

ABSTRACT

Title of Thesis: SEEKING ASYLUM:
RACE, MEMORY, AND THE AMERICAN
LANDSCAPE

Daniela Tai, Dual Master's Degree in
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Thesis Directed By: Professor, Ronit Eisenbach, School of
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The stories and places we choose to preserve tell us who we are as a people. What does it say about ourselves when the stories that are associated with a particular place are ones that we wish to keep in the dark? As we look towards the future of preservation it has become clear that our perception of what is “significant” has shifted. Modern preservation has expanded to include tangible and intangible landscapes, environmental conservation, and more voices at the table. This thesis explores how to use preservation, storytelling, and sustainable practices to respond to places of difficult history and reclaim that space, while using Crownsville State Hospital as a model. The racial and systemic trauma experienced at the formerly racially segregated mental health facility permeated the campus grounds; not only does the community need to heal, the land does too.

SEEKING ASYLUM:
RACE, MEMORY, AND THE AMERICAN LANDSCAPE

by

Daniela Tai

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Preface

Opened in 1911 as the Hospital for the Negro Insane of Maryland, Crownsville State Hospital stands at a crossroads in American history; on one side stands the triumphs of medical progress and on the other stands the racial injustice and community trauma that made that progress possible. Proper interpretation of the hospital's history must be referential to appropriate historic and cultural contexts of the time. During Crownsville's construction, the facility was seen as a benevolent source of care; when viewed through a contemporary lens, benevolence is no longer recognized as the paradigm of treatment.

This thesis will not cover the entirety of the hospital's history; instead it will focus on the portion of its past when it was responsible for the mental well-being of all of Maryland's Black citizens. It would be inappropriate to assume every patient's experience was equal, however an examination of patient treatment is limited due to lost, destroyed, and restricted records.

A noticeable shift has occurred in moral boundaries; as such, designers, preservationists, and storytellers are presented with a critical opportunity to reflect upon an uncomfortable part of our collective history to weave a much more inclusive narrative. It has been fourteen years since the last patient checked out of Crownsville, but the stigma still remains. The price of moving on should not come at the expense of forgetting why that stigma is there.

“Freedom has not made us mad; it has strengthened our minds by throwing us upon our own resources, and has bound us to American institutions with a tenacity which nothing but death can overcome.”

- James M’Cune Smith, January 29, 1844

Dedication

I dedicate this thesis to the patients of Crownsville State Hospital, both known and unknown. May it illuminate their stories and memories that have been relegated to the shadows for far too long.

Acknowledgements

Thank you to my committee, Professor Eisenbach, Professor Du Puy, and Dean Linebaugh for pushing me to be a better designer, to elevate and amplify these voices, and above all else, to simplify.

Thank you to my thesis cohort for making the nights and weekends spent in studio a tad more bearable.

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Chapter 1: Historic Site Context and Development

Site Description

Located in Anne Arundel county, approximately eight miles north of the city of Annapolis, the predominantly rural community of Crownsville, Maryland is categorized as a census-designated place¹. Major metropolitan centers including Baltimore and Washington, D.C. are twenty-two and thirty-one miles away respectively. In 2016 the estimated population was 1,784 people with a racial composition of 91.4% white, 6.28% Black, and 2.02% Hispanic. The median household income of \$103,750 was \$46,000 more than the national median.

Bounded by Generals Highway (State Route 178) to the north and the Baltimore-Annapolis transportation corridor (I-97) to the west, a sprawling campus sits vacant as a relic of medical progress, trauma, and racism. The former Crownsville State Hospital site is currently 544 acres, seventy acres of which are the water and sewage treatment plant. An additional 12.6 acres west of I-97 are reserved for the patient cemetery and is surrounded by Bacon Ridge National Reserve (Figure 1). The Anne Arundel County Fairground is located to the east, along with single family detached residences.

There are approximately sixty-nine existing buildings on the site in various states of condition, accounting for a total of 800,521 square feet. A survey conducted by the Maryland Historical Trust categorized thirty-four buildings as either historic or

¹ A census-designated place is acknowledged by the United States Census Bureau as a defined region, but its boundaries are not legally incorporated under state law.

potentially historic. The majority of the building stock was constructed between 1913 and the 1950s.

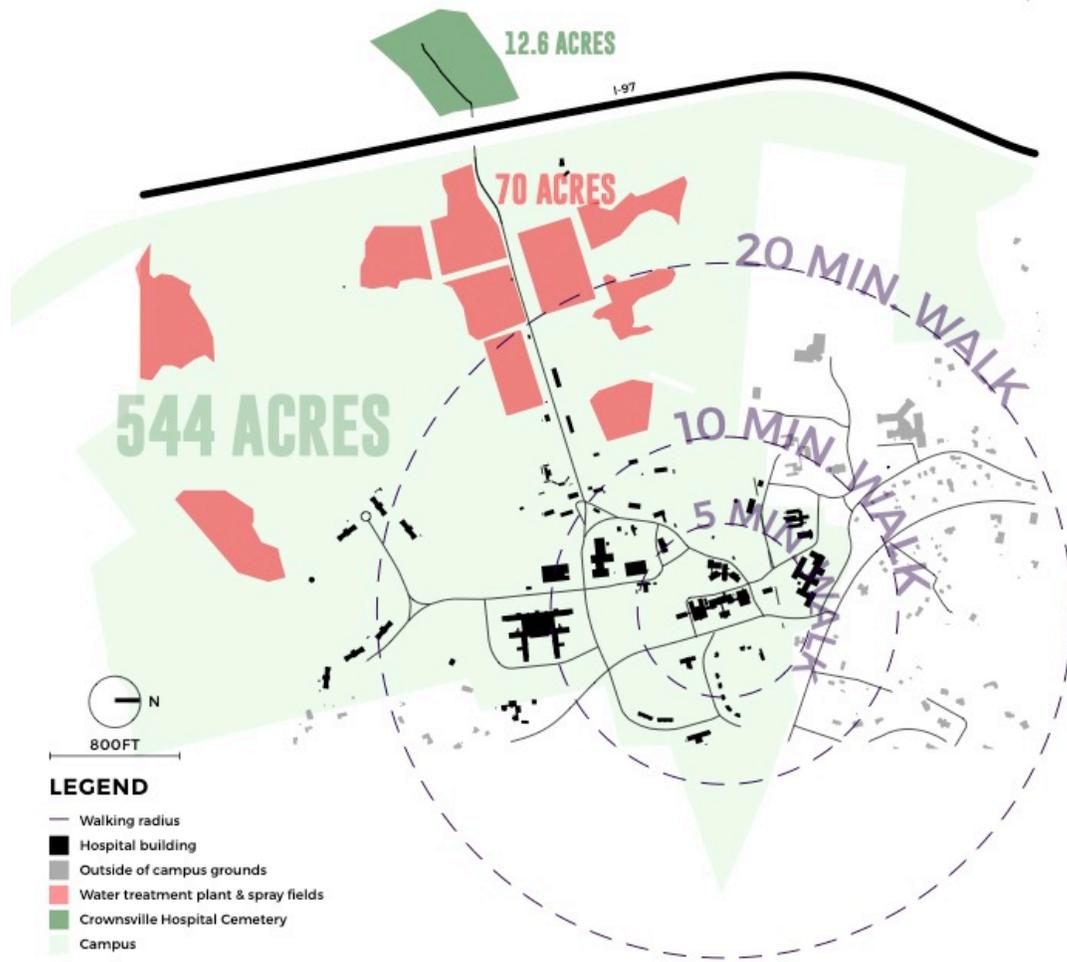


Figure 1 Existing Crownsville State Hospital site plan
(Source: Author's work)

History of Crownsville, Maryland

The broader Chesapeake region along the Bay and its tributaries was inhabited by a number of Native American communities, including the Piscataway, Patuxent, and Nanticoke tribes, for thousands of years. The arrival of the first European settlers in the 17th century brought a mixture of landowners, tenant farms, indentured farmers, and African slaves to the region. With tobacco as the given cash crop, access to the

Severn River remained key for Chesapeake settlers due to the tobacco inspection port at Indian Landing along the river.

Generals Highway, the spine of the Crownsville community, was named after General George Washington and Rochambeau's route during the American Revolution to the Battle of Yorktown. Washington reportedly used this same route while traveling from New York City to Annapolis on December 23, 1783 to resign as the Commander in Chief of the Continental Army. In 1840, the Annapolis and Elkridge Railroad completed a rail line through the Crownsville region. In 1908, the A&E Railroad merged with the Washington, Baltimore, and Annapolis Railroad to become the South Shore line of the WB&A Railroad.

Two mid-nineteenth century maps reveal the sparse development of the Crownsville region prior to the state's acquisition of land in the area. The Martenet map of Anne Arundel County (1860) shows approximately four structures within the current boundary of the hospital; none of the resources that predate the hospital's history remain on the site (Figure 2). The O. Owens property was located at the approximate future location of the Medical Surgical Building at the intersection of Route 178 and Crownsville Road. The Thomas Tongue property was situated near the future site of the Central Kitchen building. The B.H. Nichols structure was placed near the future I-97 boundary, while the Dr. Gantt property would be later developed by the hospital's convalescent cottages. The 1878 Hopkins Map indicates the Crownsville site experienced several generational deed transfers, in addition to two new developments owned by Hatch and Henry Turton (Figure 3).

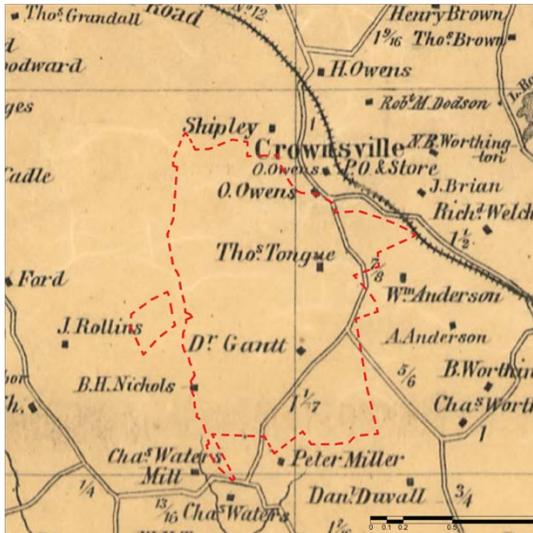


Figure 2 Martenet Map of Anne Arundel County with approximate footprint of current site, 1860
(Source: Library of Congress)

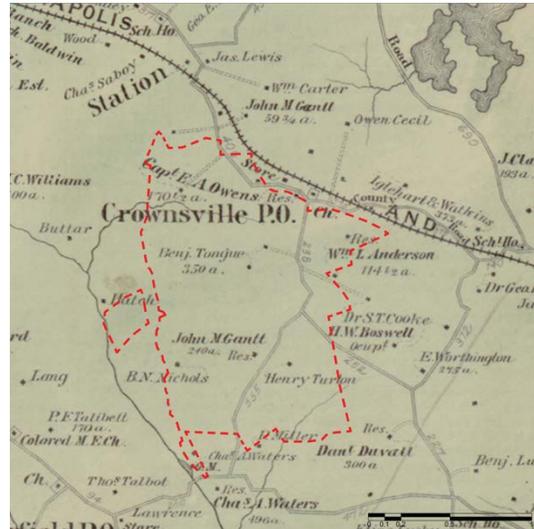


Figure 3 Hopkins Map of Anne Arundel County with approximate footprint of current site, 1878
(Source: Library of Congress)

History of the Hospital for the Negro Insane

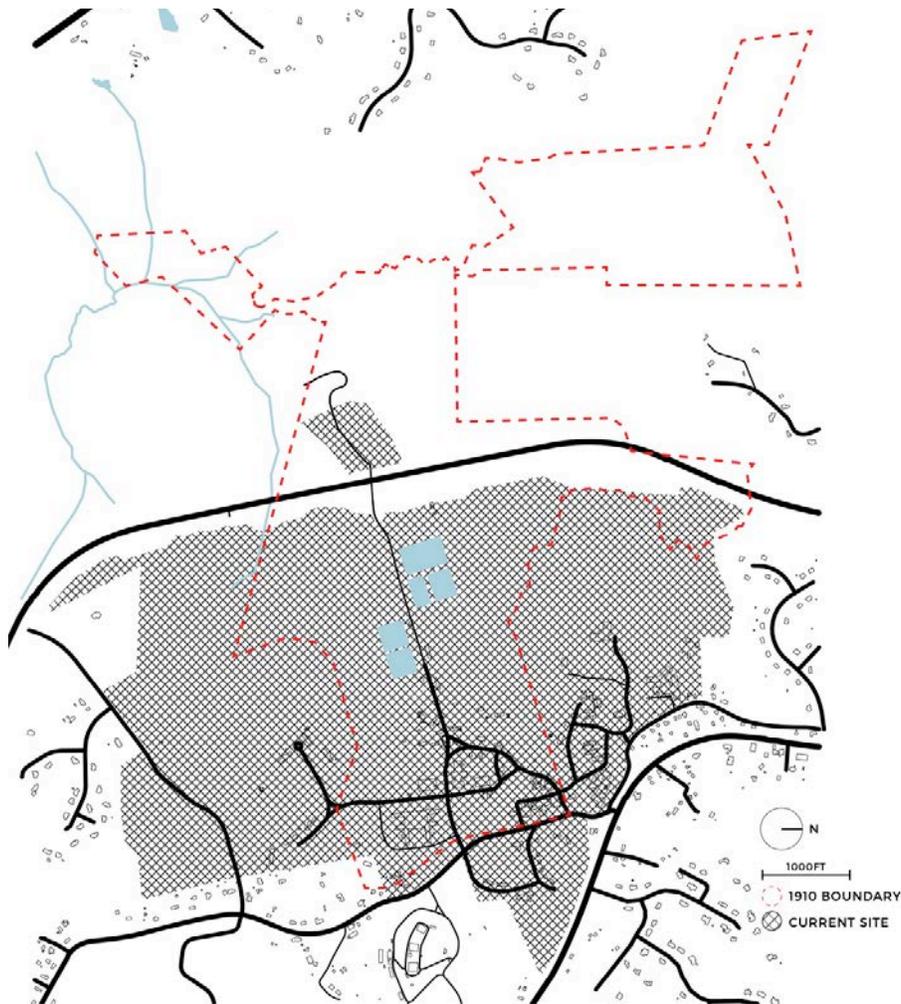
The Campus

The call to construct an asylum that cared exclusively for the African American population in Maryland was first raised by the Lunacy Commission in 1888. Formed in 1886 as an oversight body for all mental health facilities in the state of Maryland, the commission visited institutions throughout the year to report on the conditions of patient treatment. Attributed to the sentiment that “Maryland is too much of a southern State to allow the mixing of white and colored patients,” an entirely separate facility was deemed necessary by the state officials.² Despite the pressing need, it was not until April 11, 1910 that an act of the General Assembly

² State of Maryland Lunacy Commission. *Twentieth Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1905. 13, <https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101045e.pdf#search=Lunacy%20Commission%20Reports>.

appropriated \$100,000 towards the land purchase and construction of the Hospital for the Negro Insane of Maryland.

With the assistance of two Maryland Agricultural College professors, W.T. Taliaferro and W.B. Close, members of the commission toured the state for seven months in search of a hospital site with agricultural and horticultural potential. Self-sufficiency through farming and cultivation was considered a critical component of the hospital's infrastructure. On December 13, 1910 the Board purchased the Boswell-Garrett-Hatch farm plots, a total of 560 acres, for \$19,000 (Figure 4).



*Figure 4 Site plan of Boswell-Garrett-Hatch farm plot, 1910
(Source: Author's work)*

The WB&A Railroad line would grant Crownsville employees access to the amenities afforded by the neighboring urban centers of Baltimore, Annapolis, and Washington, D.C. The rail would also facilitate the ability to bring in patients from across the state with greater ease. In addition, the proximity to neighboring Baltimore and Washington medical intuitions would ideally provide staff members with the opportunity to attend medical seminars and stay up to date with the latest advances in modern medicine.

The initial plans for the hospital called for the accommodations of 560 patients, therefore the purchased farm land would provide the “proper ratio” of one acre per patient.³ The prospect of an industrial and agrarian economy made possible by patient labor was viewed as a valuable asset to the hospital. Approximately ninety-five acres of the selected farm land were considered suitable for Osier Willow cultivation. Not only was this occupational endeavor considered “safe and simple” – suitable for the “most demented cases” – it would provide a net profit that would relieve Maryland tax payers.⁴

On March 11, 1911, the first group of twelve patients arrived after being transferred from Spring Grove Hospital in Catonsville, Maryland. An existing farmhouse was used as temporary housing (Figure 5). Their state-sponsored therapy required them to grade and excavate the land for construction, prep the farm land, and harvest the willow crops. On December 27, 1912 *The Baltimore Sun* reported on this

³ Board of Managers of the Hospital for the Negro Insane of Maryland. *The First Report of the Board of Managers of the Hospital for the Negro Insane of Maryland*. 1911. 23, MdHr 793458. Maryland State Archives.

⁴ *Ibid.* 26.

“unusual” practice of using patient labor to build the hospital, painting the outdoor occupation as an excellent way to save the state at least \$3,000.⁵



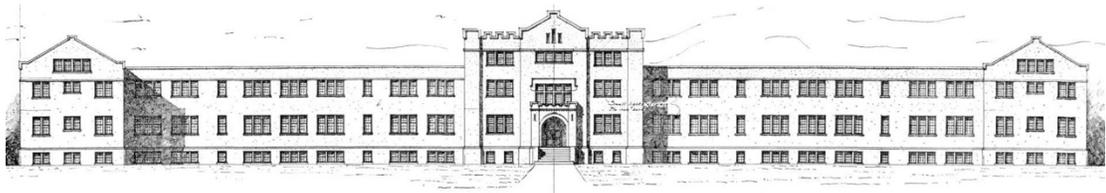
*Figure 5 Farm building utilized on the site during the construction of the hospital, 1910
(Source: Maryland State Archives)*

The “increasing demand for workers, combined with the excellent results” produced by the patient laborers justified an increased number of Black patient transfers from other Maryland institutions, including Montevue Asylum, Sylvan Retreat, and County Home of Talbot County.⁶ By the end of 1911, a total of seventy-three patients had been admitted to Crownsville, of whom three were discharged and one passed away.

⁵ "PATIENTS HELP TO BUILD." *The Sun (1837-1993)*, Dec 27, 1912. 9, <https://search.proquest.com/docview/535193850?accountid=14696>.

⁶ Board of Managers of the Hospital for the Negro Insane of Maryland. *The First Report of the Board of Managers of the Hospital for the Negro Insane of Maryland*. 1911. 31, MdHr 793458. Maryland State Archives.

The original hospital design called for a single building that would potentially house all 560 prospective patients. Figure 6 shows the 1910 proposed elevation of a medieval revival-style building with merlon detailing to emphasize the central axis. However, concern was raised that a “large building might be criticized as being too pretentious for the housing of this class of patients.”⁷ This public ‘concern’ serves as evidence of the ways in which racism and prejudice not only influenced the services provided by the hospital, but also how social biases physically manifested in Crownsville’s built environment.



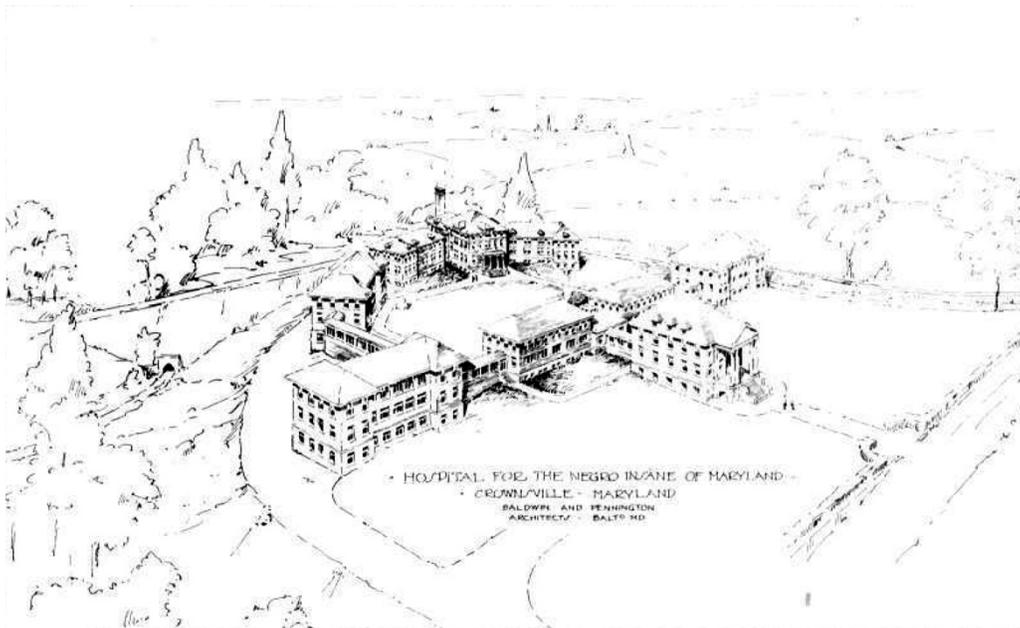
*Figure 6 Preliminary elevation for the Negro Hospital for the Insane of Maryland, 1910
(Source: Maryland State Archives)*

Dr. Robert P. Winterode was appointed the hospital’s first Superintendent and remained at that position until 1947. Prior to the hospital’s construction, Superintendent Winterode and Lunacy Commission executive officer, Dr. A. P. Herring, visited surrounding hospitals in New York, Pennsylvania, Massachusetts, and Illinois to study the advantages and disadvantages of a spectrum of hospital designs. The cottage plan was determined to be the most economically feasible and practical organization of the hospital. Cottages would allow medical staff to separate patients based on the acuteness and severity of their diagnosis. As the patient

⁷ Board of Managers of the Hospital for the Negro Insane of Maryland. *The First Report of the Board of Managers of the Hospital for the Negro Insane of Maryland*. 1911. 27, MdHr 793458. Maryland State Archives.

population increased, so too would the number of wards and cottages on site – ideally. The driving design principles of simplicity and economy contributed to a hospital scale equal parts affordable and adaptable.

