place* ed. Jean Hillier and Emma Rooksby (Burlington: Ashgate Publishing, 2005); Gordon Avery, *Ghostly Matters: Haunting and the Sociological Imagination* (Minneapolis: University of Minnesota Press, 2008); and Michael Mayerfeld Bell, "The Ghosts of Place," *Theory and Society* 26 (Dec., 1997): 813-836.
[10] Avery, *Ghostly Matters*.

theorized in the eighteenth century, with its high romance and dramatic effects, as well as Sigmund Freud's concept of the uncanny as developed particularly in his book *The Uncanny* .[11] The former is more concerned with experiencing something new, dramatic, and romantic, while the latter interrogates what was once familiar but has returned in a new guise. Both of these approaches are significant to understanding ruin, which manages to be both new and familiar by its complex interaction with the landscape.

Moving from the affect of ruin into the landscape of ruin, this dissertation draws on the analysis of ruin put forth by Dylan Trigg, Tim Edensor, and in Svetlana Boyn's interpretation of George Simmel. Trigg and Edensor both approach the ruined landscape from a phenomenological perspective.[12] Their work explores the ways in which our visceral experiences of ruin complicate our experiences and perspectives on the cultural fabric in which we live. Boyne's work with Simmel offers an analysis of ruin that highlights its utopian features. In each of these cases, the authors grapple with the ruin's ability to be affective, physical, new, and familiar all in one blow.

As an image of the destruction of the familiar, ruin is a marker of "the Other." Otherness is understood in this work through the lens of Michel de Certeau's work in *Heterologies: Discourse on the Other.*[13] Particularly important to this work is his deconstruction of Michel Foucault and Sigmund Freud's writings on the subject of the other. De Certeau's perspective,

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[11] Edmund Burke, *A Philosophical Enquiry into the Origin of our Ideas of the Sublime and Beautiful,* 1757. Reprint (Oxford: Oxford University Press, 1990) and Sigmund Freud, *The Uncanny*, trans. David McClintock (New York: Penguin Group, 2003).

[12] Dylan Trigg, *The Aesthetics of Decay: Nothingness, Nostalgia, and the Absence of Reason* (New York: Peter Lang Publishing Inc., 2009); Tim Edensor, *Industrial Ruins: Space, Aesthetics, and Materiality* (New York: Berg Publishing, 2005); Svetlana Boyn, "Ruins of the Avant-Garde: From Tatlin's Tower to Paper Architecture," in *Ruins of Modernity*, eds. Julia Hell and Andreas Schonle (Durham: Duke University Press 2010).

[13] Michel de Certeau, *Heterologies: Discourse on the Other* (Minneapolis: University of Minnesota Press, 2010).

which argues that the discourse on otherness has archaeologies, lends support to my assertion that broader (and non-specialist) conceptions of the "other" shape specialist discourse.

As otherness implies a necessary boundary between what is safe (due to its recognizability and similarity to ourselves) and what is dangerous (due to its otherness), this project makes use of Julia Kristeva's concept of abjection.[14] Abjection is the horror response inherent in the violation of real or boundaries. I argue that, contrary to narratives surrounding the asylum place, that cling desperately to a clear division between sane and insane—which is embodied in the outside/inside dichotomy of the mental hospital site—there is a continuous bleed, in actual practice, between these supposed opposites. Located in this liminal zone, abjection illuminates both the tendency to crave a boundary and the resulting horror when that boundary is proved to be illusory.

Although it is not the focus of this dissertation to closely investigate the functioning of a mental hospital or the intricate social history of mental health treatment in the United States, it is important to my inquiry to include the work of scholars who have attempted to do just that. I build on the work of social historian Gerald Grob and sociologist Erving Goffman. Gerald Grob is a social historian who has written a number of books on the history of mental hospitals and psychiatric treatment in the United States.[15] His investigations outline the history of psychiatric treatment from the asylum era through the in-community care era.

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[14] Julia Kristeva, *Powers of Horror: An Essay on Abjection*, trans. Leon S. Roudiez (New York: Columbia University Press, 1982).

[15] Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983); *Mental Institutions in America: Social Policy to 1875* (New York: The Free Press, 1973); *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991).

Goffman's 1961 book, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, explores the impact of what he calls "Total Institutions" on patients and inmates. Goffman's analyses of control and surveillance are one of the cornerstones of sociological research in this area. One of the most significant portions of his work for this dissertation is his theory concerning differing spheres of surviellant intensity. Goffman argues that although patients within a total institution are subject to constant surveillance, they actively seek physical and social realms in which that surveillance is decreased so that they may attain some semblance of freedom.[16] I build on this by examining the ways in which patients within mental hospital grounds manipulated their environment to produce private spaces.

Also important to the investigation of surveillance and power systems within the psychiatric milieu is the work of Michel Foucault. Foucault wrote a number of books on the history and cultural production of mental illness and psychiatric practice. His 1988 book, *Madness and Civilization: A History of Insanity in the Age of Reason*, outlines the evolution of the ways in which mental illness has been constructed and circumscribed from the Renaissance to the late nineteenth century. His *History of Madness* investigates the shift from ostracizing lepers to isolating persons with mental illness beginning in the Middle Ages and analyzes the significance of madness as a category of 'otherness.' In *Discipline and Punish: The Birth of the Prison*, Foucault establishes his theory of the panoptic gaze, which creates subjects through observation.[17] This is particularly interesting when taken in conjunction with Goffman's theory

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[16] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (New York: Anchor Books, 1961).

[17] Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans, Alan Sheridan (New York: Random House, 1995); *Madness and Civilization: A History of Insanity in the Age of Reason*, trans, Richard Howard (New York: Random House, 1988); *Psychiatric Power: Lectures at the College de France, 1973-1974*, trans, Graham Burchell, ed. Jacques Lagrange (New York: Picador, 2003).

of differing spheres of surviellant intensity. My research expands upon the concept of surveillance's impact on individuals by incorporating the cultural gaze of the general population.

The complex interplay between the large-scale mythology of *The Asylum* and the small-scale placemaking and understanding of a single mental hospital is also grappled with through the use Jean Baudrillard's simulacra. Baudrillard's concept of simulacra – a copy without an original that often serves to prove its opposite – offers a jumping off point for interrogating the way in which discourses on insanity and locations of treatment for insanity are actually attempts to solidify the reality and recognizability of sanity.[18]

Chapter Summary

This dissertation examines the juxtaposition between the mythology of *The Asylum* and the lived experience of the mental hospital as place. To that end, the chapters are arranged in a way that first introduces the reader to the mythology and then proceeds to the microhistory of the SPRTC as a rebuttal and tool for understanding the underpinnings of that mythology. The arc of these chapters moves from the very large and conceptual and then into the personal as a way of complicating notions of the human experience in the machine of the institutional.

Chapter One looks at two specific examples of representations of the *Asylum* and places them in the context of ruin fetishization and American culture's obsession with identifying and definitively placing insanity as a means to cope with contagion anxiety. The examples closely examined in this chapter are the video game, *Outlast*, and a photograph of patient shoes from

[18] Jean Baudrillard, *Simulations*, trans. Paul Foss, Paul Patton, and Phillip Beitchman (Cambridge: Semiotext(e), 1983).

photographer Christopher Payne's book *Asylum: Inside the Closed World of Mental Hospitals*, completed by Payne in 2009.[19]

Chapter Two deals with the establishment of the SPRTC as an institution and the architecture of its original building. It examines previous scholarship on the topic of asylums by interrogating the meshing between St. Peter and the SPRTC through a number of avenues, including the hospital's Biennial Reports, various histories written by previous staff (most notably those written by the former director, William S. Erickson and the former librarian, Elizabeth Seaquist), newspapers, and entertainments such as festivals and dances which blended the populations of the hospital and the town.

Because the SPRTC was part of the town's establishment and growth, it defines the town. This chapter highlights the porous boundary between the two. It engages with the Kristeva's notion of abjection as a means to explore how boundary issues are expressed in the sanity/insanity narrative, and the role of *The Asylum* in these discourses as a signifier for segregation and containment.

In the third chapter, I focus on patient built architecture on the campus of the SPRTC and interrogates what it means to live in and create a community in this setting. Primary research for this chapter includes field work on extant shacks as well as archival research focused on the SPRTC museum, photographs of the patient-built architecture as it once was, and interviews with staff.

The community structure outlined in chapter three is expanded upon in Chapter Four, as I turn my attention to how the memory of place is embodied within the museum at the SPRTC. It is a very curious space, as it continues to be maintained despite the fact that it is nearly

[19] Christopher Payne, *Asylum: Inside the Closed World of State Mental Hospitals* (Cambridge: MIT Press, 2009).

inaccessible. This chapter looks at the creation of the museum in 1966 by Elizabeth Seaquist, who was the librarian of the SPRTC at the time, and unpacks the implications of creating a memorial to what is often considered a less than desirable institution. It begins with the foundation of the museum and explores its connection to the SPRTC centennial celebrations and examines its continued function now that the majority of care for those with mentally illness has been moved off-site.

The majority of evidence for this chapter is primary and derived from my own experience of the place. As a museum, it is its own evidence, and my description of its arrangement and usage is presented as a reading of a particular kind of material evidence. Interviews with previous staff, particularly Betty McGraw, the most recent curator of the museum, also contribute to this chapter. Secondary research on the function of museums and cabinets of curiosity and their involvement with memory informs my deconstruction of the museum's importance to staff of the SPRTC.[20] This approach opens up an analysis of the holes left by previous scholarship, particularly that of staff absence.

Using the SPRTC as a microhistory, which focuses on the highly personal inside the institutional, this dissertation offers a new and more nuanced interpretation of the meaning of the asylum in the physical and discursive landscape. By moving through these chapters, from the concrete to the fluid and ephemeral, this project addresses historiography on the grand and the small scale. It not only speaks the language of scholarship, but engages with the personal and the everyday, the place where, ultimately, the conflict between sane and insane plays out.

A Note on Language and Terminology

[20] Susan A. Crane, ed., *Museums and Memory* (Stanford: Stanford University Press, 2000).

In the realm of psychiatric history, certain terms carry a heavy stigma. Because of this, they have a way of changing at a surprisingly fast rate and can be confusing to people not deeply involved in this area of study. The play of words to address buildings, landscapes, and people is also something this dissertation engages with as a means to untangle the connections between mythological asylum narratives and lived experience. I would therefore like to take a moment to address the issue of the language and terminology found within this project.

It is important to note that although the majority of my research sources refer to these buildings as asylums, the SPRTC was never an asylum. This term refers to a building or an institution of a protective nature, a place where people could receive help and assistance. The significance of the terms "hospital for the insane" or "mental hospital" is that for the first time these were institutions focused on healing rather than merely holding the mentally ill. The inclusion of the word hospital in their title is also representative of the attempt, on the part of treatment locations and their administrators, to finesse the public into perceiving mental illness as any other illness, which could be treated in a similar fashion.[21]

What were once asylums became hospitals for the insane or mental hospitals. These terms were later replaced by state hospital, a reference to the fact that these were the only types of medical buildings funded by the state government. The St. Peter Hospital for the Insane was established after the passing of legislation dictating that the state was responsible for these institutions; in this regard the SPRTC was always a state hospital.[22] The current term, regional treatment center, is a recent change and although it has not always been historically labeled as such, that is the term I

[21] Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York: The Free Press, 1973), 324.
[22] The Minnesota legislature passed a bill in 1866 ordering the establishment of a public hospital for the insane in the state. State responsibility for this type of institution was established when a bill failed to be passed on the federal level in 1853.

will use in reference to the facility at St. Peter.[23] I will use the term asylum, but it will often be in reference to either other scholarly work or to the concept of *The Asylum* – the mythological place – rather than a physical building.

Like the building itself, the labels placed on those within the building and within the psychiatric milieu have changed significantly. In the early to mid-nineteenth century there were no psychologists or psychiatrists. Medical doctors who took an interest in mental illness were known as alienists. There was only one type of location in which they could practice, and that was the asylum, the mental hospital, or the hospital for the insane. Alienists in charge of any these institutions were known as superintendents. Likewise, terms used for the patients have changed. It is not unusual to hear the terms insane, mad, or lunatic when looking at nineteenth century discussions of patients. These were eventually dropped for the term "mentally ill," which was in turn dropped for the term "persons with mental illness," which was then dropped for the term "persons with mental health issues."

The evolution of this terminology can be seen in documents surrounding the mental health profession, newspaper articles and books covering the topic of mental illness and treatment, and even the signage used at the hospitals and treatment centers. In his book, *On the Construction, Organization and General Arrangements of Hospitals for the Insane*, Thomas Story Kirkbride devoted an entire chapter to discussing proper terminology. He argues that the term insane is the only proper term to use in describing patients and that the term hospital for the insane should replace asylum, since the latter is not a place of medical treatment.[24] His opinions on this subject

[23] At the time it was founded in 1866, the hospital was labeled the St. Peter Hospital for the Insane. In 1893 it was renamed the St. Peter State Hospital. Governor Perpich changed the names of all Minnesota State Hospitals to Regional Treatment Centers in 1985 ("The Evolution of State Operated Services." (Minnesota: Minnesota Department of Human Services, 2007): 1-5)

[24] Thomas Story Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane, Second Edition*. Gerald Grob, Ed. (New York: Arno Press, 1973), 287-93.

reflect contemporary beliefs about insanity and its treatment. They also highlight the on-going struggle of psychology to manipulate and control language. The terms he felt were proper are today considered insulting, derogatory, and painfully out-of-date.

The terms I employ throughout this dissertation move through different times and different agendas. In regards to the buildings and locations of treatment, my usage of varying terms is often meant to juxtapose the discourse with the physical landscape. Any terms used to refer to individuals within the mental health care system are either cited from sources or match the time-frame in which they are operating. No insensitivity to the experiences of those individuals is meant by the terminology I utilize.

Chapter 1: *Outlast*ing Payne's Shoes

"Enjoy yourself out there," the Joker said. "In the Asylum."

from *Arkham Asylum: A Serious House on Serious Earth*

The graphic novel, *Arkham Asylum: A Serious House on Serious Earth*, is the first Batman comic entirely devoted to exploring the iconic asylum of the Batman mythos.[1] DC Comics published this graphic novel, produced by the synergy between Grant Morrison's writing, Dave McKean's art, and Gaspar Saladino's type design in 1989, at the height of the deinstitutionalization movement that was responsible for moving mental health treatment from large institutions into in-community locations. The vision of Arkham presented here – the quintessential Asylum – is one of chaos, violence, and the entropy of sanity. It suggests a kind of erosion that presents itself as a natural and inevitable order of things. Morrison's script moves through the asylum as though it is a living thing, following Carl Jung's lead and transforming the comic into a metaphysical tour of the human psyche.

The Joker's line is split between two panels. After battling the insane inhabitants of Arkham and embracing his own madness, Batman is finally free to leave the physical and psychological maze of the seemingly sentient asylum. Like the rest of the book (and much of McKean's oeuvre), the artwork is splattered, agitated and kinetic. Batman is little more than a dark silhouette, moving away from the viewer, while the Joker stands in the foreground, waving

[1] Grant Morrison and Dave McKean, *Arkham Asylum: A Serious House on Serious Earth* (New York: DC Comics, 1989).

cheerfully. The graphic design of the panel delivery as well as the style of art speaks to the representation of madness as a kind of euphoria.

The Joker's quote above is more than a clever rhetorical reversal that questions the inside/outside established dichotomy of *The Asylum*. Only pages before, when Batman tries to barter with the hostile patients by telling them they're all free, the Joker responds disdainfully, rolling his eyes, "Oh, we know THAT." *Arkham Asylum* implies that inside and outside are irrelevant; *The Asylum* is the world. It is both the macrocosm of the architectural space and the microcosm of the individual mind.

Arkham Asylum was written and published when the asylums of the real world were quite literally losing coherence, breaking down, and infiltrating the world "out there." As deinstitutionalization took effect, care for those with mental health issues moved out of the highly visible mental hospitals and into dispersed, less obvious in-community care systems. Massive institutional edifices could no longer be pointed to as the keepers of the mad.[2] The system's breakdown and the population dispersal was like the loss of quarantine, the release of a contagion. "In the Asylum" suddenly referred, not to a bounded institution, but to a borderless everywhere. And everyone became possible carriers.

This chapter explores representations of *The Asylum* in the landscape of the post-institutional treatment era. It asserts that these representations of *The Asylum* are founded in a psychological need to "place" insanity – a need that had been previously fulfilled by actual and highly visible institutions. Through the usage of uncanny and sublime horror and ruin, these representations function as an interlocking and complex mechanic for coping with the cultural fear of insanity's contagion. This "contagion anxiety" is produced by the invisibility of mental

[2] Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991).

illness and its threat to self-hood. Contagion anxiety is my term for the contemporary American cultural reaction to insanity and is defined by a car-wreck rubbernecking style of obsession with hyperbolic representations of insanity that, through their extremity and lack of subtle investigation, provide assurance that the viewer is sane rather than insane. This chapter will outline how contagion anxiety produces and functions within popular culture representations of *The Asylum* after the years of deinstitutionalization from the 1980s to the present.

This first chapter is the backdrop against which the following chapters rest, providing the cultural noise in which actual place acts as signal. Its purpose is to closely examine the romance of ruin and specific examples of American cultural production of *The Asylum* from the 1980s to the present and their relationships to contagion anxiety. This background noise of *The Asylum*'s meaning will be juxtaposed in the following chapters against the specific example of the SPRTC. This juxtaposition articulates the effects of deinsitutionalization on the narratives surrounding the relationship of mental illness to institutional care and the way in which place, as an affective density created by lived experience, contradicts those narratives.

Arkham Asylum: A Serious House on Series Earth is one of many narratives in the post-institutional treatment era that treats the asylum building itself as a character. In these stories, such as FX's *American Horror Story: Asylum* and the movies *Session 9* and *Grave Encounters* (to name only a few in this vast genre), *The Asylum* lives and breathes under its own power, absorbing and consuming the human characters. It is always a ruined entity, made somehow more powerful by that very ruin. This plot mechanic is part of a long tradition in haunting narratives. As Anthony Vidler points out, in his discussion of haunted houses in his book, *The*

Architectural Uncanny, the terror of these stories arises from the buildings being not haunted by spectres, but being spectres themselves.[3]

Vidler's analysis of haunted houses utilizes Victor Hugo's and Hermann Melville's literary works to excavate the spectral and sentient nature of abandoned and terrifying edifices. Vidler quotes Hugo's description of an abandoned house on the island of Jersey, which, through legend of crimes committed within was permanently changed: "The house, like man," Hugo writes, " can become a skeleton. A superstition is enough to kill it. Then it is terrible."[4] The terrible nature of the house may begin with an event, but the event mutates the house into more than a site of transgression. It is thereafter terrible in and of itself.

The sentience of a place is further illustrated in Vidler's exploration of Melville's short story, *I and My Chimney.*[5] In the story, a man describes his relationship to the enormous and central chimney in his small home. Because of its location and size, the chimney determines all movement and thus relationships within the house. As Vidler points out, the chimney is the master of the house and the narrator is its slave. The narrator sacrifices family, friends, and all relationships with the outside world to ensure that the chimney is protected. Through the narrator's description of the chimney, it becomes both sentient and immortal, something far exceeding an average chimney. The story is an exploration of a human being's fear of and deference to a powerful and sentient edifice.

A number of modern fictional Asylum narratives share this trait. *Arkham Asylum* and *American Horror Story* dance between function and ruin — jumping through time, space, or both to juxtapose a functioning mental hospital with a decimated husk. Both *Session 9* and *Grave*

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[3] Anthony Vidler, *The Architectural Uncanny: Essays in the Modern Unhomely* (Cambridge: MIT Press, 1992), 17-20.
[4] Ibid., 20.
[5] Herman Melville, *I and My Chimney*, 1855. Reprint (Kessinger Publishing Company, 2010).

Encounters explore the building at the time of its immanent collapse. But, of course, it will not collapse because *The Asylum* is more than a building and always wins in the end in these mythologies. Like Hugo's abandoned houses, *The Asylum* has been changed by events that take place within and is now terrible in and of itself. Like Melville's chimney, the architectural structure is the master and the humans within puppets that serve at its whim.

These examples do not encompass the vast amount and wide variety of Asylum stories; rather they are two specific examples to more closely examine. Rather than attempting to grapple with the entire array of *Asylum* representations, this chapter will first establish the significance of ruin as it intersects with mental illness and then proceed to focus on two examples of the imaginary Asylum. These examples are the video game, *Outlast*, released by Red Barrels in 2013 and photographer Christopher Payne's book *Asylum: Inside the Closed World of State Mental Hospitals,* published in 2009.[6]

These examples have been pulled for detailed examination because, despite their material differences, they share tropes and motifs that embody the broader cultural Asylum narrative in the modern United States since the 1980s. Video games and photographic essays both utilize the visual, but a video game is immersive and participatory, engaging the sense of touch and hearing as well as sight, whereas photographs are exterior and unalterable, relying principally on sight. Video games are often interpreted as entertaining fiction, whereas photographs supposedly report the truth.

From their places across the spectrum of Asylum narratives, these two examples offer a frame for this chapter's argument because of their similar tropes. These include references to ultimate Evil, the reliability of the photo journalist as a revealer of hidden truth, and the Nazi

[6] Christopher Payne, *Asylum: Inside the Closed World of State Mental Hospitals* (Cambridge: MIT Press, 2009).

regime as a motif of Evil. They also share a dependence on the aesthetics and moral implications of ruin. This concept of ruin is used in both of these examples as a way to mark mental illness as recognizable and definitively Othered. Before turning to the examples, however, we will first explore the concept of ruin broadly to establish how these examples can perform such a complex narrative task.

The Romance of Ruin and the Apocalyptic Dream

"One must not be too romantic about madness," Oliver Sacks writes in his introduction to Payne's collection of abandoned asylum photographs, "or the madhouses in which the insane were confined."[7] But it is precisely this romance – or something twistedly akin to romance, that fixates and slavers over the incomprehensible – that continuously brings the madhouse and the insane under our gaze.

The fiction of mental illness is consistently arresting. Tropes of romantic, tortured genius and the triumph of the spirit in crushing institutional settings abound and the two examples that follow illustrate this. These are particularly powerful when applied, like a glossy veneer, over the lives of actual people. Vincent van Gogh is a suicidal madman first and a painter second, Hemmingway and David Foster Wallace are suicides first and writers second. Another example is the life of John Nash – a mathematician in the twentieth century – as depicted in the supposedly biographical movie *A Beautiful Mind.*[8] The centerpiece of the film is Nash's struggles with schizophrenia throughout his life and how those struggles impacted him

[7] Christopher Payne, *Asylum: Inside the Closed World of State Mental Hospitals* (Cambridge: MIT Press, 2009), 5.
[8] Grazer, Brian, Ron Howard, Akiva Goldsman, Russell Crowe, Ed Harris, Jennifer Connelly, Paul Bettany, et al. *A Beautiful Mind* (Willowdale, Ont: Distributed by Universal Studios Canada, 2002).

personally and professionally. The film shows Nash's vivid visual hallucinations, his institutionalization and treatment, and his conquering illness to contribute to the mathematical world.

The film is about struggle and genius, but its impact has nothing to do with enhancing our knowledge of mathematics. Instead, it is better understood as a narrative of how brilliance rises, like a phoenix, from the ashes of madness. Viewers witness how John Nash – whose work transformed the modern stock market, game theory, and studies in artificial intelligence – is smarter than them and how he transformed pure psychosis into pure genius. This obsession with insanity giving rise to genius is not only in popular culture, but in high brow narratives as well. In the case of John Nash, *A Beautiful Mind*, which starred Russell Crowe (a far more handsome version of Mr. Nash than the real one), was not enough. PBS's American Experience also produced an episode dedicated to Nash, entitled: "A Brilliant Madness."[9] The reality, in contrast to what the titles of these stories imply, is that Mr. Nash has not lived a romantic life. Although his illness has lessened with age, he has had to contend with delusions, hallucinations, and numerous hospitalizations and insulin shock therapies throughout his life. Schizophrenia, it turns out, is less illuminating than one may have hoped. Nash may have persevered, but the artists listed above did not. In the same way that schizophrenia was a hindrance rather than the impetus for Nash's brilliance, clinical depression has never inspired painting or writing.

Nash's psychosis, Hemmingway and Van Gogh's guns, and Wallace's noose are all objects of torment that gesture toward ecstatic suffering and are as alluring as they are frightening. The extremity of them, being beyond the average experience in everyday life, takes on a quasi-religious hue. The resonance here speaks to deep and usually unconscious correlations

[9] American Experience, "A Brilliant Madness: The story of Nobel Prize winning mathematician John Nash." (*American Experience* video http://www.pbs.org/wgbh/amex/nash/index.html, 2015).

between extraordinary pain and extraordinary wisdom. But, there is a second step. After the initial romance of their conceptual reality, there is the recognition of real danger. This danger – from psychosis, guns, and nooses — and in turn *The Asylum* – threatens the physical and spiritual aspects of a human being. If, at any time the sense of extraordinary resilience and calling are stripped away, if we recognize that Nash, Hemmingway, Wallace, and ourselves are not immune from suffering, we see these things in their stark reality: as instruments of death. Here is where true fear follows on the heels of romance.

These affects move so quickly from one to the other that they are intertwined rather than separate and vacillating. Juxtaposition between romance and fear is the defining feature of our contemporary culture's approach to mental illness and the definition of Edmund Burke's sublime: "Whatever is fitted in any sort to excite the ideas of pain, and danger….that is to say, whatever is in any sort terrible, or is conversant about terrible objects, or operates in a manner analogous to terror, is a source of the sublime; that is, it is productive of the strongest emotion which the mind is capable of feeling."[10] Burke's sublime, which is marked by the terrible and dangerous – as long as it does not, in his words, "press too close"— is infused with a dizzying romance.[11]

This synergy of romance and terror is perhaps best aroused through ruin, as Burke states: "There is no spectacle we so eagerly pursue as that of some uncommon and grievous calamity," and the destruction or abandoned erosion of the built environment hints at such calamity. This is the case whether we know the impetus of such ruin through witnessing its happening or merely imagine it by gazing at what is left behind. This effect is strongest in relation to buildings that

[10] Edmund Burke, *A Philosophical Enquiry into the Origin of our Ideas of the Sublime and Beautiful*, 1757. Reprint (Oxford: Oxford University Press, 1990), 36.
[11] Ibid., 124.

visually represented some large-scale institution. Ruined shopping malls and factories speak to the larger issues of capitalism, consumption, and production; the ruined civic centers and commons of ancient civilizations hint at the transience of human achievement. Amongst the ruins, where linearity of time and civilization are destroyed, viewers experience a kind of eroticism. This eroticism arises from the transgression of the everyday.[12]

Aside from the sublime nature of this state, which is what aesthetically and psychologically draws in the viewer, how can we interpret ruin? Physical ruin, amongst other things, gives rise to a contemplation of the apocalyptic. Apocalypse is both destruction and hope. Evan Watts notes, in his article on the post-Apocalyptic ruinscape of video games, that the Apocalypse evens the playing field by eradicating the landscape that represented and embodied the pre-existing world.[13] The end of the world is the end of constructed norms and boundaries, allowing a new and better world to be born. Svetlana Boyn notes the same utopian implication of ruin in her chapter "Ruins of the Avant Garde" in *Ruins of Modernity."* Boyn summarizes the argument by George Simmel, a nineteenth-century philosopher and sociologist, which contends that ruins do more than represent destruction, they also represent hope for a utopic future: "According to Simmel…ruins… reveal in 'retrospect' what this epiphanic moment had in 'prospect.' Yet they do not merely signal decay but also a certain imaginative perspectivism in its hopeful and tragic dimension."[14] This hopeful dimension embodied in ruin allows us to imagine utopia.

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[12] Dylan Trigg, *The Aesthetics of Decay: Nothingness, Nostalgia, and the Absence of Reason* (New York: Peter Lang Publishing Inc., 2009), 189.
[13] Evan Watts, "Ruin, Gender, and Digital Games," *WSQ: Women's Studies Quarterly* 39 (Fall/Winter 2011): 247-48.
[14] Svetlana Boyn, "Ruins of the Avant-Garde: From Tatlin's Tower to Paper Architecture," in *Ruins of Modernity* eds. Julia Hell and Andreas Schonle (Durham: Duke University Press 2010), 59.

This utopia insists we believe it is possible, even if we do not see it immediately. Dylan Trigg argues that we must believe in progress because to think otherwise would undermine the human project: "Unable to rationalize decline, the aim of reason has been to shadow the mutable by affirming the permanent. The illusion is not dead. Thinking that we learn from our mistakes, we infer that during the next epoch, rational progress will finally fulfill its fate."[15] Whether the ruin we view is part of an imaginary landscape or our real, physical landscape, it enters into our imaginary concerning progress. Apocalyptic thinking approaches the end of the (or a) world as a necessary step for attaining the final, perfected state. It revels in violently sublime endings, in which impurity is washed away.

Real ruins encapsulate this mythological imagining of apocalypse by virtue of their microcosmic mirroring of the managed and maintained social, cultural, and physical whole of society. They contradict the supposed ordering of our ordinary physical space. Tim Edensor argues that it is within the chaos of ruin — the physical remains of apocalypse — that we are capable of envisioning a life devoid of imposed structure, surveillance, and organization: "Ruins stand in rather glaring contrast to the reinvented fabric of much contemporary urban space. For absent in their disordered realms are the usual sheen of aesthetic order, the surveillance of people and non-human life, the placing of things and humans in specific spaces, and the self-conscious awareness that limits corporeal expression in the midst of others."[16]

Ruins, then, give us a small space in which to imagine the devolution of the whole human project. They also encourage a conflation between the destruction of a physical space and the institutional system it once represented. Here, the apocalyptic dream assumes that this destruction was not only necessary, but inevitably gave rise to a better reality.

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[15] Trigg, *The Aesthetics of Decay*, 85.
[16] Tim Edensor, *Industrial Ruins: Space, Aesthetics, and Materiality* (New York: Berg Publishing, 2005), 167-68.

The microhistorical example to follow this chapter, the St. Peter Regional Treatment Center (SPRTC), has not been used for general population mental health care since the early 2000s, and its deinstitutionalization began in the 1960s.[17] Even so, this type of building continues to embody the discourse on mental illness. The mythology is functioning in the past, rather than in the present, and the supposed inaccessibility of such total institutions has given rise to a mythological perception of access afforded by ruin. It is not surprising that as these sites fall further into decay, their ruin becomes ever more embedded into the visual culture surrounding mental illness.

There is more at play in the interpretation of the ruins of the mental health care system than the sublime and the apocalyptic. This facet arises from the mythological inaccessibility of the total institution and the invisibility of mental illness, both of which produce contagion anxiety.As Burke writes in his essay on the sublime, nothing produces terror quite like obscurity, the inability to see and place threat.[18] The interior of the asylum is, for most people, only known through mythological narrative, whether that narrative is that of sociologist Erving Goffman or the fiction author Ken Keasey. Mental illness itself is an unseen ruin, and so *The Asylum* is always presented as its avatar, a physical ruin to fill in as synecdoche for the invisible affliction. As definitive locations with recognizable traits, the asylums of the previous era fulfilled the role of visual marker upon bodies of the ill, locating them in space and in status. With the asylum era over – and the remains of its buildings in literal ruin – the mythological Asylum steps in to fill the role of that placing.

[17] The SPRTC is currently a high security facility housing only those people whose mental illness has contributed to their violent crimes. The scope of such treatment is outside the purview of this project, due to its incredible difference from general population mental health care.
[18] Burke, *A Philosophical Enquiry into the Origin of our Ideas of the Sublime and Beautiful,* 54.

The following discussion illustrates how the concept of ruin is used in the current Asylum narrative to mark mental illness as recognizable and definitively Othered, making it highly visible through synecdoche and easily identifiable as "not me." In ways that surprisingly overlap, these different visual codifications of *The Asylum* serve the purpose of maintaining boundaries – even if they exist only in our cultural imaginary – in the asylum without borders.

What Can You *Outlast*?

