ABSTRACT

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                                AND THE TRANSFORMATIVE JOURNEY
                                FROM FEMININE MISFORTUNE TO
                                HEALING

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complicity, community, healing, human behavior, haven, shelter, asylum

        Psychiatric institutions have been notorious for the neglect, experimentation

and abuse inflicted on patients throughout the field's development. Historically,

asylums were not so much a place of healing as a place of harm and maltreatment.

From London's Bethlem Hospital to the first psychiatric hospital in the US, historical

record provides many examples of violence against patients. While this violence was

not discriminatory in choosing its victims, women were uniquely vulnerable. With a

status of minimal personal rights, women were commonly institutionalized for a

variety of suspicious, often trivial reasons, whether their spouse simply grew tired of

them or they proved to have a "disagreeable nature." The violence perpetrated within

the walls of these institutions is typically attributed to human behavior while the

structural characteristics of the environment are not commonly considered. From the

decisions made in space planning to the social culture of the staff, the harm done by

patients was reinforced as much by non-tangible factors as it was by any individual's

hand. As discussed in a series of articles in Architecture and Violence, "The notion of

spatial violence as a mute incorporation of power into the built environment has been

voiced by a number of theorists, critiquing architecture's complicity with

bureaucracy[1]. " Evidence of this complicity is written into spatial organization,

planning and quality. Paupers were housed in substandard conditions because it was

believed by designers that they "would not desire or benefit from the luxuries that

were essential for the cure of the wealthy[2]. " Deeply troubled individuals were left in

isolation in the basement where their sounds or outbursts of violence would not

trouble the outside world.

Now, many of these structures have become melancholy relics on the land,

sitting ducks for vandalism and vagrancy. There is a significant missed opportunity

in allowing these structures to decay instead of applying their vast square footage to

an important use. Though their history is mired by sorrow and abuse against women,

the story of the asylum need not end there. The mission to provide a place of healing

failed, but by adaptively reusing the old asylum, that mission may be reinvigorated.

These buildings can be reborn as positive environments by fulfilling critical needs for

struggling women today.

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[1] Kenzari, *Architecture and Violence*, 101.
[2] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 24.

By researching the history of thought and design of asylums from the 1800's to today, I aim to pull away the fundamental principles that led to the violence against patients and demise of the structures around them. With this set of fundamentals in mind, I will analyze the theoretical doctrine in the history of psychology, gender equality and the cognitive effects on self in order to determine how these institutions became such a perfect storm of disregard. Once established, I will take the doctrine and fundamentals of old asylums and compare them to principles of healing environments. This will provide me with a rubric of positive space I can use to transform the abandoned asylum into a true haven for women in need.

VIOLENCE AND OBSCURITY: ASYLUMS AND THE TRANSFORMATIVE
JOURNEY FROM FEMININE MISFORTUNE TO HEALING

By

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Thesis submitted to the Faculty of the Graduate School of the
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Dedication

This thesis was partially borne from a desire to tell a story that is often misunderstood and riddled with false information. The damage caused by these biases are often as detrimental as the mental illness itself. There are so many I hold so dear that have had to deal with this for so long. I dedicate this thesis to them, and in this small way, I hope I am able to offer some relief from prejudice. You are not and never will be alone.

Table of Contents

List of Tables

List of Figures

List of Illustrations

Introduction

The 19th century asylum was an institution borne of hope, faith and optimism for both the doctors' ability to cure and the healing powers of the institution. The word *asylum* came from a 15th century word in Greek *asylos*, which meant "refuge, sanctuary, inviolable, safe from violence[3]." These weren't just words, but promises progressive doctors and designers had made to the mental patient, who had suffered greatly by the hand of inhumanity. Old institutions like Bethlem in London had made an indelible mark on history that the burgeoning psychiatric profession never wished to repeat. From this dark history rose the 19th century asylum, a place of civic pride, medical confidence and patient hope that *the cure* was just around the corner.

From such a positive beginning, it is hard to imagine how the asylum so quickly deteriorated into a place they were never meant to be. Ghosts of Bethlem's past soon began to crop up; reports of abuses, overcrowding and poor conditions were slowly leaking from the asylum until such stories turned into a veritable flood. Women in particular were susceptible to the asylum regardless of whether they were in fact insane. They were invariably the victims of abusive reports, from physical violence to sexual assault. Mistreatment often began prior to their stay in the asylum, as behavior unbecoming of a woman was enough of an offense to land them in the institution. Husbands and other family members had the legal power to do so, but unfortunately the women had no counterbalancing legal recourse to combat that power.

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[3] "Asylum | Define Asylum at Dictionary.com."

This thesis tracks the asylum, psychiatry, and their relationship with women through the 19th century to modern day, and explores the underlining causes for the violence perpetrated behind the walls of the asylum. Rather then assuming these attacks were random acts of cruel individuals, I begin with the hypothesis that the very nature of the institution was to blame. From the attitudes percolating through both doctors, staff, and even family members to the very design of the institution, a perfect storm was created that virtually guaranteed violent acts against patients. The development of looking upon patients as *other* or somehow less than the average human being was extremely detrimental. Staff perpetrating these violent acts were free from justification at that point, as they viewed the patient as less than human. The spatial organization of the asylum was so hierarchically charged in favor of the medical staff that these attitudes were not a surprising development.

Many of the asylums charged with violent stories are now lying vacant against a forsaken landscape of chain-link fence, no trespassing signs, and vandalism. The betrayal of humanity seems to have flipped into a betrayal of the building itself. The historical victims of violence echo through the decaying structures as if their tragic legacy is now the reality of the building. Such a thick atmosphere of misfortune is difficult to deal with, and rather then doing that, the states that own these properties seem content to allow them to fall apart or bulldoze them all together to make way for new developments.

There is a lost opportunity here that doesn't need to happen. Looking at the asylum from a pragmatic standpoint, the amount of square footage offered promotes reuse. The embodied energy within these old structures can easily be reclaimed,

saving the added cost of new material, landscape and construction. Because of their troubled past, it seems appropriate the reuse of these asylums may in part be dedicated to healing, not just their negative reputation but the victims of their past as well. Where women were the historic victims of the insane asylum, they may now be the beneficiaries of the future. Women may be served with a generous place of true sanctuary and healing, especially in the case of domestic abuse. In this way, the echoes of past abuse are hushed, and the original hope, faith and optimism applied to these buildings can be restored. By adaptively reusing the asylum as a battered women's shelter, historical tragedy may be replaced with modern success.

The site chosen for this study is Greystone Park Asylum in Morris Plains New Jersey. The qualities I was looking for in a potential site were apparent at this location, and as an asylum built by a prominent architect in the late 19th century, Greystone was the right choice. There are many beautiful features at Greystone, including the exterior façade, the surrounding landscape, interior detailing, and magnificent spaces still in relatively good shape. The amount of potential within Greystone is huge, and its history, though tragic, is in keeping with the general pattern I've outlined above. Greystone was plagued with overcrowding and significant reports of abuse throughout its lifetime, which provides a great opportunity to offer a positive alternative in use for the institution. By reinventing Greystone's future, the influence of its troubled past may be mitigated.

Chapter 1: Historical Contexts

This chapter outlines the important historical developments and origins of the belief system often used to understand mental illness. The theoretical movements throughout the 19th century are outlined along with the special relationship women had to psychology even before it was considered a profession. Historical principles may be tracked in italics at the end of some sections, which will come in to play later as either program drivers or quick summaries about where the historical asylum went wrong.

History of Mental Illness

Origins of Psychiatric belief and religious influence

There was a significant paradigm shift in how psychiatric patients were viewed toward the end of the 18th century. The original thought base revolved around philosophical and religious beliefs. The lens used to understand the surrounding world was blanketed by religious overtones, and as such, the mentally ill were characterized within a strict binary set up of good and evil. "One consequence of the domination of the Christian Church was that the mind and the body came to be regarded as the province of the clerics, with the result that madness and illness were inevitably conceptualized in terms of good and evil[4]." Mentally ill individuals were considered dangerous based on this belief system. By subjecting the insane to harsh restraints and isolation, it was thought the rest of the population would be kept safe. When in "treatment", exorcisms were performed, as well as what Foucault referred to

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[4] Arnold, *Bedlam*, 29.

as "Purification of the body[5]." The treatments were based on the idea that shocking the person in some way would awaken them from their unholy stupor. For example, burning and cauterizing was believed a reasonable method to rid a person of infection through the new wounds. Immersion, or surprise bath, was another means of shocking a person back into their senses.

The surrounding community had no sympathy for the insane, either. Because they were viewed as dangerous and perhaps carrying around the devil, families and communities cast many mentally ill out on the streets. It was a common sight in medieval times to see an ill person wandering the streets looking for money. There were few hospitals offering care, and the one institution that did take them was not a place they wanted to be. Bethlem in London incarcerated mentally ill along with the poor and physically ill. The institution was well known for its deplorable conditions and patient abuse. If an incoming insane patient committed a crime while wandering the streets, however, abuse or restraints wasn't what awaited them, it was a quick execution without trial.[6]

Principle 1:   People relied on religion to explain things they didn't understand.

The Enlightenment

As the Western world entered the Enlightenment, however, the epistemology began to change from philosophical and religious to one based off scientific method, logic and observation. Religion, partially for the Church's egregious abuses and partially as a reaction to the appalling treatment of the poor, insane, physically ill and

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[5] Arieno, *Victorian Lunatics,* 68.
[6] Arnold, *Bedlam*, 24.

elderly, lost considerable power and influence. Mental illness was viewed as a physical rather then spiritual deficiency, suggesting first that harsh treatment was inhumane, and second, that rather then waiting for god to magically heal them, science could induce a cure. "It is, doubtless, less difficult to establish systems, and to imagine brilliant hypotheses respecting mental alienation, than to observe the insane, and put up with the disgusting circumstances of whatever kind, to which those are exposed, who would, by observation, study the history of the most serious infirmity. Thus, in a general view of the treatment of the insane, we should propose the skillful control of the mind and passions. We must never lose sight of the physical causes which have predisposed to, and provoked insanity[7]…".

Principle 2: Reliance shifted to the opposite end of the spectrum; the doctor was the new religion, and in some way, all ailments were thusly physical in nature.

Principle 3: Condescending pity made the control of other human beings acceptable.

Women and Healing

Formerly, caring for the sick and general healing was within the realm of local wise women that had a longstanding tradition of using herbs as medicine. Once the Enlightenment began to shift healing to a science, their practices were devalued. The new psycho-medical profession characterized these practices as old wives tales based on superstition.

While it was true the burgeoning profession of medicine was begun and eventually led to much success, its initial understanding of the human body was rather

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[7] Arieno, *Victorian Lunatics,* 69.

dubious and in many cases dangerous. What was understood as trivial superstition by the new profession often exhibited more success in treating the sick. Though the use of herbs was viewed as silly, it was a tradition based on observation of hundreds of years[8]. Discounting the wise women as peddling superstition rather then knowledge initialized a turbulent relationship between women and the medical profession that would echo strongly in psychology.

Principle 4: Out with the old, in with the new. Completely discounting tradition in favor of new concepts without enough due diligence. Forward thinking; the old is inaccurate.

History of the Theories Behind Mental Illness

Superstitions and the new profession

Both the medical and psychological industries began with a vigorous attempt to legitimize themselves. Theories were used to develop treatments for illness, and experimentation was used extensively on mental patients as a means of establishing a cure - a cure that ideally could only be administered by physicians. Many initial asylums were privately owned, but as doctors were working to create a profession for themselves, they began to see these private asylums as an opportunity to extend their efforts. "…the medical profession, which up till now had taken very little interest in insanity, began to claim that it was a disease like any other for which the usual remedies of purges, vomits, bleedings, and coloured powders, which of course only they could administer, were the cure. Many were highly respected medical men, and since recovery seemed to occur spontaneously in about 1/3 of cases anyway, doctors

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[8] Ehrenreich and English, *For Her Own Good*, 37–38.

were able to claim success for treatments which were not really any more effective than anyone else's[9]." As part of developing treatments, doctors used a variety of theories to justify their methods.

Principle 5: Authority figures are the representations/pinnacles of explaining one's environment. This is very similar to faith in religious authority figures and the psychological effect of a woman's spouse, the one that is supposed to love and protect, is in fact the one that is harming her.

Humours and Prenology

Interestingly, while doctors were quick to disregard traditional approaches to medical care, many of their initial theories were based on ancient ideas regarding the human body. Humours were a classification system used by the ancient Greeks to categorize personalities. Each of the four humours was associated with a bodily fluid and season. If any one of these bodily humours came out of balance, it was believed this imbalance would exhibit specific symptoms based on which humour was the culprit[10].

Phrenology, a branch of medicine created by Franz Joseph Gall in 1800, was based on the physical characteristics of the brain. Physical traits, talents, and susceptibilities could be determined by analyzing specific areas of the brain responsible for those determinations. While this study was summarily rejected 50 years later, it led to the pursuit of research into the localization of brain function, a major step forward in psychological theory and understanding. Gall's efforts

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[9] Johnstone, *Users and Abusers of Psychiatry*, 173.
[10] Arnold, *Bedlam*.

contributed to the epistemological change in psychology that led to more humane treatments for mental patients.

Another advocate for phrenology was Orson Fowler. He is best known for his promotion of a single architectural form in the latter half of the 19th century. He used the migrating patterns of people into the Northwest Territory, propagating phrenology and it's influence on the house form. He gave many lectures, connecting the basic concepts of phrenology to the octagon house-type. For Fowler, phrenology was a way of life, not just a scientific means of trying to understand one's personality. He promoted a sort of self-awareness and improvement program to his audiences. "Fowler's efforts to improve the life of the common man expanded to include the topic of the home. He believed that owning a good home was a key component to personal development[11]."

While Fowler's business revolved around one's dwelling, he was using a similar means of interpreting built form in a manner that would assist in the improvement of one's wellbeing. He never got into the business of insane asylums, but the parallel deepens when considering the architects he worked with. His plans for the octagon house were incorporated into Samuel Sloan's work *The Model Architect (1852)*[12]. Sloan was well known for his Victorian houses, but was also a major figure in asylum design. He assisted Thomas Kirkbride in creating base plans to explain the ideas of moral treatment within the asylum. Sloan built several asylums, including the Alabama insane asylum, the Pennsylvania asylum, and Greystone Park Asylum for the Insane in New Jersey. Sloan used concepts based on

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[11] McCarley, "Orson S. Fowler and A Home for All," 50.
[12] Ibid., 54.

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behavioral theory in both houses and asylums, as evidenced in his work with Fowler and Thomas Kirkbride. His involvement in both houses and asylums made him one of the central figures in using built form to influence behavior, and his relationship with Fowler, who was making a similar case in residential architecture, indicates a wide spread belief in the 19th century that one's environment, including structure, could induce a sense of wellbeing.

Of the 30-odd asylums Samuel Sloan designed, Greystone Park is among the few that still exist. Abandoned now, this asylum clearly personifies much of the theory developed in the 19th century. One of the primary methodologies this hospital embodies is that of Moral Treatment.

Principle 6: The built environment helps one's health and sense of wellbeing. There may be value in a variety of theories; certain aspects may be part of the learning experience, while others are not worth taking with you.

Miasmatic Theory

Other theories were derived from major epidemic events. The Miasmatic theory arose out of highly contagious diseases. Cholera, for example, decimated entire populations, making people desperate and paranoid. They believed the air itself was to blame for illness; the air was made toxic by noxious exhalations from humans[13].

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[13] Yanni, *The Architecture of Madness Insane Asylums in the United States,* 34.

Moral Treatment

Moral treatment was perhaps the most influential on the physical construction of 19th and 20th century asylums. This was a reactionary movement developed in part by William Tuke, Philippe Pinel and Thomas Kirkbride. Witnessing the harsh, abusive treatments borne on patients in institutions like Bedlam, they were both appalled and determined to establish a more humane treatment. William Tuke in particular was very critical of the deplorable conditions. Moral treatment was developed in an effort to better the situations of mental patients. The term "moral treatment" was not a moniker indicating moral superiority over other forms of treatment. Instead, the term "moral" was in reference to the mind rather then the body[14]. This was a treatment based on psychosomatic causation rather then physical. As part of the movement's reform, "the treatment of the insane embodied basic humanitarian values that represented a revulsion against earlier inhumane attitudes[15]." The asylum should be a place of healing. Patients deteriorated from the outside world, but they could be cured if they were pulled away from the negative influence of city life. Physical activity, fortifying meals, good hygiene, rest and structure were all part of the moral approach to curing patients. Mental hospitals based on these values were built in both England and the U.S.

Principle 7: Taking care of one's basic human needs in a holistic manner contributes to the health of that person.

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[14] Ibid., 24.
[15] Arieno, *Victorian Lunatics,* 69.

Diagnosis practices and women

Some of the theories developed were specifically directed at women and their societal role as mothers and wives. Doctors believed women were ruled by their physical bodies, in particular their reproductive. Treatments were based off this assumption, whether or not a woman's diagnosis had any relation to her reproductive system. If a woman was suffering from melancholia, for example, the assumption was her role as mother was not fulfilled and, as treatment, ought to be pregnant on a nearly consistent basis.[16] Similar treatments were proscribed for hysteria and invalidism. Nymphomania had its own set of treatments, the worst of which was removal of the woman's sexual organs[17].

Theories regarding the mental health of women in some cases went far afield of the otherwise standard practices of treatment. An underlying belief system had great influence on what doctors established as treatments and cures for women. A conflict between a woman's internal organs, namely, the brain and the uterus, were thought to plague women. "…women were urged to throw their weight behind the uterus and resist the temptations of the brain. Because reproduction was woman's grand purpose in life, doctors agreed that women had to concentrate all their energy downward toward the womb[18]." Apparently, great illness was brought upon women that were well educated. This belief was reflected in asylum statistics; in 1902, a

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[16] Arieno, *Victorian Lunatics.*
[17] Ehrenreich and English, *For Her Own Good*, 134–135.
[18] Ibid., 139.

study found 42% of women admitted to asylums (as opposed to only 16% of men) were highly educated[19].