In an effort to remove the stigma associated with the term “insane”, Superintendent Winterode recommended the official name be changed to Crownsville State Hospital in 1911.⁸ The official change in nomenclature took place in 1912, prior to the completion of the hospital’s construction.



*Figure 7 Baldwin and Pennington rendering of Building A, Building B, and the Administration Building, 1911
(Source: Maryland State Archives)*

On May 1, 1913, the original nucleus of the hospital’s complex, Building A, Building B, and the Administration Building, was completed by the Baltimore-based

⁸ State of Maryland Lunacy Commission. *Twenty-seventh Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1912. 6, <http://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101051e.pdf#search=Lunacy%20Commission>.

architectural firm Baldwin and Pennington (Figure 7). Building A is characterized by a central three-story building flanked by two 2.5-story wings. Originally built as the principle housing space for the patients and staff, the masonry building consisted of wards for 250 patients, administrative offices, the Superintendent and staff sleeping quarters, dorms for the nurses and attendants, and hydrotherapy wards. Constructed of load-bearing common bond brick, the building has a hipped roof and a single-story classic portico on the face of the central building.

The Administration Building is a three-story building measuring nine bays wide and four bays deep with a hipped roof. The common bond brick structure is connected to the B Building by a 1.5 story brick corridor that abuts the west elevation. A concrete water table, casement windows, and concrete window sills characterize the building. In addition to office space and a reception area, the building originally housed a mortuary, post-mortem room, laboratories, pharmacy, and exam rooms.

Over the course of the ensuing decades, the hospital experienced gradual change in terms of physical development that was often outpaced by increased patient populations and decreased operational funding. The functions of the various buildings across the site vary greatly in function, ranging from administrative to residential and industrial. Additions to the campus complemented the original design principles of simplicity with minimal ornamentation. Patient care and staff dwellings were distinguished with common bond brick exteriors and some classical elements, including pedimented porticos, Corinthian columns, and rounded arches. Support

buildings were much more austere in appearance, typically constructed with concrete blocks that were manufactured by patients in their industrial classes.

The first wave of campus expansion occurred between 1925 and 1936 under the direction of Baltimore architects Henry Powell Hopkins, Joseph Evans Sperry, and Herbert Crisp. During this span, the Hugh Young Building (1925), Superintendent's House (1925), Marbury Building (1927), C Building (1931), Nurses' Home (1931), and the Female Attendant's Home (1935) were completed. The new construction concentrated primarily around the existing complex.

Between 1948 and 1958, in response to deferred wartime maintenance and to address over-crowding and poor conditions, the hospital initiated a number of capital improvement projects amounting to \$12,218,768 in total investment. As a result, new construction included: eight buildings for patient housing, four personnel buildings, and the Campanella Rehabilitation building.



*Figure 8 Grave marker number 911 is uprooted by an adjacent tree
(Source: Author's work)*

The patient cemetery is located west of I-97 and is accessed from the hospital campus by Farm Road and a modest bridge that crosses above the interstate. Archival

efforts conducted by historian Janice Hayes-Williams estimates about 1,600 patients were buried on the site until the 1950s. The majority of the grave markers are simply distinguished by a number (Figure 8). Any records that identified the names of patients and their corresponding marker number have been either lost or destroyed. Although the gravestones were initially designed to be positioned vertically, they were all repositioned to lay flat as a means to ease lawn maintenance. A single marker stands upright as a reminder of the cemetery's former arrangement (Figure 9).



*Figure 9 Grave marker remains the only vertically positioned marker in the cemetery
(Source: Author's work)*

Annual public clean ups in recent years have addressed some threats posed by overgrowth and weathering, however additional professional rehabilitation and stabilization efforts are needed. In addition, there is a need to accurately locate – and correctly identify – all of the graves within the cemetery; the numbered grave markers are arranged sequentially, however there are sequences in the grave marker arrangement that are missing.

Patient Care

Patients were routinely classified with reference to their perceived curability and level of dependency. This classification translated into determining which ward or cottage the patient was placed in. Acute cases required hospital care and were considered curable with proper treatment. Dangerous patients posed a threat either to themselves or others; these patients were dismissed as incurable and required skilled supervision. Patients with perceived mental capacity handicaps such as dementia had to be “cared for like children”, regardless of their age.⁹

The interdependence of efficient medical service and occupational therapy was seen as key for running a successful hospital operation. Idleness was interpreted as a hurdle for progress; as such, spirited occupation served as a tool to address physical and mental degradation. Dr. A. P. Herring referred to work as one of the “great present-day ameliorating agents in the treatment of mental diseases.”¹⁰ Coincidentally, this agent of medicine would also serve to save the state thousands in annual expenditures.

Between 1911 and 1913, meticulous accounts of the savings that resulted from patient labor were published in the public reports issued by the Board of Managers of Crownsville State Hospital. The assigned roles of patients ranged from excavators, bricklayers, and farm assistants to waiters, kitchen assistants, seamstresses, and laundry assistants. In addition to contributing to the hospital infrastructure, patients

⁹ State of Maryland Lunacy Commission. *Twentieth Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1905. 5, <https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101045e.pdf#search=Lunacy%20Commission%20Reports>.

¹⁰ Ingle, Edward. "WHEN "DR. SOMETHING-TO-DO" COMES TO AID MENTALLY SICK." *The Sun (1837-1993)*, Nov 12, 1916. 2, <https://search.proquest.com/docview/542729337?accountid=14696>.

were also taught a number of craft skills, such as willow craft work, wood carving, broom-making, and cobbling, as a solution for “awakening them to their former usefulness.”¹¹ The skills of a particular Crownsville patient, King Philip, was highlighted in the *Baltimore Sun* as a case study of the positive benefits of occupational therapy in the treatment of mental disease.

The case of “King Philip” is not very unlike scores, perhaps hundreds, of others among the patients in asylums of Maryland, persons who in past years have been looked upon solely as social dead wood, but who now are being trained to be producers.¹²

Patient productivity eventually expanded beyond the boundaries of the hospital complex. During the preparedness movement that coincided with WWI, groups of fifteen patients were loaned out for two-week intervals to neighboring farms within a ten-mile radius in response to the labor shortages caused by the draft. Although they were not fit enough to be regular members of society, they were deemed fit enough to “do their part to help win the war.”¹³

The feel-good patient profiles printed by the media were also contrasted by tales of tragedy and questionable accountability. In 1918, reports of the death of Charles Miller surfaced after a fight with a hospital guard. Despite the extent of the fatal injuries – including a badly torn intestine – the injuries were determined to be accidentally received and the guard was exonerated.¹⁴ Five years later, the death of

¹¹ Board of Managers of the Crownsville State Hospital. *The Third Biennial Report of the Board of Managers of the Crownsville State Hospital*. 1917. 25, MdHr 793458. Maryland State Archives.

¹² "KING'S" WORK FOR SALE." *The Sun (1837-1993)*, Nov 15, 1916. 4, <https://search.proquest.com/docview/542640238?accountid=14696>.

¹³ Board of Managers of the Crownsville State Hospital. *The Third Biennial Report of the Board of Managers of the Crownsville State Hospital*. 1917. 10, MdHr 793458. Maryland State Archives.

¹⁴ "ATTACKED GUARD; DEAD." *The Sun (1837-1993)*, Jan 27, 1918. 16, <https://search.proquest.com/docview/534825625?accountid=14696>.

patient and former Baltimore school principal, William H. Murray, in June 1923 at the hands of an attendant further exposed the poor treatment of Crownsville patients. William Dallas, an infirmary attendant that testified during the subsequent manslaughter trial, revealed it was common for attendants to beat inmates; in fact, attendants carried clubs and broomsticks exactly for that purpose.¹⁵

Aside from their testimony in court proceedings, patients also candidly wrote to the Baltimore-based newspaper *The Afro-American* as a way to make their voices heard and their treatment public. In 1925, Bertel Edelen lamented, “This place is worse than slavery and we are treated like beasts at times and fed on food that is not fit to eat.”¹⁶ Edelen’s designation as an ‘inmate’ in the 1940 Census during his stay at Crownsville further reveals the complex social dynamics shared between patients, staff, and the outside world (Figure 10).

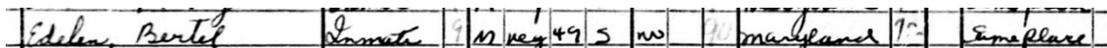


Figure 10 Bertel Edelen’s entry in the 1940 Census while interred at Crownsville State Hospital
(Source: United States Census Bureau)

Public concerns about overcrowding became critical during the 1930s and 1940s as newspapers reported on dormitory spaces spilling into day rooms, attics, and basements. By 1947, Crownsville had 1045 beds for the 1662 patients in their care; 617 patients were forced to sleep on mattresses on the floor.¹⁷ Increasing admissions

¹⁵ "CRAZY GUARDS MIND PATIENTS." *Afro-American* (1893-1988), Sep 28, 1923. 1, <https://search.proquest.com/docview/530574254?accountid=14696>.

¹⁶ "INMATES COMPLAINS AT CROWNSVILLE." *Afro-American* (1893-1988), Jun 20, 1925. 1, <https://search.proquest.com/docview/530606091?accountid=14696>.

¹⁷ Coole, Ida. "Chances for Recovery very Slim in most Mental Hospitals." *Afro-American* (1893-1988), Feb 01, 1947. 13, <https://search.proquest.com/docview/531633151?accountid=14696>.

and dropping discharge rates resulted in patient wards that were tightly packed beyond capacity. Some patients had to “crawl in over the foot of the beds” because the three-foot hospital standard between beds was not adhered to.¹⁸ Despite Crownsville’s commitment to providing patients with quality care for their illnesses, the physical conditions within the hospital were not always conducive to a path towards recovery and treatment.

As the definitions of mental illness evolved, so too did the solutions for a cure. Annual reports issued by the Board of Managers detailed additional forms of treatment including hydrotherapy, shock treatment, and lobotomies. These ‘promising’ practices served as a reaction against trends in which patients were increasingly being admitted for indefinite care. In particular, lobotomies offered medical administrations a potential solution to managing patient behavior and overcrowding. Ideally, by severing the connections between the prefrontal cortex and frontal lobes of the brain, the quick and low-cost and procedure would relieve the symptoms of the patient’s mental illness. In reality, patients experienced brain damage, decreased cognition, and loss of inhibition.¹⁹ In 1948 alone, thirty-three Crownsville patients received lobotomies; the fate of the patients is unclear.²⁰

¹⁸ "OVERCROWDING IS ANALYZED." *The Sun (1837-1993)*, Aug 22, 1948. 26, <https://search.proquest.com/docview/541951038?accountid=14696>.

¹⁹ Valenstein, Elliot A. “History of Psychosurgery.” *A History of Neurosurgery: In Its Scientific and Professional Contexts*. 1997. 499–516.

²⁰ Department of Health and Mental Hygiene. *Crownsville State Hospital*. 1949. 2, MdHr 793458. Maryland State Archives.

Staffing

The quality of patient care is intrinsically tied to the care provided by the hospital staff and personnel. During the national coverage of the 1923 the manslaughter trial, the experience and skillset of Crownsville attendants were publicly called into question. Walter Swiskowski, the white attendant that was found guilty of a patient's death, had a prior charge of criminal assault on his record. Unfortunately, this arrest history was not flagged during Swiskowski's cursory hiring process. It was also noted at the time that most of the attendants were considered inexperienced "floaters" because the \$35 per month wage made it difficult to retain workers.²¹

By 1936 the Crownsville staff turnover rate had reached 54%, due in large part to the marginal hospital employee compensation packages offered statewide. Despite working an average of eleven hours a day as the primary caregivers to the patients, the average state hospital attendant was paid approximately \$27-54 per month without any retirement benefits. Comparatively, employees of Maryland penal institutions were subject to an 11% turnover rate, received an average of \$110-150 per month, worked eight hours per day, and were eligible for retirement.²²

Employee shortages and lack of qualifications were amplified during the war effort. In 1944, the standard ratio of attendants to patients was one to eight; the Crownsville ratio was one attendant to every twenty-seven patients. In response to the hospital staff shortages, the industrial shop was closed in order to put the foreman,

²¹ "SPEED IS URGED IN ASYLUM CASE." *The Sun (1837-1993)*, Jun 20, 1923. 3, <https://search.proquest.com/docview/544382477?accountid=14696>.

²² "TURNOVER OF LABOR IN ASYLUMS CITED." *The Sun (1837-1993)*, Dec 17, 1936. 26, <https://search.proquest.com/docview/539245589?accountid=14696>.

hospital painter, and carpenter to work in the wards as attendants.²³ The professional staff, including on-site physicians, were also subject to severe shortages. In 1947, eight physicians were responsible for the care of 1,662 patients.²⁴ In the face of this employment crisis, the formal policy of denying qualified personnel simply based on the color of their skin became increasingly onerous.

Persecution & Desegregation

The murder of patient Murray forced the public to grapple not only with the brutal treatment of patients in the hospital, but also the inherent power hierarchies of an all-white staff caring for an all-Black patient population. Shortly following the 1923 publicized death of a Black patient at the hands of a white attendant, an African American branch of the Women's Republican League approached, albeit unsuccessfully, Oliver C. Short, State Employment Commissioner and Dr. A. P. Herring in regards to desegregating the Crownsville staff.²⁵ However, Board Members remained steadfast in their opposition to amending hiring policies, as evidenced by William P. Gundry's statement that he was "definitely opposed to... the hiring of competent colored persons to the staff."²⁶

While the newspaper accounts of substandard care and abuse – both substantiated and sensationalized – painted a clear picture of right and wrong for Black and white audiences, the legacy of Crownsville is further complicated by the

²³ "Mental Asylum in Critical Need of Attendants." *The Washington Post (1923-1954)*, Dec 02, 1944. 3, <https://search.proquest.com/docview/151703030?accountid=14696>.

²⁴ Coole, Ida. "Chances for Recovery very Slim in most Mental Hospitals." *Afro-American (1893-1988)*, Feb 01, 1947. 13, <https://search.proquest.com/docview/531633151?accountid=14696>.

²⁵ "TO PUT WHITE STAFF AT NEGRO HOSPITAL." *The Sun (1837-1993)*, Aug 20, 1923. 3.

²⁶ "THE CROWNSVILLE BOARD CAN'T AFFORD TO BE UNPATRIOTIC." *Afro-American (1893-1988)*, Dec 06, 1941. 11, <https://search.proquest.com/docview/531323792?accountid=14696>.

perspectives of those who held positions of power. De facto segregation stunted not only the medical care of those admitted to Crownsville, it also affected the professional development of the physicians, nurses, and associated personnel that were hired to run its operations.

In a nation emboldened by the nationalist sentiment after WWII, the opportunities for immigrant doctors were few and far between. The layers of stigma associated with the treatment of mentally ill African Americans patients left vacant positions at Crownsville that were likely accepted out of financial necessity rather than for the opportunities of professional prestige. Throughout the 1940s and 1950s, Crownsville personnel included Jewish doctors that were refugees that fled Nazi-occupied Europe.²⁷ Among these doctors was Dr. Jacob Morgenstern, Superintendent of Crownsville from 1947 to 1953.

In 1942, the Crownsville Board announced it would integrate its staff by providing housing and training provisions for qualified Black attendants.²⁸ However, it was not until 1948, under the direction of Dr. Morgenstern, when the hospital hired its first Black staff member, psychologist Vernon Sparks. After Crownsville desegregated its patient population in 1963, the state system transitioned to a regional model. Rather than solely serve the Black Maryland population, Crownsville was given the responsibility of providing care to all residents of Anne Arundel County, St. Mary's County, Charles County, Calvert County, and southeastern Baltimore City. Despite the expanded population pool, the 1960s marked a nationwide shift towards

²⁷ Richmond, Suzanne. "Social Justice through Medical Ethics." *Generations* 2009/2010 (2010). 91

²⁸ "Crownsville Board Will Mix Staff." *Afro-American (1893-1988)*, Jan 31, 1942. 14, <https://search.proquest.com/docview/531343397?accountid=14696>.

the prescription of psychotropic drugs and outpatient psychiatric care. Patient populations steadily declined until June 30, 2004 when the remaining 200 patients were transferred to remaining state hospitals and Crownsville permanently shuttered its doors.

Current Condition



*Figure 11 Current condition of the "B" Building's east elevation as of September 2018
(Source: Author's work)*

The 544-acre property and 12.6-acre cemetery parcel are currently owned by the Maryland Department of Health and Mental Hygiene (MDHMH). The seventy acres that are reserved for the water and sewage treatment facility are managed by the Maryland Environmental Service. As of 2016, there were property agreements and leases with ten tenants throughout the property, including the U.S. Coast Guard, Anne Arundel County Food Bank, Arundel Soccer Association, Inc., Guadenzia Drug Treatment, Hope House, Maryland Historical Trust, Habitat for Humanity of the Chesapeake, Maryland Institute for Emergency Medical Services Systems, and Chesapeake PC Users Group. These tenants are charged \$1 for their leases, therefore

the MDHMH does not generate any significant revenues from the building occupation. The remaining 75% of the building stock, approximately 598,601 square feet, remains vacant.

Given that the average age of the buildings on the site are over seventy years old and the property has remained mostly vacant for over fourteen years, the physical conditions of the remaining buildings vary widely. A 2016 report released by the Task Force on the Disposition of the Crownsville Hospital Center Property stated 33% of the buildings are considered to be in “excellent”, “good”, or “fair” condition, while 67% of buildings are considered to be in “poor” condition. The task of upkeeping such a large site comes at a considerable cost to the state. The projected 2016 operating expenditures for security and general maintenance amounted to \$1,176,383.²⁹

²⁹ Task Force on the Disposition of the Crownsville Hospital Center Property. *Crownsville Hospital Center Property Report*. Report. 2016.
<https://dgs.maryland.gov/Documents/AnnouncementDocs/2015CrownsvilleTaskForceReport.pdf>.

Chapter 2: Site Analysis

Examining the surrounding context of Crownsville State Hospital reveals several noteworthy opportunities for design interventions. Originally chosen for its rural seclusion, the site retains vestiges of its former life in the form of edges, axis, low density, historic buildings, and viewsheds.

Regional Context

Although Crownsville's population of 1,784 residents falls within the threshold of a rural population, it remains within driving distance of several major urban centers (Figure 12). The ability to capture users beyond a five-mile radius of the complex will be critical to financially sustain the programming, given the substantial 544-acre footprint of the site.

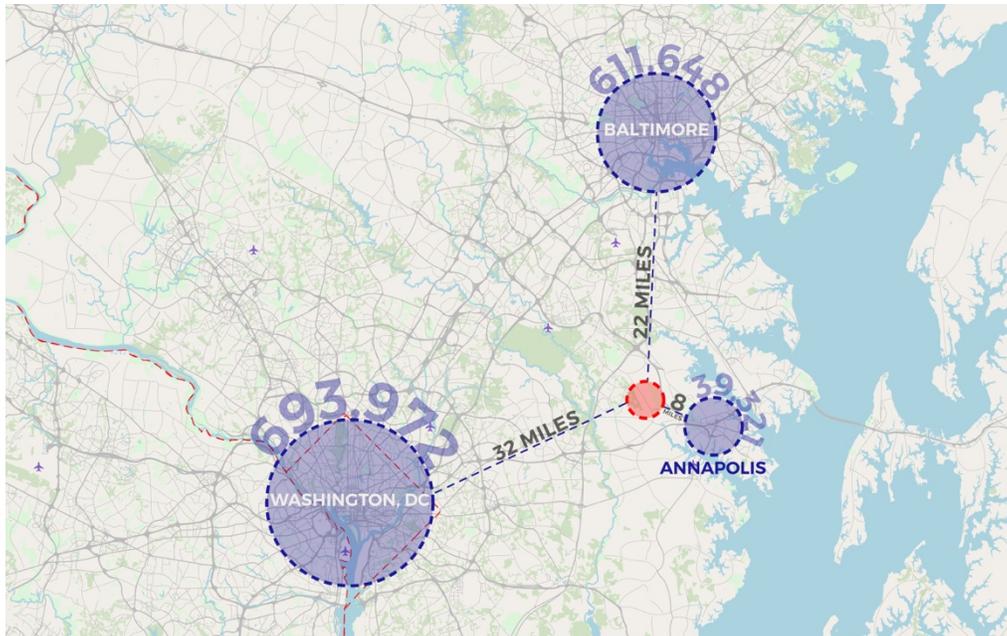
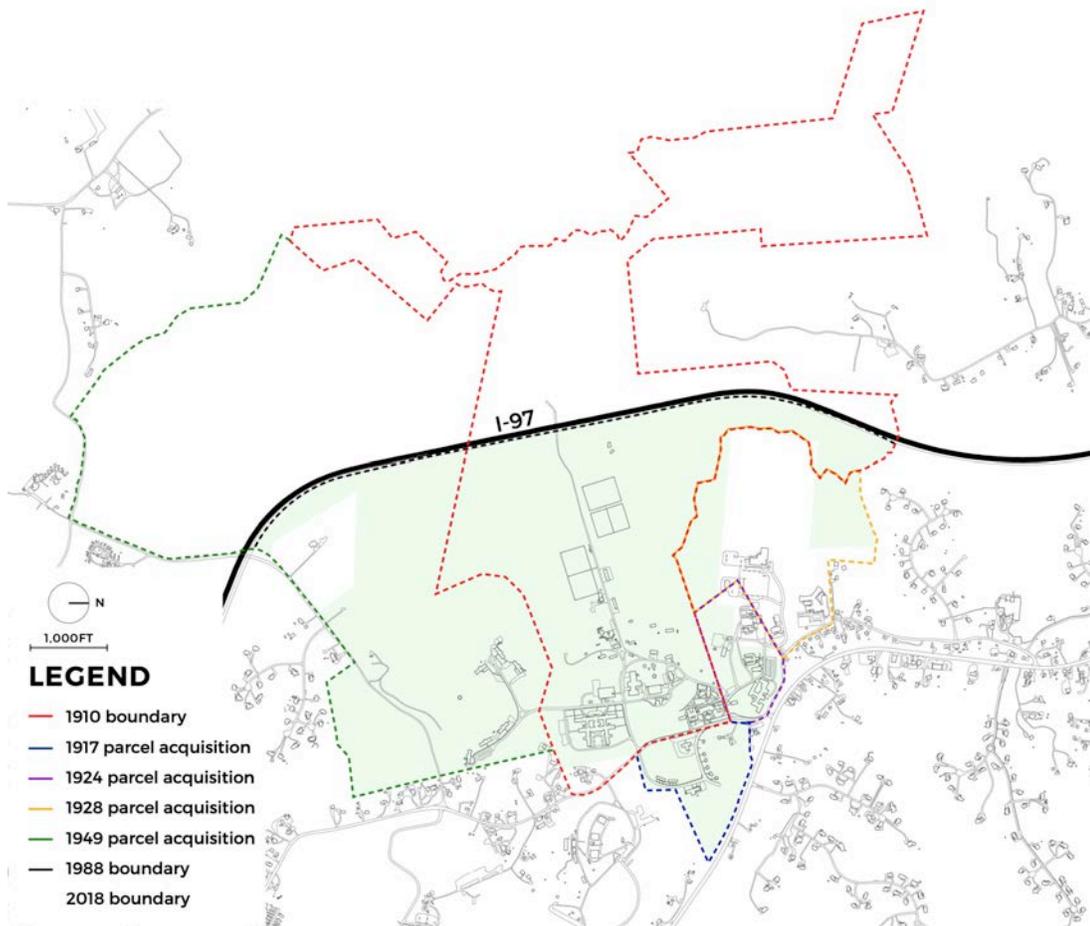


Figure 12 Map of Crownsville's regional urban context (Source: Author's work)

Site Boundaries

The current boundary of the Crownsville State Hospital follows Crownsville Road on the east, Hawkins Road on the south, I-97 on the west, and Generals Highway on the north. This boundary does not fully conform to the original 1910 platting for the hospital and includes several parcels that were obtained in subsequent years (Figure 13). The site is adjacent to Bacon Ridge Natural Area, however the introduction of I-97 in 1987 created a physical buffer to the natural resource.



