

“GONE TO MILLEDGEVILLE”: NORTHEAST GEORGIA WOMEN AND THE GEORGIA
STATE SANITARIUM, 1886-1936

by

LAURIE JANE VARNER

Under the Direction of Kathleen deMarrais

ABSTRACT

This study examined the lives of rural women of northeast Georgia through the prism of the Georgia State Sanitarium. Based on the need to fill a gap in the literature on women from Georgia, this qualitative dissertation examined ninety patient records of women from northeast Georgia who were committed to the Georgia State Sanitarium in Milledgeville and died there between 1886 and 1936. By analyzing these records, the researcher isolated three themes: the prevalence of control and confinement both on the way to and at the Sanitarium, the pervasiveness of poverty among the women and the common losses they endured. In addition to thematic analysis, the author used case studies to form a more textured glimpse of four women who were patients at the Sanitarium. Findings indicated the vulnerability of women during this period in history, the ambiguity of interactions with the Sanitarium, and the disconnect between female patients and their male physicians. Recommendations for the preservation of fragile hospital records are highlighted. This dissertation seeks to fill a gap in the literature by honoring the experiences of the many ordinary women who lived and died at Milledgeville.

INDEX WORDS: Georgia State Sanitarium, Milledgeville, rural women, northeast Georgia,
patient records, hospital archives

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In memory of my father, Aubrey Varner

I am so sorry you couldn't be here to see me "get the damn thing done."

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CHAPTER 1

INTRODUCTION

A little over twenty-two years ago, as an undergraduate at the University of Georgia, I rode in the car with my aunt to visit *her* aunt at Central State Hospital in Milledgeville, Georgia.¹ The elderly woman, who had just turned one hundred, had spent the previous thirty-five years within the confines of the mental hospital. I remember little about meeting her that day or of our visit with her, but as we left to return home, my aunt gestured toward one of the large, brick buildings on the grounds of the hospital campus. “I remember when mama was there,” she declared. I was surprised. Although I never knew my grandmother, who died twelve years before my birth, I paid close attention to all family stories, which were rooted in the rural, upper piedmont area of northeast Georgia. I had never heard this story and was immediately struck with a number of questions.

Why had two women in my family gone to Milledgeville? What events happened that led them to be institutionalized? What did they experience within the confines of the hospital? My questions about my family history, particularly the histories of women in my family who had been hospitalized for mental illness, became the very questions that influenced all aspects of my doctoral studies. The stories of my aunt propelled me forward with more questions. Oral history was the first way I began to get answers to my questions.

¹ This institution was well-known as the primary mental hospital for the state.

Rebecca Sharpless, a historian who interviewed Texas farm women from the early twentieth century regarding their experiences on the farm, argues, “Despite its complicated nature, oral history is probably the most valuable tool for studying the lives of rural people, the single best opportunity to discover the thoughts and motivations of those who will not write their memoirs.” “Without oral history,” Sharpless continues, “their lives might remain absent from the historical record.”² With this in mind, knowing that my heritage is rooted in rural people, I began conducting oral history interviews in 2001.

Sharpless found herself telling the women she interviewed what kinds of things *she* wanted to know, what “sort of work” they were to do in the interviews. But Sharpless writes that between “prodding for details, the interviewees sometimes burst forth in torrents of narrative.” Rather than disregard those spontaneous rivers of memory, Sharpless used “those eloquent words” as the core of her study.³

I had a similar experience as I began the first cycle of interviews in this study. Many upper piedmont women I interviewed spoke about those they knew who had gone to Georgia’s Central State Hospital in Milledgeville. As I spoke with older women about their general experiences growing up, I was surprised when, often without my asking, many revealed more women (and sometimes men) who had been committed to the institution at Milledgeville. The revelations became so commonplace that I was soon no longer at all surprised when my participants divulged (usually in soft voices) their knowledge of the “crazy folks” who used to live nearby. The last thing I wanted to do was to ignore what seemed most important to the women I interviewed. So I listened, and found an acceptance and trust among most of the women I interviewed. Sharpless established rapport easily as

² Rebecca Sharpless, *Fertile Ground, Narrow Choices: Women on Texas Cotton Farms, 1900-1940* (Chapel Hill: University of North Carolina Press, 1999), xiv.

³ *Ibid.*, xiv

well; the mention of her husband's children lent credibility to her as a mother and the experiences her participants shared were so familiar she felt they echoed stories she had listened to her entire life. Many of these early participants and their community were very familiar to me and when they mentioned those they knew who had "gone to Milledgeville," I could share the stories of my relatives as well.

Ellen Hooper was one of the first women I interviewed who not only knew someone who had gone to Milledgeville, she had witnessed circumstances leading up to the event.⁴ Ellen was born in Banks County, Georgia, in 1922. Before she was born, her mother Reba became the primary caretaker for her sister's two orphaned toddlers when her sister died in childbirth. The children's father took work as a hired man. But by the end of 1910, Reba had become the second wife of the widower Loy Garrison, not quite five years after her sister had first married him. Reba and Loy quickly began their own family. By 1929, Reba had borne seven children of her own and was raising them in addition to her sister's two. In 1932, her world fell apart. Loy had a stroke which left him disabled for a year. Her oldest sons quit school to take care of the farm. Then, Reba's baby Fred became ill and died. According to Ellen, "so much had happened and it was just more than she could deal with." Ellen remembered Reba's last days before she traveled to Milledgeville.

Ellen: But when my mama was... I told you about her losin' her mind? They had to send her to Milledgeville? Yeah... I went with her up there [to Lula, Georgia] 'cause she needed somebody to be right there with 'er and it was just she and I there an' poor old thing ever' time the train would go through Lula... it was close to the tracks? She'd get me. Pull me out. "Come on, now, they're comin' to get us, they're comin' to get us!" She had lost her mind after Fred died. Fred, the baby died, when he was three years old. He died and then she was going through menopause at that time and that baby died. He had diphtheria to start with and that went into double pneumonia and then from that it was spinal meningitis. Just within about three weeks' time. It was just that quick.

⁴ Each individual within this study has been given a pseudonym.

LV: How long was she down there?

Ellen: Six months. And, papa went down there and she had gained. She wasn't nothin' but skin and bones when she went down there an' she was wild. as. a. buck. She was nothin' but skin 'n bones just couldn't eat or wouldn't eat or whatever. But when she went down there she stayed six months and when he went to get her she was big and filled out. (Whispered) *He thought she was pregnant!* Boy, now, you can imagine ya know the whole crowd that was there 'n he really thought that had to be what it was! But, she was alright; when she came home, she was mama!

LV: What did the doctors say?

Ellen: Well she had pellagra; that was the main thing. The doctor said she ate cornbread. They thought that's what caused pellagra.

LV: You were with her at home when the trains would come through Lula?

Ellen: I don't know where we's supposed to be goin', but the train was a blowin' it was comin' for us. Every time a train 'ud come that's what she'd do!

LV: What do you think caused it all?

Ellen: It was just the condition she was in at the time. So much had happened and it was just more than she could deal with.⁵

From Ellen I learned the circumstances that precipitated her mother's trip to Milledgeville. I learned the supposed cause of her institutionalization, how long she was there and the circumstances of her return home. But as I continued the oral history work, I began to wonder how many more women had gone to Milledgeville.

Alessandro Portelli defines oral history as "an art dealing with the individual in social and historical context." He defines the oral historian's role.

To search out the memories in the private, enclosed space of houses and kitchens and—without violating that space, without cracking the uniqueness of each spore with an arrogant need to scrutinize, to know, and to classify—to connect them with "history" and in turn force history to listen to them.⁶

Apart from my participants' narratives, I could find little evidence that history had listened to the story of rural women's institutionalization. Clearly, history had not listened to the women I was working with. I could find no literature reflecting their experiences.

⁵ Interview with Ellen Hooper by author, April 8, 2002. Chapter six will explain pellagra in detail.

⁶ Alessandro Portelli, *The Battle of Valle Giulia: Oral History and the Art of Dialogue* (Madison, WI: The University of Wisconsin Press, 1997), viii.

But their stories deserved to be included in the historical record. The more interviews I conducted, the more women astounded me with their stories of institutionalization. Mary Dean was another woman whose mother was committed to the Milledgeville asylum, although she did not admit this until late in our conversation. Mary was born in 1918 and raised in Banks County, Georgia, the daughter of a tenant farmer and his wife. Her family moved twelve times before she married and started her own home. In the Fall of 2003, Mary talked with me for an hour and a half about her family history. Her grandmother, born in Hall County, Georgia, in 1849, lived with Mary's family until her death in 1945. Grandmother Marks bore three children; each was eventually committed to Milledgeville.

Mary: Uncle John was an epileptic and they took him to Milledgeville. And Aunt [John's wife] left and married a Jones and went to South Carolina. They took the two children to the children's home...

LV: You said that John was epileptic. Now, who was John?

Mary: My mama's brother. And he married. And she left with a Jones.

Uncle John was epileptic and went to Milledgeville, and also Aunt Glad, mother's sister, she went.

LV: Was she also epileptic?

Mary: No

LV: What was wrong with her?

Mary: Well she married this man that had been married, he was very dominant. [But] she came back and she was all right!

After looking at Mary's family in an old photo, she quietly added information about her own mother, clearly painful for her to remember.

Mary: My mama spent time there [at Milledgeville].

LV: Really? How old was she?

Mary: I don't remember specific ...

LV: Were you grown?

Mary: I was already married.⁷

⁷ Interview with Mary Dean by author, October 31, 2003.

At the time, I found it remarkable that all three of the siblings had gone to Milledgeville. I began searching for archival evidence to undergird the women's stories. Fortunately, many courthouses in northeast Georgia still have their original lunacy records. In Franklin County, Georgia, the mother for whole or parts of ten smaller counties, even the earliest records from 1845 exist.⁸ So there was an immediate way to check the validity of participants' recollections, with the added bonus of the dates, names and locations included on forms family members had to complete in order to commit a relative.

Census data provided even more information. In 1880, a supplemental schedule for the 1880 Census for Defective, Dependant and Delinquent Classes was taken. Not everyone listed on this supplemental schedule went to Milledgeville, but each person listed on the Census was categorized as suicidal, epileptic, demented, melancholic, or manic. In the years 1850, 1860, and 1930, census records named patients currently in residence at the hospital, providing even more proof of commitment.

Central State Hospital holds important material in patient records. Even before I began my interviews, I visited the hospital in 2001 and secured copies of the patient records of two of the women in my family who had gone to Milledgeville. These records contained the most valuable material of all: the voices of the women themselves, transcribed by medical staff into patient records. My initial plan was to collect enough oral history interviews, patient records, and other archival data so that I could write a dissertation about the emotional culture within one community. Unfortunately, by the time I gained access to the hospital archives, the vast majority of the patient records had disintegrated beyond repair. Of the persons whose records I sought at the time, I was able to find only one.

⁸ Franklin County Loose Records of the LoCourt in the Cases of Lunatic Idiots, 1845.

While scholarship exploring southern women has blossomed in the past decade, too many women of the past remain unknown to us now. Susanna Delfino and Michele Gillespie reflect,

Sandwiched between the tangled worlds of mistresses and slaves lived hundreds of thousands of women in the Old South. These women, white and black, have been largely left out of the historical record. . . . We know too little about the lives of ordinary women in the Old South.⁹

And I would add, we know too little about ordinary women in the post-Civil War South, particularly in Georgia. Fortunately for scholars, elite southern women often left records of their circumstances. But if in studying southern women we generalize from elite to all, we distort the lived experience of the vast majority of women, whose lives were neither refined nor unique. This study seeks to fill a gap in the literature by honoring the experiences of the many ordinary women who died at Milledgeville.

Although institutional studies of mental hospitals abound, the practice of studying narratives within patient records is relatively new and is more common in Australasia, Canada, and the UK than in the United States.¹⁰ With the exception of Peter McCandless, few scholars have made use of patient records within the southern states. No study has used patient records in order to understand the relationship of rural women to mental institutions.

The purpose of this study is to understand the lives of rural women in northeast Georgia through the prism of patient records at Central State Hospital, which was known as the Georgia State Sanitarium from 1897 to 1929. The following research questions guided the work:

⁹ Susanna Delfino and Michele Gillespie, *Neither Lady Nor Slave: Working Women of the Old South* (Chapel Hill: The University of North Carolina Press, 2002), 1- 3.

¹⁰ See literature review

1. What can we learn about northeast Georgia's rural women through the prism of the patient records of those who died at the Georgia State Sanitarium from 1886-1936?
2. What kinds of circumstances precipitated the institutionalization of women from northeast Georgia?
3. What role did the Sanitarium play in the lives of northeast Georgia women?

There are many things this study is not. This study is not about the causes of insanity. It is not an argument for whether the hospital was or was not effective. This study is not a critique of medical personnel or the hospital itself. Neither is it an analysis of medical conditions or treatments. This study is an attempt to understand rural women of northeast Georgia through the prism of the Georgia State Sanitarium. There is no other study that has done so. By making visible the information contained in the patient records, this study seeks to rectify an historical oversight: the experiences of rural women who lived and died at Milledgeville.

Chapter Two examines the development of mental institutions in the United States and reviews the literature surrounding mental institutions. Chapter Three provides a context on Northeast Georgia and the Georgia State Sanitarium from its inception to 1948, when a perceptive journalist toured, photographed and recorded his findings at the hospital. Chapter Four presents the methods used to collect and analyze data for the study. Chapter Five examines the reality of confinement for the women. Chapter Six explores the reality of poverty in the lives of the women. Chapter Seven examines the women's experience of familial loss. Each of chapters five, six and seven are accompanied by case studies. Chapter Eight presents concluding reflections, connections to literature and implications for further

study. Appendices include examples of patient record documents and an appeal for the preservation of fragile patient records.

CHAPTER 2

CONTEXT AND LITERATURE REVIEW

A Context of Mental Institutions in the United States

Before the advent of the asylum, caring for the insane was “a domestic responsibility.”¹¹ But as families and communities felt the stress of caring for their insane members, they turned to measures of restraint to manage their care. These measures of restraint included closets, cellars and outbuildings. Ultimately, insane persons were confined in prisons and poor-houses before being sent to the madhouse. Among the earliest and most well-known institutions for the insane was Bethlem, located in London; better known by its colloquial name, Bedlam. Its history reaches back to the fourteenth century. The history of madness in Europe and of European madhouses is vast, but this section will focus primarily on institutions and institutionalization in the United States.

The Mentally Ill in America

David Rothman, Nancy Tomes, and Gerald Grob provide varying accounts as to exactly how the transformation from domestic care to institutionalized care occurred within the United States. In his treatise, *The Discovery of the Asylum*,¹² David Rothman chronicled the rise of asylums not only for the mentally ill, but also for criminals, the poor, and orphans. During the pre-Revolutionary era, colonists had little faith in the rehabilitation of people exhibiting deviant and dependent behavior; they simply saw such behavior as related to sin. Those who exhibited deviance were displaying evidence of Adam’s fall. Those who were orphans or poor were the fruit of sinful behavior; their situation was deemed the will of God in the minds of those who

¹¹ Roy Porter, *Madness: A Brief History* (Oxford University Press, 2002), 89.

¹² David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Back Bay Books, 1990).

ascribed to Calvinist doctrine. Lunatics who seemed harmless were left alone to wander about, fending for themselves. Beyond the intervention of family or community, little was done to offer them help. But colonists felt increasingly threatened and uncomfortable in the presence of the insane. As it developed, the asylum would fill a “vital function, responding to a general anxiety about social order and a particular anxiety about one or another disorderly individual.”¹³

Initial Wave of Asylum-Building in America

The first hospitals in America to fill this void developed during the colonial era. The Pennsylvania Hospital, established in 1751, was a response to a petition written by Benjamin Franklin (in part) on behalf of a fearful community regarding its lunatic members. The Pennsylvania Hospital initially kept lunatics “confined in barred cells in the basement of the building.”¹⁴ In 1773, Williamsburg, Virginia followed suit in expressing its fear of dangerous lunatics by creating an entire hospital, the first in the United States, devoted to their care.

Scholars differ in explaining the reasons for the development of early therapeutic asylums. David Rothman credits Enlightenment thought, which arrived in the United States after the Revolution, for the initial enthusiasm for the creation of asylums. In the wake of the Enlightenment, lunacy and deviance were increasingly perceived as “product[s] of the environment,”¹⁵ and less as God’s will. Historian Nancy Tomes explains the significance of the Enlightenment for asylum creation:

The driving principles of the Enlightenment—that reason is the essence of human nature, that science can explain the universe, *and that society can be continually improved through human effort*—reshaped the conception and treatment of madness over the course of the eighteenth century in England and the American colonies.¹⁶

¹³ Ibid., xlii.

¹⁴ Lynn Gamwell and Nancy Tomes, *Madness in America* (Ithaca, NY: Cornell University Press, 1995), 20.

¹⁵ Rothman, 71.

¹⁶ Gamwell and Tomes, 18-19. Emphasis added.

In addition to the Enlightenment, Gerald Grob also credited the new interest in therapeutic asylums to the “Second Great Awakening—a movement that attempted to redefine the theory and practice of American Christianity in order to make it more relevant to the existing society.”¹⁷ The Calvinist notion of submission to hardship was slowly being replaced with the notion that God would have his followers intervene to help alleviate hardship.

The hardships around Americans seemed to grow rampant. Many people believed American life bred insanity. Lunacy appeared to be on the rise in the United States in the years following the Revolution. Insanity, according to David Rothman, was a product of “the style of life in the New Republic...a startlingly fluid social order.”¹⁸ Life in the United States early in the nineteenth century was unstable and transient. And “since mobility strained every faculty, the price of transit frequently became insanity.”¹⁹

In the wake of the American Revolution, more hospitals opened with wards for the mentally ill: New York Hospital and Maryland Hospital both opened before 1800, by which time, the Pennsylvania Hospital had added an entire new wing for care of the mentally ill.²⁰ The existence of places to house the insane was an improvement for those who had grown fearful of lunatics, but for many years the conditions for those within asylums was largely custodial and crude—made of physical restraint, exposure to dampness and cold, and hopelessness for any lasting improvement.