Principle 8: Intelligence was women's kryptonite. Their level of intelligence adversely affected their health. Women exhibiting strong opinion that could be related to intelligence were stepping outside the role proscribed to them by patriarchal society. By controlling women, you kept them healthy.

Dr. S. Weir Mitchell created a treatment specific to women called the Rest Cure. His treatment relied on the conflict between the female brain and uterus, as he felt lack of mental stimulation was the best cure for diagnoses like invalidism and neurasthenia. His treatment was designed to cure women by "total isolation and sensory deprivation. For approximately six weeks the patient was to lie on her back in a dimly lit room. She was not permitted to read… She was to have no visitors and to see no one but a nurse and the doctor[20]." Predictably, Dr. Mitchell's treatment was not as successful as he made it out to be. His mode of isolation did more to create a sycophantic relationship with his patients then anything else, unfortunately establishing another turbulent precedent between women and doctors.

Principle 9: By abusing one's authority, they are able to fulfill their own selfish needs. Because they are authority figures, they are not questioned. Again, connection with battered women and the authority-establishing figure in their partner.

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[19] Ibid., 141.
[20] Ibid., 144.

Mental Hygiene Movement

The Mental Hygiene Movement occurred around the same time deinstitutionalization began. A slow development, rumblings about problems within the asylum system began prior to 1900, but full deinstitutionalization did not occur until the 2000's. These rumblings revolved around three major issues. First, state-run asylums were generally led by the ideals of moral management. The problem was the cure for mental patients remained ever-elusive. The lack of positive results with moral treatment resulted in doctors losing faith in its principles. Efforts to realign the treatment of mental illness with medical practice slowly started to take place.

Financial trouble coupled with overcrowding also contributed significantly to the development of the Mental Hygiene Movement. Reports of abuses in hospitals completely over-run by the patient population were appalling. The institutions had neither resources or space to help combat the issues, which caused many doctors to move away from the asylum as the pinnacle of patient care[21].

In steps the Mental Hygiene movement in 1908[22]. Clifford W. Beers, a former patient, wrote a highly influential book about his experiences called *A Mind that Found Itself.* In it, Beers published instances of abuse, opening the issue to a wide audience. He also characterized doctors as unknowledgeable and the attendants as untrained and significantly lacking empathy[23]. He called to protect the rights of

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[21] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital."

[22] Johnstone, *Users and Abusers of Psychiatry*, 270.

[23] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital," 227.

the patients and improve the conditions of the asylums. Another aspect of reform was to take a more preventative attitude instead of relying on asylums to cure the insane. The new belief was it was much easier to prevent the onset of mental illness rather then treat it after the fact.

The Mental Hygiene Movement acted as a stepping-stone toward vast changes in the psychiatric industry. On a very basic level, the principles between moral management and mental hygiene hadn't changed; treating patients with respect, providing healthful environments, and providing beneficial care for the patients. However, the hygiene movement served as a reminder after the values of moral management had largely been forgotten in the face of financial and population challenges. With any system, constant maintenance and revisiting establishing principles is critical to the continued success of that system. Unfortunately for the asylums, no such system checks were in place, and the heavy reliance states had on them to house all manner of the disturbed virtually sealed their fate from the beginning.

History of the Asylum

The purpose-built institution

The construction of asylums was directly influenced by the methodologies and treatments of psychology. Carla Yanni, a professor at Rutgers University, refers to 19th century asylums as "purpose-built". This was in sharp contrast to earlier structures for the insane, which usually consisted of jamming asylum programming into completely inappropriate structures like old houses. An important development in institutional design, purpose-built structures enabled a number of improvements.

First, critical thought into program could be implemented into the building. Designers were able to provide a layout that correlated directly with the concerns of doctors and patients. Second, purpose-built asylums could communicate to the public in a way that wasn't previously available. The intricately designed facades indicated a place of civic importance, which also helped to validate psychology as an important field. Interiorly, the building could become an advertisement of sorts for the services provided. Visiting families could be put at ease in a comfortably designed parlor or visiting room, indicating all was well within the asylum. And finally, these new asylums were able to embody some of the psychological theory of the time.

Principle 10: By customizing a space to a specific user group, their needs are more thoroughly met.

The assumptions that led to these purpose-built structures had origins in environmental determinism. This was a strongly held belief by asylum reformers that one's environment contributed significantly in health and wellbeing. By altering the environment of the mentally ill, it was believed their cures could more easily be reached and success would prevail over the chronic nature of many patients. Critical to environmental determinism was an acknowledged rate of success. However, historically speaking, even when the times were good in asylums like York Retreat and Kirkbride's linear structures, the revolving door of returning patients didn't slow down. Nor did the rate of healthy patients returning to society improve. So, were the techniques and strategies of environmental determinism a waste of time?

Critics of determinism would say emphatically yes. In Alan Lipman's article "The Architectural Belief System and Social Behavior," he places great skepticism at

the feet of determinism. Siting a lack of empirical evidence, Lipman claims, "While laymen may be aware of the effects of their social contacts and behavior, they are largely ignorant of the mechanisms by which these are achieved and sustained. Not being in a position to question the assumptions of their specialist consultants [architects], they tend to accept their claims at face value[24]." He sites a historical change in thought from one of personal social contact between architect and client to one of a bureaucratic body acting as go-between. Where there was formerly a dynamic relationship between designer and end-user, now designers claim a one-sided coin of influence upon their end-users. The process has become completely impersonal; the architect that mass produces housing, for example is not aware of unique needs, and so their ability to truly influence anything has been vastly restricted. "By augmenting the effects of social distance, administrative distance exacerbates architectural divorce from building users. Belief that the profession aspires to, and attempts to, engineer social behavior can temper practitioner's doubts about the social value of work[25]." The idea that a designer may determine human behavior through their design decisions is reduced to a simple means of self-legitimizing.

There are many flaws with Lipman's reasoning. He appears to have a superficial and binary understanding of the relationship between end-users and designers. His romanticism of the past compared to his criticism of the present does not take into account more then one small aspect of the architectural industry. One would think the only architecture left comes off a conveyor belt hundreds of miles

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[24] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 80.
[25] Lang, *Designing for Human Behavior*, 28.

from its destination. By using a single comparative umbrella, Lipman manages to discount an entire body of evidence to the contrary. In fact, all of the built environment has an effect on the behavior of people moving through it, whether or not the designer is willing to take responsibility for those effects. The person moving through a particular environment is also not an inactive target of structural influence. "The study of the interface between environment and behavior is the study of those adaptations people are making to what is put in place for them to use: the adaptations[26]." Lipman claims designer influence is a one-sided relationship that does not in fact exist; that architects are simply designing. However, the interaction between a given environment and a person's ability to adapt to it hasn't changed. Whether or not someone has intentionally designed that given environment does not change this adaptation process; in fact, the resulting behavior can be read as evidence of success or, as in the case of asylums, catastrophic failure.

Influential people

William Tuke, a Quaker layman, was among the first to employ treatment theory to the construction of an asylum. His York Retreat was based off Moral Treatment and completed in 1796. Tuke's observation of traditional mental treatments along with his relatively unheard of notion that mental patients could be returned to society led him to rethink the entire asylum operation. Believing bleedings, blistering and evacuants completely ineffective, he directed York Retreat on a completely different trajectory. "From then on, the visiting physicians at York only attended to bodily illness, while the lay people who were in charge of the day-to-

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[26] Ibid., 32.

day running of the institution developed a new approach in place of the harsh physical remedies. Lunatics were seen as essentially human, although distressed, and in need of kind and respectful management and cheerful and homely surroundings[27]." Tuke sited his new hospital on the top of a hill away from the bustle of the city. There were no fences around the property, and the asylum enjoyed expansive views. The structure itself was rather modest; brick and only a couple stories, the patients lived in single bedrooms along double-loaded corridors. In this way, the patients could enjoy both privacy and unencumbered views of the surrounding countryside. The corridors sat on either side of a central structure. The central structure was the home of the superintendent as well as administrative offices. Tuke fed his patients well and, believing interaction with animals caused benevolent feelings in the patients, he also had airing courts to the rear of the building filled with rabbits, birds and chickens[28]. Outdoor activity was encouraged, and restraints forbidden. Side U-shaped corridors housed more violent cases, which was in a bit of contrast to the rest of the institution's philosophy; while most patients were free to move about, patients that exhibited more violent behavior were isolated in the U-shaped wards. The presence of these wards indicate a discrepancy in Tuke's general philosophy toward patients; health and safety of others was still a consideration that on occasion trumped Moral Treatment's general code. The institution was by no means perfect, but lay in stark contrast to the abusive conditions of other institutions. By keeping the principles of Moral Treatment in mind during the planning of his asylum, Tuke was able to create a much more humane environment for patients.

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[27] Johnstone, *Users and Abusers of Psychiatry*, 175.
[28] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 28.

Dorothea Dix was a prominent reformer in the U.S. during the mid 19th century. Similar to William Tuke, Ms. Dix believed each person was capable of spiritual development regardless of ailment. Originally a schoolteacher, Ms. Dix began advocating for the construction of asylums based on the deplorable conditions in almshouses and jails where the insane typically ended up. Because there was no specific location for the mentally ill, they were thrown into poorhouses when their behavior became too erratic or were deemed a danger to the surrounding community. Once housed, these individuals were subjected to horrific restraints and isolation for want of what to do with them. Ms. Dix traveled New England, touring almshouses and petitioning for asylums as she went. "At Lincoln she found, 'One woman in a cage.' Medford: 'One idiotic subject chained, and one in a close stall for 17 years.' Barnstable: 'Four females in pens and stalls; two chained certainly, I think all[29].' " Obviously, the conditions the mentally ill were housed in were completely unacceptable. Ms. Dix went to sympathetic politicians of each state to speak to the legislator because as a woman, she could not petition herself[30]. Her arguments described in detail the dehumanization of the insane and additionally claimed economic benefit to the states in building an asylum. By housing the insane in asylums temporarily – she, like many, assumed cures were possible for every patient – the state would enjoy a huge economic savings over housing them for the rest of their lives in almshouses or jails.

As a result of Dorothea Dix's efforts, states began building asylums on a more regular basis. Her petitions catalyzed the growing acceptance of asylums beginning

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[29] Shorter, *A History of Psychiatry*, 4.
[30] Yanni, *The Architecture of Madness Insane Asylums in the United States*.

with the New Jersey State Lunatic Asylum in New Jersey. Her tours continued, stretching all across the U.S., and, coupled with the rising belief in Moral Treatment, the purpose-built asylum became the expected means of caring for the mentally ill.

Principle 11: Exposure to nature and interaction with animals helps alleviate stress in patients and keep them happy.

Dr. Thomas Kirkbride, another Quaker, also fervently believed in Moral Treatment and was the founder of an institutional type under his name. He started out as a doctor at the Pennsylvania Hospital for the Insane. His experiences and beliefs in the success of Moral Treatment led him to write *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* in 1854[31]. His book became a sort of manual for both doctors and architects involved in asylum construction. In it, he outlined his principles on Moral Treatment and asylum construction.

As a physician, Kirkbride was perhaps more privy to medical theories of the time then Tuke; in particular, Miasmatic theory was fused with his ideas on Moral Treatment. If illness was created by bad air, then air ventilation and circulation was a necessary part of any asylum. Rather then the seemingly endless wards of older hospitals, Kirkbride required the wards be short, no more then 3 stories, and set back from each other to allow unhindered airflow. Each ward held social spaces and more private spaces. Day rooms, parlors and dining rooms were available to patients during waking hours. More private spaces lined the hallways. The bedrooms ideally held 1-8 beds, providing more privacy to patients, but these were only used for sleeping. The more social spaces were intended for day use. Treatments were

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[31] Kirkbride, "On the Construction, Organization and General Arrangements of Hospitals for the Insane."

performed in what they called the bathing room (figure 2). Water was still understood as a curative substance, though the surprise bath of old had gone by the wayside. Now the baths were referred to as hydrotherapy.

Principle 12: Air circulation, ventilation, and flow are extremely important to the health of building users.

The overall setback scheme of the building allowed for organization of patients based on their ailment and the severity or violence of their case. As seen in the York Retreat, those that were considered the noisiest and most dangerous were placed as far away from the central building as possible (Illustration 1). Kirkbride also suggested building options like stone and brick based on the widely held belief that these materials would make a building fireproof. The central or main block of the structure was intended for the doctor's apartments, administrative offices and sometimes held amenities like chapels and theaters for plays.

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In order to incite a cure, it was believed among hospital reformers like Kirkbride and Tuke that the asylum must be located away from the city. Family life and the chaos of the urban environment were thought to contribute to the illness of mental patients. "The removal of a person from home and the associations with which their excited, depressed or perverted feelings have arisen, is often nearly all that is required to restore the healthy balance of the faculties[32]." There was infinite confidence in the power of moral treatment and the healing effects asylums could have on the insane.

Principle 13: The urban environment is bad and infected with disease of both mind and body.

The type

The ideal hospital Kirkbride lay out for asylums became known as the Kirkbride or Linear Plan. Kirkbride entrusted illustrations demonstrating his version of the perfect hospital to Samuel Sloan, a prominent architect known for his Victorian houses. Sloan eventually became known as an asylum expert as his partnership with Kirkbride expanded to include over 30 state hospitals. The Linear plan was almost the exclusive hospital type built from 1860-1900.

The faith in Moral Treatment and the determination doctors exhibited to find that elusive cure ensured quite a bit of repetition using Kirkbride's principles. His was not the only show in town, however. As time went on, skepticism regarding the actual success of Kirkbride asylums began to grow. Moral Treatment was not delivering on the promises of curability, and as the state-run asylum populations

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[32] Gerlach-Spriggs, Kaufman, and Warner, *Restorative Gardens*, 104.

began to swell, so too did the realization the treatment methods weren't working. Even while new patients were incarcerated, few patients were ever discharged, changing many asylums to more of a custodial operation than one of healing. Skepticism regarding environmental determinism also arose, as the environment of these structures was clearly not enabling any cures. Thus began the experimentation of using other building and treatment methods, and the rise of the cottage style or segregate hospital.

The observation was made that many of the older patients were not considered curable. These patients lost touch with their families over time and rarely showed any improvement, making their care purely custodial. The illness of many elderly patients would today be attributed to Alzheimer's disease, but at the time, these patients were simply described as "objects of the utmost pity[33]." The most obvious solution was to create an institution specific to the custodial care of incurable patients. "The growing number of patients in the hospital ultimately shifted moral treatment to custodial care, thus changing the very purpose of the institution[34]." This type of institution would also help control population growth of the large state asylums, opening up space for those they deemed responsive.

The first of custodial care institutions was the Willard State Hospital located in upstate New York. Because curing these patients was no longer the goal, the Kirkbride plan was not followed for this institution. Instead, the hospital began with one single building called the Chapin House (Illustration 4). Chronic patients from

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[33] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 80.
[34] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital," 226.

almshouses and prisons were transferred to Willard, as well as the incurables from the State Lunatic Asylum in Utica[35]. Patients stuck in almshouses and jails were typically in unsanitary conditions, making the transfer a vast improvement. The institution quickly expanded to include several smaller buildings on a campus. The state took advantage of the growing institution to experiment with different types of buildings, sizes, and renovation projects of existing structures.

For some doctors, the Willard State Hospital was an embarrassment. By separating the incurable patients from the congregate hospitals, they were essentially publically admitting to their failure. Of course they had to criticize the development of these new institutions. One of the first ways they tried to save face was by blaming the lack of successful cures on families. "The asylum doctors usually claimed that the patient could have been cured if institutionalized closer to the onset of the disease, which allowed the doctors to shift responsibility back to the patient's family[36]." Not all of their criticism revolved around professional survival. Concerns regarding the care of custodial patients arose; if these patients were all housed together, doctors feared they would be treated inhumanely. They were also concerned any positive drive to be healthy would diminish, leading to both patients and family members to lose hope in any recovery. A legitimate concern for sure, as institutions like Willard could be interpreted as places where people waited to die; not unlike our hospice facilities of today.

Interestingly, the state experimentations on building types were in direct contradiction to the ideas regarding purpose-built hospitals that led to Linear

[35] Doran, "History of Willard Asylum," 2.
[36] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 80.

structures. By pulling away from this ideal, the Willard Asylum exhibited the general tendency within the industry to take emphasis away from environmental determinism. Some of the ideas regarding Moral Treatment did remain. The day-to-day running of the asylum was essentially the same, and the campus of lush green trees was still thought to assist patients in feeling better.

By using the term *Cottage Plan* to describe the new asylums, a certain sense of imagery was invoked. A sense of familial intimacy is suggested by the term, which was no doubt an intentional means of relating the hospital to a comforting family environment. The reality was something of a hybrid between an institution and an actual home. "There is something attractive and romantic about cottages and cottage life. We associate with them domestic love, roses, woodbine and luxuriant ivy running over thatched roofs; larks and nightingales; lowing cows, bleating lambs, and browsing goats… and all sorts of pastoral delights sung by poets… But the reality is apt to be very rugged prose[37]." The musings about pastoral imagery, cows grazing, etc. is a familiar one. The very same imagery was part of the picturesque driver in Kirkbride landscape considerations; the large vistas of rolling hills and desires to be self sufficient by including farms on the hospital grounds were consistent with his original declarations on what was to encourage a healing environment. With the Cottage Plan, however, there was a return to the idea that home, instead of a source of one's illness, was in fact a comforting place. At a much smaller scale (though still rather large) with rooms made to resemble parlors, the individual buildings of the Cottage Plan were reminiscent of a Kinkade Christmas card. Where Kirkbride and

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[37] Ibid., 89.

other followers of Moral Treatment felt a pastoral removal of a patient was necessary to cure their disease, the Cottage Plan began to iterate the home not as a place to avoid, but one that would comfort the patients.

Principle 14: A simulated home environment provides comfort to patients.

Principle 15: Those too ill to achieve a cure were still human beings and deserved quality care.