*Figure 13 Site plan of Crownsville's historical boundaries
(Source: Author's work)*

Circulation

Although Crownsville was not constructed with a fenced perimeter, there are limited points of access with the surrounding area (Figure 14). There is an opportunity to extend and amend the existing street network to integrate into the site. In order to alleviate potential congestion on the two-lane general highway, an additional exit off of I-97 can be built with respect to the historic buildings and landscapes.



Figure 14 Existing Crownsville hospital circulation diagram
(Source: Author's work)

The site is not served by regular public transportation services. As such, the site is heavily car dependent. Traffic counts provided by the Maryland State Highway in 2017 estimated an average daily traffic flow of 93,382 to 121,381 commuters along I-97 that frames the hospital campus, while 19,761 daily drivers used General's Highway.³⁰ Additional transit modes, such as shuttles to Annapolis and the Odenton MARC station (located eight and ten miles away, respectively), will be necessary to increase access to the site. Otherwise, future development must plan for substantial vehicle accommodations.

A primary means of access to Bacon Ridge and the Crownsville Patient Cemetery is through the Crownsville property along Farm Road, however this route is currently closed to public access due to concerns about the hazardous conditions associated with the proximity to the water treatment facility's spray fields.

Topography

The site topography is moderately hilly with spot elevations ranging from 40 feet to 140 feet above mean sea level (Figure 15). Steep valleys have been carved into the landscape by the intermittent feeder streams of the nearby Severn River. These major stream beds will be preserved for the aesthetic benefit of an open water feature and for the potential habitat benefits for local flora and fauna. The average frost line depth in the state of Maryland is thirty inches below the surface of the ground.

³⁰ 2017 TRAFFIC VOLUME MAPS BY COUNTY. Report. April 5, 2018.
https://www.roads.maryland.gov/Traffic_Volume_Maps/Traffic_Volume_Maps.pdf.

The existing buildings are concentrated on the flat ridges that overlook the streams. Future landscaping and architectural interventions will capitalize on the viewsheds towards the neighboring wooded preserves. Throughout the site's expansion, the physical topography was used as a tool to reinforce social relationships. Situated on one of the highest points on the site, the prominent placement of the Superintendent's House in the northeast region of the site strengthens the dichotomous relationship of observer and observed.



*Figure 15 Topography diagram of Crownsville
(Source: Author's work)*

Environmental

The soil of the Crownsville complex is a mixture of Collington series brown soils.³¹ Due to the soil's high moisture capacity and productivity, it is well suited for cultivation, except where they may be limitations placed by slope and erosion constraints. A wide variety of crops are able to grow on them, as evidenced by the array of produce yields recorded in Crownsville's earliest published reports.

Given the rural and low-density setting of the site, there is extensive tree coverage in the underdeveloped regions, primarily around the steep land slopes (Figure 16). The tree lines follow the topographic contours of the landscape. Additional cleared areas include the spray fields and a field adjacent to the south side of the cemetery plots. The existing tree species are primarily deciduous hardwoods, including yellow poplar, chestnut, white oak, red oak, and red gum. However, there is a small portion of spruce pine that is scattered around the mixed hardwood forest.³²

³¹ Matthews, Earl D., and Robert M. Kirby. *Soil Survey of Anne Arundel County, Maryland*. 1973. 20.

³² Board of Managers of the Hospital for the Negro Insane of Maryland. *The First Report of the Board of Managers of the Hospital for the Negro Insane of Maryland*. 1911. 25, MdHr 793458. Maryland State Archives.

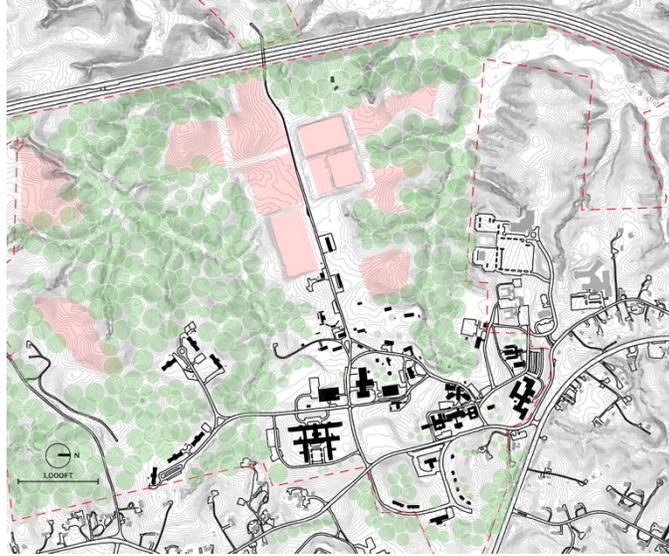


Figure 16 Diagram of Crownsville tree coverage and spray fields
(Source: Author's work)

Climatology

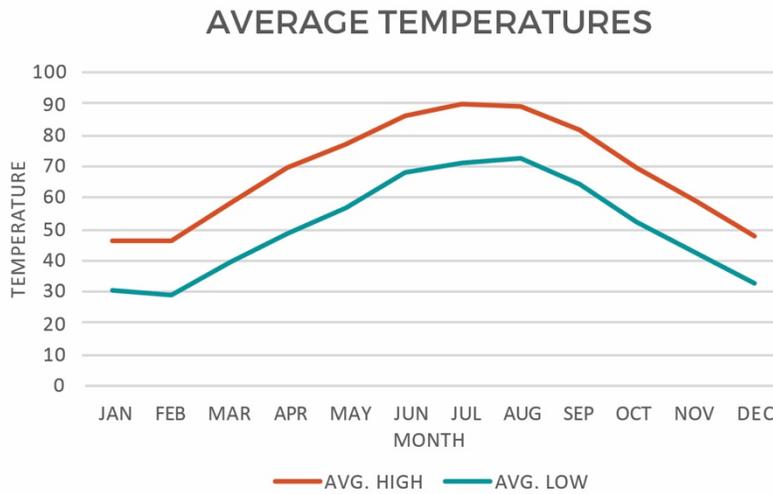


Figure 17 Crownsville's average temperatures (Source: Author's work)

Crownsville’s location in the Atlantic Coastal Plain contributes to its humid subtropical climate typified by hot, humid summers, and shorter, mild to cool winters (Figure 17). The average annual precipitation in the region is approximately 42.75 inches.

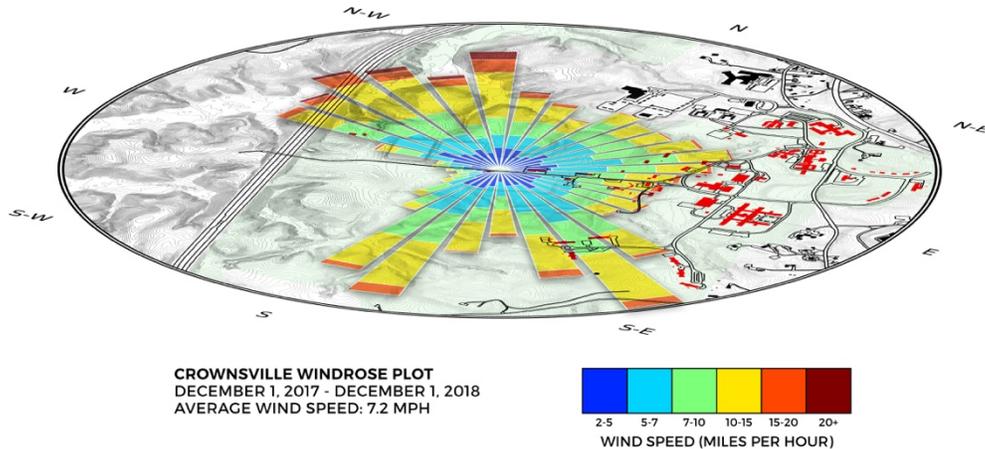


Figure 18 Crownsville windrose diagram (Source: Author's work)

The prevalent winds in Crownsville come from the southeast and northwest. The average wind speed is approximately 7.2 miles per hour (Figure 18). Climatically responsive interventions will take advantage of the wind's orientation by channeling cross breezes with strategic fenestration

Hazardous Conditions

Considerations of Asbestos Containing Material (ACM) and lead-based paint (LBP) will need to be evaluated within the context of the renovation plan and future use of those buildings. The Maryland Historical Trust has documented the presence of asbestos in some buildings, LBP in all buildings, and subsurface contamination in the water treatment spray fields.³³ Future building owners will be held responsible for ongoing management and maintenance of the ACM and LBP according to federal and state regulations after any property transfers.

³³ Task Force on the Disposition of the Crownsville Hospital Center Property. *Crownsville Hospital Center Property Report*. Report. 2016. <https://dgs.maryland.gov/Documents/AnnouncementDocs/2015CrownsvilleTaskForceReport.pdf>.

Zoning, FAR, & Current Retail Market

The site is categorized under a Rural Agricultural (RA) zoning district. This residential zoning district is intended to preserve agricultural lands and low-density development. Within the subdivision, single-family detached residential dwellings account for a density of approximately one dwelling unit per twenty acres, however there are no subject to any floor area ratio restrictions. Zoning requirements include a minimum lot size of 40,000 square feet, maximum lot coverage by structures of 25%, and a maximum height of forty-five feet.³⁴ The property would need to be rezoned in order to increased density and commercial uses.

The current retail market is characterized by low-density, scattered retail clustered around the auto-dependent General's Highway. The majority of retail is small-scale and independently owned. The area is greatly underserved by consumer basics, such as grocery stores, general merchandise stores, and sit-down restaurants.

Historical Structures

Of the sixty-nine buildings on the site, fourteen are considered contributing historic resources to the site (Figure 19).³⁵ These buildings provide a spectrum of building sizes, typologies, age, and reuse potential that can create a comprehensive development rooted in adaptive reuse and preservation practices.

The original building cluster of Building A, Building B, and the Administration Building has the ability to anchor additional development around the

³⁴ "Zoning Classifications Guide | Anne Arundel County, MD." Accessed December 14, 2018. <https://www.aacounty.org/departments/planning-and-zoning/zoning/zoning-classifications-guide/index.html>.

³⁵ Although the Winterrode Building was designated at the state level as a contributing resource to the Crownsville site, it was deeded over to Anne Arundel County in 1984.

site and attract potential users due to its proximity to Generals Highway. The architectural integrity, classical detailing, and size of the current footprint can provide a unique space and experience to a host of commercial tenants.

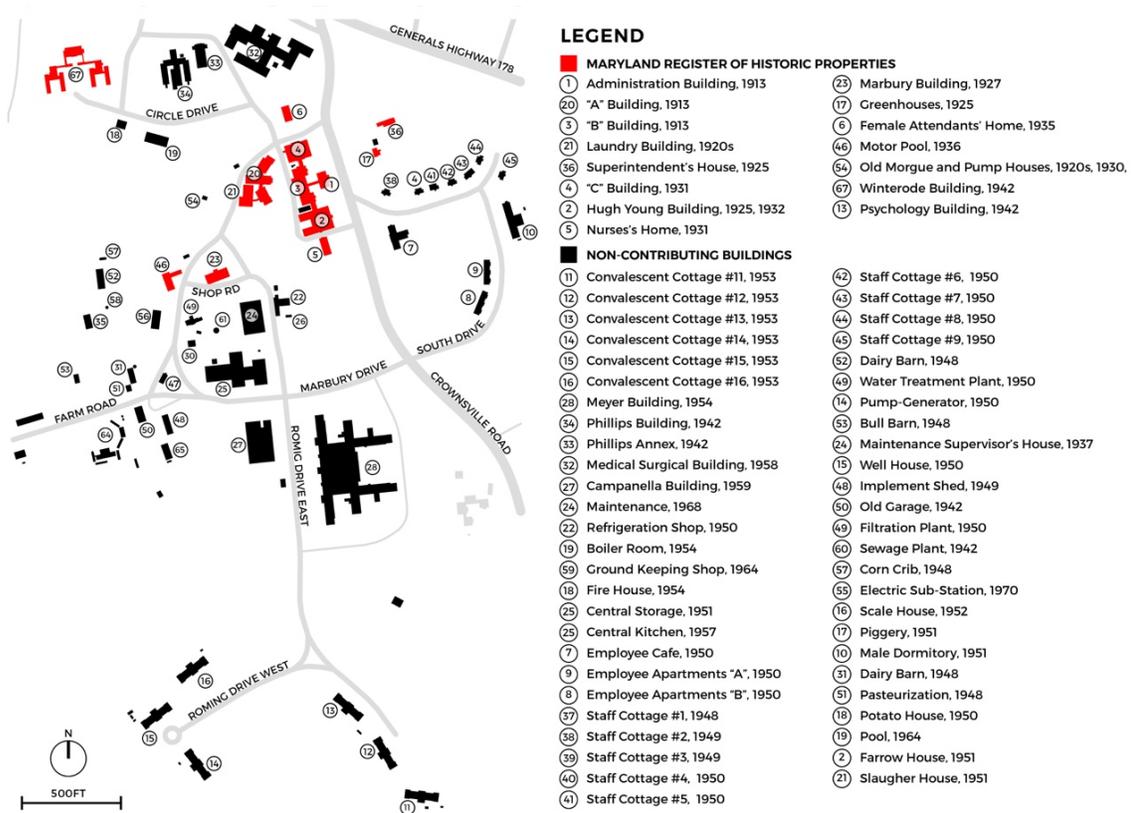


Figure 19 Site map of Crownsville's historic building stock (Source: Author's work)

Prior Development Proposals

Since the hospital's closure in 2004, several development proposals have been made public, but no clear plans have come to fruition. In 2005, Crownsville State Hospital was floated as a contender for the future Maryland State Horse Park. Annapolis Mayor Ellen O. Moyer proposed the adaptive reuse of Crownsville's building fabric could be a key feature of the new development, including turning the administration buildings into signature parts of the equestrian facility and its museum.

County executives expressed concern about the lack of infrastructure on the site and the expenses associated with asbestos cleanup.³⁶

In 2009, a call for proposals was put out by the Maryland Department of Health, resulting in eleven bids. The various options were eventually narrowed to a single developer that planned to turn the complex into a retirement community. However, financial difficulties caused by the economic downturn forced the developer to drop out of the project in 2010.

In 2017, the Chesapeake Sports and Entertainment Group, owner of the Major League Lacrosse team the Chesapeake Bayhawks, showed their interest in developing the site by unveiling an estimated \$200 million phased project. The proposed plan included the construction of a 10,000-seat stadium, 6,000-seat amphitheater, 20 full-length youth sports fields, and 2,4000 parking spaces on the hospital site and surrounding parcels.³⁷ As of 2018, the status of the lacrosse stadium remains unknown as it awaits approval from several state agencies and the Anne Arundel County government.

All of the aforementioned projects failed to address the heritage of the site beyond the physical fabric of the site. While some projects appeared to embrace the notion of adaptive reuse more than others, it was unclear how the stories of the people that lived – and died – would be preserved. This is not only a disservice to the

³⁶ Stiehm, Jamie. "Historic Sites, New Plans; Reuse: Annapolis' Proposal to Locate a Horse Park on the Site of Crownsville Hospital Center Or Other Old Facilities Meets with Praise as Well as Concern." *The Sun*, Aug 28, 2005. 1G , <https://search.proquest.com/docview/406675723?accountid=14696>.

³⁷ Cook, Chase. "Business Owners Seek Clarity on Future at Crownsville Site; Bill on Maynadier Creek Water Skiing Withdrawn." *The Baltimore Sun*, Feb 04, 2018. <https://search.proquest.com/docview/1993733557?accountid=14696>.

patients' memory, it is a missed opportunity for the state of Maryland to acknowledge its past actions alongside the considerable progress the state has made towards progressive and equitable care for all of its citizens.

Chapter 3: Bondage, Liberty and the Pursuit of Happiness

In order to understand the political and social dynamics that shaped the establishment and subsequent management of the Hospital for the Negro Insane of Maryland, it is imperative to acknowledge the “peculiar” institution that the separate-but-equal hospital was predicated upon.³⁸

Maryland’s Peculiar Institution

By the time Maryland was established as a colony in 1634, the plantation system based on enslaved African labor had already established a foothold across the western hemisphere. Thirty years after its establishment, the Maryland General Assembly formally legalized slavery in 1664, marking the beginning of slavery’s dominance in Maryland for the following two centuries. The rise in political power of Maryland planters by the turn of the 18th century marked a palpable shift in reliance on Black slaves rather than white indentured servants. By 1755 nearly one third of Maryland’s population was of African descent. The emergence of tobacco – and eventually cotton – as an economic cornerstone of the agrarian economy further engrained the paradigm of the slave plantation into the Maryland landscape.

³⁸ The euphemism *peculiar institution* was used in the 19th century amongst white Southerners as a means to strip away the negative connotations associated with the term *slavery*.

\$125 REWARD.—Ran away from the subscriber living near Crownsville, A. A. county, on the 15th inst., negro T O M. He is about 23 years of age, about 5 feet 5 inches in height and black colored, and has a beard about the chin, and a scar on the head. He has likely gone to the lower part of the county, as he has a wife belonging to Mr. Thos. I. Hall. I will give \$75 if taken in the county, and \$125 if taken out of the county. In either case to be secured so that I get him again.

THOS. J. TONGUE,
 Crownsville P. O., Anne Arundel county,
 Maryland.
 18-3t*

Figure 20 Runaway slave advertisement, September 12, 1854
 (Source: *The Baltimore Sun*)

Sandwiched between classified advertisements for property lots and handsome gold watches, the runaway ad placed in the September 9, 1858 issue of the *The Baltimore Sun* (Figure 20) reveals Crownsville was no stranger to the institution of slavery. The \$125 reward offered by Thomas J. Tongue of Crownsville was for the apprehension of a slave named Tom, likely headed to the southern part of the county to reunite with his wife that lived on a separate plantation. Thomas Tongue’s property – and the slaves that maintained it – were located on the current hospital site according to the 1860 Martenet map (Figure 2).

Inspired by the staunch ideologies that demanded freedom and independence during the American Revolution, a rising abolitionist sentiment demanded the recognition of the humanity and autonomy of African Americans that had been stripped away in servitude. National figureheads, including Frederick Douglass, prolific orator and native son of Maryland, acknowledged the disparity in the inalienable rights to Life, Liberty and the pursuit of happiness promised by the nation’s founding fathers. Mounting pressures in the form of increased opportunities for escape, Union recruitment of enslaved men, and the gradual dependency on

diversified agriculture culminated in Maryland's ratification of a new state constitution that prohibited slavery in November 1864.

Federal Regulation of the Enslaved

The landmark 1857 Supreme Court case, *Dred Scott v. John F.A. Sandford*, set a legal precedent that equated the worth of African Americans as articles of property with the following opinion written by Chief Justice Roger B. Taney of Maryland:

A free negro of the African race, whose ancestors were brought to this country and sold as slaves, is not a "citizen" within the meaning of the Constitution of the United States.³⁹

In the eyes of the highest court of the land, 15% of the country – men and women that had built the foundations of the country through their forced labor – were better suited as line items on an inventory ledger rather than acknowledged citizens in the census.⁴⁰

Ratified between 1865 and 1870, the Reconstruction Amendments leveraged federal regulations to elevate the status of African Americans throughout the country - in theory. However, the adoption of Jim Crow laws and black codes at the local level undermined this progressive effort by targeting African Americans to reinforce existing power structures rooted in white supremacy. The caveat in the Thirteenth Amendment that outlawed slavery "except as a punishment for crime whereof the party shall have been duly convicted" became an exploited legal loophole that manifested in the form of a discriminatory penal system. The widespread practice of

³⁹ "Scott v. Sandford." LII / Legal Information Institute. Accessed November 4, 2018. <https://www.law.cornell.edu/supremecourt/text/60/393>.