The Transition to Moral Therapy: Rush, Tuke, and Pinel

The growing problem of insanity combined with waves of revolutionary thought and changing conceptions of Christianity spurred an interest in not only *housing* the insane, but in

¹⁷ Gerald Grob, *Mental Institutions in America: Social Policy to 1875* (New York: The Free Press, 1973) 48-9.

¹⁸ Rothman, 114-5.

¹⁹ Rothman, 116.

²⁰ Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge University Press, 1984), 29.

attempting to rehabilitate them. Benjamin Rush was, at the turn of the nineteenth century, the most prominent physician to work with insane patients in the United States. At Pennsylvania Hospital from 1783 to 1813, he experimented on those within his care as he sought for their recovery. He designed a tranquilizer chair for hyperactive patients, a gyrator mechanism for spinning “torpid” patients, and, according to Nancy Tomes, encouraged “recreation and amusements for patients on the theory that mental stimulation might help them recover their reason.”²¹ He also “advised caretakers to try various psychological tactics to dissuade patients from their delusions and to compel them to behave. . . . Staff members would variously cajole, frighten, or punish the lunatics as if they were recalcitrant children.”²²

At the same time that Rush was working with patients in Pennsylvania, William Tuke and Philippe Pinel were working in England and in France. Their contributions to the growing understanding of the care of insane persons would soon revolutionize America’s asylums. Frenchman Philippe Pinel argued for reform in Paris’ mental hospitals. Pinel, the first *alienist*²³ to link emotion with mental illness, not only “emphasized the importance of the emotional causes of mental disease,” he also “called for more careful diagnosis and observation” of mental patients.²⁴ Pinel championed moral treatment; he “assumed that insanity was a curable disease, given understanding, patience, kindness, guidance, and proper treatment.”²⁵ He was famous worldwide not only for releasing the insane from their chains but for his writings, published at the turn of the nineteenth century. But he was not completely unique in his revolutionary work. In England, similar efforts were being made among Quakers.

²¹ Tomes, *Madness in America*, 32.

²² Tomes, *Madness in America*, 32-3.

²³ French term for psychiatrist.

²⁴ Tomes, *Madness in America*, 37.

²⁵ Grob, 42.

When one of their own was mistreated in the public asylum, Quaker William Tuke established the York Retreat in England to care for those in need of mental rehabilitation. Tuke's Retreat, established in 1796, embodied what would become known as "moral treatment:" a medical regime employing psychological techniques that emphasized the human, rather than beastlike, nature of the insane."²⁶ Patients at the Retreat were unchained, clothed, made responsible for work, expected to eat politely, and to listen at church services. Their cure was aspired to, but was not the only goal of care. "Even when no cure was possible, the Quakers found a measure of success in using moral treatment to get asylum patients to live at the highest level of humanity possible for them."²⁷ By 1813, word of the success at York's Retreat reached the United States and Quakers in Pennsylvania quickly moved to create a similar institution, The Friends Asylum.

Reform

In spite of these initial efforts, growing concern over the inadequate care of lunatic persons consumed the United States. In 1814, journalists found an American sailor who had been committed to Bethlam Hospital in London since 1800. For over ten years, he had been unable to move because he was restrained "in an iron harness riveted to an upright bar by twelve-inch-long chains." Reformers publicized his condition in both America and England and used the reaction of an outraged public to encourage reform.

By 1824, lunatic asylums had opened not only in Virginia (1773) and Pennsylvania (1796, 1817), but in Maryland (1798), New York (1808, 1821), Massachusetts (1818), Kentucky (1824), and Connecticut (1824). Gerald Grob comments, "With the opening of the Hartford Retreat in 1824 the first phase of the movement to establish mental hospitals had come to a

²⁶ Tokes, *A Generous Confidence*, 5.

²⁷ Tokes, *Madness in America*, 38.

close.”²⁸ These early years of asylum-building were a significant precursor for the greater period of asylum-building to come.

Gerald Grob writes that “the establishment of mental hospitals ... was but one phase of the larger thrust toward the creation of public structures for dependent groups.”²⁹ And social reformers began to speak up as more institutions were created. Among the most influential of these was Dorothea Dix.

The Work of Dorothea Dix

A former teacher, Dix was born in Maine but moved to Boston in her mid-teens. She first became aware of the mistreatment of the mentally ill when teaching a Sunday school class to prisoners. She found not only criminals but insane persons within the prison. Horrified at the conditions in which they were kept, Dix began what would become her life work. Several factors prepared Dix for her reform work. She had retired from teaching and inherited money from her family so she was free to devote all of her energies to inspecting facilities for the insane. She was also fortunate to have spent time recovering from illness (possibly depression) in England and had experienced first-hand the moral treatment available there. Finally, she had studied the works of Tuke and Pinel. So when she observed the conditions of the insane inmates of the prison in Boston, she immediately took measures to agitate for change.

In 1843, Dix presented her findings to the Massachusetts legislature and although some found her claims to be overstated, fellow reformers defended her statements. The legislature appropriated money to improve the state’s facilities for the insane and Dix went on to inspect

²⁸ Grob, 80. Peter McCandless argues that the first four public mental institutions in the United States were formed in Virginia, Kentucky, South Carolina and Maryland. He further claims that many historians have focused on institutions in the Northeast and Midwest, rather than those in the South. See Peter McCandless, *Moonlight, Magnolias and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill: University of North Carolina Press, 1996), 3.

²⁹ Ibid., 85.

asylums in other states. The responses to her findings were remarkable. Not only did she visit asylums, she continued to write about what she saw at each institution, to present her findings to each state's decision-makers, to publicize her findings, and then to provide her own expertise in planning the reforms she advocated. Dix soon became the greatest reformer for the insane known in America at the time. By the time she died in 1887, "she had been responsible for founding or enlarging over thirty mental hospitals in the United States and abroad."³⁰

The Explosion of Asylum-Building and Medical Superintendents

David Rothman's *The Discovery of the Asylum* presents a narrative that could be interpreted as the view of the asylum from first resort to last resort. This section will follow Rothman's narrative in explaining the history of mental institutions in America. As Dorothea Dix began her crusade for the mentally ill, officials began making plans to create new and larger environments for the "deviant" in the form of asylums of all sorts: prisons, almshouses, orphanages and lunatic asylums. Each environment was meant to correct the deficiencies of those in need. Of the mental institutions formed in America, the vast majority were created through state legislatures across the United States before 1860 at which time 28 out of the 33 states had built one.³¹ State legislatures repeatedly voted to expend enormous amounts of money in order to fund them.

In 1844, thirteen of the most prominent directors of mental institutions developed the Association of Medical Superintendents of American Institutions for the Insane (later renamed the American Psychiatric Association). These men shared experiences and difficulties endemic to their work, discussed the construction, maintenance and governance of asylums, and began to

³⁰ Grob, 107. My understanding of Dorothea Dix comes not only from Gerald Grob's work, but also from the work of Nancy Tomes and from David L. Lightner, *Asylum, Prison and Poorhouse: The Writings and Reform Work of Dorothea Dix in Illinois* (Carbondale, Illinois: Southern Illinois University Press, 1999).

³¹ Rothman, 76.

develop standards for the profession. The *American Journal of Insanity*, hosted by the Utica State Lunatic Asylum in New York State, published their proceedings. Within the *Journal*, officers exhibited a keen interest in developing an esteemed profession.³²

Superintendents of mental institutions (the psychiatrists of their day) believed that the asylum itself was a *first* resort, the most important and effective weapon in their arsenal.”³³ Because 1840’s cultural climate in America theoretically *created* insanity, institutions meant to cure insanity needed to reject the order of the outside world. “A different kind of environment, which methodically corrected the deficiencies of the community,” explained Rothman, meant “a cure for insanity was at hand.”³⁴ The construction and maintenance of the asylum space and environment *were* the cure for mental illness. Mid-century asylums were rural institutions, meant to provide an antidote to chaotic modern life in the form of a well-ordered agrarian idyll. By 1851, The Association of Medical Superintendents published a document defining *the* “proper asylum architecture.”³⁵

Medical superintendents were confident that a setting which eliminated the irritants [of the outside world] could restore the insane to health ...rather than attempt to reorganize American society directly, they would design and oversee a distinctive environment which eliminated the tensions and the chaos. ...they would try to create—a model society of their own ...to exemplify the advantages of an orderly, regular, and disciplined routine.³⁶

Such routine came about in the form of early rising, purposeful physical labor, and regular, calm meal-times and bed-times, all punctuated by the ringing of bells. The routine “reflected...the strength of a theory that ascribed a therapeutic value to a rigid schedule.”³⁷ By

³² Gamwell and Tomes.

³³ Rothman, 131.

³⁴ Ibid., 133.

³⁵ Ibid., 135.

³⁶ Ibid., 129.

³⁷ Ibid., 145.

sorting patients into groups based upon behavior and by focusing on the ideal of “kindness and good will,”³⁸ early asylums also succeeded in drastically limiting restraint.

But the golden age of asylums was short-lived. The majority of patients did not regain mental health and the asylum became an institution for housing greater numbers of outcasts, rather than an institution for rehabilitating the mentally ill. David Rothman traces the development of asylums from the antebellum to postbellum eras.

By the 1850’s almost every type of asylum was losing its special qualities, and by the 1870’s few traces remained of the original designs. In a majority of mental hospitals the careful balance of moral treatment gave way to custodial care. ... Nevertheless, the growing irrelevance of a rehabilitative program to the asylums’ daily routine did not bring about their dissolution. Despite their faults, they continued to dominate the care and treatments of the deviant and dependent classes...It was not simply a matter of the states being lethargic and economical, and hence unwilling to dismantle the costly structures that they had just erected. Rather, legislators continued to invest in institutions, enlarging existing structures or constructing others. The environmental concepts of the asylum founders at once helped to *promote* and *disguise* the shift from reform to custody. The post-Civil War asylum keeper all too predictably succumbed to the fallacy that in administering a holding operation he was still encouraging rehabilitation, that one only had to keep inmates behind walls to effect some good.³⁹

Ultimately, rather than becoming agrarian idylls, asylums succumbed to the need to respond to ever-growing numbers of patients without much hope for rehabilitation.

“Regimentation, punctuality, and precision became the asylum’s basic traits.”⁴⁰ And by the 1850’s, “the mental hospital was a useful place for locking up lunatics, even without the prospect of a cure.”⁴¹

The custodial qualities of the post-1850 asylums are easily described. The first and most common element was overcrowding and in its train came the breakdown of classification systems, the demise of work therapy, and an increase in the use of mechanical restraints and harsh punishments to maintain order.⁴²

³⁸ Ibid., 151.

³⁹ Ibid., 237-8.

⁴⁰ Ibid., 154.

⁴¹ Ibid., 239.

⁴² Ibid., 265.

Medical Superintendents who were the first to claim the great incidence of insanity's curability were also among the first to renounce those claims. In the 1870's, Pliny Earle, one of the original thirteen Medical Superintendents made an admission:

[Earle] disclosed that the antebellum figures on the number of cures were grossly exaggerated ...the institutions of the 1830's and 1840's had offered patients better care with a greater likelihood of recovery than existing ones. ... He, and other superintendents ... convinced of 'the inadequacy of hospitals to accomplish the desired end,' recommended that the milder cases of mental illness be treated at home. The awe that had once surrounded the institution evaporated. It became a place of *last* resort.⁴³

And yet, lunatic asylums remained "central to public policy. The number of patients swelled and the size of the buildings increased. Once again an institution survived long after its original promise had dissolved."⁴⁴ By the end of the nineteenth century the United States boasted hundreds of lunatic asylums (or Sanitariums, as most were known at the turn of the century). Not until the deinstitutionalization of the 1970's did legislators cease to support their vast hold on the psychiatric care of citizens. By this time, American asylums had struggled for well over one hundred years. The evidence of this struggle was evident not only in legislative debate, but also in the writings of those who encountered American asylums.

As early as the decade of the Civil War, patients and journalists wrote of their experiences in lunatic asylums. Elizabeth Parsons Ware Packard, for instance, wrote of her incarceration during the early 1860's in Jacksonville, Illinois. Packard was committed to a mental institution by her husband without benefit of any trial. After her release, she fought for the rights of those who were accused of insanity. Her work ultimately resulted in the Illinois Bill for the Protection of Personal Liberty.⁴⁵

⁴³ Ibid., 268.

⁴⁴ Ibid., 265.

⁴⁵ Rebecca Shannonhouse, ed., *Out of Her Mind: Women Writing on Madness*, (NY: The Modern Library, 2000).

In 1887, writer Charlotte Perkins Gilman experienced her own incarceration, chronicled in her popular short story, *The Yellow Wallpaper*. And investigative journalist Elizabeth Cochrane, aka *Nellie Bly*, infiltrated the Lunatic Asylum on New York's Blackwell's Island in 1887, masquerading as an insane woman. She described her experiences for the *World* and helped fan the flames of skepticism about any real validity to the mental institution as a place of healing.⁴⁶

The Work of Clifford Beers

But of all of these writings, none was more significant than that of Clifford Beers, whose autobiography, *A Mind that Found Itself*, initiated The National Committee for Mental Hygiene in 1909.⁴⁷ In his twenties, following the loss of his brother, Beers experienced what he referred to as “a mental civil war, which I fought single-handed on a battlefield that lay within the compass of my skull.”⁴⁸ In June of 1900, after attempting suicide and suffering hallucinations, Beers was kept a patient at Grace Hospital in Connecticut. When he was released and fared no better at home, he was committed to a private sanatorium, then to another private institution, and finally to the state hospital. After his release from the institution in 1905, a seemingly manic Beers wrote a detailed account of the physical abuses he encountered in each institution. His family returned him to the private hospital where he regained his equilibrium. “The doctors and attendants treated me as a gentleman. Therefore it was not difficult to prove myself one.”⁴⁹ Beers once again took up his pen and produced a manuscript about his experience. He submitted the manuscript to “all sorts and conditions of minds” and received an encouraging response from

⁴⁶ Ibid.

⁴⁷ Clifford Whittingham Beers, *A Mind that Found Itself: An Autobiography* (NY: Longmans, Green and Co., 1921). For a detailed account of Beers' life, see Norman Dain, *Clifford W. Beers: Advocate for the Insane*, (University of Pittsburgh Press, 1980).

⁴⁸ Ibid., 1.

⁴⁹ Ibid., 234.

psychologist and writer William James of Harvard University, among others. “The book ought to go far,” wrote James, “toward helping along that terribly needed reform, the amelioration of the lot of the insane of our country...”⁵⁰ James continued:

Nowhere is there massed together as much suffering as in the asylums. Nowhere is there so much sodden routine and fatalistic insensibility in those who have to treat it. Nowhere is an ideal treatment more costly. The officials in charge grow resigned to the conditions under which they have to labor. They cannot plead their cause as an auxiliary organization can plead it for them. Public opinion is too glad to remain ignorant. As mediator between officials, patients and the public conscience, a society such as you sketch is absolutely required and the sooner it gets under way the better.⁵¹

With James’ encouragement, Beers secured a publisher for his book and embarked on the creation of a “National Society...for the improvement of conditions among the insane.”⁵² The outpouring of support for Beers’ committee through letters and money was overwhelming. As the Committee formed, it honed a statement about its purpose that encompassed not only the work of asylums, but mental care beyond the asylum walls, as well:

Mental hygiene is not concerned merely with those serious forms of mental disorder which require treatment in State hospitals; it is concerned with those other forms of mental disorders which do not necessarily mean the removal of the individual from his ordinary social environment.⁵³

Beers’ National Committee realized the development of Societies for Mental Hygiene in at least half of the United States within fifteen years of its development in 1909. By educating the public about mental disorders and increasing empathy for them, Beers accomplished an enormous task. The organization he began is functioning even now, one hundred years since its inception. It is now known as Mental Health America.⁵⁴

⁵⁰ Ibid., 244.

⁵¹ Ibid., 264.

⁵² Ibid., 263.

⁵³ Ibid., 301-2.

⁵⁴ www.mha.org

In 1937, New York newspaper columnist Albert Deutsch wrote a history chronicling the advances made in mental health care in the United States, culminating in Beers' Mental Hygiene Movement.⁵⁵ Deutsch touted Beers' organization as the very model that would save mental health care. According to historian Mary Ann Jimenez, Deutsch "argued that medical science rescued the mad from this inhumane treatment in the early nineteenth century through the establishment of the asylums. He argued that the medical profession's recognition of madness as a disease gave new hope to its victims."⁵⁶ But if Jimenez's statement is true, Deutsch's hope was short-lived.

As his interest in mental health care piqued, he began his own search for "the best state mental hospital in the land."⁵⁷ Deutsch visited over 24 institutions in twelve states along with a photographer and wrote vivid accounts of what he saw in an effort to educate and motivate the public toward this reform. His findings at hospitals in the cities of Philadelphia, Cleveland, New York, and Detroit and in the states of California, New York, and Georgia were published in *The Shame of the States*.

Writing in the mid 1940's to a captive newspaper audience, Deutsch delivered a list of alarming statistics:

At least one out of every seventeen Americans is destined to spend some part of his or her life as a patient in a state mental hospital. One out of ten, probably, will suffer a mental or nervous ailment so serious that admission to a mental hospital would be advisable...More than 125,000 Americans are admitted to mental hospitals every year. One million children now in elementary schools are destined to spend some time in state mental hospitals in later life."⁵⁸

⁵⁵ Albert Deutsch, *The Mentally Ill in America: A History of Their Care and Treatment From Colonial Times* (NY: Doubleday, Doran & Company, Inc., 1937). This history is labeled "Whiggish" by historians, meaning it heralds the reform efforts of the mental health movement without carefully examining the power structures behind the reform.

⁵⁶ Mary Ann Jimenez, *Changing Faces of Madness* (Hanover, NH: University Press of New England, 1987), 5.

⁵⁷ Albert Deutsch, *The Shame of the States* (NY: Harcourt, Brace and Company, 1948), 182.

⁵⁸ *Ibid.*, 30.

