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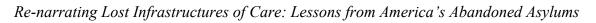
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Re-narrating Lost Infrastructures of Care: Lessons from America's Abandoned Asylums

Allia Casey Parsons
April 26, 2019

Senior Thesis
Submitted in partial fulfillment of the requirements for the Bachelor of Arts in Urban Studies

Adviser, Lisa Brawley

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This thesis is dedicated to my grandmother Helen Rose Oliver.

Introduction

I have discovered in researching and writing this thesis that the architecture of the abandoned asylum has taken on the stigma of madness, foreclosing conversations about the public infrastructure necessary for mental health architecture in urban networks. Deinstitutionalization, defined as state sanctioned closure of psychiatric institutions, colors the contemporary interpretations of abandoned asylums that blame the infrastructures for the problems within the institutions. This allowed the federal government to shirk responsibility for the medical and political context that lead to this 'failed' public provisioning of spaces for mental wellness.

A narrative of closed institutions as progress allows policy makers to turn away from complicated questions. The most precarious individuals in the asylum were transferred to new public architecture of the inner-city sidewalk or prison. My research explores the social and political context that allowed the closure of public psychiatric institutions to be smoothly incorporated into a narrative of progress while infrastructural neglect continues to push mental 'illness' to the fringes of society. This is not an argument for the revival of these institutions, it is an exploration of the possibilities that are silenced when the narrative of these buildings casts them as outdated, barbaric, and uniformly bad. These institutions are more than architectural relics of the past, they hold lessons about providing spaces for mental wellness.

Critical disability studies as a theoretical framework complicates the question of how to provide care, reassessing the rights of citizenship in the United States and who they are afforded to. In the 20th century, ethos towards public mental health shifted towards prioritizing productivity rather than 'wellness'. This yields the question of what is means to be 'well' and

whether it is possible to embrace these differences through architectural forms and urban practices. I do believe it is possible to create spaces of care that do not reiterate an architecture of stigma, there just has to be a different method of knowing.

In the pages that follow, I weave different examples together to flesh out the contemporary narrative of these institutions from their inception as aesthetically regulated spaces for therapy to the community care movement that sought to address issues of public mental health with decentralized outpatient care. Ultimately, de-funding these public institutions was the first step in a chain of events that privatized mental health treatment. Criticism of public mental health institutions from Michel Foucault, Erving Goffman, and Robert Castel reiterated stigma in the built institutional form in the name of protecting patients. Muckraking journalists were applauded as upholding the rights of the mentally disabled, yet most of these accounts missed substantive input and alternative ideas from the mentally 'ill' they claimed to serve.

The field of critical disability studies disrupts the canon of thinkers who dismantled these institutions by centering knowledge from scholars who experienced disability themselves. This framework allows a less streamlined narrative to take precedence and holds space for disagreement in contentious debates about care. There is broad consensus that when psychiatric institutions became medicalized for research and disease, the nature of treatment often became inhumane, at the very least impersonal. Many of the benign practices and paradigms of vocational and rehabilitation therapies that were the founding principles of these institutions were left out of written accounts that shaped the historical accounts of these institutions. The definitive moments for the asylum were its final years of operation when overcrowding and underfunding made these the least funded habitations in America. Critical disability studies

moves away from clinical definitions of illness and instead focuses on the friction between the 'disabled' body and the environment. Reconceptualizing the role of space in public mental health grapples with alternative approaches to treatment, making resources out of artists and pausing in the ambiguity of this unresolved issue.

I close with a project from Anna Schuleit, which astounds me because it infused psychiatric institutions with new possibilities and re-narrated the moment of closure. In 'Bloom', Haber brought 28,000 flowers inside Massachusetts Mental Health Center, reinhabiting the space from a new perspective. Her installation disrupts the typical cycle of institutional closure that quickly slips into the realm of outdated, forgotten infrastructure. Through the work of volunteers, Haber created a dynamic environment that foregrounded embodied knowledge of the institutional space. Without the pressure to grasp the institution in its totality, the four day installation introduced questions that compelled participants to consider what was lost and gained in closure. Her project engaged auditory, olfactory, visual, and tactile cues to memorialize a controversial moment. Haber created an environment to grapple with the different experiences of and opinions about psychiatric institutions. The utilization of space in this project made it magnificent. Haber reached into the crevices of the building and traversed layers of time, traveling into the basement where treatment had been provided only weeks before, and into the recreation center that had been abandoned decades prior. As the participant moved through the hallways and rooms, the question of aesthetics and nature in space for mental wellness came forth. Flowers not only disrupted the lack of nature in institutional settings, but served as complex emotional signifiers for death and mourning as well as celebration and life. They put a pulse to the arteries of the space and elicited a broad spectrum of emotional reactions.

Haber was visibly attentive to limiting her hand in curating an experience or response. Instead, she facilitated an architecture of presence, honoring the institution as a container through which thousands of lives passed, each touched in fundamentally distinct ways. Her project fits nicely into the paradigm of knowledge production that critical disability studies advocates for. Without flattening variations in human experience, Haber made space for disagreement and friction, and drew attention to the power of environment and built space to shift one's perception of self. The installation was grappling with fragility in the fleetingness of the exhibit, yet Haber used the pressure of time in the temporary moment of bloom as an opportunity to probe sustaining questions about closure and care. 'Bloom' invited the public to look back to the institutional space and sense what it provided in the past as well as alternatives for the future.

Public mental health is an urban issue. With this thesis I want to complicate the narrative of the failure of these institutions as intrinsically linked to their spatial forms. Continued geographies of exclusion do not fit easily into the narrative of progress in public mental health. Decrepit American Asylums hold cautionary tales of mistreatment, oppression, and violence in the name of medicalizing mental health. The desolate spaces evoke the lives that filled them fixtures of "once-heroic structures (our society) built to try to assuage the pain of mental illness". [1] Initially conceived around aesthetics and environmental regulation, these structures devolved into architectures of stigma holding histories of trauma and neglect. This is not an argument for reviving the abandoned buildings, rather it is an effort to grapple with the spatial responsibility of civic society to provide contexts for mental "wellness" to be moved towards. In Poughkeepsie,

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[1] Payne, Christopher. "Asylum: Inside the Closed World of State Mental Hospitals." *Change Over Time*, 2016. Print. Pg, 5

the Hudson Valley Psychiatric center will serve as a case study for "transinstitutionalization", the transference of patients from asylums to inner-city infrastructures.

My own interest in this issue was sparked when I learned that my late grandmother was involuntarily admitted to Massachusetts State Mental Hospital in 1957 after a bout of what would now be understood as severe postpartum depression. My mother was three when her mother disappeared for a year. When she returned as a shell of who she once was, she would never tell my mother anything about her time in Mass. Met. State, responding in her droning smokers voice 'Why bring up the past?'. After years of fruitless family conversations I decided to research the institution and learned that she had been a test patient for a new form of electric shock therapy being developed at this institution in the late 1950's.

My grandmother, put bluntly, was a failed result of the psychiatric project of the state. She was discharged with a lifelong prescription for "horse-tranquilizer pills" and would spend the rest of her long life shuffling in a half-conscious state between the living room where the television would play programs in different languages, and the front porch where she devotedly maintained her addiction to cigarettes. My understanding of her story is marked by gaping holes as the result of familial guilt and the limited institutional memory that surrounds mental health. However curious I was and still am about my grandmother's story, hers is not the one I wish to tell. Entering the rabbit hole of bureaucratic regulation and disappeared medical files, I discovered that stories like my grandmother's are not uncommon. The paradox is that these accounts drive the accepted narrative that public mental health institutions were simply failed projects in public provisioning of well being. Abandoned asylums became a symbol that supported a smooth narrative of the closures as progress and encouraged continued privatization

of mental health treatments. Unfortunately, this depoliticized the conversation about public spaces for mental health treatment as necessary in urban social support infrastructures, which are still today unbuilt and underfunded.

Part I: The American Asylum, A History of How We Got Here

"The science of mental disease, as it would develop in the asylum, would always be only of the order of observation and classification".[2]

The initial construction of asylums were responding to industrialization spurring urbanization. These institutions were privately owned and located on the peripheries of cities. They would become a fundamental mechanism of urban social control throughout the 20th century as they transitioned into public facilities that absorbed the "degenerate" populations produced in cities.

Enlightenment ethos rationalized segregation of "madness" outside of public space. Notions of difference and deviance had always lived in society, in the past towns and rural villages provided informal networks of social control. The madman was not monitored by institutions or formal regimens and hierarchies of power, instead was the responsibility of the family and proximal social networks. It was in the nineteenth century that disability became firmly linked through the discourses of statistics, medicine, and law to words such as 'deviance' 'abnormality' and 'disorder'. During this time the modern conception of disability emerged as a byproduct of the concept of normalcy.[3] With the development of "...statistical science and the

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[2] Foucault, Michel. *Madness and Civilization a History of Insanity in the Age of Reason*. Tavistock, 1979. Pg, 160
[3] Adams, Rachel, et al., editors. *Keywords for Disability Studies*. NYU Press, 2015. *JSTOR*, www.jstor.org/stable/j.ctt15nmhws. pp, 5

bell curve, human ability came to be understood as a continuum, with disability and disabled people occupying extreme and inferion ends of the spectrum".[4]

During the late nineteenth and early twentieth centuries, protecting the normal from the abnormal became a broad medical and social imperative undertaken in the name of progress. [5] The somatic flexibility of the former feudal economy in which labour time was discontinuous and woven between social intercourse and work "...was progressively replaced by a powerful new wage labour relation that confronted impaired people with powerfully disabling forces".[6] Labeling and categorization were designed into the urban "service model" to regulate the city in terms of productive labor. Architecture developing in this era sought to solve society's problem through spatial form. Some of the most famous architects such as Le Corbusier, William Lescaze, and George Howe were influenced by this carefully planned building that would "rationally" design social interactions.[7] A new norm for the citizen subject relationship was designed that set very clear delineations around the parameters of toleration, productive and non-productive, high and low functioning behavior. The "madman" as well as countless other non-normative bodies were cast outside of public space and relegated to controlled environments.

The city's form and structure became the context in which social rules and expectations were internalized and habituated. This "...ensured social conformity or positioned social marginality at a safe or insulated and bounded distance".[8] The asylum was an early example of

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[4] Ibid. pg, 6

[5] Brenner, Neil. "Is 'Tactical Urbanism' an Alternative to Neoliberal Urbanism?" Post, MoMA, 24 Mar. 2015 post.at.moma.org/content_items/587-is-tactical-urbanism-an-alternative-to-neoliberal-urbanism.