⁴⁰ Inter-university Consortium for Political and Social Research. "Historical, Demographic, Economic, and Social Data: The United States, 1790-1970." Inter-university Consortium for Political and Social Research [distributor], 2005. <https://doi.org/10.3886/ICPSR00003.v1>.

convict-leasing allowed for private parties to contract prisoners, in this case a disproportionately Black prison population, for labor services at below market rates. Convicts built roads, cleared sites, and worked in a range of industrial factories as a form of punishment for convicting a crime. In Crownsville, the patient labor that built the foundations of the hospital was praised as a positive form of therapy by the doctors responsible for their care (Figure 21).



*Figure 21 Patients drafting and bundling willow on site, 1910
(Source: Maryland State Archives)*

Codification of Race in Post Antebellum Maryland

The separate but equal paradigm pervaded nearly every aspect of daily life for Black Marylanders in the late nineteenth and twentieth centuries. Freedom in the form of citizenship recognition was countered with sweeping legislative measures that targeted the civil and political rights of African Americans across the country. The doctrine of Jim Crow embraced politically sanctioned disenfranchisement, intimidation, economic suppression, and segregation as a means to maintain social

power structures that were reinforced with white supremacy ideologies. Despite Maryland's role as a strategic Union state during the Civil War, the influence of Jim Crow on ratified state laws in the years that followed reveals the struggle for freedom continued long after the Lost Cause was defeated.⁴¹

Between 1870 and 1967 dozens of state statutes included provisions that addressed the enforcement of racial segregation and exclusion under the penalty of law. According to an 1884 order, interracial marriage was "forever prohibited, and void"; guilty spouses could face eighteen months up to ten years in the penitentiary.⁴² The creation of free public schools for the Black community using public funds was codified during the 1870s. Although the separate-but-equal educational provisions that stipulated no discrimination would be made in quality or accommodation were eventually added in the twentieth century, inequitable state funding models predicated upon the income taxes of the surrounding neighborhoods would ensure segregated schools were never equal. preserve

Traveling during this era proved to be difficult at best for African Americans, whether on the open road, railroad, or the Chesapeake Bay. Passengers and conductors that refused to comply with segregated streetcar and train seating arrangements could be charged with a misdemeanor and fined between \$5 and \$50, or imprisoned in jail for thirty days, or both. Steamboat statutes necessitated separate cars, sleeping quarters, and restrooms, in addition to the placement of iconographic

⁴¹ Following the end of the Civil War, the *Lost Cause* surfaced as a sympathetic ideology that framed the Confederacy's motive as a noble fight to preserve the Southern way of life rather than an effort to uphold the institution of slavery.

⁴² Johnson, Franklin. "The Development of State Legislation concerning the Free Negro." PhD diss., Law: Columbia, 1918. 119.

signage with “plain letters in a conspicuous place indicating whether for white or colored passengers”.⁴³ Beyond the discriminatory practices associated within the mode of transportation itself, access to basic accommodations along the way, such as food and lodging, carried another set of inherent risks and challenges.

On September 6, 1961, Wallace Nelson, Juanita Nelson, Kay Meyers Fields, and Rose Robinson walked into Bar H Chuck House along Route 40 near Elkton, Maryland for a meal. Instead of being served food, three of the patrons (Fields was not formally charged with the group) were served a one-way ticket to the Cecil County jail for trespassing. The arrests had followed an all too common scenario in which restaurant staff informed the Elkton Three, as they were later called by the media, that they were not permitted to dine-in. Their civil protest to the racist policy continued with their decision to refuse to participate in the court proceedings and initiate a hunger strike. In response, Judge J. DeWeese Carter ordered a mental evaluation for all three activists at Crownsville.⁴⁴ Although the hospital promptly cleared them as sane and intelligent within a day of their arrival, their mere presence at the hospital in the first place exposed two systemic issues: the flagrancy with which the experiences of the Black community were simply dismissed as madness and the ways in which the legal system was manipulated to exercise control.

⁴³ Ibid. 120.

⁴⁴ "Elkton Three Hoped 'to Say Something' to Marylanders by Long Fast in Jail." *Afro-American (1893-1988)*, Sep 30, 1961. 7, <https://search.proquest.com/docview/532036994?accountid=14696>.

Elevation of Black Consciousness

While the strict Crownsville regimen confined patients to the wards and fieldwork, Black communities outside of the hospital grounds cultivated new archetypes of self-consciousness. In contrast to the self-sacrificing, benevolent, and dependent caricatures of African Americans depicted in pop culture, such as *Uncle Tom's Cabin* (1852), *Birth of a Nation* (1915), and *Gone with the Wind* (1939), many African Americans were beginning to craft a new sense of identity that was centered on militancy and independence. The establishment of social justice driven organizations including the National Association of Colored Women's Clubs (1896), the National Association for the Advancement of Colored People (1909), and the National Urban League (1910) signaled a new generation of empowered Americans that were ready and willing to fight for their civil rights.

In 1903, W.E.B. Du Bois published an anthology of influential essays on race entitled *The Souls of Black Folk*. Embedded throughout his work is his theory of double consciousness, a unique sense of self-reflection that hinges on the perception of others. To be an American Negro, according to Du Bois, is to be under the constant and painful pressure of two warring ideologies in a single Black body. One's African soul, nurtured by millennia of rich ancestral history, is viewed with contempt and pity by the dominant culture. One's American soul is defined by the progress and privilege of the modern era.⁴⁵ African-American are African without the history and American without the promised opportunity.

⁴⁵ Du Bois, W. E. B., and University of Virginia. *The Souls of Black Folk: Essays and Sketches*. Charlottesville, Va: Generic NL Freebook Publisher, 1996. 3, <http://search.ebscohost.com.proxy-um.researchport.umd.edu/login.aspx?direct=true&db=nlebk&AN=2010737&site=ehost-live>.

This sense of duality in identity for Crownsville patients was further compounded with yet another stigma – mental illness. The institutional framework of Crownsville capitalized on the conflated shame and rejection associated with this triple consciousness. Patients that retained the cognition of ideological consciousness faced compounded layers of indignity that were reinforced by society and staff alike; opportunities for self-pride were few and far between. The result, an identity completely stripped of humanity, remains physically manifested by the numerical markers in the patient cemetery.

Du Bois' contribution to fostering Black consciousness continued through his guidance at the NAACP as one of its founders. In defiance of pressures to submit to the status quo, the NAACP adopted an assertive approach to eliminate discriminatory practices that underscored the American narrative. The national organization's powerful influence was acutely felt on the Crownsville campus by the hospital's administration. The *Afro-American* Baltimore newspaper repeatedly reported on the Baltimore chapter of the NAACP's pushback against the treatment standards and staffing policies at Crownsville throughout the mid-twentieth century.

Between 1916 and 1970 millions of African Americans left the South during the Great Migration in search of a better standard of living. The promise of jobs and opportunity in industrial cities contributed to the formation of concentrated Black communities throughout the North, including Chicago, Detroit, Washington, D.C., and New York. In particular, the cultural richness of the New York City's Harlem neighborhood during the 1920s and 1930s instilled a spirit of social activism, self-determination, and Black pride that reverberated far beyond the brownstone-lined

streets. Art and culture became the primary mediums through which the Harlem Renaissance's leaders simultaneously redefined the authentic Black experience and shifted perceptions of the African American community around the world.

Visionary writers such as Alain Locke and Langston Hughes navigated the same social circles of legendary performing artists including Billie Holiday and Duke Ellington. These cultural visionaries, equal parts extravagant and revolutionary, reclaimed the Black portrait by pushing the limits of expression through the collected experiences of oppression, freedom, and pride. Art in all of its forms burned the degrading caricatures of the Black community that had come to dominate the American narrative; an entire movement was spawned from its ashes.

Chapter 4: Race, Diagnosis and Treatment

The majority of Crownsville's historic patient records were either lost, destroyed, or damaged due to poor recordkeeping practices. What patient records do remain are restricted for confidentiality reasons under Maryland Annotated Code General Provisions Section § 4-329. As a supplement to limited public documentation regarding the hospital's patient history, prevalent discourse in the medical and psychiatric fields around the country is used in the following chapter to infer the treatment ideologies and justifications in Crownsville.

Physical Peculiarities of the Negro Race

Despite the presumptive higher standards of care afforded by time and academic prestige, higher institutions and respected journals were not immune to racist deductions in the years following Emancipation. Published medical journals remained riddled with pejorative terms such as 'slothful', 'savage', 'uncivilized', 'subordinate', and 'tractable' as ways to describe African Americans well into the twentieth century. The basic tenets of racism that legitimized slavery are rooted in the assumption that the Black race is born with a predetermined biological deficiency – inferior brains affording limited capacity for mental growth. Medical academics drew a firm line between savagery and civilization; one's skin color determined which side of the line you were on.

Time and again the argument to rationalize white supremacy framed the Black community as needy victims, while the white race was painted as a paternalistic figure that benevolently accepted the burden of care. John C. Calhoun, the southern

statesman and impassioned leader of the pro-slavery faction in the Senate, boldly claimed to have irrefutable proof for the necessity of slavery after reviewing the results of the 1840 census: “The African is incapable of self-care and sinks into lunacy under the burden of freedom. It is a mercy to give him the guardianship and protection from mental death.”^{46,47} To be clear, slavery was not an act of inhumanity, it was an act of mercy.

In 1851, Samuel A. Cartwright, M.D.’s *Report on the Diseases and Physical Peculiarities of the Negro Race* extended the “othering” of African Americans far beyond the color of their skin and mental capacity.

Besides, it is not only in the skin, that a difference of color exists between the negro and white man, but in the membranes, the muscles, the tendons and in all the fluids and secretions. Even the negro’s brain and nerves, the chyle and all the humors, are tintured with a shade of the pervading darkness.⁴⁸

This pervading darkness, Cartwright goes on to explain, contributes to the primal laziness that impedes the entire race from mental and moral progress. Thus, it becomes the moral obligation of the white man to provide African Americans with the opportunity to “exercise” outside in order to expand the mind, improve the morale of a destitute people, and benefit the world:

The compulsory power of the white man, by making the slothful negro take active exercise, puts into active play the lungs, through whose agency the vitalized blood is sent to the brain, to give liberty to the mind, and to open the door to intellectual improvement. The very exercise, so beneficial to the negro, is expended in cultivating these burning fields in cotton, sugar, rice and

⁴⁶ The U.S. Census Bureau introduced the “insane and idiots” category in the 1840 census.

⁴⁷ Thomas, Alexander, and Samuel Sillen. *Racism and Psychiatry*. (New York: Brunner/Mazel, 1972) 17.

⁴⁸ Cartwright, Samuel A., M.D. "Report on the Diseases and Physical Peculiarities of the Negro Race." *The New Orleans Medical and Surgical Journal*, May 1851, 692. Accessed October 11, 2018. <http://heinonline.org/HOL/Page?handle=hein.slavery/disphycnr0001&id=1&collection=slavery>.

tobacco, which, but for his labor, would, from the heat of the climate, go uncultivated, and their products lost to the world.⁴⁹

Despite their prevalence, proponents of scientific racism were neither unified in their arguments, nor fully embraced by the entire scientific community. In 1779, noted German anthropologist Johann Friedrich Blumenbach's pioneering explorations of humanity's natural history distinguished the human species as five principal races: Mongolian (East and Central Asia), American (Native American), Caucasian (European), Malayan (Southeast Asian and Pacific Islander), and Aethiopian (Black). Contrary to the future rhetoric of Dr. Cartwright, Blumenbach's research – guilty of prejudiced language in its own right – argued that the Black race distinguished itself by “examples of perfectibility and original capacity for scientific culture, and there by attached itself so closely to the most civilized nations of the earth.”⁵⁰ Despite the wide spectrum of positions on the origins of mankind, broader social and moral ideologies continuously underscored perceived correlations between race and mental illness in the years leading up to the establishment of the Hospital for the Negro Insane of Maryland.

Late Nineteenth and Early Twentieth Century Treatment of African American Patients in Maryland

Similar to the earlier rhetoric used to justify enslavement, subservience was argued by leading medical professionals to be in the best interest of the mental

⁴⁹ Cartwright, Samuel A., M.D. "Report on the Diseases and Physical Peculiarities of the Negro Race." *The New Orleans Medical and Surgical Journal*, May 1851, 714. Accessed October 11, 2018. <http://heinonline.org/HOL/Page?handle=hein.slavery/disphycnr0001&id=1&collection=slavery>.

⁵⁰ Blumenbach, Johann Friedrich, Thomas Bendyshe, K. F. H. Marx, and John Hunter. *The Anthropological Treatises of Johann Friedrich Blumenbach: With Memories of Him by Marx and Flourens and an Account of His Anthropological Museum*. 1865. 312.

wellbeing of the Black population. In other words, the freedoms and privileges afforded to white males that were extended to include African Americans contributed to increased cases of stress and lunacy within the Black community.

There can be no doubt of the fact that the progress of the negro from slavery has been attended with a very marked increase of insanity in this race. In the slavery days insane negroes were not often seen, if we can credit the reports. As life has become more strenuous for them, mental diseases have notably increased. The complications of life, the added responsibilities, the marked increased prevalence of tuberculosis and syphilis among the people of this race have greatly increased the number of the insane.⁵¹

Social welfare provisions with regards to the treatment of the dependent black population in nineteenth century resembled a one size fits all model fixated on social removal rather than individual treatment. State and city hospitals, county asylums, county almshouses and private and corporate institutions often provided accommodations based on one's level of dependency rather than individual diagnosis; patients considered a threat to themselves or others required more attention than patients with a reduced mental capacity. The wretched conditions under which the mentally ill – and African Americans in particular – were treated can be inferred from a report given by a Lunacy Commission member following a 1900 institutional visit:

The cabins for the negroes, to which attention has frequently been called, are a disgrace to the county. One room, at the time of the Secretary's visit, was occupied by two men and two women, all colored... It is a satisfaction to report that the case, which for so many years has been chained to a tree in summer, and shut up in a cell in winter, has at last been removed to an institution for the insane.⁵²

⁵¹ State of Maryland Lunacy Commission. *Twenty-first Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1906. 25, <http://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101046e.pdf#search=Lunacy%20Commission>.

⁵² State of Maryland Lunacy Commission. *Fifteenth Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1900. 24-25, <https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101040e.pdf#search=Lunacy%20Commission%20Reports>.

It is imperative to note that few mental institutions and wards in Maryland were willing to admit Black patients at this time; as such, the improper care provided at county almshouses was in most cases the only available option.⁵³ Despite the Lunacy Commission's assurance that the Maryland county almshouse system was as "good as that in most other States", the substandard care afforded to African Americans was strikingly clear: "The negro patients are generally provided for in a dilapidated cabin, more or less unclean, and always overcrowded."⁵⁴ Contrary to the benevolent intentions of almshouse organizers, human dignity much less sufficient medical care, remained out of reach for many in need.

Evolving social, economic, and political climates during the nineteenth century inspired sympathetic politicians and activists such as Dorothea Dix to push for the operation of state-run asylums. Citing the benefits of occupation, fresh air, and the concentration of modern medical treatments, municipal organizations including the Maryland Lunacy Commission began to embrace the role of the state in the facilitation of centralized institutions. Originally framed as efficient facilities that would provide higher quality and more economical care for an increasing patient population, the prospect of new state hospitals including Crownsville offered an avenue of medical treatment rooted in patient needs.

⁵³ By providing free food and shelter, charitable almshouses served as a last resort for the most vulnerable members of the community: the poor, disabled, and elderly. Lack of regulation and limited care options contributed to the inclusion of children, mentally ill, and developmentally disabled within almshouses across the country.

⁵⁴ State of Maryland Lunacy Commission. *Eighteenth Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1903. 11, <http://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101043e.pdf#search=Lunacy%20Commission%20Reports>.

According to Lunacy reports, the racial integration of hospital staff in Maryland was initiated in the 1890s, more than half of a century prior to Crownsville's dismantling of the professional racial barrier in the 1950s. The care for Black patients by Black attendants in an outbuilding at Montevue Hospital appeared to be short lived, however; by 1910 the Black attendants had been formerly replaced by white nurses and attendants. Hospital officials had concluded the latter were "better able to control the negro patients than attendants of their own race."⁵⁵

Asylum Architecture: Drafting a Cure for Mental Illness

The mythical origins of the term "asylum" do not begin in the stigmatized wards of grand institutions, but rather in the ruins of Greek temples and altars that offered refuge. The Greek word "ásylo" refers to the lawful protection offered by designated sacred spaces sought by the lower castes of society - slaves, debtors, and criminals.⁵⁶ Christian theology reinforced the concept of an asylum as a protective territorial prerogative granted by the Church.⁵⁷ The radical shift in public perception of an asylum from a place of sanctuary to one of madness is intrinsically tied to advances in modern medicine with respect to mental illness.

The introduction of specialized institutions devoted to the treatment of diagnosed mental disorders references the classical association of asylums as metaphorical beacons of hope and places of refuge. The design of these institutions

⁵⁵ State of Maryland Lunacy Commission. *Twenty-fifth Report of the Lunacy Commission to His Excellency the Governor of Maryland*. 1910. 87, <http://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/013000/013150/unrestricted/20101050e.pdf#search=Lunacy%20Commission>.

⁵⁶ "A Dictionary of Greek and Roman Antiquities (1890), ABACTO'RES, ARMILLA, ASY'LUM."

⁵⁷ Gil-Bazo, María-Teresa. "Asylum as a General Principle of International Law." *International Journal of Refugee Law* 27, no. 1 (March 1, 2015): 21. doi:10.1093/ijrl/euu062.

was seen as an integral tool for the successful treatment of patients, leading to the formal exploration of asylum architectural theory. The development of Kirkbride Institution design principles in the mid-nineteenth century and the emergence of the Cottage Plan in the following century addressed circulation, efficiency, scale, light, and air to complement modern medical advances. Hospitals abiding by these design guidelines underscored the importance medical professionals placed on customizing new spaces to properly address the needs of a growing patient population.

The Kirkbride Plan

Dr. Thomas Story Kirkbride (1809-1883) became a national figure for moral therapy ideals and combined the concepts of moral treatment and integrative architectural design into holistic asylum design. Born on a Pennsylvania farm in 1809, Kirkbride's love of nature was cemented in his rural upbringing. After graduating from the medical department at the University of Pennsylvania in 1832, Kirkbride began a medical residency at Friend's Asylum in Frankfort, Pennsylvania. During his residency, Kirkbride was exposed to moral treatment methods of mentally ill patients rooted in the Quaker belief that God resides in every person, regardless of the presence of mental illness.⁵⁸ Far removed from the stressors of urban life, the scenic countryside asylum offered good ventilation, private rooms, occupational therapy, and recreational activities for patients.

⁵⁸Asylum for the Relief of Persons Deprived of the Use of Their Reason. *Contributors to the Asylum for the Relief of Persons Deprived of the Use of Their Reason. Account of the Rise and Progress of the Asylum, Proposed to Be Established, near Philadelphia, for the Relief of Persons Deprived of the Use of Their Reason with an Abridged Account of the Retreat a Similar Institution near York, in England.* Philadelphia: Kimber and Conrad, Merrit, printer, 1814.

In 1833, Kirkbride moved on to a residency at Pennsylvania Hospital. In stark contrast to the rolling hills and fresh air afforded to the Frankfort patients, the overcrowded basement ward at Pennsylvania Hospital provided mental health patients with unheated cells in close quarters. Unable to instill a sense of order or improve the quality of patient care, Kirkbride ended his residency after a year and opened a private practice. In the summer of 1840 he was approached with the opportunity to manage a new hospital for the mentally ill and effectively breathe new life into psychiatric medicine.⁵⁹

After becoming Superintendent of Pennsylvania Hospital for the Insane in Philadelphia, Kirkbride further cemented his presence in the medical field as a founding member of the Association of Medical Superintendents of American Institutions for the Insane (AMSAAI), the precursor of the American Psychiatric Association. As the head of a progressive institution and a medical education organization, Kirkbride became the go-to consultant for the best arrangements of mental institutions and eventually published *On the Construction, Organization, and General Arrangements of Hospitals for the Insane* in 1854, a comprehensive guide on the proper construction of mental hospitals.

Kirkbride insisted state hospitals are a community asset that must address the needs of every class of citizen, not just the privileged few. Despite the high-profile names of designers that worked on commissioned hospital projects, such as H. H. Richardson and Frederick Law Olmsted, Kirkbride maintained an architect would

⁵⁹ Nichols, Charles Henry, and John Hill Callender. *Memoir of Thomas S. Kirkbride, M.D., LL.D.* E. Cowan & Company, printers, 1885.

never be able to fully address patient needs, thus the input and knowledge of medical professionals should be heavily considered in the design process. Proper treatment environmental conditions, Kirkbride optimistically insisted, had the prospect of curing between eighty and ninety percent of cases.⁶⁰ In order to ensure such high success rates, Kirkbride's manifesto detailed nearly every aspect of asylum construction, from ceiling heights down to the ideal finished floor materials in dormitories. Kirkbride determined the maximum number of patients that should be cared for at one time should be capped at 250 total patients – the maximum number of patients a medical superintendent could be expected to properly see throughout the course of one day. The culmination of these carefully curated design decisions would ideally create a cheerful and welcoming environment that served as a protective bubble from the triggers of the outside world.

Location and the orientation of the design in relation to the surrounding site context were paramount in determining the therapeutic character and utility of the institution. Kirkbride insisted on a “healthful, pleasant and fertile” countryside location on at least one hundred acres of land.⁶¹ Approximately thirty to fifty of these acres should be set aside for separate male and female “pleasure grounds”. Despite the need for easy accessibility for visitors and supplies, Kirkbride specified the spacious site must be located at least two miles away from the nearest town to insure a sense of privacy from the prying eyes of those with morbid curiosity.

⁶⁰ Kirkbride, Thomas Story. *On the Construction, Organization and General Arrangements of Hospitals for the Insane*. (Philadelphia: Lindsay & Blakiston, 1854), University of Alberta Access, 24.