Outlast begins with a cut scene, an in-game movie style clip in which the player has no control, but merely watches. From a first person perspective, the viewer drives a bouncing jeep down a winding and tangled road. The radio, playing the sound of a man talking as though he is being interviewed, is overrun by intermittent static until it finally dies away completely. It is sunset dark, with lightning flashing in the red and purple sky, silhouetting some monstrous Gothic building against the horizon. That monstrosity, Mount Massive Asylum, is the viewer's destination. Upon arriving at a the guard station just outside the heavy stone and metal fence that surrounds the asylum, the cut scene ends, the player takes hold of the controls and the game begins.

To say that *Outlast* is terrifying is a stunning understatement. In the game's first moments, I made my way through the asylum gates and, as the storm rolled in and rain began to hammer down, I climbed inside an open window. I was immediately confronted by atramentous darkness – until a television on the wall clicked to life of its own accord and I could see, against its static, an enormous splash of blood across its screen. The play of darkness and light in *Outlast*, violently juxtaposed to a degree that they take on elemental implications, produced an

immediate fight or flight reaction. By the time I glimpsed my first humanoids in that twilit place – roughly twenty minutes into gameplay – I stopped playing because the visceral agitation was too overwhelming.

The game's genre, first person survival horror is defined by terror, but *Outlast* pushes the boundaries – and the player's nerves – to a point that well exceeds its genre-mates. Genre labels for video games are defined by a mixture of mechanics and style. "First person" refers to the game mechanic of the view afforded to the player of the in-game avatar, or player-character. In first person games, the player sees through the eyes of the player-character, occasionally catching glimpses of the player-character's hands and legs, depending on the action being taken. "Survival horror" refers to the style of the game's execution and narrative. Survival horror games are a great deal like horror films; but unlike the viewer of a horror movie, who passively watches action that does not impact them directly, the player is inside the active and responsive narrative of the game, attempting to survive until the end. Most survival horror games with first person views are also what are called "first-person shooters," meaning that the player's view is often down the barrel of a gun or other projectile weapon. But there are no weapons in *Outlast*, a particularity I will address shortly.

The plot of *Outlast* is that Miles Upshur, an independent reporter, is investigating the abandoned Mount Massive Asylum on a tip from a whistleblower within the institution. According to an email, the MURKOFF Psychiatric Systems' facilities at the Mount Massive Asylum have been experimenting on patients, and the whistleblower wants it exposed. When Upshur breaks into the Asylum, he first finds dead bodies and then the living, mutilated, and murderous inmates of the institution. Unable to escape the Asylum, Upshur is forced to move through its entirety, armed with only a camera capable of night vision. What he discovers in the

documents left behind by "doctors," is that Mount Massive was the location of a Nazi-driven MKULTRA experiment to produce a super-soldier, and everything has gone wrong. The "experiment," the Walrider, is now on the loose, along with a horde of altered beings, called Varients. These include two homicidal twins who discuss wanting to eat Upshur's liver and tongue, a giant named Chris L. Walker who relentlessly pursues Upshur throughout the game, a mad "priest" who believes the Walrider is the second-coming, and the lunatic Nazi scientist who created the thing in the first place.

Following the lead of survival horror games like *Silent Hill: Shattered Memories* and *Amnesia*, *Outlast* capitalizes on fears of the dark and vulnerability.[19] When pursued by opponents, there is only one option for survival: run and hide. In most cases throughout the game, the player must run and hide through pitch-black rooms while seeing only in night vision through his camera, which offers a blurry, myopic, and slightly green vision of the world, heightening the fear of running with the fear of blindness (Fig. 1.1). Evan Watts writes that *Silent Hill: Shattered Memories* – the first of this genre to use this mechanic – is a notable departure from traditional survival horror and that it "presents only one option for *survival*, with no options at all for solving the problem. It is an approach that forces the player into the position of victim of a situation rather than dominant over it, and then demands that the player *acknowledge* this inability to dominate the situation if he or she has any hope of surviving."[20] Acknowledging the inability to fight back or to change the landscape of the game by removing the opponent obstacles increases the psychological stress created by the game.

[19] *Silent Hill: Shattered Memories* (Konami, 2009) and *Amnesia* (Frictional Games, 2010). Previous games, such as *Thief* (published in 1998 by Looking Glass Studios) encouraged stealth over violence, but continued to include weapons.
[20] Watts, "Ruin, Gender, and Digital Games," 260.

Outlast uses another typical game mechanic, "bread crumbs," to create psychological stress. Bread crumbs refers to the mechanic of using game appropriate imagery to indicate which direction the player should move in to make progress in the game.[21] Other spaces are open for investigation, and should be explored for information or items, but the bread crumb line indicates what direction the linear narrative moves in through an open virtual game space. Bread crumbs take on a number of different designs, as they must fit whatever game they are being used for. In *Outlast,* this mechanic is illustrated by enormous amounts of blood, splattered on the walls and floor (Fig. 1.2). Early in the game the player is told to "follow the blood," a statement that takes on disturbing implications when those deep splashes of blood lead into total, pitch-black darkness (Fig. 1.3).

The visceral experience of gaming versus passively viewing other visual media is important for our analysis of this representation. This is a generative narrative, that will is unique to each particular player regardless of following an outline. Every player will take different turns at different times, encounter adversaries in different orders, die in different ways, and successfully complete levels after a different amount of times. This alters the narrative according to Grant Tavinor: " Modern video games are fiction machines" that affect players deeply because,"we can have emotions that depend on our existing in the same world as a fictional character, because we do so through a player-character proxy."[22] When the player manipulates the controls, the player-character responds. Because all players interact with their controls differently, their experience in the game world is unique and affective.

[21] Ernest Adams and Joris Dormans, *Game Mechanics: Advanced Game Design* (Berkeley: New Riders Games, 2012), 72.
[22] Grant Tavinor, "Bioshock and the Art of Rapture," *Philosophy and Literature* 33 (April 2009): 91-106, 94.

The experience of identifying with a player-character proxy is particularly strong in first-person views, as the player "sees" through the eyes of the player-character and loses the distance afforded by a third-person view.[23] By simulating real sight, the body of the player is directly implicated in the actions of the player-character. This makes the experience of place and narrative within the game a much more powerful phenomenological experience.

My own experience playing the game was that it was almost too horrifying to endure. Moving from room to room, often running and jumping over obstacles while maniacs with clubs or large pieces of glass pursued me until I hid in a locker or under a bed, was nerve-wracking. Especially because the player-character breathes audibly like a trapped animal in these situations and, occasionally, the Deviants would find me and pull me out from my hiding place to slaughter me.

The mechanics of the game are simple (and standard), but its affective stimuli are not. At a number of points, while using the night vision to navigate in the pitch darkness, the sudden appearance of a Deviant would cause me to scream and push and the computer away. I was capable of playing the game for only two hours at a time, at most. Occasionally, I managed to play for only fifteen minutes before having to stop. I very rarely played it alone. This was the impact of the game, despite the fact that I knew I was playing it for the sole purpose of critiquing its representation of *The Asylum*. As an expert on this building type, I was keenly aware that the building design of Mount Massive was completely fictional and over the top. For example, the interior of the building was far too large and labyrinthine to fit inside the exterior seen at the beginning of the game and a nineteenth-century mental hospital does not have long series of

[23] Ibid., 100-102.

airlocks built in to the wards. The psychological pressure of the game, however, negated that knowledge, and the landscape of Mount Massive became all too real.

This experience of game-play intensity is not unique. An article written on-line near the time of the game's release for PC in 2013 is titled, "Why I Will Probably Never finish *Outlast*:"

> Typically a horror situation always comes down to "why wouldn't this person just leave?" or "why would you investigate that creepy noise?", but here it isn't that at all, you want to get out, you just can't. All of this is coming from a person who loves the horror genre, who wants to be scared, *Outlast* has certainly scared me in a way I never thought a game could. It is a game by horror fans for horror junkies to show them that there are indeed things in the dark worth being scared of…[24]

A number of other reviews ranked the game as the scariest they had ever played.[25] Promotional videos for the game showed individuals actually taking off their headphones and walking away from their monitors in the middle of the game.[26]

The horrifying backdrop in which *Outlast* plays out, with mutilated bodies strewn across the floor (an entire section of the game requires the player to wade through and hide amidst corpses), blood splattered everywhere in flickeringly lit hallways, all within a crumbling and eroding architecture, heightens the impact of the narrative. It brings what might have been an intellectual consideration of the dangers of *The Asylum* down to a visceral, flight-or-fight level of instinctual reaction to the horror that is the body of the mentally ill.

The storyline of *Outlast* culminates with the discovery that the ultimate weapon, the Walrider, is "hosted" by one of the patients. When Upshur attempts to destroy the body of the patient to destroy the Walrider, he becomes the new host, a new body for the monster to spring

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[24] Lackluster, "Why I will Probably Never Finish Outlast," Viralize, 2013, http://n4g.com/news/1349887/why-i-will-probably-never-finish-outlast.

[25] Marty Sliva, " The Horror, The Horror: Outlast Review," *IGN*, http://www.ign.com/articles/2013/09/04/outlast-review ; Carolyn Petite "Run Like Hell: Outlast Review," *Gamestop*, http://www.gamespot.com/reviews/outlast-review/1900-6415664/. IGN, "How Scary is Outlast," Youtube Video, 5:52. April 26, 2013, http://www.youtube.com/watch?v=1Vcgdl4xQ18.

from as an emergent property. This is the final scene of the game. After running, hiding, searching, and striving for only one thing: escape, Upshur is finally overtaken by the spirit of Mount Massive.

Outlast is ultimately about the dangers inherent in blindness. Within the previously unseen depths of an Asylum, monsters – created by a secret company, using secret MKULTRA techniques, administered by Nazis in hiding – lurk in rooms too dark to perceive. The epitome of these monsters and the embodiment of insanity, the Walrider, is an unhuman cloud of nanites, completely invisible unless seen through the camera in night vision mode. But it is the final fate of the player-character and the player that speaks most directly to our collective narrative concerning mental illness.

Upshur's (and by proxy, the player's) infection by the Walrider is the ultimate reflection of contagion anxiety, that all of us are susceptible to infection, or outright possession by, insanity—at any time and—no matter how hard we struggle. Dylan Trigg, in his book, *The Thing: A Phenomenology of Horror*, discusses how the violation of the self through the invasion of the body by the alien other reflects deeply held human fears of losing touch with identity and the stability of being-in-the-world. He takes as his point of departure the films of David Cronenberg and John Carpenter, specifically *The Fly* and *The Thing* respectively. His analysis speaks to the Walrider in *Outlast* as well. According to Trigg, the infection of the alien other ruptures the continuity of the human to transform it into the unhuman: "If horror is the image of abjection "then anxiety, as Lacan imitates, is the recognition that the horror is already there, within the flesh and thus the subject."[27] This return of the recognizable (the human self) as something unrecognizable (the unhuman and alien) is a direct reference to Freud's uncanny.

[27] Dylan Trigg, *The Thing: A Phenomenology of Horror* (Washington: Zero Books, 2014), 138.

Infection by the Walrider, quite literally the infection by madness itself in elemental form, expresses a deeply held mythology that presents insanity as an invisible infestation or possession that comes about through a weakness in the soul of those afflicted.

Ian Bogost, game designer and theorist, argues that games do not exist outside the influence of cultural narratives: "…games cannot help but carry the baggage of ideology."[28] The ideology of *Outlast* is rooted in horror and loathing for mental illness. No setting other than an asylum, with its implicit gestures to examining what is human, could elicit such an extremely uncanny and haunted reaction to human experiments. Its narrative is extreme, but its function is to place insanity firmly within *The Asylum*. Through virtue of its fictional hyperbole, *Outlast* confirms insanity as un-human while allowing the player a physically (if not psychically) safe space in which to experience this un-humanness. This experience, in turn, allows the player to recognize insanity and thus Other it. By way of comparison between the fictional realm of the game and the solidity of the real world, the experience of fictional infection by the Walrider allows the player to negate their all too real contagion anxiety. They can carry this into the real world with them, superimposing their knowledge of insanity as a highly recognizable and extreme condition onto a landscape that no longer contains the markers of that insanity. *Outlast*, by virtue of its horror, renders the real world safe.

Payne's Shoes

Like *Outlast*, Christopher Payne's book, *Asylums: Inside the Closed World of State Mental Hospitals*, takes us inside the restricted space of the mental institution. Unlike *Outlast*,

[28] Ian Bogost, *Unit Operations: An Approach to Videogame Criticism* (Cambridge: MIT Press, 2008), 135.

Payne's book engages with the real, rather than imaginary, landscape. It is a photographic tour of the ruin landscape of abandoned mental hospitals in the United States. The book is arranged by spatial type rather than locational narrative, and in such a way that it takes us from the exteriors of these places – landscapes we could access on our own – and then deep inside, into interiors that would be inaccessible to the average individual. Picture after picture barrages the viewer with exteriors and then wards, and then minutia until the desolation of the whole project becomes overwhelming.

Ruin on this scale is the ultimate sublime: it calls up deep uneasiness about the meaning and permanence of the human condition. But Payne, in using the abandoned mental hospital as his subject, has tapped into something deeper and darker than a fear of the collapse of capitalism. He has resurrected the ghost of mental illness and the fear of insanity contagion.

Part of this becomes clear when we realize there are no people in Payne's photographs. All we are presented with, as viewers, are the buildings, and because these buildings are presented in pieces (as groups of types rather than parts of a singular locational narrative), they become interchangeable with one another. As we move through the book, from the exteriors in all of their grand and imposing architectural glory, to the wards with paint peeling doors flanking their emptiness and then finally to the material detritus of abandoned mental health care, we move closer and closer to the human. Objects, such as the toothbrushes in "Patient toothbrushes, Hudson River State Hospital, Poughkeepsie, New York" (Fig. 1.4) are presented to us as mere catalogue, objects in orderly display. But these toothbrushes, of various bright colors like orange and blue and green, neatly hanging on their rectangular white wooden rack, with only a few lying haphazardly on the shelves, imply the presence of the human beings who once used them. Only the border surrounding this rack, which is the white, peeling paint and crumbling plaster of a

wall, alerts us to their abandonment. This juxtaposition, between the orderly arrangement of the average and everyday human tool—the toothbrush—and a wall that is clearly in decay, incites an uncanny foreboding in the viewer's gut: if the signs of life are here, where have the people gone? What if they have not? Are there ghosts?

Another image, similar to that of toothbrushes but more evocative of uncanny unease is an image of shoes. In "Men's and Women's gym sneakers, Wernersville State Hospital, Wernersville, PA" (Fig. 1.5) two piles of shoes occupy a pale room lit by diffused sunlight. A haphazard pile of black, Converse-style sneakers lies in the foreground of the image, and another, slightly smaller, pile of white sneakers in the same style occupy the background, near what appears to be a door. The floor and the walls of the room are slatted wood and were probably both white in previous times, but in this picture the floor appears slightly grey. Aside from loose, grey-brown dirt pressed up against the baseboard in the top right corner of the photograph, the shoes are the only objects in the room.

Neither pile is grouped by pairs. Close inspection reveals that they're not even all the same type of shoe, but are only similar in general appearance. The black shoes in the foreground have white rubber soles and black tops, but some of their white rubber soles are striped in black and some are striped in red. Some of the white shoes in the background are high-tops and some are low tops. Each pile is thrown together based, one assumes, based on Payne's title, on whether they are men's or women's shoes, but beyond that there is no organization. We don't even know which pile is which.

This raises the question of how Payne knows that they are men's and women's shoes at all. There is no explanation of his assessment of these shoes, only the title, announcing that they are men's and women's gym sneakers. Was there a sign? Were these shoes near a gym? On that

account, they are presented page opposite from a photograph of a gymnasium, in which a sign reading "SNEAKERS ARE REQUIRED IN GYM AT ALL TIMES" (Fig. 1.6) lies against the one closed door. Through the open door in this photograph we can see the basketball hoop (net still intact), standing out against the interior brick walls and white ceiling. We "read" this gym, read the sign, and then look to the following page and see the pile of sneakers. We assume these images fit together to form a whole. But the caption below the photograph of the gym tells us that this place is in the Harlem Valley State Hospital, not the Wernersville State Hospital, where the sneakers reside. Given the non-descript environs in which the sneakers lie, the pale wedge of floor and bare glimpses of wall at the top of the image, we have to ask: where are these shoes, exactly? Now we have to question whether these are men's and women's sneakers, let alone trust that they are gym sneakers at all. We have no way of knowing anything about these piles of sneakers, except to implicitly trust the artist/author Payne.

Once this troubling state of the attribution of these sneakers is questioned, it is impossible not to be reminded of a previous discussion involving shoes that took place via responsive essays by Martin Heidegger, Meyer Shapiro, and Jacques Derrida. Their conversation, as it were, began with Heidegger's 1935 analysis of a painting of shoes by Vincent van Gogh, in which he asserted that the defining feature of a work of art was its ability to express the so-called truth. To Heidegger, van Gogh's shoes (women's peasant shoes, according to the author) expressed the truth of the equipmentality of the shoes-as-things, a state that naturally referred back to the state of those who wore the shoes.[29] Meyer Shapiro's retort, which came thirty years later in 1968, is that, first of all, the shoes were van Gogh's own and not peasant shoes at all, and secondly, Heidegger's assertion of truth in the work of art erases the presence of the artist himself as the

[29] Martin Heidegger, "The Origin of the Work of Art," in *The Art of Art History: A Critical Anthology*, ed. Donald Preziosi (Oxford: Oxford University Press, 2009), 284-95.

producer of the image.[30] Not only is the entire basis of Heidegger's argument unfounded, given that he is working on the assumption that these are peasant shoes, but he has, in turn, forgotten the personal and non-transcendent relationship of the painter to the shoes in question. To Shapiro, this painting should be analyzed, not as an object of essential and universal truth concerning shoes-as-things, but rather as a glimpse into the relationship between van Gogh and his own shoes, embedded as they would be with memory and experience of the artist's life. Derrida, responding ten years later in 1978, takes both authors to task. From his perspective, neither interpretation is interesting or fruitful to analysis. He suggests, instead, that we look at the absences in both of the previous scholars' analyses. He asks questions similar to those I have asked above, concerning the sneakers of Wernersville State Hospital: how do we know the attribution of these shoes at all? What about the specifics? Are these shoes relevant because they are shoes or because they are specifically sexed shoes? He asks of both authors: how do we know this is a pair of shoes? And, does it matter if it is?[31] Derrida is interested in the process of narrative building that both previous authors are participating in and aims to highlight how assumptions (of both authors and readers) perpetrate particular narratives by evading recognition of blank spots in knowledge.

This series of essays speaks to the issues surrounding Payne's photograph of sneakers in the Wernersville State Hospital. Like van Gogh's shoes, the sneakers are presented as a kind of truth, yet we have no reason, aside from faith, to believe that any truth is in fact revealed here or what that truth may be. The difference here is that there was no definitive title for van Gogh's shoes, given by van Gogh himself, to clear up any confusion. In Payne's book, we have the

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[30] Meyer Shapiro, "The Still Life as Personal Object: A Note on Heidegger and Van Gogh," in *The Art of Art History: A Critical Anthology*, ed. Donald Preziosi (Oxford: Oxford University Press, 2009), 296-300.
[31] Jacques Derrida, "Restitutions of Truth in Pointing [*Pointure*]," in *The Art of Art History: A Critical Anthology*, ed. Donald Preziosi (Oxford: Oxford University Press, 2009), 301-15.

author's word that these are men's and women's gym sneakers, but, following Derrida's lead, we have to question the author's knowledge (which is hidden from our view both compositionally in the photograph specifically and in the body of the book generally) and specificity.

Once we question the so-called truth of these sneakers, the inquiry expands to the rest of the project. What Truth, exactly, are these sneakers speaking to? Let us assume that we know nothing about these sneakers except that they are in piles and are bereft of human presence. Their haphazard state implies sudden and swift abandonment, as though an apocalyptic event (the Rapture, perhaps, of two tightly formed groups of asylum inmates) arose and the shoes were left behind because of their superfulousness to survival.

As human accoutrement, or equipment as Heidegger would have stated it, these forlorn piles of shoes gesture to the feet that once occupied them. If they had been presented in any context other than Payne's book, there might be very little that seemed sinister about them. But, within the broader Asylum narrative presented by the book, their empty and disorganized presence hints at the absence of feet and thus bodies of the persons with mental illness and reinforces the narrative of ruination and abandonment.

This photograph follows a particular trope, used in photographs and museum displays of the Holocaust, of using human accoutrement as a synecdoche for absent bodies. The Holocaust photographs and displays from the Auschwitz Museum use piles of objects to reference the dead. A photograph of shoes and clothes found in Auschwitz-Birkenau after the war attempts to give the barest understanding of human loss. In the image, the shoes and clothes are piled in seemingly never-ending heaps on either side of a small walking path inside what appears to be a warehouse. Similarly, displays at the Auschwitz museum maintain this piling disorder and

feature shoes, suitcases, among other objects not so much arranged within but dumped into cases and display stands.

Payne's book contains not only the previously discussed image of piled shoes, but another image of abandoned suitcases. (Fig. 1.7) The visual reference to Holocaust imagery is multiple and exists in these specifics as well as in the overall project of ruin. The troubling aspect of the visual association between Payne's photographs of human accoutrement within abandoned asylums and the photographs and displays of the Holocaust is the inference of death on a massive and (all too human) inhuman scale. In the case of Holocaust imagery, this inference is accurate. In the case of Payne's photographs, it is not. The feet that once occupied the sneakers of "Men's and women's gym sneakers, Wernersville State Hospital, Wernersville, Pennsylvania" are or were attached to bodies that were not dead, but rather very much alive. This perpetrates an erasure of patient experience and existence. To associate mental illness with obliterating death – a death that attempted to erase all that made a human being human – is to associate insanity with the inhuman. It also, in turn, presents the mental hospital and thus *The Asylum* as uniformly murderous.

The state hospitals were not places of holocaust and the patients within them did not disappear into the aether when the hospitals shut down. They filtered back into their communities and moved through the in-community care system that was meant to replace the institutional one. Not only did those patients who were originally in institutional care continue to exist, but so do new individuals coping with mental health issues.

Payne's ruin plays to our need to see *The Asylum* clearly, to know where it is at all times, and to be reassured in its destruction. The photographs of the architecture tell us that the institution is gone and the photographs of the objects – the shoes, the toothbrushes, the suitcases

– tell us that the people are gone as well. Don't worry, Payne's project seems to suggest, the dark days are over.

Conclusion

Outlast and *Asylums* both fetishize the ruin of *The Asylum* and embrace the apocalyptic. They both have a photo-journalist as their protagonist (although the viewer never sees Payne, his presence is implicit). They both present a landscape devoid of the human (although *Outlast* does include humanoids). They both evoke the religious in the heart of insanity. They both make reference to the Nazis. And finally, they both use the same mental hospital, Buffalo State Hospital of Buffalo, New York, as their touchstone. *Outlast*'s Mount Massive Asylum is clearly a reproduction of Buffalo State's southern façade (Fig. 1.8), with only minor changes in window design. It is the same Richardsonian Romanesque of heavy block, with sharp gables on either side of its entry and two towers, with steeply gabled metal caps. Buffalo State, in black and white and creepily underlit glory, graces the back cover of Payne's book (Fig. 1.9).

For very different cultural artifacts, *Outlast* and *Asylums* have a surprising amount of things in common. When I chose these examples as exploration points of the imaginary Asylum, I honesty had no idea these commonalities existed. One proof of the veracity of a theory is its ability to predict an outcome. The previously unknown yet predicted similarities between these very different artifacts and their presentation of *The Asylum* goes at least a small way toward supporting my assertion that these mythologies stem from and serve a greater purpose: to make visible and place insanity as a means to quell contagion anxiety in a world without asylums.

Miles Upshur and Christopher Payne were our guides through the imaginary Asylum. There are a great many such guides in popular culture and the majority of them, like Batman or the Joker, would take us along similar paths. But these are all, despite some claims to the truth in documentation, fictions. Each of them approach *The Asylum* as a thing, a synecdoche, and a site--onto which are mapped the now familiar patterns of sublimity, uncanniness, ruin and horror.

The following chapters explore a single micro-historical example of a mental hospital. They turn away from the idea of *The Asylum* and toward a very physical, very corporeal exploration of a specific place, the St. Peter Regional Treatment Center in St. Peter, Minnesota, to undercut and "place" insantiy. The deeply dug microhistorical example of the SPRTC is not meant to gesture to the rest of the mental hospitals in the United States. It is meant to root us in the real and the phenomenological, as a means to outpace the spectre of Asylum mythology.

These chapters stand in contrast to what we have begun with and approach the institution as a place with a density of meaning created by the interactions of human beings in a space. The difference is not incredibly vast, but I can promise that there are no ghosts in what follows (at least not the kind who can possess us). No Walriders to take control of our bodies, and no Nazis to imply the presence of pure evil. In a way, the next step is the more frightening. As Arendt pointed out in *The Banality of Evil*, it is the ordinariness of threat, its complete lack of dramatic exceptionalism, that terrifies.[32] Confronting an actual mental hospital raises questions that, in some cases, cannot be answered or summed up in neat packages. It sets mental illness free, and allows it to be invisible without a need to build walls around it. It can also lead us, through the existential discomfort of our contagion anxiety, to a better understanding of what it means for an institution to be a place rather than a synecdoche to comfort us at night.

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[32] Hannah Arendt, *Eichman in Jerusalem: A Report on the Banality of Evil* (New York: Penguin Books, 1977).

Chapter 2: The Beginning, the Building, and the Boundary

St. Peter is a typical rural small town in the farming heartland of southern Minnesota. Located on the western side of the Minnesota river valley, it is the kind of place where you can buy sweet corn from the back of a truck in the grocery store parking lot in the summer and half of the trucks at the gas station are fronted by snowplows in the winter. If you drive all the way through town, heading south on highway 169, you will hit all of four stoplights on the wide main drag (Fig. 2.1).

As you near the southern end of town, you will pass below Gustavus Adolphus College, a private liberal arts school, which resides at the top of the valley, looking down across the town and the river towards the east. Gustavus was established in St. Peter in 1876 and is a major part of the small town's identity. If you were to turn right onto College Avenue, you would go up the steep valley hill and enter directly into the campus.

But if you drive even further south, past that last stoplight, you will see a sign for the St. Peter Regional Treatment Center (SPRTC). If you are not from the area, you might wonder what a treatment center is. From the highway, all that is visible are manicured lawns, rising up and away to the west, with vague buildings obscured by trees in the distance. Even if you were to take the exit onto Washington Avenue to get a closer look, you would not get very far before you hit the gate that regulates who enters and exists the SPRTC property. (Fig. 2.2)

Today, the SPRTC is a high security mental health facility for patients who have been found guilty of committing serious crimes by virtue of their mental illness. It is the only location of its kind in the state. It was not always this type of facility. Before it became strictly high security in 2003, the institution was called the St. Peter State Hospital and served a broader range

of patients. When it was established in 1874, this institution was known as the St. Peter Hospital for the Insane and had only one, large institutional building on its vast acreage to house and treat patients who lived on-site for long periods of time.[1]

Unlike Gustavus Adolphus, the SPRTC – often referred to in town as "the southern campus" – is largely invisible. Even its name disguises it. But the SPRTC is an intimate part of St. Peter's history, development, and identity. To be a citizen of St. Peter is to be highly aware of the SPRTC – either through work, recreation, or town folklore. This relationship between the town and the institution has become less intimate with the SPRTC's status change to high security because access to the campus is now, necessarily, limited. The place that offered that kind of care is now gone, distributed throughout the state of Minnesota, an issue that will be explored in greater detail in Chapter Four. This chapter begins by exploring the foundations of that place in the form of the original linear plan hospital and its connection to the town of St. Peter.

Given that the majority of research on mental hospitals arises from and focuses on their status as failed institutions, understanding a specific mental hospital's position as one of the essential foundations of the community it adjoins challenges established notions of what *The Asylum* means at the cultural level. By shifting the focus from the very large and encompassing to the very small and intimate, this chapter confronts the way in which previous scholarship on these institutions approaches the building and the place as a type, making it a fetishized object rather than a place with a density of meaning produced by human experience. It calls attention to the way privileged authors – writing from a position of obscured authority – have worked within and constructed a grand narrative that shaped the meaning of *The Asylum* as an imaginary with

[1] Anonymous, *The Evolution of State Operated Services* (Minnesota: Minnesota Department of Human Services, 2007), 1-5.

broader implications than mental health care modalities. This imagined Asylum – always looming over actual places – has acted as a signifier for insanity and upheld comforting beliefs in non-porous boundaries between insane and sane. The discourses surrounding this mythical Asylum have produced recognizable attributes for sanity by fetishizing its opposite.

As Chapter 1 has shown, through the examination of cultural productions, the imagined space of *The Asylum* almost universally places it in geographic and social isolation, as though it existed completely autonomously. The fact that sociologist Erving Goffman could examine a mental hospital using models that had previously been utilized to understand whole autonomous cultures reveals a propensity to view asylums as cut-off from their surroundings.[2] Similarly, other studies focusing on either the history or architectural space of mental hospitals neglect to engage with the towns or cities that lie in their proximity, instead separating the buildings from the broader cultural landscapes of which they are part and in which they operated historically.

This relationship, in fact, shapes both the institution and the community that surrounds it. While the existence of what would become the SPRTC was predicated on the prior existence of the town of St. Peter, the dependence worked both ways. St. Peter's growth and continuation as a town was made possible by its winning the bid to be the location of the first state funded mental institution in Minnesota. More than that, the town's identity is wrapped up with the existence of the SPRTC. This chapter covers a brief history of buildings of the SPRTC type, the original building and its function, and the intimate connection between the institution and the town of St. Peter.

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[2] Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*.

Kirkbride, Sloan, and Building the St. Peter Hospital for the Insane

During the first half of the nineteenth century, superintendents and alienists in Europe and America were developing ideas of how to better treat insanity. Drawing on the movements of non-restraint and moral treatment that originated during the eighteenth century, these men began to establish ground rules for successful treatment. These rules covered methods of treatment, proper location for treatment, and the proper design and construction of asylums and hospitals for the insane.

There was an entire network of superintendents working together, publishing articles, and arguing over the intricacies of these issues. In America, the Association of Medical Superintendents of American Institutions for the Insane (AMSAII) was established in 1844.[3] This group comprised twelve superintendents of various hospitals who collectively established theories regarding treatment and advised state governments on how best to construct, staff, and organize hospitals for the insane. They insisted that, because of their experience with the insane, they were the only group with the sufficient knowledge to advise authorities on these issues.[4]

According to the AMSAII, the proper environment for treatment was a purpose-built hospital for the insane. Therefore, considerations concerning the site location and how to best construct a hospital for the insane were paramount. These issues were discussed at length by both the AMSAII and non-affiliated alienists in both America and Europe.

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[3] Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840-1883* (Cambridge: Cambridge University Press, 1984), 6. The AMSAII eventually developed into what is known today as the American Psychiatric Association.

[4] Grob, *Mental Institutions in America: Social Policy to 1875*, 324.

Although the AMSAII formulated and expounded its theories as a group, one founding member was particularly influential, Thomas Story Kirkbride. Kirkbride was the superintendent of the Pennsylvania Hospital for the Insane from 1840 to 1883. At the time the AMSAII was founded, Kirkbride was thirty-five years old and had been the superintendent of the Pennsylvania Hospital for four years.[5]

Kirkbride's theories were covered in detail in his book, *On the Construction, Organization and General Arrangements of Hospitals for the Insane,* which was originally published in 1854 and then again in 1880.[6] The book covers every aspect of the proper design and organization of a hospital for the insane. Kirkbride outlines the ground rules for site location, the ideal architectural design, proper dimensions of hospital spaces, floor and wall materials, ideal heating and ventilation systems, and the duties of the various staff.