[6] Parr, Hester. *Mental Health and Social Space: Towards Inclusionary Geographies?* (Wiley, 2011). Pg 15

[7] Curtis, William J. R., *Modern Architecture Since 1900*, third edition (London: Phaidon, 1996). Pg, 70

[8] Grosz, Elizabeth. *Bodies-cities.Places through the body*(1998) pg, 42-51.

standardized space and aesthetics as currency for determining good design. Thomas Kirkbride was the first architect to establish an architectural standard for the modern asylum in 1854. His plan for treatment called for an architecture that maximized sunshine and fresh air. The popularity of his plans for institutions and grounds marked the end of asylum medicine's desire to mimic the family and trend towards environmental regulation to promote wellness. Kirkbride wrote in 1860 that his institutional design was primarily concerned with separating the patient from his or her home and family, a division that he believed was an unfortunate demand for the "cure". A typical building's program featured staggered patient wards flanking an administrative core. To create a community environment, Kirkbride advocated that fewer than 250 patients live in each structure. Over forty Kirkbride Plan hospitals and asylums were built between 1848 and 1900 in the United States and Canada.

The asylum Kirkbride proposed was a palatial building including high ceilings, lofty windows, and spacious grounds. These asylums opened an opportunity for a new life " within this protective structure, one (had the) freedom to be as mad as one liked and, for some patients at least, to live through their psychosis and emerge from their depths as saner and stabler people" [9]. The design of these early institutions were intended to treat the dual nature of mental illness, medical and social, biological and constructed by societal norms, a programmatic response to the geographical separation in industrialization that increased the numbers of displaced and family-less people.

These first asylums replaced tasks previously considered the responsibility of the family and were explicitly not under state jurisdiction. "Lunatic asylums" were private projects funded

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[9] Yanni, Carla. *The Architecture of Madness: Insane Asylums in the United States.* NED - New edition ed., University of Minnesota Press, 2007. *JSTOR*, www.jstor.org/stable/10.5749/j.ctttt2gd. Pg 55

by philanthropists who were trying to establish a space to deliver moral treatment, to "bless, soothe, and restore, wandering intelects…".[10] Early 19th century psychiatrists considered the architecture of their hospitals the "...most powerful tools for the treatment of the insane".[11] These institutions primarily functioned as social spaces.Patients farmed, cooked their own food, made their own clothes, and participated in recreation activities. The first psychiatrists were called "asylum doctors" whose primary occupation was to manage the "prosaic life of institutions".[12]

"Lunatic asylums" were only medical in the deliberate separateness from the home, setting the precedent for architecture and space as crucial steps in the recognition and acceptance of patients insanity. As more asylums were built they became a formally modern project that stressed reason, empiricism, and secular progress. Governing principles in urbanization sought to "displace the subjection to dependency particularly associated with that era's theology, substituting this for the liberating themes of independence". [13]Asylums were privately owned and operated well into the 19th century. In 1854 President Pierce vetoed a bill to transfer mental health care to the federal budget because he believed that this would "open the fountains of charity" [14]. In 1847, reformer and activist Dorothea Dix and her supporters began lobbying the federal government to use the proceeds of 12,225,000 acres of federal land to build state psychiatric hospitals. Dorothea Dix won the proceeds to go towards public mental health institutions and soon after asylum architecture became a profession and field of study.

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[10] Yanni,T*he Architecture of Madness: Insane Asylums in the United States*. Pg, 55
[11] ibid.
[12] ibid.
[13] Lyman, Stanford M. "Without Morals or Mores: Deviance in Postmodern Social Theory." *International Journal of Politics, Culture, and Society*, vol. 9, no. 2, 1995, pp. 197–236. *JSTOR*, www.jstor.org/stable/20007236.
[14] Torrey, E. Fuller. American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System. Oxford University Press, 2014. Pg 48

State funded institutions shifted function away from social control through physical separation to medicalized spaces for the production of knowledge through research and clinical study. As public institutions, the buildings themselves grew in size and frequency lining the suburbs of urbanizing America. As the 20th century progressed and populations increased, buildings accommodated medical progress and enhanced social control creating tension between benevolence and surveillance. By 1917 there were 297 institutions for insanity in America. The interior space was hierarchical and patients were aware of their place in the numerical wards, placement on a clean quiet ward was a concession that could be taken away at any moment.

 In the 1920's and 1930's the public mental health institution was no longer referenced as "asylum" instead called 'psychiatric institutions' or 'mental hospitals'. This signaled a shift in how space was conceived in dealing with disease. Asylums became structures for categorizing and treating symptoms, mental patients had to fit the 'normate template' of defined illnesses. Variations in 'illness' would be simplified, broad categories of symptoms were used to quickly identify 'cures' normally ni the form of pills, lobotomies, or ECT. The development of antipsychotic drugs reinforced a scientific model for diagnosis that George Kline, the commissioner of the Massachusetts Department of Mental Health, called in 1927, "... a remarkable extension of the sphere of psychiatry beyond the walls of the mental hospital". [15]

Psycho-pharmaceuticals de-spatialized therapy. The livelihood of patients became secondary to their role in research. Variety in experience previously addressed with embodied therapies of poetry, art, talk therapy, walking, and work gradually fell away, as professionals sought to streamline treatment along narrow definitions of rehabilitation. Work opportunities for

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[15] Yanni, *The Architecture of Madness*. Pg 147

patients in the public mental health institutions began to disappear under the guise of protecting their rights. Some argued that this deprived patients of an important therapeutic mode that provided a rhythm to life, offering a sense of responsibility and routine. The therapies that worked with the body to establish relationships became an expensive luxury. Antipsychotics that lessened hallucinations and delusions of schizophrenia were popularized, however these did little for the apathy and passivity, lack of motivation, or ability to relate to others, became popular. Most of the medication was reported to lower productivity and produce its own sense of apathy. Some intolerable side effects such as parkinsonism or tardive dyskinesia could persist for years after the medication had been stopped. Nonetheless, psycho-pharmaceuticals became the popular form of treatment.

After WWII, postmodernism emerged as a critique of "existing systems of difference which organized social life into patterns of domination and subordination...".[16] The sociological and political theorists shifted the ethos surrounding institutionalization and segregation, calling for state-de-funding of these institutions. This was at odds with new demands on public mental health as soldiers came back from the war suffering psychological trauma. In 1945 there was a plan proposed to create a National Neuropsychiatric Institute, that would use federal funds to train more mental health workers and create community health clinics. Mental health treatment shifted focus towards prevention through modification of environment. In 1947 Robert Felix, the chief of the Mental Hygiene Division of the Public Health service proposed a plan that would have one outpatient clinic for every 100,000 of the population [17]. This lofty goal never reached

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[16] Lyman, Stanford M. "Without Morals or Mores: Deviance in Postmodern Social Theory." *International Journal of Politics, Culture, and Society*, vol. 9, no. 2, 1995, pp. 197–236. *JSTOR*, www.jstor.org/stable/20007236. Pg, 212
[17] Torrey, American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System. Pg, 21

fruition, however in 1948 Felix used a $2.1 million dollar budget to help forty-five states develop outpatient community mental health clinics. These funds also went towards teaching practicing physicians updated psychiatric information, "especially the newest accepted conceptions of the role the emotions play in illness"[18]. As institutional residencies and community care plans were rolled out, there was an increasing discontent from political theorists and journalists that cast doubt on the validity of this bureaucratic decision making, ultimately damning the community mental health movement that was short-lived and poorly executed.

In 1954 the American Psychiatric Association created the Joint Commision on Mental Illness and Health that would hold a series of public hearings between 1955 and 1960. The purpose was to build a consensus and persuade the public and Congress to expand national mental health programs. The final report of the commission entitled *Action for Mental Health* stated that public mental hospitals were bankrupt beyond remedy. The proposed solution was to coordinate community mental health centers with a "massive financial participation by the government" [19].The report was ill-fated, it's suggestions came at the height of suburbanization in the 50's that lead to massive disinvestment from cities. The suggestions were even more illegitimate due to the concurrent discovery and popularization of Chlorpromazine sold in the U.S. under the name of Thorazine. This drug was discovered in France in 1952 "...dramatically reduced hallucinations, delusions, and manic symptoms of many patients with severe psychiatric disorders… first used in the U.S. in Philadelphia 1954 with 142 patients, it was shown to reduce severe anxiety, reverse or modify a paranoid psychosis, quiet mania or extremely agitated

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[18] Ibid. Pg, 26
[19] Ibid. pg, 31

patients into a quiet, easily managed patient…"[20] Thorazine and the first antidepressant drug

Imipramine were discovered in 1952 and 1957 respectively, the first psychopharmaceuticals to

be widely used. The availability of psycho-pharmaceutical drugs "strengthened the idea that

hospitalization need not be custodial or lifelong".[21] Throughout the 1950's rather than to observe

patients, the goal was to send people home and continue treatment on an outpatient basis.

Sociologists warn against the deterministic argument that drugs caused deinstitutionalization.

Psychiatrists had administered other drugs including tranquilizers and barbiturates previously

within the asylum.State policy makers eliminated certain categories of patients from state

hospitals to keep costs down. Drug abusers, alcoholics, autistic children, and any voluntary

self-commitments were not allowed into state hospitals. Public mental health institutions became

the lowest level of state-funded habitation in America.The idea that state mental hospitals were

therapeutically bankrupt grew with highly publicized exposes of state mental hospital conditions

in the late 1940s, perhaps most influential was Albert Deutsch's *The Shame of the States,* a photo

journal of deplorable conditions in state funded psychiatric institutions. Films and novels such

as the 1948 film noir *The Snake Pit,* 1962 novel *One Flew over the Cuckoo's Nest,* and the 1972

BBC radio drama, *Rules of the Asylum* all perpetuated the image of the asylum space as stark,

austere, and rigidly controlling.

In 1958 The American Psychiatric Association recommended that state mental hospitals

be liquidated rapidly "in an orderly and progressive fashion" so that community mental health

centers could take over the function[22]. 1955 was to be the high-water mark of patients in these

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[20] Ibid. pg, 33
[21] Payne, "Asylum: Inside the Closed World of State Mental Hospitals." Pg, 5
[22] Torrey, *American Psychosis*. Pg, 44

institutions, there were 558,922 patients in state mental hospitals throughout the country. In 1956 there were 7,542 fewer patients, the first such decrease in more than a century. Proposed community mental health centers never came to fruition and those that were built were not put in contact with closing state hospitals. The National Institute for Mental Health (NIMH) claimed to would award Community Mental Health Care Clinics (CMHC) grants. These funds were to be transferred to cities, counties, and other local entities but the alleged funds never received the approval of state authorities. Funds that did exist were rarely transferred effectively and little federal spending went into the construction of community mental health centers. The Community Mental Health Centers Construction Act of 1963 encouraged the closing of state mental health centers. This Act included no plan for the future funding of community mental health centers, instead focusing resources on "prevention" of mental "illness".

De-institutionalization progressed, institutions closed, and the responsibility of care was transferred away from spaces for treatment, to larger decentralized urban networks ill-equipped to provide adequate care. The closure of the asylum de-spatialized locations for critique. Infrastructure for public mental health was re-conceptualized in contending reformist outlooks, with no one system of care prioritized over any other and became a "broad transfer of care that produced a complex set of organizations (e.g. acute and long-term hospitals, day treatment, treatment teams, group homes, nursing homes, community mental health centers, alternative care, and peer -poperated systems)". [23] Persons that entered the mental health system in the decades following 1950 encountered a complex maze of organizations and programs that landed

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[23] Pavalko, Eliza K., et al. "Mental Illness Careers in an Era of Change." *Social Problems*, vol. 54, no. 4, 2007, pp. 504–522. *JSTOR*, www.jstor.org/stable/10.1525/sp.2007.54.4.504.

the most severely mentally "ill" individuals with the fewest social supports back on the sidewalk and in prisons.