⁶¹ Kirkbride, Thomas Story. *On the Construction, Organization and General Arrangements of Hospitals for the Insane*. (Philadelphia: Lindsay & Blakiston, 1854), University of Alberta Access, 31

View corridors from both the facility and the pleasure grounds were maximized to exhibit the duality of vibrancy and serenity in life. The emphasis on view instead of a sense of confinement resulted in the stipulation that any walls that secured the facility should be placed on low ground as to not obstruct any views. The masked enclosure also maximized the perceived liberties of patients while they roamed the grounds on supervised strolls. The onus was put on trained attendants to deter and monitor escape attempts, rather than physical barriers that would disconnect the hospital from the community.

Kirkbride also incorporated farm plots and barn structures into the site plans for the cultivation of a sustainable and independent food source. Kirkbride proudly boasted, “labor is one of our best remedies” because it promoted economic incentives, social identities, and self-sufficiency amongst the patients, which in turn would ease the transition back to a rational mindset.⁶²

Kirkbride Plan asylums primarily consisted of a central administration building that was symmetrically flanked by linked dormitories. The center building housed the kitchen, reception area, superintendent’s office, visiting center, chapel and employee housing. The most disturbed – and noisy – patients were housed in the outermost wards, out of earshot from visiting family members and friends. The staggered succession of the pavilions offered sweeping picturesque views of the landscape instead of a neighbor’s barred window in quadrangle and U-shaped plans (Figure 22). The wildly popular theory of contagion at the time, the assumption that

⁶² Kirkbride, Thomas Story. *On the Construction, Organization and General Arrangements of Hospitals for the Insane*. (Philadelphia: Lindsay & Blakiston, 1854), University of Alberta Access, 17

toxic air contributed to the spread of disease, contribution to the near obsession with open ventilation in medical construction. By placing operable windows at the respective ends of each pavilion, cross ventilation was designed to carry fresh breezes and to rid the wards of possible contagions.⁶³

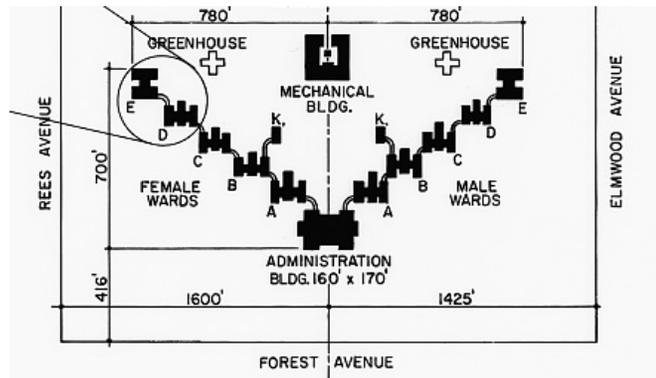


Figure 22 The Buffalo State Asylum plan demonstrates the distinctive staggered Kirkbride configuration of symmetrical wards
(Source: Library of Congress)

The shallow “V” formation formed by the main building allowed the administration to facilitate a hierarchical system of segregation according to sex, illness, and social class. Due to the strict bilateral symmetry of the plan, assumptions concerning the need for the equal housing of male and female inmates were inherently integrated into the plan, regardless of practicality. The Victorian attitude toward the separation of sexes extended to caretaking as well with Kirkbride’s strict ban of male attendants entering any female wards. Each flanking pavilion was no more than three-stories tall; outer pavilions often tapered to shorter buildings since the more extreme cases were expected to be fewer in number. Each floor consisted of

⁶³ Yanni, Carla. “The Linear Plan for Insane Asylums in the United States before 1866.” *Journal of the Society of Architectural Historians* 62, no. 1 (2003): 29. doi:10.2307/3655082.

a separate ward with a double loaded central corridor measuring at least twelve feet wide.

Kirkbride asserted all patient rooms should be located above ground with twelve-foot high ceilings and a complementary window to the natural world. Patient rooms, or dormitories, held between one and six beds depending on the severity of a patient's condition. Kirkbride estimated approximately one quarter of all patients would be housed in these associated dormitories.⁶⁴ The majority of the dormitories remained locked during the day as a means of encouraging social interaction between patients, in addition to fostering a sense of community to combat social isolation in the parlors and other day rooms.⁶⁵

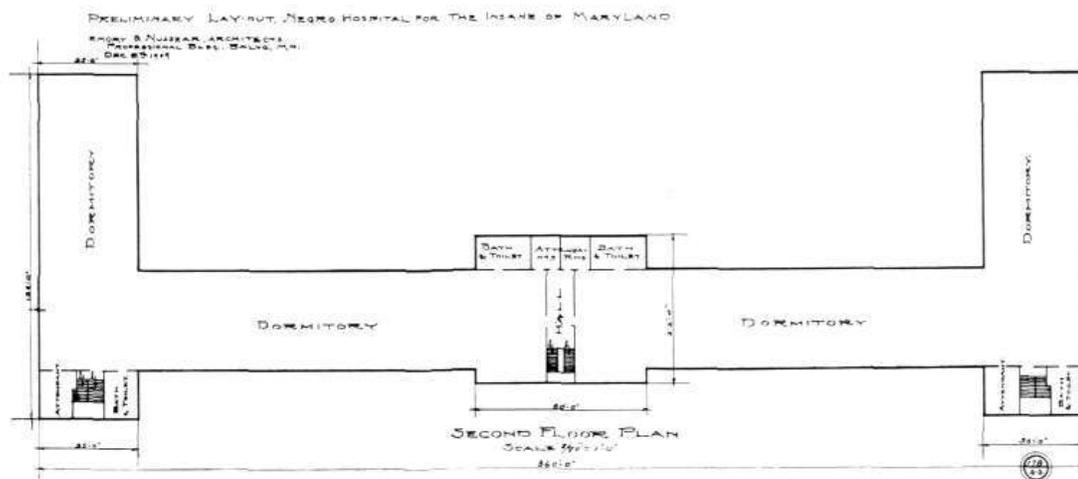


Figure 23 Second floor plan of the Negro Hospital for the Insane in Maryland as reported by the Lunacy Commission in 1909 (Source: Maryland State Archives)

⁶⁴ Kirkbride, Thomas Story. *On the Construction, Organization and General Arrangements of Hospitals for the Insane*. (Philadelphia: Lindsay & Blakiston, 1854), University of Alberta Access, 25.

⁶⁵ Payne, Christopher, and Oliver Sacks. *Asylum: Inside the Closed World of State Mental Hospitals*. Cambridge, MA: MIT Press, 2009. ebrary <http://site.ebrary.com/id/10347247>.

The initial plan proposal Crownsville as seen in Figure 23 reflects the major design principles promoted by Dr. Kirkbride. The symmetrical floor plan is characterized by a central building flanked by separate accommodations for patients based on their respective sex. Located in the central building, the dining room, offices, attendants' rooms, and waiting room served as the anchor of the building. The narrow wings provide ample amounts of light and ventilation as a supplement for patient treatment. Each open dormitory would provide beds for 150 patients. Although this particular plan was never built, the subsequent design of Building A – a central block with flanking wings – also alludes to some of Kirkbride's ideals.

Kirkbride's initial assessment that eighty to ninety percent of patients could be cured in a psychological understanding and therapeutic environment proved to be desperately hopeful. A large influx of patients, namely the urban poor, began to enter the asylums faster than patients could be adequately discharged. In 1866 the AMSAI voted 8 to 6 in favor of increasing the number of patients that could be treated at one time from 250 to 600. Kirkbride voted against the initiative.⁶⁶ Increased demand also led to Kirkbride facilities expanding to impractical proportions. Buffalo State Hospital measured nearly 1/3-mile-wide, hindering the staff's ability to easily and efficiently navigate between the wards.

Kirkbride institutions were primarily state institutions and were held accountable to state legislatures and fiscal policies. Lawmakers began to allocate less funding to mental health initiatives as the promise of effective cures began to fade.

⁶⁶ Yanni, Carla. "The Linear Plan for Insane Asylums in the United States before 1866." *Journal of the Society of Architectural Historians* 62, no. 1 (2003): 49. doi:10.2307/3655082.

Inadequate funding contributed to low wages, high employee turnover rates, and the employment of inexperienced attendants.⁶⁷ Squalor and neglect soon became rampant. The trend towards long-term institutionalization sparked the creation of a subgroup of chronic mental patients that was stigmatized because of their illnesses and deteriorating living conditions – the very same stigma Kirkbride devoted his life to changing.

The Cottage Plan

New schematic designs for mental health facilities, such as the Cottage Plan, shifted away from the monumentality associated with Kirkbride institutions to more community-oriented site scales. By dividing campuses into smaller homelike cottages, physicians argued patients would be able to receive treatment in a quiet and pleasant domestic environment. Although Kirkbride argued supervision would be difficult with scattered cottages instead of a continuous plan, many Kirkbride facilities, such as the Buffalo State Hospital, used specialized detached out-buildings to expand the original Kirkbride plan.⁶⁸

The belief that the built environment had a tangible impact on the well-being of patients continued to be supported by medical professionals, however the design approach changed as overcrowding worsened in institutions across the country.

Proponents of the cottage plan, including Dr. John M. Galt, a member of the

⁶⁷ Payne, Christopher, and Oliver Sacks. *Asylum: Inside the Closed World of State Mental Hospitals*. Cambridge, MA: MIT Press, 2009. ebrary <http://site.ebrary.com/id/10347247>.

⁶⁸ Goody Clancy. "Richardson Olmsted Complex Historic Structures Report." https://richardson-olmsted.com/files/documents/planning_and_reports/historic_structures_full_report.pdf.

Association of Medical Superintendents, argued that the linear Kirkbride plan cemented insanity rather than cured it.⁶⁹

The tenets of cottage asylum management continued to be framed around moral treatment, patient classification, health and comfort, and pragmatic economics. The smaller concentration of patients was intended to lessen the impression of constraint and replicate the scales of the built environment in the outside world. The more modestly-sized wards would not only facilitate a greater sense of self-reliance among patients, it would also grant attendants greater “facility for preventing evil habits and tendencies.”⁷⁰ The village-like appearance would also minimize the threat of institution-wide outbreaks of disease by containing possible exposure to individual cottages rather than entire wings of the hospital.

The opportunity for continuous expansion due to increasing patient populations produced economies of scale for institutional operations. As evidenced by Crownsville’s construction chronology, various allocations by the state contributed to noticeable construction flurries around the campus at various intervals. Beginning with a small but efficient complex formed by Building A, Building B, and the Administration Building, the hospital was able to grow into a more elaborate compound through the addition of distinct administrative, industrial, or residential facilities. The shift of the mental hospital’s role as a temporary place of healing to a patient depository caused the scale of the individual cottages and dormitories to grow

⁶⁹ Yanni, Carla. “The Linear Plan for Insane Asylums in the United States Before 1866.” *Journal of the Society of Architectural Historians* 62, no. 1 (2003): 43.

⁷⁰ Toller, E. “Suggestions for a Cottage Asylum. (with Plans).” *Journal of Mental Science* 10, no. 51 (1864): 343.

as a means to address overcrowding; this trend in cottage construction thus raises the question of how these larger masses influenced the impression of constraint they were originally meant to mitigate.

Chapter 5: Time, Place and Renewal

Adaptation Ideologies

Preservation of Crownsville's built environment is integral to remembering the legacy of the people and practices associated with the historic campus. The conceptual relationship between time and the built environment – and by extension the relationship between time and man – has been dissected and re-dissected for centuries. The notion of architecture as a function of time acknowledges the qualitative relationship of a building and time, the influence and ideologies of capitalism, and the context of a building's lifespan in order to provide an overall framework for deconstructing a building in time.

The general assumption that time 'takes' and buildings 'give' - albeit unwillingly - implies a hierarchy of power that is engrained in the building lifecycle. Architectural theorist, Marvin Trachtenberg, argues time takes on the role of creator rather than destructor; without time, a project would not be able to "brought into its fullness of material being".⁷¹ Mohsen Mostfavi and David Leatherbarrow further the counterargument of a parasitic relationship between a building and time by noting the process of weathering has the potential to add, both in the form of tangible sediment and intangible romanticism.⁷² The Gothic palace, the Palazzo Ducale in Venice, Italy exemplifies a building that was been brought into a sense of "fullness" after centuries of renewal, addition, and subtraction. The staining of time on the building's façade

⁷¹ Trachtenberg, Marvin. *Building-In-Time: From Giotto to Alberti and Modern Oblivion*. New Haven: Yale University Press, 2010. 7-14.

⁷² Mostafavi, Mohsen, and David Leatherbarrow. *On Weathering: The Life of Buildings in Time*. Cambridge, Mass: MIT Press, 1993, 16.

has culminated in a perceived “age value” that enhances the cultural landscape instead of staining it. Crownsville’s contribution to the cultural landscape of Maryland’s history is stained both in its worn edges and its tragic history.

The physical manifestation of time on architecture can be subject to both high value and great disdain; placement on the spectrum is often determined by the ebbs and flows of the capitalist market and cultural trends. Stuart Brand claims consumers place such a high value on the appearance of age that they have invested in faking it for centuries with revival references. However, the fickleness of this cultural consumerism is underlined with the caption, “boredom plus money plus fashion equals new wallpaper every seven years,” in reference to the thirteen documented layers of wallpaper found at the Nathan Beers house.⁷³

Although the presence of a physical building implies permanence, Brand argues the idea of a fixed and unchanging structure is an illusion. “From the first drawings to the final demolition, buildings are shaped and reshaped,” thus the life of a building must be viewed with a temporal lens that expands beyond the rigid timeframe of design conception and the date of substantial completion.⁷⁴ By reframing the period of significance that is used to analyze architecture, the critical role of time in architectural existence is expanded. When examining Crownsville’s historic landscape, the contributions of additions and renovations that may fall outside the traditional period of significance should still be considered as an important part of the campus’ legacy. The outliers, the cottages, the workshops are all integral to the

⁷³ Brand, Stewart. *How Buildings Learn: What Happens After They're Built*. New York: Penguin Books, 1995. 12.

⁷⁴ Brand, Stewart. *How Buildings Learn: What Happens After They're Built*. New York: Penguin Books, 1995. 2.

history of the hospital they framed, further complicating what is considered worthy of saving.

Artists in the twentieth century pushed the boundaries of innovation with the use of living memory as their medium. The new cultural interpretation of material and visual context elevated the significance of found objects that were often overlooked – the worn, the damaged, the fragmented, and the altered. The work of Joseph Cornell repackaged objects by building new elements from the remnants of the old. The elevation of the ordinary blurred the artist’s role as creator, archivist, and storyteller. Gordon Matta-Clark’s site-specific work recontextualized the ordinary by hyper-juxtaposing it with a new environment; embedded in a new context, the ordinary was granted clarity. The collision between contradictory elements – the old and the new – thus becomes a vehicle to create a new paradigm that questions the contexts of one’s environment.

Case Studies of Adapted Institutions

Walter Reed National Military Medical Center

The former Walter Reed Army Medical Center served as the primary medical facility for the United States Army until its closure and relocation of existing functions in 2011. Located in Northwest Washington, D.C., the 110.1-acre parcel was originally covered by 4.1 million square feet of building floor area and served as the battleground of the Civil War Battle of Fort Stevens. The Walter Reed Army Medical Center Historic District was listed on the National Register of Historic Places in 2015, and consists of forty-nine contributing resources and historic landscape features.

In addition to the 874 to 1073 estimated casualties associated with the Fort Stevens battle site, Walter Reed's connection with pain and trauma extended well into its tenure as a military health facility.⁷⁵ After a series of investigative articles were published by the Washington Post in 2007, reports of patient neglect and poor housing conditions were given national attention; the ensuing cloud of scandal loomed over the campus until its eventual closure four years later.

The initiative of the Walter Reed redevelopment plan is part of a larger citywide initiative to target underserved and underinvested areas through neighborhood revitalization and job creation. After a lengthy community engagement process, a vision for the future use of the site was framed around the community goals of: neighborhood integration, mixed use programming, job and revenue creation, and site activation.⁷⁶

After a century of being walled-off from the neighboring communities, the campus was reintegrated into the city fabric through the placement of strategic open spaces and extended circulation corridors (Figure 24). Similar to Crownsville's proximity to Bacon Ridge, Walter Reed is bounded by a natural woodland setting, Rock Creek Park. Allusions to the natural setting are made throughout the landscape with expansive green spaces and informal placement of trees to suggest a park-like setting. Several open space typologies were used to reinforce the sense of community integration including, amphitheaters, water features, pedestrian features, urban

⁷⁵ Wilcher, Seth. "Walter Reed Army Medical Center (WRAMC) Historic District." National Register of Historic Places Inventory/Nomination Form. Parsons, Washington DC, September 2014. <https://planning.dc.gov/sites/default/files/dc/sites/op/publication/attachments/Walter%20Reed%20FINAL%20NOM%20SIGNED%20BY%20KEEPER.pdf>

⁷⁶ *The Redevelopment of Walter Reed: A Primer*. Report. 2014. http://www.walterreedlra.com/wp-content/uploads/2014/05/The-Redevelopment-of-Walter-Reed_A-Primer.pdf.

agriculture, courtyards, gardens, and heritage trails. An integrated mix of residential, retail, educational, health, hospitality, and cultural related uses was also included to maximize the economic impact of the site.

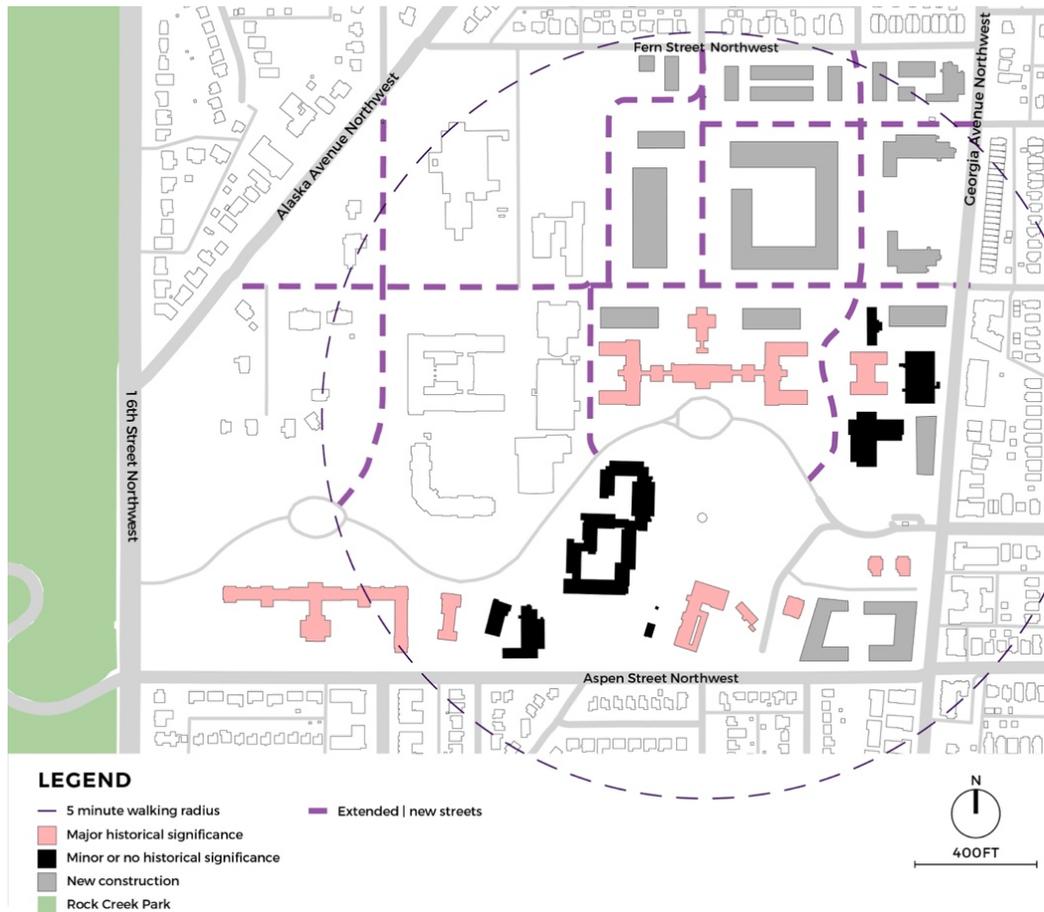


Figure 24 Diagram of Walter Reed's reuse master plan
(Source: Author's work)

Rebranded as the Parks at Walter Reed, the one-billion-dollar investment plan positions the former flagship medical center as a major economic catalyst for the Washington, DC metropolitan region. The 66-acres that were delegated to the community development include 3.1 million planned square feet of mixed-use development, including 190,000 square feet of retail, 325,000 square feet of office

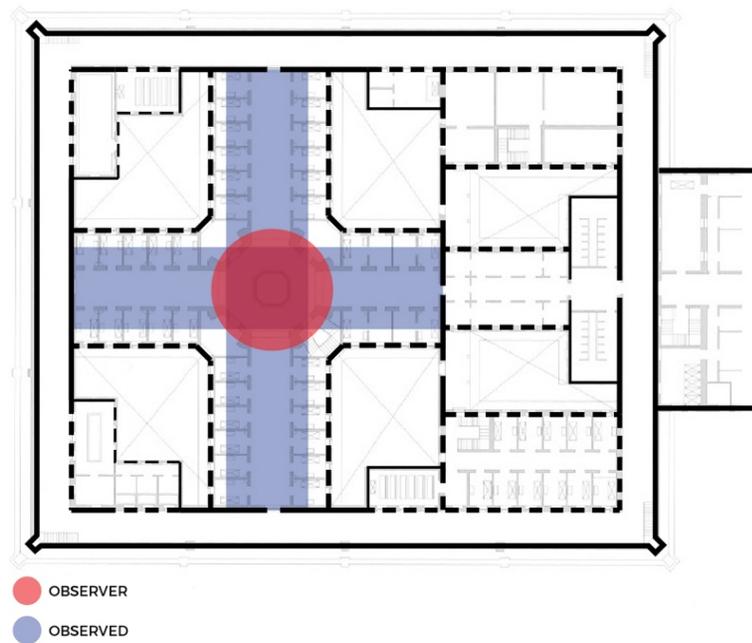
and medical spaces, and 20,000 square feet of cultural uses. Twenty percent of the more than 2,000 dwelling units will be reserved for affordable housing. Framed as a city gateway between the old and new, the assortment of programs is thoughtfully balance historic and new building fabric to honor the legacy of Walter Reed.