The public's "stake" in mental institutions was great, he concluded. "Hardly a household in the land is left completely unaffected by this huge problem."⁵⁹ And not only was it alarming that so many Americans were likely to become patients in mental institutions, the institutions themselves were far from desirable. He states, "*Not a single state mental hospital in the United States meets, or ever has met, even the minimum standards set by the APA in all major aspects of care and treatment!*"⁶⁰;

Subsequent to Deutsch's rally cry came *The Snake Pit*, writer Mary Jane Ward's novel about a fictional character, Virginia Cunningham, and her sojourn at a public mental institution.⁶¹ As a Book-of-the-Month selection in 1947, Ward's book was widely read by Americans, and in 1948, premiered on-screen, in a film version starring Olivia de Havilland. The book alone "earned more than \$100,000 in its first month."⁶² Mental institutions had clearly taken center stage as objects of interest for the American public. "What people saw, they could act on if they chose," wrote Nick Clooney in *The Movies that Changed Us*. "After seeing *Snake Pit*, they chose to put the heat on. Public servants had no choice but to respond to an aroused electorate."⁶³ Between the rise of the Mental Hygiene movement, Deutsch's work, and *The Snake Pit*, America was ready to return their gaze to institutions for the mentally ill, a move which would result in public scrutiny and in critical scholarship over the next sixty years.

⁵⁹ Ibid., 32.

⁶⁰ Ibid., 39.

⁶¹ Mary Jane Ward, *The Snake Pit* (London: Cassel & Company, 1947).

⁶² Gail A. Hornstein, "Narratives of Madness, As Told from Within," *The Chronicle of Higher Education*, 25 January 2002, sec. B, p. 9.

⁶³ Nick Clooney, *The Movies That Changed Us: Reflections on the Screen* (NY: Atria Books, 2002), 144.

Review of the Literature

Stephen Garton writes that “the history of mental illness and the history of lunatic asylums are not the same thing.”⁶⁴ The history of psychiatry is still another field of study. And yet, often the three are combined into one subject. This literature review will focus not on the history of mental illness or on the history of psychiatry, but will focus specifically on work relating to how women’s lives overlap with mental institutions. In the mid-twentieth century, as more Americans faced institutionalization and interest in the realities of life in mental institutions escalated, more scholars found them worthy of study. Of the theories about institutionalization proposed by scholars, two are most significant: the asylum as instrument of social control and the asylum as “an arbiter of social and familial conflict.”⁶⁵ This chapter will focus on literature espousing those theories, particularly where they intersect with studies of women.

Theory of Social Control

In 1948, newspaper columnist Albert Deutsch defined insanity “as a state of mental disorder of such kind or degree as to render a person socially inefficient and to make it necessary to place him under some form of social control.”⁶⁶ But Deutsch’s notion of social control was likely different from the idea scholars have in mind when they use the term today. David Rothman explained the transformation of the concept of social-control before and after World War II. According to Rothman, before the war, sociologists developed the term social control, a concept they applauded as representative of American common values, the institutions of family, school and church. But after the war,

⁶⁴ Stephen Garton, “Asylum Histories: Reconsidering Australia’s Lunatic Past,” in *Madness in Australia: Histories, Heritage and the Asylum*, eds. Catharine Coleborne and Dolly MacKinnon, (Perth, WA: University of Queensland Press) 2003, 11.

⁶⁵ Mark Finnane, “Asylums, Families and the State,” *History Workshop* 20 (Autumn 1985):135.

⁶⁶ Deutsch, *The Shame of the States*, 9.

Marxist scholars made it synonymous not with persuasion but with imposition of state or class authority over the lower classes. Social control was equated with repression and coercion...it was with this negative connotation, not with its Progressive roots, that social control came to the attention of historians.⁶⁷

Scholars could no longer view the asylum as a solely benevolent institution. The theory of social control provoked scholars “to stop taking claims of benevolence at face value and to start investigating the purposes, benign or not so benign, that a purported reform might fulfill...The result was to promote fresh questions about the asylum, and fresh answers as well.”⁶⁸

“The asylum,” explains historian David Lightner,

was an instrument of social control that arose because America’s elite, feeling threatened by such forces as industrialization, urbanization, and immigration, decided that the restive elements in society should be controlled through incarceration in penitentiaries and asylums. ...That mental hospitals functioned in some sense as mechanisms of social control can scarcely be denied. The declared purpose of moral treatment was to alter patient behavior and thought so as to conform to the norms of society. Prominent among those norms were expectations relating to race, class, and gender. When asylum superintendents allowed their upper-class patients to play chess or enjoy carriage rides while requiring their lower-class patients to milk cows or clean bathtubs, the superintendents certainly were reinforcing the existing class structure. ...class oppression ... is at the heart of the social-control theory.⁶⁹

So the social control theory applied to the development of institutions as well how individuals were treated within those institutions.

The Work of Erving Goffman

Historians were not alone in viewing the asylum through the lens of social control. In 1961, sociologist Erving Goffman published *Asylums*, an account of his ethnographic field work at St. Elizabeth’s Hospital in Washington, D.C. during the 1950’s. He encapsulates his approach thus:

⁶⁷ Rothman, *The Discovery of the Asylum*, xxxvi-xxxvii.

⁶⁸ Ibid., xxxvii.

⁶⁹ David L. Lightner, *Asylum, Prison & Poorhouse* (Carbondale: Southern Illinois University Press), 114.

It was then and still is my belief that any group of persons—prisoners, primitives, pilots, or patients—develop a life of their own that becomes meaningful, reasonable, and normal once you get close to it, and that a good way to learn about any of these worlds is to submit oneself in the company of the members to the daily round of petty contingencies to which they are subject.⁷⁰

Goffman's aim was to capture the social world of St. Elizabeth's from the perspective of the patients, whom he identified as "inmates." He labeled mental hospitals as examples of total institutions: places "of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."⁷¹

Goffman characterized this initial transition to the total institution as "mortification," a time of relinquishing almost every freedom associated with the life before—clothing, toiletries, and the common use of items as mundane as eating utensils. The inmate, who likely experienced belonging within some group before, entered as one unknown to the mental institution. Within the institution, the inmate entered into a forced relationship with caretakers, many of whom may have privileged information about his personal past life. He also entered a world of punishments and privileges. Privileges often came in the form of coffee, cigarettes and food items; a better bed, privacy, and outside time. Punishments came in the form of removal of privileges, isolation, physical punishments and placement on the list for electroshock therapy.⁷² Goffman found inmates' mail was sometimes censored or withheld, inmates sometimes watched the staff inflict physical assaults upon other inmates and their verbalized needs were often ignored. Inmates within total institutions, at least initially, lived with the "chronic anxiety about breaking

⁷⁰ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Chicago: Aldine Publishing Company, 1961), x.

⁷¹ Ibid., xiii. Other total institutions include prisons, orphanages, boarding schools and reformatories.

⁷² Ibid., 53.

the rules and the consequence of breaking them.”⁷³ The inmate, according to Goffman, had no choice but to adapt.⁷⁴ Although the mortification process would lead to a high level of stress for most, Goffman surmised: “For an individual sick with his world or guilt-ridden in it mortification may bring psychological relief.”⁷⁵

Goffman discusses the transition from home to institution. “Inmates arrive at the institution with a ‘presenting culture’ ...derived from a ‘home world’—a way of life and a round of activities taken for granted until the point of admission to the institution.” Goffman claimed that the tension created by the home and institutional worlds acted as “strategic leverage in the management of men.”⁷⁶ This seems particularly true as inmates sought release from institutions. Mental hospital administrators offered “the possibility of a ‘clean bill of health’” to those who “earned” it.

Goffman defined the “moral career” of the patient.⁷⁷ At the beginning of the moral career, the patient would enter into a time of betrayal by family members during the pre-patient phase. The family of the patient would present their rationale for committing their member, a rationale that would become the initial case history for the patient. During the inpatient phase, the patient would gradually become oriented to the ward system, “a series of graded living arrangements built around wards, administrative units called services, and parole statuses.”⁷⁸ Concurrently, the patient would begin creating a story or “apologia,” an explanation of how he came to be a patient at the asylum to be shared with others. Goffman elaborates,

The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the

⁷³ Ibid., 42.

⁷⁴ Ibid., 65.

⁷⁵ Ibid., 48.

⁷⁶ Ibid., 13.

⁷⁷ Ibid., 128.

⁷⁸ Ibid., 148.

person by himself and those around him. This special kind of institutional arrangement does not so much support the self as constitute it.⁷⁹

Finally, Goffman presents the underworld of the mental institution, including the ways patients work the system. Patients made-do with what they had, scavenged for what they did not, sought privileged status, bought and sold items, “jockeyed for workable assignments,”⁸⁰ formed their own intimacies, and claimed their own unique spaces during their time at the institution.

Goffman explains:

The interpretative scheme of the total institution automatically begins to operate as soon as the inmate enters, the staff having the notion that entrance is *prima facie* evidence that one must be the kind of person the institution was set up to handle. A man in a political prison must be traitorous; a man in a prison must be a law-breaker; a man in a mental hospital must be sick. . . . this automatic identification of the inmate is not merely name-calling; it is at the center of a basic means of social control.⁸¹

Goffman’s detailed description of life within the institution illuminates the daily reality of asylum existence from the perspective of a perceptive non-patient. His study was extremely popular and influential. Not only did Goffman’s portrait of the asylum stem directly from the theory of social control, it also hints at the social construction of madness.⁸²

The Work of Elaine Showalter

Numerous scholars have since used the theory of social control and its focus on women to undergird their own studies. With regard to women’s institutionalization, no work parallels that of Elaine Showalter. Showalter, professor of English at Princeton University, used “legal, medical, and literary texts...painting, photography, and film” in addition to examining psychiatry in England in order to write “both a feminist history of psychiatry and a cultural history of

⁷⁹ Ibid., 168.

⁸⁰ Ibid., 220.

⁸¹ Ibid.,

⁸² While fascinating and certainly relevant to this study, the social construction of madness is beyond the scope of this literature review.

madness as a female malady.”⁸³ This section will focus on her findings about women and women’s intersections with the asylum.

Since the only work deemed appropriate for women during the Victorian era was motherhood, Showalter believed “mental breakdown, then, would come when women ...sought alternatives or even additions to their maternal functions.”⁸⁴ The Victorian era witnessed a rise in nervous disorders, specifically hysteria. Showalter concluded that “nervous women” were actually “ravenous for a fuller life than their society offered them...their nervous disorders expressed the insoluble conflict between their desires to act as individuals and the internalized obligations to submit to the needs of the family, and to conform to the model of self-sacrificing ‘womanly’ behavior.”⁸⁵

Showalter connected female hysteria to male shell shock. For centuries, hysteria had been “the quintessential female malady,”⁸⁶ the very name was derived from the Greek *hysteron*, or womb; but between 1870 and World War I—the ‘golden age’ of hysteria—it assumed a peculiarly central role in psychiatry and in definitions of femininity. By the end of the nineteenth century, “hysterical” had become almost interchangeable with “feminine,” where it stood for all extremes of emotionality.

But during the Great War, soldiers experienced an epidemic of hysteria. “The hysterical soldier was seen as simple, emotional; unthinking, passive, suggestible, dependent, and weak—very much the same constellation of traits associated with the hysterical women.”⁸⁷ She continued,

⁸³ Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London: Virago Press, 1987), 5.

⁸⁴ *Ibid.*, 123.

⁸⁵ *Ibid.*, 144.

⁸⁶ Andrew Scull, *Hysteria: The Biography* (NY: Oxford University Press, 2009), 30.

⁸⁷ Showalter, 175.

It is not to be wondered at that the conditions of war should have inspired an identification with the female role in men who had to endure them. As the sociologist Erving Goffman has noted, with regard to lack of autonomy and powerlessness the soldier is in an analogous position to women. That most masculine of enterprises, the Great War, the “apocalypse of masculinism,” feminized its conscripts by taking away their sense of control.⁸⁸

Showalter believed the very lack of power and of autonomy to be at the crux of women’s mental illness. “Women understood the lesson of shell shock better than their male contemporaries: that powerlessness could lead to pathology.”⁸⁹ And pathology led directly to the asylum.

Showalter’s most prominent claim was that more women than men inhabited mental institutions during the Victorian era.⁹⁰ Numerous scholars have found these findings to be inconsistent with their own. In examining Canadian asylums during the Victorian era, Moran, Wright, and Savelli found that “the evidence supporting Showalter’s famous claim for the disproportionately high rate of incarceration of women in Victorian asylums becomes very weak, if not non-existent, for Canadian asylums at this time.”⁹¹ Historian Peter McCandless found the same to be true for the South Carolina Lunatic Asylum. McCandless used quantitative data, primarily the institutions’ Annual Reports, to support his claim that madness was not inordinately female in nineteenth century South Carolina.⁹²

According to Showalter, most female madness was credited to the female reproductive system. Psychiatrists attempted to bring equilibrium to the women by stabilizing their reproductive systems. McCandless examined patient records and admission books at the South Carolina Lunatic Asylum from 1828 to 1915 in order to determine whether similar claims to

⁸⁸Ibid., 173.

⁸⁹ Ibid., 190.

⁹⁰ Ibid., 3, 17, 51-2.

⁹¹ James Moran, David Wright and Mat Savelli, “The Lunatic Fringe: Families, Madness, and Institutional Confinement in Victorian Ontario,” in *Mapping the Margins: The Family and Social Discipline in Canada, 1700-1975*, ed. Nancy Christie and Michael Gauvreau (McGill-Queen’s University Press, 2004), 282.

⁹² Peter McCandless, “‘A Female Malady?’ Women at the South Carolina Lunatic Asylum,” *Journal of the History of Medicine and Allied Sciences* 54: no. 4 (October 1999): 547.

Showalter's were true in South Carolina. Only a minority of female insanity was attributed to the female reproductive system. Rather, McCandless found insanity in women most likely (42%) to be attributed to physical causes: "heredity, congenital conditions, senility, epilepsy, cerebral hemorrhage, and injury to the head."⁹³ He found reproductive causes were recorded by physicians in only 16% of cases and situational causes were recorded in 13% of the cases.

In the following section, I will look at studies influenced by Showalter's seminal work. Several threads overlap, in particular their discussions of gender, race and class.

Studies Influenced By Showalter

In her article, "The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums," Anne Shepherd studied women's experiences at two institutions in England, one geared to the poor and one geared to the middle-class. Shepherd concluded that "both gender and class must be taken into the equation. ...poor women had a different psychiatric experience from that of their middle-class sisters."⁹⁴ Shepherd found clear differences in her study of two institutions. Chief among these was the finding that although there were similar numbers of women and men in the institutions she studied, "more women than men remained in the asylum...indeed for certain groups of women, life in the asylum was preferable...the women, on a superior diet and freed from the rigours of extended child-bearing and dangerous employment, became healthier and lived longer."⁹⁵ This article was important because it highlighted the fact that the asylum could provide a better situation for women than what they had at home.

In her study of the West Riding Poor, Marjorie Levine-Clark attended to both gender and class, using Showalter's work for a basis of comparison. She found clear differences between

⁹³ McCandless, 559

⁹⁴ Anne Shepherd, "The Female Patient Experience in Two Late-Nineteenth-Century Surrey Asylums," in *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry*, ed. Jonathan Andrews and Anne Digby (Amsterdam: Editions Rodopi B.V., 2004), 225

⁹⁵ Ibid.,243-4.

Showalter's Victorian women and her own West Riding Poor. Levine-Clark examined 1,489 female patient case histories from the West Riding Pauper Lunatic Asylum from July 1834 to November 1852 as "representations of family life" in order to understand "what their medical records reveal about the social history of family relationships and the links between what the state understood as insanity and the patients' family lives." Levine-Clark explained Showalter's work in this way: Showalter found that middle class women used insanity "as an expression of protest to escape the confinements of domestic life. ...when a woman was ill, she did not have to obey the rules of feminine behavior and domestic responsibility and thus obtained a small space of freedom, however limiting."⁹⁶ Levine-Clark explained the difference in middle class and working poor women with this comparison: The middle-class woman felt "*constrained by the empty existence of domesticity*." The working poor woman would have been "*delighted to experience the comfort of the ideal of domesticity*." Contrary to Showalter's middle-class Victorians, the women Levine Clark studied

were women of the working poor, and their insanity had little to do with struggling against a limited domestic role or filling up empty spaces. Rather, as the cases suggest, poor women's struggles had more to do with the pressures involved in creating healthy familial relationships in the face of numerous domestic difficulties."⁹⁷

Her research suggests that for many women of the West Riding Poor population, time spent as a patient at the asylum would have offered a "comfortable space," a reprieve from strained family relationships.⁹⁸

Where Showalter's middle class women used insanity as a "protest, a means to secure freedom" from a middle-class domestic life, Levine-Clark's poor women had a different need to

⁹⁶ Marjorie Levine-Clark, "Dysfunctional domesticity: Female insanity and family relationships among the West Riding Poor in the mid-nineteenth century," *Journal of Family History* 25, no. 3(July 2000): 346.

⁹⁷ *Ibid.*, 342.

⁹⁸ *Ibid.*, 342.

escape. Although many of them did experience abuse at the hands of husbands, hard, never-ending working lives and the difficulties of child-rearing, “many would have hoped to attain the comfortable space—financially and emotionally—in which they would be able to devote themselves to home.”⁹⁹

Although Peter McCandless did not find Showalter’s findings relevant to the South Carolina asylum, he does begin to hint at the racism inherent there. Because his work focused on a southern asylum, McCandless paid careful attention to the issue of racism. When black patients began to arrive at the institution after Reconstruction, unlike white middle-class patients, they were afforded no “programs of amusement, but they were given plenty of work. ...Black women did most of the laundry, cleaning, and kitchen work, and black men most of the heavy and dirty outdoor labor.”¹⁰⁰ The forces of social control were in play in each of these studies, particularly in regard to racism and classism. But more scholars began to question the degree to which the social control thesis was the most helpful lens with which to view asylums.

According to Shepherd, “there is little evidence to support suggestions that either of these particular institutions [Brookwood Asylum and Holloway Sanatorium in Surrey] operated an overt agenda of social control in relation to disorderly women.”¹⁰¹ Shepherd continues:

For all women, particularly if poor or unmarried, the options for discharged female lunatics were few...but it would be a mistake to assume that where there is evidence of high incidences of mental disorder in women that this is necessarily indicative of their oppression...female incarceration was in some instances a desirable option for a variety of interested parties that cannot neatly be explained by accusations of social control.¹⁰²

⁹⁹ Ibid., 355. This point is particularly relevant to my own study.