As for the site, Kirkbride states that it should be at least one hundred acres of land "in a healthful, pleasant, and fertile district of country," following the established nineteenth century ideal of the healthy countryside. The building itself should be arranged by a physician with knowledge regarding the needs of the insane, as an architect working alone would be incapable of properly designing an institution fit for successful treatment:[7]

> For an institution like that referred to, it is believed that the best, most convenient, and most economical form will be found to be a centre building with wings on each side, so arranged as to give ample accommodations for the resident officers and their families, and for the classification and comfort of the patients, and all employed in their care. ... In the centre building should be the kitchens, sculleries, main store rooms, a reception room for patients, a general business office, superintendents office, medical office and library, visiting rooms for friends of patients, a public parlor and managers' room, a lecture room or chapel, and

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[5] Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840-1883*, 44.
[6] Ibid., 6.
[7] Thomas Story Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane, Second Edition*, ed. *Gerald* Grob (New York: Arno Press, 1973), 38-42.
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> apartments for the superintending physician's family, - in case that officer resides in the building, - and for the other officers of the institution.[8]

The linear plan was also supported by the AMSAII. In 1851 and 1853 the AMSAII had declared how hospitals for the insane ought to be constructed and organized, as social historian Gerald Grob explained:

> A building should not be constructed in a haphazard manner, but should rather reflect its essential functions. The ideal mental hospital, therefore, usually had a center building that housed the superintendent, his family, and the administrative offices and quarters. Extending laterally on both sides were the patient wings, which could be further divided into wards to house the different categories of patients. If additional accommodations were required, a similar structure could be repeated, either joining existing wings at right angles or else lapping on at the end and extending in a parallel line. Such a structure was based on the assumption that all patients were to be directly under the care of the chief medical officer; the floor plan was intended to provide him with easy access to all patients and thereby to maximize observation and control.[9]

Kirkbride had a tenacious obsession with perfecting mental hospital architecture. The linear-plan hospital became his legacy in America and these buildings are still often referred to as "Kirkbrides." Although the AMSAII largely supported his theories and efforts, Kirkbride would not have succeeded without the assistance of architect Samuel Sloan, who drew up Kirkbride's imagined hospitals and then went on to create those hospitals in the landscape according to his instructions. Kirkbridge credited Sloan in his concluding remarks on architecture:

> I cannot close these remarks on the construction of buildings for the insane without acknowledging my obligations to Samuel Sloan, Esq., the distinguished hospital architect, - examples of whose taste and ability are to be seen in so many sections of the country, - for his suggestions and assistance in the long period during which I have often had occasion to avail myself of his professional services. No one of his profession in this country or elsewhere, has had equal opportunities for a practical knowledge of every detail of hospital architecture, or

[8] Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, 52-53.
[9] Grob, *Mental Institutions in America: Social Policy to 1875*, 170.

> has done more to elevate its style and to promote the convenient arrangement of these buildings.[10]

Sloan was largely responsible for Kirkbride's success in promoting the linear plan. Kirkbride, in turn, was highly influential in Sloan's success in establishing himself as a professional architect. By the 1860s, Sloan had designed Western State Hospital in Kentucky (1854), Kalamazoo State Hospital in Michigan (1854), Department for Males at the Pennsylvania Hospital for the Insane (1856), and the New Jersey State Lunatic Asylum (1855).[11] In all, Sloan designed thirty-two hospitals for the insane throughout the U.S.

Perhaps this is why, when the state of Minnesota required a mental hospital of its own, Sloan won the bid. He was a premier institutional architect and, through his association with Kirkbride, his name represented the most advanced treatment for mental illness at the time. Understanding the significance of Sloan's involvement in the SPRTC sheds some light on the very beginnings of the connection between the town of St. Peter and the institution. To begin, we must first examine a brief history of the town and its status at the time the SPRTC was built.

St. Peter, which grew out of land purchased by the St. Peter Company from William Dodd, was officially established in 1854, five years after the establishment of the Minnesota territory.[12] Treaties with local Native American tribes had been reached only four years earlier and conflicts between white settlers and the original inhabitants of the land were nearly constant. In 1862, one year after the beginning of the Civil War, a series of attacks in Minnesota by the Dakota, who were

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[10] Ibid., 152.
[11] Harold N. Cooledge, "A Sloan Checklist," *The Journal of the Society of Architectural Historians* 19 (Mar., 1960): 35.
[12] The St. Peter Company was a joint-stock company, created by the Great Northern Railway in 1854. Joint-stock companies are entities that hold and distribute money and stocks that can be bought and sold by the public. The St. Peter Company was most likely created as a means to establish the town of St. Peter and to aid the Railway in its push to the West. William D. Erickson, "This Great Charity: Minnesota's First Mental Hospital at St. Peter, Minn. 1866-1991." (St. Peter: St. Peter Regional Treatment Center, 1991), 14-15.

angered by failed treaties, resulted in the deaths of 486 settlers.[13] Troops were stationed in St. Peter for the next two years to combat the so-called Indian threat.[14]

During that same year, the state began to face difficulties in dealing with the large and ever increasing population of indigent insane, which was the result of a swelling in the general population. The first solution was to send patients to the hospital for the insane in Mount Pleasant, Iowa. Unfortunately, this could not be a permanent answer to the problem, as Iowa was also wrestling with a growing general population. Within four years the superintendent of Mount Pleasant's hospital for the insane notified Minnesota officials that all Minnesota patients had to be removed from his hospital. When other transfer options failed, the legislature passed a bill in 1866 ordering the establishment of a hospital for the insane in Minnesota.[15]

The committee in charge of selecting the site required two things: first, the availability of at least twenty acres of land for the location of the permanent hospital; and second, the existence of a building that could be used as a temporary hospital until the larger, permanent hospital was complete. A number of communities applied to be considered as the site including Mankato, Red Wing, St. Paul, St. Anthony, and St. Peter.[16]

St. Peter had a location to be used as the temporary hospital – housed at the Ewing Hotel (Figs. 2.3 and 2.4) – but it had another advantage: the members of the St. Peter Company were willing to purchase the 210.9 acre Dorrington farm, which lay just south of the town. The committee's decision to select St. Peter as the location of the hospital was due, in part, to the incredible size of the land purchased by the St. Peter Company, which was ten times what the

[13] University of Minnesota-Mankato, History of Minnesota Website (http://www.mnsu.edu/emuseum/history/mnstatehistory/timeline.html#1700) last accessed 30 December 2013.
[14] Erickson, *This Great Charity,* 21.
[15] Ibid., 22-25.
[16] Ibid., 26.

committee required. Other important factors that led to St. Peter's success in the bid were the existence of a running water source on the site, the site's proximity to a Kasota stone quarry (which lay only 400 feet from the building site) and the abundance of clay on the property that could be made into bricks.[17]

Sloan submitted a design and was selected as the architect of the project. The first mention of Sloan in St. Peter is found in an 1867 article from the *St. Peter Tribune*: "Mr. Sloan, of Philadelphia, who was to draw the plan for the permanent buildings, arrived last week, and at once entered upon his duties. Yesterday these plans were submitted to the Board of Trustees, at a special meeting, and unanimously adopted."[18] There may have been other submissions but there is no mention of them in hospital files, newspaper articles, or annual reports.

The fact that the committee in St. Peter, an isolated outpost without paved roads, sewage or water system, and no school system, was willing to pay an architect of Sloan's caliber is testament to the prestige associated with being the location of a hospital for the insane.[19] Not only did the establishment of a hospital for the insane signal St. Peter as a morally upright, stable, and growing community; it also suggested that the presence of such an institution guaranteed both continual state funding to the town and perpetual job opportunities. Ensuring that the design of the building would reflect well on the institution itself and the community was paramount, and Sloan, in both name and execution of the design, could guarantee that. In addition, the ability to state that an established East Coast architect had designed a building in the town of St. Peter was itself a distinguishing credit to the town's modernity. Sloan's name was a civilizing force, lending the town of St. Peter cultural capital it previously lacked.

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[17] Elizabeth Seaquist, "St. Peter State Hospital," *Minnesota Welfare* (Summer, 1961): 10.
[18] *St. Peter Tribune*. July 10, 1867.
[19] Erickson, "This Great Charity,"30, 32.

The town's investment in the hospital signals a very different conception of what a mental hospital meant in the 1860s as compared to current narratives that have been shaped by the a perceived "failture" of the institutional system. St. Peter fought for the privilege of being the location of the first mental hospital in the state of Minnesota. Both the building and the institution as a social force were highly desired. While the SPRTC functioned autonomously, there was an inherent understanding of its interconnection with and reflection on the town. Sloan's building was imagined as a symbol of St. Peter's advancement, deepening cultural capital and proactive social engagement.

The Original Hospital Building of the SPRTC

> The symmetry and vastness of the pile brought back to memory some of the sights admired beyond the distant Atlantic, and I can vouch positively, that I have never gazed on a building denoted to similar purposes in the new or the old world, very decidedly superior to this edifice erected by a young and benevolent State for the benefit of the most unfortunate human beings.[20]

Viewing it in 1874, the admirer comment on St. Peter's hospital shortly after the completion of the building. The board of trustees was equally pleased with the building: "In all their arrangements and appointments, we regard these buildings as admirably adapted for the humane ends for which they have been erected."[21] The building met two important criteria for a hospital for the insane: it was functional and it was beautifully impressive.

Built on a foundation of solid rock, the hospital faced east, looking out over the Minnesota River valley. At its back was the sloping valley wall, which blocked the wind coming

[20] *St. Peter Tribune*, Wednesday December 2, 1874.
[21] Seaquist, 9. The trustees use of the word "buildings" is reference to not only the main building but the utility buildings, such as the barn and the slaughterhouse.

from the southwest. The earliest extant image of the completed hospital is from 1876 (Fig. 2.5), and it shows how strikingly different the prairie terrain was to the wooded environment that currently surrounds the hospital and its grounds. Landscaping and a beautiful, countryside environment were both important aspects of treatment philosophy during the nineteenth century. Over the course of years the landscaping of the hospital grounds grew more complex and evolved (Figs. 2.6 and 2.7).[22]

The full facade of the hospital was more than 800 feet long and made of cut Kasota stone.[23] The aesthetic of the building was simple Italianate, yet grand in its sheer size. The center, Old Main and the ends of the return halls on each side of it were capped with impressive pediments. On the ends of the returns, these pediments each had a roundel window set in the middle. All the corners were adorned with rustic quoins.

The facade had a total of four entrances. Two of these entrances were on Old Main. One of these was under the *port-cochere*, the other was at the top of the grand staircase, under the portico. This entrance was for physicians, workers, patients being admitted or discharged, and visitors. The other two entrances were located on the ends of the first returns, which protruded from the facade on either side of the main. These entrances were also used by physicians and workers but were off limits to both patients and their families.

Although there is no documentation regarding the stylistic choices lying behind the design of the building, it is likely that the Board of Trustees, rather than Sloan, was responsible for selecting the final design. Sloan's emphasis was always on function and convenience and he had very little interest or personal investment in ornament or aesthetics. He was more than willing to allow his

[22] Due to the fact that the campus is restricted, photographs of the campus grounds as a whole are now forbidden. I regret that I cannot include any current images of the campus.
[23] Seaquist, 9.

clients to dictate the appearance of the building.[24] It is tempting to attribute the simplicity of the facade of the St. Peter Hospital for the Insane to Sloan's adherence to Kirkbride's tenets, one of which states that too much ornament is only disturbing to insane patients.[25] However, given the very diverse, and in the case of Central Indiana's Hospital for the Insane, very ornate, aesthetics of Sloan's hospitals (Figs. 2.8, 2.9, 2.10, and 2.11), it is more likely that he simply let his clients choose what they wanted.

Given that taste shifts by region, allowing the Board of Trustees in St. Peter to select the design and ornament they preferred ensured that the aesthetic function of building performed its duty. This duty, small in comparison to the demands placed on the structural function of the building, was to ensure that the people of St. Peter, the families of patients, and the patients themselves recognized the power and authority of the hospital. In the case of the residents of St. Peter, it was important that they feel pride in this institution. In the case of families and patients, it was necessary that they believe the hospital was a place capable of affecting a cure as well as providing moral and respectful care. As Kikbride wrote, Kirkbride states: "Although it is not desirable to have an elaborate or costly style of architecture, it is, nevertheless, really important that the building should be in good taste, and that it should impress favorably not only the patients but their friends and others who may visit it."[26] This awareness of aesthetics reflects the visibility of the SPRTC, its inherent connection to the town of St. Peter, and its broader social impact. Something designed to be invisible – on physical, social, and cultural levels – would not be so invested in aesthetics.

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[24] Cooledge, *Samuel Sloan, Architect of Philadelphia, 1815-1884*, 19-20.
[25] Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, 47.
[26] Ibid., 52.

The original design submitted to the building committee at St. Peter was a standard linear-plan design (Fig. 2.12). It included a center main containing superintendents quarters, admitting, a kitchen, and a dining area. Extending from the main on either side were the wings. Each wing had a total of three main halls, each set back from that which preceded it.[27] These halls were connected to one another by returns, which were situated parallel to the center main and perpendicular to the halls, that ran toward the back of the building. The last two returns, which flanked the final hall on both the north and the south, each terminated in a small, quasi half-hall. Unlike the inner halls, these end returns and their "T" shaped terminations were single loaded.

This design strongly resembled the one found in Kirkbride's book labeled "Improved Linear Plan Hospital (Fig. 2.13)." This is unsurprising given that it was Sloan who was responsible for the drawings in Kirkbride's book. Most importantly, however, this submission emphasizes Sloan's endorsement of Kirkbride's architectural and therapeutic theories. Rather than develop a new and completely original plan, an approach that Kirkbride stated would "hardly fail to lose in usefulness what it gained in novelty,"[28] Sloan followed Kirkbride's suggestion to "profit by the experience of the past, by the knowledge of those who have had a practical familiarity with the wants and requirements of the insane."[29] He therefore submitted a design that followed his and Kirkbride's drawings for an improved linear plan.

The final design of the St. Peter Hospital for the Insane was different than Sloan's original proposal. Unfortunately, the blueprints for the final design no longer exist, but there are, two blueprints from later years that give the basic shape of the building. The first of these is the print

[27] The term ward is also appropriate here. However, at St. Peter they were never referred to as wards but as halls, so I will use that term.
[28] Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, 46.
[29] Ibid.

concerning the building of a coal hopper in 1915 at the back of the center main, near the train depot (Fig. 2.14). The second is the blueprint for the electrical wiring of the entire hospital building in 1910 (Fig. 2.15).[30] It can be observed in these blueprints that the final design primarily differed from the original in that it had only two main halls, rather than three. Careful observation reveals that the final design simply does away with the halls closest to the center main, moving the outer halls, with their long returns, towards the middle (Fig. 2.16). The only change to these returns is that the first of the two, on either side, has had its small terminating hall removed. Getting rid of the first set of halls on either side of the center main meant, in part, that the main ran further back from the front of the building than the returns at the ends of the halls. It is likely that the change in size was made for the simple purpose of saving money on construction expenses.

As for the interior of the building, the center, Old Main, remains to this day. Although the functions of its spaces have changed, the basic original configuration can still be observed. Small changes, such as the additions of false ceilings in some of the halls and offices of the first floor and the inclusion of fire-doors and walls on the stairway cannot obscure the original design (Fig. 2.17). This design segregated the use of the center main as follows: The first story was used for offices, the second story as the residence of the superintendent and his family, and the third and fourth story were occupied by members of the medical staff and other officers. The rear section of the third and fourth stories was also used as both a chapel and an auditorium (Fig. 2.18).[31]

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[30]St. Peter State Hospital, 1855-1974, Buildings and Grounds, Southern Minnesota Historical Center, Minnesota State University-Mankato Library.

[31] Third Biennial Report of the Board of Trustees and Officers of the Minnesota Hospitals for the Insane at St. Peter, Rochester, and Fergus Falls, To the Governor of the State of Minnesota for the Biennial Period Ending July 31, 1898, Box 10, Folder 3, St. Peter State Hospital, 1855-1974, Southern Minnesota Historical Center, Minnesota State University-Mankato Library.

One of the problems with succinctly labeling rooms in a diagram of Old Main is that the functions of the rooms were always changing. It is nearly impossible to be positive as to which rooms were used for what purpose and in what year. For example, medical staff and officers occupied the fourth story during the early years of the hospital, but it was also the location of the surgery by the 1920s (Fig. 2.19). Nevertheless, it can be said with certainty that the first floor was used solely for administrative purposes. The floor was dedicated to office space and within this space there were two rooms that can be labeled with certainty. Upon entering the front door of center main, the superintendent's office was located immediately on the right and a parlor for visitors was located immediately on the left (Figs. 2.20 and 2.21). This is as far as visitors got in the hospital. Patients being brought in for treatment were moved to another part of the floor for admissions, but their families did not travel beyond the parlor. No one other than hospital staff, aside from reporters and visiting officials, stepped foot on the halls.

The first floor of the center main was also longer than the subsequent second, third, and fourth floors. Although all the rooms cannot be reliably or specifically labeled, it is likely that they followed the plan in the original design. This back section was the location of the workroom, the first laundry room, boiler room, and coal storage. The south side of the back section of the first floor was also the location of the train stop (Fig. 2.22). The largest kitchen in the hospital was located in the basement of Old Main (Fig. 2.23).

The wings of the building, which were (and still are) commonly called the Flats, were finally torn down in 1966. Despite Sloan's knowledge of fire-proofing and a claim in an 1874 article of the *St. Peter Tribune* that "no fire can possibly injure [the hospital] to any extent,"[32] the North Flat was gutted by fire in 1880 after flames that began in the basement swept up through

[32] *St. Peter Tribune*, Wednesday December 9, 1874.

the main floors (Figs 2.24 and 2.25). Because the walls were made entirely of stone they did not burn. Unfortunately, the wards were full of flammable material, including the wooden floors, and although the roof was made of slate, the girders of the roof were made of timber (Fig. 2.26). When the North Flat was rebuilt (construction was completed in 1882) it was made identical to its predecessor. Sometime around 1904 alterations were made on both the North and South Flats where they connected to the center main.[33] Both Flats were separated from the main, except at the ground level, where a small causeway maintained their connection (Fig. 2.27).

To gain a picture of the original design of the Flats, we must turn to photographs and newspaper articles from the time of their original construction and usage. The North and the South Flats were designed to be mirror images of each other, a fact reinforced by a St. Peter newspaper article from 1870 that details the spaces and some of their dimensions on the Flats:

> The sections and returns on each side are designed to be similar in all their arrangements, the one for the male and the other for the female patients.[34] Those on the north are designed for the male patients and a general description of them will suffice for all. The section next to the central building is 103 feet long and 40 wide, three stories above the basement and the return has the same width, and running 113 feet back. Through the center of each floor runs a hall 13 feet wide and well lighted. This constitutes the day room for that class of patients, and has comfortable iron frame settees fastened to the floor. On each side are the sleeping rooms. Each hall has its separate dining room and food is sent to each dumb-waiters. Everything is made substantial - all walls are stone or brick, doors are heavy and the windows have iron sash and iron protectors. Each floor has three large rooms for parlors, sitting room, or dormitories as needed and two sick rooms separated from the others by small halls. All walls have hard finish and painting is plain save the doors which are grained, the first story being chestnut, the second oak, and the third story maple. Each story is furnished with dining rooms, bathing rooms, water closets, clothes rooms, etc.[35]

[33] Seaquist, *untitled*, 20.
[34] What this author refers to as sections are what I call the halls; we both use the term returns to indicate the sections of the building that ran parallel to the center main and perpendicular to the halls.
[35] *St. Peter Tribune*, February 2, 1870.

Although the final design deviates from the original blueprints it is likely that the dining rooms, bathing rooms, water closets, large rooms for parlors, sick rooms, and clothes rooms were located in the returns between the halls (Fig 2.28). This would create a separation of functional spaces, keeping the recreational "day room" of the hall independent from utilitarian areas. In addition to the spaces mentioned, this area was also most likely the location of the stairs. The thirteen foot wide hall in the center of each hall meets the standards of Kirkbride, who declared that the hall should be no smaller than twelve feet wide.[36]

Photographs of both the North and the South Flats show this first long hall, with benches up against the walls between the doors to the patient's rooms (Figs. 2.29 and 2.30). Unfortunately, the majority of the photographs of the halls are the same. They are mainly of the lower first hall, of either the North or the South Flat. There are no contemporary images of the upper floors or the outer halls, and only a few of the second halls. A number of pictures show the dining rooms or large parlors found at the end of the first halls, where they connect to the returns (Figs. 2.31 and 2.32) An article from the 1898 *St. Peter Journal*, described the first hall of lower Flat South as follows: "A description of one ward is practically true of them all; their furnishings and equipment being similar."[37] The final outer halls, most likely, were like the original blueprints: single-loaded rather than double. This speculation is supported by photographs of the upper third halls of both Flats, taken, most likely, in the early twentieth century (Figs. 2.33 and 2.34). The images show what appear to be patient room doors along one side of the hallway, opposite of the entryway that connected them to the returns. On either side of the entry are windows.

[36] Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, 65.
[37] *Saint Peter Journal*, January 15, 1898.

Like all linear-plan hospitals, the St. Peter Hospital for the Insane was designed with patient classification and proper location in mind. Men and women occupied separate wings and it was customary to place the more bothersome patients in the outer halls (Fig. 2.35). For this reason those halls were usually single-loaded as a safety measure. That way an attendant would never have his back to a patient's door when approaching another patient's room.

In addition to the administrative and social spaces of Old Main and the patient specific spaces of the halls, the hospital was also designed with a complex tunnel system connecting the two. In later years, the tunnel system would branch out extensively to connect all of the separate buildings, creating a virtual warren of passageways underground. In the beginning, however, there were only the tunnels running underneath the linear hospital. There were, however, two sets of these tunnels. One, the sub-tunnels, was the location of the steam pipes that were used to carry hot water from the boilers to the rest of the building. These tunnels were low, with brick arches over the pipes and unfinished floors (Fig 2.36). They were used primarily by maintenance crews. The other set of tunnels, which were higher than the sub-tunnels, were used for staff as a means of moving through the hospital without having to traverse the wards. They were also used to transport food and patients. These tunnels had higher ceilings, were made of stone rather than brick, and had marble floors. These sets of tunnels were interconnected.

Understanding the design and construction of the hospital is only part of comprehending the institution as an entity. Kirkbride understood this, which is why his book was concerned with the structure of the building and the organization of staff and their governance that occurred within the building. In his design of the original SPRTC building, Sloan implemented all of his knowledge of the proper construction of such an institution, which was based on those theories. Both Kirkbride and Sloan were operating within a paradigm that upheld the single institutional

building and autonomous hospital community as the solution to mental health treatment problems.

Like most mental institutions, the SPRTC could fit this bill, at least in its earliest years. It was located in the countryside on the outskirts of a small town. With its large farm, livestock, slaughterhouse, and cold-storage building, it was largely self-sustaining. In addition, there was a train stop at the back of Old Main, which meant that supplies that could not be created in-house could be delivered directly to the hospital. [38]

In addition to autonomy, Kirbride and other members of the AMSAII believed that the mental hospital could produce a simulacrum of family. Victorian ideals of the family and the prevailing opinion that insanity was caused by a faulty environment led to an institution that was meant to mimic family life. It went one step further in that the synthetic family found in the hospital was meant to surpass the original family in morality and healthfulness.[39]

The synthetic family as a psychological construct, and the autonomous community, as a physical construct, were both intentionally manufactured structures of the hospital for the insane. However, the family structure was reliant on the ratio of the number of patients to the number of staff in the hospital. Initially, the AMSAII regarded 250 as the optimal number of patients.40 With a staff including the superintendent, a matron, an assistant physician, and an unspecified number of attendants, this was the greatest amount of patients that could be reasonably handled. Unfortunately, despite the claims of the AMSAII, the number of people cured and thus

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[38] "The Evolution of State Operated Services," 2. The farm increased to this quantity of acreage in 1892.
[39] Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans, Richard Howard (New York: Random House, 1988).
254. Foucault is the only scholar who addresses the idea there may be something vaguely sinister about an institution that removes people from their real families and places them in a synthetic family situation that is meant to morally surpass the true one they have been removed from.
[40] Kirkbride, *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, 49-50.

discharged from the hospital never outpaced the number of people coming in. In 1866 the AMSAII changed the optimal number of patients to be allowed in one hospital from 250 to 600 .[41]

According to the annual report for the fiscal year ending on November 30, 1877, the SPRTC was originally designed to hold 500 patients.[42] In that year the population had already reached 578.[43] As early as 1876, there were at least eighty patients sleeping on the floor.[44] By 1886 the patient population had reached 874 and the numbers kept rising. Further evidence of over-crowding at St. Peter was the establishment of two other hospitals in the state. The Rochester Hospital for the Insane was begun in 1874 (the same year the SPRTC was completed) and completed in 1880.[45] The Fergus Falls Hospital for the Insane was begun in 1887 and completed in 1890.[46] By 1904, regardless of the new institutions, the population at the SPRTC had reached 1,022.[47] There were also two new detached wards, to the north and the south sides of the linear-plan hospital. The reports do not list the population by building, so it is not possible to determine how many of those patients were in the original building and how many were in the detached wards. The dream of the single building as treatment salvation quickly went out the window in the face of over-crowding.

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[41] Yanni, *The Architecture of Madness,* 78.
[42] *Second Annual Report of the Board of Trustees and Officers for the Minnesota Hospital for the Insane, Located at St. Peter, to the Governor of Minnesota*, 3. Although the Board asserts that the building was originally designed to hold 500 patients and there is no concrete way of proving otherwise, I believe it was actually designed to hold 350 at most. The number of small rooms in all halls and on all floors, according to my reconstruction of the building, totals 324. I believe it is unlikely that the building was designed with the intention of putting more than one patient in a single room. However, whether the building was designed for 350 or 500, over-crowding was still an issue.
[43] Ibid.
[44] Erickson, "This Great Charity," 43.
[45] "The Evolution of State Operated Services," 4.
[46] Ibid., 7
[47] St. Peter State Hospital Biennial Report of the Superintendent for the Fiscal Period Ending July 31st, 1904, 4.

There are no staff records predating 1904, so it is impossible to tell exactly how many nurses and attendants were working in the hospital before that time. However, in 1875 there were only two physicians, the superintendent Cyrus Bartlett and his assistant physician Jacob Bowers. In 1875 there were also two subordinate officers, the supervisor for the male department, Francis Dunn, and the supervisor for the female department, Evaline Dunn.[48] Regardless of the number of nurses and attendants, there were only two people in the institution who were actually qualified to treat insanity and, including the supervisors, only four individuals with significant experience dealing with the insane.

Not only was the ratio of patients to staff severely unbalanced at St. Peter; there was also a continuous problem with hiring and keeping attendants. The positions were poorly paid, and employees were required to live on the halls with the patients, and they had only every other Sunday off.[49] This resulted in the practice of hiring patients as attendants once they were discharged. Occasionally, they became the attendants of the very same halls they had once been patients in.[50] This breakdown of boundaries between the keepers and the kept, along with the shifting ratios of staff to patients, resulted in the inevitable failure of the family structure, if it had ever existed beyond the level of prescription and mythology in the first place. More buildings for patients followed the detached wards of 1904. Their erection changed the landscape of the SPRTC and reflected an evolving institution that was no longer tied to the mythical linear plan building. The autonomous community remained, but to say that the boundaries of that community were anything but porous would be incorrect. Over the years between the inception of the hospital and its restructuring as a high security facility – roughly 1864 through 2003 – the

[48] The physicians and the supervisors are listed in the frontispiece of the First Annual Report of the Board of Trustees and Officers for the Minnesota Hospital for the Insane, Located at St. Peter, to the Governor of Minnesota.
[49] Erickson, "This Great Charity,"43.
[50] Ibid.

engagement between the town of St. Peter and the institution was highly fluid. Even after 2003 the SPRTC continued to play a large role in the identity of the town.

The significance of this engagement lies in the way it complicates *Asylum* narratives that characterize them as isolated and absolute institutions. By offering a perspective that lies outside the framework that takes the boundary between sane and insane as an absolute, this engagement highlights the way in which mental hospitals, and Kirkbride buildings specifically, have been fetishized as sentient edifices rather than approached as places with a density of meaning produced by the human actors within them.

Boundary and the Mythical Asylum

The representation of the mental hospital as encased in impermeable boundaries saturates the scholarship on these institutions. Goffman referred to them as "total," treating the space within a mental hospital as an isolated community.[51] Foucault called them "austere," imagining the asylum as an entity quite separate from the rest of the world. He originally determined they recreated life outside in a microcosmic simulacra, and later he imagined them as a place where sanity and insanity engaged in a power struggle for dominance.[52] Grob summarized their status as follows: "In many respects hospitals were self-contained and isolated communities, a fact that seemed to maximize opportunities to institute controls and minimize adverse external

[51] Erving Goffman, *Asylums* (New York: Anchor Books, 1961).
[52] Michel Foucault,. *Madness and Civilization*, trans. Richard Howard (New York: Vintage Books, 1988) and Michel Foucault. *Psychiatric Power: Lectures at the Collège de France, 1973-1974*, ed. Jacques Lagrange and trans. Graham Burchell (New York: Picador, 2003).

influences."[53] Yanni's typology necessarily takes mental hospital buildings in isolation, so as to distinguish them from other building types.

From a prescriptive standpoint, the goal of total isolation was real enough. An isolated and specific location for treatment was, after all, one of the foundations of moral treatment and the institutional era. But prescription is one thing and reality another. No matter what prescriptions are put in place, they exist at a theoretical level that neccesarily breaks down when it encounters real life practice.

This is the juncture at which micro-history offers a necessary foil to the analytic structures engendered by larger institutional inquiries. Because of the SPRTC's foundation in the traditions of moral care and adherence to Kirkbride's and the AMSAII's prescriptions, it is connected to the matrix of hospitals for the insane throughout the country. A close examination of the SPRTC as a place, rather than a mythical object in the form of a Kirkbride, presents the institution of *The Asylum* as socially and culturally far more complex than institutional inquiries previous have.

In addition to the functional spaces that often define our imagining of the mental institution, the SPRTC's original main building also had a large auditorium, complete with a stage (Figs. 2.37, 2.38, and 2.39). The auditorium was located at the back of the middle section of the building and fulfilled a number of roles. It could serve as a location for worship (a number of services took place throughout the week to accommodate various faiths), a setting for plays and concerts, and a place to hold dances, which occurred on a weekly basis.[54]

This architectural space is not unique to the SPRTC. Most mental institutions founded in the nineteenth century had something comparable. Moral treatment emphasized both work and

[53] Grob, *Mental Institutions in America: Social Policy*, 176.
[54] Interview with Betty McGraw, 2010.

recreation as therapies, and these auditoriums offered multi-functional spaces in which patients could participate in recreation.[55]

Similarly, the library, which was located on the second floor in the center of Old Main between the 1960s and the late 1970s offered recreational space for patients. The SPRTC librarian, Elizabeth Seaquist, organized a number of on-going projects that involved patient participation, including Library Days (Figs. 2.40 and 2.41). Library Days was a small festival held at the SPRTC, spilling out from the library and onto the lawn in front of the original building.[56]

This lawn was part of a series of outdoor spaces that fulfilled recreation purposes. The largest of these outdoor spaces was Gleuck Park. The park, which includes a large pond stocked with fish and edged by birch and oak trees, is located on the northwest corner of the SPRTC campus.

All of these spaces could fit into a moral therapy framework, but because they were also spaces of the institution that were open to the public, they are precisely the locations at which the so-called boundaries of the institution break down. The inherent investment, in economic and social terms, of the town in the SPRTC has already been established. St. Peter, as large-scale entity wielding a particular quantity of power in an abstract sense, was and still is intertwined with the hospital. But it is within the recreational spaces of the SPRTC that personal, small-actor engagement and boundary challenging occurs.

The weekly dances, Library Days, and Gleuck Park were all accessible to patients and staff as well as members of the St. Peter community at large. St. Peter residents attended plays, concerts, and dances in the auditorium from the time it was built until it was demolished in

[55] Yanni, *The Architecture of Madness*, 119.
[56] SPRTC Museum Archives.

1967.[57] Library days and other parades taking place on the lawns were attended by patients, staff, and anyone from town who wished to come. Gleuck Park was a popular location among St. Peter residents for fishing, grilling, and camping until the hospital became high security and access was no longer open.