Lecrác - Centro Cultural Antigua Cárcel

The city of Palencia, capital of the Palencia province, lies in the northern region of Spain. Its rich and layered history spans millennia, beginning with Celtic occupation and transitioning between Greek, Castilian, Moorish, and Spanish influence as the centuries progressed. The nucleus of the city matured and evolved largely within the confines of the medieval city walls well into the nineteenth century. On July 2, 1891 Direct General Don A. Hernandez Lopez signed the approval for the construction of a new penal institution, located approximately half of a mile southeast of the ancient city wall. Seclusion and distance from urban development were leveraged as tools to ensure public safety. The intended function of the provincial prison at the time was to serve as a compliance center for those convicted of common crimes; over a century later its dark legacy would be further stained by the brutal hand of fascism.

The plan of the Antigua Prisión Provincial de Palencia follows the primary principles of panoptic institutional design, a building typology originally developed by English theorist Jeremy Bentham in the late 18th century. The design scheme was predicated upon a rigid system of control and surveillance as a means to efficiently regulate prisoner behavior. Palencia watchmen on duty were stationed at the central

intersection of the four radiating two-story wings, granting them 360° sightlines of cell doors and exterior exits (Figure 25). Individual cells were constructed throughout the cell blocks rather than larger, social group cells, further exercising a sense of control through prisoner isolation. In 1900, five years after the intended opening, the first group of prisoners were transferred to the provincial prison.⁷⁷



*Figure 25 Diagram of Palencia prison's original first floor plan
(Source: Author's work)*

The prison's symbolic presence of dominance and control took a dramatic shift during the Spanish State, the period between 1939 and 1975 during which Francisco Franco controlled Spain under a fascist political framework. Franco's prosecution – and execution – of political opponents, repression of regional heritage

⁷⁷ Asamblea contra el museo y archivo de la policía en Palencia. *La Gran Estafa Palentina. La Gran Estafa Palentina*. 11, [www.dropbox.com/s/h34c0yvndf7c0xp/Dosier ACAMP Palencia.pdf?dl=0](http://www.dropbox.com/s/h34c0yvndf7c0xp/Dosier%20ACAMP%20Palencia.pdf?dl=0).

and language, and censorship of the media established a repressive cloud of authoritative over the entire country. The Spanish provincial prison system model transformed from operating primarily preventive detention centers to facilitating overcrowded and inhumane depositories for the resistance.

For nearly four decades, the records – and voices – of the opposition were deliberately destroyed by those in power. The tangible traces that remain, including the remnants of the Palencia Prison, carry the burden of exposing the ephemeral scars of history steeped in pain and shame. In 1997, the remaining prisoners in Palencia were relocated to a more modern facility, and the prison was officially shut down after nearly a century in service.

The Palencia City Council announced a public contest in 2005 to turn their vision into a reality. In 2006, the project was awarded to Madrid-based applicants Angel Sevillano and Jose M. Tabuyo of EXIT Architects in collaboration with Eduardo Delgado Orusco. On July 1, 2014 Lechrác (prison spelled backwards in Spanish) Centro Cultural Antigua Cárcel, was finally opened to the public.

The prison's accessibility and opportunity to cater to community needs was strengthened by its proximity to housing and commercial traffic along the major city thoroughfare, Av. Vallalodid. The primary function of the foreboding masonry that surrounded the prison was to keep the public out; branded as a future civic center, it was imperative for the architects to modify the enclosure – physically and metaphorically – as means to invite the public in (Figure 26).

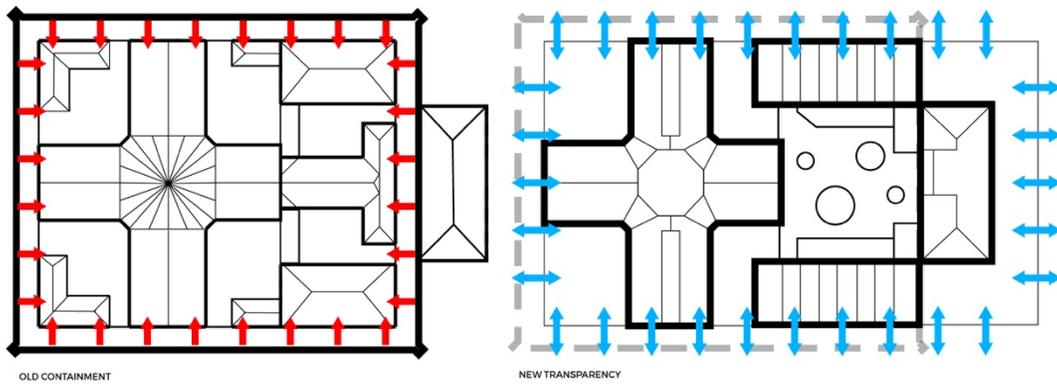


Figure 26 Palencia prison's treatment of the wall through concepts of containment and transparency
 (Source: Author's work)

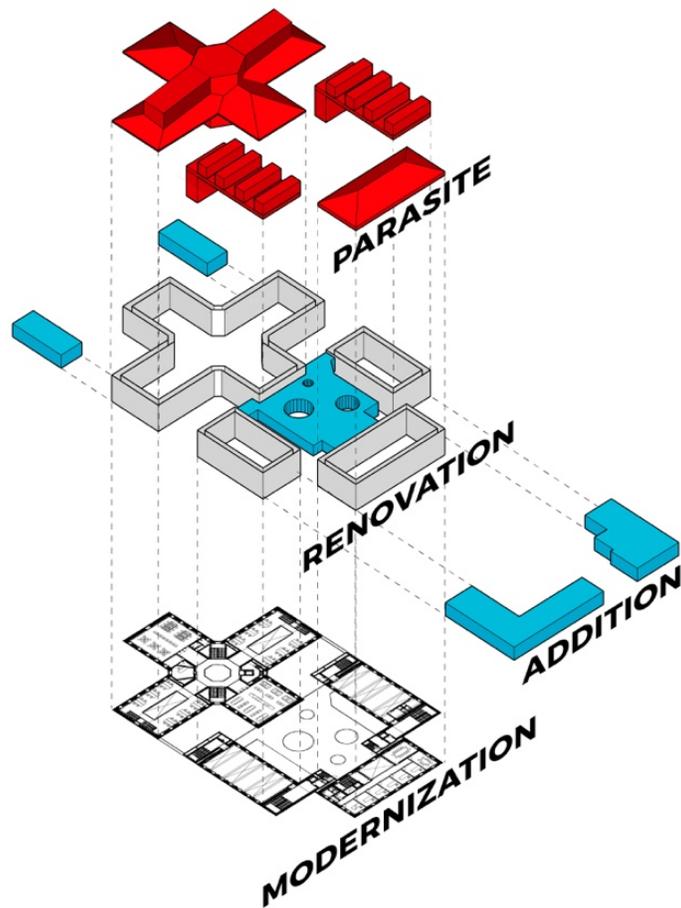


Figure 27 Palencia prison architectural intervention process
 (Source: Author's Work)

The full extent of the architectural intervention consisted of a series of restoration, modernization, and addition processes, as demonstrated in Figure 27. The shell of the building was kept and restored in reverence to its status as a cultural asset. The interior was completely stripped of failing slabs, roof tiles, metal enclosures and interior partitions. New slabs, roofs, and pavilions were added to improve user circulation and daylighting.

The pervading big idea to positively change the public perception of the institutional building was explored mainly through transformations in plan and massing. There is a striking disconnect in the architects' treatment and modification of the original building between the interior and exterior. By completely stripping the interior of all references to its former uses and replacing it with a white washed and sterile interior, the interior intervention fully dominates the identity of the original building. On the exterior however, the zinc and glass additions act as a parasite to the existing brick shell, implying a sense of dependency through a meaningful recognition of the past. The architect's intent to highlight the old and the new by contrasting the materials further heightens the spatial and contextual awareness that is lacking on the inside.

It is necessary to acknowledge that physical interventions are by no means the only way to change a site's public perception. The sense of ownership that pervades those personally tied to the suffering that occurred within the walls of the prison greatly contributed to the public objection that followed a 2014 update to the project: the prison wings that were initially reserved for a community library would now become the Police Documentation Center. Artifacts including police uniforms,

archival photographs, tools, would be put on public display in order to retell the history of the Police Force. Rather than honor the memory of those that suffered within its walls, the new and improved prison would immortalize the memory of those that caused their suffering. The 30-year lease covered over 21,500 square feet, or approximately 36% of the total gross square footage. The City Council of Palencia argued the public museum and archive would “help improve the dissemination and knowledge by citizens of the police function with the consequent positive impact on the city and the residents of Palencia.”⁷⁸

At its core, the Antigua Prisión Provincial de Palencia was designed for control. Control of behavior. Control of willpower. Control of humanity. The benevolent transformation of the former institution into a community resource, while ambitious, fails to fully address the needs of the community it serves. It remains to be seen how the future usage of Lecrác will leverage its historical roots to create a place full of life and meaning that belongs to the people of Palencia, rather than those in power.

⁷⁸ Borrador del Acta de la Sesión Ordinaria Celebrada por el Excmo. *Ciudad de Palencia*. 15 May 2014.

Chapter 6: Memory as Artifact

Sites of Consciousness

When approaching sites heavily weighed down by emotional gravity, one is faced with the physical scars of time and the ephemeral scars of history. Heritage sites interpret these scars to establish roots to the past, but an important question is raised when the scars make us uncomfortable. Should the price of moving on be at the expense of conveniently forgetting portions of our history? The rising global interest in sites of consciousness suggests people are not willing to bury the uncomfortable past; on the contrary, they are willing to travel across the world to confront it.

Memory is a series of negotiations between warring values, perspectives, and power. These negotiations often take place between users; however, it is possible for these negotiations to be an entirely internal process as well. Users that confront the tangible remnants of history engage in an intimate relationship between the experience and the self. Self-consciousness, including the double consciousness first explored by Du Bois, becomes exposed and malleable as memory and understanding become closely intertwined. James E. Young captures the precarious relationship between time and personal recollection by relegating it as a “fragile calculus of remembering and forgetting, a constant tug and pull between memory and oblivion.”⁷⁹

⁷⁹ Young, James Edward. *The Stages of Memory: Reflections on Memorial Art, Loss, and the Spaces Between*. Amherst: University of Massachusetts Press, 2016. 16.

Françoise Choay, the French architectural theorist, argues the relevance of the hospital as a ‘monument’ is intrinsically tied to the ways in it informs memory, and which voices it acknowledges – and suppresses. For those personally affected by the legacy of the segregation and second-class citizenship, the hospital stands as a stark symbol of state-sanctioned repression. If the monument serves as a “defense against the traumas of existence” by revealing our history, as Choay suggests, the monument’s present role in society is much more contentious when the symbol itself is one of trauma.⁸⁰

The resonance of architecture lies in its ability to spatialize political, social, and historical relationships through time. Whether consciously or subconsciously, users of a space have the ability to engage in an outward-facing process of reflection that leads to an inward act of reflection. It is within this reciprocal relationship of give and take that the power of the past has the potential to influence the future.

Commemoration and Memorialization

Consideration must be taken with regards to who the new landscape is for, whose story is acknowledged within, and how those choices reveal greater social priorities and values.⁸¹ Potential users of the space will come with and without any personal connections to the hospital. As marches on and the number of those with direct experiences pass on, it becomes increasingly imperative to keep their collective memories alive.

⁸⁰ Choay, F. *The Invention of the Historic Monument*, Cambridge University Press: 2001. 7.

⁸¹ Barnard, Sara Jenny. 2017. “Prison Limits: Intersections of Culture and Imprisonment in Twenty-first Century Spain.” The University of British Columbia.

In addition to respecting the intangible voices and experiences of those associated with the site, caution must also be heeded in terms of how the physical fabric is interpreted. While key features that defined the asylum experience, such as tarnished surfaces, barred windows, and restricted views, are able to tangentially communicate the experience of life within the hospital, elevating the prominence of these elements might actually detract from the overall goals of commemoration and remembrance. The potential of romanticizing the innate beauty associated with the age value of the site comes at the risk of fetishizing the narrative of loss and trauma. A misaligned attempt at a design intervention could bring the hospital full circle in attracting morbidly curious visitors seeking a voyeuristic experience, similar to the crowds that peered through the gates of Kirkbride hospitals in the nineteenth century.

Informal community-oriented memorialization events have been performed on the Crownsville site since its closure. Known as *Say My Name*, community organizers invite members of the community to the Crownsville Patient Cemetery to participate in a ceremony that honors the patients that time had forgotten. Based on Janice Hayes-Williams's archival research that examined Anne Arundel county death records and death certificates of individuals that died in Crownsville during the early to mid-twentieth century, a database has been compiled of potential patients buried within the cemetery grounds. During the ceremony, a song is performed with a call and response portion that invites participants to say the name of one of the patients in the database. In life, the patients were stripped of their identity and reduced to a number; In death, their dignity is reclaimed through the voices of loved ones and strangers alike.

African American Preservation

The twentieth century was subject to a noticeable shift in focus on what should be considered worth preserving. No longer are grand symbols of white wealth, such as Washington's Mount Vernon Estate, seen as the strict model for preservation ideologies. Attention has increasingly been redirected to vernacular and architectural inconspicuous resources that fail to meet architectural significance standards; however, their cultural contributions to the historical narrative are nevertheless worthy of recognition.

Over a century after the National Association of Colored Women launched a successful grassroots campaign to save Frederick Douglass' Cedar Hill home in 1917, the Obama administration continued the NACW legacy of using conservation practices, the art of storytelling, and public/private partnerships to empower underrepresented and underserved communities. Between 2011 and 2017, President Obama made thirty-four national monument designations, more than any other president since the executive power was granted by the American Antiquities Act of 1906.

The breadth of President Obama's record-breaking monument nominations began and ended with places rooted in Black activism and achievement: Fort Monroe National Monument (2011), Reconstruction Era National Monument (2017), Birmingham Civil Rights National Monument (2017), and Freedom Riders National Monument (2017). This bookended achievement speaks volumes about the conscious effort of the Obama administration to share the lived, shared experience of African Americans and how these stories shaped the nation.

It is no coincidence that resources associated with marginalized communities, particularly African Americans, fall within the new generation of preservation designations. As evidenced by Crownsville's history, Black resources often faced limited access to initial investment, considerable spans of deferred maintenance, and increased levels of antipathy from those in positions of power. As such, many of these resources have been lost to time; those that remain have either been adapted beyond recognition or remain in severe states of disrepair. By illuminating the forgotten and unrecognized collection of places and stories associated with people of color and the Black experience, a critical gap in the country's cultural narrative can be filled to reflect the perspectives of all Americans.

Memorial Case Study

Oregon State Hospital Memorial

Founded in 1862, the Oregon State Hospital continues to operate as a public psychiatric hospital, however the original building fabric has experienced extensive demolition and renovation. The controversial 2004 discovery of 3,500 copper urns that contained the ashes of former patients, staff, and residents of Salem, served as a catalyst for campus renewal. Building 60, the former pestilence house and morgue, was designated as the future memorial site to the deceased. Ten years after the remains of the patients were uncovered, the new intervention transformed a difficult site associated with neglect into a public memorial defined by dignity and simplicity. The artists' awarded the design commission, Lead Pencil Studio, placed human experience above all else with the following statement:

This is not a design problem or an issue of abstraction...or aesthetics. It seems to us that this is an issue of emotional alchemy; the opportunity to accept specific human experience and provide the emotional context for individuals to create personal transformations.⁸²

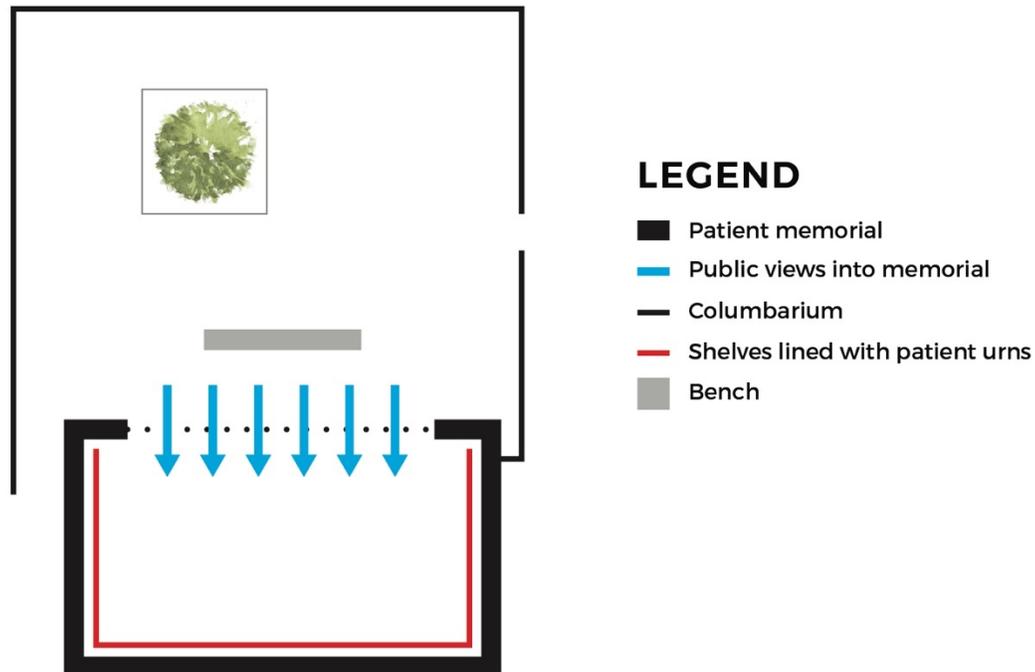


Figure 28 Site diagram of Oregon State Hospital Memorial
(Source: Author's work)

Originally built in 1896, the restored Building 60 is not open to the public for security reasons, however visitors are encouraged to look through a wall of Plexiglass at the interior installation. Just beyond the transparent barrier, visitors are confronted by shelves of the oxidizing copper urns that were rediscovered by State Senator Peter Courtney in 2004. Laid out sequentially according to the original numbers on the urn, the illuminated installation serves as a sobering reminder of a dark past. Urns that

⁸² Oregon Arts Commission. *Oregon State Hospital Memorial*. Accessed October 9, 2018. <https://www.oregon.gov/oha/osh/Documents/OSH-Memorial-Booklet.pdf>.

have been claimed by relatives leave a gap in the sequence – a symbol of a reunited family.

The memorial's exterior courtyard traces the footprint of the former crematorium that was attached to Building 60. During the memorial's construction, the ashes of the deceased were transferred from the degraded urns to new ceramic vessels that were placed into a columbarium wall. Each slot in the wall is engraved with a name, birth and death dates (if known), and the original number on the copper urn. Similar to the copper urn installation, relatives that claim the cremains of the deceased leave empty spots in the wall; in time, the memorial will continuously be physically altered with each reunited family. Serving as the courtyard's enclosure, the columbarium provides a sense of privacy and stillness in an otherwise active hospital campus.

This living memorial stands as a humble – and powerful – testament to the human experience. A mutual exchange of memory and understanding for visitors, in addition to an exchange of closure and cremains for family members, allows the memorial to facilitate a continuous dialogue on loss, dignity, and progress. While the final resting place of the deceased may be simple in form, the sanctity of the site and the story it has to tell speaks volumes.

Chapter 7: Design Approach

Values

The ability to ascribe a value to an object, a person, a moment, or a place in time suggests the capacity to perform a routine cost-benefit analysis in which there are clear winners and losers. The amorphous nature of cultural heritage, with values ranging from the sociocultural (age, beauty, spiritual, political, etc.) to the economic (market and nonmarket values), renders the simplicity of value assessment to be implausible. The complexity of Crownsville's tangible and intangible heritage, in addition to ongoing external pressures that currently affect the fate of the site, results in an amalgam of symbiotic, competing, and often conflicting values.

Traditional methods of ascribing value in conservation planning were firmly rooted in a subject's relation to the past. To be the site where General Washington once laid his head was long worthy of admiration from both the general public and Hollywood screenwriters alike. However, as the preservation field evolved, so too did our ability to analyze through a critical lens that expanded to include shifting contextual and sociocultural aspects of the site in question. While not quite as clear as a character defining feature, these aspects of the site are nevertheless integral to weaving the full story; as such, the quality of storytelling is just as imperative as the preservation of the physical artifacts that remain.⁸³ The following identification of

⁸³ Mason, R. "Assessing Values in Conservation Planning: Methodological Issues and Choices." In *Assessing the Values of Cultural Heritage: Research Report*, edited by Marta De la Torre and Getty Conservation Institute, 5. Los Angeles: Getty Conservation Institute, 2002.
http://www.getty.edu/conservation/publications_resources/pdf_publications/values_cultural_heritage.html.

values associated with Crownsville State Hospital is meant to be neither exhaustive nor inclusive, but rather indicative of the flexibility and diversity of methods required to develop design strategies and experiential goals that address the values in question.

The sociocultural values that are woven throughout the site's context in both time and circumstance reflect the traditions, habits, and patterns of a collective – albeit one defined by unequal allocations of power. The age, artistry, and beauty of the campus can be readily seen in its stately facades meant to reassure patients and visitors alike that the wellbeing of Crownsville patients was in the protective and well-funded hands of the state. At its peak, Crownsville's idealistic social value was defined as a symbol of hope and progress for a population of Marylanders that had been denied institutional care because of the color of their skin. At one of its lowest points, Crownsville's political value was leveraged as a tool to enforce power structures like in the case of the Elkton Three. The visceral spiritual value that permeates the patient cemetery grounds continues to draw an annual pilgrimage of volunteers to the Say My Name memorial event.