¹⁰⁰ McCandless, 568.

¹⁰¹ Shepherd, 225.

¹⁰² Shepherd, 244.

The women Shepherd studied sometimes chose the asylum as a more “desirable option” to being released. Rather than being constrained by the theory of social control, they were able to make their own choices, an “ambiguity” for the social control thesis, according to Shepherd.

The theory of social control has enabled scholars to tease apart issues of sex, class and race at the asylum. But more scholars are beginning to turn to the role of the family in understanding the dynamics of the asylum. Nancy Tomes, in her history of the Pennsylvania Hospital for the Insane, focused on the superintendent Thomas Kirkbride and his correspondence with families of his patients from 1840-1883. Rothman credits Tomes with showing that families were initially reluctant to institutionalize their members, but when they chose to do so, they effectively “helped stamp a functional, as opposed to reformatory, character on the institution.”¹⁰³ Furthermore, Tomes’ work revealed the growing ease with which families institutionalized their members over time: “increasingly families sought asylum care for patients who could still be managed at home without resorting to extreme measures.”¹⁰⁴

Theory of Asylum as “an Arbiter of Social and Familial Conflict”¹⁰⁵

In the 1980’s, Mark Finnane submitted to historians that understanding family relationships was essential to understanding institutional commitment. Fellow scholars referred to Finnane’s theory as “an intellectual watershed in the history of asylums.”¹⁰⁶ According to Moran, Wright, and Savelli, Finnane’s theory articulated the move of scholars, particularly scholars in Canada, away from the strict focus on social control to exploring the importance of families to the institutions and the institutionalized. They write,

Finnane referred to the asylum as an ‘arbiter of social and familial conflict.’ The asylum, he asserted, should be seen ‘as an institution whose role and function was

¹⁰³ Rothman, . xlii.

¹⁰⁴ Ibid., xliii.

¹⁰⁵ Finnane, 135.

¹⁰⁶ Moran, Wright and Savelli, 277.

mapped out by a lengthy process of popular usage and custom as much as by the legal and financial imperatives which the state erected around it.’¹⁰⁷

Clearly, Finnane articulated a theoretical shift others were ready to embrace. Moran, Wright, and Savelli claimed that scholars “agreed that the process of confinement was more complex than the ‘social control’ theses enumerated by the first ‘revisionist’ wave of asylum historiography.”¹⁰⁸ Grateful to Finnane for conceiving such a shift, the scholars concluded, “The social history of madness in the nineteenth century thus has been reconceptualized to consider the family as central to the care, control, identification, and regulation of insanity.”¹⁰⁹ Finnane found numerous other scholars engaging in asylum study through the lens of the family.

For example, in her work *Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905-1915*, historian Mary-Ellen Kelm drew evidence from 774 case files of women patients in order to reveal the significance of families’ influence over every aspect of their members’ stay at the asylum. Kelm, as well as other scholars, found that “Relatives resolved to institutionalize [family members] only when they became profoundly dangerous or disruptive or when previously used care networks broke down.”¹¹⁰ But even when families resolved to institutionalize their members, they continued to wield influence over their care. By careful examination of case files, Kelm found evidence of family involvement in the form of visits, correspondence both during and after institutionalization, and at the process of discharge. Family was clearly and inextricably connected to the entire process.

Catherine Coleborne has named the entry of women into the asylum as “the calamity of insanity.” Coleborne’s work within asylums has integrated both theories of asylum as agent of

¹⁰⁷ Ibid.

¹⁰⁸ Ibid., 278.

¹⁰⁹ Ibid., 279-80.

¹¹⁰ Mary-Ellen Kelm. “Women, Families and the Provincial Hospital For the Insane, British Columbia, 1905-1915” *Journal of Family History* 19: no. 2, (1994): 179.

social control and as “arbiter of social and familial conflict.” In her 2006 study, *His Brain was Wrong, His Mind Astray*, Coleborne reviewed case notes, payment information, and correspondence at three public asylums in Australia and New Zealand for the language family members used in order to communicate about their ailing family members. The asylum depended upon families to provide background information. Coleborne found evidence of the family’s background information turning up repeatedly in case notes of medical personnel over time. Ordinary family language was repeated in psychiatric case notes, which ultimately “shaped asylum discourse.”¹¹¹ Coleborne further found information included in case notes; information about families and households, both physical and moral causes of insanity, and general language used by “ordinary people to describe mental states.”¹¹² The wealth of information included in asylum archives caused Coleborne to appeal for more examination of asylum archives and a reopening of “the case of the family in history.”¹¹³ Some of the gaps Coleborne has sought to fill in the scholarship are articulated well here:

I want to investigate how families coped in the past. What kinds of exchanges took place between families and institutional personnel? What kind of language was used to describe states of mental disorder, by families and asylum authorities? What happened to inmates once they were confined, and were their relationships with family members encouraged or did these fail? I argue that by examining a range of patient cases with an eye on familial relationships and colonial life we might find fresh insights into the dynamic between families and mental health in both the past and present.¹¹⁴

In another article, *Families, Patients and Emotions*, Coleborne extended her work examining language to include gestures within asylum archives. Following her extensive study, she expanded her discussion to include emotional response within the records. The asylums, whose

¹¹¹ Coleborne, Catharine., “‘His Brain Was Wrong, His Mind Astray’: Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880’s-1910” in *Journal of Family History* 31, no.1(January 2006),

¹¹² Ibid., 45.

¹¹³ Ibid., 58.

¹¹⁴ Catharine Coleborne, “Families, Insanity, and the Psychiatric Institution in Australia and New Zealand,” *Health and History* 11, no. 1 (2009): 1. www.historycooperative.org.

archives chronicle how families and patients emotionally managed mental illness, “became a site for the discussion and performance of ‘emotion.’”¹¹⁵ Again recognizing the value of asylum archives in order to access the lives of people who left behind few written records, Coleborne used this article to focus on emotional lives within the asylums before placing those lives within the emotional culture of the time. Within the asylum records, Coleborne found a rich range of emotion. “Mental breakdown revealed itself through a disturbance of emotions in most individuals committed to institutions. ... The asylum aimed to restore inmates to an appropriate state of emotional balance.”¹¹⁶ “Extreme expressions of emotion were one indication of mental instability,” she writes, “another was the *lack* of emotion.”¹¹⁷ Coleborne’s turn to focus on emotion within “insanity’s archive” is one of her most recent endeavors in the field.

This chapter has followed scholars from viewing the asylum as a strict means of social control to viewing the asylum as a functional institution for families. The turn of many scholars to begin probing patient narratives for information also means a group of women whose experience has not been known before can be known now. The majority of the work in asylums using patient records is currently happening in Australia, New Zealand, Canada, and the United Kingdom. Although some scholars, notably Peter McCandless, are working to weave patient narratives into asylum history in the United States, this work is rare. Though there are many institutional histories in the United States, there is a gap in scholarship examining the lives of women, particularly rural, poor women as they intersect with asylums in the United States. Furthermore, with the exception of McCandless’ work on the South Carolina Asylum, the

¹¹⁵Catharine Coleborne, “Families, patients and emotions: Asylums for the insane in Colonial Australia and New Zealand, c. 1880-1910,” *Social History of Medicine* 19, no.3, (2006): 427.

¹¹⁶ Ibid., 432

¹¹⁷ Ibid., 426. Coleborne has published a compilation of her work in *Madness in the Family: Insanity and Institutions in the Australasian Colonial World, 1860-1914* (Great Britain: Palgrave MacMillan, 2010).

southern asylum has been neglected. The racism prevalent in the South during this era will yield a different sort of narrative from those of other United States' asylums.

This literature review highlights two prominent theories regarding asylums: asylums as instruments of social control and asylums as “arbiters of social and familial conflict.” The present study was designed to extend the body of research by exploring the intersection between rural women of northeast Georgia and the mental institution in Milledgeville. This study will fill the void of scholarship focused upon this institution and regarding this group of people.

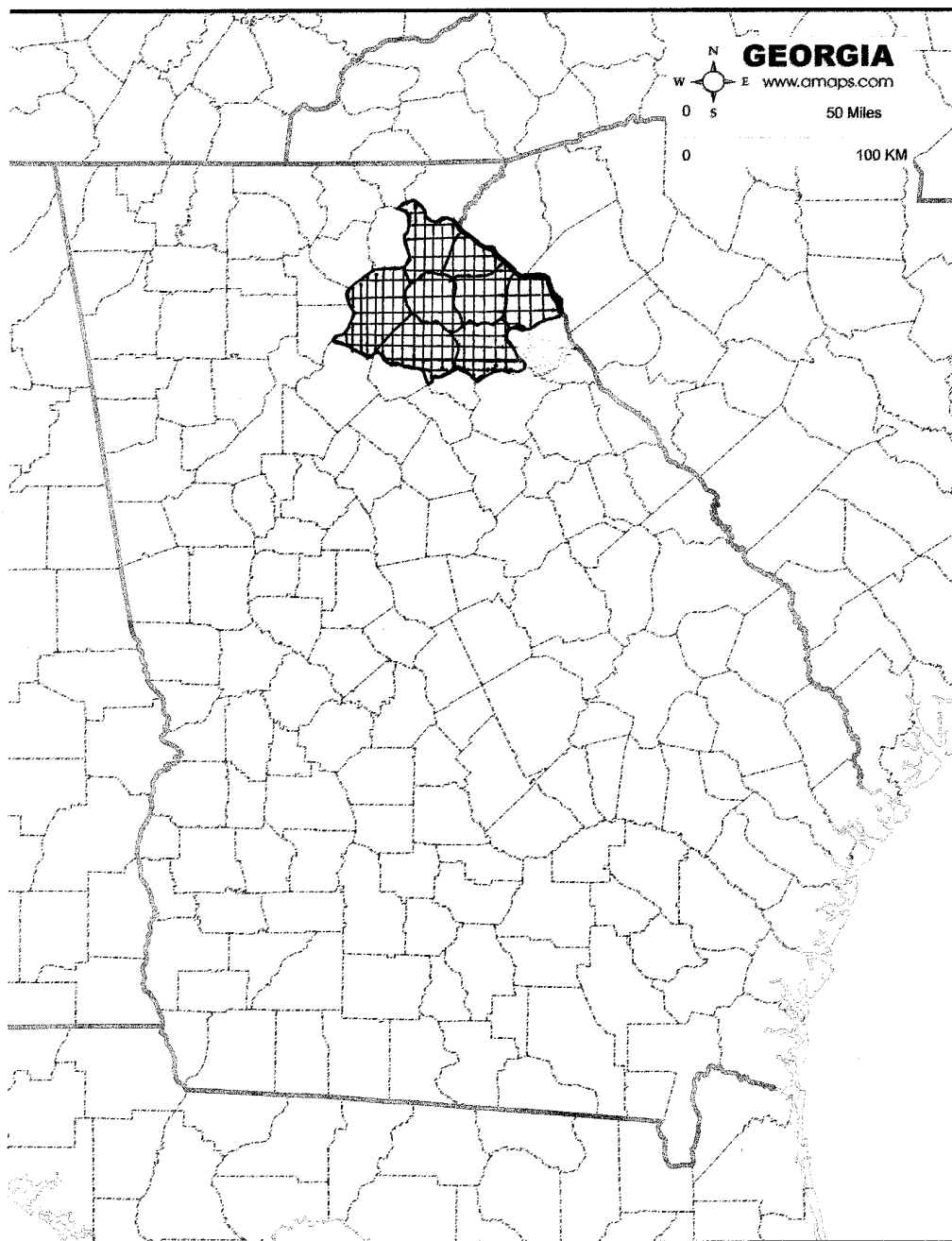
Although a handful of studies have looked at southern institutions, very few have focused on Georgia. And though some studies have looked at rural women within mental institutions, those studies are focused in England, Australia and New Zealand. This study fills a niche as the only study to use patient narratives at Milledgeville in order to illuminate the lives of Georgia's rural women.

CHAPTER 3

HISTORICAL CONTEXT

Northeast Georgia

The upper piedmont region of northeast Georgia as defined by this study, consists of an area comprising eight counties which were all part of the original Franklin County. The counties include Banks, Franklin, Habersham, Hall, Hart, Jackson, Madison, and Stephens.



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Northeast Georgia, as defined in this dissertation.

In the first half of the twentieth century, the area was little different from much of the rural South of that era. “The overwhelming portion of blacks [nearly half the population at the beginning of the century] and a large portion of whites lived in or near poverty.”¹¹⁹ Some white families, faced with severe poverty, left the countryside in order to pursue steadier work and housing in mill communities. In northeast Georgia, Gainesville, Athens, and Commerce all attracted rural people to the promise of mill labor. Those who remained in rural areas faced lives of sharecropping and the desperation of living on credit under the watchful eye of the landowner. Historian William Holmes states,

For people who stayed on the countryside over the life cycle of a family, or the course of generations, increases in well-being came in exceedingly small increments—a mother freed from field work for part of the year, a mule that lifted the household out of the cropper status and into tenancy, a cabin with screens in place of the old one infested with flies.¹²⁰

Still others remained behind on family farms, trying to eke out a livelihood from the earth even as their families burgeoned and their living conditions grew continually bleaker. Northeast Georgia was largely devoid of the large landowning elite that populated the middle Georgia area. Instead, as Jacqueline Jones articulated, the upper piedmont landscape consisted mostly of:

[the] small owner-operator, a family man who relied on a mule, fifty acres, and the labor power of his own household...to hold onto their land, they often had to sacrifice the education of children kept hard at work in the fields. Most farmers, regardless of tenure status, had to live on credit during the year, unless they could earn enough in wages or from the sale of chickens and eggs to support their families.¹²¹

¹¹⁹ William Holmes, *Struggling to Shake Off Old Shackles: 20th Century Georgia* (Savannah, GA: Beehive Press, 1995), vii.

¹²⁰ Jacqueline Jones, “The Political Economy of Sharecropping Families: Blacks and Poor Whites in the Rural South, 1865-1915” in *Joy and In Sorrow: Women, Family and Marriage in the Victorian South, 1830-1900*, ed. Carol Bleser (New York: Oxford University Press, 1991), 199.

¹²¹ *Ibid.*, 210. For more background on the people of this region, see Steven Hahn, *The Roots of Southern Populism: Yeoman Farmers and the Transformation of the Georgia Upcountry, 1850-1890* (New York: Oxford University Press, 1983); LuAnn Jones, *Mama Learned us to Work: Farm Women in the New South* (Chapel Hill: The University of North Carolina Press, 2002); Rebecca Sharpless, *Fertile Ground, Narrow Choices: Women on Texas Cotton Farms, 1900-1940* (Chapel Hill: University of North Carolina Press, 1999) and numerous works by Melissa Walker, including *All We Knew Was to Farm: Rural Women in the Upcountry South, 1919-1941* (Baltimore: The Johns Hopkins University Press, 2000).

For many, the desperate cycle of hard work for money already spent continued until Roosevelt's New Deal and the advent of World War II. Still, long afterward, families of the area lived in desperate situations, most of them clinging to kinship networks for their sustenance.

Most women, even into the 1930's, bore children from marriage to menopause without a break, then suffered the fearsomeness of childbirth and child loss right along with the fear of losing husbands. A woman from the upper piedmont in the first half of the twentieth century was lost without a husband to provide for her family. Husbands were a necessity; the lack of one meant almost certain poverty for any woman. Compounding infant and child mortality was the dire health situation in the South. Georgia made great gains in health care early in the century, but the difficulties of overcoming disease, inadequate diet, and improper sanitation took their toll on many Georgians before they were resolved. Holmes explains,

Prior to World War II, Georgia made more advances in public health than in education. At the beginning of the century, Georgians remained highly susceptible to a variety of diseases. Investigations in the 1910's revealed that in some areas hookworms infected over half the residents. The diets that many rural people consumed—which consisted largely of corn meal, sow belly, and molasses—contributed to the overall low state of health. Between 1910 and 1940, with the assistance of private agencies like the Rockefeller Foundation and New Deal programs, Georgia made substantial gains in improving health conditions. By the outbreak of World War II malaria, hookworm, pellagra, tuberculosis and yellow fever no longer posed the serious threats they had at the beginning of the century.¹²²

Many women came to the institution at Milledgeville ill-nourished, a condition which made them vulnerable to mental illness. For those that suffered the niacin deficiency of pellagra, by the time they came to Milledgeville they were likely close to death.

¹²² Holmes, xi-xii.

The Institution

Located in middle Georgia, approximately ninety miles south of the upper piedmont on highway 441, the Asylum quickly became known as a last resort for many in Georgia who faced overwhelming mental anguish. First named the “State Lunatic, Idiot, and Epileptic Asylum,” the institution’s name was changed to the “Georgia State Sanitarium” in 1897, “Milledgeville State Hospital” in 1929 and “Central State Hospital” in 1967.¹²³

Often families hesitated to send their loved ones to the asylum, commonly referred to in Georgia by the name of its location: Milledgeville. “In order to go to Milledgeville,” according to one local woman, the family “had to . . . go to the court. You had to get the sheriff to talk to you and declare you insane. That was very traumatic for everybody.”¹²⁴ And yet, all traumas aside, ever increasing numbers of people had family members committed over the years. In an article written in the *Georgia Bar Journal* in 1941, slightly after the period of this study, the author explicated steps taken in determining insanity:

- a. There must be a petition on oath, stating that another is liable to have a guardian appointed (or subject to commitment to the State Mental Hospital).
- b. Notice to three nearest adult relatives, if any in the State, unless such notice is waived in writing by them.
- c. Affidavit by one of such relatives that party is insane, and likely to do himself bodily injury.
- d. Ordinary [probate judge] appoints physician to examine patient.
- e. Physician certifies to insanity.
- f. Ordinary appoints commission to examine party as to insanity consisting of two physicians, county attorney or someone appointed by him, or solicitor in counties where there is a county attorney; in counties where there is none, the commission consists of a doctor and five men qualified for jury service.
- g. Commission sworn by any officer authorized to administer oaths.

¹²³ “Central State Hospital,” *New Georgia Encyclopedia*. Retrieved July 5, 2011: <http://www.georgiaencyclopedia.org>.