The first half of the twentieth century had marked a period of stability in the system of care for persons with mental health disorders. The state mental hospital served as a core location for the treatment of persons thought to be mentally ill, "...as well as a wide range of other 'deviants' who didn't have another place to go".[24] The use of total institutions in urban networks had been readily supported because the onus of responsibility for institutional support had previously been the responsibility of the state. As de-funding lead to deteriorating institutional practices, political movements challenged state authority. In the 1970's the Anti-Psychiatry movement introduced actors who resisted mental "illnesses" as a fabrication of establishment thinkers. Leading proponents R. D. Laing and Thomas Szasz rejected psychiatry's oppressive demands for compliance and a sameness of human experience. They criticized electroshock therapy, involuntary hospitalization, and believed psychopharmacology was a means of covertly controlling patients. Facing slashed budgets, stays grew shorter throughout the 1970's and 1980's and patients often fell victim to syndromes of the "revolving door" and "falling between the cracks" moving from underfunded institution to institution. By the mid-1980's public institutions for mental health were almost entirely closed. Under President Nixon virtually suspended investment in psychiatric research due to his skepticism of psychiatry as a science.

Concurrently, homelessness became a national crisis. Homelessness and its relationship to mental 'illness' is an area of study that will not be explored in depth. However, the correlation between the near wholesale closure of mental health institutions by 1990 and the massive spike

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[24]ibid.

in urban homelessness in the 1990's shows strong correlation between public infrastructures for

mental health and urban homelessness. Without adequate infrastructural alternatives, the final

architectural setting for a "..welfare dependent schizophrenia or manic depressive after

institutionalization, was not a building, it was the street".[25] De-institutionalization removed the

public mental health institutions from the "urban service model". The state was still

economically responsible for the subject, in fact the cost of care per bed increased as institutions

closed and trans-institutionalization caused mental patients to be relocated to prisons. In 2010

the Association of Community Living issued a report (Figure. 1), that showed the cost per bed,

demonstrating that NFP or non-for profit residential programs coordinated by NGO community

mental health programs were half the price, at maximum, of holding individuals

de-institutionalized patients in prisons.

Generally, costs of other settings – per bed per year - are approximately:

Community Hosp. inpatient:	$350,000
State Inpatient:	$250,000
Nursing Home:	$150,000
Prison:	$ 85,000
Jail:	$65,000
NFP residential program:	$7,800 - $40,000 depending on level of care[3]

Figure1:http://www.budget.state.ny.us/pubs/press/2010/econRevForecastConf/2010-11ConsensusReport.pdf

Asylum closures did not simply arise from political or economic motivations. It was in

the confluence of critique, shifting ethos around funding the public provisioning of care, and

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[25] Yanni, The Architecture of Madness. Pg, 23

psycho-pharmaceutical treatment that allowed closures to be marketed as improved treatment and policy makers to overstate the effectiveness of drugs in order to legitimize their cutbacks. The bottom line is that patients went from having a curated relationship to medicine to one that was hands-off and self-regulated. Patients who had no familial support were made responsible for themselves and often would stop taking antipsychotic drugs that they were prescribed. The family was made a substitute to pick up slack for broader collective support and when there was no family the system completely failed at providing care.Discharged patients faced segregation and exclusion due to the pathologization leaving limited modes of existing in urban space.

Part II: Disability and the City

"The city is a state of mind, a body of customs and traditions, and of organized attitudes and sentiments that inhere in this tradition. The city is not, in other words, merely a physical mechanism and an artificial construction. It is involved in the vital processes of the people who compose it, it is a product of nature and particularly of human nature" (Robert E. Park, 1914).

This next section examines how disability is produced and reinforced by urban space. "Disability" has been a part of the English Language since at least the sixteenth century. According to the Oxford English Dictionary, "the current sense of a "physical or mental condition that limits a person's movements, senses, or activities (or) the fact or state of having such a condition" was first used in 1547".[26] By the nineteenth century the term covered a broad range of 'abilities' or 'incapacities' that included inability to pay a debt or to worship God with a full heart and some conditions currently treated as disabilities were not regarded as such. Later on in the nineteenth century 'disability became firmly linked through the discourses of statistics,

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[26] Adams, Rachel, et al., editors. *Keywords for Disability Studies*. NYU Press, 2015. *JSTOR*, www.jstor.org/stable/j.ctt15nmhws. Pp 5

medicine, and law to words such as 'deviance''abnormality' and 'disorder'. During this time the

"modern conception of disability emerged as a byproduct of the concept of normalcy…. With the

development of statistical science and the bell curve, human ability came to be understood s a

continuum, with disability and disabled people occupying extreme and inferion ends of the

spectrum".[27] During the late nineteenth and early twentieth centuries, protecting the normal from

the abnormal became a broad medical and social imperative concretized in urban space.

Citizenship is constructed through relationships to one's environment and the ability to be

mobile within it. Citizenship is most often understood as membership of an abstract political unit

that is usually spatially determined as the nation-state, and by which rights and privileges are

accorded to those who fulfil certain obligations. "...this conception of citizenship relies on the

notion of a modern citizen who (rationally) identifies with the state and whose identity is partly

defined by it (in political terms at least)".[28] This positions the mentally 'ill' in their very

constitution as an exception to the norm that 'threatens' the national body.

The figure of the mental patient constitutes a break in normative thinking about 'human

rights'. The paradox of the social and political reasoning that legitimated disabled bodies,

constructing their otherness, withheld right*s*. This is constitutive of the contemporary

citizen-subject relationship in which the state sets the parameters of the right to be protected,

defines eligible participants, and has the right to withhold protections. The possibilities for

challenging and re-thinking this negotiation and the modes of operation are, for the purposes of

my argument, to be considered in terms of urban space. A more expansive understanding of

citizenship is introduced when we listen to bodies cast outside of this fortress of rights.

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[27] Davis, Lennard J. "Crips Strike Back: The Rise of Disability Studies." *American Literary History*, vol. 11, no. 3, 1999, pp. 500–512. *JSTOR*, www.jstor.org/stable/490130.
[28] Hamraie, Aimi. *Building access: Universal design and the politics of disability*. U of Minnesota Press, 2017.

Michel Foucault, Erving Goffman, and Robert Castel were political, sociological, and legal theorists who wrote about the paradoxical relationship for disabled people in terms of rights, critiquing the institution from different perspectives. It is important to note that Foucault, like Goffman, and Castel all come at the issue of rights from the position of we as 'normal', a limited position of knowledge especially in the realm of advocating for disability rights. l It is also worth noting that from this 'normal' position, Foucault, Castel, and Goffman asume the agency of the mental patient as actor is largely compromised by institutional structures. From their limited perspectives as 'outsiders' from the broad category of those with mental disabilities, they are writing from the gap between efforts of advocacy and limited experience.

Michel Foucault was a vocal political theorist who wrote about the design of the asylum as defining the doctor-patient relationship that "…served to legitimize a medicalization of patients identities and behaviors into an abstract framework of (ab)normality through which disordered selves were rendered legible as pathologies (Foucault, 2006). He criticized the intra-asylum distribution of patients that exerted control over bodies through separation not based on symptoms but on subjective characteristics such as the curable and incurable, calm and agitated, or punished and unpunished. He argued that this organized bodies with intimidation tactics and created a deterministic fate in which patients understood themselves based on what surrounded them. The intra-asylum distribution was an exertion of medical control, the "psychiatrists body-asylum space", in which the omnipresence of the psychiatrists body was enacted through stroll and inspection. Foucault attributed the articulation of every gesture to the powers at be within the institution, universalizing the effects of the institution and flattening the category of patient. The total institutions, once designed to foster movement and therapeutic

embodiment were now understood as "coercive architectures", institutional spaces that were the extension of a single authoritative body or frame of knowledge. This sort of institutional understanding reiterated institutional failure.

Foucault was a part of postmodern discourse and critique that developed in the 1960's and 1970's. He scrutinized public mental health institutions as "houses of deviance", that afforded patients a very specific set of rights and solidified their "otherness" in society. Postmodern critiques of these institutions often focused on the form of the building, arguing that spatial methods of surveillance and control had deeply internalizing effects. Political theorists such as Michel Foucault, as well as Erving Goffman and Robert Castel who will be explored later on, wrote influential exposes about asylums that was not a catalyst, but certainly an encouraging force in the deinstitutionalization. They shaped academic discourse and historiography of public mental health. While advocating for patients rights, this school of thought had deleterious effects, discounting more minute scales of interpersonal relations and dynamics of agency among individual mental patients that were very broadly defined.

In 1961, Erving Goffman wrote *Asylums* after conducting an ethnographic analysis of the assimilation of patients to the experience of being hospitalized within St. Elizabeth's Mental Hospital in Washington D.C. Goffman diverged from Foucault's interest in the enunciations of spatial control on bodies and instead identified a service model of production and expenditure that he believed influenced all social relations. Through detailed ethnographic observations of the routines of institutional life in a 7,000 in patient psychiatric facility, Goffman both confirmed and disrupted Foucauldian understandings of the disciplining of the mad. Goffman showed how asylum practices affect what he "...calls the "mortification of self" through personal defacement

(a loss of civil identity), submission, and regulatory conduct (s). Indeed Goffman argued that

total institutions are fateful for the inmates' civilian self…"[29].

"Often during hospitalization and post-hospital care there is a split introduced into the

patient's environment within a bandage or cast or otherwise bounded part of the body, a

medically adjusted environment is intensively maintained, the condition in which

everything outside this boundary is maintained can then be rationalized not on the direct

grounds of its salubriousness, but as a basis for ensuring the maintenance of inner

environment".[30]

Goffman's primary critique was the institutions failure as a social establishment and its

impacts on perceptions of the self. This 'self' "...can be seen as something that resides in the

arrangements prevailing in a social system for its members...dwell(ing) rather in the pattern of

social control that is exerted in connection with the person by himself and those around him".[31]

Goffman has been incorporated by some into the Critical Disability studies lexicon because of

this focus on the patterns of socializing and minute details of daily life and understanding

interactions in the undercover systems of communication. Goffman's influence on the disability

studies community is contentious, often narrated as impactful without the consent of critical

disability scholars themselves. Perhaps this wasn't so different from Foucault's analysis of the

mental hospital as a site for primarily occupational relationships, each theorist believed the

individual patient was merely filling a categorical role and that dynamics of power were

predetermined, focusing on the performance of patienthood and the performance of the medical

[29] Goffman, Erving, and William B. Helmreich. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Routledge, Taylor & Francis Group, 2017.
[30] Goffman, Erving. *Asylums*. Anchor Books, 1961. Pg, 348
[31] Ibid. Pg, 168

server. Goffman's most notable difference from Foucault was his interpretation of the relationship between doctor and patient. He believed that laboratory work and medical research were sophisticated negotiations and dependencies that did not screw power so lopsidedly towards authority as Foucault saw it because the doctors remained dependent on the patient for reporting symptoms.