During the 1980s and 1990s, the hospital's gymnasium and pool were used for family get-togethers and birthday parties.[58] When the SPRTC put in a Frisbee golf course in the 1980s, fifth and sixth graders from nearby South Elementary were taken out to the campus to play the game in lieu of regular gym class.[59]

I recently attended a church service in St. Peter, and the pastor gave the example of someone who has worked at the SPRTC all their lives to illustrate interconnectedness within the community. The SPRTC was his example of everyday life for town residents and the fabric of the community. Heads throughout the church nodded at this reference. The SPRTC is woven into the experience of St. Peter on a personal and a community level. Everyone in town has a story about the SPRTC, whether it's a family member who worked there or the time they found a patient in their living room.

None of the interactions between the town and the institution altered the SPRTC's treatment program, but they complicate the boundary between patients and non-patients, institutional and non-institutional modes of operation, and the institution and the community. The boundary that is often assumed to exist between a mental institution and the space that surrounds it is a production of desire to divide sane from insane, not a reflection of actual spatial or cultural practices.

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[57] Betty McGraw, St. Peter Regional Treatment Center Map and Building Timeline, circa 2007.
[58] Interview with Kristin Wilson, 2014.
[59] Interview with Brenna Brelie, 2014.

Focusing on the boundary, whether explicitly or implicitly, reflects the contagion anxiety discussed in the previous chapter. The fear of infection or absolute possession by insanity makes it necessary for mythic narratives on *The Asylum* to imbue the Kirkbride building with autonomous sentience, transforming it into a force capable of maintaining the boundary between sane and insane.

of the instinctual fear of the abject – anything that violates borders and norms. Julia Kristeva argues that our sense of violation stems from what upsets the orderly narrative: "It is thus not lack of cleanliness or health that causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite."[60] Violating borders, norms, and rules (social, cultural, legal) is often the hallmark of the severe mental illness most often imagined in *Asylum* narratives.

Because of mental illness's invisibility, the need to maintain visible boundaries between the sane and the insane is of utmost importance. The horror of imagining a world without boundaries between sane and insane founds the drive to establish fictional boundaries where none exist in reality. In all of its years, the SPRTC never had a fence, a wall, or any kind of constructed boundary that separated it from the surrounding landscape.

By lending unnatural agency—like that discussed in the previous chapter—to buildings like Kirkbrides, a narrative is reinforced in which *The Asylum* and the boundary between sane and insane is upheld. This narrative is necessarily oversimplified, designed as it is to ease contagion anxiety and fears surrounded abjection. This fixation with the boundary between sane and insane lends a kind of agency to the institution as a whole and the Kirkbride building specifically.

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[60] Julia Kristeva, *Powers of Horror: An essay on Abjection* (New York: Columbia University Press, 1982), 4.

This agential attribution is reflected in cultural representations such as *Outlast* and Payne's *Asylums* discussed in chapter 1. *Outlast* derives a majority of its horrifying power from the implication that Mount Massive itself is darkly sentient and opposed to the player. Payne's project capitalizes on the agency of the mental hospital building to different ends. By fetishizing the ruin of mental hospitals across the country (and lumping all of them uncategorically under the title of "asylum" no less), Payne's project conflates the destruction of the buildings with the destruction of institutional care and therefore indicates the "end" of mental illness.

This chapter has outlined the ways in which the SPRTC fulfills the requirements of a Kirkbride planned institution, and given an overview of how the boundaries of such an institution are highly permeable. The following chapters continue to deconstruct the narrative of the Kirkbride and the agential Asylum by focusing on specific spaces on the SPRTC campus – outside and within the walls of the Kirkbride itself – illustrating the way in which the reality of institutional space complicates the mythology of the Asylum.

Chapter 3: Creating Community on the Grounds: The Shacks

During the late 1960s, a patient at the SPRTC—whom I will call Earl—built a small hideaway for himself in a ravine at the center of the campus (Fig. 3.1). Constructed with care and skill from the remains of demolished institutional buildings from elsewhere on the campus, Earl's "shack" was part of a tradition of patient-constructed buildings on the campus of the SPRTC between 1940 and the late 1960s.[1] Earl's building and all of those that came before it—in their individual existences as well as their production of patient space—beg the question: What constitutes a community within the boundaries of a mental hospital in the twentieth century?

On the surface, this appears to be a simple question. But what happens when you ask it in the context of what Goffman called a "total institution," an institution whose "encompassing or total character is symbolized by the barrier to social intercourse with the outside and to departure that is often built right into the physical plant."[2] Can a mental hospital embody or contain an authentic community? According to research that focuses on the clinical—or the battle between sanity and insanity, as Foucault once put it—the answer has been "no" since the asylum era of treatment ended in the 1960s. [3] However, if we turn our gaze toward non-clinical institutional

[1] Interviews with Betty McGraw, director of Volunteer Services, and Ken Ziegler, past nursing aide. July 2010.
[2]Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), 4.
[3] Michel Foucault, *Psychiatric Power: Lectures at the Collège de France 1973-1974,* ed. Jacques Lagrange; trans. Grahm Burchell (New York: Picador, 2003), 7.

space and interrogate the way place is made within the boundaries of a twentieth-century mental hospital, a different answer emerges.

This chapter examines the patient built architecture located on the campus of the SPRTC during the middle decades of the twentieth century as a means to deconstruct narratives surrounding community in the context of mental hospitals during the Institutional Era. This chapter argues that the patient constructed shacks at the SPRTC illustrate an autonomous patient manifested and authentic community place within institutional space, challenging Asylum narratives of the sterile and inhuman condition within total and austere institutions.

This chapter begins by positioning the SPRTC within the broader deinstitutionalization narratives of the 1960s through the 1980s. It then moves to a historical exploration of spatial usage by patients and the shacks built by patients on the SPRTC campus between 1940 and 1960. The chapter concludes with a fieldwork-based examination of extant ruins and a single extant shack and interrogates the way in which these remainders of the built environment run up against *The Asylum* mythology, offering a more complex and human analysis of institutional space.

The SPRTC and Broader Narratives

As discussed in the previous chapter, Kirkbride's linear plan hospital was meant to act as a treatment for insanity. The building's design was, in a way, the main method of treatment until the mid-1940s, when a series of new treatment practices were developed. The SPRTC, as a hospital for the insane designed by Samuel Sloan to match Kirkbride's prescriptions, functioned in just this way. As one institution among many, it was similarly caught up in treatment modality changes beginning in the 1940s.

Grob states that the practices with the most impact on the system and the perception of the mental hospital were: psychotropic drugs, milieu therapy, electroshock, lobotomy, and psychotherapy.[4] SPRTC director Dr. William Erickson noted in his 1997 "History of Treatment" pamphlet that the introduction of psychotropic drugs—especially Thorazine—to the treatment regimen of the institution changed the way the hospital functioned.[5] These new possibilities in treatment altered the perception of mental illness, at the SPRTC and across the country, as a condition requiring secluded treatment, and made the deinstitutionalization movement possible.

According to Grob, the intense social critique of the mental hospital as an institution began shortly after WWII, with a series of exposés in the media of newspapers, magazines, novels and movies. However, Grob argues the real push toward deinstitutionalization was impossible until this evolution in therapies occurred:

> These new therapies suggested the possibility of integrating community and outpatient facilities with a large but troubled public mental hospital system in imaginative ways... Such innovations seemed to confirm the hopes and aspirations of a postwar generation driven by the belief that new policies and practices would facilitate the movement of mentally ill persons from institutions into the community.[6]

Federal engagement with deinstitutionalization began with Kennedy's Community Mental Health Act, passed in 1963, which provided federal funding for community mental health centers in the United States.[7] The focus of the deinstitutionalization moment—which I assert can be seen as a movement, despite its varied members and goals—was the systematic replacement of state-run psychiatric hospitals with in-community care and the reintegration of patients into their communities. As Grob explains, a number of disparate individuals and groups with a variety of

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[4] Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991), 124.
[5] William Erickson, "The History of Treatment" (St. Peter: St. Peter Regional Treatment Center, 1997).
[6] Grob, *From Asylum to Community: Mental Health Policy in Modern America*, 124
[7] Ibid, 113.

backgrounds and extremely different goals all came together during the 1960s to advocate for deinstitutionalization.[8] The movement was focused on ending the stigma that segregated person's suffering from mental illness from the rest of the population. This segregation, of course, was exemplified by the practice of treating mental illness in the bounded location of the mental hospital. The deinstitutionalization movement placed an emphasis on the importance of community life and often cited the freedom found in community living, in sharp contrast to the way the lives of patients were heavily controlled within the confines of an institution, as a condition necessary for recovery. Life in a community, personal freedom, and the reduction of stigma, according to the deinstitutionalization movement, were the keys to properly treating mental illness. Before the end of the 1960s, ideas about integrating community care with institutional care would be replaced by the agenda of replacing the institutional system entirely with community support.[9]

In the years before psychotropics and other modes of treatment developed between 1945 and the 1960s, living outside of the mental hospital while coping with a severe mental illness was nearly impossible. Individuals lacked a means to control their illness directly, and therefore relied on the coping strategies – such as work and interaction with the landscape – established by institutional care. This is not to say that medicinal intervention was the end-all be-all solution to issues of mental health, but to assert the reality that before such intervention was available, long-term care in an institution was often the only course of action for those with severe illnesses who sought treatment. It was not a perfect system, of course, and people often fell out of the scope of care, having to cope on their own.

[8] Ibid, 180.
[9] Ibid.

With the newly legitimized option for those with mental illness to live outside of institutions, the push towards deinstitutionalization gained momentum. Part of the acceleration of the movement was tied to changing the narrative surrounding the mental hospital and the meaning of community. The assertion became that the hospital itself had never been a real community and that only life outside the institution could offer acceptable treatment of mental illness.

This was, in part, tied to a general backlash against the field of psychiatry, which originated from a number of different points on the cultural map, as Grob explains: "The emergence of a psychiatric counterculture in the 1960s was not an isolated or indigenous movement. On the contrary, it crossed national boundaries and defied clear ideological categorization."[10] Grob cites, among others, the examples of Goffman's *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, and Foucault's *History of Madness* as participating in the anti-psychiatric—and in my term, deinstitutional—context of the 1960s.[11] It is not an accident of timing that Foucault's assertions concerning the ersatz family structure of the mental hospital were developed during this time.[12] Nor is it an accident that Goffman's famous book on the topic of institutional inmates was published in 1961.[13] The changed narrative of the mental hospital's relationship to the meaning of community was all-pervasive.

This, in turn, affected the meaning of stigma. Presented as a veritable prison, devoid of any real meaning, the mental hospital was marked as the producer of stigma upon the bodies of patients. Goffman noted in *Asylums* that being placed in a mental hospital resulted in a

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[10] Ibid, 282.
[11] Ibid, 283-288.
[12] Foucault's exploration of this family structure is found in *Madness and Civilization: A History of Insanity in the Age of Reason*, trans Richard Howard (New York: Random House, 1988).
[13] Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* (New York: Anchor Books, 1961).

permanent change to an individual's social reputation: "...The psychiatric view of a person…. becomes significant only in so far as this view itself alters his social fate—an alteration which seems to become fundamental in our society when, and only when, the person is put through the process of hospitalization."[14] Obviously, gaining treatment within the community rather than in a specialized location would ease, or even possibly erase, the burden of such social labeling.

I argue that we can build on Goffman's assertion concerning the social marking created by the process of hospitalization. If we accept that the mental hospital functions as a signifier for mental illness, an operation which nearly obliterates the general understanding of it as a lived place, it offers a new way to think about the issue of stigma. Stigma does not exist within the boundaries of a mental hospital because it requires the shock of difference to exist. The definition of stigma – a mark of disgrace or infamy – requires, absolutely, that an individual deviate from accepted norms. The accepted norm within a mental institution is that nothing, and no one, will socially, psychically, or physically adhere to any prescribed norm. While the goal of the institution prior to medication was to regulate life as much as possible through strict scheduling, chaos was the generally accepted norm.

Stigma, therefore, is produced only from outside of the mental hospital system and because mental illness is a largely invisible otherness, mental hospitals themselves became the visible marker for this stigma. In turn, institutions were and continue to be viewed as distinctly unnatural and therefore an ersatz or non-communities, in contrast to those that existed outside of their boundaries, which were granted the distinction of being "real." This is particularly true in the case of Foucault's analyses of the power dynamics within mental hospitals. While Goffman clarifies that the community of mental hospitals, while strange, is not significantly different from

[14] Goffman, *Asylums,*128.

any other community, Foucault remains dedicated to the falseness of asylum social structures.[15] As outlined in *Madness and Civilization: A History of Insanity in the Age of Reason*, Foucault critiques the manufactured family organization of mental hospitals as misleading and even cruel.[16] Although he later changed his approach to understanding power and the treatment of insanity, a shift that can be seen in his lectures from the Collège de France in 1973-74, his original conception of mental hospitals was rooted in the deconstruction of the tricks perpetrated by reason against madness.

What his discourse evaded was the recognition his own position within his era. This is a general critique of Foucault put forth by Michel de Certeau in his essay "The Black Sun of Language: Foucault," in which he argues that despite his archaeologies of discourse, Foucault does not position himself within history.[17] In this instance, the moment he is forgetting that he is a part of is the moment of deinstitutionalization. He also neglects to address the inherent safety in locating false realities within the boundary of the asylum.

In designating the social experience of the hospital as false, we can see that the signifier "asylum" is fulfilling the role of a simulation, as explained by Jean Baudrillard in his book *Simulations.*[18] By establishing the world within the mental hospital as distinctly inauthentic and mad, we can assure ourselves—beyond its boundaries—that our own communities are real, solid, and sane.

Arguments and deconstructions focusing on the falseness of the asylum social structure—most likely because they evolved in step with the deinstitutionalization movement's narrative—

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[15] Ibid.,130.
[16] Michel Foucault, *Madness and Civilization*, 252-53.
[17] Michel de Certeau, "The Black Sun of Language: Foucault" in *Heterologies: Discourse on the Other*, trans. Brian Massumi (Minneapolis: University of Minnesota Press, 2010), 183.
[18] Foucault clarifies that despite the falseness of the social organization of mental hospitals, they do create what he called a "real psychological situation." See *Madness and Civilization*, 254.
Jean Baudrillard, *Simulations*, trans. Paul Foss, Paul Patton, and Philip Beitchman (Semiotext[e], 1983), 23-29.

failed to address the fact that, prior to psychotropics, mental hospitals such as the SPRTC could *only* offer community as a means to cope with mental illness. This is why patient participation in the daily routine of the hospital was such a central part of treatment, and why work that engaged with the landscape – particularly farming and raising animals – was considered the most effective. It made individuals an active part of the community in which they were living. This was the foundation of the moral treatment of the nineteenth century and the milieu therapy of the 1940s.

Of course in both instances, those ways of engaging with the community were prescribed and encouraged by the institution. It is only by expanding the scope of inquiry beyond the clinical architecture of the mental hospital to examine the physical and social spaces occupied by patients during the asylum period that we see a different kind of engagement with place and community.

In the Landscape

One of the most important aspects of treatment at any psychiatric institution prior to the invention of psychotropics and deinstitutionalization was occupational therapy, and the SPRTC was no exception. Aside from the importing of salt and coal (brought to the hospital grounds by the Great Northern Railway), the SPRTC was entirely self-sustaining until the 1960s.[19] This was made possible by the labor of patients, who grew all the vegetables, raised and slaughtered all of the animals, did all the cooking, made and washed all the bedding and clothes, and fulfilled a

[19] Elizabeth Seaquist, "Timeline of the St. Peter State Hospital," in the SPRTC Museum (St. Peter: St. Peter Regional Treatment Center).

wide variety of other tasks on the campus that were required to sustain the physical plant and the everyday lives of patients and staff.

According to SPRTC patient work records, this work was highly gendered. Women fulfilled traditional household roles, such as working in the kitchen, the laundry, and the upholstery and sewing shop, while men participated in external labor such as farming, carpentry, and working in the machine shop.[20] Because of the nature of their work, men and women had different levels of physical freedom and experienced different levels of surveillant intensity. For example, women, whose occupations in the laundry room or kitchen kept them either inside the main building or within a dozen yards of it, had a limited amount of autonomous interaction with the landscape of the campus (Figs. 3.2 and 3.3).

Gender was not the only factor that impacted the engagement of patients with the landscape. Liberty, or the earned right to move with greater freedom within the campus, was a major determinant in how great or how small a given patient's networks and interactions were. The SPRTC Manual of Industrial and Occupational Therapy and Occupational Listing detail precisely how much liberty was required for each occupation on campus. The privilege of liberty was determined by the amount of danger a patient posed to himself and to others. While it was not always the case, chronic patients were more likely to have liberty than those suffering from acute illnesses.[21]

Chronic male patients, therefore, had the greatest freedom on the campus and were those with the greatest ability to make a place for themselves within its landscape. Their work allowed them to traverse the campus and work in locations far removed from the main hospital building.

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[20] *Manual of Industrial and Occupational Therapy* (St. Peter: St. Peter State Hospital, undated).

[21] The *Manual of Industrial and Occupational Therapy* states, for each position, how much liberty is necessary. The determination that chronic patients were more likely to be on liberty jobs was established in my interview with Ken Ziegler, former employee at the SPRTC, in 2010.

Working on the farm or the slaughterhouse, for example, took the men roughly two miles away of the main hospital building. The farm lay to the west and the slaughterhouse to the south (Fig. 3.4).

This allowed them a greater interaction with the entire landscape as well as reduced the intensity of their surveillance by hospital authorities. Work on the farm, raising crops and animals, involved over one hundred patients who were overseen by only fourteen attendants at any given time and were often out of sight of those attendants for long periods.[22] The relative freedom experienced by patients in places and situations of reduced surveillance was noted by Goffman in *Asylums*.[23] He stated that patients were capable of finding pockets of autonomy within total institutions such as the SPRTC by taking advantage of such gaps in control.

This in itself is a challenge to the conception of hospital life as defined by the complete domination by the authorities over the lives of patients, and this was definitely the situation in the case of work performed by men with liberty on the campus. However, Goffman's analysis asserts that patients found the locations and the opportunities for these pockets, which is a far different thing than making them. While the act of finding hints at allowed freedoms, it is the act of making that indicates a particular kind of agency on the part of patients. Although it remains circumscribed by the boundaries of the institution, this agency reflects the same small-scale tactics utilized by any person or group in an attempt to attain some semblance of control and autonomy in the world.[24]

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[22] *Occupational Listing* (St. Peter: St. Peter Regional Treatment Center, 1945).
[23] Goffman, *Asylums*, 230.
[24] Michel de Certeau, *The Practice of Everyday Life*, trans. Steven F. Rendall (Berkely: University of California Press, 1987).

Such place-making is exemplified by the buildings constructed by male patients on the SPRTC campus between the later 1940s and early 1960s. These "shacks" offered patients places of their own. These places are both the singular buildings constructed by individuals and also the communities that arose from the groupings of shacks in a variety of locations throughout the campus.

Unfortunately, due to the passage of time, the repeated flooding of the Minnesota River, and the building of Highway 169 through the eastern portion of the campus during the mid-1960s, the majority of the shacks have been destroyed. The next section will focus on my fieldwork on a single, extant shack; it seeks to understand this shack in the context of the historical landscape and the shacks as they once were.

The Shacks that Were

According to maps of the campus, the number of hospital buildings on the SPRTC grounds had multiplied by the 1940s and the campus land itself had grown four times around them, with an area that then exceeded 850 acres.[25] A large majority of that land was undeveloped, made up of ravines and woods, and to the east of the campus, bordered on the Minnesota River (Fig. 3.5). Patients took advantage of these secluded areas, which were outside the sphere of control by hospital authorities and rarely, if ever, visited by them.

Photographic records from the SPRTC museum and interviews with staff reveal that there were three major communities of shacks at the SPRTC. The largest was located on the eastern border of the campus, running along the Minnesota River.[26] The second largest was located on

[25] *The Evolution of State Operated Services*, (Minnesota Department of Human Services, 2007).
[26] Interview with Betty McGraw, 2010.

the southwestern edge of the campus, in the woods and deep ravines. The smallest comprised only four shacks and was located in the wooded ravine between the main hospital complex and the farm, right in the middle of the campus. (Fig. 3.6) There are no direct references to the shacks in official SPRTC documents, so it is difficult to know if this practice evolved solely from patient activity or as the result of institutional directives. Interviews with staff, primarily Betty McGraw and Ken Ziegler, suggest that the administration tolerated the shacks rather than encouraged them.

The article "A Place of Their Own," by Tom Ratzloff, which appeared in *The Old Times Newspaper*, a paper printed locally in St. Peter, in 1994 explored and documented the shacks in depth. Each of the shacks was built out of different materials and with different levels of skill. The majority of the materials came from the institution itself in the form of demolished building scraps and assorted junk from remodels and other projects. Patients were allowed by the administration to take anything they wanted from the hospital junkyard for the construction of their shacks, as it was generally agreed that the building and maintaining of these buildings was therapeutic for them on a number of levels.[27]

Most of the shacks were relatively small, approximately twelve feet by fifteen feet at the most. The execution of designing and building a shack depended on the patient building it. This is not because of some metaphysical relationship between mental illness and architecture, but because carpenters, masons, farmers, and English teachers are equally likely to have problems with their mental health. Obviously, the former two groups built the best shacks. In some of these cases, the term "shack" is hardly appropriate. For example, an image from the SPRTC museum collection shows a building that looks more like a cottage than a shack (Fig. 3.7). It is

[27] Tom Ratzloff, "A Place of Their Own," *The Old Times Newspaper* (St. Peter, MN), 1994.

built into the hill of the ravine south of the campus, looking east towards the Minnesota River. The body of the shack is made of stone, most likely mortared together with cement. In addition to a well-placed door, that is set back from the face of the building, and two windows, it also has a brick chimney. Less skilled builders used only what was available for free from the hospital junkyard such as tin siding, wire mesh, and discarded wood. An example of this is a shack that looks more like a lean-to than a building. It is constructed from random pieces of wood and corrugated siding that are fit together just well enough so that the building remains upright (Fig. 3.8). More advanced builders often saved what money they could and bought extra materials, such as cement or nails, from the town of St. Peter.

The arrangement of these varied buildings was somewhat haphazard, but it managed to manifest a certain semblance of order. Historic photographs show that although their arrangement is not exactly linear, most of the shacks had clearly delineated yards, some of which were bounded by fences (Fig. 3.9). Walkway paths connected most of the plots and united them as a community. Other paths connected these communities to one another – particularly in cases of the River and Southwestern communities – and to the heart of the campus, where patients were required to return to sleep for the night.

Aside from sleeping and occasionally taking meals in the hospital dining rooms, patients with shacks spent the majority of their time outside of the hospital buildings.[28] They were either working on the farm, on other liberty jobs, or spending time in their shacks. Time spent in the shacks was not idle. A majority of patients sold goods they produced at their shacks, to both hospital staff and the people of St. Peter, which brought them extra income. A few patients raised

[28] Interview with Betty McGraw, 2010.

chickens and sold their eggs, some sold the fish they caught in the river, and one patient even had a small mink operation.[29]

These practices were possible solely because they had their own places, which were often designed to fit the needs of these activities. For example, the shack of a patient in the southwestern cluster who raised chickens had a large chicken coop, constructed of small tree trunks and limbs, in front and below the main building (Fig. 3.10). This shack also included a water trough, most likely gathering fresh water from one of the many springs in the area.[30]

Whether they were designed for a specific entrepreneurial purpose or for no other purpose than to create a place of their own, away from the official hospital, the shacks provided patients with autonomous spaces. It is important to remember that this was a time before living in the community outside of the hospital was a real option, and many of the men who built these shacks had spent the majority of their lives at the SPRTC. To them, it was their community. While the hospital directed their lives in the form of work and the requirement to sleep on the wards, these men manifested their own autonomy by actively engaging with the landscape in the form of their self-constructed shacks and their organized communities. They made these places their own, regardless of the fact that they were technically located on hospital property.

The parts of the shacks that remain in that landscape are a reminder of a different era of treatment. They are ghosts that haunt the campus, recalling a time when institutional care was the primary method of treating mental illness, a time when the SPRTC was a different kind of institution than it is today.

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[29] Tom Ratzloff, "A Place of Their Own."

[30] Readily available fresh water was also a major influence on the choice of St. Peter for the location of the hospital in the first place.

Their Haunted Remains

During the late 1960s, work on the farm portion of the campus was terminated and all related buildings (except for the cattle barn) were demolished.[31] As the process of moving patients back into their communities accelerated during the 1980s, fewer staff were needed on campus and fewer buildings were required for the continued operation of the hospital. Maps constructed by the SPRTC physical plant department illustrate changes in the campus.[32] Buildings were torn down, old roadways became mere paths through the woods, and the engagement with the landscape, of both patients and remaining staff, was reduced.

As a forensic facility, the SPRTC currently functions in a state of high security—something which is obvious by visiting the campus. Only small areas of the grounds are intensively used. These include the central portion, surrounding what remains of the original hospital, and the security and the geriatric building, which are located on the bluff to the west of the central area (Fig. 3.11). The areas where the shacks stood are rarely, if ever, traversed by patients or staff. In the case of the river community of shacks, the area has been completely obliterated by State Highway 169. Only the southwestern community and the central community areas remain (Fig. 3.12). These have been rendered nearly invisible, both by time and disuse of the landscape.

Only ruins remain of the southwestern community. An observer with no knowledge that the shacks had ever existed might suppose the dell was a dumping ground. The lowest segment of the area is strewn with old paint cans, bricks, wire, planks of wood, and sections of rusted

[31] Betty McGraw, St. Peter Regional Treatment Center Map and Building Timeline, circa 2007.
[32] SPRTC Physical Plant Department, *SPRTC Campus* (St. Peter: St. Peter Regional Treatment Center).

corrugated metal. At first glance, this detritus appears to be random, but closer inspection reveals order to the chaos.

One pile of debris is obviously the remains of a shack (Fig. 3.13). The corrugated metal segments are connected to supports of wood and have fallen in on one another in a rough shape of a square. Beneath these remains lies a foundation of more metal. Small windows can be seen in some of the wall pieces, and are made of the same wire mesh that was used in the main hospital's wards and other buildings (Fig. 3.14).

The rest of the landscape is more chaotic than this, and it is difficult to determine the boundaries of any other shacks. However, the debris are clumped at various intervals and are arranged along both the lowest level of the dell and along a man-made tier that is cut into the rise of the hillside. Along with the various objects mentioned above, there are a number of brick and broken concrete foundations on both levels.

This southwestern area is large and greatly removed from the center of the campus but reveals only a hint at what the shacks once were (Fig. 3.15). The central shack area, on the other hand, is small and a mere 217 yards from the closest hospital building. Among the brick and concrete foundations of what were once three shacks, there remains one intact structure.

Despite its location at the heart of the campus, the central area is isolated by its geography. It is nestled in a ravine that runs west to east, down the hill that separates the security hospital on the high west from the center of the campus on the low east. This area is largely ignored by both current staff and patients, as the road that runs to the security hospital from the central portion of the campus circumvents it. Only a few members of the staff know that the shacks in this area ever existed and none were aware, in 2010 when I was conducting my field work, that one was still standing.

The closest building is the administration building, at the back of which is a lawn that stretches out for roughly 190 yards before it encounters the woods. At the edge of the trees, there are two landmarks that indicate the beginning of the path towards the central shacks. One is the landscaping where the run-off stream from the ravine is diverted into an underground culvert and the other is a tall gate, to the right, constructed of metal poles (Figs. 3.16 and 3.17).

Passing through the gate and entering the woods, there is an overgrown path that runs parallel to and above the creek bed, travelling into the dense trees and undergrowth. This path angles further and further above the creek as it moves into the ravine and is part of a tiered portion of the hill. Twenty-four yards from the gate, along the side of the path and against the rise of the ravine, lies the first of three shack foundations.

This foundation is roughly five feet by six feet, and constructed of brick and limestone. Both of these materials were used in the construction of the original hospital buildings and their use in this foundation dates the shack to sometime during the mid- to late 1960s, when a number of the original buildings were demolished.[33] The other remaining foundations, which lie close together along the path and to the west of the first at a distance of approximately eight yards, are constructed of the same materials and are the same size.

Nine yards from the two grouped foundations, higher along the path, lies the single extant shack (Fig. 3.1). This shack was built in the late 1960s by Earl, a patient who lived on the SPRTC campus from the time he was twenty until he died in his eighties. Earl had been a stone-mason before his commitment, and his knowledge of building is reflected in the design of his shack and in other landscaping projects he completed in the ravine.[34]

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[33] Detached Men's Ward was demolished in 1965, Detached Women's Ward in 1967, and the North Flat (Wing) of the original hospital in 1968. These buildings were constructed, respectively, in 1884, 1886, and 1870 (though the original North Flat burned in 1890 and was rebuilt identically in 1895) out of local limestone and brick.

[34] Interview with Betty McGraw, 2010

Earl's shack is settled on a tier situated roughly two feet above the path. The main body of the shack is constructed of brick and limestone and is nestled into the hillside, so that its roof is covered in dirt. Extending from this is an overhang of corrugated metal supported by a wooden post and lintel support painted black. The overhang is designed in such a way, with its sides bent at slight downward angles, that water would flow to the end and then off to the sides (Fig. 3.18).

The exterior of the body of the shack is only five by seven feet, but the facade is wider than the body by nearly three feet on either side. This was no doubt to prevent dirt from sliding down the hill and surrounding the front of the shack. A similar preventative measure can be seen at the front of the overhang, on either side of each post. Here, limestone and brick edging curves away from the entrance to the shack, creating a run-off area for rain-water from the overhang, protecting the front lawn area from sliding dirt, and creating an aesthetic organization to the landscaping (Fig. 3.19).

The front "door" of the shack is a large and heavy rectangle of rusted iron, which is held in place against the opening with a concrete block (Fig. 3.20). Whether this was the method of closing the door when the shack was in use is unknown. Inside, the floor is dirt and the ceiling/roof support is comprised of two and three quarter inch piping, which is embedded into the walls with concrete. Above each pipe is a wooden slat and across these rest wooden planks (Fig. 3.21). All of the wood is treated with pitch, to make it waterproof. The space within the shack is roughly four feet by six feet, with a ceiling height of approximately five feet. According to interviews I conducted with past and present staff, the size of this shack was dictated by Dr. Grimes, director of the SPRTC from 1948 until 1975, who told Earl that it could not be large

enough to sleep in.[35] I crawled inside this small space to take photographs while conducting fieldwork. It was dark and claustrophobic and cool, despite the summer heat.

Even though the space within the shack was small, Earl's personal place was quite large. In addition to his landscaping efforts at the site of the shack, he also landscaped the run-off stream bed at the bottom of the ravine. Near the shack, this landscaping includes a decorative pattern of large stones set in concrete along the stream's higher edges. The stones are grey and roughly oval, giving the architectural implication of crenellations along the stream's edge (Fig. 3.22). Further away from the shack, near where the woods of the ravine meet the lawn, Earl paved the stream-bed with similar stones and concrete. His work on this project, which he completed over the course of a year, provided the campus with a functioning drainage line for the stream, ensuring that the lawn at the back of the administration building did not flood each spring. In later years, his work was not replaced, but covered over to create the culvert that is there today.

Earl's efforts to create a place for himself altered his small space of the landscape and impacted the physical plant of the SPRTC itself. His projects near his shack were well designed, functional, and aesthetic. They were created for his own use and enjoyment. His paving of the streambed, however, benefitted both him and the SPRTC. That project signals his participation in the community he helped to shape within the ravine and also the larger community of the institution. He did not pave the streambed because he had to, or because he wanted to do the SPRTC a favor, but because the SPRTC was his home and he believed his home needed a proper drainage system.[36]

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[35] Interviews with Betty McGraw, director of Volunteer Services, and Ken Ziegler, past nursing aide. July 2010.
[36] Interview with Ken Ziegler, 2010. Ken stated that Earl found the flooding of the lawn annoying and he felt compelled to right the situation.