Another manifestation of the Cottage Plan was exhibited at the Illinois Eastern State Hospital. Here, the campus was designed as a village for the insane, complete with a grid system of streets. Boulevards created a perimeter around the property and were lined with cottages and large trees. This was also the first property to combine both cottage plan and Kirkbride sensibilities. Unlike the Willard, this hospital held both custodial and acute (curable) patients. The property was served by a railroad for deliveries of supplies, similar to many other asylums. A main structure built in the Kirkbride style held administrative offices and the acute patients. The plan of the building was consistent with other Kirkbride structures; parlors were included on every floor, the sexes were separated by the central block, and the surrounding grounds were designed to make a beautiful backdrop for the patients to enjoy. The cottages dotting the property held milder, chronic patients. These "cottages" had more in common with smaller estate houses then actual cottages; they each held between 50 to 100 people[38]. Unlike the Linear plan, these cottages had no single bedrooms, but rather mini wards, as shown in Illustration 6. Obviously, the home

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[38] Yanni, *The Architecture of Madness Insane Asylums in the United States.*

analogy only went so far, but cottages still contained some home-like comforts in their day rooms (see Illustration 5).

The Village at Illinois Eastern State Hospital was an innovative means of providing different types of care for different types of patients. Where the chronically ill were typically placed in the back wards of Kirkbride plans, they were now housed in relatively homey environments within cottages. While some doctors met the move to separate, smaller structures with much skepticism, it marked an important transition. As Moral Treatment and Kirkbride buildings began to show weakness in care and funding, deinstitutionalization slowly became more attractive to state legislatures. It would be years before the deinstitutionalization movement truly took hold, but the beginnings of this trend can be traced back to the rise of the cottage plan.

Chapter 2: Women in the Asylum

Introduction

This chapter illustrates the lives of 3 specific women out of the thousands that were incarcerated in asylums throughout the country. Their tales are indicative of the social climate, political conditions, and helplessness that faced women during the 19th and 20th centuries. Some of the issues each of these women faced are not far apart from what modern women face in domestic violence situations. Each demonstrates in a very personal manner the characteristics of the average female's stay in state asylums and show in a very real way how good intentions could go so very wrong.

Elizabeth Parsons Ware Packard (1860-1863)

Introduction to Elizabeth

Elizabeth Packard was not an activist. She was the wife of a reverend and a woman dedicated to her religious beliefs. She was thoroughly dedicated as a mother, and prior to her forced incarceration, there were no negative reports about her sensibilities, practicality, or gentility as a woman. The seed that led to her eventual forced admittance to the asylum sprouted between her and her husband. Her personal beliefs regarding religious freedom were not inline with his, and her unwillingness to suppress her own opinions led to her husband forcing her into the asylum.

Illustrative effects

I was in a Bible-class in Manteno, Kankakee County, Illinois, that I defended some religious opinions which conflicted with the Creed of the Presbyterian Church in that place, which brought upon me the charge of insanity. It was at the invitation of Deacon Dole, the teacher of that Bible-class that I consented to become his pupil, and it was at his special request that I brought forward my views to the consideration of the class.... I had not the least suspicion of danger or harm arising in any way, either to myself or others, from thus complying with his wishes, and thus uttering some of my honestly cherished opinions. I regarded the principle of religious tolerance as the vital principle on which our government was based, and I in my ignorance supposed this right was protected to all American citizens, even to the wives of clergymen. But, alas! my own sad experience has taught me the danger of believing a lie on so vital a question. The result was, I was legally kidnapped and imprisoned three years simply for uttering these opinions under these circumstances....

I saw my husband approaching my door with two physicians, both members of his church and of our Bible-class – and a stranger gentleman, sheriff Burgess.... The trio approached my bed, and each doctor felt my pulse, and without asking a single question both pronounced me insane. So it seems that in the estimation of these two M.D.'s, Dr. Merrick and Newkirk, insanity is indicated by the action of the pulse instead of the mind!...My husband insisted upon it that I had no protection in the law, but himself, and that he was doing by me just as the laws of the State allowed him to do. I could not then credit this statement, but now know it to be too sadly true; for the Statute of Illinois expressly states that a man may put his wife into an Insane Asylum without evidence of insanity. This law now stands on the 26th page, section 10, of the Illinois statute book, under the general head of "charities"!... I cannot believe that there is any class of convicts or criminals in our land, who are not treated with more humanity – with more decency – with less of utter contempt and abuse, than you treat your insane patients here. Most criminals have some sort of a trial before they are punished; but here, all that is required, is the misrepresentation of an angry attendant, who thus secures to her helpless victim the punishment, which her own conduct justly merits upon herself... Is there any spot in this great universe where human anguish is equal to what is experienced in Lunatic Asylums!

Are we not experiencing the sum of human wretchedness?... Insane Asylums are the "Inquisitions" of the American government… Whoever can leave an insane asylum without a feeling of moral degradation, and a self-loathing, debased feeling of himself, as a human being, must have attained to the highest plane of divine influences. His human nature must have been sublimated into the divine[39] *...*

Conclusions

Mrs. Packard's experience establishes several important factors regarding women and their relationship with social status and legal rights. First, women were the legal subjugate of their husbands. They do not have any legal right to representation outside of their husband. They also have no personal protections under law. Patients had no voice within the asylum. Any utterance could be discounted or completely ignored by a staff member.

She also clearly illustrates an instance of someone wrongfully diagnosed as mentally ill. No medical procedure was required to determine one's insanity. Any one doctor, had the legal ability to diagnose a person on site. Forcibly incarcerating a patient had the same procedure as arresting and jailing a person. Women had no legal recourse to dispute claims of instability or wrongful incarceration.

The behavior of the doctor, the sheriff, the husband, and Mrs. Packard collectively describe the origins of psychiatric and social bias. Women in the 19th century were given a very specific role to play, that of mother and wife; any deviance from that was considered out of the norm and socially unacceptable. The asylum then, could be viewed as a holding facility for those who made others uncomfortable. The woman's assigned role also did not leave room for intellectual inquiry as

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[39] Geller and Harris, *Women of the Asylum*, 59–67.

discussed in Chapter 1. This is easily translated into "women should be simple", so their voice could be disregarded as silly. The authority was the male.

Principle 16: No person shall be regarded or treated as an Insane person, or a Monomaniac, simply for the expression of opinions, no matter how absurd these opinions may appear to others.

Principle 17: No person shall be imprisoned, and treated as an insane person, except for irregularities of conduct, such as indicate that the individual is so lost to reason, as to render him an unaccountable moral agent.

Lydia A. Smith (1865-1871)

Introduction to Lydia

Lydia Smith was a pious woman that lived in Michigan with her husband and children. Her life was a quiet one with many friends and dedication to church. Unfortunately, her husband found another woman. Upon their planning, Lydia was chloroformed and dumped into an asylum by the pair. She was placed in the ward for the most violent patients. Whether this was a stated reason from her kidnapper husband or an assumption on the asylum's part is not clear[40].

Illustrative effects

On the patient's arrival at the asylum they are first put into a bath. This is necessary and perfectly right, if done in a proper way. In a most inhuman manner I was plunged into a bath, the

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[40] Smith, *Behind the Scenes, or, Life in an Insane Asylum*.

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water of which was not quite boiling hot, and held down by a strong grip on my throat, until I felt a strange sensation, and everything began to turn black. Just at this time I heard a person say to the unnatural brute who was acting as attendant;: "Oh, my! Let her up quick; she is black in the face."... A short time after... this same inhuman monster [the attendant] came to me with a cup in one hand and a wedge in the other. This wedge was five or six inches long, on inch thick at one end, and tapered down to an eighth of an inch in thickness, and was used to force the mouth open, so that medicine, etc., could be poured down the throat of the patient. I soon felt the weight of the attendant on me, with one knee pressing directly on my stomach, and one hand, like the grip of a tiger, on my head. The wedge was then forced into one side of my mouth, crowding out a tooth in its progress... causing the most excruciating pain. I cannot tell why, unless it was convulsions, caused by the great pressure on my stomach, but my teeth were set, my lips seemed glued together, and I could not have opened my mouth, even had I known what they wanted me to do. Crash! Crash! Went another of my teeth, and another, until five were either knocked out or broken off.... Not content with knocking my teeth out and forcing the medicine down me, which I would have willingly taken had I known what they wanted me to do, the attendant, after giving me the medicine, which was all that was required of her, clinched my throat, while her teeth grated together with rage for the trouble I had given her...

It is a very fashionable and easy thing now to make a person out to be insane. If a man tires of his wife, and is befooled after some other woman, it is not a very difficult matter to get her in an institution of this kind. Belladonna and chloroform will give her the appearance of being crazy enough, and after the asylum doors have closed upon her, adieu to the beautiful world and all home associations... You might plead and beg; it would all be taken for insanity. Yes, all you could say and all you could do would only be some symptom of the fatal disease. If you were quiet and passive, even submissive, you would be reported as a hopeless case; but if you would rave and storm, as almost any one would, you would be put in the close room[41].

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[41] Geller and Harris, *Women of the Asylum*, 133–136.

Conclusion

While this horrifying account is quite gruesome and spectacular, Lydia Smith's experience gave much nuance to the treatment of patients that reinforce Mrs. Packard's writings several years before. Not only did a woman have no voice, she was not meant to speak at all. Lydia's treatment by the attendant, while awful, illustrates this. Upon her arrival, she was not given any sort of physician attention, but rather treated like an animal going to the butcher block. Assumption and lack of knowledge on the attendant's part played a huge role in the abusive events. There was no evidence this attendant knew anything at all about a mentally ill patient; to her, this patient was subhuman. There was no reason to explain, talk or treat the patient with any respect. Her inhumanity extended to her assumption that the new patient would resist and struggle. Her actions were immediately violent in efforts to subdue a struggle that didn't need to happen. Without knowing what was going on, Lydia of course did struggle out of shear personal preservation. These events provide insight into how and why violence was the norm in asylums. What is key here are three things; 1. The attendants had no training or understanding of what mental illness actually was. 2. Lack of communication to the patients caused more stress and opportunities for violence to occur. 3. Doctors were very rarely ever present, so any benefit they may have provided was never observed by most attendants[42]. The concept of intentional violence was completely lost on truly mentally ill patients. So, when attendants attempted to evoke control over them by abusing them, the patients didn't understand why they were being attacked. The abuse caused fear, but not

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[42] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital."

necessarily a subdued patient[43]. Violence was a controlling mechanism used by ill-equipped attendants as a means to subjugate the patients and was generated by the assumption that patients were inherently violent people.

Principle 18: In order to maintain control, staff members within asylums used fear and violence extensively.

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[43] Smith, *Behind the Scenes, or, Life in an Insane Asylum*.

Introduction to Frances

Frances Farmer was a prominent actress on both stage and in Hollywood. Similar to Mrs. Packard and Ms. Smith, she was not an advocate or reformer. She was famous and perhaps a little dramatic, but her problems began when she was arrested in 1942 for having her high-beams on in a wartime blackout zone. Her subsequent erratic behavior in the courtroom landed her in a sanitarium. Furious with her arrest, she claimed the police had violated her civil rights and threw things about in the courtroom. Her behavior was enough to land her in jail, and then into a sanatorium. She was later transferred to Western State Hospital.

Illustrative effects

It was a critical time. Tax-supported institutions could not provide high enough salaries to entice people away from defense work, and it is an indisputable fact that during this period they asylums were operated by the inmates.

Where I was, wild-eyed patients were made trustees. Homosexuals wormed their way into supervisory positions. Sadists ruled wards. Orderlies raped at will. So did doctors. Many women were given medical care only when abortions were performed. Some of the orderlies pimped and set up prostitution rings within the institution, smuggling men into the outbuildings and supplying them with women. There must be a twisted perversion in having an insane woman, and anything was permitted against them, for it is a common belief that 'crazy people' do not know what is happening to them.

Buildings crumbled in filth and decay. Heating plants broke down and went unrepaired. Rats nested in every ward, and it was not uncommon to see them leaping onto food trays, fighting with patients for morsels…

The trustee pointed to an unmade cot, telling me to remember which one was mine, then steered me through the ward into a small room fitted with three bathtubs…

Before I could organize myself, the trustee had taken down three canvas straps from a hook on the wall and looped one around my chest, pinning my arms against my sides until my breath was cut short. The second was buckled around my thighs, and the third around my ankles.

She [the attendant] left the room as I tottered to keep my balance. I tried to hop after her but tumbled headlong. My chin cracked against the floor and I felt a sharp pain as my teeth sliced my lower lip…

The first crash of icy water hit my ankles and slipped rapidly up my legs. I began to shake from the shock of it, screaming and thrashing my body under the sheet, but the more I struggled, the more I realized that I was helplessly restricted in a frozen hell.

I began to gnaw on my lip, flinching from the pain of my teeth digging into the wound but praying that it would take my mid off the freezing water that burned my body like acid…

I lay there in the glacier grip until my mind had gone blank. I felt it slipping from me, but I tried to keep it active by thinking of addresses, phone numbers, nursery rhymes. I counted forward and backward. I became confused. I recited the alphabet, but everything was jumbled. I struggled, and screamed, and froze. Then… I slid out of awareness and tumbled into gibbering, scrambled maze.

For the next twenty-four days I was depersonalized in hydro. The physical pain, the spiritual injury, the mental torture mashed one day into another, until all thoughts hinged on either being in or out of the tub. Nothing else existed[44].

Conclusion

Ms. Farmer's account is among the most disturbing and difficult to read. Her experiences were among the most violent and despairing. She touches on a number of issues in detail throughout her narrative. Sexual deviance against women within the asylum was a significant issue, and the orderlies that perpetrated these crimes

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[44] Geller and Harris, *Women of the Asylum*, 320–323.

were often the bottom of the barrel when it came to staffing. The War had taken away many of the well respected staff of asylums, and in their absence, poorly educated and poorly trained staff members took their place.

The lack of care demonstrated by these staff members became crystal clear in their interpretation of hydrotherapy. Formerly meant as a means of relaxing patients, the ordeal had turned into torture sessions. Patients were placed in icy waters sometimes for hours; it's a wonder they didn't all die.

Ms. Farmer also illustrates the decaying buildings through her descriptions. The 1940's were a bad time for asylums built prior to the turn of the century. These structures had been around for a long time, and without the funding available to keep the facilities well maintained, the conditions quickly diminished to squalor.

Principle 19: This is not violence perpetrated against another, because to be another *you have to be first human being, and since insane patients were categorized as* other *rather then human, violence was justified. Non-humans don't understand violence.*

Chapter 3: Degradation, Deinstitutionalization, and Social Manifestations

Introduction

This chapter identifies some of the key factors behind the organization of the asylum and the presence of mind that led to some of the abuses against patients. Different types of violence, from physical assault to something as subtle and subversive as constant surveillance are discussed, as well as the affect each had on the patient. These were among the reasons deinstitutionalization took hold, and developments in the psychological field including new treatments are also outlined.

Social and Violent Manifestations

Hierarchy and communicative form

The planning of asylums was not solely a means of organizing patients. The building itself was a representation of psychiatry as a profession, the state's success in caring for the mentally ill, and often, civic pride. The ornate facades were reminiscent of Greek, Roman and French classical structures; tree-lined lanes and bold porticos accentuated the main entrance, and the materials used were of high quality[45]. The design was much more then aesthetic pleasure, the building was communicating to its visitors.

Depending on who approached the building, its presence ranged from impressive to horrifying. As a patient, quite a bit of fear and uncertainty colored the

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[45] Yanni, *The Architecture of Madness Insane Asylums in the United States*.

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building; the shadows cast from the great façade were forbidding and the anticipation of what lay ahead quickly became a fulfilled prophecy. However, as a visitor, the experience was entirely different. Visitors were whom the grand entrance was for. Whether such visitors were family members anxious to reassure themselves, a doctor from another institution, or a potential source of funding, the building was designed to welcome them with much opulence. As in Greystone Park, the grand hall often exuded luxurious finishes.

A very specific pattern was choreographed by designers and superintendents to show off the asylum in the best light possible[46]. The pattern was completely independent of the actual conditions within the wards. Visitors would enter a grand hall, then would move along into other impressive spaces; the chapel, entertainment rooms, parlors in the closest wards, and the superintendent's apartments. The path of visitors was more or less an advertisement for the asylum. Regardless of the average condition of patients, all visitors ever saw were the best behaved. Since the closest wards to the central block housed the mildest cases, it was easy to use these wards as exhibits for the visitors. The most violent patients were held furthest away from both the central block and visitors; any cries or altercations were never witnessed.

As figure 1 shows, patients were set up in a hierarchy of illness severity. The status of patients was also considered when determining their placement in the asylum. In support of the visitor's path, the most affluent were often placed closest to, if not part of, the central block. They were typically allowed to bring their own furniture and servants. "By employing space as the medium for securing status, we

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[46] Johnstone, *Users and Abusers of Psychiatry*.

are building material barriers between individuals on the basis of wealth[47]." Even while separate from the general population, or more likely because of that separation, the socially affluent were ideal candidates as representatives of the patient population. Their quarters created a literal diagram of civilized nature deteriorating as one moved further away from the main entrance[48].

Control and regularizing mechanisms

One of the primary purposes of the asylum throughout its history was to provide order and structure to a population assumed incapable of both qualities. Control within the patient populations often seemed to invite its closest relative, violence; where there was one, there was often the other. Patient and general population control was generated by fear; fear of surveillance, brutality, and threats. Buildings were typically spatially organized in a manner that allowed staff to observe the activities of many patients from one spot. Not quite the radial pattern of notable prisons like the Eastern State Penitentiary, patients were still under nearly constant surveillance in many asylums. Most wards consisted of long hallways, which allowed nurses to observe the actions by the patients from a single vantage point. Exercise yards were large, but typically surrounded by watchful eyes in both wards and the central block. Surveillance was near constant; the patients had no privacy even in their cells. Any staff member could enter at any time, making surveillance highly effective as a control mechanism. It wasn't just the obvious surveillance; the possibility of surveillance did as much to instill fear in the population[49].

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[47] *Architecture of Fear*, 98.
[48] Barham, *Closing the Asylum*.
[49] Foucault, *Madness and Civilization*.