¹²⁴ Interview with Frances Varner Armstrong, by author, July 13, 2001.

- h. Examines him as to his capacity to manage estate.
- i. Unanimous verdict of insanity by commission.¹²⁵

Persons declared legally insane might escape criminal charges; they were unable to “make a will, a contract, to vote, to be a witness or to do other acts which require the use of discretion and judgment.”¹²⁶ They could not be witnesses. “Insanity at the time of marriage is a ground of total divorce in Georgia . . . since a lunatic has not the capacity to enter the marriage contract.”¹²⁷ Although correspondence at private sanatoria was a right guarded by law, the right to correspond was “not granted by law to the patients at the State Hospital in Milledgeville.”¹²⁸

Georgia’s asylum came about as part of the second wave of asylum-building in the United States. In 1834 Governor Wilson Lumpkin requested that the legislature “pay serious attention ‘to idiots, lunatics, and [the] insane’” of the state.¹²⁹ The next governor of the state, William Schley echoed Lumpkin’s request for an asylum and the legislature appropriated \$20,000. The institution was situated outside of Milledgeville, Georgia’s capital. The building was modeled on the McLean and Worcester hospitals in Massachusetts and designed by an architect from Maine. From the beginning, Gerald Grob explained that Georgia’s institution was unique. It was intended for “the idiotic and epileptic in addition to the mentally ill” and secondarily, the legislature “made no provision for a superintendent,” instead vesting “authority in a three-member board of trustees,” all of whom were physicians living in Milledgeville. Nonetheless, one of the three physicians, Dr. David Cooper, was elected superintendent in 1843 one year after the Georgia Lunatic Asylum accepted its first patient. Grob described Cooper:

¹²⁵ Andrew W. Cain, Jr., “The Georgia Law of Insanity,” *Georgia Bar Journal* 3 (May 1941): 28.

¹²⁶ *Ibid.*, 35.

¹²⁷ *Ibid.*, 44.

¹²⁸ *Ibid.*, 46. Presumably, the rights afforded sane persons could be withheld from those adjudged insane.

¹²⁹ Grob, 361.

“Although apparently not lacking in ability, he [Cooper] proved highly eccentric.”¹³⁰ Dorothea Dix had been informed that Cooper “is really insane, but being harmless, the Trustees consent to his remaining in charge of the Institution.”¹³¹ From this inauspicious beginning, the asylum in Georgia was inaugurated.

Dr. Thomas Green succeeded Cooper in 1847 and retained his position for over thirty years. In Green’s first decade as superintendent, his most noteworthy accomplishment was the abolishment of restraint in 1848. Edward Shorter reflected on Green’s tenure: The “asylum in Milledgeville, Georgia ... initially possessed the noblest of therapeutic intentions. Its superintendent would personally release new patients from manacles as they were brought for admission.”¹³² Noble intentions soon gave way to custodial care.

In Green’s second decade as superintendent, Dorothea Dix visited the asylum, securing [from the legislature] the commitment to greater funds and materials.¹³³ “As early as 17 August 1865 ... the insane asylum reluctantly received its first black patient, and the superintendent, Dr. Thomas F. Green, feared the arrival of many more.”¹³⁴ Historian Peter Wallenstein explained Green’s common beliefs about freed men and women:

From a perspective that appears typical of men in his position after the war, Dr. Green observed in his 1865 report that, under slavery, blacks “enjoyed entire freedom from cares and anxieties, and in the rare instances in which an insane negro could be found, there was an owner who could and did take care of the poor creature.”¹³⁵

¹³⁰ Ibid., 361.

¹³¹ Ibid., 362.

¹³² Edward Shorter, *A History of Psychiatry From the Era of the Asylum to the Age of Prozac* (NY: John Wiley & Sons, Inc. 1997), 45.

¹³³ “Central State Hospital Sesquicentennial,” Supplement, *Milledgeville Union-Recorder*, January 17, 1992.

¹³⁴ Peter Wallenstein, “Laissez Faire and the Lunatic Asylum: State Welfare Institutions in Georgia—The First Half-Century, 1830s-1880s,” in *Before the New Deal: Social Welfare in the South, 1830-1930*, ed. Elna C. Green (Athens: The University of Georgia Press, 1999), 16.

¹³⁵ Ibid.

Far from the “freedom” Green and his contemporaries believed the freedmen enjoyed in the past, after emancipation, they believed them to be “undoubtedly under the influence of almost every exciting cause of disorder of the brain.”¹³⁶ It was no surprise to men of this belief that the newly freed people would be making their way to the asylum.

In response to his concern, the state appropriated money to provide accommodation for freedmen. The building became full by August of 1867 and “in the absence of state money for these items in 1867 and 1868, the Freedmen’s Bureau supplied monthly rations.”¹³⁷

During the third decade of Green’s administration, the institution received repair and renovation. “Gravel roofs were replaced with tin. Modern gas lighting was installed. More adequate heating, ventilating and bathing facilities were introduced. Bridges were thrown over creeks. ... In a word, the hospital was undergoing a monumental cleaning. Most of the work was done by patients.”¹³⁸ Significantly, by the end of Green’s tenure, the asylum boasted “one doctor for each 112 patients. This enabled the physicians to see the patients every day ... a medical situation so favorable that it was never again to be matched at Milledgeville.”¹³⁹ In spite of these successes, in 1872 the Georgia legislature appointed two physicians to examine the asylum. Their findings were not so flattering. Gerald Grob wrote of their visit:

Despite his [Green’s] long tenure, the hospital continued to have serious problems and remained considerably below the level of other public institutions. As late as 1872 two physicians who conducted a study for the legislature were moved to write that ‘we have commended nothing, and for the very simple reason, *that we saw nothing to commend....* We can say nothing about the Asylum but that in the past it has been a failure, and now needs a thorough reorganization.’¹⁴⁰

¹³⁶ Ibid.

¹³⁷ Ibid., 17.

¹³⁸ Peter G. Cranford, *But for the Grace of God* (Augusta, GA: Great Pyramid, 1981), 37.

¹³⁹ Ibid.

¹⁴⁰ Grob, 362.

Important changes would occur over the last seven years of Green's term, including a decision by the Georgia Legislature in 1877 to make "the asylum free to all bona fide citizens of Georgia."¹⁴¹ Reorganization would come most effectively with the following administration. In a report to the governor written toward the end of Green's tenure in 1878, the trustees reflected that Dr. Green saw "the Institution grow up under his fostering care, from a small affair with only about 60 patients, to its present dimensions, with seven hundred and thirty-eight inmates under his treatment."¹⁴² Green left a fine legacy, but one not nearly as auspicious as that of the next superintendent.

Dr. Theophilus Orgain Powell, who had served as a physician at the asylum for seventeen years, was appointed superintendent in 1874 at the age of forty-two. A medical school graduate of the Georgia Medical College who left an early practice in Sparta to join the Confederacy, Powell "organized the hospital along army lines."¹⁴³ It was during Powell's administration that many of the women from northeast Georgia included within this study, lived and died at the institution. The next section of this chapter will focus on changes at the institution from 1886 to 1936. Newspaper articles yield important information about the social and political culture of the time and the themes pervading not only the South, but the institutions within the South. The themes evident to us were the lived experience of the women; the very air they breathed.

The Institution as a Setting for This Study

In 1886, the first woman from the patient records used in this study was admitted to the asylum. By 1890, four years after she was admitted to the asylum, the patient population had doubled from the time of Dr. Green to over 1500 patients in the charge of Dr. Powell.¹⁴⁴ The

¹⁴¹ "Central State Hospital Sesquicentennial," 5

¹⁴² Cranford, 39

¹⁴³ Ibid., 40.

¹⁴⁴ Cranford, 46

1890's were an important decade at the institution. In 1892, the Central Railroad of Georgia began to run ten regular trains to the asylum, fifteen on Sunday."¹⁴⁵ In 1897, the institution's name was changed from the Georgia Lunatic Asylum to the Georgia State Sanitarium and infirmary wards "became standard."¹⁴⁶ In 1898, the "colony farm" began producing food and cattle for patient consumption.¹⁴⁷ And early in the first decade of the 1900's, the Sanitarium's first dentist was hired,¹⁴⁸ the institution dealt with an epidemic of smallpox¹⁴⁹ and the *Atlanta Constitution* celebrated the Sanitarium as Georgia's "Noblest Charity" in a full page spread.¹⁵⁰

Racism

William Holmes reminds us that "between 1891 and 1908, Georgia enacted segregation statutes and added disfranchisement amendments to its constitution that further restricted black citizens by separating them from whites in most public places."¹⁵¹ The *Atlanta Constitution's* 1902 article is a good example of this separation at the Sanitarium and the racism inherent in the South at the time. In describing the institution, the author noted two large brick buildings that flanked the main building were "used for various forms of white sufferers."¹⁵²

In an effort to explain black deaths by tuberculosis, the author of the article also revealed a common, shared racism. He wrote,

It [blacks' death by tuberculosis] was due to the fact that Negroes cannot stand confinement and he [Senator Van Buren of Georgia] proposed that a colony for the negroes be organized and all that could possibly be made to do any farming be put on his colony. This was done and the improvement in the health of negroes began at once, and it is now believed that this will work out the solution of the

¹⁴⁵ Central State Hospital Sesquicentennial, 7.

¹⁴⁶ Cranford, 48

¹⁴⁷ "Central State Hospital Sesquicentennial," 7

¹⁴⁸ Cranford, 50.

¹⁴⁹ T.O. Powell to *Carnesville Ordinary*, January 23, 1902.

¹⁵⁰ Edward Young Clarke, Jr. "State Sanitarium, Georgia's Noblest Charity," *Atlanta Journal Constitution*, November 30, 1902, In ProQuest Historical Newspapers *Atlanta Constitution* (1868-1942): D 10.

¹⁵¹ Holmes, vii

¹⁵² Clarke, D 10.

negro problem at the Sanitarium. By their labor a greatly increased amount of farm product will be raised and the health of the negroes improved.¹⁵³

Not only at the institution, but in the South in general, Blacks provided cheap—in this case, free—labor. No mention was made of the fact that every tuberculosis victim would likely benefit from being outside, free from confinement and enjoying fresh air.¹⁵⁴ These men determined to make “the negro problem” into a solution for themselves: free farm labor in exchange for securing the [supposed] physical health of the laborers.¹⁵⁵ Clarke continues:

It was formerly thought that negroes could not have consumption, but it is rapidly spreading all over the south among them and is proving very destructive. One of the officials in discussing the matter said: “I really believe that unless something is done to check the spread of tuberculosis and moral vice among the negroes twenty-five years will witness their almost complete extinction.”¹⁵⁶

Tuberculosis was certainly endemic to the South at the time. But this article reveals that not only tuberculosis, but the addition of “moral vice” was believed to be endemic to blacks. Surprisingly, the author attributed these vices to “the white man.” Vice was not the problem for blacks, the problem was the lack of moral sense in order to *deal* with vice.

The negro race have, so to speak, taken up the white man’s vices, and they do not know how to take care of themselves, and consequently the race is being swept by a regular plague. Most of the cases that come here [to Milledgeville] are due directly to moral vice, and indeed the whole race seems absolutely devoid of any moral sense.¹⁵⁷

Blatant racism was widespread at the time and accepted by the general public for years to come. When a black patient killed a nurse with an ax handle two decades later in 1925, the community reacted no differently than they would have in any other Georgia community. Cranford

¹⁵³ Ibid.

¹⁵⁴ Although the prevailing view was that fresh air was the best treatment, an abundance of food and bed rest [not physical labor] yielded the greatest recovery rate. See Mary Jane Hunt, “Facilities for Care and Measures for the Control of Tuberculosis in Georgia,” (Master’s Thesis, Tulane University, 1946).

¹⁵⁵ Joel Braslow writes of the substantial savings farm labor meant for the state of California in *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century* (Berkeley: University of California Press, 1997), 29.

¹⁵⁶ Clarke, D 10.

¹⁵⁷ Ibid.

documents, “That night, entrance was forced into the colored building and the insane negro was killed in the same fashion.”¹⁵⁸

Broad statements were commonly attributed to entire populations, particularly black populations. The fruit of racism, whose seeds had been planted with slavery, was prevalent at the time. But the seeds were just being sown for a new way to deal with undesirable differences in human beings in the future.

Eugenics

In April of 1913, the *Atlanta Constitution*, particularly concerned that “so large a proportion of the negro population is given over to sloth and vice,” reported that Sanitarium officials drafted a bill “providing for ‘the sterilization of all the criminally insane, idiots, rapists or moral degenerates within the confines of the hospitals.’”¹⁵⁹ Presumably, the majority of these people were black. At the time, many people believed that by preventing the breeding of non-desirable traits in people, science could effectively extinguish criminal behavior, insanity, idiocy, and immorality. After hearing a presentation on sterilization and “reviewing the background of all 1,108 patients admitted in 1912” for evidence of heredity, Milledgeville officials “began recommending the enactment of a compulsory sterilization law for Georgia, which they continued doing until they achieved this goal a quarter century later.”¹⁶⁰ But the context of categorizing individuals on the basis of not only race, but mental ability, morality, mental illness and heredity was very much a part of the institution’s culture at the time.

¹⁵⁸ Cranford, 78.

¹⁵⁹ “Declares Sterilization is Solution of Negro Problem” *Atlanta Journal Constitution*, April 20, 1913, In ProQuest Historical Newspapers *Atlanta Constitution* (1868-1942): 7.

¹⁶⁰ Edward Larson, *Sex, Race and Science: Eugenics in the Deep South* (Baltimore: The Johns Hopkins University Press, 1995), 45-6. Larson explains further that serious consideration came in 1935, one year before the completion of this study. According to patient records, only one woman of the 91 within this study was sterilized. She was a white woman who exhibited promiscuous behavior. Since “serious sterilization” came not until 1935 and this study ends in 1936, an examination of patient records after 1936, if they could be found, would need to be executed in order to learn more of prevalence of sterilization at the institution.

Pellagra

After the death of Theophilus Powell in 1907, Loderick Jones assumed the superintendent's role, with 3,148 patients within the Sanitarium. Early in Dr. Jones' administration, electricity came to the Sanitarium and the institution's gas lights were no longer needed.¹⁶¹ Tuberculosis pavilions were added to the campus of the institution. But the disease of pellagra lurked close by and would confound scientists and physicians for the next few decades. The Georgia State Sanitarium played an important role in the study of "the new disease," pellagra. Lynne Wilcox explained the etiology of pellagra well:

Diet [was linked] to the seasonal economies of cotton: salt pork, corn meal, and cane syrup were staples, while vegetables, milk, eggs, and fresh meat seldom appeared on the dinner table of a sharecropping family, especially in the winter. Pellagra was widespread. The initial symptom, a 'butterfly' dermatitis that spread across the face and other sun-exposed parts of the body, created the red-neck stigmata that popular national culture extended to the South as a whole, though the rash was by no means limited to those of light skin. Diarrhea soon followed and when the afflicted grew demented their family members knew that death might come soon (mortality rates at this stage were 50% and higher), completing the '4 D's' of the pellagra syndrome.¹⁶²

In Mt. Vernon, Alabama, a pellagra epidemic broke out in 1906 at the Alabama Institute for Negroes. Physicians from South Carolina alerted the South Carolina Health Department of their concern about the new disease, and a questionnaire was sent out to superintendents of state hospitals across the United States. "To 164 inquiries, 120 replies were received." South Carolina, Georgia and Alabama reported the highest numbers of persons with pellagra.¹⁶³ This information led to a national pellagra conference which convened in South Carolina in November of 1909.

¹⁶¹ Cranford, 57

¹⁶² Lynne S. Wilcox, "Worms and Germs, Drink and Dementia: US Health, Society, and Policy in the Early 20th Century," *Preventing Chronic Disease: Public Health Research, Practice, and Policy* 5, no. 4 (October 2008): 1-12. http://www.cdc.gov/ped/issues/2008/oct/08_0033.htm. Although Ms. Wilcox is writing specifically of the pellagra epidemic which surrounded the Mississippi flood of 1927, her explanation of pellagra applies also to the Northeast Georgia piedmont region.

¹⁶³ Daphne A. Roe, *A Plague of Corn: The Social History of Pellagra* (Ithaca, NY: Cornell University Press, 1973), 80.

Pellagra was first noticed at the sprawling Georgia State Sanitarium in Milledgeville in 1908, when forty cases and twenty-three deaths were reported. Those afflicted ranged in age from six to seventy-five; nearly all who died were female ... that year tuberculosis was the leading cause of death at the Milledgeville hospital, and pellagra was second. A year later, pellagra was the number one killer there, causing seventy-three deaths, 16 percent of the hospital's total.¹⁶⁴

At the time, the hospital spent “thirty-seven cents per patient per day.”¹⁶⁵ Although corn was suspicious to all involved with pellagra patients, no one knew what it was about corn that caused the illness. The first suspicions surrounded the quality of corn and the idea that moldy corn might cause disease.

By the time pellagra patients reached the Sanitarium, they were very ill indeed, both physically and mentally. The question of contagion was prevalent and some compared the appearance of pellagra patients as that of lepers. But at Milledgeville, Elizabeth Etheridge explained that the isolation of pellagra patients was not due to the fear of contagion. “An informal isolation of pellagra patients was carried out at the Georgia State Sanitarium in Milledgeville,” she wrote, “not because the physicians there thought the disease contagious, but rather because, as one doctor expressed it, these were ‘extremely filthy cases and ... we put them there so they can be treated better.’”¹⁶⁶

Salvarsan, an arsenic compound, was tested on pellagra patients at Milledgeville, where pellagra increased so rapidly from 1908 to 1912 that doctors tried almost anything to control it. Some of the patients showed marked improvement after treatment; others seemed better for a time but then relapsed. The final tally showed 18 percent recovered, 45 percent unimproved or relapsed, and 36 percent dead, hardly an impressive showing.¹⁶⁷

¹⁶⁴ Elizabeth W. Etheridge, *The Butterfly Caste: A Social History of Pellagra in the South* (Westport, Connecticut: Greenwood Publishing Company, 1972) 5.

¹⁶⁵ *Ibid.*, 5.