Goffman is correct in his determination that mental hospitals function as total institutions that attempt to regulate the lives of those bound up within their matrices through absolute control. As long as it is understood that it is the attempt that is total, not the actual effect.[37] The problem with assigning the term "total" to any situation or institution in terms of the effect is that no system can be so absolute. Entropy, as Robert Anton Wilson once pointed out, requires no maintenance.[38] This is as much the case in social institutions as it is in the universe at large.

The patient constructed shacks at the SPRTC complicate the notion that the total institution is an entirely ersatz community built on protocol and control. They also demystify the Kirkbride as the one and only sentient architectural center that holds *The Asylum* intact. These shacks occupy a liminal zone between the myth of the Asylum and the experience of place. They are abandoned ruins, haunting the landscape of institutional care. As such, as artifacts, they harmonize with the utopian myth of progress. Their existence was possibly utopian in the first place – small scale gestures to a pastoral ideal that emphasized a connection to the land.

But they strike a discord with the myth as soon as their usage – rather than their appearance – is brought into play. These shacks were deeply personal places, constructed and organized by patients the patients who actively used them. The shacks are a reflection of a direct engagement with the landscape by patients at the SPRTC. Although they were and continue to be circumscribed by an institution, they are proof of authentic community building and engagement within a so-called total and austere institution.

What the patient constructed buildings on the SPRTC campus reveal is that our conception of the totality and ersatz nature of the institution as a place is largely built on myth. It

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[37] Anna Vemer Andrzejewski, *Building Power: Architecture and Surveillance in Victorian America* (Knoxville: University of Tennessee Press, 2008), 13-42.
[38] Robert Anton Wilson, *Schrödinger's Cat Trilogy* (New York: Dell, 1979), 40.

is a comforting myth because it allows us to simultaneously believe in the stability of our own places (as though boundaries were a non-permeable reality) and the imagined superiority of the current system of care for those with mental illness in the United States. This myth allows us to believe in progress.

That progress is illusory, dependent solely on the dualistic community tropes established by the deinstitutionalization movement. Earl's shack—that he built and maintained with such care—is not proof that the mental hospital was a superior institution over in-community care. Rather, it is a marker that hints at a greater complexity in the nature of place, community, and identity within such an institution.

Earl's shack, and all of those that haunt the landscape of the SPRTC in their various forms, invite us to re-evaluate the structure of the narrative concerning mental health treatment in this country. These patient-constructed buildings suggest that the meaning of community is not so easy to assess, not so easy to pin down, as the deinstitutionalization narratives would have us believe.

Chapter 4: The Museum

In 1966, the SPRTC marked its centennial. Celebrations for the event included a staff banquet, which included speakers praising the hospital's history and a dance for patients and staff. A compendium of articles on the past one hundred years was produced, written by SPRTC librarian and historian Elizabeth Seaquist.[1] These articles were published in the hospital newsletter as well as the the local newspaper, *St. Peter Herald*. After all, the SPRTC was an inherent part of the town, and the impact of its history went beyond institutional boundaries to define the history of St. Peter.

This active and conscious historiography was particularly important, given the narratives produced by deinstitutionalization concomitant with the anniversary. The identity of the hospital was under constant threat of appropriation and revision. The anxiety felt by members of the SPRTC staff in response to this reimagining of their place is implicit in their approach to the centennial, which was posed as a festive celebration of a venerated institution's history. This history was marked as valuable from a social, medical and deeply personal perspective. Experience of place, found in testimonies of long-time staff, was central to the speeches given at the centennial banquet.[2] This emphasis on the personal would continue, particularly in the oral histories of staff collected by Phillip L. Kent in 1995.[3] Kent's oral history collection includes stories from a number of staff members, who held positions such as groundskeepers, nurses, and therapists. Each interview contains stories told by the interviewees about the more private side of the institution, such as the way the kitchens were run, or particular patients with whom they had

[1] Centennial, Miscellaneous, Newspaper Clippings and Programs, 1966, Southern Minnesota Historical Center Collection.
[2] Centennial, Speakers 1966, Southern Minnesota Historical Center Collection.
[3] Philip L. Kent, ed., *Oral Histories of St. Peter Regional Treatment Center* (1995).

had a close relationship. The SPRTC seems to generate a need to tell, to share personal experience of the place.

The most significant gesture to the personal in the history and particularly the centennial historiography was the creation of the hospital's museum in conjunction with the centennial in 1966 by Elizabeth Seaquist with the help of Mary Alice Donary, the Assistant Director of Nurses. Originally located in the basement of Bartlett Hall, a continuous treatment building that was constructed only a year before the centennial, the museum was created for this event with two goals in mind: to celebrate the history and collective memory of the hospital and to create a space where that history and memory could be protected and remembered.[4]

This chapter is a phenomenological exploration of the SPRTC museum. Its contention is that the museum functions as a cabinet of curiosities, a highly personal spatial/curatorial practice that reflects a staff-to-institution relationship grounded in everyday life experiences rather than strictly professional ones. This chapter asserts that the museum functions as an anchor for the SPRTC staff's collective memory and a symbolic ward against the ruin mythology of *The Asylum* by utilizing space, displays, models, and photographs to focus on the lived experience of place.

This chapter will briefly outline the foundation of the museum, then move on to describe it and its displays, and establish its status as a cabinet of curiosities. The significance of this status shift will be explored by placing the museum within a broader, state-wide context of institutional memory preservation. Finally, this chapter will conclude with my own experiences in this place and an examination of the shifting middle ground between myth and reality.

[4] Interview with Betty Mcgraw, 2010.

In the Museum

Mary Alice Donary explained the creation of the museum in her interview in the oral histories collected by Philip L. Kent in 1995:

> So we went out and found things—begged and borrowed and set up rooms to show the way things had been all those years. And a lot of things had been given away or destroyed, and a lot of things had been sold. We tried to show all of the different departments, because it was a closed community. Everybody lived there—they made their own sheets and mattresses. They made their clothes. They brought salt in for the softener, and coal in... and everything else was here. Everybody did their bit. So that is what happened and everybody helped.[5]

Donary's description of creating the museum captures at least one of the narratives handed down through the years to hospital staff: the singular self-reliance of the institution. This narrative appears again and again. The two major contributors to and organizers of SPRTC history, Elizabeth Seaquist and William S. Erikson, both repeatedly emphasized this self-reliance in their writings.[6] The museum itself continued this narrative with exhibits that highlight how such independence was achieved. Most of this was reliant on patient labor, but the entwined lived experience of patients and staff allowed staff to see this labor as an extension of their own.

There is a definite romance to the idea of showing "the way things had been all those years," but it is Donary's involvement with the narrative of the hospital as a place with a heart, where everyone lived together and contributed to the good of the institution, which establishes what was at the core of the museum's creation. The last sentence, "so that is what happened and everybody helped" may refer to the way the hospital was historically run or to the way she and

[5] Kent, *Oral Histories of St. Peter Regional Treatment Center*, 10.
[6] Articles and letters from Elizabeth Seaquist: Centennial, Miscellaneous, Newspaper Clippings and Programs, 1966, Southern Minnesota Historical Center Collection; William D. Erickson, "This Great Charity: Minnesota's First Mental Hospital at St. Peter, Minn. 1866-1991." (St. Peter: St. Peter Regional Treatment Center, 1991).

Seaquist worked to set up the museum. This semantic bleed between the past and Donary's experience signals the tendency of SPRTC employees to identify strongly with the hospital's history and collective memory.

Today, all new staff members are required to visit the museum as a part of their training.[7] In taking a position at the SPRTC, they become more than employees; they are also inheritors of the hospital's entire history. Their positions may change as the SPRTC changes, but their inheritance of history persists. This mindset, of becoming part of the SPRTC on a deeper level, was consistently reflected in conversations I had with current and previous employees while I was working on site.

The museum, too, has persisted through the years and institutional changes of the SPRTC. It remained in the basement of Bartlett Hall until the mid-1970s, when it was moved to the second floor of Old Main, the remaining center of the original linear plan hospital. There it had the space—two large rooms that comprise the entirety of the second floor—to expand in its new location. Betty McGraw, director of volunteer services from 1978 until 2009, executed the majority of the museum's expansion and structural reimagining.[8] Although Seaquist's dedication to documenting the hospital's history brought the museum into existence, McGraw was the reason for its persistence and evolution. Her work on the museum is remarkable for two reasons.

First, curating the museum was not a part of her job description. As Director of Volunteer Services, McGraw's job entailed over-seeing hospital/volunteer relationships, donations from the community, and managing the Trading Post, the SPRTC's general store for patients and staff. Her work on the museum was entirely extra curricular, done with the blessings rather than the funding of the institution.

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[7] Interview with Betty McGraw, 2010.
[8] Ibid.

Because of this, all the props and exhibits of the current museum were cobbled together, by McGraw (in much the same way that Seaquist and Donary had), out of the original museum and objects on hand in the SPRTC. With no experience in curating or formal education in the presentation of history, McGraw's arrangement of objects is possibly closer in type to the cabinet of curiosities of the nineteenth century than a museum, an issue that I will cover in more detail later in this chapter. But what is noteworthy, in either case, is McGraw's dedication to the arrangement of the museum and expression of the SPRTC's history and memory.

Second, as the SPRTC evolved, eventually becoming a high security forensic facility, the visibility of the museum became, for those outside of the institutional system, almost completely obscured. With the rare exceptions of students in psychology courses brought there for a history lesson, or researchers such as myself, the only people who see the museum are patients and staff. And within that already restricted viewership, it is largely ignored. It exists in a strange limbo, a space that creates the meaning of place within a place that has moved on.

After all of its transformations, Old Main is a strange building. This building has fulfilled a number of different functions over the years and has been physically altered a number of times. It burned twice (the North Flat burned in 1880 and was rebuilt, the auditorium at the back, west side of the Main burned in 1965 and was never replaced) and when the wings of the Flats were torn down in 1967, leaving Old Main the only remnant (Figs. 4.1 and 4.2).[9] Memory shadows of the Flats still remain on Old Main's sides, and the extant building seems a bit taller than it is, without their presence. It looks truncated and strange, but it also feels strange. Part of that is the nostalgia that comes from walking into a building that is over one hundred years old and beautiful, and part of it relates to what the building is. Moving around in what you know is a

[9] *The Evolution of State Operated Services* (Minnesota: Minnesota Department of Human Services, 2007).

mental hospital means that an aura of uncanny strangeness permeates even the simplest objects, such as the doors through which you enter the building. Made of smooth polished wood with delicately engraved frosted glass, these doors are within a small vestibule on the southern side of Old Main and stand directly opposite to a door that no longer goes anywhere, because it used to be the entrance to the Southern Flat (Fig. 4.3). In contrast to the doors that take you into the building, this door is dirty, with cracked glass and wire mesh, bolted shut against nothing. It is somewhat tricky, given this sort of entrance, to not engage in some slightly romantic thinking about the space.

Old Main is the perfect location for the museum, as the building itself is part of the display. Today the lower level of Old Main is an administrative space (which isn't much different than its original function), the second floor is the museum, the third floor is dedicated to occupational therapy, and the fourth floor is composed of the Trading Post and the Volunteer Services Office. But it is, no matter how it performs today, the only remaining heart of the original linear plan hospital. And it feels like that, an artifact of the past that haunts the present.

A stairway leads from the first floor administrative spaces of Old Main up to the second floor where the museum is located. The stairways of Old Main may have been somewhat grand in the past, but now they have been fitted with fire doors that required blocking over the continuity of their shape with concrete block at every floor. The contrast between the block and the old marble stairs is less than appealing, though it does aptly embody the spirit of the place: never standing still, always evolving.

There is also a rickety, old, Otis elevator that can be taken up to the museum. The elevator was installed in the 1950s and its dependency is somewhat questionable. Its peeling

paint and old labels next to the buttons evoke a feeling of decay that resonates with the building's overall spirit of age and disuse (Fig. 4.4).

Coming out of the elevator onto the second floor, the first thing one notices is a slightly odd collection of objects in the hallway. There are chairs, an old hospital bed, and trolleys for moving paperwork about. (Fig. 4.5) This kind of assortment of seemingly unrelated objects is common in the Old Main, where there is not enough room to keep anything, so it all ends up in places it does not seem to belong. This also brings to mind the disuse of the building as a location of treatment and the ruin mythologies of the haunted Asylum, an issue I will return to at the end of this chapter.

The museum comprises the two large rooms on either side of this second floor hallway, both of which are always locked. Although this is no longer a space of treatment, it is commonly traversed by patients and staff, requiring security protocols to be observed at all times. Only when there is a tour are both of the rooms open simultaneously.[10]

The east side of the museum is a one-room display, with the room divided by a large, false wall. On one side of this wall are photographs and a model depicting the campus around 1950 (Fig. 4.6). The model shows about three quarters of the total space of the campus at that time, focusing on the active treatment space at the center of the campus. Represented within the model are the building the museum is in, when its wings were still attached, the north and south detach wards, and the admissions building, which is called "psycho," by employees, in reference to its full original title, the psychopathic building. The original security hospital and the train tracks are also visible.

[10] The only time I have moved freely between these rooms was when I was a part of either a school or historical tour. The majority of my time in the museum spaces was spent conducting research, and at those times I was locked into whichever room I was currently working in. I had to call up to the Volunteer Services office on the fourth floor to be let out.

This room contains the doorway that leads to the grand steps on the front of the building (Figs. 4.7 and 4.8). This entrance was almost never used, except when this room was part of the library and patients, staff, and the residents of St. Peter could enter directly into the library without engaging with other parts of the hospital. Those seeking professional care and their families always entered the door beneath the *porte-cochere*. Staff often used side entrances.

On the other side of the false wall is an exhibit representing one of the nurse's apartments. The display includes a large, wood frame bed, a small dresser with a large upright mirror, and a mannequin seated next to the dresser, representing a nurse getting ready for her day. On the wall above the bed is a sepia toned photograph of a similar room, circa 1890. In the early years, before the nurses' residence was constructed in 1908, nurses lived on the wards with the patients.[11] This display emphasizes the connection between the lives of the staff and the lives of the patients. Other objects in this room include the switchboard company register, various pieces of desk furniture, and the safe from the steward's office (Fig. 4.9).

The western side of the museum is organized in an attempt to give the impression of the movement of patients through the SPRTC in its earliest years. This movement is imposed upon the museum viewer through the layout of the room, which is organized into a winding path through the usage of displays acting as walls. Upon entering from the hallway, there is a display of large posters depicting the hospital building, memorable figures in hospital history, and a timeline of that history (Fig. 4.10).

The pathway implied by the arrangement of displays pushes the viewer toward a door labeled "Entrance, Typical State Hospital (Fig. 4.11)." This section of the museum comprises a

[11] Erickson, *This Great Charity*,12.

hallway and number of small rooms, each dedicated to a different aspect of typical hospital life. The first room depicts the first stage of patient admittance: the baths.

The room is located at the top of three, grey stairs and is small, square, and coldly grey itself, lit by a narrow wire mesh covered window on the southern wall. A mannequin is posed next to a hamper, holding a towel in her broken hand, head tilted as though listening to instructions (Fig. 4.12). A single white, porcelain tub with orange metal deposit stains caused by well water sits alone in a dark adjacent room (Fig. 4.13).

Before they could be put on the wards, new arrivals were given full baths, screenings, and new clothing. This was done in an attempt to control the spread of lice and disease. In some cases, the clothing patients came in with was burned. In others, it was kept in closets to await their release. Unfortunately, it was quite common for these articles to go missing or be destroyed before such an event.[12]

In the hallway, there is a tall, wooden cabinet kept perpetually half-open, full of medical objects, and a podium with further information about treatment (Fig. 4.14). The adjacent room shows a typical treatment room (Fig. 4.15). The room is glowingly sterile white, with chipped white subway tile halfway up the wall and white paint continuing up to its nearly twenty foot ceiling. A wire mesh window sits high on the southern wall, letting in sunlight that illuminates a mannequin wrapped tightly in white sheets on an old, white, metal bed.

Although the original building was intended to provide separate rooms for each patient, over-crowding meant this may have been the case for all of two or three years. The only time patients would have this much room to themselves would be when they were undergoing therapy of some sort. This room is meant to show the water therapy known as wrapping. Both agitated

[12] Interview with Betty McGraw, 2010.

and depressed patients were occasionally wrapped in warm or cold wet sheets. The temperature of the sheets depended on the state of the patient. This room also has a placard explaining salt rubs, which were used to increase blood circulation in inactive patients (Fig. 4.16).[13]

The next room shows what is often thought of as a more modern therapy: electro-convulsive therapy (Fig. 4.17). ECT was actually originally pioneered during the late eighteenth-century and was used throughout the nineteenth. The therapy has steadily advanced throughout the years and is still considered highly effective in treating uni-polar depression. Although the treatment technology has evolved, this is one display in the museum that is linked to current practice, highlighting the fluid nature of treatment.

This room contains the doctor's desk, a table covered in ECT equipment, and the bed in which the patient would lie to receive treatment. This is an early twentieth-century model ECT machine, with a square black body and silver interface on its top, below the removable lid.

This room previously contained a mannequin with the nodes attached to her head. We might well ask why the display was changed. When I first visited the site for research in 2008, the room was set up with the mannequin. Upon later trips to the museum, around 2011, the room had been changed to its current design. On the whole, the museum is surprisingly unflinching about the history it represents. Perhaps in this instance, the story of ECT being performed on a human simulacrum was too close to the bone.

The final room off of this hallway is the restraint room (Fig. 4.18). The room is small and tiled in white, with a male mannequin in a camisole, seated before other forms of restraint, that hang on hooks along the wall: muffs, cuffs, another camisole, and straps. Restraint and its uses are probably the most deeply misunderstood segment of hospital life. First of all, the object most

[13] Interview with Betty McGraw, 2010.

often called a straight-jacket is not, in fact, a straight jacket; it is a camisole. Straight jackets were pieces of canvas that went from the shoulders to the knees and were often stitched onto the patient, meaning they had no movement capabilities whatsoever. The camisole allowed patients to move about, but not strike out violently at themselves, other patients, or staff.[14]

This distinction is relevant in that it highlights the force of mythology in the psychiatric milieu and its impact on the narratives of place. Although neither is pleasant, the true straightjacket is far crueler than the camisole. But it lacked the aesthetic for infamy. For the perfect myth, both the proper name and aesthetic were required, resulting in what we know as the infamous "straight-jacket."

Muffs hardly appear in asylum myth stories (over-zealous mittens are hardly the stuff of nightmares), but were used for a purpose similar to the camisole: they made it impossible for patients to scratch. The one undeniably barbaric form of restraint was the crib, which you can see pictured on the wall of this room (Fig. 4.19). Cribs could vary in design, but their purpose was to completely immobilize patients within a small, lockable, enclosed contraption that resembled an adult sized version of a child's crib. The crib pictured on the wall in the restraint room is a slatted, wooden, horizontal cabinet, elevated from the ground by four legs. Patients were locked inside the crib in a prone position, unable to move, often for long periods of time. All forms of restraint were finally outlawed in 1949.[15]

This hallway leads the viewer back into the main room and into the displays dedicated to occupational therapy. These displays are split between men's and women's work and feature photographs of labor as well as the tools used by patients to complete that labor. The majority of men at the hospital worked on the farm; this display features pictures of the various farm

[14] Erickson, *This Great Charity*, 63-64.
[15] Ibid.

buildings and landscapes (Fig. 4.20). This farm is one of the major signifiers in the SPRTC's narrative of self-reliance because it sustained the entire institution. Patients and staff grew vegetables, raised cows and pigs, and slaughtered them. For the first one hundred years of the hospital's existence, absolutely no food was required from the outside world.[16]

The women did not work on the farm; instead, they worked inside the hospital building, typically sewing, knitting, and cooking. The occupational therapy displays that visually summarize their labor include photographs, an ironing board, and various fabrics (Fig. 4.21). Women made all of the curtains, all of the clothes, and all of the linens for the hospital. They were also largely responsible for the laundry.[17] Like the farm, the place-constructing activities of women support the narrative of insular self-sufficiency within the institution of the SPRTC.

Adjacent to the displays of occupational therapy are those representing recreational therapy. These include photographs of hospital sports teams, a case of sporting equipment including a croquet set, and a case of arts and crafts created by patients (Figs. 4.22 and 4.23). Recreational therapy was as much a part of everyday SPRTC life as occupational therapy. The hospital held weekly dances in the auditorium until it burned down in the early 1960s. Both staff and patients participated. Parties and picnics were a regular occurrence when the weather was good and, as mentioned in Chapter 2, it was not unusual for citizens of the town of St. Peter to go up to the campus to take part.[18]

The next portion of this side of the museum is dedicated to the medical aspects of life in the institution. One display is the medical station, which focuses on medication before the development of psychotropic drugs. As such, its focus is on physical ailments rather than mental

[16] *The Evolution of State Operated Services*, 2.
[17] Interview with Betty McGraw, 2010.
[18] Ibid.

ones (Fig. 4.24). The medical station is wholly re-built within the museum, with its counter, stocking shelves, and pick-up window intact. Various bottles of pre-psychotropic treatment standbys in old, brown pharmacy bottles sit on the counter.

There is also a display depicting the hospital surgery, including mannequins in hospital uniforms standing around an original operating table, circa 1920, with a photograph of nurses in the real operating room hanging on the wall behind them (Fig. 4.25). The surgery was a later addition to the hospital, established sometime around 1920, and was located on the fourth floor of the center building. The majority of these surgeries were strictly medical as opposed to psychosurgeries, such as lobotomy, which were performed 90 miles away in Rochester, Minnesota.[19]

The final display is that of patient living. Images on the walls show the way the wards were arranged in different time periods and different locations of the hospital. The arrangement of the two beds in the display, almost impossibly close to one another, with mannequins lurking beneath the sheets, shows sleeping arrangements for most of the hospital's history. There was very little available room and most sleeping areas did not even have a walking space between beds (Fig. 4.26).

Both rooms of the museum attempt to arrange and depict hospital experience. They engage with the lives of staff and the lives of patients because both were a part of the community in essential ways. According to Susan A. Crane, museums are "sites of interaction between personal and collective identities, between memory and history, between information and knowledge production."[20] Museums are more than collections of objects, where people can come to learn. Their purpose is to codify and narrate history and memory. This is, to some extent, true

[19] Interview with Ken Ziegler, 2010.
[20] Susan A. Crane, ed., *Museums and Memory* (Stanford: Stanford University Press, 2000), 12.

of the SPRTC museum, but it seems to function slightly differently. While it offers a site in which visitors can engage with the personal and the collective aspects of memory and history, and shares information while generating a type of knowledge regarding the institution, the SPRTC museum is highly isolated and speaks to and about a very specific population, specifically the hospital staff.

This isolation is largely due to its location within a still functioning and high security mental hospital, but it is also because the museum has always been aimed at the above group, rather than outsiders of the institution. This variation on usage and audience raises the question of whether or not this space is a museum at all. The next section will explore that question and what the status of the site means to its interpretation.

Museum or Cabinet?

In her chapter "Curious Cabinets and Imaginary Museums," in *Museums and Memory*, Susan Crane distinguishes between cabinets of curiosity and museums:

> Cabinets were known by reputation and the occasional catalog published at auction; museums regularly produce catalogues and guidebooks and are listed among educational institutions. Cabinets were intensely personal and private by nature, even when their contents reflected participation in a universal discourse of science and natural history. Cabinet admission was regulated by the owner; museums are open to the public.[21]

As a state run institution, the SPRTC is ostensibly open and available to the public, but that availability is complicated by its status as a high security treatment center. Members of the public are free to go there, but only if they know who to call for permission and know, in the first

[21] Susan A. Crane, "Curious Cabinets and Imaginary Museums," in *Museums and Memory* (Stanford: Stanford University Press, 2000), 65.

place, that there is a reason to go. In this way, the museum at the SPRTC actually fulfills two criteria for being, instead, a cabinet. It is known by reputation (if at all) and admission is controlled by the owner.

What of the third criteria, that a cabinet be intensely personal and private by nature? The SPRTC museum is engaged with the historical discourse of a mental health treatment facility and therefore engaged in broader historical issues of treatment. Its focus is on maintaining the history and more importantly the memory of place. It is, like the staff testimonials of the centennial celebrations in 1966 and the oral histories of 1995, engaged with the deeply personal experiences and memories.

These artifacts and the museum ultimately declare that the institution is more than a space or a site, rather they convey a sense of place – one filled with the history and memory of the many people who have lived and worked there. Minute, everyday patient and staff experiences are the foundation of the museum, but the museum is mainly for the staff. It is to the museum's credit that it has never tried to be a voice for patients.

The potency and relevance of staff-driven history would be easy to dismiss if the SPRTC was the only institution in Minnesota to be so deeply engaged with its personal history, but it is not. The SPRTC is one of many institutions in the state and operates beneath the Minnesota State Operated Services (SOS). As of 2008, the SOS defined itself as a department that, "consists of an array of campus and community based programs serving people with mental illness, developmental disabilities, chemical dependency, and traumatic brain injury."[22]

[22] *The Evolution of State Operated Services*, 3.

Currently, these programs operate in a variety of spaces, integrated into communities and the medical treatment landscape. For the most part, the original treatment centers have closed. Some have been torn down, some have been reclaimed as prisons, and some stand empty.[23]

The SPRTC is the only location with a museum proper because it is the only functioning institution left in existence. Of the original seventeen Minnesota institutions, eight of which were dedicated to the treatment of mental illness, only the SPRTC remains intact as an in-patient mental health treatment facility.[24] Its actual function and the functions of its physical plant have shifted, but it is materially present. The presence that remains has the capability and the interest in maintaining history and memory on-site.

While the other locations of treatment, being divested of their locations, no longer exhibit their historical collections, these collections *do* exist, but now as a diaspora, spread throughout a variety of historical societies and archives. This dispersal of historical documents and artifacts has occurred with the SPRTC as well (collections of very different documents and objects from the SPRTC can be found at the Southern Minnesota Historical Society, the Nicollet County Historical Society, The Minnesota Historical Society, and the SPRTC itself), but the museum has acted as an anchor for memory.

In 2008, I attended an SOS organized presentation of all of the treatment locations' historical collections. Set up in St. Paul at the Department of Health and Human Services, each of the treatment centers was given its own room in which to display their histories. The lobby of the building was furnished with introductory billboards with reproductions of institutional post-cards from all of the SOS campuses. From there, visitors could turn and walk through a series of

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[23] Ibid.

[24] The treatment center at Moose Lake is currently used for in-patient, high security treatment of level three sex offenders. Due to the difference between that patient population and the population of non-psychopathic patients, I do not consider it a mental health facility. Other opinions on the topic exist.

rooms, each dedicated to a different campus. The SPRTC room contained pieces from the museum, including a nurse's uniform on a sewing dummy, kitchen appliances and cafeteria trays from the 1950s, photographs of the kitchens and the wards spanning from the late nineteenth century to the 1960s, the infamous "Press to Treat" ECT machine, and a collection of ward keys, laid out on a crimson fabric under glass.

Other campus exhibits featured historical photographs and reproductions of post-cards. The Rochester exhibit included a short black and white propaganda film from the 1950s or 1960s about how people living in the town near the hospital could help residents at the institution transition into community life. One of the suggestions was inviting them over for dinner with the family, a vignette acted out by a perky blonde who reminded me of an old situation comedy actress.

This event marked the first time I met Betty McGraw, who had transported the pieces of the SPRTC collection to St. Paul and was overseeing the display herself. McGraw's warmth and enthusiasm for the history of the SPRTC was evident and was expressed through her presence as well as through her arrangement of the exhibit, which was the richest of those present.

The event was partially a celebration of the SOS history and partially a final farewell to the institutional system. 2008 marked the beginning of a new, community integrated SOS, which had been evolving since the 1960s. In a way, this was a triumph of the deinstitutionalization narrative over the treatment centers' isolated and self-sufficient one, and the SOS event was a rebuttal to that.

The event clearly, if not explicitly, aimed to reassert the humanity of the SOS institutions as places in defiance of the way they had been reimagined as cruel social failures. This assertion was made through the diversity of the treatment centers' collections, but more importantly, it was

practiced in the way people engaged with the event, emphasizing the individual and deeply personal relationships between themselves, their co-workers, and the institutions themselves.

The pamphlet created for the event, titled "The Evolution of State Operated Services," contains a timeline for each institution.[25] Not surprisingly, each of these timelines is illustrated with photos of the campuses and their various buildings. This conflation between timeline and architecture is relative to our discussion of place and should be examined a bit further.

The objects of the various treatment center collections—like the SPRTC museum—are important, but without the buildings they were used in, they lack a stage to encompass them and give them life. The SOS pamphlet attempts to establish that stage through images, in absence of architecture, the foundation of place. The buildings—cottage plan of Hastings, the (almost) Richardsonian Romanesque of Fergus Falls—exist by proxy through their photographs. They are more than representations of site: in the context of the SOS historical event, they were evocations of place.

That sense of dense place-ness was central to the SOS event. The majority of attendees were current or former staff members, who had come to reminisce and bid farewell to the lives they had known in the hospitals. I witnessed a number of conversations between people as they moved through the exhibits. People identified themselves to one another by stating their hospital and the years they worked there. This always set off a call and response: "Did you know so-and-so?" "I worked with him/her in the _____"

People were drawn to the images of their institutions' buildings the way people respond to photographs of an old home. They approached objects with an "...I remember these..." sense

[25] The pamphlet was created for the event only and is no longer in circulation.

of nostalgia. One man described his experience with the old ward keys from the SPRTC, talking about all the different locked doors he had to negotiate on a daily basis.

One of the things I observed over the course of years that I spent doing fieldwork on location at the SPRTC, was a particular attitude among current and former staff toward the institution and mental illness itself. This affect is difficult to capture with words, but is very close to "What's the big deal?" tinged with a gallows humor that shrinks from nothing. For example, on one visit to the SPRTC, McGraw and I were going down into the basement of Old Main to access the tunnels that run beneath it and connect to the other buildings on campus. We stepped out of the old Otis and into the dim, cave-like hall, filled with boxes and an indescribable array of tools and unknown objects, piled along the halls. A small tour of three people came towards us, to get on the elevator and leave the basement. As they got in, one asked McGraw, "Do you think there are ghosts down here?" with an overly jocular and laughing tone. She smiled brightly and replied, "No. You want the fourth floor, where the surgery was. Far more people died up there than down here."[26] And then the elevator doors closed on their no longer smiling faces. Of course, no one had died in surgery at the SPRTC – all of the procedures were minor – but the idea of ghosts in the basement halls was such a ridiculous and outsider notion to McGraw that she could not help but have a little fun at their expense.

An outsider perspective on the ward keys might be very different from that of someone who had worked in an institution. The outsider might think of all those keys and locked doors in never-ending progression they implied and imagine a dark and terrible hellscape of an institutional nightmare. However, as I overheard at the SOS event, a previous employee, thought

[26] Interview with Betty McGraw, 2010.

only of the amusing, almost slapstick quality of never being able to find the right key for a particular door.

The staff in the SOS institutions is aware of the outsider aura – they can see the little synchronicities between their experiences and the myths, like McGraw and the ghosts in the basement – but that is not their perspective. Mental illness is, for them, strictly human and mundane, even in extraordinary circumstances.

For example, there was the woman in the nightgown. I was scanning photographs in the Volunteer Services office on a particularly cold morning in January. It was one of those bright and hard Minnesota winter days, nearly fifty degrees below zero without windchill; my car had refused to start in the morning and my hair had literally frozen to my face in the steam of my breath because of the extreme cold.

As I was scanning, a call came in from the local hospital, requesting clothing assistance. A woman had been found walking in the park in her nightgown wearing nothing else. Not even socks. I listened to McGraw's side of the conversation, as she determined what to bring to the hospital. She later told me that the woman was an SOS employee, who had had a psychotic break due to a manic episode. There was no judgment, no worry, no fear at seeing someone break down in this way. Arrangements to help the woman were made and a new plan for her treatment was established. Whether she was capable of her job was never questioned.