Economic value is primarily expressed as a function of supply and demand – a market price that can be related to a consumer base. Time and again in the proposals that have been floated for Crownsville's future development, the economic value of the land has taken precedence over its cultural and heritage value. A century's worth of built and cultural heritage is wiped away to make room for a sea of parking lots and athletic fields. Crownsville is not alone in this trend; as a society we continue to turn our backs on history in order to move toward a promising bottom line.

Strategy

Land Remediation

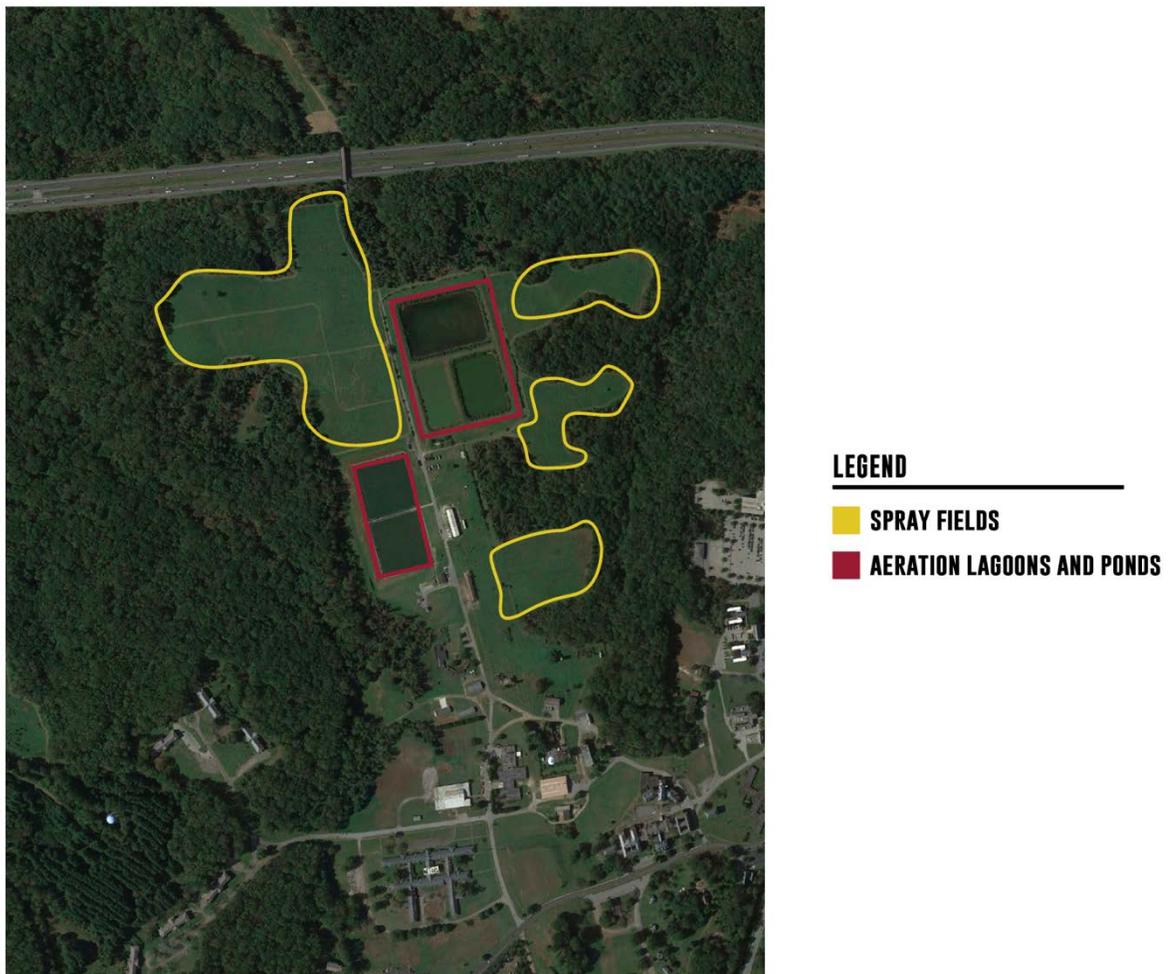
The physical land in which patients, staff, and visitors wandered, cultivated, and managed played a significant role in the overall site's history as an agent of healing. For nearly a century Crownsville essentially operated as a self-sustaining city, and so it has many of the contaminants and pollutants associated with an urban site. Given the sheer size of the campus, the site needs cost-effective solutions to clean up and mitigate the risks from the soils, groundwater, and existing infrastructure of buildings and obsolete power and wastewater treatment.

Traditional remediation technologies such as soil removal, mechanical pumping, and chemical treatment of groundwater can be costly, invasive, and disruptive. Planting, phytoremediation, and stormwater management strategies have the ability to create an integrated landscape system that requires less energy, water, and monetary investment to maintain.

The highlighted areas in Figure 29 emphasize the cleared areas of the landscape associated with the on-site wastewater treatment plant. The aeration lagoons and ponds are used as water retention vessels in which artificial aeration and microbial actions are introduced to the wastewater as part of the treatment process. The treated wastewater is then sprayed over large parcels of the land where it either evaporates, soaks into the soil, or recharges the subsurface ground water.⁸⁴ While this

⁸⁴ Schreffler, C.L., Galeone, D.G., Veneziale, J.M., Olsen, L.E., and O'Brien, D.L., 2005, Effects of spray irrigated treated effluent on water quantity and quality, and the fate and transport of nitrogen in a small watershed, New Garden Township, Chester County, Pennsylvania: U.S. Geological Survey Scientific Investigations Report 2005-5043, 158 p.

recharges the surrounding watershed, it also contributes to increased nitrate, chloride, and other contaminant concentrations in the surrounding soils and ground water. In addition to wastewater contaminants, the Crownsville soil has also been exposed to hazardous elements associated with older building stock, namely lead and asbestos contaminated material, particularly in the regions surrounding the existing building footprints.



*Figure 29 Crownsville site map with current wastewater treatment boundaries
(Source: Google Maps with author overlay)*

Phytoremediation as a restorative design strategy has the opportunity to stabilize the topsoil, mitigate the dispersion of hazardous contaminants in the air, and increase the compromised fertility of the soil. The re-greening of a landscape once defined by its fertile and curative properties not only addresses the environmental damage caused by the hospital's development, it also grants the land the agency to heal itself.

Preservation

The scope of this thesis does not include an architectural proposal that responded to a detailed assessment of existing conditions of any single building in particular. Limited access to architectural drawings, in addition to restricted admission to the site itself, pushed the project towards a comprehensive framework that preserved the cultural landscape as a symbiotic whole than individual pieces.

Nevertheless, for all instances of potential adaptive reuse of existing buildings on the Crownsville site, comprehensive historic preservation and environmentally sustainable principles must be considered in tandem. Although the preservation and restoration of architecturally significant exterior features will be complemented with modern upgrades, sustainable technologies will be integrated where appropriate. The embodied energy associated with the existing buildings support the decision to preserve and restore materials than replace them completely.

In order to improve energy efficiency, obsolete mechanical systems will be replaced with newer technology that achieves higher efficiency benchmarks. A number of the industrial buildings on campus, including the Laundry Building and Marbury Building, have flat roofs which can permit the installation of green roof

systems to further address energy efficiency and mitigate stormwater runoff. If a green roof retrofit is not physically possible, simply painting the flat roofs white can reduce the heat island effect on the building.

Chapter 8: Design Proposal

Existing Architectural Fabric

A major challenge of the present site is filling the existing fabric with economically sustainable programming that is able to reach markets beyond Crownsville's rural community context. The solution to this programmatic constraint is moving state agencies into the existing buildings on-site, as well as continuing to subsidize leases for community service providers and nonprofits (Figure 30). The cornerstone of these relocated agencies would be the Maryland Historical Trust, the state institution responsible for the policies regarding the protection, identification, and recognition of Maryland's historic properties. This symbolic move not only serves to acknowledge the State's role in the history of the campus, it positions Maryland to be progressive stewards of how this history is framed and saved future generations. As of 2018, the Maryland Historical Trust's headquarters is located less than a half mile than the front steps of Crownsville's Administration Building.

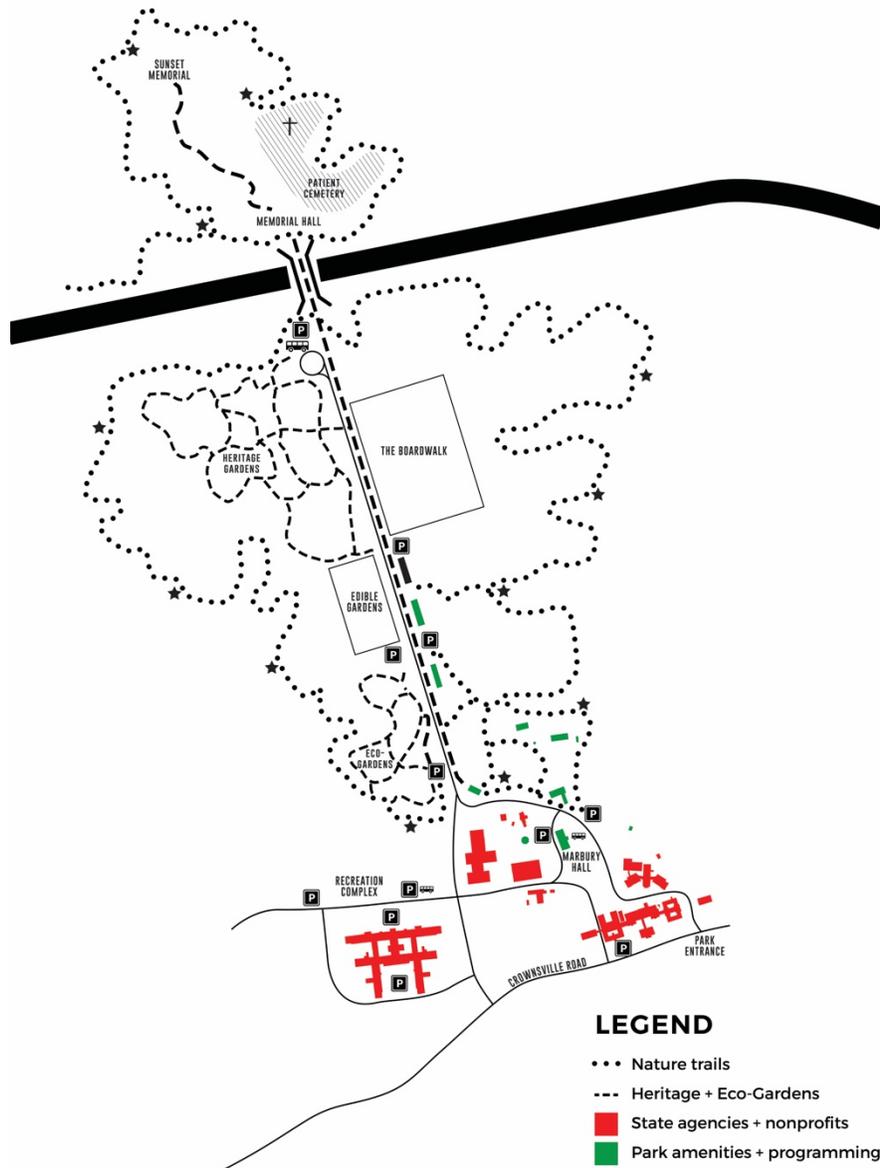


Figure 30 Campus plan with proposed use of existing fabric
 (Source: Author's work)

Healing the Land

The remainder of the remediated campus grounds is reserved for the creation of a new statewide resource in Maryland's Department of Natural Resources:

Crownsville State Heritage Park (Figure 31). The journey of visitors from the park

entrance to its conclusion at Sunset Memorial is crafted to replicate the passage of time through the lens of a patient: initial arrival byway of the patient-oriented brick buildings, introduction to occupation and industry through indoor and outdoor programming, and a final moment of rest at the patient cemetery. By leveraging the expansive phytoremediation plantings required to clean up the site as a public amenity, the campus grounds are transformed into an open-air classroom centered on African American cultural heritage and sustainable practices.

Nature Trails

The miles of serpentine nature trails that trace the outer topography of the site invoke a sense of serene agency that starkly contrasts the existing axis of strict circulation that regulated patients and staff (Figure 32). Along the nature trails visitors will come across twelve strategically placed heritage markers scattered across the site, in honor of the first twelve patients transferred to Crownsville in 1911 to assist with site clearance. These markers not only serve as wayfinding devices by including informational signage that highlight entangled relationship between patients and the landscape, they also provide moments of rest and admiration for the landscape by literally framing key views for the visitor (Figure 33).

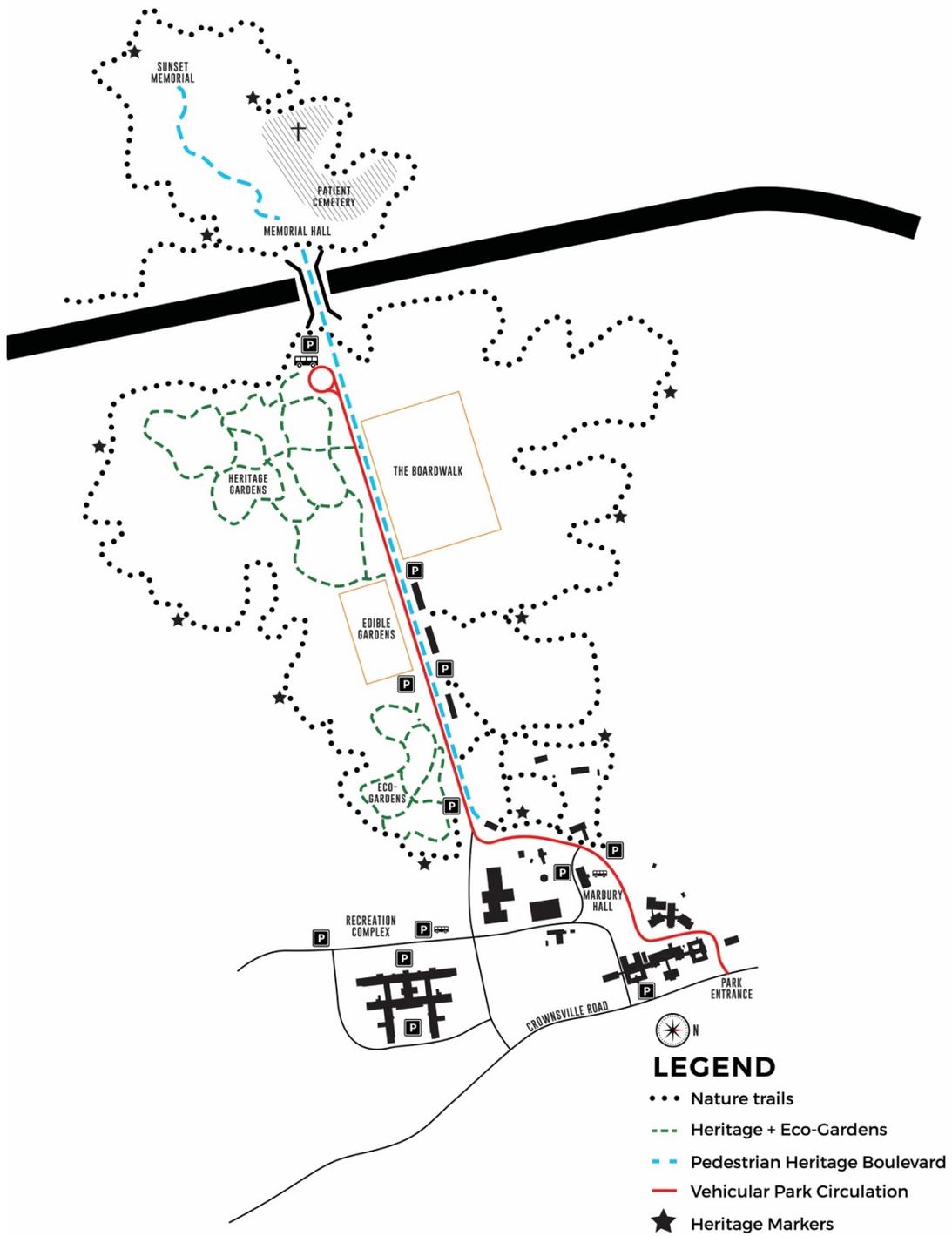


Figure 31 Programmatic site plan of Crownsville State Heritage Park



*Figure 32 A cyclist enjoying the proposed nature trails on the outskirts of the heritage park
(Source: Author's work)*



*Figure 33 Twelve heritage markers frame key views around the site.
(Source: Author's work)*

Heritage Gardens

The planting strategies of native phytoremediation species noted in Figure 34 and Figure 35 coincide with the associated contaminants of the land's present use. Embedded within these remediation zones are a variety of seasonal programming, ranging from outdoor cooking classes in the summer to guided bird-watching tours during the colder months when the trees have shed their leaves.

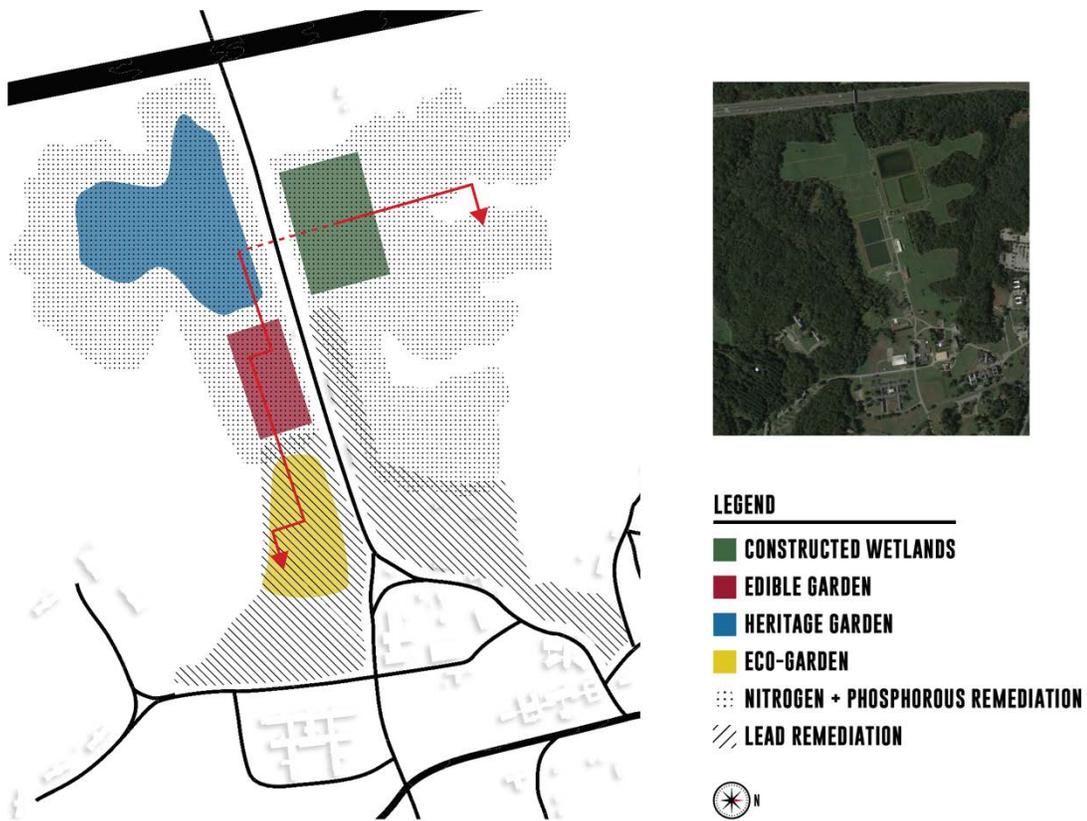


Figure 34 Site plan of planting strategies
(Source: Author's work)

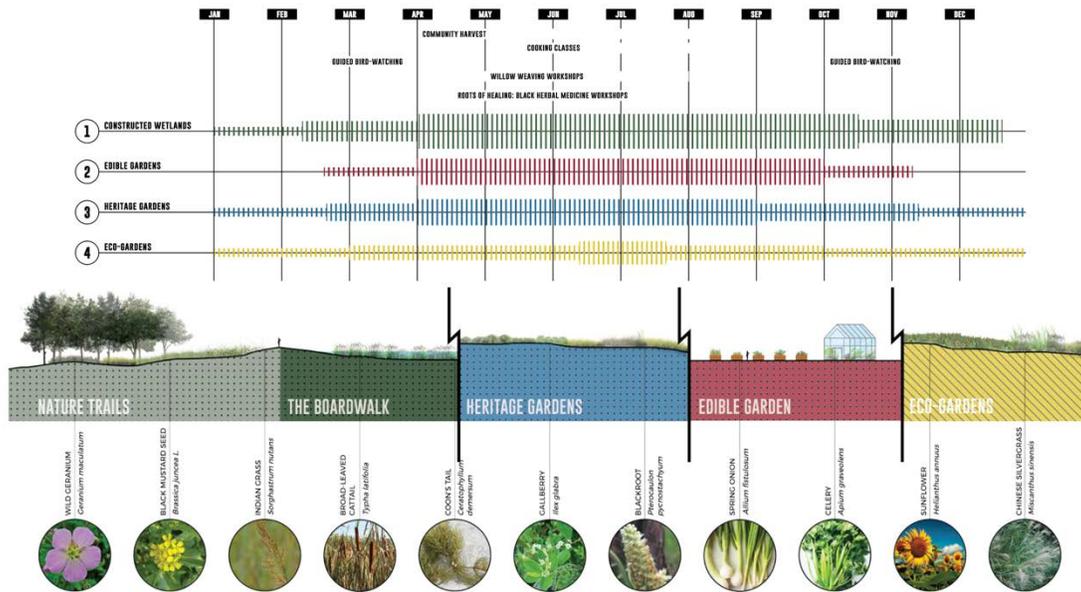


Figure 35 Planting strategies site section and seasonal programming
(Source: Author's work)



Figure 36 A family enjoying the constructed wetlands known as The Boardwalk
(Source: Author's work)

The northern aeration lagoons will be converted to constructed wetlands known as The Boardwalk, allowing visitors to hover above a variety of aquatic species as they crisscross the boardwalk paths (Figure 36). The southern aeration ponds will be converted to edible gardens with above-ground planters that will grow crops associated with Crownsville's historic cultivation. Strategic partnerships with grassroots organizations such as the local food bank can ensure every garden harvest has a sustainable and profound impact on the community beyond the garden walls.