An element of control specific to women went beyond surveillance to voyeurism. Women were often victims of rape by staff and doctors. Sexual "treatments" were even proscribed to women to cure melancholia, nymphomania, hysteria, etc. These "treatments" included removal of the clitoris to cure nymphomania and stimulation, performed by the doctor, for melancholia. As told in Ms. Farmer's narrative, some sexual activity wasn't concealed at all; the practice had become so commonplace it was very nearly an accepted event. What we now consider gross sexual misconduct today was a major source of intimidation and control for women incarcerated in the asylum[50].

Sexual assault was not the only form of violence. Brutality toward the patients was a very physical means of obtaining dominance by the staff. As in Lydia's story, the introduction of violence was almost immediate upon arrival. This strategy was meant to break down a patient or take the fight out of them. Couple that with restraints, isolation from any sense of normalcy, and stringent structure conducted by the staff that beat them, patients quickly lost their grip on dignity and sense of individuality. Their self-understanding was essentially stripped from them[51].

Principle 20: Fear as a control mechanism was achieved via constant pressure of surveillance, physical violence and sexual assault.

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[50] Ehrenreich and English, *For Her Own Good*, 136.
[51] Barham, *Closing the Asylum*, 66–84.

The State of Individualism

Segregation, separation, and dehumanization

In reading much of the history of asylums and the pour souls deemed insane, a constant question was *"why?"* How was the recurrent violent behavior of attendants, family members, and doctors even possible? The answer lies in analyzing the organization of asylum institutions and social extrication of individuals not considered part of their immediate community.

The entire asylum process for any patient began with a social determination, generally not from physicians but from peers, that they were unfit for the community they were in. Their behavior was deemed sufficiently *other* that many labels like dangerous, insane, dirge to society, useless, hopeless, were all assigned to that person. Common within all these terms are two things; violence and dismissal. These were the assumptions a patient arrived with at the asylum.

As the 1900's approached, moral treatment began to fall away. The overcrowded conditions of the asylums and lack of success in obtaining a cure for most patients delegitimized moral treatment. At this time, psychiatry was a young enough profession that self-preservation was still a top priority. Since moral treatment clearly wasn't working and the asylums were bursting at the seams, psychiatrists began to blame their failure on the disease itself[52]. Asylums, absent a cure, were becoming custodial institutions for those unwanted or useless to the outside world.

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[52] Barham, *Closing the Asylum*.

The growth in patient populations also put stress on the doctors and nurses. Patient to doctor ratios could reach as high as 1:500 and patient to nurse ratios were even higher at 1:1,320[53]. It was impossible for one doctor to conceive of each patient as an individual body with specific needs, mannerisms, and temperaments. So many patients also made it virtually impossible for a doctor to see them all every day. "Thus, to the medical officer these are not so many *individuals*, having particular characteristics and bodily dispositions, with which he is thoroughly acquainted, but they are apt to become so many lunatics, whom he has to inspect as he goes on his round of the establishment, as he inspects the baths and the beds'[54]." In these circumstances, the individuality of a given patient began to fade, and was replaced with a nameless mass consistent with all patients, further dehumanizing them.

The process of dehumanization was fed in part by the labels patients were admitted on. As *other*, patients were distanced from *person*; the degree to which the average socialite could identify with a patient was vastly reduced. "They're not like me" as a refrain was extended to staff as well. Once separated to the isolated asylum, decreed insane, and faced with the climate of doctors assuming them incurable, patients were further degraded. Even their ability to communicate was critically compromised. Having reached a near alien status of *other* from those around them, asylum staff assumed them incapable of speech. "So it happened that the clinician became increasingly accustomed to seeing… an autistic attitude on the part of the patient. The patient and those who were healthy had ceased to understand one

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[53] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital," 227.
[54] Barham, *Closing the Asylum*, 73.

another. The patient gives up, in abject resignation or total embitterment, any effort to make himself understood. He either no longer says anything or says nothing intelligible. In so doing the naïve observer declares, out of hand, that the patient has lost his reasoning powers[55]." This was clearly demonstrated in Lydia Smith's story in Chapter 2. The attendant admitting her to the asylum did not even bother to explain to her where she was or what was wanted of her, but instead subjected to brutality off the assumption that Lydia was crazy, incommunicative, insane, useless, *other*.

Individualization

The pattern of dehumanization in psychiatry has never ceased. Even as modern psychiatry has built a much more respected and scientific practice, the old biases remain in popular culture and even subtly within the profession itself. The *otherness* that followed patients within asylums has developed into different forms of dehumanization today. Popular culture perpetuates the assumptions of the Victorian asylum through horror films, books and urban legends that typically create interpretations of the psychotic more for dramatic value rather then accuracy. As the general frame of reference for most people, those biases seep into their real-life understanding of the mentally ill. As shown in the previous section, the degree of separation disallows the average person any ability to identify with a mental patient. Thus, the *other* labels continue, and are even used as insults toward those showing too much emotion. "you're crazy," "what a psycho," "are you mental?" etc.

While this may seem like a minor detail, similar language occurs within psychiatry. Evidence of dehumanization lies in how psychiatric professionals view

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[55] Ibid., 77.

and talk about their patients. Rather then conceptualizing a patient as someone with a disease that is not an originating body, therapists refer to their patients as the disease itself. For example, it is equally likely that a psychiatric patient be referred to as "a patient with schizophrenia" or "a schizophrenic." The latter creates ownership of the disease. The person is identified now as the disease instead of patient with a disease.

The difference in language is an important one. As exhibited in the historical asylum, the labels assigned to patients directly affected how those patients were treated. The same holds true for the given example of schizophrenia. Once labeled a schizophrenic, it is very difficult for that person to become something else. Their condition has semantically become them, and, if chronic, that illness is permanently attached to them. "The term 'chronically mentally ill' has come to be practically synonymous with a person with schizophrenia… Variations on the theme of 'once a schizophrenic, always a schizophrenic' still persist in plenary addresses at national meetings, in conferences with families, in case supervision, [and] in academic classrooms[56]…" By labeling someone as the disease, their personality becomes second to their illness. Mental illness, as a condition, creates a separation from general society, and so the "schizophrenic" has become, as in history, *other.*

Connections to domestic violence victims today

Dehumanization of domestic violence victims is a primary source of control by the oppressor. Otherwise known as intimate terrorism, the pattern of an abuser towards their victim begins and ends with intimidation and control. The experience may begin by the constant presence of the abuser in every activity the victim takes

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[56] Ibid., 90.

part in. Like the patients, constant surveillance starts from the outset. Slowly, isolation from friends, family, work and anything familiar help the abuser take further control of the victim's life. As in the asylum, isolation is a vital step toward achieving complete control by implementing social disorientation and separation for the victim. By effectively separating a victim from their loved ones, the abuser is then able to use that isolation as ammunition and intimidation. No one will hear the worst cases scream from the back wards, and no one will come looking for the domestic violence victim that has been cut off from their normal life. That is the narrative given to the victim, and since their perceptions have been so narrowed, their reliance on the abuser is complete. Threats of violence against the victim and actual sessions of brutality create a world full of fear for the domestic violence victim. Similarly, the corrupt asylum uses brutality and threats to control the patients. Because violence is a very real factor of both the domestic violence victim's and asylum patient's lives, threats of brutality are believed[57].

Paradigm Shift

New treatments and technology

The development of new technology-based treatments, new discoveries and psychotropic drugs also influenced the move to decentralize asylums. Around 1900, it was discovered that syphilis was the culprit of many "insane" patients. This gave hope to psychologists that physical causes for other maladies might soon be revealed. In the 1930's, several new types of treatment enjoyed much popularity. Insulin

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[57] Follingstad et al., "The Role of Emotional Abuse in Physically Abusive Relationships."

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therapy or insulin coma therapy (1944) was thought to calm particularly ill patients. Schizophrenics were injected with massive doses of insulin, which put them in comas that could last several days. Claiming magical results this therapy was widely used until it was discovered insulin did a lot of harm to the patients and really no good at all. Electro-convulsive therapy was developed in 1947. Both psychiatric patients and epileptics (who were also thought insane) were given electro shock because doctors believed the resulting seizures would help cure the patients. These seizures were violent, often resulting in broken bones. However, instead of concluding the treatment was faulty, doctors fed patients drugs that caused temporary paralysis before beginning the shock treatments. Finally, experimenting with psychosurgery led to transorbital lobotomies being introduced between 1947-1950. When performed, the lobotomy removed nerve fibers in the frontal lob of the brain by literally drilling a hole through one's skull. Touted as a wonder treatment initially, it soon became clear lobotomies induced harmful side-effects: seizures, behavioral changes, impairment and death[58]. Nevertheless, the optimism with which these new therapies were received was echoed in the belief the psychiatry was moving forward in a positive direction.

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[58] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital," 224.

Deteriorating Institutions

Financial distress

Deinstitutionalization of the state asylum was a result of a number of factors. Financial distress and the revolution in psychotropic drugs are the most widely accepted causes of deinstitutionalization. When state legislatures decided to build large-scale asylums, they failed to account for a couple things. First, many asylums were expected to run in a self-sufficient manner, however, they were still in need of basic civic services like electricity. Second, the states didn't take into account operating costs, including administrative tasks like book keeping, payroll, and patient coordination.[59] These costs left asylums strapped for cash almost immediately after construction. As debts rose, cutbacks began; institutions slowly deteriorated physically and in treatment practices. Third, the population of asylums exploded in the early 20th century and again around 1950. Coupled with the shortage in funds, asylums became overrun and underfunded, leading to many abuses against patients by overtaxed doctors and attendants. When these abuses were splashed across the front pages of newspapers, the state-run facilities were viewed as a terrible burden and embarrassment.

Abuse reports and overcrowding

In 1930, the Mental Treatment Act was passed. It "provided for the creation of out-patient clinics and for 'voluntary' admissions to mental hospitals[60]." Out-patient clinics along with custodial institutions for the chronically ill were partially

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[59] Ibid.

[60] Barham, *Closing the Asylum*, 3–4.

designed to lessen the population burden on large asylums. Where was this population growth coming from? Some attribute it to a general population growth of the U.S., indicating the more people, the more mentally ill. Others feel the asylum played an interesting role in social process. Those that were deemed abnormal or inconvenient were dumped in the asylums; as demonstrated by Mrs. Packard and Lydia Smith, whether or not they were in fact mentally ill was beside the point[61]. Something of great influence was also occurring during the time of population growth. World War II had just ended, and families had been separated for years. "…the loosening of familial ties and networks made families less able to cope with disturbed members and more willing to have recourse to professional help[62]." The spike in new patients created great stress on the asylums, and while the new outpatient clinics helped, overworked staff and deteriorating structures prevented them from meeting basic human needs of patients. Neglect was often a first step toward abuse running rampant[63]. The resulting reports of heinous abuse often led to forced closure by the state, leaving the immense asylums empty.

With the number of original Kirkbride buildings all around the country, the idea that all were left vacant and decaying is somewhat baffling. Most of these asylums offered a great deal of square footage and architectural interest. Unfortunately, rather then taking advantage of the open space, many counties and states decided to demolish them. Lack of occupancy for many years, the elements, vandalism and vagrancy has made many of these old hospitals a mess, and while

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[61] Barham, *Closing the Asylum*.
[62] Ibid.
[63] Osborn, "From Beauty to Despair: The Rise and Fall of the American State Mental Hospital," 226–229.

some have reached the point of no return for occupancy, there were many years prior to that when the asylum had not yet decayed to that point[64].

The Abandoned Asylum

Demolition and community resentment

Reasons for demolishing rather then reusing these structures are a little hard to define. Many of the asylums were originally sited in the country, leaving much ground between them and the nearest urban environment. However, as time has gone on, many of these sites are now part of municipalities with large populations and demand for business. And yet, the tendency to demolish remains. A more subtle source may be social more then economical. Many asylums didn't completely close until the 1990's, some even into the 2000's, so there is still a large part of the population that remembers the asylums while they were still functioning. This doubtless left an uncomfortable mark on many communities. For those who endured the embarrassment of repeated reports of abuse in the newspaper, there may be a certain amount of resentment, also. So, if old asylums have been lucky enough to survive thus far, they are left open to vandalism and pilfering of semi-valuable items like copper and fixtures. The social stigmas surrounding these structures prevent them from being anything except a nasty urban legend and fodder for horror stories.

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[64] McElroy, Ethan, "Demolished Kirkbride Buildings."

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Chapter 4: Old Contextual Pitfalls and New Beginnings

Introduction

This chapter introduces the concept of wellness and how it may be applied to asylum-specific programming. Behavioral needs and implications are explained as well as how they may be applied to space. The current state of women in need in the state of New Jersey is outlined, then a discussion regarding the historical principles identified in previous chapters establishes which were counterproductive and which may be carried forward in adaptively re-using Greystone.

Wellness

Healing as primary use

Kirkbride and Tuke were not far off in their attempts to create a positive environment for the patients in their asylums. The principles they laid out held nature as a primary source of comfort and healing. Clean air circulation, exercise or walks through nature, extensive views of rolling fields and forest, all these principles would have contributed to the wellbeing of patients. But what exactly is wellness and wellbeing?

From a societal perspective wellness initiatives weren't particularly important until the 1970's. Most healthcare was based solely on disease treatment and cure; prior to that, yearly financial allocations for preventative research reached as low as 2.5%[65]. The big turning point began in the 1960's; the surgeon general reports on

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[65] Jamner and Stokols, *Promoting Human Wellness*, 21.

smoking and the health consequences of smoking were the first real indicators that a specific human behavior, smoking, was literally dangerous to our collective health. Anti-smoking campaigns arose. Other campaigns, including HIV/AIDs in the 1990's, excessive alcohol use, depression, and obesity have become major priorities in preventative care. Now, as our healthcare system slowly moves toward prevention rather then symptom-based treatment, new ideas relating to alternative medicine, exercise programs and work-related wellness programs are much more widely accepted.

Part of the transition to collective wellness was spear headed by research conducted. "Research in the field of public health have recognized for many years that patterns of health and illness are closely linked to a variety of sociocultural, political, and physical-environmental conditions within communities[66]." Our health is not solely based on physical wellbeing, but many other factors including our life styles, choices and the communities we live in. Sociocultural influences may initially indicate a difference in reaction to things like nature that might suggest the health benefits of natural environmental exposure may not necessarily be successful. However, history suggests otherwise. Whether it was the hanging gardens in the Middle East or the nature inspired Haiku's of Japan, nature has always been revered by every culture. The universality of this concept alone draws a strong case that our need for nature is not a culturally taught need. Studies done by Stephen and Rachel Kaplan, prominent research psychologists, have indicated exposure to nature in nearly any form physically reduces the indicators of distress. Heart rates decrease, as does

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[66] Ibid., 24.

blood pressure and behavioral symptoms of anxiety[67]. The argument that there is no hard evidence suggesting the success of alternative therapies like horticultural theory have little ground to stand on. While a healthy skepticism of different treatments is necessary and even helpful, alternative therapies in conjunction with traditional medical treatment have consistently proven themselves effective.

Part of the reason behind the failure of many asylums through the 19th and 20th centuries is due in part to the lack of understanding of psychological illnesses in the first place. As described in Chapter 1, many treatments were so off base they actually created more problems then they solved. The reliance in moral treatment on nature and good meals was not enough to treat the underlining illness; there was no understanding of modern techniques in talk therapy, how the brain actually works, or what mental diseases were out there. Those that were misdiagnosed were in a perpetual state of suffering due to the ignorance of the caregiver. For example, Alzheimer's and Huntington's disease, Syphilis, and Hypoglycemia were either unknown or misunderstood as a type of psychosis. With more education and a much deeper understanding of mental illness, the alternative therapies used in the 19th century may have enjoyed much more success.

Accounting for behavior

When it comes to combining design with behavior, it seems the overwhelming assumption is there is not a relationship between the two; that in fact, the two run completely separate of the other. As discussed regarding environmental determinism, there seems to be a reluctance for architecture and behavioral studies to come

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[67] Gerlach-Spriggs, Kaufman, and Warner, *Restorative Gardens*, 36.

together. However, there is an interdependent relationship between the two. By quantifying the details of the issue, a more clear understanding of how one plays off the other occurs. To this purpose, Roger Barker, a psychologist and author, created the concept of "behavior-setting".[68] This term refers to a physical space with both physical and temporal boundaries. This space is not dependent on one person or object, but exists on its own. It provides the context for human behavior. By using this as a base unit, one can start identifying specific variables within a given behavioral setting and how they influence the behavior that occurs within that space when added, taken away, or observed over time. Objects within a given space in this way reveal their influence of the behavior that occurs. Such a study also clearly identifies a symbiotic relationship between behavior and objects in space.

As an example, a field study done by psychologists Maslow and Mintz showed a strong correlation between behavioral changes and environmental changes in an asylum's solarium. They replaced the furniture within the solarium to comfy seating, and over a several month period, they observed a very distinct change in the patients. Their passive behavior (hanging out) that occurred in the hallway was moved to the solarium. The behavior didn't change from passivity, but the specificity of the environmental setting changing clearly shows a strong relationship between space preferences for a given behavior[69]. Plainly stated, by putting comfy chairs in the solarium, the hallway became a less desirable place to hang out in. The patients expressed their special preferences for hanging out by changing the setting they hung out in.

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[68] Lang, *Designing for Human Behavior*, 184.
[69] Ibid., 190.

While convenient this particular example was done within an asylum, the universality of effectiveness doesn't change. Considerations regarding how space is formulated based on preference and desired behavior may be used to create a more successful environment. Even with regard to movement, objects within space may control the type and speed of conveyance through it.

The quickest and clearest example of mind is the Holocaust museum in Washington DC. Everything about the museum is designed to impart emotion upon the visitors. Narrow passages, the smell of shoes, letters, images, darkness, a winding path, barriers before TV's to control the exposure to the intense content that was playing, all contribute to the overall goal of communicating and controlling the experience.