¹⁶⁶ *Ibid.*, 31-2

¹⁶⁷ *Ibid.*, 35.

Etheridge further explained how panicked officials at the Sanitarium accompanied by a rise in pellagra deaths led to intervention on a national level.

Since 1911 the trustees of the Sanitarium had urged the United States Public Health Service to send someone to Milledgeville to study pellagra, but it was not until the pellagra work was greatly expanded that the invitation could be accepted. By 1914 ... the need for help at the Georgia State Sanitarium was acute. There was a remarkable increase in the number of pellagra patients at the institution that year—a total of 365 cases. Of these, 190 died.¹⁶⁸

In 1914, Dr. Joseph Goldberger, a physician and Public Health Service officer from New York, was assigned by the United States Public Health Service to study pellagra in the South. Goldberger was well equipped for the task, having studied many diseases, including yellow fever in Mexico, Puerto Rico and Cuba, dengue fever in Texas and “Stramberg’s disease”¹⁶⁹ in Philadelphia. Just as he began working on a diphtheria outbreak in Detroit, he was reassigned to the South.

Goldberger’s first concern was that pellagra was contagious, but through close observation, he was able to eliminate this concern. Although the nurses at the Sanitarium ate the same foods in the same location as the patients, nurses “always served themselves first, selecting the best and the greatest variety, giving the patients what was left. In addition, they had opportunity to supplement their diet elsewhere.” Goldberger began to entertain the possibility that pellagra was due to the southern majority’s limited diet: fatback, cornmeal, and molasses. On the basis of this possibility, Goldberger directed two physicians from the Public Health Service to provide an altered diet for “twenty-seven acute cases of pellagra.” The group was given “at least a half pound of fresh beef a day, several eggs, green vegetables, and milk. Seven of the patients died, and the condition of three remained unchanged, but thirteen others

¹⁶⁸ Ibid, 63.

¹⁶⁹ Ibid, 68-9. Goldberger solved the mystery of Stramberg’s disease within 48 hours after having volunteers sleep on the same mattresses infected sailors used. The culprit was a mite.

improved, and four were designated recoveries.”¹⁷⁰ These findings provided Goldberger and his team the encouragement to widen their experiment.

Superintendent Loderick Jones gave the team “complete control over two wards of female pellagra patients,” one white and one black.¹⁷¹ In less than five months, Dr. Goldberger made an announcement: “inadequate diet caused pellagra.” With this certainty, “diet therapy” began in the fall of 1914.¹⁷² “Some patients improved so rapidly under the [new diet] regimen that they were released from the hospital before the year’s study was complete, but seventy-two remained under observation for almost a year, or at least until the anniversary date of their last attack. Not one showed any sign of pellagra.”¹⁷³ The therapy was a total success. “Even before results of the diet tests at Milledgeville were announced to the public, officials at the Georgia State Sanitarium were praising the Public Health Service. In 1915, there were 210 patients at the hospital with a psychosis due to pellagra; in 1925, there were but 23.”¹⁷⁴ But Goldberger still faced serious opposition, both scientifically and politically.

Scientists still did not know the reason for pellagra, what they did know was that there was a “mysterious missing quantity in the Southern diet.”¹⁷⁵ Goldberger and his associates knew with certainty “pellagra was the fruit of poverty,” but there was no quick solution to the problem of poverty. And hostility on the part of southerners made improvement of the situation even more elusive. Etheridge states “there was only Southern pride and anger that it [widespread malnourishment in the South] should be mentioned at all. When Goldberger finally mentioned the unmentionable, Southerners became very angry with him indeed.”¹⁷⁶ Alfred Jay Bollet writes

¹⁷⁰Ibid., 72-4.

¹⁷¹Ibid., 63.

¹⁷²Ibid., 72.

¹⁷³ Ibid., 80-1.

¹⁷⁴Ibid., 181.

¹⁷⁵Ibid., 145.

¹⁷⁶Ibid., 145.

of the situation: “Politicians and the general public felt that it was more acceptable for pellagra to be infectious than for it to be a form of malnutrition, a result of poverty and thus an embarrassing social problem.”¹⁷⁷ Acceptance and utilization of Goldberger’s findings were many years in coming. The success he experienced at the Sanitarium did not even render an immediate change in diet there. As late as a 1916, a study found that patients had “too much side meat and biscuits and not enough of the cheaper and more nutritious lean beef. Despite the previous work of Goldberger, there was no effort made to remedy the diet with additional proteins.”¹⁷⁸ Mary Katherine Crabb wrote that Goldberger’s “results were angrily denounced by southern physicians, legislators and the general public. Nearly 20 years elapsed before his conclusions were finally accepted and a coordinated public health effort was begun.”¹⁷⁹

In the 1920’s, having answered with satisfaction the question of how to cure pellagra, Goldberger, who had previously been working in Alabama, South Carolina, Georgia, and Washington, “reduced his field of operations to [only] two points: the Hygienic Laboratory in Washington and the Georgia State Sanitarium at Milledgeville.”¹⁸⁰ Systematically adding one extra food to the hospital diet for his sample groups, he narrowed the possibility of finding the mystery ingredient. In working with rats, he found yeast a component which could reverse pellagra. This single finding would save thousands of individuals over the next two decades. Yeast as a pellagra cure was tested in 1927 within the theatre of a national disaster.

In 1927, when the Mississippi River flooded, “the Red Cross created a massive, uncontrolled natural experiment,” distributing 12,000 pounds of brewer’s yeast to affected areas. “Two teaspoonfuls three times a day for adults, or half that much for children,” mixed into milk,

¹⁷⁷ Alfred Jay Bollet, “Politics and pellagra: The epidemic of pellagra in the U.S. in the early twentieth century,” *Yale Journal of Biology and Medicine* 65 (1992): 211.

¹⁷⁸ Cranford, 73.

¹⁷⁹ Crabb, 89.

¹⁸⁰ Etheridge, 170.

molasses or fruit juice, cured the pellagra in the area. The distribution was followed by a rapid decline in the number of reported cases and improvement in disease symptoms.”¹⁸¹ Although after his death in 1929, pellagra was found by Goldberger’s associates to be caused by a deficiency of niacin, the complete disappearance of pellagra would not occur until the enrichment of bread became widespread in the 1940’s.¹⁸²

Overcrowding from 1914-1916

The issue of overcrowding plagued the institution throughout its history.¹⁸³ Not unlike other mental hospitals across the country, Milledgeville grew alarmingly and could not keep up with the growth. According to Peter Cranford, “by 1914, there were more than 3,500 patients. The negro building which was designed to accommodate 570 had 1000 patients. The white female department was overcrowded. More than 1,300 new patients were admitted during the year.”¹⁸⁴ In 1916, the *Atlanta Constitution* reported an alarming death rate and continued overcrowding at Milledgeville:

In the negro department where the over-crowding is greatest, the death rate is 20 per cent of all cases under treatment; while in that for whites, where somewhat better conditions are obtained, it is only slightly above 7 per cent. When it is recalled that a death rate of 2 per cent [sic] in the general population, considering children and all others, is a very large one, it will be seen how serious are conditions at the state Sanitarium.

The newspaper decried the lack of funds for building more facilities to accommodate those in need.

In the 72 years since the Sanitarium was established, 28,653 patients have been admitted to it, while 12,901 have been received since January 1, 1904. Almost 50 per cent of the total admissions for the 72 years have been within the last 12

¹⁸¹ Wilcox, 8.

¹⁸² This is illustrated in the article “Nutritional Disease in Georgia” reprinted from the *Journal of the Medical Association of Georgia* 54: 7 (July 1965), 252-3. Table 1 shows deaths by pellagra in Georgia from 1920-1955. The highest incidence of death was 709 people in 1930. By 1940, the number was 253 and by 1945, 107 people died of pellagra. The number of deaths by pellagra dropped to 23 in the year 1955.

¹⁸³ See Cranford, 38, 41, 45, 46, 69.

¹⁸⁴ Cranford, 69.

years, during which time absolutely no added provision has been made for patients. The number now in the institution is more than 4,100. The newspaper continued to criticize, this time the Sanitarium itself for admitting patients when they had not the room for them.

At the beginning of 1915 there was not a single vacancy in the department for white females, yet 491 white women were admitted during that year. In the white male department some of the dormitory wards intended for 80 patients now accommodate 125. The negro department, with a capacity for 560 patients, contained at that time 976, while during the year 614 were received, a number greater than the estimated capacity of the whole department. In a single one of the wards for negroes in which 50 patients are supposed to sleep, there are crowded 150.¹⁸⁵

Clearly, the Sanitarium was very overcrowded, but without needed funds little could be done to accommodate more patients.

Depression Years

In 1929, the name of the institution was changed once again, from the Georgia State Sanitarium to Milledgeville State Hospital. The institution included over 5,000 patients.¹⁸⁶ By 1930, Joseph Goldberger's work resulted in an improved diet at the hospital: "more milk and eggs, fruit and vegetables." Peter Cranford reported, "patients now get eggs at least once a week when formerly they got them only once or twice a year."¹⁸⁷ The hospital supplemented with other foods, as well. Although "the mental complications which sometimes accompany this disease [pellagra] were responsible for 5.69 per cent of the new patients admitted during 1929,"¹⁸⁸ "yeast and canned haddock [acted] as pellagra preventatives."¹⁸⁹ The hospital was finally responding to Goldberger's findings.

¹⁸⁵ "State institutions inadequate or insanity is on the increase," *Atlanta Journal Constitution*, June 13, 1916. In ProQuest Historical Newspapers Atlanta Constitution (1868-1942): 8.

¹⁸⁶ Cranford, 78.

¹⁸⁷ Cranford, 80.

¹⁸⁸ Carter Brooke Jones, "State hospital carries on despite lack of adequate aid. work humane and vitally important," *The Atlanta Georgian*, 8 July 1939.

¹⁸⁹ Carter Brooke Jones, "State hospital carries on despite lack of adequate aid. Work humane and vitally important.

In 1930, in a one-week series, *The Atlanta Georgian* probed the condition of the Milledgeville State Hospital. Amazed that the campus had grown “from a little stone building completed in 1842,” to the sprawling campus it was ninety years later, the newspaper suggested, “if the pioneers of the state hospital could see it today, they would be amazed.” The newspaper’s initial article focused on the overcrowding and lack of funding from the state. At the time, the institution had been “running on credit for months” to provide for 5,325 patients on “\$.63 a day.”¹⁹⁰ Meanwhile, “some 300 persons adjudged insane are held in county jails throughout the state, denied medical treatment, because there is no place for them in the congested State Hospital.”¹⁹¹

A group of large buildings is spread over the hills above Milledgeville. The hospital owns some 3,600 acres. Miles of farm land stretch out from the main buildings. The farm supplies vegetables, fruits and dairy products. The hospital has its own water works, ice plant, laundry and heating system. More than 700 employes [sic] are necessary to look after the physical equipment of this huge institution and to care for its 5,325 patients.¹⁹²

Beyond describing the campus and the work required to maintain its smooth functioning, the newspaper also focused on patient care, specifically on occupational therapy. Occupational therapy varied depending on whether one was a man or a woman. Men found work in the carpenter shop, machine shop, farm, dairy or kitchen. Women “sew or knit or weave. And they turn out beautiful baskets, vases, embroidered towels and centerpieces, artificial flowers, coverlets, all manner of delicate handicraft.”¹⁹³ “Perhaps as they rock and work,” wrote the sentimental reporter, “a phonograph plays a lively air.”¹⁹⁴ With this level of care, suggested the

¹⁹⁰ Ibid.

¹⁹¹ Carter Brooke Jones, “Debt of \$500,000 and overcrowding grips Ga. Asylum,” *The Atlanta Georgian*, 6 July 1930. 1.

¹⁹² “Ga. institution now a city in itself,” *The Atlanta Georgian*, 1 July 1930.

¹⁹³ Carter Brooke Jones, “Program of work, diversion aids state hospital inmates,” 9 July 1930, 16.

¹⁹⁴ Ibid., 24

article, the recovery rate in 1929 “was 58.50 per cent. Patients received during the year totaled 1,229, and those released number 698.”¹⁹⁵

By 1937, a year after the last women in this study died, the population of the hospital “went over 8,000.”¹⁹⁶ In the same year, E.D. Rivers assumed the governorship of Georgia and once again, “summoned state lawmakers to Milledgeville for an inspection of the state hospital.” Alarmed with the “deplorable” condition of the facility, officials committed ten million dollars of state funds to improve the neglected hospital.¹⁹⁷ But when a newspaperman from New York visited Milledgeville ten years later as part of a tour of nine state mental institutions within the United States, he deemed the hospital similarly abhorrent to others in his survey. Perhaps recollecting the experience of Goldberger and fearful of being viewed as another Yankee to place judgment on the South, Albert Deutsch initially feared that “people in the South, already skinned raw by Northern criticism, might get defensive and adopt a do-nothing attitude if subjected to yet another expose by another Northerner.”¹⁹⁸ But Atlanta’s Mental Hygiene Association invited Deutsch to speak in October of 1946, and to tour Milledgeville; the governor extended a formal offer.

At the time of his visit, Deutsch, like many others, stood amazed at the campus. He wrote later that “scores of building are scattered over 1,870 acres, and its nearly 9,000 patients represented the largest mental hospital population in the world.”¹⁹⁹ Although Deutsch claimed “physically, the best I saw at Milledgeville ranked with the best I’ve seen anywhere; the worst was the worst I had ever seen,”²⁰⁰ he spent the majority of his time ruminating over the worst,

¹⁹⁵ Carter Brooke Jones, “Program of Work,” 24.

¹⁹⁶ Cranford, 82.

¹⁹⁷ Edward Larson, 136.

¹⁹⁸ Deutsch, p. 88

¹⁹⁹ Deutsch, 90.

²⁰⁰ Ibid., 91.

documenting in photographs much of what he witnessed. “Georgia’s per capita budget,” declared Deutsch, “ranks fourth from the bottom among the nation’s mental hospitals. Decent custodial care alone would require tripling the present allowance; good psychiatric treatment would require at least six times as much money.”²⁰¹ Deutsch found 633 patients to one physician, a severe shortage of nurses and only one social worker on staff. Attendants worked twelve hour days, six days a week for \$76 and room and board. The hospital pathologist,

whose job should be to conduct research and perform autopsies, spent his whole time until recently embalming patients who died—there were 790 deaths in the year ending last June—because there was no refrigerator in the morgue and bodies had to be embalmed quickly to keep them from spoiling!²⁰²

But he was careful to lay the blame not on Georgia and not even on the South. “If I found shameful conditions at Milledgeville, they differed only in degree, not in kind, from those found in most American mental hospitals. The shame is not Georgia’s alone, nor the South’s, but the nation’s.”²⁰³

The current superintendent, Dr. Yarbrough, toured the hospital with Deutsch, who later recorded an exchange between the two.

At one point, he [Yarbrough] turned to me [Deutsch] with bitterness and said: “I’ve never seen anything worse than this anywhere and you can quote me on that. I’ve tried hard and mostly in vain for many years to work up enough interest in the legislature and the public to get decent care and modern medical treatment for these poor people. But what can you expect on an appropriation of 76 cents a day per patient? Why, we spend more than that for prisoners.”²⁰⁴

In fact, Deutsch found evidence of the truth of Yarbrough’s statement. “The finest, most up-to-date building I saw under construction at Milledgeville, at a cost of \$450,000, was intended to house the criminally insane! I remarked to [State Welfare Department Head] Judge Hartley, as

²⁰¹ Ibid., 91.

²⁰² Ibid., 92

²⁰³ Ibid., 90

²⁰⁴ Ibid., 90-1.

we were inspecting it, that I would be tempted to commit a crime were I a civil patient in one of Milledgeville's old firetraps, in a desperate effort to break into this wonderful building for criminals."²⁰⁵ In addition to the facility for the criminally insane, Deutsch toured a tuberculosis facility. Rather than fixating on the grandeur of the building, however, he seemed appalled at the racism evident there. Although the "TB wards, incidentally, represent[ed] about the only part of Milledgeville where the hypocritical 'separate-but-equal-facilities' Jim Crow law of Georgia is observed"²⁰⁶ [the building] was erected with two wings—one for whites, the other for Negroes. Duplicate X-ray and other equipment had to be installed for both races," wrote Deutsch, "illustrating the high cost of Jim Crow."²⁰⁷ Furthermore, Deutsch found evidence of racism in the annual report of Dr. Yarbrough. Deutsch writes,

The operation of the Jim Crow policy in the Milledgeville state hospital, outrageously evident in the physical quarters for white and colored patients, is reflected in the latest annual report of its superintendent, Dr. Yarbrough. It tells how daily clinics were held over a six-month period "for the purpose of interviewing every *white* patient to determine whether or not they have shown sufficient mental improvement to be released from the hospital." Nothing is said about interviews with the Negro patients for the same purpose. The report also notes that "all wooden beds throughout the white department were replaced by metal beds, and this was also done in the new colored building." Colored patients in the old building still sleep in broken-down, vermin-infested wooden beds, when they don't have to lie on mattresses thrown on the bare floors.²⁰⁸

Disgusted, Deutsch bemoaned the fact that Georgia had no mental health wards in any hospital but Milledgeville. "Hence people who became mentally sick can be sent only to Milledgeville or to a county jail. Many mental patients still languish in jails awaiting commitment to Milledgeville."²⁰⁹ Furthermore, Deutsch reported, "no patient can be voluntarily admitted to the

²⁰⁵ Ibid., 93.

²⁰⁶ Ibid., 94.

²⁰⁷ Ibid., 94.

²⁰⁸ Ibid., 94.

²⁰⁹ Ibid., 94.

state hospital; he or she must, in each instance, go through a humiliating court procedure leading to legal commitment—very much as if insanity were akin to crime.²¹⁰

When on the heels of Deutsch's book came *The Snake Pit*, in both its book and film versions, Georgians, just like the rest of the country, grew more distrustful of the Milledgeville Hospital. Twenty years later, in 1967, the name of the institution was changed once again, from Milledgeville State Hospital to Central State Hospital. Shortly afterward, deinstitutionalization began and the hospital's population went from a high of nearly 13,000 to 3,000.²¹¹

This chapter has presented a historical context for not only northeast Georgia, but for the institution in Milledgeville. The next chapter will explain the methods used in the study.