These examples, in part, illustrate the difference between the insider and outsider views of the institution and mental illness itself. Like the museum at the SPRTC, the SOS event was open to the public, but the public was largely absent – not out of disinterest necessarily, but out of ignorance. This world has its own culture and population and this exhibit was produced for them. This is, of course, an echo of the insularity and self-sufficiency narrative, which does not

aim to exclude outsiders from knowledge, but simply assumes their inability to relate. With this in mind, we can see the SOS event as a kind of mobile cabinet of curiosities, with its deeply personal aspect.

The desire to mark history and establish memory is not, as the SOS exhibit of 2008 illustrates, unique to the SPRTC, but the museum is the last of its kind possible because it is still rooted in place. Place is key to memory. In *Remembering: A Phenomenological Study*, Edward Casey suggests that all memory is tied explicitly to place. According to Casey, there is no such thing as a placeless memory.[27] While Casey's focus is on the phenomenological experience of memory and remembering, we can extrapolate that, given the necessity of place for the action of memory, a museum that functions in the place it depicts is capable of evoking personal and collective memory in a way that would be impossible out of place.

Place is the key to understanding the museum. In the wake of deinstitutionalization and the SPRTC's transformation into a forensic and restricted location, the museum persists as a beneficial mirror and ward against outside narratives. But how does the museum – of place and in place – run up against broader narratives surrounding *The Asylum*?

Locked in the Museum: Hauntings and Erasures

The SPRTC is not haunted by ghosts of the dead or of the past, but in a way, it is haunted. In a strange inversion, the hospital is haunted, not by its own history or itself as an institution, but by the future, which threatens to manifest a narrative contrary to what those who have lived within it feel it to be. Not even the museum is haunted by the past. Instead, it is a

[27] Edward S. Casey, *Remembering: A Phenomenological Study* (Bloomington: Indiana University Press, 1987), 183.

mnemonic device to ward off these future specters. It strengthens the memories of employees against a narrative possession that would strip them of their identities, which are so closely tied to the hospital's place identity. This kind of haunting, which moves forward and backward in time, applies to all locations in which the experience of individuals is more potent than the place itself.[28]

People who work in the SOS and the SPRTC specifically are witnesses to their own erasure in the narrative of deinstitutionalization. This story, in all of its iterations, depicts them as either shallow monsters or mere, inhuman extensions of the Institution, machines that execute the will of a faceless and malevolent system without any agency or tactics of their own.

The narrative erasure of staff or the flattening of their character when not fully erased is prevalent in popular culture and scholarly discourse. Popular culture and everyday discourse on mental illness have had an enormous impact on the perception of mental illness and *The Asylum* as place and signifier. The way these discourses have shaped the identities of those who work in the mental health field cannot be underestimated. Nor can their impact on scholarship be dismissed. The popular everyday is the milieu from which specialist discourse arises and then returns.[29] Its narratives matter not only in that regard but in their prevalence and power.

One excellent example is that of the character Nurse Ratched from Ken Kesey's *One Flew Over the Cuckoo's Nest* and its infamous film adaptation. Nurse Ratched is cruel, heartless, and ruthless towards her charges, a group of chronically mentally-ill men. When confronted with an outsider who challenges the social construction of mental illness and threatens to enlighten the

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[28] Stephen Pile, "Spectral Cities: Where the Repressed Returns and Other Short Stories" in *Habitus: A Sense of Place*, ed. Jean Hillier and Emma Rooksby (Burlington: Ashgate Publishing Company, 2005), 220.

[29] Michel de Certeau, *The Practice of Everyday Life* (Berkeley: University of California Press, 1984), 29.

characters trapped in the system, Ratched's response is to rob him of his free will through the most dreaded and infamous procedure in *The Asylum* narrative: the lobotomy.

Nurse Ratched's character never shows an ounce of humanity and is the horror of the *The Asylum* made flesh. She is not really a person; she is merely an extension of the mental hospital, the epitome institutionalism's monstrous puppet. But even characters whose names do not stick quite like hers, such as Ben Kingsley's moderately benevolent asylum superintendent in *Shutter Island* or Whoopi Goldberg's caring head nurse in *Girl Interrupted* are circumscribed by institutional motives, incapable of being autonomous or free. They may exhibit more humanity than the infamous Ms. Ratched, but in the end, they are cogs in a system meant to control the weak through force.

Scholarly discourse is only slightly less fanatic, less ideological, less frightened of the mentally ill, and less alarmist about those whose job it is to care for them. The major difference between popular culture and scholarly/specialist discourse is how they treat the staff. The first transforms them into puppets and monsters, the latter often erases them completely.

The differences between popular culture and scholarly production are not always easy to distinguish. Consider, for example, the back blurb for the Vintage Books 1988 edition of Foucault's *Madness and Civilization*:

> ...Foucault examines the archeology of madness in the West from 1500 to 1800 – from the Middle Ages, when insanity was considered part of everyday life and fools and crazies walked the streets freely, to the time when such people began to be considered a threat, asylums were first built, and a wall was erected between the "insane" and the rest of humanity.[30]

This caption drips with sensational fear of mental illness. By invoking the "fools and crazies," it appeals to the basest interest in asylum history. Even the highly specialist discourse of Foucault

[30] Michel Foucault, *Madness and Civilization*.

(not necessarily known for his lack of sensationalism in the first place), is packaged for general consumption as an extension of entertainment.

The packaging is dramatic, but the content is also problematic, in that it creates this erasure of staff within the asylum. Any attempts to correct the erasure of the human in the institution focused on the lives and experiences of patients. This is perhaps because the primary inspiration for historians' focus on *The Asylum* was, according to David J. Rothman, the declining social legitimacy of these institutions.[31] As such, one of the primary concerns of scholars was to investigate the way patients had been systematically disenfranchised by faulty institutional systems.

These perspectives are vital and cannot be over-valued. But the staff is the other silenced voice, which occupy a strange liminal zone between the institution proper and patients. By focusing on the tragic stories of patients within the hospital system (a tragedy that is in no way fabricated, but all too real and often horrific) and excluding the reality of staff experience, Asylum narratives are able to position the battle of Insanity vs. Sanity as a strict dichotomy with a clear villain.

Strict dichotomies such as these lend themselves to mythologies of evil. The ruin mythology of *The Asylum*, as discussed in Chapter One, is particularly tricky because, as mentioned earlier in this chapter, there are synchronicities between the reality and the myth of large-scale mental institutions. We have explored the museum as a place and as an object, we have placed it within its larger context, but if we turn an affective, phenomenological, and psychoanalytic eye toward the previously discussed content, we can see the eerie narrative bleed between the museum and *The Asylum*.

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[31] David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (New Brunswick: Aldine Transaction, 2002), xx.

There are three motifs that *The Asylum* mythology and the museum have in common. These are ruined abandonment, uncanny haunting, and locked/inescapable/impenetrable boundaries. The museum feels like a found thing, some strange spatial artifact one might stumble upon after sneaking into an abandoned mental hospital. The space is empty and immense. Although administrative duties are being tended to a floor below and the Volunteer Services office is two floors above, the second floor feels like an empty, depopulated no-man's land. While working in the museum – taking photographs, looking through postcards, generally poking around to explore the space – I was always locked inside. I spent the majority of my time in the west room, but if I wanted to change sides of the hall (a trip that door to door would be no more than eight steps), I had to call McGraw to ask her to let me out and then lock me back up on the opposite side.

I was usually alone in there, locked away and forgotten for the afternoon. The feeling of being forgotten is not hyperbole. McGraw had admitted to me that she had, on occasion, forgotten people locked in the museum. I thought she was joking until a patient in the Volunteer Services office once asked me repeatedly if we were locked in (and whether I was going to lock him in), asserting that McGraw was always leaving people locked in the rooms of Old Main.

The museum was freezing cold in the winter because the institution did not want to waste the energy to heat its large and mostly unused space. I conducted winter research in full winter garb, sifting through photographs and records in a coat, scarf, hat, and mittens. Photographs of myself from when I was documenting the space show me in my winter coat, making the image feel as though I had discovered a long abandoned collection of oddities rather than an established, institutional museum (Fig. 4.27).

Of all of the museum's features, the mannequins were particularly disquieting. During the time I spent in the museum, I came upon a mannequin in green pajamas stuffed under a table, limbs akimbo, and a rogue mannequin hand lying nonchalantly on an antique dresser next to a pair of dapperly attired mannequins – all crammed into a closet (Figs. 4.28 and 4.29). These mannequins seemed to have the run of Old Main. In the basement there was a bucket of torsos with heads next to a shelf full of limbs (Figs. 4.30 and 4.31). The bathroom in the Volunteer Services office had three mannequins in the shower, their hip and leg portions standing on their own disconnected torsos (the discovery of which was a permanent lesson in why, despite compulsion, one should never look behind the shower curtain). It would not be a stretch to say that, on any given visit, I saw more mannequins than people.

The echoes of inhuman and uncanny mythology are everywhere in that place: the mannequins, the metal gurney in the hallway, the erosion of the physical structure, the frightening old elevator. Despite the best intentions, and a mindset distinctly against the fetishization of mental illness, it is difficult not to transfer mythological fear onto a human simulacrum that is lurking under a table when you are alone and locked in a freezing room with it. This is especially true when you know there are more of this kind behind the closet door and piled in various outposts throughout the building.

If the museum acts, in part, as a ward against this very mythology, how can we account for the narrative bleed between the two? The answer lies in that particular mindset of mental hospital employees. When I told McGraw how I had jumped and screamed at the discovery of the mannequin under the table, she laughed at me and at the obviousness of my response. She, and other employees, were well aware of the echoes of horror movies and fear narratives in the hospital at large and the museum specifically.

This is because those narratives arose from the disquieting affective experience of the real thing. There simply is no point in asserting that a mental hospital is not a weird place. It is. The key difference between Asylum narratives and the a real mental hospital is an acceptance that weird does not always equal evil.

The practices that are used in Asylum narratives to denote the crushing power of the institution or merely practical in a real institution. Locking people in rooms is standard practice in an operating mental hospital, saving energy by cutting the heat to rarely used rooms is an obvious way to help the budget, and mannequins are useful tools for the explanation of hospital living. The museum absorbs, appropriates, and owns its uncanny weirdness, its echo in the chambers of mythology.

The museum captures and embraces that weirdness, which is part of the personal experience of the place. To be a part of the staff of a mental hospital is to be witness to weirdness and to accept that it is an inherent part of the human condition. The museum does not dichotomously contradict Asylum narratives. It embraces them and offers a more complex and affective response to the mental institution, one that encourages empathy and acceptance rather than horror.

Conclusion

This dissertation has shown that the lived experience of place in the context of a mental institution is more complex and nuanced than representations of *The Asylum* in popular culture and scholarly discourse present. Through the progression of its chapters, from the mythic and over-arching landscape of *Asylum* discourse, to the concrete and small world of the SPRTC, this dissertation has illustrated the various ways in which these aspects overlap to produce the meaning of place and the definition of sanity. It has shown that *The Asylum* continues to be of interest to scholars and lay people alike because it serves a signifying purpose: demarcating the space of the sane from the insane.

Beginning with the origins of horror tropes in popular *Asylum* narratives, the first chapter explored the ways in which ruin—both physical and existential—lent an unnatural agency to mental hospital buildings. By closely examining the video game *Outlast* and the ruinous photos of Payne's book, *Asylums,* the first chapter of this dissertation explored the idea of the haunted house and its relationship to the uncanny. It questioned the ways in which a similar kind of agency was utilized in the case of the mental hospital as a means to bound mental illness in the signifier of *The Asylum.* The purpose of this agential attribution was a way to combat contagion anxiety— the existential fear of being infected by mental illness—which prevailed when locations of treatment, and therefore mental illness itself became less visible.

The following chapters of this dissertation offered a foil to this over-simplified narrative by examining the SPRTC as a microhistorical example of a typical mental hospital of the nineteenth and twentieth centuries. By engaging in the deeply personal, these chapters addressed the issues of ruin, contagion anxiety, boundary, and the meaning of community and memory in

the context of a mental hospital. In turn, they offered arguments opposing the historical tyranny of the deinstitutional narrative.

The second chapter of this dissertation examined the history of the original building at the SPRTC and the intertwined relationship between the town of St. Peter and the institution. In many ways, the original building at the SPRTC was a textbook example of 19th century mental hospital design and function. Based on the theories of the alienist Kirkbride and executed by the preeminent mental hospital architect, Sloan, the building and the grounds conformed to all the prescriptions of moral treatment. As the chapter shows, prescription and lived reality often differ. Although moral treatment stated that the institution should be its own world, separate from its surroundings, that was not the case at the SPRTC. Relationships between the hospital and the town were fluid, and although the SPRTC existed as a community in its own right, the two were in constant contact and socially overlapping. A great many people from St. Peter were employed at the hospital over the course of its history and individuals from the town regularly used recreational spaces on the SPRTC campus. Similarly, patients with liberty were often in town.

The third chapter continued a critique of labeling the mental hospital as total or complete and austere by offering a different view of patient place-making and community building within the confines of a so-called total institution. By looking critically at the patient built architecture on the SPRTC campus, this chapter disrupts the deinstitutional narratives of the 60s and 80s that asserted that the ersatz nature of mental hospital communities were inherently detrimental to the well-being of patients. This chapter highlighted the fact that these narratives were made possible only by the invention of psychotropic medications and their availability for treatment in the 60s.

By fixating on the illusion of progress, the deinstitutionalization movement perpetrated the erasure of previous treatment, which was, by necessity, grounded in the production of

community. That community, of course, was largely produced by the institution itself in the form of regular routines—as far as they could be applied to an irregular population. However, the patient built architecture—the shacks—illustrates that, although encompassed by the institutional landscape, patients were capable of producing their own individual places and complex communities. These buildings reflect an agency on the part of patients that exceeds what was "allowed" or "produced" by the institution itself.

The meaning of place at the SPRTC is denser than merely an institutional or prescriptive attribution. The final chapter of this dissertation further examined the meaning of place, from the perspective of employees at the SPRTC, by engaging with the institution's on-site museum. This chapter grappled with issues of memory and history and what it means to maintain the personal in the face of narratives that aim to contort and erase it. While maintaining memory and history are not unique to the SPRTC, it is unique in the state of Minnesota as the last institution that keeps a museum dedicated to both on site.

The museum, created in 1966 for the centennial celebration of the SPRTC and in the midst of deinstitutionalization's growing fervor, attempts to depict the average life of a patient in the institution. It does this through a variety of installations that show everyday life at the SPRTC, including treatments, sleeping arrangements, and a variety of therapies from the inception of the hospital to the present day. The museum is particularly interesting in that it does not stand in direct opposition to ruinous *Asylum* narratives, but instead embraces them and makes them its own. The reality of spending time in a mental hospital is a reality of weirdness—the very same weirdness that eventually gave rise to the tropes found in horror movies, video games, and television shows that take as their focus the mental hospital.

Although it depicts life for patients, the museum primarily belongs to the staff as a tool for understanding their place in the SPRTC's history and preserving their memory in the narrative of the new in-community care paradigm. The voice of staff particularly important because the staff of mental hospitals is almost always erased from scholarly discourse on the mental hospital—seen merely as extensions of the institution—or made into mindless monsters in cultural productions. Focusing on their production of memory and history allows for another understanding of the mental hospital institution to become visible.

The central purpose of this dissertation, embodied by an intimate microhistory of the SPRTC, is to make visible the highly personal narratives that counter or absorb the ruinous horror of *The Asylum*. So much of the fetishization of mental hospitals is rooted in the invisible—from the horror of *Outlast* to the mythic totalitarian and difficult to breach image of asylums produced by Grob, Goffman, and Foucault—that it is necessary to shed light on what is so often left out: the deeply personal. There are human experiences, even within the routine of the institutional, that complicate interpretations of meaning and impact. It is far easier to apprehend the institutional, to determine the meaning of a place such as a mental hospital, when the personal is erased or neglected. By focusing on the personal rather than the purely institutional, it is possible to challenge the notion that a mental hospital is an efficient machine, bent on domination and destruction.

The shift in focus to the personal also moves toward an analysis that functions without giving undue agency to the building in which the mental hospital was housed. While the history of these buildings—with their emphasis on design as a means for a cure—lends itself to fetishization of the architecture itself, it is vital to remember the difference between lofty utopian goals and the reality of the built environment. The building is just a building. Nothing more.

It is the argument of this dissertation that the fetishization of this mythic building is precisely what has diverted attention away from what replaced it: the dispersed in community-care system. This system is far less visible than *The Asylum* and thus escapes architectural and theoretical analyses, as well as the wild imaginaries of popular culture.

Examining the relationship between the mythic *Asylum* and the densely lived place of the SPRTC allows us the opportunity to identify and upset the myth of progress inherent in the deinstitutionalization movement's narrative. This narrative, which dismantled the institutional care system and replaced it with the in-community care system, is ingrained in the majority of discourse concerning the mental hospital.[1] *The Asylum* still looms large—despite the fact that institutional care of that sort has not existed for at least forty years—simply due to the invisibility lent to the in-community care system. Complicating our understanding of the current in-community care system requires an evaluation of the cultural history of mental illness in the United States. As this dissertation has shown, this history was shaped by both specialist and non-specialist discourse.

In the rush to condemn large scale mental institutions, their replacement has been inherently accepted as "progress" and therefore superior. However, the in-community care system is not succeeding in a way that puts the old mental institutions to shame. On the contrary, in-community care is under severe stress and appears to be failing to meet the needs of people it was meant to save from institutional life. As of 2009, it was estimated that 20 to 25% of the homeless population in the United States suffered from at least one form of severe mental illness

[1] Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press), 1991.The general outrage at the asylum system can be seen in the rise of civil rights movement's impact on practices on hospital campuses in the 1960s and the creation of the National Alliance for Mental Illness (NAMI) in 1979.

and mental illness was considered the third largest cause of homelessness for adults.[2] Clinical studies illustrate that 6 to 15% of people in city and county jails and 10 to 15% of individuals in state prisons suffer from severe mental illness. It is important to note that prison studies focus on severe mental illnesses and the percentages would rise greatly if minor illnesses, such as anxiety and addictive disorders were included in these calculations. [3]

This is not a utopia. It is a failure of a more invisible sort than what it replaced. It remains invisible because it lies in the shadow of myth thrown by institutional care and all the discourse that surrounds it. By dismantling the myth of *The Asylum*, this dissertation offers us a route through which to approach the in-community care system, its spaces, its places, and its people. This is an important avenue to pursue because, despite what the myths may want us to believe, the end of *The Asylum* was not the end of mental illness. I would like to believe that, in the end, it is the human beings we care about—not the buildings, not the fetishizing attempts to prove our own sanity—simply the human beings. That, if even in the midst of the institution there existed these small gestures to the human, there remains that possibility for care, out here, as the Joker would say, in the *Asylum.*

[2] National Coalition for the Homeless website: www.nationalhomeless.org. Last visited 11/14/2011.
[3] Richard H Lamb. and Linda E. Weinberger, "Persons with Severe Mental Illness in Jails and Prisons: A Review" *Psychiatric Services* Vol. 49: 483-492, April 1998.

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Image List

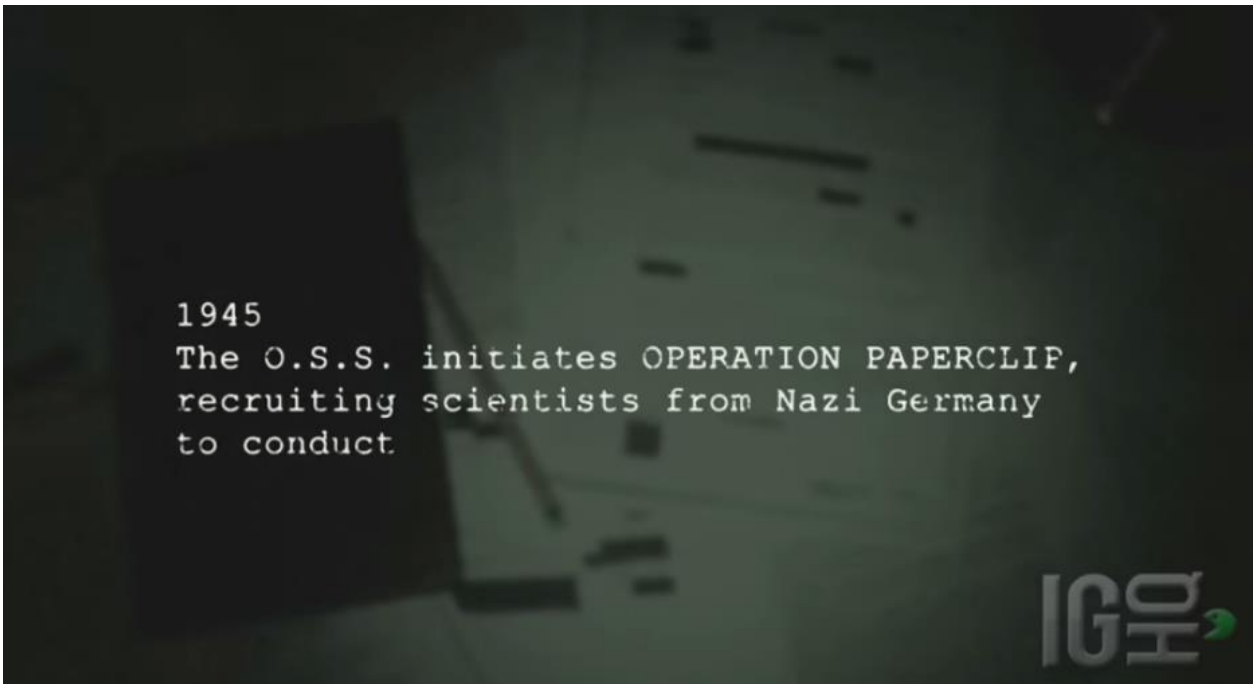

Figure I1. *Outlast* trailer, published by Red Barrels Production Company, distributed by Indie Game HQ October 31, 2012. (Image courtesy of Red Barrels Production Company).

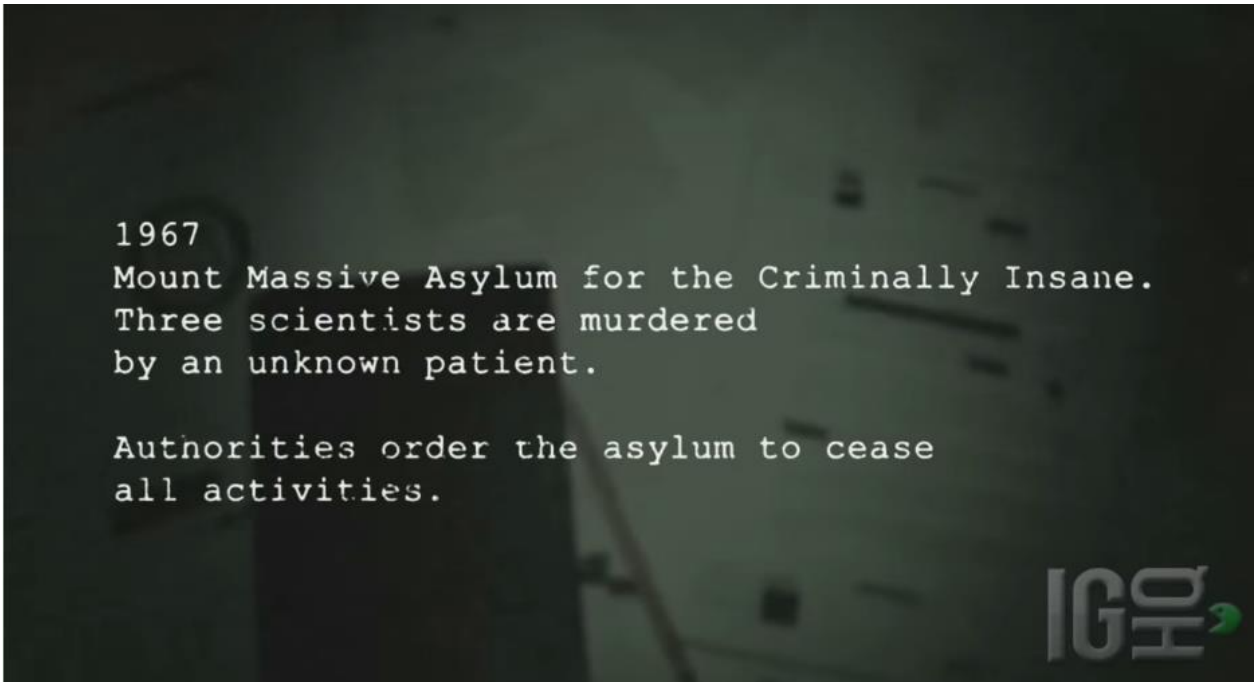

Figure I2. *Outlast* trailer, published by Red Barrels Production Company, distributed by Indie Game HQ October 31, 2012. (Image courtesy of Red Barrels Production Company).

Figure I3. *Outlast* trailer, published by Red Barrels Production Company, distributed by Indie Game HQ October 31, 2012. (Image courtesy of Red Barrels Production Company).

Figure I4. *Outlast* trailer, published by Red Barrels Production Company, distributed by Indie Game HQ October 31, 2012. (Image courtesy of Red Barrels Production Company).

Figure I5. *Outlast* trailer, published by Red Barrels Production Company, distributed by Indie Game HQ October 31, 2012. (Image courtesy of Red Barrels Production Company).

Figure I6. The earliest image of the hospital, taken in 1876. (Image courtesy of the University Archives at Minnesota State University, Mankato.

Figure 1.1. Night vision in *Outlast.* (Image Courtesy of Red Barrels Production Company)

Figure 1.2. Blood splatter "breadcrumb" mechanic in *Outlast.* (Image Courtesy of Red Barrels Production Company)

Figure 1.3. "Follow the Blood" down the drain in *Outlast.* (Image Courtesy of Red Barrels Production Company)

Figure 1.4. Christopher Payne, "Patient toothbrushes, Hudson River State Hospital, Poughkeepsie, New York." (Image courtesy of Christopher Payne)

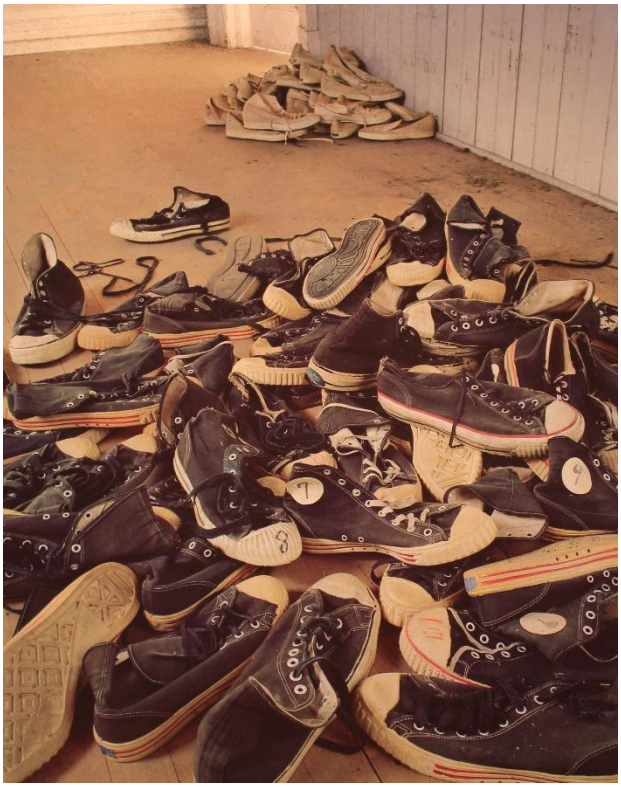

Figure 1.5. Christopher Payne, "Men's and Women's gym sneakers, Wernersville State Hospital, Wernersville, PA." (Image courtesy of Christopher Payne)

Figure 1.6. Christopher Payne, "Gymnasium, Harlem Valley State Hospital, Wingdale, New York ." (Image courtesy of Christopher Payne)

Figure 1.7. Christopher Payne, "Patient Suitcases in ward attic, Bolivar State Hospital, Bolivar, Tennessee" (Image courtesy of Christopher Payne)

Figure 1.8. Mount Massive in *Outlast.* (Image courtesy of Red Barrels Production Company)

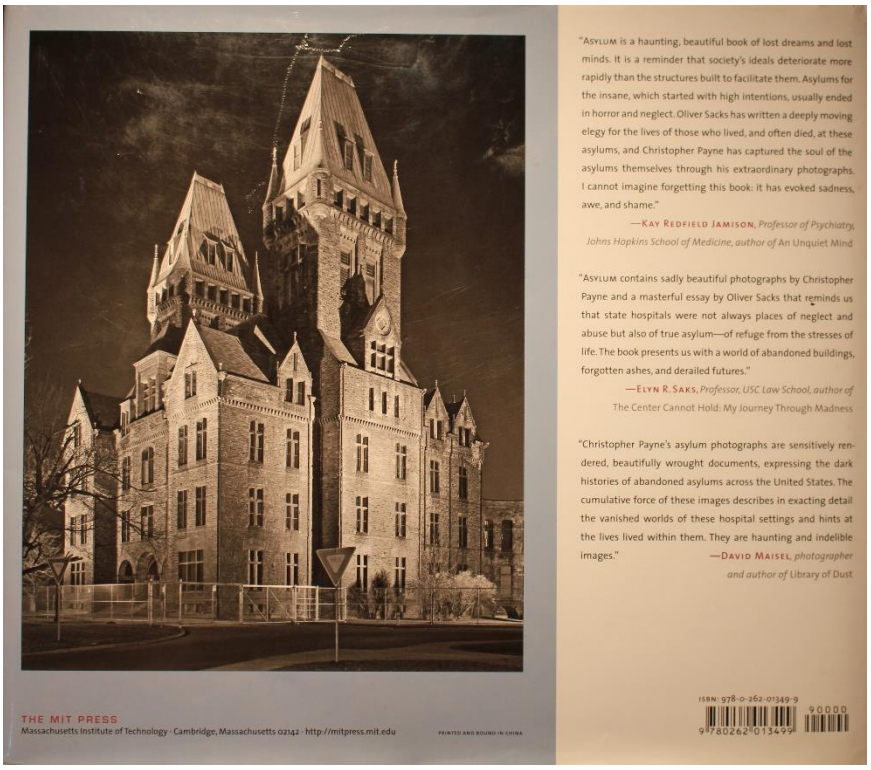

Figure 1.9. Back cover of Christopher Payne's book, *Asylums: Inside the Closed World of State Mental Hospitals.* (Image courtesy of Christopher Payne)


Figure 2.1. Downtown St. Peter

Figure 2.2. Entrance to the SPRTC

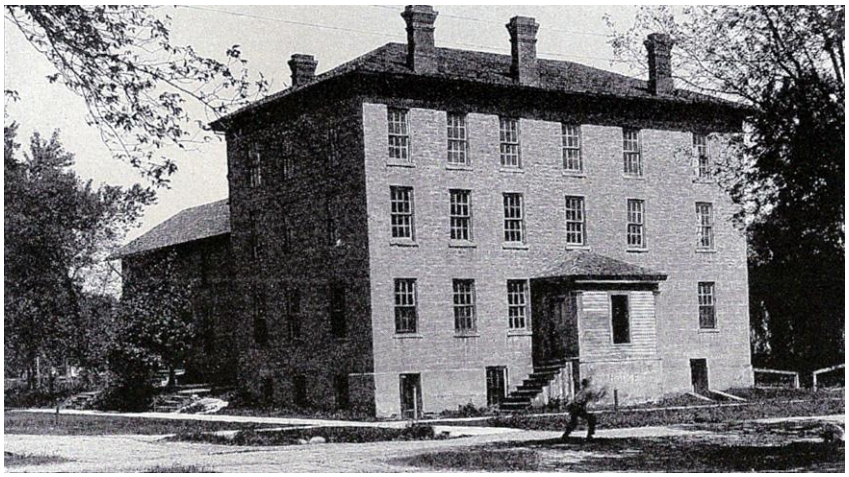
Figure 2.3. Ewing Hotel, date unknown
(Image courtesy of *Reflections of the Minnesota River Valley*)

Figure 2.4. Ewing Hotel, now being used as an apartment building.
(Photo by the author, 2008)

Figure 2.5. The earliest image of the hospital, taken in 1876. (Image courtesy of the University Archives at Minnesota State University, Mankato.)