Understanding inherent personal mechanisms

Sterility of program is not the only challenge facing hospital and clinical buildings. A key component of many asylums' demise revolved around overcrowding within the wards. The general pattern looked something like this; once over crowding became the norm, the asylum fell into disrepair, abuses ran rampant, and the environment deteriorated to such a level that the asylum was shut down. How does overcrowding affect the patients? Putting a magnifying glass on this aspect of the situation, many of the determining factors revolve around personal perception of space, lack of control over one's environment, spatial constraint and lack of semi-private areas for social interaction and personal influence. On a very personal level, overcrowding amounts to an overwhelming environment that kicks in coping mechanisms that try to restrict the amount of exposure to what appears so

overwhelming. "This conceptualization implies that a situation in which there is too much stimulation will lead to processing of only high priority inputs. In situations of high density, where an individual is subjected to frequent interpersonal contact and social stimulation, such selective processing may occur. As the level of stimulation climbs, an individual may become less comfortable with the amount of information that is being processed and may begin to disregard those inputs that are of little value. Such a situation would lead to a proliferation of superficial social relations and to a certain degree of enforced withdrawal from many settings[70]." Essentially, one's natural reaction to an overwhelming stimulation results typically with mental withdrawal, making the person feel more isolated around too many people rather then more socially connected. On a direct parallel, feeling isolated and overwhelmed exacerbates many psychiatric conditions. In the case of overcrowded asylums, if a patient was bombarded by these emotions for an extended period of time, the likelihood of their behavior becoming more erratic increases, which would likely contribute to the abuses inflicted upon them by the staff. Also, without any identifiable space of their own, patients' sense of spatial anchor may be lost. A spatial anchor here is defined by a space one is attached to, identifies as their own, and able to alter to their liking. In the case of many individuals, their spatial anchor is their house; their house is an owned space by the inhabitants, a space they are free to influence in accordance to their living patterns. In the case of patients, their spatial anchor would most likely be their rooms. Social spaces within their wards could also act as anchors in the sense that, in the ideal situation, social interaction is controlled

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[70] Baum and Valins, *Architecture and Social Behavior,* 5.

by the size of and access to the assigned space. When all these spaces are filled to the brim with people, the patient has no ownership or understanding of belonging. This is most often referred to as density stress.

Dormitory type spaces within the wards are not free from responsibility of density stress. In many asylums, even Kirkbride buildings, space was organized at least in part with economical concerns in mind. Corridors were double loaded, halls were made long, bathrooms and exercise areas were made for large numbers all in an effort to accommodate more patients. While this design certainly maximized accommodations and minimized space per person, it did little to provide the opportunity for patients to interact in controlled groups. Once aggravated by overcrowding, the positive design intentions of the Kirkbride seemed to disappear.

Keeping that in mind, space can be reorganized in a dormitory setting that reduces the risk of density stress. By modeling the average person's relationship types and applying each type as a spatial boundary, social interactions are more clearly organized. The hierarchical nature of the organization also provides spatial cues that identify spaces as more or less private. Hierarchical organization also determines ownership; this is my space, our space, their space, the ward's space.

Dormitory space may be organized in a way that encourages relationships with like-minded occupants, while also providing spaces of privacy the occupant can personalize.

Women and Wellness

Current state of women and violence

Violence against women is a significant problem in the U.S, and only recently have major resources been allocated to support these women. As a report from the Domestic Violence Resource Center states, between 600,000 and 6 million women are victims of domestic violence every year. In 2004 (the most recent year with these statistics available), 30% of homicides with female victims were attributed to domestic violence[71]. Of the women within the U.S. 76% of them reported they had been raped or physically assaulted by an intimate partner. Unfortunately, child victim statistics of domestic violence are closely related to women. In a family situation, 50% of men that were violent toward their wife were also abusing their children.

The site chosen, Greystone Park, is in a state no different from others when it comes to violence against women. New Jersey has a significant population of victims from domestic violence and abuse. In 2010, 74,244 cases of domestic violence were reported to New Jersey police[72]. Of these, only 31% resulted in arrest. These numbers clearly show a significant gap in legal coverage for women, and at the very least, indicate a lack of resources available. Whether or not the reports account for all instances of violence against women is highly unlikely. Cases involving domestic violence and assault notoriously go unreported. There is an entire body of evidence regarding this specific issue, but the length and intricacies in these situations lie outside the scope of this dissertation. The numbers reported are high enough to illustrate a problem that keeps growing. (Table 2-3)

[71] Lang, *Designing for Human Behavior,* 32.
[72] NJ State Police*, 28th Annual Domestic Violence Offense Report 2010,* 1.

Women's shelters

Women's shelters, crisis units, clinics, and some hospitals generally provide the types of services these women look for. However, the capacity for providing services to women in need is rarely enough to cover everyone. In the 2010 National Census of Domestic Violence Services, New Jersey programs reported an inability to provide necessary support; reasons sourced revolved around lack of funding, not enough space or staff, no access for necessary equipment, and not enough specialized services were available (Figure 5). Many facilities had to turn away women, even those that had acute emergency situations. 262 requests for services were unmet - "Many programs reported a critical shortage of funds and staff to assist victims in need of services, such as emergency shelter, housing, transportation, childcare, and legal representation. Of these unmet requests, 93 (35%) were from victims seeking emergency shelter or transitional housing[73]. Slight improvements were made in 2011, although critical shortages in funding, staff, available space and counseling stayed the same or got worse[74]. Clearly, there are not enough resources available to keep these women and their children safe.

Right now, as seen in table 2-3, services are separated by county. A common set up for most states, this creates a truncated network of services that don't communicate with each other nearly as well as they could. If no room is available in one county, could there not be an opportunity in another? Certainly proximity to

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[73] National Network to End Domestic Violence, *Domestic Violence Counts*, 2010, 33.
[74] National Network to End Domestic Violence, *Domestic Violence Counts*, 2011, 33.

one's home is of limited value in the situations these women find themselves in. If women could be transferred safely to another county that does have space, additional victimization could clearly be avoided.

In the case of Greystone, vast amounts of square footage are available for use. By creating a fully functioning network of shelters, clinics, etc. women would find assistance at a much higher rate, and with the space available in an abandoned asylum, an obvious opportunity presents itself. By reviewing the information provided by the state of New Jersey, existing women's shelters are critically short in emergency and transitional housing as well as specialized services. Some of the special services include career training and job programs, therapy for adults, children, adolescents, human trafficking and substance abuse, medical services and advocacy, and bilingual services.

Primary Programmatic Spaces for a women's shelter

Housing types	Emergency 12-24 hour	Transitional
	Semi-permanent	Permanent
In house Services	Career training	Therapy
	Advocacy center	Language services
	Childcare	
Other services	Hospital/medical care	

Table 1 : Women's shelter program broken up by service provided

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Women's shelters have been around since the 1970's. The intent and public perception of these shelters have fluctuated over 40 years; overall, the support for shelters has never been that high. "Historically, theories and treatment of the problem have been influenced by the prevailing patriarchal structure of society and its organizations, society's denial of the prevalence of the problem, and religious views of the intact family as safe and sacred[75]." Similar to the medieval understanding of the insane, religion plays a significant role in how people organize and understand their lives. Unfortunately, many religions have patriarchal structures that seem to define the male as the authority figure, which further complicates the problem of domestic violence. Pressure to keep up appearances of a wholesome family often keep women in bad situations, and their understanding of the authority of the abuser makes self-reproach and guilt huge obstacles for women to overcome before they seek help. For a long time, women's shelters have been battling a social culture that places utmost privacy within the home and to some extent, still believes in "family business" rather then approaching domestic violence as a community problem. Evidence rests on the pitifully low number of shelters within the U.S. Only 1,637 emergency shelters were open at last count[76].

At present, women's shelters can generally be categorized in a couple different ways. They are either subsidized by the government or are privately run be advocacy and politically motivated groups. Neither runs particularly efficiently; while shelters under government subsidy can rely on a more regular money supply,

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[75] Donaghy, "Beyond Survival: Applying Wellness Interventions in Battered Women's Shelters," 3.
[76] National Center on Domestic and Sexual Violence, "Domest Violence Shelters in the U.S."

the organization is very hierarchical, with those they're serving generally at the bottom of that hierarchy. Politically motivated independent groups are constantly struggling with income, and many times the women that need assistance take a back seat to the political aspirations of the group[77].

Shelters are also broken up into stages, from immediate shelter to transitional housing to permanent housing. All three options are not necessarily present in every shelter, but each has an important role to play toward the recovery of domestic violence victims. The most acute need, emergency shelter, is usually a 24-48 hour affair, while transitional housing is designed to empower women with skills that enable them to survive on their own in their own community. Permanent housing may serve otherwise homeless women or women that become role models for others in need. (See Deborah's Place, pg. 107)

The Wellness Model

different housing needs may be placed under one roof, which develops a symbiotic relationship between the women at different stages of their particular recovery. Rather then employing a highly structured one-size-fits-all program, each female upon intake is created a specific program based on her stated goals. Kathleen Donaghy would call this a Wellness Model. With this approach, the services provided for each woman is tailored to her specific needs using a number of dimensions reflecting directly on her health. These dimensions are social, occupational, spiritual, physical, intellectual, and emotional. Put another way, the wellness model takes into account the nuances involved in her social, occupational

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[77] Donaghy, "Beyond Survival: Applying Wellness Interventions in Battered Women's Shelters."

and emotional interactions in addition to the physical scars she may be carrying. Rather then prescribing a specific denominational religious approach, a purely physical approach, or mental health approach, her needs are defined by multiple determinants to make her journey to healing a much more successful process[78].

Despite some critics of environmental determinism, most would be hard pressed to deny that a blank concrete wall has a completely different emotional generation then say, lattice work covered in vines. "Even when we're well, radiant, sunlit interiors with garden or landscape views tend to make us feel better than hermetic, coldly institutional places. It's hardly a lofty concept. And the logic goes, if the surroundings enhance our mind-set, increasing relaxation and reducing stress, then our physical condition--our health and healing processes will benefit. This thinking rests firmly on twin principles of intuition and experience[79]." A behavioral scientist named Roger S. Ulrich performed a landmark study in the 1980's in which "… he found that surgical patients overlooking a verdant landscape required shorter hospital stays, fewer narcotics, and less nursing care than patients, just across the hall, with brick-wall views. Despite variables in every illness and individual, researchers have rigorously built on this study[80]." From scientific evidence to common sense, implementing basic ideas about general wellness within a given environment at the very least fulfills intangible needs of patients. And, as our medical care system slowly makes the transition from a symptomatic focus to a more preventative focus, these design strategies are enjoying a surge of use.

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[78] Ibid.
[79] Amelar, "Healing Architecture; Focusing on Clinics: How Can Health-care-facility Design Improve Medical Outcomes and General Well-being?," 115.
[80] Ibid.

What does this mean for the program of a structure with a primary use of healing? In the case of Donaghy's 6 principles of wellness, spaces may fall under those categories as support to the underlining purpose. Each programmatic element can be reorganized in this way to determine relationships that may or may not have been appreciated before. Table 5

By combining the basic programmatic requirements based on need in figure 7 with the spaces related to personal program elements, new adjacencies and space requirements are slowly revealed.

Changing the paradigm of endless hallways lined with many doors and sterile floors is another logical first step. These changes may be as simple as incorporating a hearth, or as complicated as restructuring the type entirely[81]. As seen in Herzog and De Meuron's REHAB in Switzerland, the hospital type has been completely rethought into a new, dynamic and enjoyable space (pg).

Theoretical Pitfalls

Review of historical principles

The collected principles from asylum history are as follows:

Principle 1:   *People relied on religion to explain things they didn't understand.*

Principle 2:   *Reliance shifted to the opposite end of the spectrum; the doctor was*

the new religion, and in some way, all ailments were thusly physical in nature

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[81] Jencks and Heathcote, *The Architecture of Hope.*

Principle 3: *Condescending pity made the control of other human beings acceptable.*

Principle 4: *Out with the old, in with the new. Completely discounting tradition in favor of new concepts without enough due diligence. Forward thinking; the old is inaccurate.*

Principle 5: *Authority figures are the representations/pinnacles of explaining one's environment.*

Principle 6: *The built environment helps one's health and sense of wellbeing. There may be value in a variety of theories; certain aspects may be part of the learning experience, while others are not worth taking with you.*

Principle 7: *Taking care of one's basic human needs in a holistic manner contributes to the health of that person.*

Principle 8: *Intelligence was women's kryptonite. Their level of intelligence adversely affected their health. Women exhibiting strong opinion that could be related to intelligence were stepping outside the role proscribed to them by patriarchal society. By controlling women, you kept them healthy.*

Principle 9: *By abusing one's authority, they are able to fulfill their own selfish needs. Because they are authority figures, they are not questioned. Again, connection with battered women and the authority-establishing figure in their partner.*

Principle 10: *By customizing a space to a specific user group, their needs are more thoroughly met.*

Principle 11:   *Exposure to nature and interaction with animals helps alleviate stress in patients and keep them happy.*

Principle 12:   *Air circulation, ventilation, and flow are extremely important to the health of building users.*

Principle 13:   *The urban environment is bad and infected with disease of both mind and body.*

Principle 14:   *A simulated home environment provides comfort to patients.*

Principle 15:   *Those too ill to achieve a cure were still human beings and deserved quality care.*

Principle 16:   *No person shall be regarded or treated as an Insane person, or a Monomaniac, simply for the expression of opinions, no matter how absurd these opinions may appear to others.*

Principle 17:   *No person shall be imprisoned, and treated as an insane person, except for irregularities of conduct, such as indicate that the individual is so lost to reason, as to render him an unaccountable moral agent.*

Principle 18:   *In order to maintain control, staff members within asylums used fear and violence extensively.*

Principle 19:   *This is not violence perpetrated against another, because to be* another *you have to be first human being, and since insane patients were categorized as* other *rather then human, violence was justified. Non-humans don't understand violence.*

Principle 20:   *Fear as a control mechanism was achieved via constant pressure of surveillance, physical violence and sexual assault.*

Reinventing historical principles

Some of the historical principles are quite valid and have positive relevance to modern women's shelters. Others are highly damaging. In order to inform the program of a new shelter, each principle is reestablished for modern use. Those that are not helpful still provide insight on the historical state of mind and can be translated into valuable parts of the puzzle.

Principle 1: *Allow scientific, sociological, and psychological theories guide the program, and enable some flexibility to adapt as information grows.*

Principle 2: *Modern theory and historical study may tell pieces of a whole story that are valuable in concert with new information. Binary thinking isn't so useful.*

Principle 3: *Care and empathy go a long way in helping another human being. Pity just demoralizes a person because it communicates a sense of hierarchy; that one individual is somehow less than another.*

Principle 4: *Accept the positives of old and combine with the new.*

Principle 5: *Social hierarchy is useful on a limited basis. Leadership is highly valuable, condescension is not.*

Principle 6: *Use the surrounding environment to assist in wellbeing, both built and landscaped.*

Principle 7: *Taking care of one's basic human needs in a holistic manner contributes to the health of that person.*

~~Principle 8:~~

Principle 9: *Taking advantage of one's low status is abusive and cowardly. Re-establish the value in each person.*

Principle 10:   *By customizing a space to a specific user group, their needs are more thoroughly met.*

Principle 11:   *Exposure to nature and interaction with animals helps alleviate stress and improves one's overall wellbeing.*

Principle 12:   *Air circulation, ventilation, and flow are extremely important to the health of building users.*

~~Principle 13~~:

Principle 14:   *Reinventing one's definition of home is critical in one's ability to recognize norms that are healthy vs. those that are not.*

Principle 15:   *All persons deserve dignity.*

Principle 16:   *No person shall be regarded or treated as an Insane person, or a Monomaniac, simply for the expression of opinions, no matter how absurd these opinions may appear to others.*

Principle 17:   *No person shall be imprisoned, and treated as an insane person, except for irregularities of conduct, such as indicate that the individual is so lost to reason, as to render him an unaccountable moral agent.*

Principle 18:   *A balance must be reached between healthy structure and expressive individualism. Provide proper and varied outlets.*

Principle 19:   *Not a single human being on this planet is* less than *or* other.

Principle 20:   *Personal safety is vital to battered women. Therapies to alleviate fear take time; a certain level of self-sufficiency should be present at Greystone.*

Organization under contingencies:

Physical Environment: Principles 1, 6, 7, 10, 11, 12, 20

Psychological Environment: Principles 1, 2, 4, 7, 9, 10, 14, 18, 19

Leadership and Treatment: Principles 3, 5, 7, 15, 16, 17, 18

Chapter 5: Historical and Modern Precedents

Historical Precedents

Friends Asylum

Built: 1812-1813

Founded: by Quakers

Original Name: The Asylum for Persons Deprived of the Use of Their Reason

Therapy types: Healthful living conditions, exercise, early moral treatment

Incorporated animal therapy in 1830

The integration of horticultural therapy began in 1879[82]

NRHP nomination: 1999

FRIENDS HOSPITAL

Mission Statement: "To provide for the suitable accommodation of persons who are or may be deprived of the use of their reason and the maintenance of an asylum for their reception, which is intended to furnish, besides requisite medical aid, such tender, sympathetic attention as may soothe their agitated minds, and under the Divine Blessing, facilitate their recovery."- *Friends Hospital Mission Statement, 1813*[83]

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[82] "A Journey Through Time - Friends Hospital."
[83] "Our Mission - Friends Hospital."

LESSONS LEARNED

Incorporated a multidisciplinary approach to mental health in 2011 called FIRST – Family, Individual, Recovery, Strengths, Trauma-informed care.

Uses a continuum model, offering care to children through adults; out-patient care through semi-permanent and permanent housing.

Incorporates a variety of therapy sources including horticultural practice and therapy animals.

Provides training onsite for continuing education and internships for upcoming psychiatric professionals.

York Retreat

Opened: 1796

Founded: William Tuke, Quaker

Therapy Type: First Moral Treatment hospital

All manner of restraints forbidden

Early example of occupational therapy in farm labor, and crafts

Early example of animal and garden therapy

LESSONS LEARNED

The original principles outlined by William Tuke and the resulting moral treatment philosophy is still closely followed, centered around respect for the patient.

Looks at healthcare with six basic ideas – hope, life, courage, space, relationships, and quality & honesty.

Specific pathways are designed to address a patient's needs rather then a general admission procedure[84].

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[84] "The Retreat York - Mental Health Care Provider."