The heritage gardens will feature flora species specifically relevant to African American heritage, including traditional herbs and medicines, along with willow and sweetgrass species that support traditional craft making. Figure 37 highlights a group of visitors attending a willow harvesting and weaving workshop on site. Not only was the willow industry an integral part of the hospital's early industry, the artisanal act of weaving has been cultivated and passed down for over three hundred years in the Black community. Crownsville's reimagined role as a vehicle to pass down cherished cultural traditions to future generations is key to the communal healing process that has escaped the site thus far.

The Eco-Gardens will transform the active beauty of the phytoremediation process into an outdoor classroom with programming and signage that break down the remediation process for the curious visitor. Sprinkled amongst the gardens will be natural playscapes that will provide genuine moments of recreation and stimulation that were routinely denied to patients (Figure 38).



*Figure 37 A group of park visitors attending a Willow Weaving Workshop
(Source: Author's work)*



*Figure 38 Children enjoying the natural and interactive playscapes located in the gardens
(Source: Author's work)*

Telling the Full Story

Memorial Hall

As the visitor meanders through the site along the heritage boulevard axis, they eventually arrive at the pedestrian bridge that crosses Interstate 97 and transitions them into the sacred cemetery grounds.

Mental health is an issue that makes most of us uncomfortable and because of this we tend to distance ourselves. We distance ourselves from anything that tangentially approaches the topic of mental illness, and that includes the memories and voices of those most affected. Whether the identities of patients were stripped away in the form of numeral demarcations on their grave markers, or with a literal black strip across their face in newspaper publications, it is important to remember that these patients are also people and each of them have a story worth preserving.

The personal accounts of Crownsville patients such as William H. Murray, the Elkton Three, and Lucile Elsie Lacks, daughter of Henrietta Lacks, reveal the fact that Crownsville lies at a much broader intersection of racial injustice, social activism, and disempowerment that extends far beyond the campus boundary. Memorial Hall will serve as a venue for tying these resonant themes together while inviting visitors to see the person beyond the diagnosis (Figure 39).



Figure 39 Procession towards Memorial Hall
(Source: Author's work)

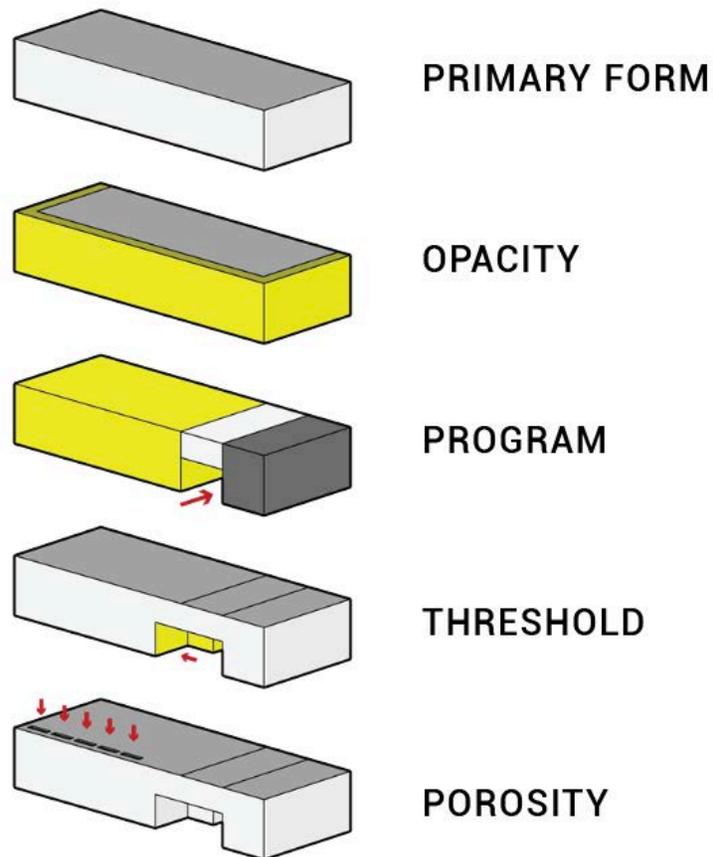
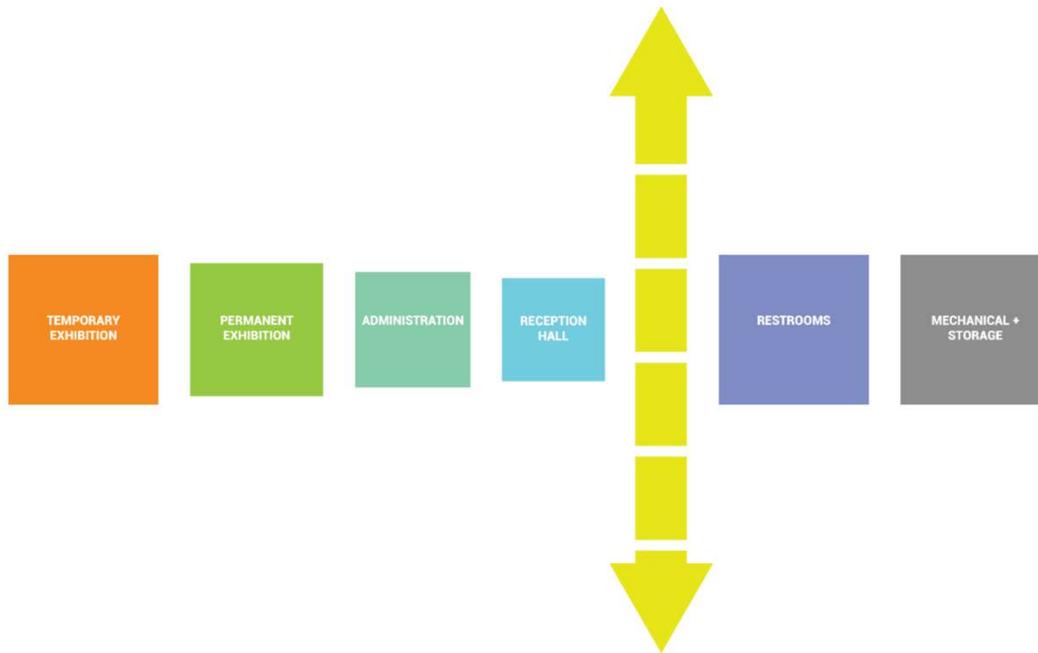


Figure 40 Parti development of Memorial Hall
(Source: Author's work)

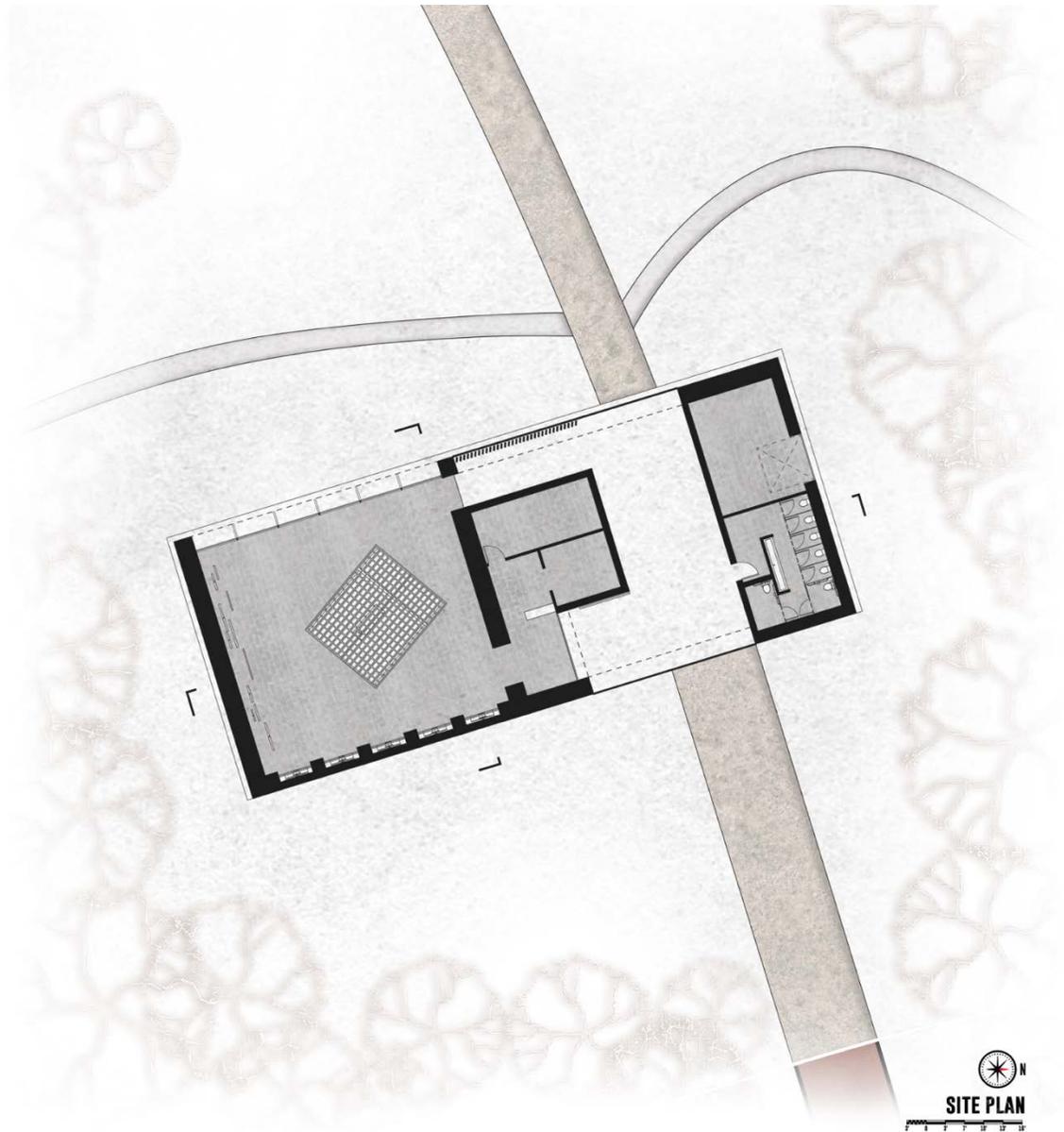


*Figure 41 Programmatic diagram of Memorial Hall
(Source: Author's work)*

The building itself serves as a literal threshold into the sacred cemetery grounds and is grouped into six major functions as noted in Figure 41. The functions flank the main axis, creating optimal views to the grounds, access to natural daylight, and optimize internal connections. In reverence to the sacred land, all of the functions are compressed linearly into a modest and practical footprint (Figure 42).

The simple and quiet facades are intended to be read as secondary to the surrounding landscape (Figure 43). The material palette of concrete and wood is referential to the historic connection of patients to concrete masonry construction and the dense woodlands. This portion of the site is not open to vehicular access, however the main thoroughfare through the building allocates enough space to accommodate any routine maintenance vehicles that need access for landscaping and site

maintenance. In addition to a small physical footprint, the carbon footprint of the structure is meant to be as minimal as possible; as such, operable windows on the east and west elevations allow for cross ventilation during Maryland's hot and humid months, while radiant flooring heats the space during the winter season (Figure 44).



*Figure 42 Plan of Memorial Hall
(Source: Author's work)*

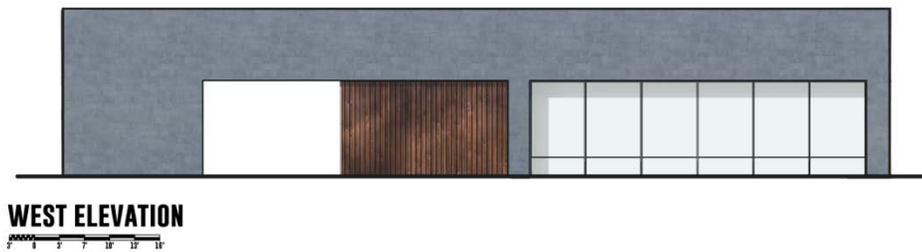


Figure 43 East and West elevations of Memorial Hall
(Source: Author's work)



Figure 44 Lateral and longitudinal sections of Memorial Hall
(Source: Author's work)

The anchor of Memorial Hall is the main exhibition hall. Within this safe space visitors will ground themselves in the emotional weight of their surroundings by engaging with exhibit materials specifically tailored to tell the personal story of a patient whose life was touched by Crownsville's legacy. Along the east wall, carved out chapel-like spaces allow for natural light to filter through roof openings and cascade over the wall installations (Figure 45 and Figure 46).



*Figure 45 Perspective of east exhibition wall
(Source: Author's work)*

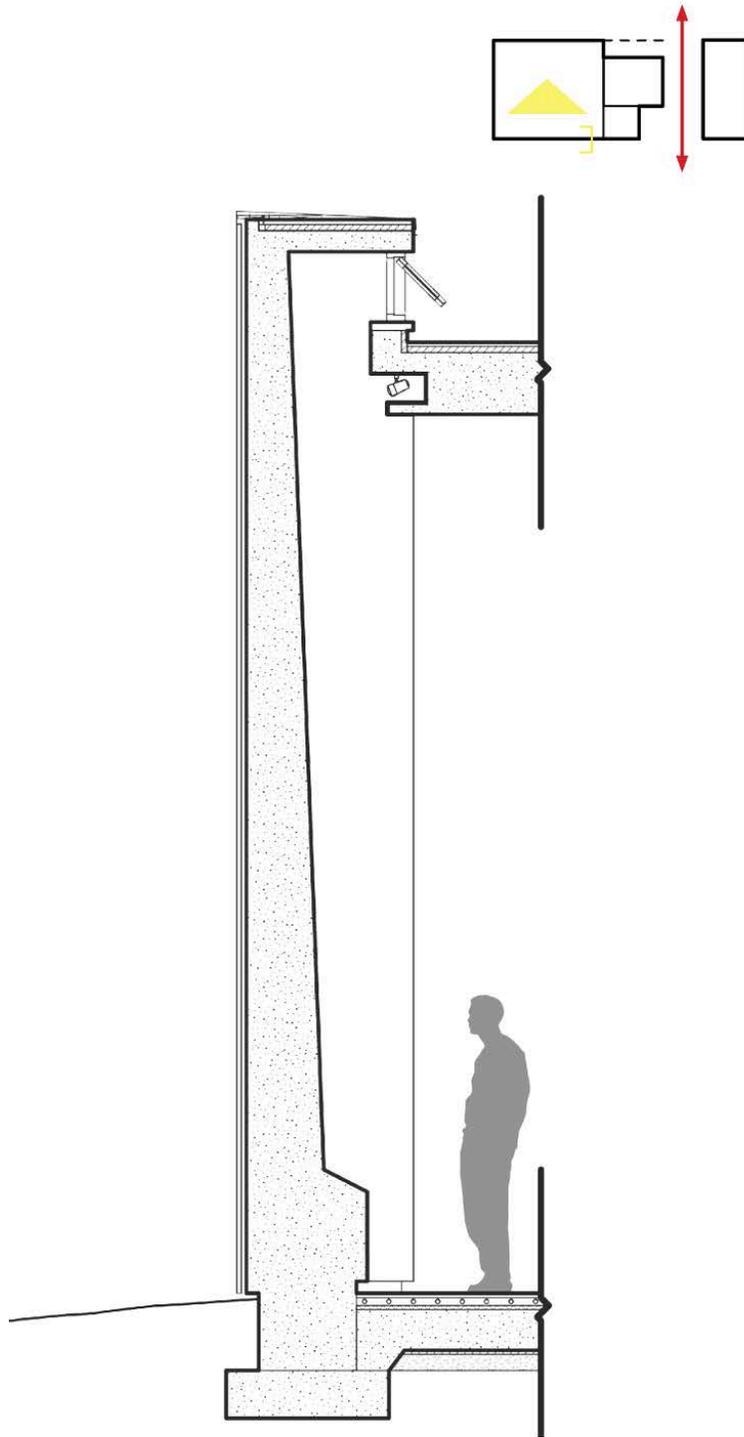
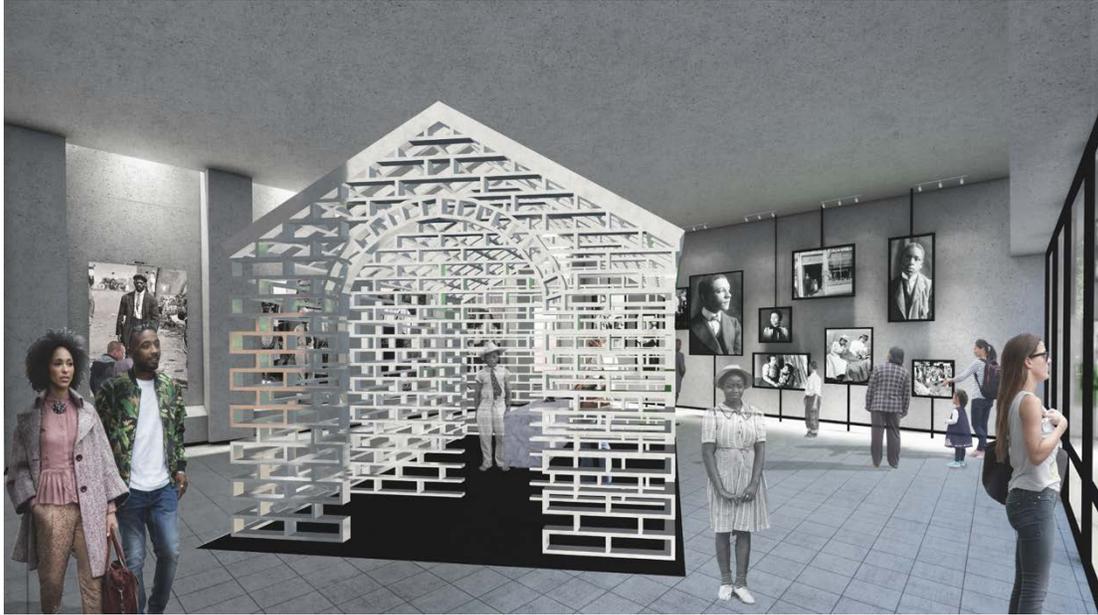


Figure 46 Section detail of east exhibition wall
(Source: Author's work)



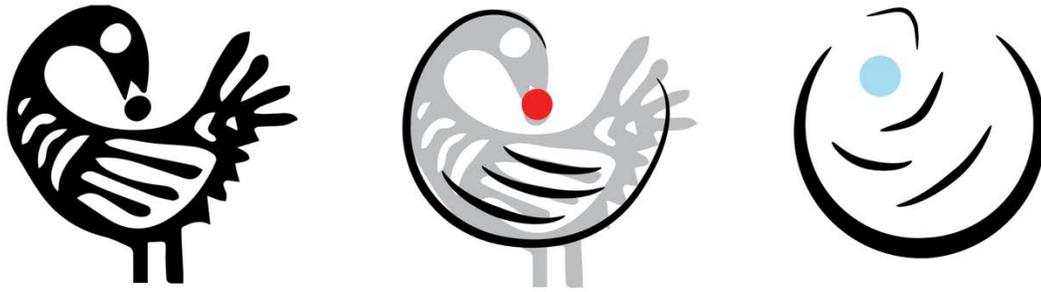
*Figure 47 Interior perspective of morgue installation
(Source: Author's work)*

As visitors circulate the space, they are confronted with a scaled replica of the concrete morgue located closer to the entrance of the park (Figure 47). As the sun moves across the sky throughout the day and illuminates the room through the large reveal window, the shadow play of the morgue serves as a continuous marker of the passage of time. Within the powerful paradigm of life and death, visitors are able to empathize with the forgotten by retracing their footsteps to the other side.

Sunset Memorial

Within the African diaspora there is a concept known as “Sankofa” which literally translates to go back and fetch it in the Twi language of Ghana. The Asante Adinkra symbol that typically represents the word is of a bird with its feet firmly planted on the ground with its neck turned backwards. Essentially, in order to move forward, one must be able to acknowledge and embrace the past. This symbol, which

so succinctly captured the spirit of Crownsville’s preservation efforts, became the basis of design for the Sunset Memorial (Figure 48).



*Figure 48 Sankofa symbology and Sunset Memorial parti
(Source: Author's work)*



*Figure 49 Site plan of Sunset Memorial
(Source: Author's work)*

Perched on a high elevation point just west of the patient cemetery grounds, the memorial is intended to both physically and symbolically uplift the names of the patients presumed to be buried in the on-site cemetery. Along the wall of names are

cut outs to reinforce the design strategy framed views of the surrounding landscape (Figure 52). One final moment is spent at the heart of the memorial, which serves as a gathering space for conversation, reflection, and celebration, before turning back to the cemetery and towards a history that need not be lived again (Figure 53).



*Figure 50 Perspective of Sunset Memorial approach
(Source: Author's work)*



*Figure 51 Wall of Names featured in the Sunset Memorial
(Source: Author's work)*



*Figure 52 Gathering space located at the heart of the memorial
(Source: Author's work)*



Figure 53 Perspective of the patient cemetery grounds (Source: Author's work)

Chapter 9: Conclusion

All too often, the price of moving on is repressing history that makes us uncomfortable. The stories of Crownsville, as shameful as they are, matter. This thesis will allow the public to uncover those stories as they engage with the remediated grounds of the former institution. By addressing the tangible, intangible and environmental elements of the past, Crownsville will serve as a model of preservation for the future. Although it was founded to be a place of healing, historical records have shown time and again it strayed from that path. Justice Brandies once said, “sunlight is said to be the best of disinfectants.” It is time for Crownsville to see the light and sense of healing it was once promised.

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