Goffman and Foucault's analysis of these institutions contributed in various ways to the envisioning of a community mental health care movement, simultaneously damning the asylum for inhumane institutionalization and exposing the mental health institution's custodial and therapeutic functions. Foucault and Goffman uncovered research programs that lead treatment to be dictated not so much by the needs of the patients but by the requirements of the research design. Goffman and Foucault agreed that doctors wielded enormous power in determining patients' social fate. Each understood the social implications of an institution as physically and symbolically isolating an individual from larger society. The spatial organization of these institutions was critical to their understanding of the patient as a passive subject. The postmodern theories of control did not situate different viewpoints and instead assumed a 'panopticonic' theoretical critique.

Returning to this notion of citizenship with regard to mental "illness", there are limits of rights due to the "...modalities of 'exception' articulated in human rights legislation…"[32] Although some sociologists and political theorists argue that social rather than political citizenships are more relevant in discussions of inclusion and exclusion, insiderness and outsiderness, legal theorist Robert Castel explored the public mental health institution from the

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[32] Castel, Robert. *The regulation of madness : the origins of incarceration in France / Robert Castel ; translated by W.D. Halls* University of California Press Berkeley 1988. Pg, 55

perspective of liberal democratic legal theory. In *The Regulation of Madness*, Castel argued that the liberal-contractual society emergent in the late eighteenth and early nineteenth centuries faced a dilemma with the mentally disordered who could "neither participate in rational exchange nor be held responsible for their actions…" [33]. In western society the mentally disordered were relegated to subordinate legal status. The were placed "under a relation *de tutelle,* or relationship of tutelage or guardianship within which they were legally guaranteed to be subject to a regime of (principally medical) paternalism".[34] Castel wrote that:

> "The contractual basis of liberalism necessitates the comparison of the insane person with the child. This is the great pedagogical anthology of the medicine of mental health within whose framework its whole history develops. Either the family relationship or guardianship by official mandate for medicine there is no other alternative."[35]

Castel differentiated between two forms of legalism that emerged over the course of the 20th century.

> The first "emanated from the fact that psychiatric coercion was seen as implicating inconsistent populations: the same as well as the insane. At the gateway of the institution, when commitment was at stake, the possibility of medical error or corruption endangered the same. But the same were the proper bearers of contractual rights. This created a space for the dispute as to whether commitment procedures should be fully judicial in character or merely diagnostic and administrative… A second type of legalism associated with modern Anti-Psychiatry and especially with the thinking of Thomas Szasz, argues more

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[33] Unsworth, Clive. "Mental Disorder and the Tutelary Relationship: From Pre- to Post-Carceral Legal Order." *Journal of Law and Society*, vol. 18, no. 2, 1991, pp. 254–278. *JSTOR*, www.jstor.org/stable/1410140. Pg, 254
[34] Ibid Pg, 254
[35] Castel, *The Regulation of Madness*. Pg, 38

radically that the insane, on the basis of their fundamental common humanity, should

themselves be accepted into the contractual fold, endowed with rights, and benefit from

the privileging assumptions of judicial discourse. This equalization of the legal status of

the mentally disordered would spell the end of the tutelary relationship itself and usher in

a new super-liberalism."[36]

Castel wrote that mental patients receiving human rights was a "super-legalism", he

didn't problematize the law that can intervene in the doctor-patient relationship to impose special

cautionary procedures and determine the 'best course'. In differing ways Foucault, Goffman, and

Castel overlooked the ways patients create a negotiation context for themselves, subscribing to

and reiterating the cultural practice of othering in the effort to advocate for patients rights.

Part III: Case Study The Architecture of Trans-institutionalization in Poughkeepsie

"the major problems of urbanization today [. . .] are grounded in the inability of institutions of

urban development to more meaningfully engage urban informality, socioeconomic inequity,

environmental degradation, lack of affordable housing, inclusive public infrastructure, and civil

participation."[37]

Note: All images in this section were taken by me and are do not have citations, more images

‘De-institutionalization’ cast the institutions as inhabitable without accounting for the

shifting medical agenda in an increasingly privatized landscape of care. Government defunding

of public mental health institutions in favor of "outpatient" psychiatric care began in the 1960's.

The history of public mental health uses language of deinstitutionalization to explain the

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[36] Ibid. Pg, 256
[37] Brenner, Neil. "Is 'Tactical Urbanism' an Alternative to Neoliberal Urbanism?" *Post*, 24 Mar. 2015,
post.at.moma.org/content_items/587-is-tactical-urbanism-an-alternative-to-neoliberal-urbanism.

government roll backs of investment in institutions. This is a false narrative of deinstitutionalization. Patients were not simply sent home when institutions closed. Therefore, the appropriate vocabulary that accounts for the effects of deinstitutionalization on patients is 'trans-institutionalization'. This describes the de-spatialization of mental health treatment, transferring care of patients to sidewalks, acute care facilities (e.g. emergency rooms), and prisons.

Racialized 'ghettoization' in inner-cities also concentrated individual in the 'zone in transition' in the 1950's and 1960's during the rapid suburbanization that enforced segregation and isolation along racial lines. "Ghettoization" similarly withheld social services but is a phenomena that cannot be equated to the discharged mental health patients that landed in the same neighborhoods. I mention ghettoization to illustrate overarching trends of neglect in state providing services to marginalized groups. Each phenomena shows oppression played out in space, the city became a site of gross injustice, normalizing plight and neglect.

Racial segregation and trans-institutionalization were both state projects to re-spatialize the way "things" were produced and bodies covered in cities. American Sociologist Robert E. Park wrote about the federal design of the ghetto in the early 20th century. He didn't live to see that the black ghetto became concretized after WWII "...through state policies of public housing, urban renewal and suburban economic development intended to bolster the grid spatial and social separation of blacks from whites."[38] There were different motives for the marginalization of mental health patients, however the discharge of tens of thousands of mentally disabled people from state institutions,

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[38] Wirth, Louis. *The Ghetto*. Chicago: University of Chicago Press, 1956. Print.pg, viii

"...added a new indigent group to the inner cities of large metropolitan areas. The disabled competed with other welfare recipients for community based treatment, care, and services. The former asylum residents, not unpredictably, became ghettoised in those sections of the cities that had run-down boarding houses and seedy residential hostels, the dumping grounds for the disadvantaged and their caretakers".[39]

Trans-institutionalization re-enforced the "boundedness" of the ghetto. Urban Sociologist Loic Wacquant's suggested that the ghetto was a "bounded ward", a spatial analogy describing the ghetto as enclosed illustrated the reliable modes of treatment coming from social support within the inclosure, relying on informal networks. Loic Wacquant described the collective violence that was not "uncontrolled and undesigned" process. Similarly, trans-institutionalization was 'designed' through neglect to construct community mental health clinics and and poor maintenance of residency programs and other intermediary social support infrastructures. The state showed itself as the most powerful re-spatializing agent. Patients discharged from public mental health facilities relocated to the 'zone in transition', the zone of the inner city that immigrants were supposed to pass through that became a site for underfunded and inadequate public housing and social support services that doomed plans for "rehabilitation" and "reintegration". The 'inner-city' became an "uncontroversial setting for facility locations".[40]

Hudson Valley Psychiatric Center demonstrates resounding impacts of institutional closures on urban networks. The building was designed in High Victorian Style in 1867 by English architect Frederick Clarke Withers in collaboration with landscape architects Frederick Law Olmsted and Calvert Vaux. The team was commissioned to design the second public mental

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[39] Elaine, and Wolpert, J. (1974), FROM ASYLUM TO GHETTO. Antipode, 6: 63-76. doi:10.1111/j.1467-8330.1974.tb00614.x. Pg, 63
[40] Torrey, *American Psychosis*. Pg, 248.

hospital in New York State that opened in 1870. The Main building was designed in the Thomas Kirkbride style, the architectural standard for psychiatric institutions in the United States at the turn of the century. The building is invaluable, a hinge to look backwards at the sorts of medical, political, and social values that were inserted into these buildings, and to look forwards at what lays in the wake of the massive downsizing in state funded public mental health programs today. Withers designed civic infrastructure, he was most famous for his British High Victorian Gothic churches however his later, more famous works became include secular Gallaudet College that would become an important institution in the development of critical disability studies. Withers used an expressive Gothic Revival style and today is one of the last of these institutions standing due to its status as a National Historic Monument.

Hudson Valley Psychiatric Center's main building, later referred to as Building 51, was monumental in size. It's area of 1,500 feet (457 m) in length and over 500,000 square feet (45,000 m²) sat on top of a hill just above Route 9, a small thoroughfare at the time. From this vantage point, magnificent views of the Hudson River are visible. The internal programming of

the building and its relationship to the landscape were conceived to aid in patients' recovery. Patient wings split off the u-shaped Kirkbride building, segregating patients based on gender. The fragmented wings were designed to control noise and separate patients based on symptoms. Doctors lived on wards furthest from the most severe patients so that they would not hear screams. The discontinuous length of the ward offered privacy and the opportunity to strategically place patients based on amount of supervision needed.

The Hudson Valley Psychiatric Center had 6,000 patients in 1955 when it reached peak capacity. Not long after, the north and south wards of the main building began to empty in 1976, concurrent with drug study programs that began on premise in 1972. By this time, the hospital's patient population had fallen to 1,780 and would continue to decline until it closed in 2012. In 1979 the supervisors of HVPC began composing and sending requests to the Office of Mental Health to review and consider requests for the complete demolition of recently closed patient wards of the Main building. The wards were deemed an "attractive nuisance" and a risk to patients and staff. The 108 year-old structure became too expensive to maintain and posed a safety hazard with collapsing roofs, and the efforts of passionate supporters put "Building 51" on the National Historic Registry and protected it as a national landmark. The Kirkbride influence and gothic architectural style afforded protected the building as the Office of Mental Health's continued to demolish other treatment centers, and other buildings at HVPC that were remnants of in-patient care.

The Hudson Valley Psychiatric Center demonstrates the tension between historical gothic aesthetics confronting modern psychiatric function. I visited the grounds a month before the proposed reconstruction began. The first step of the plan to construct a shopping mall and

apartment complex ways to flatten the entire campus, cutting down almost every tree over the course of a week. Once construction began, entry was incredibly difficult because the previously abandoned site was now occupied by timber vehicles and security cameras. When I visited, the main entrance was completely blocked off and the the only way to access the Kirkbride building was from the service road that ran along the back side of buildings on the campus. This was the artery of the campus connected each building, demonstrating the transition of the campus over the course of the 20th century from an aesthetic approach to institutional design towards stark modernism that favored utilitarian function.

Approaching the main building from this road meant crossing underneath a covered walkway overpass before entering the courtyard surrounded on three sides by the main facade and wings of the building. In the past there was a chapel behind the central administrative ward that interrupted the space of the courtyard, muting the sensation of openness and blocking visibility so that patients could not see into the rooms of the opposite sex. Today, hardly any remnants of the chapel stand providing a false sense of capaciousness in the interior courtyard.