Modern Precedents

REHAB – Herzog and de Meuron

Built: 2002

Location: Basel, Switzerland

Site: 6 acres

Building SF: 246,387

Architect: Herzog and de Meuron

Type: Spinal Cord and Brain Injury Clinic

Key Components: interior courtyards, therapy pool

LESSONS LEARNED

Every patient's room has immediate visual and physical access to the landscape via sliding doors that open out to a deck.

Courtyards and gardens are incorporated throughout the floor plan to break up the interior space, providing constant connection to the outside environment.

Materials and lightness of the building are used to deinstitutionalize the building and elevate the wellbeing of both patients and staff[85]..

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[85] Stephens, "Architectural Record Building Types Study | REHAB, Center for Spinal Cord and Brain Injuries."

Dalseth family dental clinic

Built: 2003

Location: Apple Valley, MN

Building SF: 7,000

Architect: Altus Architecture + Design

Type: Dental clinic

Key Components: siting, green environment, naturally lit spaces, hearth use[86]

LESSONS LEARNED

The landscape of tall grasses fuses with the interior using floor to ceiling windows.

A hearth contributes a sort of softness reminiscent of one's home.

By deregularizing the one long hall in the building, the interior remains light and comfortable rather then exuding a feeling of constriction

Opportunities to enjoy the outdoors is encouraged by providing simple exterior programming like seating.

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[86] Hammel, "Dalseth Family Dental Clinic."

North Memorial Hospital healing garden

This is a project completed by the Landscape Horticulture dept. of Dakota County Technical College. A patient from North Memorial Hospital worked with the students to create a healing garden for patients. The students used research on healing benefits of gardens and planned for patients with various levels of mobility.

Buffalo State Asylum

Built: 1871 – 1895

Architect: H. H. Richardson

Landscape: Frederick Law Olmsted and Calvert Vauz

Style: Cottage style with Kirkbride main building.

Materials: Stone and brick façade, slate roof

Demolished: 3 outer male wards in 1969

NRHP nomination: 1973

Closed: 1994

Area: 91 acres

Total project sf: 480,000

Uses: Architectural Center, Regional Visitor Center, Boutique Hotel, Event Space in first phase

Strategy: phased project. Buildings treated as separate but connected development properties

Provide public outreach and community involvement in the development project – help revitalize the surrounding communities, gain broad community support for the project.

Investment to date: $9 million in stabilization and emergency repairs

LESSONS LEARNED:
Manage scale of site with mixed use and phasing over an extended period of time.

Allow for flexibility in the process to make different or changing needs easier to incorporate.

The grounds can be one of the greatest assets of the property. Resist the tendency to develop or parcel away the land.

Create relate-able mixed uses to encourage making the site as a community.

Incorporate grounds by offering a means to interact with it – hiking trails, biking, recreational pavilion, etc.

Northern Michigan Asylum for the Insane

Built: 1885

Style: Victorian-Italianate

Area: 135 acres

Closing: 1989

NRHP nomination: 1978

Uses: asylum, working farm, greenhouse, furniture construction, hospital for epidemic diseases

Features: electricity and heat produced on site

THE VILLAGE AT TRAVERSE COMMONS

Renovation Project: began in 2000

Investment: $300 million over 12 years

Area: 60 acres

Use: residential, retail, commercial

Amenities: historic arboretum, historic front lawn, farmers market, hiking and biking trails, winery, restaurants, offices, luxury residences

LESSONS LEARNED:

Scale – provides opportunities for complementary mixed use in a 12 year phased plan.

This project was able to transform an extremely run down space into something beautiful and enjoyable.

Caution – There isn't much relational quality to the building's past. In the effort to beautify the space, all elements of historical value were eradicated.

Deborah's Place II – Chicago, IL

 Architect: Thompson Architects

Original Use: former church, goods store, and manufacturing facility

Type of shelter: transitional, overnight, and permanent housing for women that were

formerly homeless. The advantage is the permanently housed maintain a community,

while those in other programs can switch as needed

Spaces: kitchen, dining room, learning center

LESSONS LEARNED
Provides a direct example of converting an old building into a women's shelter.

Engages in community programs to get women involved, providing opportunities for

social networking, work experience, and self-development.

Location – access to these shelters and programs is vital for women in need. This

facility is located immediately off the L-train.

Chapter 6: Analyzing Greystone Park Asylum

Introducing Greystone Asylum

Greystone Park Psychiatric Hospital is located in Morris Plains, NJ. It sits among woods that extend from the northeast, northwest and southwest elevations. There are a couple nearby bodies of water, and the hills toward the northeast provide a lovely natural backdrop. The hospital presents itself at the end of Central Ave., a street that creates a direct axis straight up to the front door. The wings of wards on either side spread away from the central block, and there is a clear hierarchy exhibited by this view. The central administration block has a pedimented front, and consists of 5 grand stories. In contrast, the wings are each 4 stories, packed vertically much closer together. The street pattern around Greystone rings the hospital almost completely, and public transportation is available via the local bus route. The bordering streets are not close enough to the site to cause any noise, and direct sight lines into the Kirkbride building are limited even in winter by thick trees. The asylum sits as a mammoth reminder of a history riddled with troubling incidents, but Greystone's current existence does not readily exude the force of its tragic past.

History of the Asylum

The state of New Jersey already had an asylum in Trenton. However, that hospital was bulging at the seams with patients, and officials soon began looking for a location for another mental hospital. In 1871, Morris County, 35 miles East of New

York City, gave the state a tract of land for the purpose of building the new asylum that was so desperately needed. The site was particularly beneficial, as it contained a stone quarry, nature springs, fertile soil, and sand pits ideal for building materials. The surrounding area was covered in mature trees, offering a very attractive natural vista. So began construction for Greystone Park Psychiatric Hospital.

Samuel Sloan was the architect that designed Greystone with Kirkbride's design ideology. The two had worked together since the mid 1800's, when Sloan completed a set of drawings for Kirkbride that illustrated the linear plan. Kirkbride had conducted many experiments at the Department for the Insane between 1945-1947, and they "resulted in concrete evidence supporting his theories on the interrelation of physical plant and treatment[87]." Once Kirkbride determined to publish his findings, Samuel Sloan was the one he employed to illustrate his ideas in drawings. The two worked together a number of times, and Kirkbride started recommending Sloan to anyone looking to build an asylum. Sloan designed 32 asylums throughout the country and was considered an expert in asylum and hospital design. Greystone was his biggest project; the structure had the largest foundation in the country until the Pentagon was built, and the site featured a pavilion-related design Sloan had used in many hospital designs.

The pavilion system was one born from French precedent in the middle ages, and the modern system was recommended by the French Academy. The details were very similar to those employed by Kirkbride in asylums; "Patients were separated, according to sex and treatment required, into a series of pavilions, which also

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[87] Cooledge, *Samuel Sloan, Architect of Philadelphia, 1815-1884*, 40.

contained treatment facilities and nurses stations. These pavilions were connected by long wards, the center corridor of which carried the circulation between pavilions, making them the equivalent of a 'long gallery.' Such an arrangement provided maximum supervision by minimum staff and was easily expandable… centering on the administrative pavilion[88]." While Greystone and linear asylums in general were formed more by symmetrical wings then pavilions, the administrative block was still the organizational and physical center of both types. The linear plan also used the same categorical logic; patients were placed by sex, type of disease, and severity of case, each ward with its own nurses' stations and treatment rooms. Sloan designed each ward within Greystone to include hydrotherapy rooms and nurse stations, as well as more Kirkbride specific spaces like exercise, dining, and parlor rooms.

As mentioned, the pavilion system was used most often for general hospitals, but the similarities between this system and the linear plan suggest a stronger connection. While asylums during this period were purpose-built, they were not independent structures existing in a vacuum; they related very closely to other institutions. The fact that Sloan was considered a master of both hospitals and asylums shows the strength of interplay between institutional type. Sloan also had a few prisons in his lengthy portfolio; among the most famous was Eastern State Penitentiary.

The ease with which one design could morph into another type is disconcerting when considering the relationships between user groups. Prisons, generally, are designed in a fashion to maximize control, a structured environment,

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[88] Ibid., 78.

constant surveillance, and minimizing self identity. Unfortunately, this string follows along through the other types Sloan was a master in as well. Sloan's design of Greystone in many ways was no different from the 30 some other asylums he had designed. As the chosen representative for the asylum type, then, one can easily identify elements of prison organization.

Completed in 1876, Greystone was a large Kirkbride building initially designed to hold 600 patients. It was situated on a formally landscaped lawn with a tree-lined avenue directing visitors straight up to the main entrance. The initial 342 patients admitted to Greystone on its opening day was a modest beginning, but the building was over capacity by 1895. Like many asylums of the time, the overcrowding caused major problems; cots were placed in any available space including the activity and exercise rooms and even the hallways. There was an outbreak within the hospital of typhoid fever, which was blamed on the water supply. The lack of general cleanliness was evident in the lack of care to the cots. Those that were set up in the halls were taken up daily and passed out again each evening, regardless of whether they were soiled by a patient the night before[89]. Finally, in 1901, a dormitory building was completed and the overcrowding was eased for a time. However, by 1911, the hospital was again bursting at the seams, with 2,672 patients. The hospital used this opportunity to install a photography room and documented patients, "in hopes of cataloging facial expressions and characteristics which go with certain mental disorders[90]."

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[89] the Preserve Greystone organization, "Preserve Greystone."
[90] Ibid.

The advent of technology-based treatments meant expansion for the hospital. Each was incorporated into Greystone as they came on the scene, including electro convulsive therapy and hydrotherapy. Greystone throughout it's history had followed the treatment types of many of its predecessors. Patients started by working on the hospital's farm and performing groundwork. An Industrial building was added in 1914, which opened the door to more work therapy options; men made everything from brooms to books, and women began participating with sewing and crafts (Illustration 47).

Greystone's problems reached far into present day. Abuses, overcrowding, and decrepit conditions were reported up to 2008. A new hospital was built behind Greystone, which became the new home for the patients. Greystone had lost some of its outer buildings by the time it closed, some due to decay, others to make room for modern convenience – parking lots. The 300 acre site fared a little better, though over time it also shrank. Morris Plains installed skating rinks and built a ball field on the property, and plans to incorporate community amenities such as a dog park, athletic complex are also underway[91]. Unfortunately, no current plans exist for the main Kirkbride building and, not being on the National Register for Historic Places, the building has little protection.

Spatial Organization of the Asylum

The central structure separated two wings with men on one side and women on the other. The wings maintained a consistent height of 4 stories with U-shaped

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[91] Ibid.

wards at the end of each wing sitting at one story. These outer wards were designed to hold the most violent patients. Sloan used this arrangement in 1856 in Pennsylvania's Hospital for the Insane[92]. In the central block, Sloan placed apartments for employees on the upper floors, but the 3rd floor was reserved for a patient entertainment room. This floor also held a chapel for everyone's use (Figures 44-46). Administrative offices were on the lower floors[93]. The main entrance was on the ground floor and as such, was designed in a particularly grand manner.

Each ward was designed to hold 20 patients with exercise rooms, activity rooms, and a dining room at the ends. The finishes were high quality even in the wards; Sloan chose high-end wood, rugs and accessories to populate the wards. Many also included a piano. Porches were located on the end of each ward also facing the rear of the building. The bedrooms in each ward were typical of other Kirkbride buildings; there was a mix of bedroom sizes, anywhere from 1-8 beds per room. Sloan was particular about making the wards and overall building fireproof (Illustration 44). A sort of primitive firewall of brick separated each ward. The ceilings consisted of iron beams with brick vaults between them, and "the stone was gneiss over concrete foundations[94]." This was just as well, because by 1935, the building had suffered 3 fires, altering the main building's façade (Illustration 44).

The organization of the overall building was directly related to the classification of patients. As mentioned earlier, those that were most disturbed were housed in the outer most U-shaped wards. Noisy patients were placed furthest away

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[92] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 119.
[93] the Preserve Greystone organization, "Preserve Greystone."
[94] Yanni, *The Architecture of Madness Insane Asylums in the United States*, 119.

from the central building, but as patients improved, they were slowly moved closer to the center. Furnishings and finishes progressed in the same manner, with the grandest located immediately adjacent to the central block.

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Analysis of the Site

Greystone Park Asylum began on 743 acres as a self-sustaining institution. Part of Dr. Kirkbride's healing strategy was occupational therapy; he believed patients at work were far better off then patients left idle. As part of this program, patients participated in all sorts of activities that helped to keep Greystone Park autonomous. The site held many different functions that supported the institution, including farming and field cultivation, a slaughter house, gardening, ice house, and cattle yards.

Changes over time

The physical site of Greystone has slowly changed over time. When initially built, the asylum was capped with mansard roofs, and the site consisted of roughly twenty-seven buildings spread over 743 acres. As times changed, however, so too did Greystone. Conflagrations in 1929 and 1930 permanently altered the building's

character; the mansard roofs with cupolas were all destroyed and the pedimented front of the administration building shrank to 2 rather then 3 floors. The land was also slowly sold off, the final of which included 300 acres purchased by Morris County in 2003, which included some dilapidated buildings of Greystone[95]. Several buildings were demolished, leaving the abandoned site as it sits today.

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[95] the Preserve Greystone organization, "Preserve Greystone."

Demographics

Demographically, Morris Plains rates higher in income and housing costs then the state average. The area is also not particularly dense. Morris Plains is a bedroom community to New York City, which is reflected in the median commute times for employed citizens. A mere 18% both live and work within Morris Plains[96].

The lack of density and high level of median income seem to indicate a stable housing market. However, the lack of reasonably priced housing coupled with a significant enough population with a household income of below $50,000 says otherwise. The expense of housing in the area effectively bars those with a lower income from reasonable housing.

Morris Plains Climate

The climate of Morris Plains is fairly consistent with national averages. The amount of heat in the summer and snowfall in the winter indicates strong representations of each season. For Greystone then, heating during the winter is not optional. Both the use of insulation and measures

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[96] City-Data, "Morris Plains, New Jersey (NJ 07950) Profile: Population, Maps, Real Estate, Averages, Homes, Statistics, Relocation, Travel, Jobs, Hospitals, Schools, Crime, Moving, Houses, News, Sex Offenders."

to protect the building from the elements are important, as high winds, snowfall, and high precipitation are all common for Morris Plains[97].   Transformative spaces throughout the building that allow for optional open-air or enclosed rooms would be very appropriate to enhance use in all four seasons.   Enhancing natural light penetration, especially in thick interior spaces, would maximize sunny days and provide light even during the cloudiest of days.

Existing Site

Greystone Park has been dormant since 2010, when the last of administrative functions abandoned the building. The new psychiatric hospital to the north crowds the old site, and the surrounding residential has slowly crept up to the property lines of Greystone. Clearly, the site is much less rural then it once was, but this growth has not affected the secluded, natural setting of the old asylum. Rather, Greystone is still ideally located to maintain a natural, tranquil feel while having the benefit of nearby services, commercial and retail. The residential in the area is all low density, so the congestion levels on the surrounding streets are low. Though Morris Plains has experienced steady growth, the green space that nearly surrounds the site is protected by the state of New Jersey, so that particular feature is never going away.

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[97] Ibid.

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Transportation within the area relies heavily on vehicular traffic. Even the public transportation options center around the use of local buses. A bus stop is located about 50 feet from the front door of Greystone. As a sleeper community, however, there is also a commuter line that takes residents directly into New York City. The train station for this line is located about ½ mile away from the site, making it both within walking distance, but too far away to cause consistent noise at Greystone. There are a few major streets that border the site, but the thick wooded areas between the streets and the Kirkbride building prevent any direct sight lines into Greystone. The area around Greystone Park is quite active, but the Kirkbride building remains insulated and very private from the activity.

In reviewing the conditions of the Kirkbride building, I wanted to establish exactly how well both light and air actually penetrated the building. For a building that was designed off these principles, it was important to establish their effectiveness in execution. I began by mapping out the wind patterns of Morris Plains to determine how the Kirkbride building was exposed.

I used the same strategy in analyzing the sun's path throughout the day and year, which determined where shadows lay and how much sun bathed the Kirkbride building during all different times.

An added benefit to light penetration within the building was the exposed segmented arch structure. The curve of each arch runs perpendicular to the exterior windows, which enables the arches to bounce the light coming in around the room more thoroughly.

Community Response and Integration

Establishing the community's collective attitude

Greystone had an impressive number of articles in local newspapers. Public hearings regarding the abuses, illegal activities and Senate task forces kept the institution in the public eye for a long time. It would be a reasonable assumption that community members were ashamed of the major institution within their midst, and perhaps at some point that was the case. But today, Greystone Park is an integral part of the Morris Plains story. Pamphlets advertising features of the community with Greystone on the cover are common[98]. A museum called Morris Plains Museum has dedicated a permanent exhibit to the history of Greystone Park, and public events sometimes occur at the adjacent park under the same name.

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[98] the Preserve Greystone organization, "Preserve Greystone."

Integrating social services and events

As a structure, Greystone holds many opportunities with it's vast square footage. Hospitals abound in the surrounding area, and though Greystone was formerly considered a hospital, it's systems and facilities have become completely inappropriate and outdated for such a use. Barring that, single use of so much square footage is highly unlikely. The space is too far removed for commercial or retail; surrounding markets are busy, but certainly not overrun. Instead, Greystone could meet a number of uses determined from local community needs. In addition to providing a full service women's shelter, complimentary programming may also become part of Greystone. Since housing is already part of the programming for the women's shelter, housing for the community could easily be incorporated.

Supply needs to the community

The neighborhoods around Greystone are all small single family homes. Few opportunities for reasonably priced housing could easily be remedied by providing small condos within Greystone's structure.

The surrounding community consists of modest neighborhoods of bungalows and cottages. A park still surrounds Greystone, which effectively insulates the structure from direct adjacency. An Interfaith Food Pantry sits to the southeast of the property; this is a small building dedicated to feeding the hungry for the surrounding area. Just northwest of the old hospital sits the new psychiatric hospital, which is also called Greystone Park, though there is no relationship beyond name between institutions. Barely a quarter mile from the site, there are a number of public

resources; The Morris County Housing Authority along with the Office of Temporary Assistance are local service providers, and a healthcare center, nursing home, Volunteer Management Center and Public Safety Training Academy are all closely knit together. These services in concert offer a unique opportunity to expand and integrate the needs of the community.