²¹⁰ Ibid., 95

²¹¹ "Central State Hospital Sesquicentennial," 11.

CHAPTER 4

METHODS: A JOURNEY INTO THE ARCHIVES

In 2001, I entered Central State Hospital as the descendent of three women who were patients there from 1948-1989. After visiting the hospital, I signed an affidavit at the Baldwin County courthouse, attesting to the proof of my kinship and received the patient records by mail. But each page of the patient record I received was stamped prohibiting their use in any sort of publication or presentation. I knew that in order to access patient records for scholarship, even if they were records of my own family members, I would require IRB approval from the University of Georgia as well as approval from the State.

Eight years later, as part of the process of applying to access patient records from Central State Hospital archives, I agreed to de-identify each woman within the study. State law protects the confidentiality of patient records less than seventy-five years old. But I chose to de-identify even the women who were admitted and died at the hospital over seventy-five years ago.

Australian scholar Janet MacCalam explained well the reasons for de-identification. “Even when I believed I was covered by the 75-year rule, I resolved not to use patient names,” she wrote. She continued,

I have learned from past experience that Melbourne is still a very small town with a relatively stable population by international standards. While many immigrants come, once here, they mostly stay. Your potential readers always include direct descendants of patients and thousands of enthusiastic family historians who trawl every new publication for mention of an ancestry. Quite rightly, they would not appreciate (and neither would their grandmothers), having intimate

gynaecological problems linked to the real name of the patient in the public record, let alone their syphilis or septic abortions...it will be many years before the descendants of those patients cease to care about such revelations and access to them will need to be tightly policed. There is always a tension in scholarship between the need and right to know, examine and understand, and the individual's right to privacy and the protection of reputation.²¹²

If Melbourne is “a very small town,” northeast Georgia is a small group of counties, as well.²¹³

Many people still live in the communities of their great-grandparents. By de-identifying women, I am also protecting families. Medical historian John Harley Warner provided further explanation for avoiding identification of actual patient names; access to records could easily be revoked were scholars not careful to safeguard identities.

Using the names of patients even from 19th-century records runs risks of invading family privacy and offending descendants...a single challenged instance of abuse by an insensitive historian might be enough to bring a backlash restricting access. And my own practice has been to consistently mask patient names, at least encountered in institutional records.²¹⁴

Early on, I determined to do the same. The patients as well as their families are given pseudonyms. I have made every effort to de-identify small communities as well as any other piece of information which would make a woman's true identity known. Although I provide citations that enable scholars to retrieve the specific patient records I used, only by receiving permission from the Georgia Department of Behavioral Health & Developmental Disabilities would a scholar be able to access them; and then only after guaranteeing de-identification.

In the fall of 2009, I applied to the University of Georgia and to the Georgia Department of Behavioral Health & Developmental Disabilities to gain access to approximately 30 patient records reflecting a small community in northeast Georgia. In the summer of 2010, after gaining

²¹²Janet McCalman, “Writing the Women's—Hospital History with Medical Records,” *Health and History* 1:2/3 (1999): 135-6.

²¹³ For the purposes of this study, northeast Georgia counties include Banks, Franklin, Habersham, Hall, Hart, Jackson, Madison, Stephens Counties. These counties were all part of the original Franklin County boundary.

²¹⁴ John Harley Warner, “The Uses of Patient Records by Historians—Patterns, Possibilities and Perplexities,” *Health and History* 1:2-3 (1999): 110.

access to the patient records, I began searching for the records themselves. At the Georgia Archives in Morrow, Georgia, I found paragraph-length records kept on patients as they entered the institution both on microfilm and within the reading room. At Central State Hospital, I found a room of index cards, one per patient admitted to the institution,²¹⁵ admissions registers listing dates of admission, furlough and discharge, death logs, obstetrics logs, and other odds and ends.²¹⁶ On these early excursions to the archives and the hospital, I found further evidence that the patients I sought had been at the institution. Emboldened, I intensified my search for actual patient records. Ultimately, I found them in three locations. Two locations at Central State Hospital in Milledgeville house approximately 145 volumes from 1919- 1937. The Georgia Archives houses 109 volumes of patient records from 1909-1919. But working with these patient records proved daunting. In time I found what appeared to be a lack of organization was actually a very organized method.

Limitations of the Data

Catherine Coleborne uses the term “insanity’s archive” to refer to the psychiatric casebooks she works with in Australasia.²¹⁷ The Georgia records, although containing similar information, have been filed into notebooks. The notebooks were difficult to locate and once found, equally difficult to decipher. Initially, I read through volumes but could find no logical sequence to the records. Although each patient was intact, it seemed as though someone had scattered them, then picked them up off of the floor and placed them in no conceivable order in

²¹⁵ The staff states that each person ever admitted to the institution has a card here, but there were several I was unable to locate although I knew with certainty the woman had been admitted.

²¹⁶ One most interesting document logs names of 688 individuals whose “bodies [were] sent [by train] to Medical College, Augusta.” The cadavers were also sent to the Medical Department of UGA and to Emory University from the early 1930’s to 1953. For more on the Medical Department of UGA, see <http://www.georgiaencyclopedia.org/nge/Multimedia.jsp?id=m-11183> and <http://www.georgiahealth.edu/about/history/> (both accessed July 11, 2011)

²¹⁷ Catherine Coleborne, “Reading Insanity’s Archive: Reflections from Four Archival Sites,” *Provenance: The Journal of Public Record Office Victoria* 9 (2010).

the binders. Frustrated and unable to find any staff member who had experience with the records, I found the telephone number for the retired hospital archivist, Judy Carlisle, who had helped me find my family records in 2001. She explained the records I reviewed were organized by date of death. No matter when a patient *came* to the institution, their record was filed into the notebooks chronologically by the date of their death or discharge. Furthermore, when Ms. Carlisle explained her procedure for locating patient records by accessing “retrieval books,” I tried to duplicate her method to no avail. No staff member at the institution at this time has knowledge of the retrieval books. The knowledge base Ms. Carlisle developed left the institution with her retirement in 2006. The only patient records I found were [Date of] Death records; of the thirty-three patients whose records I sought, I found only one.

Catherine Coleborne continues her description of “insanity’s archive:”

The sources are usually housed in official archival collections, mostly state-run repositories, but they are also sometimes located in hospitals themselves. In rare, but instructive, examples, the archival material may be found rotting in the basements or cupboards of disused institutions and rescued by the researcher.²¹⁸

The majority of the records Ms. Carlisle retrieved were on microfilm. Although the film for Milledgeville was in a cabinet perfectly suited to its function, the microfilm itself has suffered what may well be irreparable damage. The case of microfilm sat on the basement floor of a building on the Central State Hospital campus where most of these original patient records are also stored. According to the labels on the boxes, the microfilm contained case histories, correspondence, and death and discharge records. I received permission to take the microfilm to Georgia College and State University in Milledgeville, where I attempted to decipher the data using microfilm readers.²¹⁹ Although I tried on two different occasions to read a sampling of the microfilm, I was disheartened to find each roll completely unreadable. Each roll of film I

²¹⁸ Ibid.

²¹⁹ Ms. Carlisle explained the microfilm reader at the hospital was broken even before her retirement in 2006.

inspected was warped and crumbling; a layer of fine particle dust covered the floor underneath the cabinet, from which a strong vinegar smell emanated. Although I was unable to get all ten microfilm drawers open, I estimated they contain about 650 rolls of microfilm. Without prompt intervention, the data contained there will soon be completely lost. These rolls of microfilm may well be the only surviving documentation of patients who did not die at the hospital, but were rehabilitated there. It is priceless information. Ms. Carlisle retired in 2006 at which time she was regularly making copies from the microfilm at the local university. I believe that the damage has occurred over the past five years, possibly because of the microfilm's location in a damp basement storage room.

Enlarging the Data Sample

Because I found only one record of the 33 I sought, I received permission from Donald Manning, the Medical Director of the Georgia Department of Behavioral Health & Developmental Disabilities Office, to enlarge my data sample from one small community of women to encompass all women from the upper piedmont area of northeast Georgia who were patients at the Sanitarium and who died as patients at Central State Hospital between 1919 and 1937.²²⁰ Specifically, I sought women from rural areas of the original Franklin County portion of Georgia, which currently consists of the counties of Banks, Franklin, Habersham, Hall, Hart, Jackson, Madison and Stephens. I excluded from the study Clarke, Oconee and Barrow counties, which I believe to be more oriented toward the city of Athens than their rural, neighboring counties. With permission in hand, I returned to the hospital.

²²⁰ The boxes at Central State Hospital housed only patient records of women who had died during this period of time.

Methods of Data Collection

In November and December of 2010, I spent approximately two full weeks gathering ninety patient records from Central State Hospital. I began with the very first [Date of] Death Notebook, scanning each notebook from beginning to end and copying any record of a woman from any of the eight counties mentioned above. Many scholars have recently made use of patient records in their own studies.²²¹ Marjorie Levine-Clark wrote of her work in England, “the patient casebooks from the West Riding Pauper Lunatic Asylum are extremely rich sources to explore the social world of the patients, including their family relationships and the connections between their domestic circumstances and their mental health.”²²² Catharine Coleborne agrees: “Patient case notes should be reexamined as rich sources of information about families, households, [sic] and, most importantly, the language used by ordinary people to describe mental states.”²²³ The Milledgeville patient records are so rich at times, it is very hard to focus on the task at hand, (looking for women from eight counties) for reading the fascinating stories contained within them. But not all within the patient records is fascinating. The Georgia patient records from this period are not as detailed and verbose as a scholar would hope. John Harley Warner wrote, “The typical 1880 patient chart of American hospitals [is] terse.” He continued,

Compared with the earlier records...the overall visual impression of the opening page begins to be one of standardization, regimentation, and streamlining, even more so in the quantification, visualization, and freedom from patient’s words in the second and final page.”²²⁴

Peter McCandless states a similar concern.

²²¹ Among the many who use patient records in their own studies are Catherine Coleborne, Elizabeth Lunbeck, Marjorie Levine-Clark, and others.

²²² Marjorie Levine-Clark, “Dysfunctional Domesticity: Female Insanity and Family Relationships Among the West Riding Poor in the Mid-Nineteenth Century,” *Journal of Family History* 25 (July 2000): 342.

²²³ Catherine Coleborne, “His Brain was Wrong, His Mind Astray’: Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880’s-1910,” *Journal of Family History* 31 (January 2006): 45.

²²⁴ John Harley Warner, “The uses of patient records by historians—patterns, possibilities and perplexities,” *Health & History* 1, no. 2/3 (1999): 108-9.

As the asylum's population became more numerous, poorer, and blacker, and as early optimism about curing large numbers of them faded, case records generally became far more perfunctory. ... by the late nineteenth century, evidence about patient care is more often general and statistical than specific and anecdotal.²²⁵

Still, there is much to be gleaned from patient records.

Contents of Patient Records

Patient records for this study vary in length and depth of detail.²²⁶ Most records begin with the document of death, stating the woman's admission date, death date, reason for death, hospital diagnosis, and other varied pieces of information. Usually, the hospital documented whether her body would be returned home and how (by train or ambulance or funeral home), or whether her body would be buried on hospital premises.²²⁷

The second document is usually the history form. Apparently, when a woman was slated to come to the Sanitarium, officials would send a history form to the county ordinary (probate judge). Although Sanitarium officials requested a physician fill out the forms, sometimes they were completed by the ordinary himself, by a family member, or by an official from the patient's previous institution. Historian Catharine Coleborne claimed, "Case histories were largely reliant on details given by those closest to the patient—family friends, and neighbours."²²⁸ The history form requested basic information such as name, county, nativity, age, civil condition, occupation, and family contact information. The form requested information about the number of children born to women and the date of the woman's last birth, the first symptoms of the "attack," symptoms manifested, the probable cause of the "attack," and a host of questions probing the

²²⁵ Peter McCandless, "A Female Malady? Women at the South Carolina Lunatic Asylum, 1828-1915," *Journal of the History of Medicine and Allied Sciences* 54 (October 1999): 553.

²²⁶ Examples of patient record forms are in the Appendix.

²²⁷ Dates of burial and numbers assigned to graves were recorded in another record book in order to safeguard the anonymity of those buried at Milledgeville. See Larry Fricks, "The Georgia story: how to successfully restore a state hospital cemetery," <http://www.galileo.usg.edu/express?link=ggpd&parms=action%3>

²²⁸ Catharine Coleborne, "His Brain was Wrong, His Mind Astray": Families and the Language of Insanity in New South Wales, Queensland, and New Zealand, 1880's-1910," *Journal of Family History* 31 (January 2006): 50.

possible heredity of “diseases” from idiocy to consumption to moral depravity. Finally, the history form requested information on any suicide attempts or homicidal tendencies, use of drugs,²²⁹ tendencies toward violence, “filthiness”²³⁰ or “mischief with fire.”

The third set of documents combined initial observations, examinations and interviews of patients by medical staff. If a patient was unable or unwilling to converse, staff would often appeal to a family member, sometimes by writing a letter requesting information and sometimes by interviewing the husband, father, mother, sibling, or cousin directly (particularly if they were available at admission). From these interviews, observations, and examinations, the physician assigned to the patient would record family history, personal history, mental and physical summaries, reflections on the “attitude and manner” of the patient, examples of the patient’s “stream of mental activity” and a synopsis of the patient’s general mental attitude. Often, the direct transcription of dialogue between the patient and physician was recorded so that a comparison can be made between the direct transcription and the doctor’s synopsis of the conversation.

The fourth document is often a record of the assigned physician’s tentative diagnoses and the dialogue between that physician and the other physicians on staff. Each one would present a statement in affirmation or disagreement with the tentative diagnosis with an attempt being made to classify the patient. With classification came assignment to a specific ward based on the patient’s needs.

Finally, notes were kept on each patient for the duration of their stay at the Sanitarium. These notes recorded patient behaviors, and rarely, patient’s narratives. Sometimes the notes were kept monthly, but more often notes were recorded twice a year. In some cases, years went

²²⁹ The majority of women entering the institution during this time used snuff.

²³⁰ Probably refers to excrement

by without any recorded comments. It is impossible to know whether this is because there were none taken or because the notes were somehow lost.

Additional items were sometimes included in patient records, such as clinical notes from tests for tuberculosis or syphilis, letters from family, furlough records, accident reports, and coroner's inquests, among them. Records of furlough consisted of the date of admission, date of furlough, the condition of the patient at the furlough (improved or unimproved) and the identity of the person taking them home. Patients who returned within a year might provide information about their time at home and often medical staff would record their condition and attitude upon return. A patient who was furloughed and not returned within the year would have to go through all the steps of being committed in order to return to the institution. Any time a patient suffered injury, a form was filled out by the attendant on duty explaining the circumstances of the injury and locating the physical injury on a pictorial representation of the front and back of a man's form. Women who suffered with epilepsy sometimes had many of these accident reports from the falls they suffered while having convulsions. Finally, in the case of a woman's suicide at the institution, a coroner's inquest would be included as a document in her file.

After securing the patient records, I found all the index cards available on each woman within the index card room at Central State Hospital. The index card contains information about her location at the institution and additional information about her family and their directions in case of her illness or death. I then searched online for any genealogical information, census data, and death certificates available in order to create the most complete portrait of each woman possible.²³¹ For a select few women who exemplified the themes I found most relevant to the study, I engaged in additional scrutiny at the archives and at county courthouses and libraries.

²³¹ Many of the women died between 1919 and 1927, so their death certificates were available online through The Georgia Archives.

These extra pieces of information lent themselves to richer descriptions of the lives of women who would become my case studies.

Methods of Data Management & Analysis

Carol Warren, author of *Madwives: Schizophrenic Women in the 1950's*, explains the process of data analysis:

Interpretation of qualitative data consists of repeatedly reading the material in order to develop analytic themes and categories from the intersection of the data with the analyst's own understandings of the world. This process is reflexive, with prior understandings being modified by immersion in new data and the reinterpretation of the data undergoing continuous revision from the original vision, incorporating the views of reviewers and editors as well as of the author.²³²

From the time I began collecting patient records, I entered in to this reflexivity. Each step I took in the process immersed me in the material. Reflecting all the way through and gaining the perspectives of others, I engaged in constant revision of which Warren writes.

Initially, I organized the patient records and additional information found on each patient into files. I then began isolating pieces of data into an Excel spreadsheet. The spreadsheet helped me to begin to see patterns and to ask questions of the data. For instance, I was prepared to note differences between the treatment of black women and white women, but at first glance the differences were few, if any. However, the more I worked with the data, the more differences were revealed. For instance, as I worked with the spreadsheet, it became apparent that black women were more likely to have been in jail than white women. This finding yielded more questioning, more writing, and more evidence that my original hypothesis was valid. A search for more literature on Georgia's jails further strengthened the finding I would report as part of my conclusions.

²³² Carol A.B. Warren, *Madwives: Schizophrenic Women in the 1950's* (New Brunswick, NJ: Rutgers University Press, 1987), 6.

After organizing as much information as possible onto the spreadsheet, I then transcribed every bit of narrative information I could find that the woman had spoken herself or that the staff physician had recorded in his description of her experience. This information went into a table and as the table grew in length I began to have a sense of the themes inherent in the narratives. I began to divide the narratives into three overarching themes: poverty, confinement, and loss.

At this point, I began to write my own narrative of what I was learning. Narrative scholar Eliot Mishler “reminds us that ‘we do not *find* stories; we *make* stories.’ In fact, ‘we retell our respondents’ accounts through our analytic redescriptions.’ We, too, “are storytellers and through our concepts and methods ... we construct the story and its meaning.”²³³ In writing around the themes of poverty, confinement and loss, I constructed such a narrative.

The organization I chose to use is thematic. Three themes were apparent throughout the work. I have made every effort to include as many voices of women as possible within the themes and have not hesitated to use their voices even if it was filtered through their doctors. Additionally, four women within the study crystallized individual themes and became case studies. Leslie Bloom wrote,, “The task for the narrative researcher. . .is to be dually conscious of the individual and the societal-cultural contexts in which the individual experiences and interprets her life.”²³⁴

The case studies were my effort to contextualize. Not many patient records contain enough information to lend themselves to case study. I chose the four case studies because they did include ancillary information. The first case study contained detail of each trip to Milledgeville, as well as a narrative spoken late in life by the woman and recorded by a

²³³ Sharan B. Merriam and Associates, eds., *Qualitative Research In Practice: Examples for Discussion and Analysis*, (San Francisco: Jossey Bass, 2002), 287.