The Main Building was both magnificent and haunting. The scale of the building, and the surveillance of the courtyard with hundreds of windows facing inwards. created a sort of interior and exterior environment, maintaining the surveillance of the institutional structure even outside of the building. The grounds did not sprawl off the center point of the Main Building, clearly that

buildings on the site continued to be constructed until 1950 were built without reference to the initial structure.

The grandeur of 'Building 51' and the abandonment of the Hudson Valley Psychiatric Center leaves one to wonder what sort of infrastructures, if any, have taken over the spatial functions of providing a living space for mentally 'ill' in urban communities. Throughout the 1990's more of the site would be abandoned as state policy shifted towards a new mantra of "least restrictive environment" for patients, and in-patient psychiatric care became federally disinvested from. By 2012 Hudson Valley Psychiatric Center was officially closed. Withers' monument was an attempts to produce space for the mentally "ill" that could promote wellness. This is a sharp contrast to contemporary treatment for mental health largely happens on sidewalks in the center of cities or in prisons on the periphery. Both architecturally and historically significant, this monument illustrates infrastructural neglect in contemporary political and cultural conceptions of mental health treatments.

Mitch Barden was a practicing psychiatrist at Hudson RIver Psychiatric Center when it closed. He told me that most of the patients and staff were transferred to nearby "Sing Sing" Prison in Ossining, New York, a maximum security male prison where they have an Intermediate Care program and Residential Crisis Treatment team for patients with mental "illness". All other patients were transferred to Rockland Psychiatric Center or to community residences. Three of the five community facilities, Haven House and Edgewood in Dutchess County and Tudor House in Ulster County that were operated by the center have since closed.[41] Today, there are still people who live and work very near the grounds. Highview and Edgewood Residences are state

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[41] Associated Press. "New York State Plans to Close Poughkeepsie Psychiatric Center." *Syracuse.com*, Syracuse.com, 13 May 2011, www.syracuse.com/news/index.ssf/2011/05/new_york_state_plans_to_close.html.

operated Community housing residential programs for adults in Dutchess county located on the northernmost edge of the HVPC grounds. These group-living residential programs that focus on interventions necessary to address specific "functional and behavioral deficits" which prevent residents from accessing generic housing. The staff is 24 hours on site providing "intensive help usually of limited duration".[42]

The closure of Hudson River Psychiatric Center is shrouded in ambiguity. The enormous campus used to be a village, complete with its own farms, dairy, shoe and clothing factories, golf course, billiard room, greenhouse, churches, staff housing, reading rooms, library, bands, sports teams, power plant, trolley station, nursing school, and post office. The total institution covered 752 acres at its height. The limited on-site and nearby residencies for discharged patients are completely disproportionate to the level of care once provided. Stephen Madarasz, the spokesman for the Civil Service Employees Association who represented about 200 employees involved in patient care at HVPC said the union was concerned about the future of mental health patients across the state and that the closure "was a budget-driven decision and not necessarily good public policy".[43] New York state has gone from 599 psychiatric beds per 100,000 citizens down to twenty eight since 2000. The result is "...simply transferring the seriously ill to the criminal justice system. New York incarcerated 14,000 people with serious mental illness largely because OMH only has beds for 3,600. There are more mentally ill in a single jail, Riker's

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[42] Wolf, Craig. "$200 Million Plan for Old Psych Center Site." *The Poughkeepsie Journal*, Poughkeepsie Journal, 17 July 2015, www.poughkeepsiejournal.com/story/news/local/central-dutchess/2015/07/16/200-million-plan-old-psych-center-site/30149983/.

[43] ibid.

Island, than all state hospitals combined".[44]It is now the status-quo to place mentally ill individuals in prisons.

What was demonstrated when psychiatric institutions closed wasn't a shift in economic priorities but a shift in social and cultural priorities away from rehabilitation towards disciplining and punishment. In some cases, closing public mental health facilities were re-purposed to be prisons, as with New York State's Marcy State Psychiatric Hospital that later became the Marcy Correctional Facility with a 100-bed Residential Mental Health Unit. "...seriously mentally ill individuals who were once treated in the psychiatric hospital may end up being treated exactly in the same building, except now it is called a prison" . The Office of Mental Health Commissioner Michael Hogan called this specific project a "collaborative and innovative approach that to our known knowledge is the first of its kind anywhere…. Government at its best".[45]

Trans-institutionalization progressively de-valued space in mental health treatment. In Poughkeepsie, the acute care facilities responded with limited resources. The national plan for closure of state mental health institutions included the construction of community mental health centers, residences, and roommate programs but only a handful of these community residences exist in Dutchess county and all of these housing programs have extensive waitlists. One of the only available resources is the Hudson Valley is the Psychiatric Response Treatment Center that can evaluate individuals on an outpatient basis but is unable to provide resources to people without health insurance. Uninsured residents can contact Family Health Services (FHS) and work out a payment plan on a sliding scale based on income. This assumes individuals have a phone, an address, and disposable income so that initial treatment will be self-financed and

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[44] Wolf, Craig. "$200 Million Plan for Old Psych Center Site." *The Poughkeepsie Journal*
[45] Torrey, *American Psychosis.* Pg, 120

reimbursement will be sent later on. Moreover, individuals without income are not guaranteed

referral to a case manager from the Hudson Valley Response Treatment Center. Mental Health

America is another out-patient service providing intake and evaluative procedures on the

premise. This group can pair individuals to a case representative after referral from FHS. One

public shelter exists in Poughkeepsie and when I called in March of 2019 it had a waitlist of

over a week.

All of these services are not available immediately. Individuals who need urgent care will

be sent to St. Francis Hospital Psychiatric unit. A representative of Dutchess County Health

Services explained that the emergency room and Dutchess Outreach Catholic Charities or other

private charity organizations are the only infrastructural support services that provide durational

in-patient care. Poughkeepsie Stabilization Center is listed as a "public shelter", but is really a

psychiatric intake facility where individuals receive medication assessment and the maximum

stay is 23 hours. A representative from Dutchess Outreach Catholic Charities expressed sadness

that Hudson Valley Psychiatric Center had closed, most individuals in need of urgent treatment

care are now turned away.

Pathologizing mental "illness" lends itself to severe mis-steps in handling discharged

patients. In Poughkeepsie, the job of maintaining public order falls on"helping professionals"

who are police officers and social workers tasked with mediating the effects of institutional

closures. In 2018 officers and Dutchess County's Department of Behavioral and Community

Health psychiatrists went on patrols to find individuals "who might need help navigating the

world of mental health treatment". The program is called the "Behavioral Evaluation and

Assistance Team" or BEAT, convening once a week to patrol Poughkeepsie. It was unclear to

me whether these patrols used solely visual cues to approach individuals. The parameters and

regulations of the program were not available online. Officer Mike Baron said,"'We're basically

bringing the services to them (the mentally ill)'".[46] Officer Baren reported a 'huge increase' in

the number of individuals on the street suffering from mental 'illness' since the closure of the

institution. He claimed there was a broad consensus that since the closure of HVPC, added foot

patrols have become " especially important".[47]

Along with these 'helping professionals', various inner-city infrastructures, from small

businesses to public parks have assumed the responsibility of the asylum. "...the primary

meaning projected onto donut shops is one of sanctuary and congregation with ex-psychiatric

peers. For this population, the inner city environment offers few places of rest."[48] Urban

infrastructural developments created to mediate the effects of deinstitutionalization include

public housing, congregate homes, and "other services that tended to be located in the inner

city…"[49]

Since the early 1980s, there have been reports that at least one-third of homeless

individuals are seriously mentally ill and these numbers continue to rise.The number of homeless

in Dutchess County in 2018 was the highest it had been in the last five years, according to

preliminary numbers for the Annual Homeless Assessment Report by Dutchess County

Continuum of Care. Christa Hines, executive director of Hudson River Housing said, "There

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[46] Nandy, Ben. "Prevention in Poughkeepsie." *Spectrum Local News.com*, 21 May 2018,
spectrumlocalnews.com/nys/hudson-valley/news/2018/05/21/police-partner-with-social-workers-to-fight-mental-illn
ess
[47] ibid.
[48] Kearns, K. C. (1968), ON THE NATURE AND ORIGIN OF PARKS IN URBAN AREAS. The Professional
Geographer, 20: 167-170. doi:10.1111/j.0033-0124.1968.00167.x. pg , 13
[49] Dear, M J, and Jennifer R. Wolch. *Landscapes of Despair: From Deinstitutionalization to Homelessness.*
Cambridge, UK: Polity Press, 1987. Print. Pg, 248

just aren't the resources out there for people'". [50] Low-income, uninsured residents suffering

from mental health complications are entirely vulnerable to the shift in funding of social support

infrastructure.

Hudson Valley Psychiatric Center is illustrative of trans-institutionalization in which

infrastructural responses were either unbuilt or poorly coordinated. The raft of policy changes

during the mid to late twentieth century focused directly upon the plight of the institutionalized

mentally ill. Top-down choices changed the geography of mental health, decentralizing care and

re-spatializing modes of treatment and cultural legibility of mental health. Today, mental illness

visibly coheres in public space, lack of adequate infrastructures have created an exclusionary

geography of deinstitutionalization. Discharged patients, previously segregated from

communities in institutions, still experience isolation but now in hyper-visible urban settings.

Part IV: Neoliberal Urbanism

"*When the activity of individual human capital appreciation becomes the ubiquitously

governing norm, when through responsibilization, privatization, and dismantled infrastructure,

along with the dissemination of neoliberal metrics to every sphere of existence, this bad ontology

becomes the governing truth... homo oeconomicus becomes normative across all spheres...*" [51]

Post-industrialized America marked and measured human bodies in terms of efficiency.

In densifying urban centers clustered around industrializing zones there emerged a standardized

typification of abledness. At the core, this definition of normalcy centered the ability to do work.

Spatial and political oppression withheld rights from the disabled in modes similar to, though

certainly with different motivating factors to racial oppression and marginalization. The system

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[50] Barry, John. "HUD: Homelessness on Rise in Hudson Valley." *The Poughkeepsie Journal*, Poughkeepsie Journal, 7 Dec. 2017, www.poughkeepsiejournal.com/story/news/local/2017/12/06/homelessness-rise-dutchess/928710001/.

[51] Brown, Wendy. *Undoing the Demos: Neoliberalism's Stealth Revolution*. 2015. Print. Pg, 104

of 'ableism' relies on two elements: "the concept of the normative (and the normal individual) and the enforcement of a divide between a 'perfected' or developed humanity and the aberrant unthinkable, underdeveloped, and therefore not really human." (Hamrie, 14). The privatization of public resources and disinvestment in public mental health shows the power of productivity in creating a citizenship that is not embodied but that demands bodily and psychological conformity.

After industrialization in the 20th century, citizenship became contingent upon the ability to do work. In the medical community and the burgeoning discourse of self-help, citizenship involved taking advantage of the opportunities one was provided, particularly medical therapies and vocational rehabilitation. National belonging, in other words, became the right to be rehabilitated." (Hamraie, 62) This "Disqualified citizens...whose perceived dependency and simultaneous failure to assimilate cast them as non-productive and therefore failing to uphold the duties of citizenship" (Hamraie, 61). The state's power to evaluate and spatially isolate individuals created a concentration of discharged patients from mental health institutions into zones with limited opportunities for work, inadequate housing, and disinvested medical and social support.