Taking a page out of other therapy programs, animal therapies could be a great addition to Greystone. When looking at the surrounding communities, resources for animal placement, shelters, and training are not particularly within convenient reach. Combining an animal shelter and training facility with a women's shelter enables a unique opportunity to implement a recovery program between the women and the animals. Animal therapy was used very effectively at the Friends Asylum and York Retreat to keep up morale. Modern programs in prisons and hospitals also use animals as a form of therapy for their troubled populations. Similar to horticultural therapy, working with animals can increase a troubled individual's sense of confidence, self-importance, achievement and ability to connect with others[99]. A rich program of working with animals could be something the surrounding community could share both as resource and learning opportunity.

Greystone's location is rich with services that directly relate to the needs outlined in Chapter 4 for women entering a shelter. Local providers include healthcare services, housing assistance, temporary assistance, career training and psychiatric care. Each could potentially offer job placement for women in the shelter or volunteer positions. In the case of the Interfaith Food Pantry, women could both

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[99] Fine, *Handbook on Animal-assisted Therapy*.

volunteer in a safe environment and contribute skills they are building. For instance, if women were studying cooking, they could practice what they were learning at the Food Pantry. In turn, the Food Pantry would have capable volunteers consistently available. By creating similar symbiotic relationships with the other service providers in the area, women could be thoroughly integrated into the community in a positive way. Social, training, and healthcare exposure would prevent a sense of isolation within Greystone, and accentuate the feeling of community for the residents of the shelter. These relationships could also alleviate one of the biggest challenges all shelters face, lack of funding. If a series of mutually beneficial associations were established, funding issues for the shelter could potentially be significantly reduced. Greystone could provide volunteers, employees, facilities for intern training, promotional events, and community outreach.

Local Service Providers and Collaboration Potential:

INTERFAITH FOOD PANTRY

The Pantry assists residents of Morris County by providing food, nutrition education and related resources including: youth involvement programs, community awareness and advocacy, volunteer program, and home delivery[100].

As a non-profit, the Food Pantry is always in need of volunteers. In addition, the Pantry offers education on nutrition as well as a program dedicated to enabling families and individuals become more financially independent. Greystone's women could connect with the Food Pantry by becoming a volunteer or participating in their

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[100] "Interfaith Food Pantry Programs."

education programs. Greystone could also offer event space for larger events, like holiday food service to those in need around the community.

MORRIS COUNTY HOUSING AUTHORITY

The housing authority provides multiple housing unit-types to those in need and coordinates placement of families and seniors. They also provide community level services including case management, community service programs, family self sufficiency programs, weekend meal programs, and recreational/educational and health programs.   Welcomes collaborative efforts with surrounding service providers[101].

The housing authority would benefit significantly from more space. More housing units would help control wait lists, and, while the housing authority does not deal with acute need of housing, Greystone could easily provide that housing type as an extension to the 3 housing phases of the women's shelter. Their educational programs would also benefit the women of Greystone.

MORRIS OFFICE - TEMPORARY ASSISTANCE

This office provides temporary, although not acute, services to those in need. They have already set up a collaborative program with the nearby healthcenter, food pantry, and works with the NJ Battered Women's Service to fulfill the needs of victims. No direct services, like housing, therapy, etc, are provided at this office[102].

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[101] "Morris County NJ Housing Authority."
[102] "Human Services."

PUBLIC SAFETY TRAINING ACADEMY

This training facility provides courses for police and firefighters, as well as EMT training, firearms qualification, and education in domestic violence[103].

MORRIS VIEW HEALTHCARE CENTER

Morris View is a sub-acute healthcare center that provides both short-term medical and continuous care. Health and wellness are the primary focus of this facility, and they impart a similar program to the Wellness Model. Also provides for those with dementia and general hospice care[104].

MORRIS VIEW NURSING HOME

An extension of the services provided at the healthcare center, the nursing home houses the more long term patients. Again, the focus is on wellness. Opportunities to volunteer in their gardening program, friendly visitor program, and assistance in the computer labs are all available.

VOLUNTEER MANAGEMENT CENTER

There are management centers throughout the state of New Jersey. The purpose is to coordinate volunteer positions, raise awareness about providing for the community, and expand non-profit training and education programs. This is an office

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[103] "Morris County NJ Public Safety Training Academy."
[104] "Morris View Healthcare Center :: Subacute Rehabilitation."

heavy on collaboration with others for volunteer positions and determining community service needs[105].

In establishing complimentary and collaborative opportunities among all the service providers of the area, it became clear there was quite a bit of overlap in the referrals process. Each office referred individuals to the others, making a complicated web of communication that had many points of potential miscommunication. With one phone call, a person could be transferred to each and every office, only to return to the one the call originated from. As a typical downfall of cable companies, mobile service and banks, complicated miscommunication can lead to many problems. The services provided in the offices surrounding Greystone are much more important then a cable bill, which makes the current communication system less then ideal. Because Greystone would be a location dispatching individuals to each of all the service providers, it would make sense to have a centralized Coordination and Referral office at Greystone. In this way, one space would have the needs, opportunities and training schedules of every service provider, and with one phone call, any one office can determine exactly where to send someone with a much smaller change of runaround or mistakes. Simply implementing an organizational computer program common to all locations would be enough to accomplish this.

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[105] "VMCNJ: About VMC."

Chapter 7: Programming

Existing Programming

The Kirkbride's existing programming is a bit of a paradox; for a building designed around maximizing light and air penetration, the interior ended up being rather dark and closed off. The double loaded corridors insulate the hall space from most direct sunlight, which essentially terminates any opportunity for cross ventilation. The light coming from either end of the corridors is not enough to penetrate the entire 140' long hall, and while the alcoves provide some centrally located light, the overall effect is dimness interrupted by a few spots of sun. Similarly, the building is anything but open. Each room, particularly for the patients, is tiny, and the rest of the interior space is consistently interrupted by cut up spaces, narrow rooms, and interiorly located hallways that have no natural light at all. In these cases, light and air penetration relies solely on the whims of the inhabitants' desire to keep the doors to each room open or closed. As a psychiatric hospital, it is a near certainty these doors were kept closed.

Principles, Wellness, and Applied Program

Historical principles and problems revisited

There is quite a bit of value in many of the historical principles derived from the 18th century. Kirkbride's attempts at achieving the cure for his psychiatric patients were not without merit. Unfortunately, the ideals Kirkbride tried to establish within the asylum context got lost along the way. Using light and air, ventilation, access to nature, and specifying space to particular uses are all important in what we

consider healthful living today. The similarities between our modern definition of Wellness and Thomas Kirkbride's cure are very strong. We define Wellness as "an active process through which people become aware of, and make choices toward, a more successful existence." The characteristics of that new existence fall into 6 categories: social, spiritual, occupational, intellectual, emotional, and physical. By balancing these six aspects of our life, we are able to achieve a more healthful body and mind. That is the same overarching goal Kirkbride had in his asylums.

In applying the concept of Wellness to a women's shelter, I first identified what the typical programmatic pieces were. The spaces fell under three types:

Housing	Support	General
Emergency	Therapy spaces	Kitchen
Transitional	Administrative	Dining
Permanent	Non-emergency clinic	Activity
	Market/pharmacy	Living
	Transportation	Library
	Reflective space	
	Education and training	

By reorganizing these spaces based off the Wellness model, a new, more comprehensive women's shelter begins to emerge. Now, these programmatic pieces are placed according to which of the six aspects of Wellness that space helps fulfill.

From this reorganization, the overlapping spaces (the spaces that help fulfill multiple needs) suggest adjacencies and relative size requirements for each aspect.

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Some of Kirkbride's ideas about alternative therapies were incorporated into the original site at Greystone Park. The exercise yards behind each ward were open for patient use, the patient's took part in a variety of activities through occupational therapy, they participated in gardening, crafts and even animal interaction. Most of these site details are no longer recognizable, but many of them hold potential as a rehabilitation option for the sheltered women. As shown at the Friends Hospital, gardening and horticultural education are invaluable as both a physical and intellectual resource. Physical exercise has time and again been proven beneficial in all sorts of ways, and even using animals as part of therapy programs or rehabilitation programs have been shown to vastly improve the health of patients.[106] By reincorporating some of these alternative therapies into the site, the future use of the structure will reflect the historical narrative, translate original site functions to modern interpretations, and offer a more thorough approach to assisting women within the shelter in healing.

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[106] McCardle, *How Animals Affect Us*.

Chapter 8: Preservation

The Secretary of the Interior has four standards for historic preservation that professionals are required to follow. Each standard has its own set of guidelines for a historic structure. The intent of each is as follows:

PRESERVATION

Applies measures necessary to sustain the existing form, integrity and materials of a historic property.

REHABILITATION

Makes possible a compatible use for a property through repair, alterations, and additions while preserving those portions or features which convey its historical, cultural, or architectural values.

RESTORATION

Calls to accurately depict the form, features, and character of a property as it appeared during a particular period of time by means of the removal of features from other periods in its history and reconstruction of missing features from the restoration period.

RECONSTRUCTION

Depicts, by means of new construction, the form, features, and detailing of a non-surviving site, landscape, building, structure, or object for the purpose of replicating its appearance at a specific period of time and in its historic location[107].

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[107] Weeks, "The Secretary of the Interior's Standards for the Treatment of Historic Properties with Guidelines on Preserving, Rehabilitating, Restoring and Reconstructing Historic Buildings."

For Greystone Park, I focused primarily on the standard for Rehabilitation. This was done in part to maximize flexibility of design within the site, which has a multitude of structures with varied history, as well as grounds that have changed in many ways over time. Greystone Park is not conducive to representation on a specific date or period due to its long history and period of significance. Because of this, reconstruction and restoration are inappropriate choices.

From the very beginning, the asylum was significant because it was a primary example of asylum architecture in the late 19th century. The prominence of both Thomas Kirkbride and Samuel Sloan also contributed to that significance. The shear size of the structure remained significant as the largest foundation in the nation until the Pentagon was constructed in 1943[108]. Through the years, however, the building and grounds went through many changes; additions to the Kirkbride building were made, the structure was altered several times, and outbuildings were added and lost. All this makes choosing one date to label as "most significant" very difficult and potentially destructive toward the rest of the asylum's history. Rehabilitation involves elements of preservation, restoration and reconstruction, however, since preparation for future use is the main focus rather then representations of the past, rehabilitation makes the most sense with the intended use. The design and intent for the site is to help women in need, which is a very transformative process, and the standard that most reflects and celebrates the journey through time and into the future is rehabilitation.

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[108] "Pentagon."

Greystone Park Asylum Inventory

The image above illustrates how the original grounds and building looked. Behind the main building, the train rail called "Asylum Railroad" is shown as it was originally routed up to the rear building. This train delivered supplies to Greystone. A trolley also stopped at Greystone, and was the means of arrival for many patients. The pastoral nature of the image is true to the original site. Evidence of the rear exercise yards can be seen, as well as fencing surrounding the grounds. I have not been able to verify the existence of a fountain at the grand front entrance, but the mansard roofs and ornate 3-story pedimented front were the original features of the building.

Style: Second Empire, aspects of Greek Revival particularly at the grand entrance.

Period of Significance: 1876 – 1960

Function: Mental Hospital

Materials:

Foundation - gneiss stone Structure – load bearing gneiss stone and brick. Sandstone detailing. Iron beams

Roof – wood mansard structure with slate shingles.

Architect – Samuel Sloan

Acreage - 743

Original Main Administration building features:

1. 3 bays on the front protruding façade, 3 bays also on either side. The windows are long and narrow with segmented arches, keystones, stone-block surround and solid stone sills. (typical windows)

2. Thick molded belt courses above first and third floor. Large quoins on each of the 4 corners of main rectangular structure.

3. 3 - story temple front, a pediment supported by columns at second story, and large pediment at third floor spanning all three bays.

4. Pilasters separate the windows above the pediment on the fifth floor.

5. Mansard-domed roof with round French dormers on each of the 4 faces covers the protrusion.

6. Mansard roof with arched dormers on main structure of the building.

Original Ward features:

1. The front face of the ward is 140' with a central gable bump out. The typical windows on either side of the bump out are in rows of 4 for each of the 3 stories. The windows on the bump out are larger and in runs of 3 with stone surrounds. Quoins are on each corner of the bump out, and a cornice line balustrade that lines the roof.

2. 4 gabled dormers are placed evenly along the hipped roof, which is capped in the center with a cupola.

3.   The hyphens between each ward extend beyond the main façade wall. Typical windows in rows of 3 line each story, quoins cover the corners. The roof of the hyphen is a mansard roof with rounded French dormers like the administration block. The cornice balustrade continues around the hyphen with a larger scale cupola.

4.   Wards were double-loaded in each corridor. An arched alcove served as a gathering space. There was also a parlor (lavender), activity room (pink), enclosed gallery for exercise (light blue), and a dining room (tan). The interior walls were brick covered in plaster with a wooden chair-rail molding. The floor was covered in vinyl tile at some point, although the original reference in the 1918 Sanborne map was just "concrete floors".

Greystone Park Today

Period of Significance: 1935 – 1970

Acreage (est.): 400

Function: completely abandoned since 2010

Greystone Park today is much smaller in scope. The property line is cut right at the front entrance, and many of the campus buildings have been demolished. The

kirkbride building remains, as does the south attendant's building, the male nurses' home and a small service building, among others.

The original mansard roofs were destroyed in several fires, and by 1935, the roof structure was replaced by a fourth floor and basic hipped roofs. Cupolas were not reincorporated into the new roof system. The roof today is not in great condition; the male ward wing in particular has a series of holes in the roof. The poor condition of the current roof system offers an opportunity to return the original mansard roofs with cupolas.

The pedimented front of the grand entrance was also altered; instead of the 3 story columned pediment, the main pediment is now on the second floor. This area is in relatively good shape, but is a poor reflection of the original character.

Inventory

Feature	Location	Materials	Date	Image
Stone	Exterior, kirkbride	gneiss	original	**REDACTED IMAGES. THIS PAGE INTENTIONALLY LEFT BLANK.**
Quoins	Exterior, Kirkbride	gneiss (estimated)	original	See above
Windows (typ)	Exterior, Kirkbride	6 over 6, double hung stone segmented arch stone panel and sill	original	**REDACTED IMAGES. THIS PAGE INTENTIONALLY LEFT BLANK.**
Molded belt-course	Exterior, Administration Central block, Above 1st and 3rd stories	stone	original	**REDACTED IMAGES. THIS PAGE INTENTIONALLY LEFT BLANK.**
Pediment front	Exterior, Administration	stone columns, pediments with dental cornice detail and stone railing/balustrade	original, altered in 1935	**REDACTED IMAGES. THIS PAGE INTENTIONALLY LEFT BLANK.**
Roof	Exterior	Shingle, asphalt (estimated), cornice with	Since 1935	

		stone decorative bracketing and return Hipped/gable		
Dormers	Roof	Simple dormer with gabled roof	Since 1935	
4th Floor	Ward wings	Stone brick with solid band between 3rd and 4th floors. Windows tall and thin with 5 horizontal panes	Since 1935	See above
Walls	Interior, wards	Painted plaster over brick, wooden chair-rail molding	original	
Alcove	Interior, ward	Brick walls and arch, wooden chair-rail continues	original	
Hall	Interior, ward	Concrete floors, vinyl (estimated 1940's) Paneled wood doors for patient rooms, ceiling revealing plaster covered iron beams	Original, except floor covering	
Room	Interior, ward	Plaster covered brick interior walls with combination exterior wall. Thickness exhibited at window. Plaster covered iron beams above.	Original, this may have been a parlor, dining room, or larger patient room	
Patient room	Interior, ward	Peeling plaster with patient graffiti on the wall "The Lord is my shepard, I shall not want."	original	
Wall painting	Interior,	During the WPA	1935-	

	throughout	era, wall murals were commissioned. Paintings found throughout wards	1943	
Chapel	Interior, central block	Polished wood pews, wood ceiling with trusses and detailing, stained glass windows, painted plaster, brass organ	original	
Chapel	Interior, central block		today	
Grand entrance	Interior, central block	Wood molding and paneling on lower half of plaster walls. Tile mosaic floor, wood stairs and carved null posts	original	
Office	Interior, central block	Plaster walls, wood shelving and filing, wood molding	original	
Basement	Interior, kirkbride	Plaster covered brick walls and columns. Pipes run through the ceiling – the wood is supporting the pipes as a stop-gap. stone floor.	original	
Tunnel	Interior, underground between buildings	Plaster covered brick barrel vault with stone floors (estimated). Machinery track to other buildings seems missing.	original	
Tunnel	Interior,	Iron cart used for	original	

transportation	underground	transportation through the tunnels		
Other Structures				
Nurses' building	Exterior	Brick structure with stone quoins, one over one windows with stone sills and shallow segmented arches. 3 bays, hipped roof and 2 gabled dormers on either side.	Added after 1910, estimated around 1935	
Male attendants' building	Exterior	Brick building with hipped roof and 2 gabled dormers on either side. Stone quoins and a small stone belt-course. First floor flat roof porch extending the length of the building. Windows with small stone lintels and sills.	Added after 1910, estimated around 1935	
Service building	Exterior	Brick building with large windows, aluminum gutter system, front porch with wood columns and railing. Asphalt shingle clipped gable roof with center gable.	Not original. Built by 1910	

Proposal Strategy

Though rehabilitation is the primary approach toward the Kirkbride building and grounds, there are examples of all four standards within the proposal. Rehabilitation, in preparing a site for future use, encompasses strategies from the other three Secretary Standards. Generally speaking, great care was taken toward preserving the structure, materials and details of the original Kirkbride building while designing for the women's shelter. Incorporating modern requirements and conveniences was done with as light a hand as possible. The additions, as non-contributing structures, were more freely adapted to the new program. The grounds were altered perhaps the most through time, and very few original features of the site are currently present. No discernable effort was made during these changes that suggested a desire to maintain a relationship with the original site features. Instead, much of the original organization has been lost to the detriment to the grounds. With this in mind, original site features were reintroduced, but altered to support the new uses for the Kirkbride building.