Figure 2.6. An aerial view of the campus, taken in 1954. The linear plan hospital can be seen surrounded by trees in the middle left area. (Image courtesy of the University Archives at Minnesota State University, Mankato.)

Figure 2.7. An aerial view of the campus, taken from the south-east, circa 1980. The Flats (or wings) have been torn down and the center main can be seen in the top middle, towards the right side. (Image courtesy of the St. Peter Regional Treatment Center Museum collection)

Figure 2.8. Alabama Hospital for the Insane at Tuscaloosa, date unknown.

Figure 2.9. Kalamazoo State Hospital in Michigan, date unknown.
(Image courtesy of Western Michigan University)

Figure 2.10. New Jersey State Lunatic Asylum, also known as Greystone, date unknown.

Figure 2.11. Central Indiana's Hospital for the Insane, date unknown.

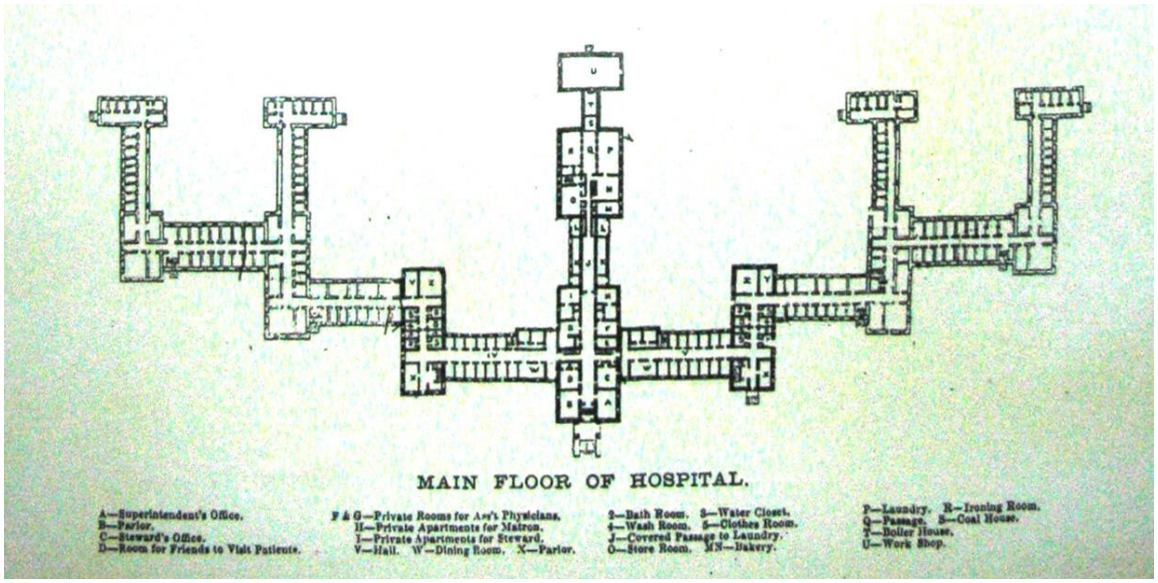

Figure 2.12. Sloan's original design of the St. Peter Hospital for the Insane.
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

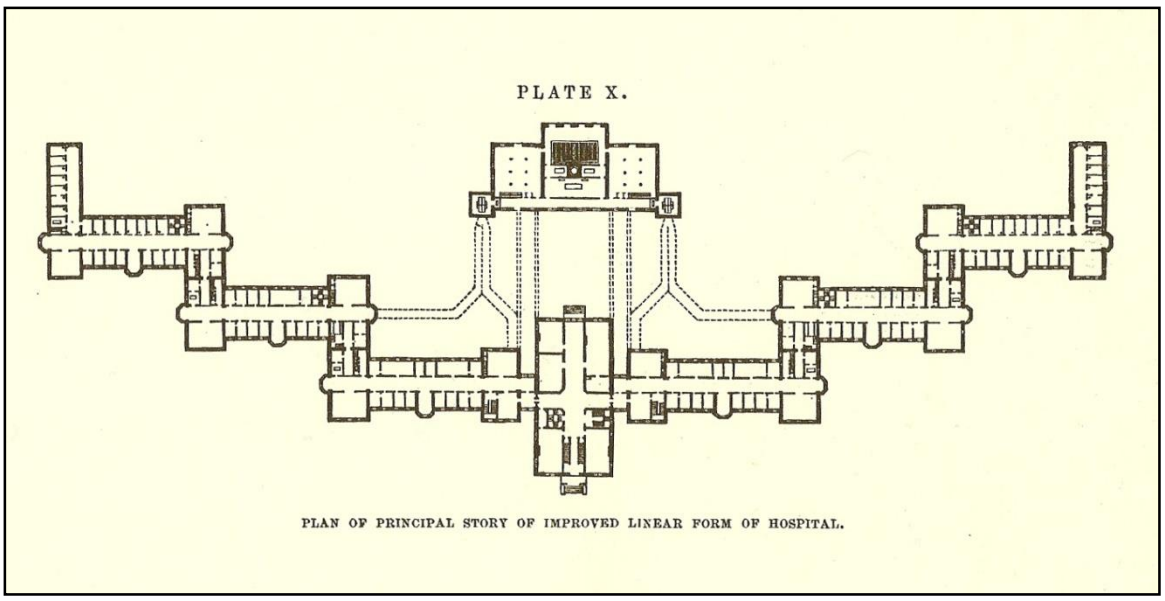

Figure 2.13. Improved Principle Story
(From Thomas Story Kirkbride's *On the Construction, Organization, and General Arrangements of Hospitals for the Insane*, p. 163).

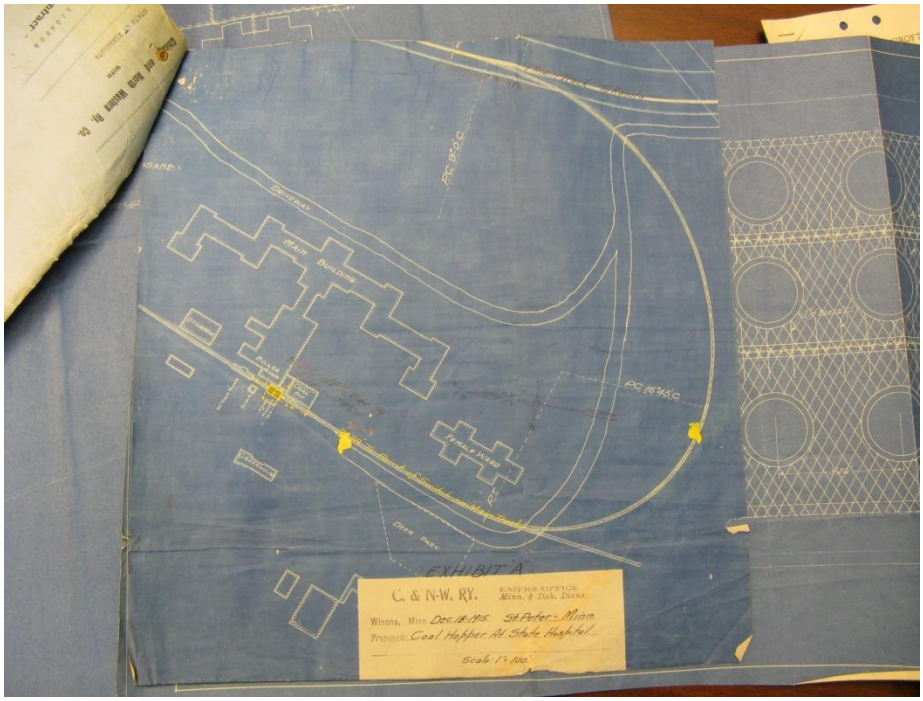

Figure 2.14. Blueprint for the construction of the coal-hopper in 1915.
(Photo by the author, 2008. Blueprint courtesy of the University Archives at Minnesota State University, Mankato.)

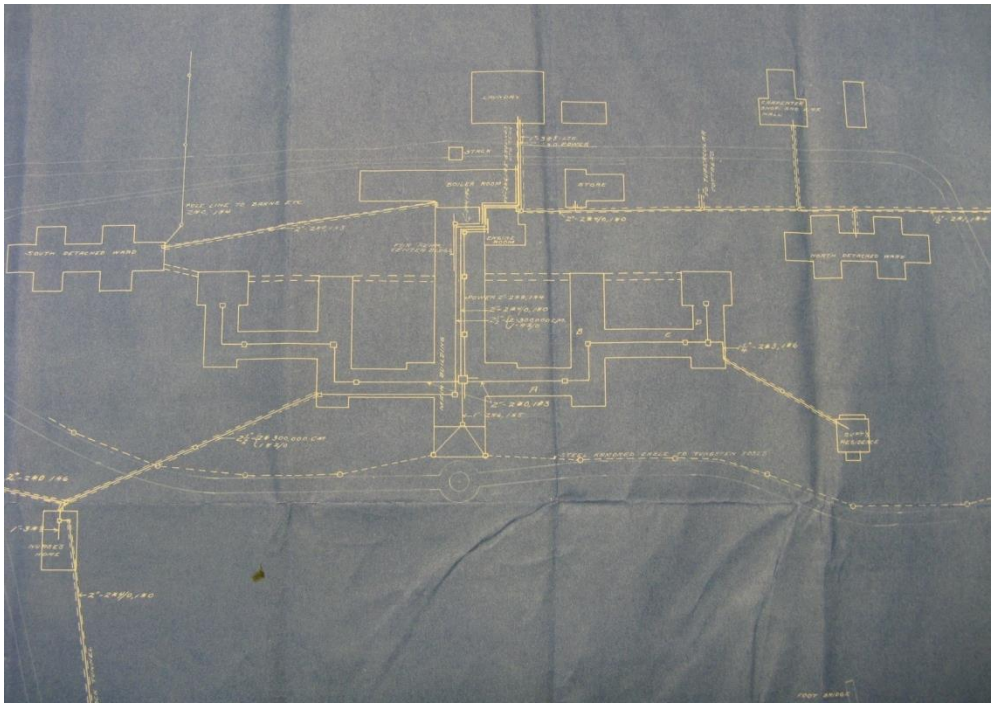

Figure 2.15. Blueprint for the electrical wiring of the linear plan hospital.
(Photo by the author, 2008. Blueprint courtesy of the University Archives at Minnesota State University, Mankato.)

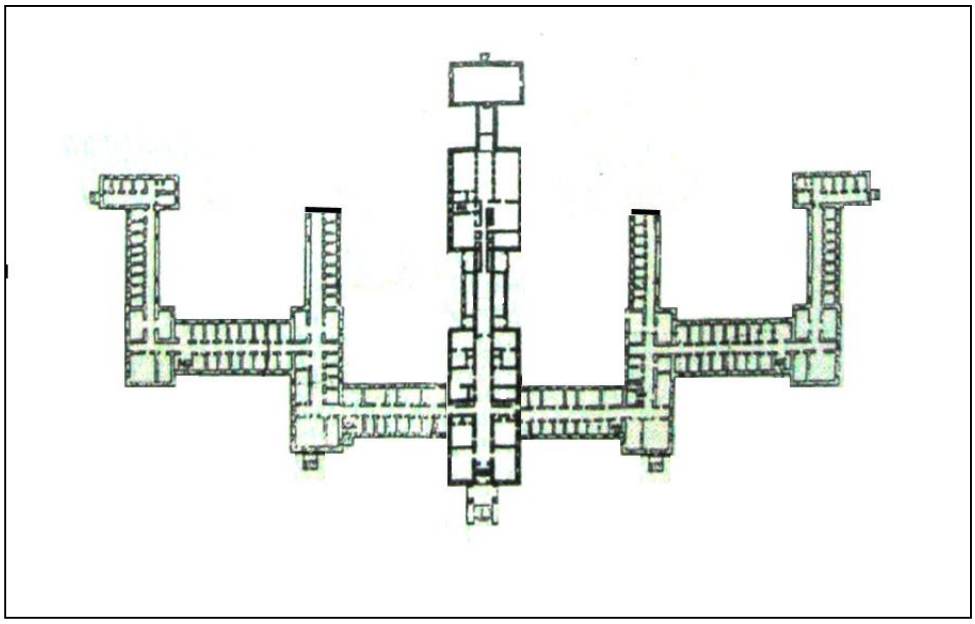

Figure 2.16. Reconstructed image of the final plan
(Design by the author)

Figure 2.17. The door in Old Main that once led to the southern ward,
also known as South Flat. The false ceiling can be seen cutting off the top of the window.
(Photo by the author, 2007)

Figure 2.18. The auditorium of the hospital.
(Photo courtesy of the Minnesota Digital Library, Minnesota Reflections website,
http://reflections.mndigital.org/index.php)

Figure 2.19. The operating room on the fourth floor of Center Main, circa 1920.
(Image courtesy of the St. Peter Regional Treatment Center Museum collection)

Figure 2.20. Originally the superintendents office, this room has been remodeled in 2008 to serve as office space for administration. The wall on the left side of the room was a previous addition, but it is unknown in what year it was put up. The door, doorframe, and glass panes are original.
(Photo by the author, 2008)

Figure 2.21. Originally the parlor for visitors, this room has been remodeled in 2008 to serve as a meeting room. The false ceiling is newly installed and conceals a ceiling of at least two feet more in height.
(Photo by the author, 2008)

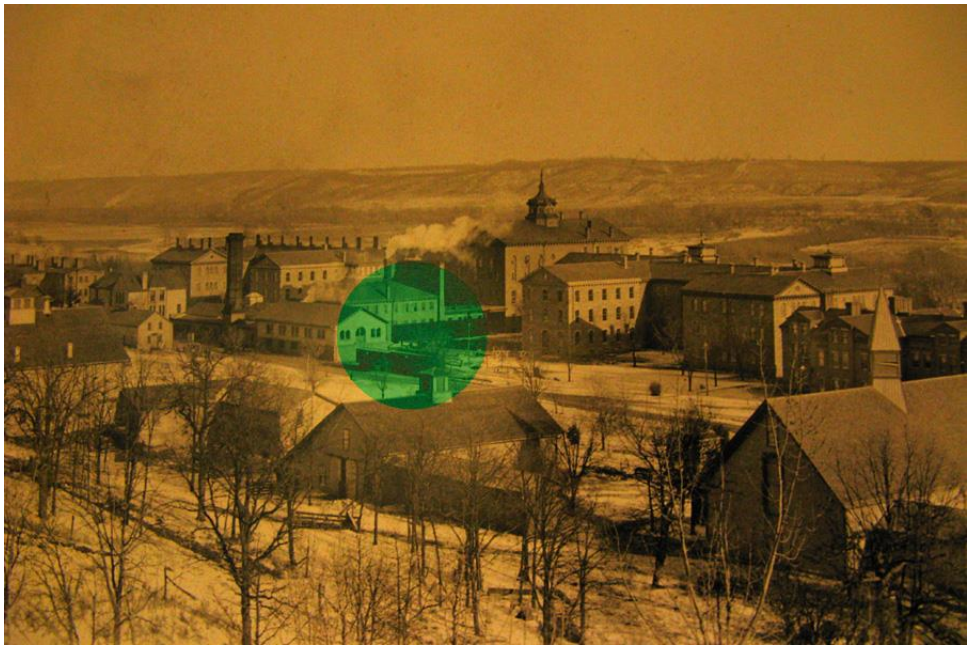

Figure 2.22. Back of Main, location of the train stop
(Image courtesy of the St. Peter Regional Treatment Center Museum collection, modifications by the author)

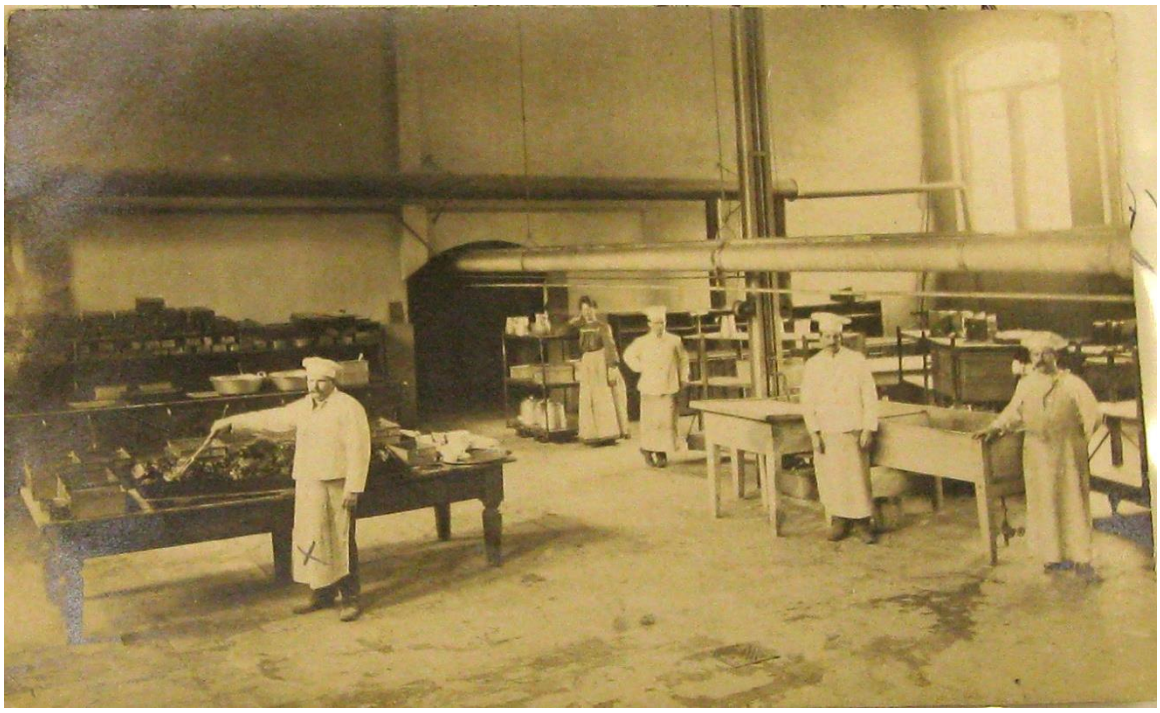

Figure 2.23. Main Kitchen in the basement of Center Main. The large black doorway in the back of the room leads into the tunnels.
(Image courtesy of the University Archives at Minnesota State University, Mankato.)

Figure 2.24. Looking down what used to be the hallway of the North Flat, 1880.
(Image courtesy of the Minnesota Digital Library, Minnesota Reflections website, http://reflections.mndigital.org/index.php)

Figure 2.25. The hospital, from the north-east, 1880. You can see how the shell of the building remains while the roof and the interior have been burned away.
(Image courtesy of the University Archives at Minnesota State University, Mankato.)

Figure 2.26. The framing of the roof of the Center Main.
The roofs of the Flats were constructed with the same materials.
(Photo by the author, 2007)

Figure 2.27. Separation of Flats from Main, circa 1910
(Photo courtesy of the St. Peter Regional Treatment Center Museum Collection)

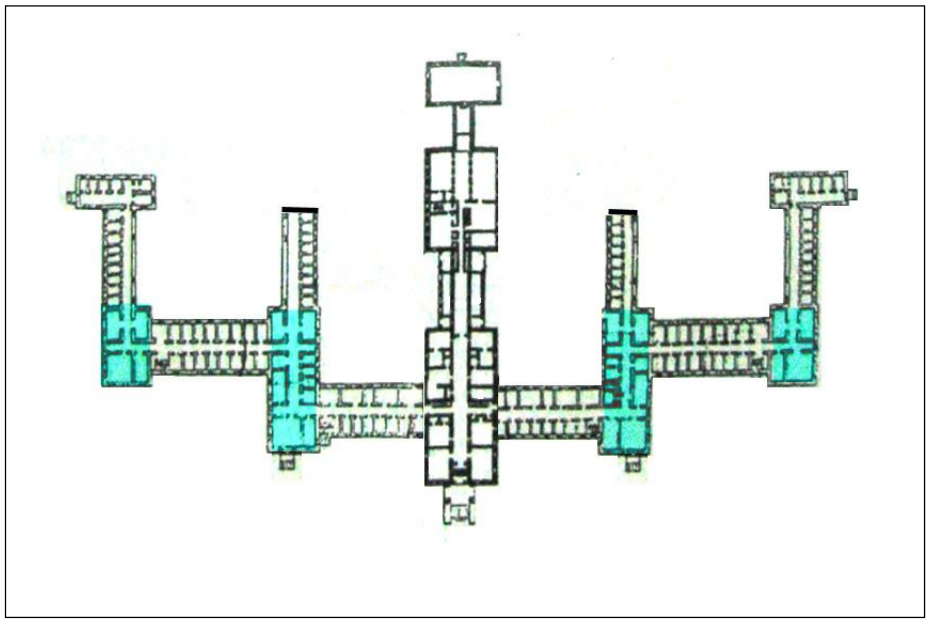

Figure 2.28. Functional rooms at the end of wards
(Drawing by the author)

Figure 2.29. Lower Flat South, 1893.
(Image courtesy of the University Archives at Minnesota State University, Mankato.)

Figure 2.30. Lower Flat North, looking south, toward the doorway
to Old Main. Date unknown.
(Image courtesy of the University Archives at Minnesota State University, Mankato.)

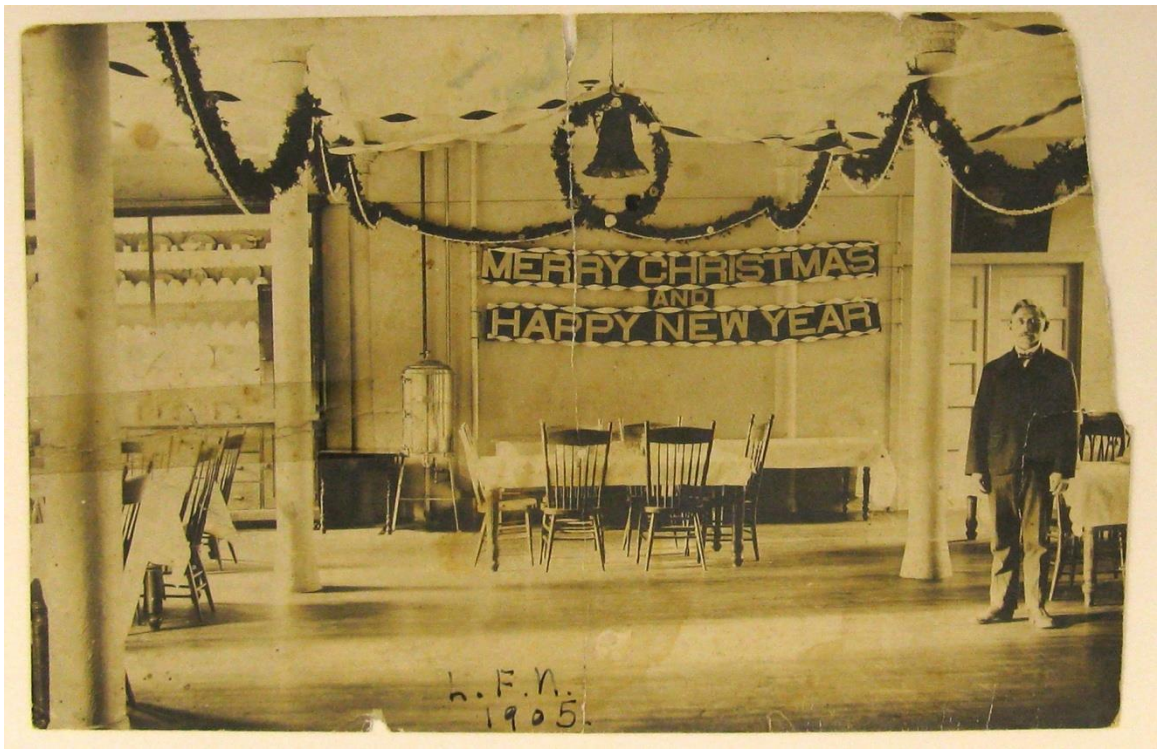

Figure 2.31. Dining hall of Lower Flat North, 1905.
(Image courtesy of the University Archives at Minnesota State University, Mankato.)

Figure 2.32. Dining hall of Lower Flat North, circa 1910.
(Image courtesy of the Minnesota Digital Library, Minnesota Reflections website, http://reflections.mndigital.org/index.php)

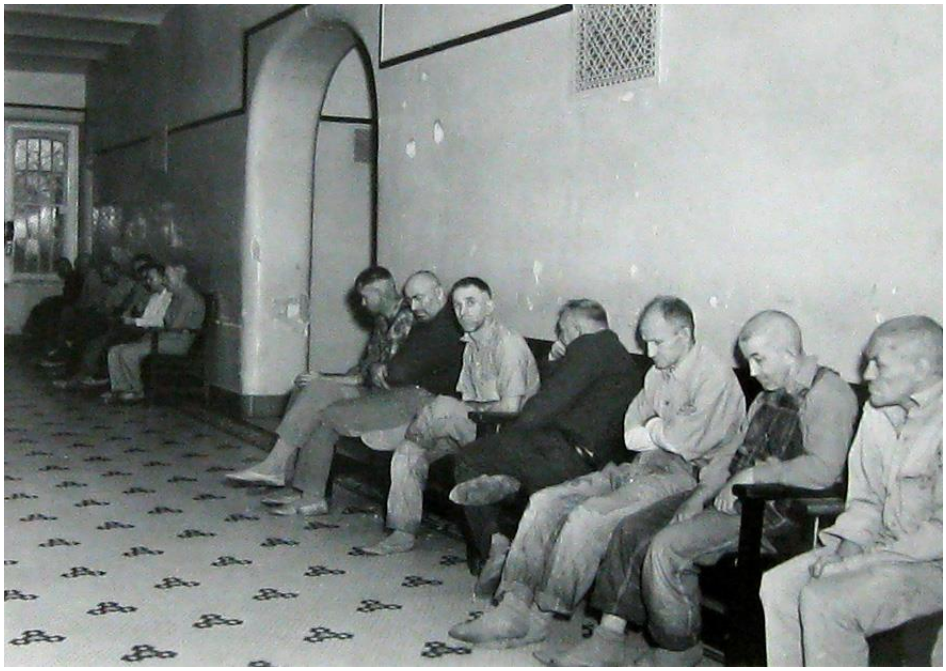

Figure 2.33. Upper Flat North, Third Hall. Date unknown.
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

Figure 2.34. Upper Flat South, Third Hall. Date unknown.
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

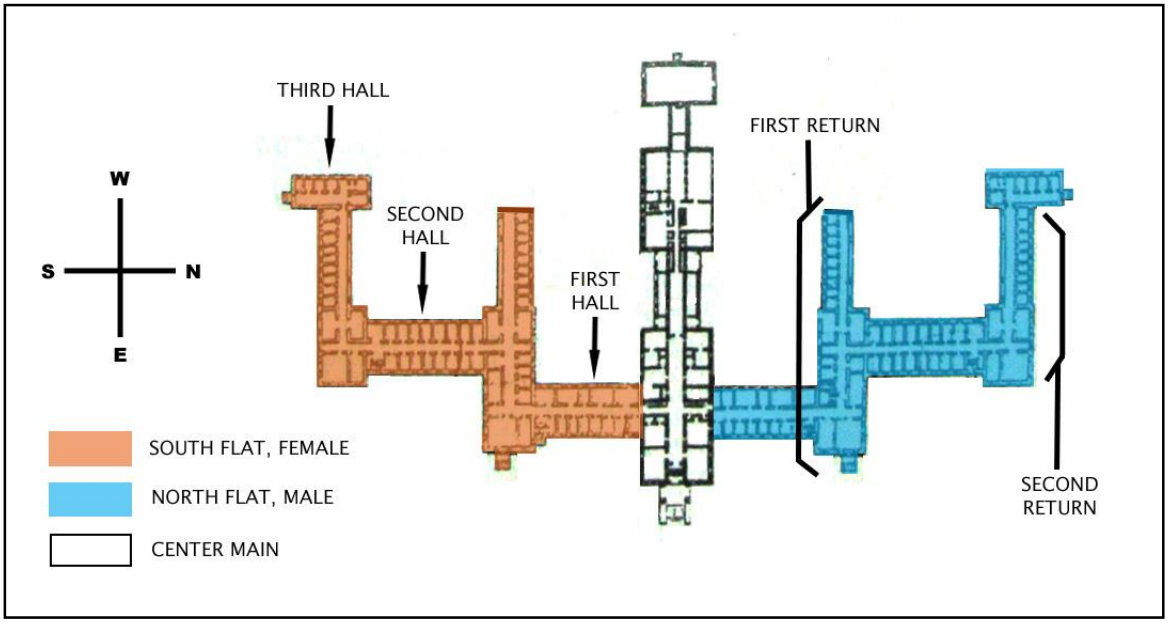

Figure 2.35. Reconstructed design, by the author. 2008

Figure 2.36. Utility tunnel running east and west beneath Center Main. The end of this tunnel connects to the higher level common tunnels that run north and south.
(Photo by the author, 2007)

Figure 2.37. The SPRTC Auditorium
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

Figure 2.38. The SPRTC Auditorium
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

Figure 2.39. The SPRTC Auditorium exterior, shown in its relation to Old Main, pictured at left, circa 1960. (Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

Figure 4.40. Library Days on the lawn, circa 1960.
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

Figure 2.40. Library Days on the lawn, circa 1960
(Image courtesy of the St. Peter Regional Treatment Center Museum Collection)

Figure 3.1. Earl's shack. Photo by the author, 2010.