Transinstitutionalization is an example of neoliberal urbanism. The de-spatialization of public mental health and individuation of treatment demonstrates political theorist Wendy Brown's theory of neoliberalism as a federal project that "responsibilized" citizens that configured all aspects of human life around modes of economic accumulation. In neoliberal urbanism, the subject of the political agenda is *homo oeconomicus*, "someone....eminently governable...the correlate of a governmentality...determined according to the principle of the

economy".[52] No longer are citizens most importantly constituent elements of society, members of publics, or the bearers of rights. The state that in theory derives its power from the people controls citizens so that they can best produce "human capital" and therefore the human subject is relevant to governance in the stark dichotomy "...of contributing to or being a drag on economic growth: (human subjects) may be invested in or divested from depending on their potential for GDP enhancement."[53]

This politics of investment and disinvestment in citizens is reflected in in urban space. Discharged patients within the inner-city hastened the infrastructural decay and neglect "...in areas of low-cost housing, proprietary homes, or deteriorating neighborhoods".[54] This dispersion of mental patients into disinvested areas is illustrative of the parameters for citizenship that are contingent on standardizing along terms of racial and embodied conformity. In neoliberal urbanism the state is able to disqualify certain bodies based on 'inability' to conform to these standards, placing them in stagnant, disinvested zones for the 'not productive-enough.

Neoliberal urbanism creates exclusionary geographies. The neoliberal project "...represents a broad *syndrome* of market-disciplinary institutions, policies, and regulatory strategies".[55] Previously, the asylum was a space of enclosure that operated to organize bodies that weren't inculcated into these rhythms of city life. The power and authority granted to the asylum came from the supposed truth and objectivity granted to science. Those who were institutionalized and pathologized entered institutional life, in which spatial separateness "forged an enclosure of self-identity precisely not dependent upon the walls of the asylum, but readily

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[52] Ibid. Pg, 110
[53] Ibid. pg, 110
[54] Talbott, John A. "Deinstitutionalization: Avoiding the disasters of the past." *Psychiatric services* 30.9 (1979): 621-624.
[55] Brenner, Neil. "Is 'Tactical Urbanism' an Alternative to Neoliberal Urbanism?"

leaked beyond the distinctive geography into the everyday spaces of social life, persistent across time and space and now lived out by the deinstitutionalized."[56] The enclosed-ness of the asylum carried with it a dense cluster of meanings "...it wrought a sort of confinement, dispossession, incarceration… and social transformation all at once."[57]The non-adaptable medical and design strategies became the definition of these institutions.

The state over-extended its reach and then failed to protect the rights of citizenship for mental health patients, placing the burden of responsibility for public mental health care on individuals and their surrounding communities.The much more informal rules and norms shared by 'local majorities' become the governing norms in social systems, "...which undoubtedly create a sense of who can be included and who cannot".[58] Urban environments must be understood as "....living entities, not as background or passive entities but as actively shaping forces''.[59] These spaces hold potential to re-enforce or disrupt the limited parameters of citizenship protracted by the state.

Disability studies takes issue with dichotomies of normal/abnormal, healthy/unhealthy, fit/unfit, and able/disabled in"... the very foundations of our systems of rights and our valuations of worth and membership".[60] Sociologist and Urbanist Neil Brenner writes about a disruption to neoliberal urbanism that he calls tactical urbanism. He defined this as "... promoting a grassroots, participatory, hands-on, do-it-yourself vision of urban restructuring, in which those who are most directly affected by an issue actively mobilize to address it, and may continually mobilize to

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[56] Parr, *Mental Health and Social Space: Towards Inclusionary Geographies?* Pg, 164
[57] Watts, Duncan J. "Six Degrees the New Science of Networks." (2004).pg, 51
[58] Painter, Joe, and Chris Philo. "Spaces of citizenship: an introduction." *Political geography* 2.14 (1995): 107-120. Pg, 115
[59] Hamraie, Aimi. *Building access: Universal design and the politics of disability*. Pg, 81
[60] Ibid. Pg, 39

influence the evolution of methods and goals'".[61]Tactical urbanism is an open-source model of

action i that seeks reappropriation of urban space by its users. Perhaps his idea aligns closely

with Disability studies that seeks flexible design, that is "…a quality of products made to

anticipate a broad range of users rather than a singular normate".[62] There could be a moment of

friction between the potential for grassroots design in tactical urbanism to be co-opted into the

neoliberal model and displace state responsibility for structural inequity. This is the downfall of

"acupunctural" interventions that are short lived and non-influential. Despite this I think that

tactical urbanism is an approach that shifts conversations about what is possible and can

ultimately have long term effects by drawing ideas out of the hypothetical and into the tactile. In

redesigning public infrastructures for mental health, we must question who we are designing for,

under what conditions, where, via what methods, and with what consequences.

The narrative of mental illness that has been co-opted such that the experience of

disability entered the historical record "...largely through the words of those who tried to cure,

tame, correct, or end it...disability studies scholarship is now focused on building-as well as

excavating from the past- a rich and self-conscious record of the perspectives of disabled people

themselves."[63] The project of finding viable alternatives to neoliberal privatization that made the

difficult questions surrounding mental health less visible requires new modes of urban

intervention. The historical model tends to distance the users of institutions from designers,

however, disability studies is an approach to knowledge production that can radically localize

impacts on communities by allowing the implications of lived experience to have more

influence.

[61] Brenner, Neil. "Is 'Tactical Urbanism' an Alternative to Neoliberal Urbanism?" *Post*, 24 Mar. 2015
[62] Hamraie, *Building Access*. Pg, 41
[63] Adams, Rachel, Benjamin Reiss, and David Serlin, eds. *Keywords for disability studies*. NYU Press, 2015. Pg, 7

Part V: Disability Studies and Reconfigure(ing) the Mental Patient

"A Cultural model of disability...explores the disabled body's interface with the environments in which the body is situated… disability itself always begins and ends with the subjective impressions of the individual who experiences the world through her body." [64]

As asylums became medicalized, the nonlinear complex patterns of mental 'illness' were overshadowed by the standardized definition of the mental patient who become increasingly anonymous, constituted by a cluster of symptoms. The state of waxing and waning, uncertainty and fluctuation that are fundamental realities to living with mental illness were replaced by static ascriptions of difference with clinical approach to mental 'illness' understood as disease. Mental 'illness' often involves uncertainty, indeterminacy, and fluctuation. These subjective experiences were too complex for clinical formats of diagnosis, the mental patients in asylums became standardized along a "normate" template that broadly defined and predicted the livelihood of the patient. The idea of the "normate" was popularized by disability studies scholar Rosemary Garland Thomson. She wrote about the history of the term as having 'legs' as it moved into the vocabulary of disability studies, "because it apparently answers the need to make something in a single word that went unnamed. Normate is not my word, however... The word came to me at my first Society for Disability Studies (SDS) conference...in 1989. The president of SDS, Daryl Evans, mockingly flung out the word normate... Daryl could pass for a "normate", which is a burden for anyone, of course, because it is such a fragile position, what I called 'the social figure with which people can represent themselves as definitive human beings'". [65]

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[64]Ibid Pg, 6
[65] Garland Thomson, Rosemarie. *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature.* New York: Columbia University Press, 1997

Rosemarie Garland Thomson is a critical disability studies scholar who writes about "the politicized consciousness of disability" that inherently resists "fitting" and "passing" as the goals for disability activism. The move to define the normate even in a categorical 'other' space of the mental institution illustrates far reaching wishes to impose standards on human experiences that are deviant from one's own. Conversations about the future for public mental health infrastructure are uncomfortability situated in uncertainty. Each embodied iteration of 'mental illness' will not be accounted for. Therefore, the function of participative design to re-open the narrative of public mental health care through 'discursive geographies' that come from those with lived experiences becomes paramount. Design is a tool to counter broad simplifications of experiences of those previously within the asylum and those who have been discharged. The tradition of top down choices in the federal project to regulate mental health is difficult to avoid, the resources of the federal government will be necessary to roll-out change that reaches the most precarious mentally 'ill'. "...disability contributes a narrative of a genuinely open future, one not controlled by the objectives, expectations, and understandings of the present. Disability, then, rescripts modernity's and the modern subject's temporal practices and understandings." [66] The generative process of designing programs and methods of care must is an opportunity to format this narrative of knowing making disability into the urban form.

The social model of disability studies encounters 'ambivalent relationships' to technology, in this case the buildings that held mental health technologies, informed by histories of failure and denials of access. As a framework, disability studies does not center "... assistive technologies that aim to cure or rehabilitate bodies...but centers how disability design and

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[66] Garland-Thomson, Rosemarie. "Building a world with disability in it." *Keynote paper presented at the Contact Zone: Disability, Culture, Theory conference, University of Cologne, Germany.* 2012. Pg, 60

politics co-materialize."[67] This politics is concerned with the possibility of knowing-making in disability or mental illness where 'misfits' to the current model are resources in re-designing. This requires resisting the 'normate' template, challenging categories that become universalizable. This also shifts expertise to those with "lived experiences of disability and away from the outside experts often designing in their name."[68]

The distinction of patients in mental health institutions from regular citizens is an example of human bodies understood as 'passing' or 'non-passing'. This is a differential consciousness, "the experiential paradox between one's felt and ascribed identities".[69]Living with disability can mean that ones felt identity, how one experiences oneself as an embodied, perceiving, conscious subject at the center of one's own world is at odds with the ascribed identities of disability historically regarded as perverse. The study of passing "...involves a consideration of why and how individuals engage in the active manipulation of their identity… (and) the larger socio-political context and the way in which identity categories are socially constructed on a macro-level".[70] From this perspective, the extensive specialized systems for mental illness that are segregated, from special education to separate treatment centers, continue sharp distinctions between able and disabled or felt and ascribed identities and heighten "...the tensions around passing and receiving people's choices about how to identify".[71] Closing public mental health institutions disappeared the figure of the mental patient nad cast animosity onto the former institutions that further stigmatized previous patients. Non-passing is a felt reality when

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[67] Hamraie, *Building Access.* Pg, 103
[68] Ibid.
[69] Garland Thomson, Rosemarie. Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature. New York: Columbia University Press, 1997
[70] Adams, et al. *Keywords for disability studies.* Pg, 142
[71] Ibid. Pg, 143

living with "mental illness" that allows segregation to become a cultural norm. Regardless of physical separation in institutions, the social isolation often remains.

Part VI: Art and Madness

"....critical art is art that foments dissensus, that makes visible what the dominant consensus tends to obscure and obliterate."[72]

In issues as complicated and existentially loaded as the public provisioning of mental 'well-being', art as social practice and political commentary is powerful. Artistic geographies both within and outside of the asylum illustrate the sustaining link between creativity and wellbeing.[73] Work across disciplines of artistic media, including visual art, craft-making, sculpture, writing, film making and performance have been used as treatments in inpatient and outpatient care. Art therapies emerged within the spaces of the asylums but have become increasingly prominent social practices in the context of deinstitutionalization. Art can provide a non-clinical practice that evokes experiences of stability, important precursors for sensing belonging in proximate social networks and physical places.