Preservation

The original materials of the structure, including the windows, gneiss and brick walls of the exterior, as well as the 19th century segmented arch support system, will all be preserved. The interior wall locations will be preserved as much as possible within the new program as well.

The segmented arch support system of the floors was chosen as a fireproof form of construction. The system consisted of iron beams with brick arches that spanned between them, tie rods, and concrete fill up to the wood floor above. The

original structure is a great feature in the old wards and in many places remain exposed. The locations where the structure has been plastered over or covered with dropped ceilings will all be uncovered and repaired. All the original structure will remain.

Some of the original architectural features, particularly in the central core, will also be preserved. This area was generally more ornately finished then the wards and patient's rooms. Some of these details include the tiled floor, original door hinges, and WPA paintings.

Rehabilitation

In rehabilitating the site to accommodate a comprehensive women's shelter and reciprocated service spaces, specific changes were made to the histo ric fabric of the Kirkbride building. These changes were designed to incorporate modern code requirements, environmental comfort, and improvements to the original valu es of light and ventilation penetration.

Modern code requires accessibility within the historic structure. In addition to ramps and spatial requirements for hallways, restrooms, and counter heights, elevators had to be incorporated into the building where none previously were. Since the original building was never designed for elevators, they would have to be retrofitted. Placement would require filling some windows in preparation for the elevator shaft. While the window itself is removed, the location and shape of the window would be maintained as a physical part of the building's historic record.

The original heating system for the asylum was a boiler and radiant heating. Air conditioning has been added in the form of numerous window units. The radiators are still present, but the system is inefficient. With each ward measuring 140' in length and the boiler centrally located, by the time the heat reached the radiators in the violent wards at either end, the pressure and actual heat must've been minimal at best. Clearly, a new system would be required. Among the options for heating systems, zoned radiant heating offers the most control with the least interference in the historic structure. There are no ducts, the required piping network is small enough it could replace many of the old pipes used for the radiators, and the heating system itself could be hidden within the floors by raising them a mere 3". While a modern convenience, HVAC would destroy a vast amount of historic structure and fabric. The duct sizes and vibrations would threaten the old materials and walls, making this system an undesirable option.

Air conditioning is another issue. The window units in use just before the building closed are still present. They are unsightly, but that could be forgiven if they didn't also potentially damage the old window surrounds. Air conditioning is not required, and the traditional forced air system is not a viable option due to its invasive installation. Instead, there are a couple advantages to the new use of the Kirkbride building that would assist in keeping the relative interior temperature comfortable. First, the 18" thick walls have enough thermal mass as masonry units to slow down the absorption of summer heat. The 3' thick floors would also prevent heat from

rising throughout the entire building uninhibited. Second, the height of the ceilings helps keep hot air away from the inhabitants. Third, the new design shifts some of the hall locations to the rear walls of the ward, which allows more open space and larger units. This also prevents are from stagnating in small spaces. Ceiling fans were used prevalently in the original structure, and reintroducing them would also prevent hot spots.

Restoration

There are two specific features that will be restored to their original character. The fires of the 1930's destroyed much of the original mansard roof and permanently altered the front grand façade of the Kirkbride building. The interior spiral stairs and paneled wood walls were also lost. What replaced these features were plain, shallow hipped roofs with asphalt shingles and an equally plain interior, much to the detriment of the entire building. Both the roofs and the main façade will be returned to their original character.

Perhaps the most fantastic interior spaces of the Kirkbride building are the chapel and the grand hall on the third floor of the central core. Both were very ornately finished, and while much of the original detailing remains, both spaces have fallen into disrepair. Each offer wonderful opportunities in programming for the new shelter and healing spaces. The chapel is an obvious place that helps fulfill the spiritual aspect of wellness. I could not find records determining whether the chapel was meant to serve a specific denomination of Christianity or how thoroughly religion was integrated into the patient's daily lives, but in the modern context, a

Christian-based chapel would be inappropriate. Women in need come from all backgrounds, and each of those backgrounds carries a different view on religion, spirituality, and personal introspection. The chapel, then, will be restored to serve as a nondenominational place for spiritual reflection. The grand hall located right next door to the chapel presents itself like a ballroom, and while it's unclear exactly what the space was originally used for, restoring it to serve as a more formal event space would serve community members looking for a grand atmosphere for their particular event.

Protections

Currently, New Jersey state law has reserved Greystone Park and site for park, farm, open space and historic purposes. Unfortunately, the state has also declared the site surplus property and appraisals to convert Greystone into commercial use have already occurred[109]. Given the amount of space Greystone Park currently holds, the demolished site could easily be converted into large commercial and residential developments. From a planning perspective, the increase in sprawl would be immense, and if the demolition occurs, there would be a great loss in a historical resource for the community that they clearly appreciate.

The State Historic Preservation Office (SHPO) has recognized Greystone as part of a historic district, but the property does not currently sit on either the state or National Register for Historic Places[110]. Funding for the preservation, restoration, rehabilitation and stabilization of historic properties is determined through an

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[109] the Preserve Greystone organization, "Preserve Greystone."
[110] Historic Preservation Office, "New Jersey and National Registers of Historic Places."

124

eligibility process outlined by the Morris County Open Space, Farmland, and Historic Preservation Trust Fund. Currently, Greystone is not allocated any funds, but because the building is located within a historic district, it is eligible for funds[111]. An application for a specific project with estimated construction costs, plans, and timeline are required as part of an application. Provided enough interest could be garnered from residents, and government officials, Greystone Park may be saved after all.

The non-profit group Preserve Greystone is doing just that. Their ultimate goal is to prevent the structure from falling prey to developers by providing enough protection for the old asylum through legislative acts and presenting an alternative means of development. Because the project I'm proposing offers a specific use, strategy, and detailed plan, conceivably, Greystone Park could be saved. By appealing to local officials in offering integrative opportunities within the community, by providing much needed services and facilities for local businesses, Greystone Park could become a vital part of Morris Plains.

Contributing vs. Non-contributing

The structures on the site today come from a variety of different periods. As shown below, there have been a number of additions to the original Kirkbride building, and the surrounding buildings were added slowly over time. What's not present are some of the significant structures that have already been demolished because of their abandoned, dilapidated condition.

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[111] Morris County Board of Chosen Freeholders, *Rules and Regulations*.

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Based on construction dates and the historic narrative, the green structures below are considered contributing historic resources. While the additions to the Kirkbride building are still present, their lack of cohesiveness to the original structure in material and structure preclude them from any historic significance. The remaining contributing resources include the men's and women's nurse residences and the field house to the front of the property, and the male and female industrial building, firehouse, and painter's house to the rear of the property. All of these structures are worth preserving, but for the purposes of this thesis, the focus is the central Kirkbride building.

Chapter 9: Proposal

Between the women's shelter and related therapy and healing spaces, the entire site and Kirkbride building are broken up into a couple different categories. The Women's Residences refers to the new women's shelter. The Holistic Healing Center houses many support spaces for both the Women's Residences and community related spaces. The Center includes therapy space, education and workshops, spaces designed for physical activity, occupational training, recreation, and quiet reflection in addition to event spaces. The community related spaces offer classrooms, meeting space, multipurpose rooms, offices, and a small historic museum exhibiting the original Greystone Park Asylum. Additional functions, including general housing and even retail, could be subjects visited down the road.

One of the major concerns for the Women's Residences is of course security. Typically, women's shelters do not advertise their actual location by signage. In the case of Greystone Park, the Women's Residences will not be advertised, either, but rather, left a quiet function of the building. Entrances into the Women's Residences would all be controlled access with punch codes. Punch codes were chosen because they are the easiest to manage and offer the most flexibility; new codes can be created quickly just as old or compromised codes can be deleted. Access to different parts of the shelter could also be controlled in this way, so that staff would have access to offices and supply space and the residents would not. Punch codes cannot be replicated, lost or stolen as a normal key card could. The lack of signage would also enable the Kirkbride building to perform it's own sort of security. The shear size of the structure and site make it highly unlikely any individual off the street would be

able to find their target, and without signage, the perpetrator is far more likely to get lost. Urban explorers today often break into the building, taking pictures or videos of their experiences. Nearly every subsequent report talks about getting lost at least once while in the building. This characteristic, while alarming to the explorer, is ideal for preventing unwanted guests. Flexibility within the programming itself could also help inhibit would-be threats, as women could be housed in different rooms, floors and sections throughout their stay based on their particular need for security. A Morris County police station is also located at the corner of Koch and Hanover Streets, which is the Northwest corner of the site, making response nearly immediate.

Site

For comparative purposes, the next page holds the earliest aerial photograph of the site that was taken in 1921, and though it was taken much later then the opening date of Greystone Park Asylum, many of the sites' original features, including the fields in the back, the strong axial approach, and winding paths around the front property are all still visible. Many of these original features have long since disappeared, but would provide very complimentary functions to the women's shelter, healing center, and community spaces.   I have taken the original placement of site features and reintroduced them in support of the new uses for the Kirkbride building. Where the fields were located are now orchards; the field day track location now holds a shelter-run farmers market, a general activity field, and permeable parking for market visitors and staff. Walking and jogging paths have been reincorporated along with the terraced ground on either side of the structure. Exercise yards located to the rear of the kirkbride building are now cultivated gardens, and the main approach has

regained some of its formal quality while also offering a location for drop off visitors

and moments to rest beneath the curved arbors that receive the terminating axis.

There are 2 main entrances to the Kirkbride building. The first is the main entrance off Central Ave., which primarily serves visitors and some staff. The rear entrance is a turn-off from Koch Ave., which serves as a staff, delivery and resident entrance.

Focusing in on the Kirkbride building, the former exercise yards have been converted not only into cultivated gardens, but also offer places to gather, relax and enjoy the outdoors. Low rise 5' wide steps serve to slowly follow the elevational change and offer a place to lounge. Small pools offer a place to dangle feet. The drop off is covered by a glass porte-cochere, and the open grass areas offer a place for children to play and games.

To help break up the shear mass of the building, pass-thrus have been introduced at the center of each ward block. Where the small gable marks the interior alcove location, the ground floor has been cut through, exposing the arched structure and brick walls, offering a means of getting from the front paths of the property to the rear gardens. The pass-thrus take the place of the alcove locations, and are meant to read literally like the path has been cut, hence the exposed structure and brick walls.

The general program is illustrated in figure XX. The women's wards have been converted into the Women's Residences. The central core features administrative, therapy space, and the Holistic Healing Center. Finally, the former male wards hold the community spaces and future use plans, as well as an Animal Rehabilitation Center that offers alternative therapy for the women of the shelter.

Holistic Healing Center

The Holistic Healing Center takes up most of the central core. In the existing plan, a U-shaped addition interrupts the center line of the building. The spaces within, while more modern in structure, are very awkward. Narrow halls bisect each of the addition's wings and create equally narrow spaces on either side. Other additions have been tacked on to the central core as well, leaving a messy collection of roof tops and building corners. Strange additions also mark the very rear structure, where sunken rooms with skylights and side entrances flank either side. All of these

additions make a collection of poorly planned spaces that take away from the original intent of the structure.

In creating the Healing Center, many of these additions will be removed to clean up the space and make room for the drop-off. The U-shaped addition remains, but significantly altered from its original character to contribute more fully to the Healing Center Program. The sunken rooms will be removed and filled to eliminate the awkward, nonsensical space.

As discussed earlier, most residents will come in from the rear entrance, so this is where the intake offices and non-emergency clinic will be located. Shallow reflecting pools will brighten the narrow spaces in the middle, and larger pools flank the core for recreational use. The narrow hallways will be removed to open up the entire interior and make room for physical activity, education and therapy spaces.

Each floor is connected to the rest of the main structure via copper passages that will remain. These were added along with the U-shaped addition, and while not original, holds some historic value, as the structure and detailing is more consistent with the Kirkbride building. Great care was clearly taken in constructing these passages, so they will be preserved. There is a first floor to the passages that was not part of the original, so that will be removed. This will also help with the new programming of the spaces.

First Floor

On the first floor, the windows of the U-shaped addition will be extended to the ground level to create a walk-out space to the recreational pools. This will also

allow for strong transparency through the addition's wings and cross-ventilation. Hydro-therapy will be reintroduced to the site on the left side with the inclusion of the therapy pool and supply. Physical activity will begin with a yoga room, which has a fireplace to help extend the season for open windows. The centrally located kitchen incorporates a number of site functions with occupational therapy. The cultivated gardens and orchards provide produce for the farmer's market and kitchens, while the kitchens are used as a catering source for events and support the shelter-run café.

Second Floor

The second floor holds spaces for general activities, workshops in support of site functions, and classroom spaces.

Third Floor

The third floor holds the two grandest spaces, the chapel and the grand hall. As discussed previously, the chapel will be rehabilitated as a nondenominational place for spiritual reflection, while the grand hall will be a formal event space.

Fourth Floor

The fourth floor is active in the two wings of the U-shaped addition only. This is where the educational greenhouses will be located. Glass will replace much of the walls and the roof will have glass venting to help control the temperature of the greenhouse underneath.

A note about Preservation and the addition

As a non-contributing resource within the historic context, there are no reservations about destroying the historic narrative by altering the U-shaped addition. As Rehabilitation allows, the alterations created in this central section actually contribute to the continuing story of the Kirkbride building because the changes to it overtime can be easily tracked. The changes are also in keeping with the intent of the new program.

Women's Residences

The Women's Residences inhabit the entire left side of the Kirkbride building. As part of a comprehensive shelter, the residences offer four different types of housing units: 24-hour or emergency, temporary, semi-permanent, and permanent. Each of these is based off the level of support a given female may need, and also allows for a progression to independence for those that are ready for that transformation. These women may begin with 24-hour care, then transition to temporary, semi-permanent, then move on to their own living space outside of Greystone or choose to inhabit the permanent residences offered within the Kirkbride building. Each floor has a different combination of units and populations as follows:

Unit type	definition
40 units - 24-hour/ emergency	females in eminent danger, often leaving with nothing
25 units - temporary	women in need of temporary support. 1-12 months

34 units – semi-permanent	women transitioned out of temporary support either at Greystone or other facilities but need extended care and support. 3 months – 5 years
4 units – permanent	women that are completely independent but wish to stay at Greystone. Other units may be located at the other structures on the site. Treated as rental units.

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As shown in the Chapter on Preservation, some of the hallways within the women's shelter are shifted to allow for larger units and a more open feel. The hallways lead from ward to ward without interruption, and large open spaces within each hyphen between wards offers places to lounge and gather. At the entrance of each semi-permanent unit, the hall is slightly squeezed to delineate the space as a sort of front door zone. This zone acts as a space for resident personalization just as they would a front stoop.

Zoned spaces located throughout each floor of the Women's Residences offer support spaces for the women or general activity. Therapy offices have also been interlaced through each floor providing more immediate access to guidance for those that need it. As one moves through the large halls, different zones become visible. A gaming and living zone sits at the entrance from the central core, providing a buffer in noise and activity level before reaching the actual residential units. Further along, the alcoves act as gathering spaces for the women, and specified rooms offer a library and study space, a daycare room, and computer education room. Alcoves located among temporary units offer large, shared kitchen spaces. These kitchens support all that stay within the temporary units, up to 5 families.

The unit plans are kept very open as well to maximize the lightness and airiness. Interior windows are introduced between the units and alcove spaces to offer more light, but are set high to maintain the resident's privacy. The original transom lights above each door are extended and frosted glass is introduced at the unit entrances for more natural light exposure.

Another main goal is to provide a means of defining one's space. This is done by creating flexibility within the units. The residents are then able to personalize and customize their unit to suit their needs. Flexibility is introduced through adjustable spaces and storage. Within all the unit types, the closets are mobile so the resident can move them around as needed. The rooms within the temporary, semi-permanent and permanent units can be separated by sliding walls and curtains, so the resident can control the level of openness within their unit.

The use of plants, carpets on wood floors, and decoration on the plaster are reintroduced as part of the historical aesthetic. The baseboards, chair rails, corner guards and wood doors are all preserved from the original structure by reclaiming them and using them within the new hall spaces.

Resolution

As we have seen, the history of Greystone Park is burdened with the memories of violence, fear, control, and intense stratification. While the perpetrators are long gone, what's left behind is a quiet relic sagging in the shadow of its past. The massive structure of the Kirkbride building appears to have been forgotten, but that is not the case. Through the efforts of preservation societies and public interest, Greystone has so far managed to avoid demolition. This suggests that though the memories within the asylum's walls are laden with discomfort, there is still a place here, in the modern world, for Greystone Park.

Victimization through different forms of violence has been shown to subdue and subjugate entire populations of people, and in the case of asylums, the institution became a mechanism for social censorship. Women were particularly vulnerable to just this sort of control; they had no recourse to object to asylum incarceration, regardless of how and why they got to the asylum. Today, women are still victims of violence within their home environments. With major shortages in public services and space for these women, many are left without help.

Both of these subjects must heal, Greystone from its past, women from their present. Where Greystone was formerly the source of violence for women, it may now embody "asylum" and become a haven for them. In this way, women in search of protection and shelter may look to Greystone for both. By turning the historical violence of Greystone on its head and providing critical services, women of the present can help heal the wounds of women from the past, and the future for both Greystone Park and the women of New Jersey will become imminently brighter.

Glossary

Embodiment A tangible or visible form of a concept, quality, or feeling

Asylum Shelter or protection from danger.

> refuge - shelter - sanctuary - haven - retreat – home

Domestic violence violence in the form of physical, mental or sexual abuse directed toward one's intimate partner

Criminally insane A defense asserted by an accused in a criminal prosecution to avoid liability for the commission of a crime because, at the time of the crime, the person did not appreciate the nature or quality or wrongfulness of the acts.

Stress density A source of stress caused by intense crowding of physical space. Lack of a sense of ownership or understanding of belonging to a specific space.

Spatial anchor A sense of personal space; ownership over one's environment; the feeling of belonging in a specific space.

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