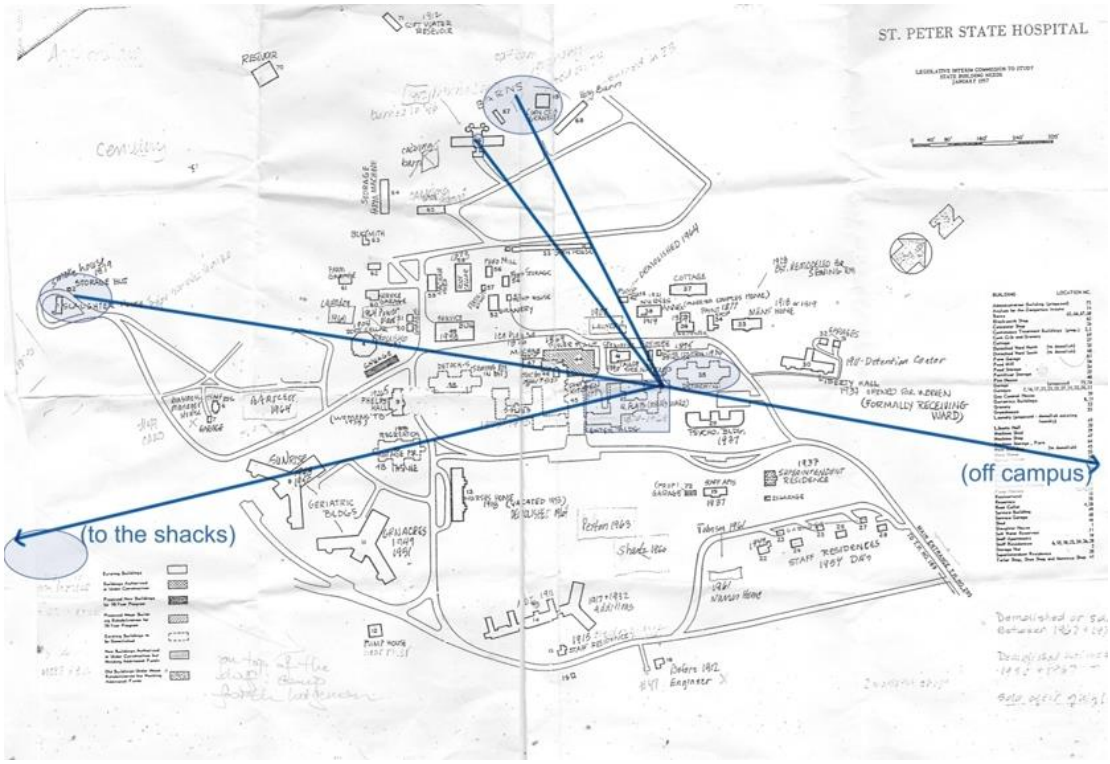

Figure 3.2. Map of Male Patient interaction with the SPRTC campus. (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum Collection, diagram by author)

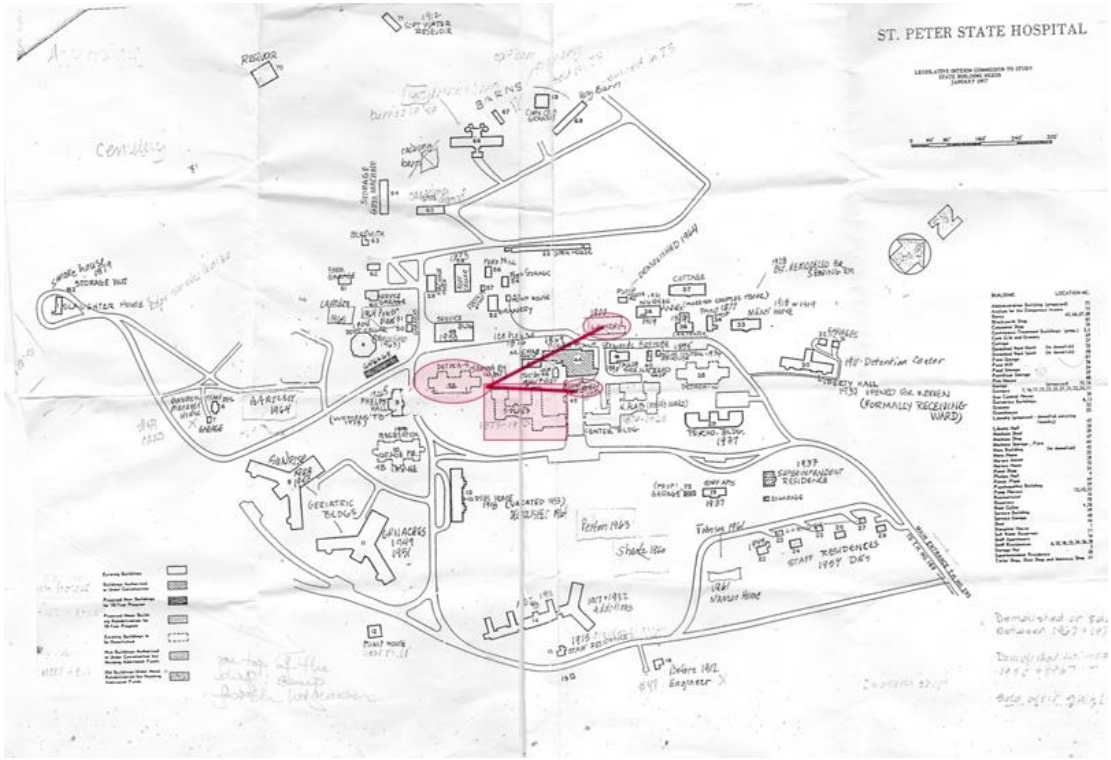

Figure 3.3. Map of Female Patient interaction with the SPRTC campus. (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum Collection, diagram by author).

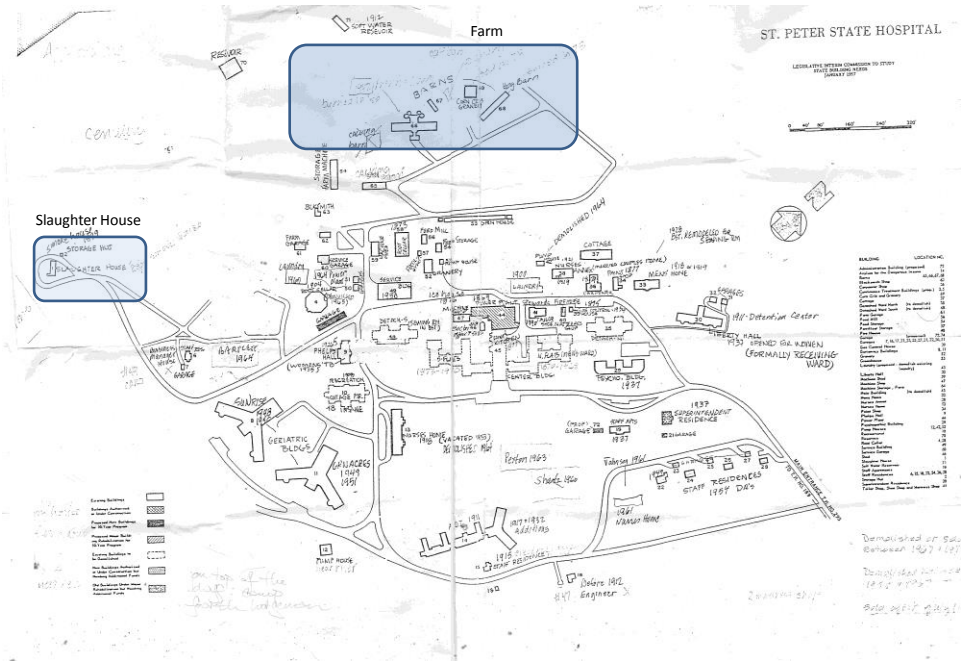

Figure 3.4. . Map of Slaughterhouse and Farm on the SPRTC campus. (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum Collection, diagram by author).

Figure 3.5. An aerial view of the campus, taken in 1954 (Image courtesy of the Minnesota Historical Society).

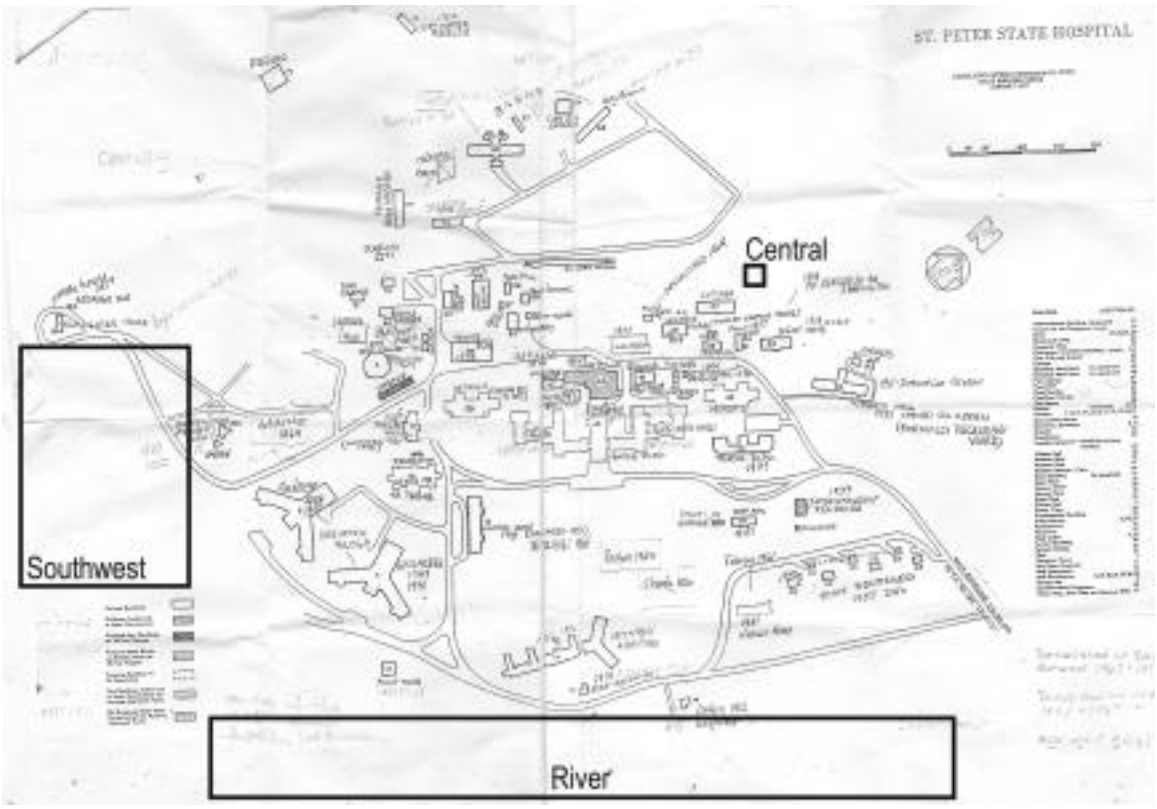

Figure 3.6. Locations of shack communities (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum Collection, diagram by author).

Figure 3.7. Patient constructed shack, date unknown (Image courtesy of the St. Peter Regional Treatment Center Museum).

Figure 3.8. Patient constructed shack, date unknown (Image courtesy of the St. Peter Regional Treatment Center Museum).

Figure 3.9. Patient constructed shacks, date unknown (Image courtesy of the St. Peter Regional Treatment Center Museum).

Figure 3.10. Patient constructed shack, date unknown (Image courtesy of the St. Peter Regional Treatment Center Museum).

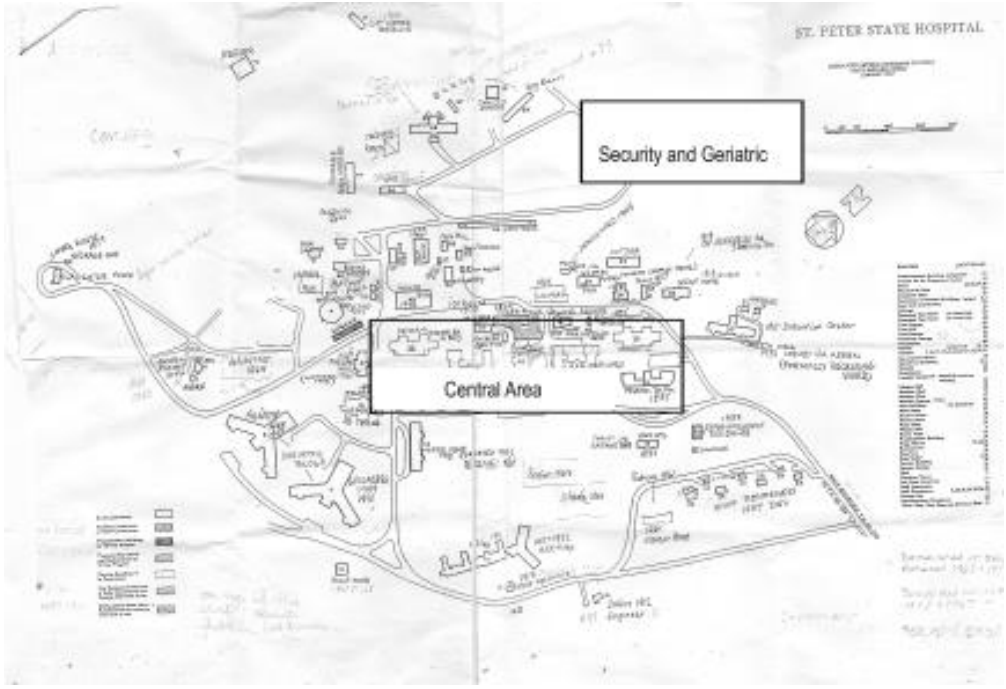

Figure 3.11. Locations of the central area, security hospital, and geriatric building (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum, diagram by author).

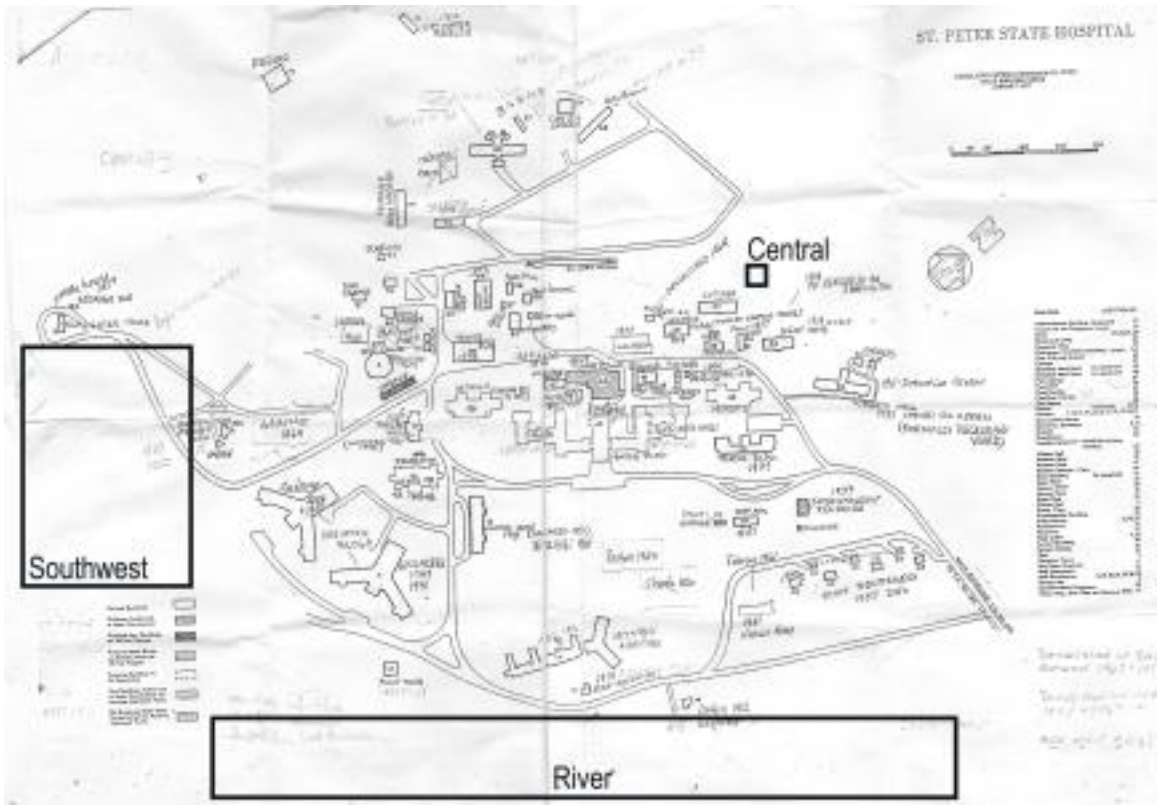

Figure 3.12. Locations of shack communities (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum, diagram by author).

Figure 3.13. Shack Remains in the Southwestern area (Photo by the author, 2010).

Figure 3.14. Wire mesh window in Southwestern shack (Photo by the author, 2010).

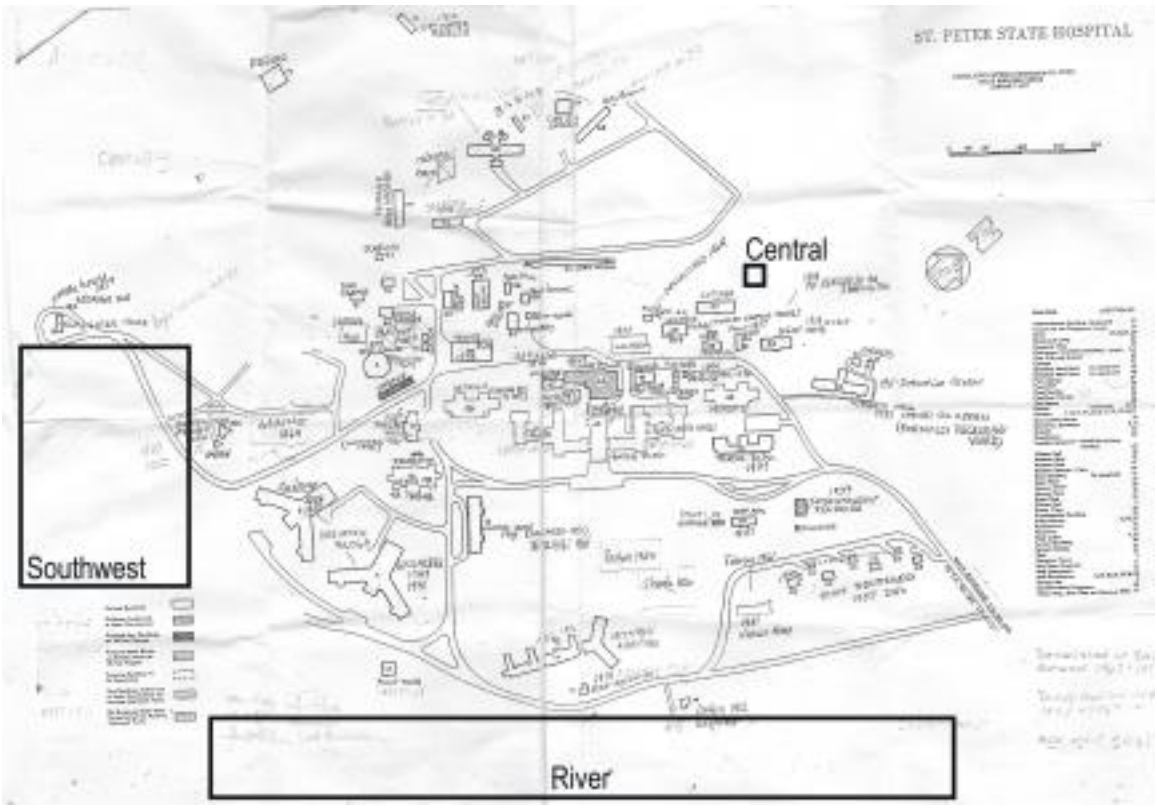

Figure 3.15. Locations of shack communities (Map, 1957, courtesy of the St. Peter Regional Treatment Center Museum, diagram by author).

Figure 3.16. Run-off stream (on the lower left) and pole gate leading to the Central shack (middle right) (Photo by the author, 2010).

Figure 3.17. Pole gate leading to the central shack (Photo by the author, 2010).

Figure 3.18. Overhang design (Photo by the author, 2010).

Figure 3.19. Landscaping near the front of the shack (Photo by the author, 2010).

Figure 3.20. Shack door detail (Photo by the author, 2010).

Figure 3.21. Ceiling/roof support inside Earl's shack (Photo by the author, 2010).

Figure 3.22. Earl's decorative landscaping near the stream (Photo by the author, 2010).

Figure 4.1. Demolition of the South Flat, 1967. (Photo courtesy of the St. Peter Regional Treatment Center Museum).

Figure 4.2. The Old Main next to the demolition of the Flats, 1967. (Photo courtesy of the St. Peter Regional Treatment Center Museum).

Figure 4.3. Door to the South Flat. (Photograph by author, 2010).

Figure 4.4. The Otis elevator at the SPRTC. (Photograph by author, 2010).

Figure 4.5. The hallway outside the museum at the SPRTC. (Photograph by author, 2010).

Figure 4.6. Display depicting the campus at the SPRTC museum. (Photograph by author, 2010).

Figure 4.7. Door (inside) in the SPRTC Museum that used to be an entrance to the library. (Photograph by author, 2010).

Figure 4.8. Door (Outside) in the SPRTC Museum that used to be an entrance to the library. (Photograph by author, 2010).

Figure 4.9. Steward's safe at the SPRTC museum. (Photograph by author, 2010).

Figure 4.10. Timelines and Photographs from the SPRTC Museum. (Photograph by author, 2010).

Figure 4.11. "Entrance, Typical State Hospital," from the SPRTC museum. (Photograph by author, 2010).

Figure 4.12. Mannequin in the admission's bath. (Photograph by author, 2010).

Figure 4.13. Depiction of the baths from the SPRTC museum. (Photograph by author, 2010).

Figure 4.14. Medical cabinet and information podium from the SPRTC museum. (Photograph by author, 2010).

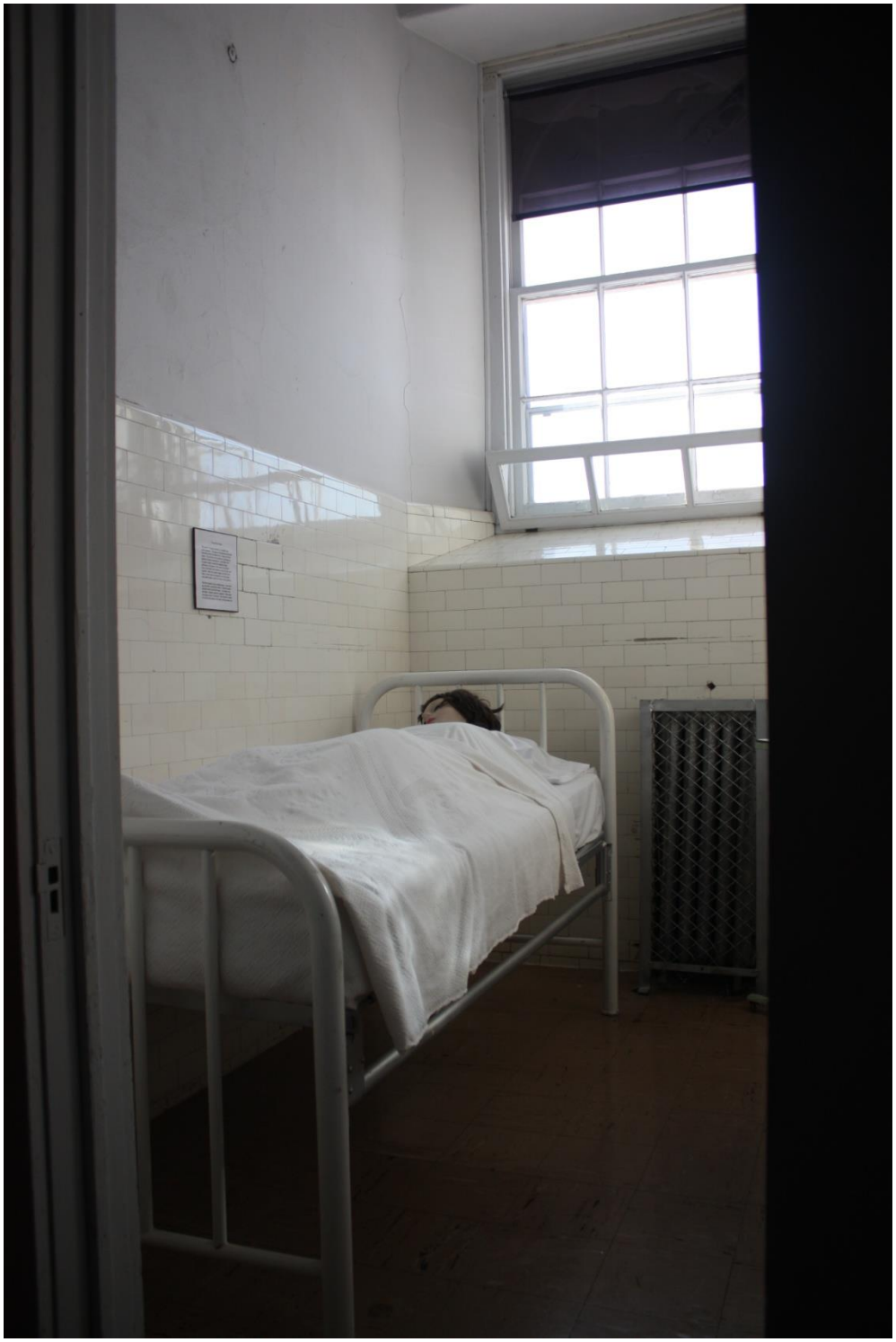

Figure 4.15. Typical treatment room from the SPRTC museum. (Photograph by author, 2010).

Figure 4.16. Display of wrapping procedure from the SPRTC museum. (Photograph by author, 2010).

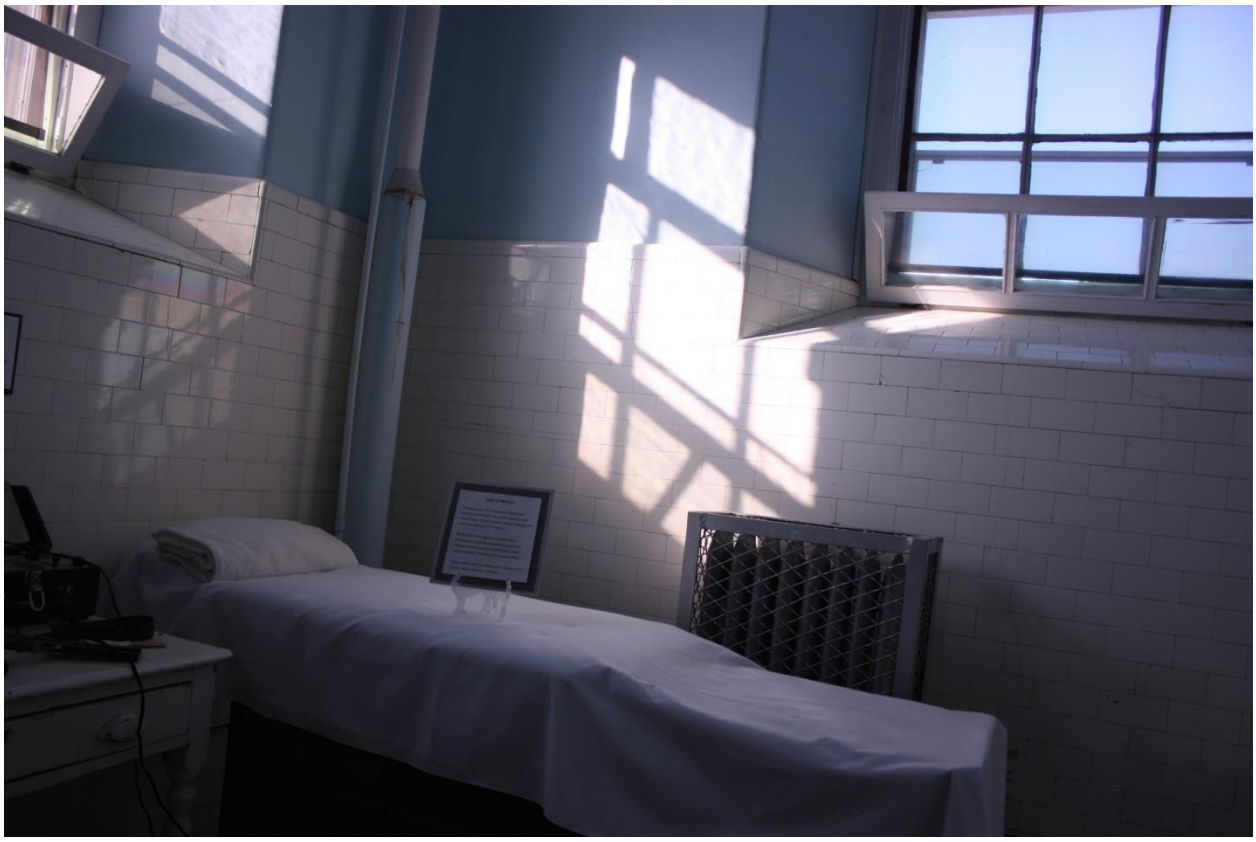

Figure 4.17. ECT room from the SPRTC museum. (Photograph by author, 2010).

Figure 4.18. The restraint room from the SPRTC museum. (Photograph by author, 2010).

Figure 4.19. The restraint room from the SPRTC museum. (Photograph by author, 2010).

Figure 4.20. Men's and women's occupational therapies, photos are of the kitchens and the farm, from the SPRTC museum. (Photograph by author, 2010).

Figure 4.21. Women's occupational therapies, photos are of the kitchens, from the SPRTC museum. (Photograph by author, 2010).

Figure 4.22. Sport recreational therapy from the SPRTC museum. (Photograph by author, 2010).

Figure 4.23. Arts recreational therapy from the SPRTC museum. (Photograph by author, 2010).

Figure 4.24. The Pharmacy from the SPRTC museum. (Photograph by author, 2010).

Figure 4.25. Depiction of the Surgery from the SPRTC museum. (Photograph by author, 2010).

Figure 4.26. Depiction of sleeping arrangements from the SPRTC museum. (Photograph by author, 2010).

Figure 4.27. Self-portrait of the author in the museum. (Photograph by author, 2010).

Figure 4.28. Hand on the dresser. (Photograph by author, 2010).

Figure 4.29. Mannequins in the closet. (Photograph by author, 2010).

Figure 4.30. Bucket of mannequin torsos and one leg. (Photograph by author, 2010).

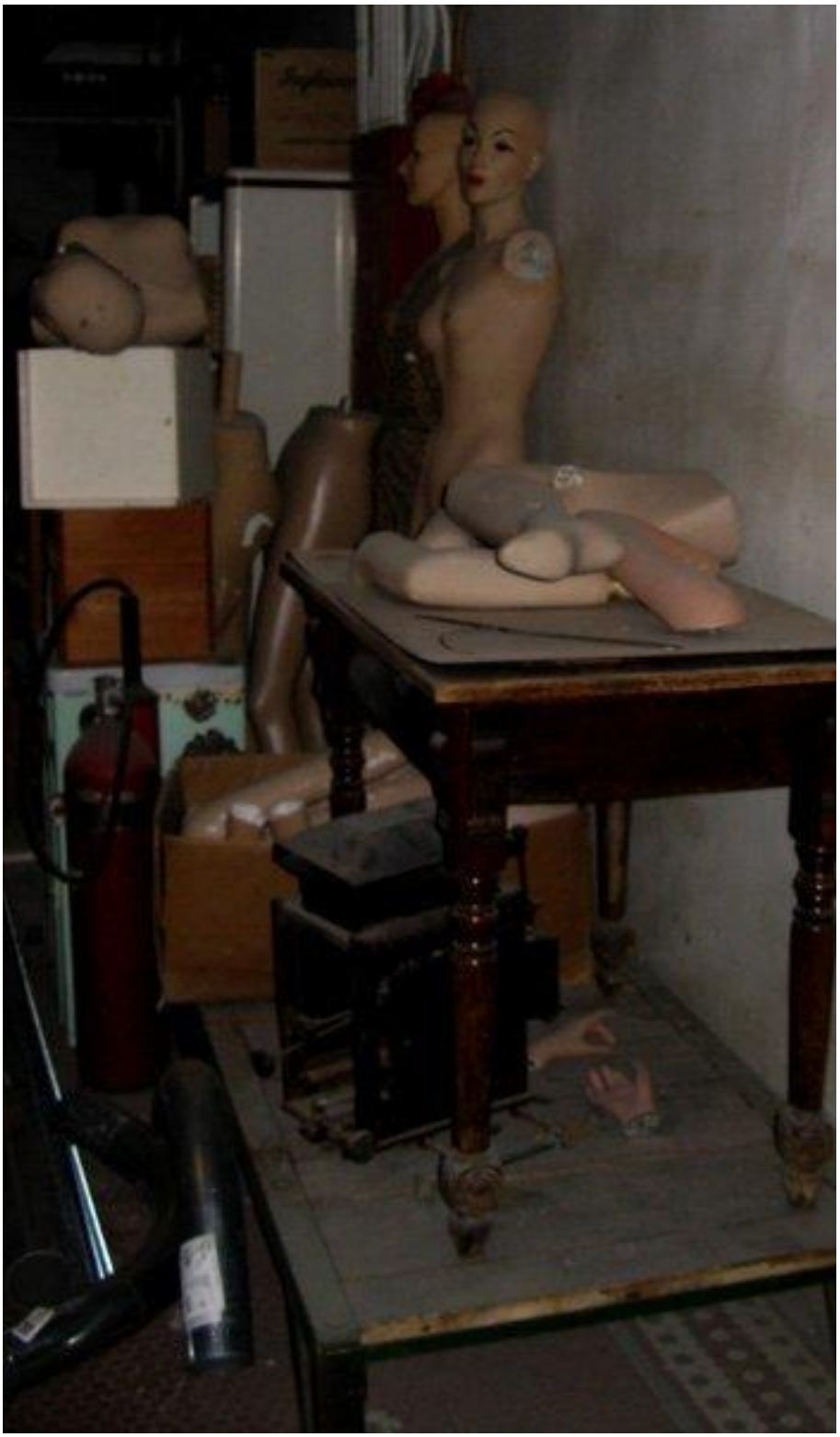

Figure 4.31. Torsos, limbs, and hands in the SPRTC basement. (Photograph by author, 2010).