Collective art spaces can be symbolic and literal places of belonging ,"The artistic experience might involve the possibility of situated belonging, and may be creative of versions of social insiderness for people with mental health problems…"[74]In the context of

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[72] Mouffe, Chantal. "Artistic Activism and Agonistic Spaces". V: Art Research." *A Journal of Ideas, Context and Methods*(2007). Pg, 7

[73] The tradition of visually representing madness within the asylum through asylum art points towards the need of society to identify the mad absolutely. "Society defined itself as same and needed to localize and confine the mad, if only visually, in order to create a separation between the sane and insane. (Gilman, 1988, p. 48). 'Art brut' was coined by French painter Jean Dubuffet (1901-85) as a catch all phrase "for everything that is ostensibly raw, untutored and irrational in art" (Rexer, 2005, 6). This idea gave rise to a category of "outsider art", primarily made by self taught, idiosyncratic and unusually self expressive artists. Historically, "insane outsider" art work was produced in asylums and even exhibited by institutions, the earliest being the landmark exhibitions of 'psychotic art' organized by the Royal Bethlem Hospital in London in 1900 and 1913 (Rhodes, 2000). Perhaps the art produced in the asylum legitimized the "mad", their creations were something to show for their insanity. Regardless of why the 'outsider' art became popular, processes of art creation remained an important therapeutic mode in the institutions.

[74] Parr, Hester. "Mental Health, the Arts and Belongings." *Transactions of the Institute of British Geographers*, vol. 31, no. 2, 2006, pp. 150–166. *JSTOR*, www.jstor.org/stable/3804378. Pg, 155

deinstitutionalization, the daily or weekly attendance at and in art project spaces arguably

provides structure routine, and opportunities for expanding social networks for project

participants,"this goes beyond the usual dimensions of other daycares because they provide

opportunities for specific kinds of art-talk, peer advice giving, reciprocity, facilitation of

workshops and participating in cultural events like exhibitions within and beyond art project

space".[75] In the city, a mundane embodied occupation of available artistic community spaces

generates a feeling of welcome-ness and confidence to sit in cafes and bars with other artists and

workers.

> "...giving voice through the vehicle of public art can be the means of drawing the
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> invisible into the urban narrative, it also has a role in drawing in those citizens and spaces
>
> whose marginalization stems from other causes….stigmatization, the stereotyping of
>
> particular groups and the urban spaces they occupy, is a commonplace source of
>
> marginalization"[76]

Art makes subjective experiences legible to the public. Belgian political philosopher

Chantal Mouffe called this 'artistic activism' that challenges existing consensus through

'agonistic' practice that widen the field of social spaces available to intervene in and to oppose.

This process "...can offer a chance for society to collectively reflect on the imaginary figures it

depends upon for its very consistency"[77], shifting cultural landmarks of self-understanding.

'Agnostic' artistic practice produces political questions that aren't technical issues to be solved

by experts, but open to the public who can enter and explore conflicting alternatives. 'Bloom' is

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[75] Ibid.
[76] Ibid.
[77] Mouffe, Chantal. "Artistic Activism and Agonistic Spaces". V: Art Research." *A Journal of Ideas, Context and Methods*(2007). Pg, 7

an interactive public art project that I will use to explore this agnostic mode of art making that resists the contemporary understanding of asylums as haunted relics and "com(es) to terms with the lack of a final ground and the undecidability which pervades every order".[78]

'Bloom' is an example of artistic activism that is nuanced, dwelling in the ambiguity of contemporary absences of public mental health infrastructure while acknowledging the repressive capacity of federal public mental health praxis of the past. 'Bloom' shows public art as epistemic activism that shifts the knowledge production and dissemination practices in politics by granting marginalized perspectives authority. Epistemic activism is an opportunity for user-participation to produce knowledge through embodied understanding, shifting the conversation of blame for the failures of asylums away from the persons who inhabited the space to the political and social practices injected into these environments.

Artistic practices in community mental health spaces offer a reconceptualization of what constitutes treatment. The next section will examine public art practice as epistemic activism, drawing out questions about whose perspectives are granted authority in construction, design, and treatments within institutional spaces. Participatory projects re-frame the narrative of environmental and spatial failures of asylums by underscoring the experiences of the persons who inhabited them.

Part VII: Ambivalence in 'Bloom'

"It was a strange duality: at its core this project was intended to allow people free access to a building that had always been locked and mysterious, while opening its doors also (and

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[78] Ibid. Pg, 8

especially) to those who had been there for years. The building meant many things to many

people, as a workplace, a refuge, a place of confinement."[79]

Anna Schuleit Haber activated the interior of Massachusetts Mental Health center with

public art, "...guided by the fact that Mass. Mental itself is a whole with connected limbs, busy

centers, quiet ends, wings, nooks, and crannies, and nonetheless a living, moving whole." [80]

Massachusetts Mental Health Center closed in 2003 after nearly a century of operation.

Anna Schuleit Haber created a living monument in this logistically complicated and unexpected

environment, four days before the institution's doors closed forever. Haber brought 28,000

flowers into the institution, honoring every patient that had received treatment in the institution

with a living flower. "All of the flowers were in bloom at the same time, creating a continuous,

unbroken composition of color and scent throughout the building."[81] With the help of volunteers,

Haber brought life into every hallway, room, staircase, even the empty swimming pool in the

recreation center. Haber used a different type of flower in each hallway, highlighting the axes of

the building, channeling the flow of bodies throughout the space, ushering bodies throughout the

complex layout. Haber's use of natural vibrancy contrasted the color-less hallways that ran

throughout the building.There was an an absurdity in overabundance, the sea of flowers

pronounced their foreign-ness in the institution, an almost ridiculous amount of aesthetic beauty

within the clinical interior and yet it fostered coherent movement through the space.

Haber's work probed questions instead of narrating the closure. On the first day of

'Bloom', the Massachusetts Commissioner of Mental Health, Elizabeth Childs convened a

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[79] Interview from Anna Schuleit Haber in Jacobson, Christopher. "Bloom: 28,000 Potted Flowers Installed at the Massachusetts Mental Health Center." *Colossal*, 16 May 2013, www.thisiscolossal.com/2012/03/bloom-28000-potted-flowers-installed-at-the-massachusetts-mental-health-center/.
[80] Schuleit-Haber, Anna *BLOOM*, www.1856.org/bloom/concept.html.
[81] ibid.

day-long symposium that consisted of five round tables to trace the evolution of mental health

treatment for "...affective disorders, the seriously ill and schizophrenia; and the evolution of

pedagogy and research at MMHC".[82] The following morning people gathered on the front steps

for an open forum of "...memories, stories, wishes, questions, musings, hopes victories,

reflections and descriptions of what the Massachusetts Mental Health Center… meant to its

people over the years".[83] The flowers introduced an element of nostalgia in the wake of

nationwide closures of public institutions in favor of carceral management. Flowers grappled in

beauty and in mass with the terrain of institutional space.

The flowers were complex emotional signifiers that held a multitude of meanings; for the

lives of patients, the death of places, and the cultural practices and associations that happened

within the institution. Flowers can be a symbol of healing given to the sick in hospital settings

but are often shockingly absent in psychiatric institutions. On a less literal note, the flowers

symbolize transition, commemorating the institutional structure, and holding space for closure

that could simultaneously be a thing of loss and gain. The fleetingness of blooming flowers

explicitly played on the temporality of the exhibit. Haber invited the public into the building,

presenting the building as an ecology of interdependent parts that contained contradictions. One

patient wrote a response,"My therapist's office was in the basement and the floor is covered in

grass. Grass does not bloom but it cushions and it is in the right place. It is the foundation, it

softens everything. Conceptually it is brilliant."[84]

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[82] Bell, Susan E. "Claiming Justice: Knowing Mental Illness in the Public Art of Anna Schuleit's 'Habeas Corpus' and 'Bloom.'" *Health*, vol. 15, no. 3, May 2011, pp. 313–334, doi:10.1177/1363459310397979.
[83] www.1856.org/bloom/concept.html
[84] Ibid.

This memorial addressed loss and injury. It could have been a simple history of the building or its inhabitants, presenting a clean and closed narrative of the space with plaques and pictures. However, honoring every patient with a flower implied the diversity of experiences held in the institution. I reached out to Anna Schuleit Haber to ask about her artistic process. Through our correspondence it was clear that she intended to insert herself minimally as the artist. She said:

> "I felt that the entire project grew out of the spaces of the building. I spent one entire week with the idea itself: revising it in my head until it felt right, tweaking it, dismissing parts, adding others. The building had two courtyards that were covered in layers of ivy. Long ago, those courtyards had been designed and used for the recreation of men (in one) and women (in the other). When I presented the project concept to my planning committee, which consisted of many doctors who had worked in the building for years and even decades, I said that the idea of flooding the building with color and scent came from observing the ivy in the courtyards. Working with what was already there."[85]

'Bloom' created a powerful display of particularities of the institution. The flowers were arranged so as not to disrupt the last moments of the institution, they surrounded chairs left in hallways and came right up to the papers scattered on desks, incorporating "furniture, scrap paper, files and other office supplies that had been abandoned when its occupants moved out three weeks earlier... into the fields of color".[86] Choosing not to move these abandoned pieces of institutional life, Haber fostered coherence between people who moved through the rooms and

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[85] Anna Schuleit Haber, personal communication November, 2018.

[86] Bell, Susan E. "Claiming Justice: Knowing Mental Illness in the Public Art of Anna Schuleit's 'Habeas Corpus' and 'Bloom.'" *Health*, vol. 15, no. 3, May 2011, pp. 313–334, doi:10.1177/1363459310397979.

mingled with the ambient soundscape of the institution. She bridged " life and motion of the site with its impending abandonment".[87]Haber paused in the moment of abandonment, showing the interior space exactly how it was before it closed, bringing flowers right to the edges of abandonment, presenting the resonance of architecture as a body that absorbs all that has happened within it.

The flowers in Bloom foreground the ambiguity of the closure. Flowers as material facilitate flexible design, that is "a quality of product made to anticipate a broad range of users rather than a singular normate."[88] Flowers have no ascribed meaning, merely presenting a contrast to the clinical environment. At the root of this relationship is injury that needs addressing, but Haber believed that,

"...the flowers seemed to react less "against" the environment than to flow through it.

Jobson, Christopher. "Bloom: 28,000 Potted Flowers Installed at the Massachusetts Mental Health Center." *Colossal*, 16 May 2013, www.thisiscolossal.com/2012/03/bloom-28000-potted-flowers-installed-at-the-massachusetts-mental-health-center/.

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[87] www.1856.org/bloom/concept.html.
[88] Hamraie, Aimi. *Building access: Universal design and the politics of disability*. Pg, 41

Absence was felt everywhere, of course, especially since the building was literally

undergoing its closure. But older absences were noticeable, too, in some of the old

offices, the gymnasium, the derelict pool, and some of the top floor hallways and spaces.

The flowers and recorded sounds were able to reach into all those spaces in an absurd,

non-literal way. That was the wish."[89]

Haber carefully curated the smells, touch, vision, and scents to disrupt expectations when

entering institutional settings through visceral sensations. Flowers as organic evoke the comfort

of being around other living elements[90] and bring the participants more intensely into the present

moment. Flowers are also a hinge to look forwards and consider alternative equivalents to

bringing flowers into institutional interiors.

Haber's exhibit included an element of risk. To experience the installation required active

engagement with the space, to participate with the exhibit meant offering ones body to moving

through the building's arteries. 'Bloom' had an auditory component. The sounds of the closing

institution were recording during the final month of operation and played at a low volume over

the PA system. The project lended itself to stunning photographic documentation, however, it

was intended to be an interaction that inhabited the space, not a project for photography. In an

interview in 2003 Haber said that had the project been intended [only] for photography, it

wouldn't have required nearly as many flowers, but what she wanted was a project for the

everyday passerby. Engaging all of the senses, Haber placed people in an environment that could

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[89] Anna Schuleit Haber, personal communication November, 2018.
[90] "The power of nature included a particular sort of organic disciplinary power….Being in natural spaces, Foucault intimates "reveals natural powers, more constraining for madness, more likely to subjugate its essence, than the whole of the old limiting and repressive system" (Foucault, 1967, pp. 195-196).

only be understood in real time. Walking throughout the space and confronting a multitude of

greetings on every floor, participants entered into deeper understanding of the former inhabitants.

'Bloom' was a process based installation made through the help of volunteers.

"Twenty-eight thousand flowers arrived on trucks in the span of a few days, all needing to be

watered as they came in, all having to be placed in the building, unwrapped, arranged, and then

watered again. A team of about eighty volunteers helped out, they were all spontaneous helpers".

[91] Community members were empowered to reshape and reclaim the interior. The process of

'making' was democratized when Haber received donations of time and physical labor from the

public to make the installation. Active participation made volunteers into curators. This

collaboration changed the nature of the 'public brought into 'Bloom'. The relationship between

the art and artist was expanded to include the community, and the scale of this collaboration was

a part of the art itself. After the building was closed, the volunteers delivered all twenty-eight

thousand flowers to shelters, halfway houses, and psychiatric hospitals throughout New England.

Haber wrote that the flowers would continue onward beyond her installation. The production,

donation of material, and public engagement to bring the installation to life captures the

capaciousness of Anna Schuleit Haber's vision.

'Bloom' depended on the generosity of others, embodying the marriage of art and social

well-being coming together. Haber was not at the center of this installation, the building held all

of the power, showing what was emitted by a place and drawing out larger questions about the

power of aesthetics in public mental health institutions that are typically devoid. Haber was

explicitly interested in the architecture, encouraging the flow of bodies throughout the space and

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[91] Jobson, Christopher. "Bloom: 28,000 Potted Flowers Installed at the Massachusetts Mental Health Center."
Colossal, 16 May 2013,
www.thisiscolossal.com/2012/03/bloom-28000-potted-flowers-installed-at-the-massachusetts-mental-health-center/.

pushing the boundaries of where art and nature can live. The psychological impacts of blurring

traditional categories left the participants and viewers to arrive at questions. What might

alternatives look like in the curation of spaces for mental 'well-ness'?

Haber disrupted the typical closing cycle of public mental health institutions in the

United States. 'Bloom' was an invitation to enter or re-enter a world beyond public scrutiny and

parse through confusion, trauma, and possibility. Flowers as elements of mourning rituals tapped

into the "...fragile and uncertain alliances among those making mental health policy, living with

illness, and caring for those living with illness".[92] The exhibit was for the passing visitor,

radically opening, however briefly, the possibility of engaging the public in a stigmatized space.

After 'Bloom' closed, Massachusetts Mental Health Center (re)entered the mythic realm, leaving

it as an embodied memory, and site of possibility. An alternative vision had momentarily

occupied the institutional space.

Art can do work beyond the symbolic and effect real change, opening new points of

access to contentious issues, drawing differently situated individuals into deeply personal

conversations. 'Bloom' was an installation that created context for discussion. A guest book in

the lobby filled up with entries, here are some of the things people said about the experience;

"I walked through Bloom with a close friend of mine who has spent a great deal of time inside
similar hospitals. He was close to tears and repeated said he felt the desire to jump into the
flowers, sum bold for the freedom and the celebration of his own growth and healing. We
recognized that Bloom brought beauty and wonder to what has always been an inherently taboo
subject matter."

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[92] Bell, Susan E. "Claiming Justice: Knowing Mental Illness in the Public Art of Anna Schuleit's 'Habeas Corpus' and 'Bloom.'"

"'Never worry alone' was a Dr. Tom Gutheil classic line, but because of the lack of social support, too many patients who came here had to worry alone. Anna saw these corridors as places to be filled with growth. For all the patients who never received flowers, these flowers are for you."

"My mother told me, 36 years ago, "Hang on. They'll find a cure." I was suffering alone until I came to MMHC. And today… oh so grateful… beyond any words, so grateful. Lives and sufferings have been redeemed here, and today we celebrate and honor, all of us, in this place, for better or for worse. Today, we flourish. The list of what we cannot do grows shorter and shorter. We become comfortable in a world of three dimensions; we gladly surrender the fourth, fifth, and sixth."[93]

Final Thoughts

Anna Schuleit Haber temporarily changed institutional space to impact conversations about public mental health infrastructure. Her work re-narrated the closure of Massachusetts Mental Health Center by not narrating it at all. Resisting static memorialization and any gestures of visually representing madness or previous inhabitants, Haber left space for all that she did not know. Unlike the work of Foucault, Goffman, and Castel, she engaged with the issue of public mental health infrastructure by offering a brief experience of the unknowable histories. The walls of the institution came to life as they pressed up against the sea of color, disruptive and contentious questions about mental illness were momentarily foregrounded and coupled with an element of peace. The work of volunteers brought thousands of flowers into a closed off landscape, offering them to Massachusetts Mental Health Center, and then donating them to other spaces of unknown traumas and recoveries to extend their reparative work. Haber's art acknowledges the dense, sometimes palpable memories and histories that attach to institutional

[93] Jobson, Christopher. "Bloom: 28,000 Potted Flowers Installed at the Massachusetts Mental Health Center."

landscapes. She revived a public infrastructure that would have been left to decay. In doing so, Haber honored the building and it's previous inhabitants, allowing the institution to be seen and remembered in alternative modes that are not linked to shame and guilt.

'Bloom' delved into the possibility of considering the abandoned institution as a site of shortcoming in worthwhile efforts towards creating spaces for resilience. This brings me back to my initial motivations for this project. My grandmother could have been cared for inside of Massachusetts Metropolitan State Hospital. I wish I could have held her hand as she entered the building for the first time. I wish I could move through the inside of the institution with her as a phantom shield. Hers was not the first or last story of mistreatment and malpractice, and now I can understand it as more than just a cautionary tale. When she entered the institution her body became a collection of symptoms, no longer afforded the right to make choices. The building may have been the site of trauma but the agency that was withheld came from the medical and cultural understandings of mental 'illness'.

American Asylums make visible the difficult questions that disability poses. The institutions expose the chasm between the built environment and the lived reality of mental 'illness'. Over the course of this research I've learned that the discharged mental patient's status as forgotten and invisible has less to do with where one's body is located than with the presumed and predetermined categories a 'disabled' body falls into. The issue of public mental health is now more visible than ever and urban landscapes are the terrains of exacerbation.

History shows that not every step forward will be correct and sometimes there won't be a right answer. If a new program for infrastructures of mental health were to be rolled out, there is

risk of new trauma. However, living in the borderland as abandoned state projects, asylums are derelict and without opportunity for reconciliation. The nugget of empathy that inspired the first wave of construction disrupts casting these institutions as mis-steps that should be erased. Anna Schuleit Haber made space for a more nuanced history to be acknowledged and carried into the present. What if reconciling mind and city meant the provisioning of public mental health care met individuals in need with an overabundance of blooming flowers?

Appendix

Interview 1: Email Exchange with Anna Schuleit November 2018

Bloom was created over the course of three and a half months: August, September, October, and half of November. It opened to the public on Nov 14 and was open for four days, then it closed and all flowers were donated (and delivered) to people behind bars, in shelters, halfway houses, psychiatric wards and hospitals, and in prisons.

For that entire duration, starting in August, I had my own office inside the Massachusetts Mental Health Center. I had an office for this project because my work was otherwise entirely unpaid. I had no income, no artist fee, so I decided that at least I could have an office from which to create this entire project. I also had interns and volunteers, whose help increased as we came closer to the project's opening, and without whom I could have never created this work. It was an immense team effort.

During the time of my project preparations, the building of MMHC was closing: offices were moving to other spaces in the city, furniture was being given away to other state agencies, and there was a lot of packing and commotion on all floors. The psychiatric shelter remained open until the very end, and many doctors' offices remained in use until the end. Nobody was leaving the building gladly. It was a much-beloved space with many many busy lives connected to it. The entire transition was significant for everyone involved.

Many people lamented that the central location of access to psychiatric care for those who needed it the most, for anyone, really, might be lost if MMHC had to close. Many of its services migrated to the Shattuck Hospital in Jamaica Plain. It would be interesting to do some interviews there to find out how that transition played out, how it was experienced. The consensus was that MMHC was a special place for many reasons. Location being one, and the merging of state care with Harvard scholarship was another. I am not sure if those aspects were able to be preserved past the closure.

Interview 2: Notes from Phone Interview with Mitch Barden on March 17, 2019.

Worked in Hudson Valley Psychiatric Center from 1990-2010 at Cheney Hospital on the grounds, working with the last 100 patients that couldn't be discharged. Dealing with refractory paranoia and schizophrenic patients. Had to go to court for medication over objection, when patients refused the medication the judges decided and Mental Health Services would represent patients who did not want to take the medication. Main medications prescribed were risperidone, seroquel, and in the 1980's haldol which brought with it abnormal twitching and other movement side effects like dyskinesia, dystonia, and parkinsonism. Issued 1pc-937 which was when doctor sent patient against their will to St. Francis Hospital psychiatric emergency room.

The Main building only had administrative offices no patients when he worked there. Several times a week there was a code green on a specific ward, meaning there was a dangerous patient and all the staff of the hospital would rush there to restrain the violent patient and give them medication. Different levels of recreation, level 5 was ability to go out on the grounds, walk around, and even go off grounds and visit their families. Mainly poor, lower socio-economic, multi-racial patient population.

Direct Quotes: "It was like working in a prison. Some of the psychiatrists who were transferred after HRPC closed were moved to prisons because they were paid more money."

"It definitely left me with PTSD ...I would not work in a psychiatric unit again."

"They really trusted me, they didn't injure you, mentally ill recognize kindness. I was very kind to my patients, I didn't over prescribe, tried to get them on the lowest amount of medication."

"Psychiatrists were very conscientious and kind, dedicated, limited use of force … only to prevent someone from getting hurt."

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