²³⁴ Leslie Rebecca Bloom, “From Self to Society: Reflections on the Power of Narrative Inquiry,” in *Qualitative Research In Practice: Examples for Discussion and Analysis*, eds. Sharan B. Merriam and Associates,.(San Francisco: Jossey Bass, 2002), 311.

transcriptionist. This narrative explained the circumstances of her youth and the reasons for much of what happened in her life. Because the second case was a woman known to my family community, I was able to do oral history work with her relatives, which created a depth of understanding about the woman's situation. The third and fourth case studies' records both contained letters written to the hospital on behalf of family members. These letters yielded insights otherwise lost to time and helped me to identify the deep losses experienced by each woman.

Limitations of Patient Records

Even before I was deeply enmeshed in the data, concerns were uppermost in my mind. Everything that went into the patient records was filtered through the lens of medical personnel at the hospital. As much as I would love to imagine that each women's narrative was as natural as it might have been had she been sitting at her own kitchen table, the truth is that each woman was most likely deeply uncomfortable at least at her initial interviews with medical personnel. Not only was her doctor a stranger, but he was also a man and she would have known that he came to her with preconceptions of who she was based on her very womanhood, her race, her age, her level of education, her occupation, and the statements her family had made about her. It was not uncommon within the records to find blatant comments of physicians that yielded evidence of their own preconceptions about "negroes," "farm women," "mountain people," and those with little education. With this in mind, how should a scholar filter a woman's response?

Peter McCandless writes about his work regarding the South Carolina Lunatic Asylum,

With rare exceptions, the evidence about the 'kept' ...comes from the 'keepers.' The historian must rely mainly on asylum records, especially case records kept by physicians who, until 1896, were always men. Occasionally, the patients' voices can be heard in these documents, but we hear only what the asylum staff chose to, or had time to record.²³⁵

²³⁵ Peter McCandless, 544-5.

But rather than finding patients' voices to be rare, I found their voices in the majority of the records. My response has been to treat each strand of narrative as a miracle in the fact that it was even recorded and to do my best to verify the woman's statements through other research. I trust that though her doctor may have viewed her through a lens that limited him from seeing her in all honesty, he also came to her as a caregiver and one who presumably (at least at the beginning of her confinement at the Sanitarium) wanted to help her. I have been impressed by the number of women's narratives surrounded by quotation marks and the knowledge that a transcriptionist, most likely a woman, would have been present in the room to record the voice and experience of the woman patient.

The Perspective of Mentally Ill Women

A second primary concern in analyzing this data is the believability of mentally ill women themselves. At times in reading through the patient records, a woman's situation would sound so impossibly harsh I could not in good conscience "use" the data without finding corroborating evidence of her statements. I found supporting documents, to be absolutely necessary if I was to trust what I was writing as reliable. Fortunately, there is a great deal of documentary evidence: census, military records, lunacy and pauper's records, and newspapers, among others, to support the statements of the women. I was limited only by time in pursuing the truth of many stories.

I found narratives of women who clearly suffered delusions, particularly religious delusions, to be very difficult to filter. And the very hardest narratives to interpret or validate were some which came from women with dementia praecox (schizophrenia), whose ramblings, although at times darkly humorous and amazingly detailed, sometimes lacked the coherence

needed to form a narrative. It was my choice as the researcher in this situation to exclude these types of data from the analysis.

This chapter has attempted to provide a detailed understanding of exactly which methods were engaged in this study, how decisions were made and how the data were analyzed. The next chapter will introduce the first of three findings from the data analysis: confinement.

CHAPTER 5

CONTROL AND CONFINEMENT

On their path to Milledgeville, most women experienced a measure of control or confinement within their homes and sometimes, home communities. Among these types of control and confinement were watching, guarding, and restraining at home and confinement within county jails. Many women experienced gradations of control and confinement. As their illnesses intensified, and particularly their threat to themselves and others increased, so did their form of confinement. This chapter will discuss these gradations of control and confinement with examples of each.

Home Surveillance

The most benign form of control expressed within the intake patient records prior to commitment was “being watched.” Many of the women’s intake records reflected that they were *watched* at some stage before coming to Milledgeville. Patients’ families saw watching as the most lenient form of control available to them for mild cases of insanity. When asked if they had utilized any confinement in the care of Sallie Crews, for instance, her family noted they were “only watching her.”²³⁶ Lola England’s family denied “confinement, but [admitted to] close watch.”²³⁷ Callie Green was “watched and cared for by [a] sick daughter & a friend.”²³⁸ Some

²³⁶ Central State Hospital (CSH), Box 30, Book 147, pp. 137-144.

²³⁷ CSH, Box 44, Book 217, pp. 261-279.

²³⁸ CSH, Box 49, Book 242, pp. 372-383.

women faced “nothing but watching all the time,” “careful watching,” and “continual” watching.²³⁹

Families sometimes elaborated on their reasoning behind the watching and communicated this reasoning to hospital personnel. Josie Hardy, a black woman, was admitted to the Sanitarium in 1930 at the age of 67. Although she did not know the place of her birth, she did know that she “was born in slavery time and was about nine years old when freedom was declared.”²⁴⁰ While admitting Josie, her son explained that she had had a fever that lasted six months in 1926. Afterward, she began wandering off and getting lost. She “would also talk foolish and [had a] tendency to build fires unnecessarily,” recalled her son. She thought someone was trying to kill her and he had to have “someone to watch her all the time.”²⁴¹

In 1913, Sarah Stone’s family related that the seventy year old woman had fallen “about a year ago, [and] at times ever since she has been imbalanced.... [we] only had to watch her,” they continued. “She would runaway [sic] and got to so we could not keep her at home at all.”²⁴² Sarah remained at the institution until her death in 1935. Jessie Allen’s family noted that she was “harmless,” but they “guarded [her] to keep her from leaving home.”²⁴³

Not all of the women were harmless. As women’s insanity intensified into violence, so did their families’ response. With the threat of harm came the need for something more than just *watching*. According to her son-in-law, Lula Willis was talkative and inclined to run away, but she was also becoming violent. An intake official reported his explanation of why she had to be watched prior to her third admission to the institution:

²³⁹ CSH, Box 44, Book 217, pp.261-279.

²⁴⁰ CSH, Book 206, pp. 271-284.

²⁴¹ Ibid.

²⁴² CSH, Box 50, Book 48, pp. 24-40.

²⁴³ CSH, Box 48, Book 239, pp. 1-31.

She was far from normal at the time of her coming into his home. At times she would be very talkative, would talk to herself at times, no sense to a thing she would say. For the past six weeks patient has been very talkative, talking day and night, running away, had to be constantly watched, threatening those about her, threatening 'to burn and shoot' at times very profane and vulgar, preaching, praying, holloing [hollering], at times noisy all night, at times saying she was lost and was going to hell, at other times saying she was saved and going to heaven, at one time said she was to be killed, would run away at night.²⁴⁴

When her insanity increased in spite of their watching, the response of her family was to take her to Milledgeville.

Watching itself, combined with growing violence of the patient, often became too much for families. At age 39, Lizzie Duncan's family described her growing disorientation and violence:

She has had to be watched constantly for [the] past 2 years, and recently her mind has become much worse; at times she doesn't seem to know anyone. She would fight her sister-in-law, and has become so violent that it is not considered safe for her to remain at home any longer, hence her commitment.²⁴⁵

It was no longer safe to keep Lula or Lizzie at home. They were no longer harmless but had become violent and their families chose to move them to Milledgeville. But some families delayed the move to Milledgeville in favor of another strategy at home.

Home Confinement: Kept, Confined & Guarded

As families became more concerned about their afflicted women, they moved from simply watching them on to other means of control. For some, this move was as basic as to keep the woman in the house. For others, confinement at home, sometimes forced, was the choice of the family. Emma Sikes, a woman of some means, was fortunate enough to face confinement in private rooms at her brother's home and at private sanitariums.²⁴⁶ But her situation was unusual for

²⁴⁴ CSH, Box 48, Book 237, pp. 17-42.

²⁴⁵ CSH, Box 35, Book 171, pp. 313-327.

²⁴⁶ CSH, Box 36, Book 180, pp. 111-148. The most well-known private Sanitarium for Georgians was Dr. Brawner's in Cobb County, close to Atlanta.

women of the northeast Georgia piedmont. Most women facing confinement could not afford private sanatoria; they were kept at home. Harriet Bruce, for instance, was confined at home after suffering through the center of the 1936 Gainesville tornado. "Patient was in the center of the tornado," revealed her family, who chose to have Harriet "confined to [her]home under constant attendants."²⁴⁷ In addition to being confined, both Lizzie Oliver and Lizzie Ward exhibited increasing violence and were guarded at home. Lizzie Oliver was "guarded by men and women" after attempting suicide.²⁴⁸ After Lizzie Ward "attacked her husband and tried to jump in [the] well," she was "guarded day and night at home."²⁴⁹

Twelve-year-old Liza Goode's condition grew worse after her family removed her from the Baptist Orphan's Home. Liza slept "very little screams and moans, walks at night." Liza was "locked in [a] room" at her uncle's home. Her uncle wrote to intake officials:

Symptoms of insanity for 6 years. Continues to grow weaker. Receives nature [urinates and defecates] any where and any time, alone or with company. Been inmate of Baptist Orphans Home for two years. Sent her to her uncle to see if a change would improve conditions. Did not but grew worse and we now must keep her confined.²⁵⁰

Liza seemed to prefer Milledgeville to her previous homes. When asked "Had you rather be here than at home?" Liza answered, "I am going to stay here." Her doctor noted of Liza: "Cheerful. Mingles to a degree with other patients. Likes the place. Thinks she does not care to go back to the Orphans' Home." After four years, Liza was released to her family in 1919 and then returned by her brother in October of 1920 at the age of eighteen. "Weak-minded all her life," according to her brother, Liza began "wandering away from home" in May of 1920. Doctors found nothing wrong with her "other than imbecility."

²⁴⁷ CSH, Box 53, Book 264, pp.58-68.

²⁴⁸ CSH, Box 30, Book 150, pp. 81-95.

²⁴⁹ CSH, Box 32, Book 151, pp. 196-211.

²⁵⁰ CSH, Box 44, Book 216, pp. 171-198.

Dr. #1: This patient gives no trouble on the ward. I think if her relatives would take her and look after her she would get along all right at home. I recommend that she be furloughed.

Doctor #2: She has no psychosis other than imbecility. I agree.

Doctor #3: I agree.

Dr. #4: I agree that this patient is a harmless imbecile and has shown no psychotic symptoms since being under our observation, and might come under the group of harmless patients. I recommend that she be sent home.

Although her relatives were “notified to come for her,” they apparently did not. The institution released her to the sheriff of her home county late in December of 1921. She remained at her brother’s home until August of 1925. Liza was returned to Milledgeville by her brother at the age of 22. He wrote that she had “been insane since childhood,” but was “getting worse and dangerous: on two occasions she has attempted to kill one or two of the children (her brother’s children).” Hospital personnel recorded the following regarding Liza:

Removed from this institution on Dec. 24, 1921, since which time she has been living with brother, informant. About three months after going home began fighting the other children, knocking one child on the head with a broom, and probably would have killed the child had she been left alone. Since then above [named patient] has been ‘getting mad, fighting, obstinate, and hard to control, run away and hide in the woods. These came on in episodes lasting about a week, sometime shorter. These episodes occur about every month. Informant insists that he is unable to keep patient around his four little children, as he is afraid she might kill some of them.

In light of Liza’s increasing violence, she was “guarded at home” until her family decided to send her to Milledgeville. Liza flourished at the institution, going to school until 1931, when her physical and mental health began to deteriorate. She died at the age of 33 after contracting influenza.

While Liza experienced being watched, locked within a room, guarded and confined in an orphans’ home before being sent to Milledgeville, such home-based confinement was not effective for all women. Many families chose to physically restrain the women of their concern,

especially when they became suicidal. The delusions that accompanied many women's suicide attempts further alarmed their families.

Physical Restraint

Physical restraint was a desperate and often futile last attempt to prolong the inevitable trip to Milledgeville. Bell Wilder, a thirty-year old textile worker, suffered insanity after contracting influenza in 1919. "Had flue [sic] in November," wrote her family physician, "been crazy ever since." Her family chose to restrain her at home (though we know not how) after she attempted suicide.²⁵¹ Amanda Oglesby had "to be guarded and restrained constantly" after attempting suicide. And Catie Osley, 29, fought restraint "violently" within her home. Her husband told intake officials that her confinement was the "best possible, but patient gets away any possible way she can." She "changes from [an] apathetic state to maniacal when she will run away through window or door thinking someone is trying to kill her."²⁵²

In many cases there is no record of the means of physical restraint, but some patient records do document techniques families used to restrain women. Jessie Allen, 73, was once deemed insane, but harmless by her family. Eventually, "due to restlessness, they had to fasten her up in the house."²⁵³ When Lottie Woods, thirteen, became delirious after hookworm treatment in 1929,²⁵⁴ she was "tied to a chair." Her family recounted that "she began trying to eat the bed cover and became delirious, didn't understand when spoken to and would jump out of bed and run a bout [sic]." Lottie was unable to speak after the hookworm treatment. "She cannot

²⁵¹ CSH, Box 48, Book 237, pp. 427-438.

²⁵² CSH, Book 203, pp. 410-422.

²⁵³ CSH, Box 48, Book 239, pp. 1-31.

²⁵⁴ CSH, Box 45, Book 223, pp. 1-14. Hookworm treatment at the time consisted of being dosed repeatedly (as many as five times) with thymol until all worms had been expelled. See C.A. Wells "The Unicaria Americana in Georgia," *The Journal of the American Medical Association* LIV (June 1910), 1-8; "Thymol for hookworm: Government expert calls it best-known remedy for the disease." *The New York Times*, 7 October 1911; Dr. A.G. Fort, "Rural sanitation and hookworm disease" lecture, American Public Health Association, Jacksonville, Fla., December 1, 1914), 1038-1043.

talk but makes a whining noise like an animal.” During the winter, her family made sure to have someone “sitting up with her constantly,’ to keep her covered at night.” They “carried her” to doctors in Hoschton, Atlanta, and Franklin, North Carolina, before finally resorting to restraining her at home. “When not tied in a chair,” they claimed, she “would walk restlessly up and down the room.”²⁵⁵ Amanda Oglesby entered Milledgeville in May of 1933 at the age of 48. The year before, Amanda spent six months in the tuberculosis Sanitarium at Alto in Banks County. She told her doctor she was sad at home because “they got to locking me up and would not feed me.” According to Amanda, her husband and his hired help “would help to hold me and tie me to the bed.”²⁵⁶

Hannah Waters, 25, was described by the ordinary as “the worst for years” in her home county and “perfectly wild.” Hannah “refused to eat or sleep, [was] wild, trying to kill herself & others.” Hannah’s family chose to employ “physical force holding her in bed” until she was taken to Milledgeville where she died only thirteen days later of a vaginal ulcer. According to her doctors, “This condition was discovered a short time after admission due to the very offensive odor. Almost the entire vulva sloughed away along the perineum. This seemed to be a vaginitic [sic] type of ulcer, and was thought to be the immediate cause of her death.”²⁵⁷

Patsy Teasly, 21, was similarly “bound and held to [the] bed” at her home, where she suffered with puerperal insanity²⁵⁸ after the birth of her first child.²⁵⁹

²⁵⁵ Ibid.

²⁵⁶ CSH, Box 44, Book, 220, pp. 14-28.

²⁵⁷ CSH, Book 93-128 (approximately #115) pp. 406-407.

²⁵⁸ CSH, Box 31, Book 156, pp. 247-257.

²⁵⁹ Ibid.

After living with her daughter and son-in-law for 35 years, Mattie Jones' family resorted to using handcuffs in order to restrain her in her eighty-fifth year. Her son-in-law explained to the intake personnel at Milledgeville how her situation progressed:

Her mind was alright up to eighteen months or two years ago at which time she began talking at random, talking to imaginary people and to her dead mother and father, did not seem to have mind enough to do the household duties she had been accustom to doing, would pull the buttons off her clothes, pull her clothes off and try to put them on again, but never getting them right, pick and pull at her clothes, disarrange things about the house. In Nov. last year began tearing up her clothes, up and down all during the night, arranging and rearranging her bedding, her night gown, throwing the bed covers up and down and over her head, moving her bed about, etc. In Dec. last year became dangerous with fire, instead of building a fire in the stove tried to build it under the stove, wandering about the house, seemed to be very restless, on the go all the time. In Jan. began running away, wandering about, crawling under the house and having to be brought out by force. For the past month and half the informant states she has become uncontrollable. Does not try to fight, but resists everything they try to do for her. Will not keep her clothes on, etc, and he [her son-in-law] got a pair of handcuffs and when she was unmanageable he would put them on her.

Apparently dissatisfied with the use of handcuffs, her son in law concluded that she was "beyond control at home" and requested that she "should be sent off at once."²⁶⁰

Mattie's son-in-law was not alone in his use of dramatic means of restraint. Other families sought and found them, as well. Anna Harris, 32 and the mother of five, left her husband for her father's home in early 1924, claiming her husband had mistreated her. At first, her family believed her and sheltered her in their home. Soon, however it became clear to them that something was wrong with Anna. Her husband explained that "her people were afraid of her. She fought her father, and it was necessary to tie her to a tree to control her. She talked all the time about sexual affairs, accusing everybody of being immoral. Was very talkative, laughing, and crying, would play the organ all night."²⁶¹ Anna also threatened "to drown herself by

²⁶⁰ CSH, Box 28, Book 136, pp.235- 246. For her part, Mattie said "they acted like a goose when they brought her here," and "insists her mind aint clear wrong."

²⁶¹ CSH, Box 33, Book 165, pp. 136-146.

jumping in [the] well or river.” When her father and brothers brought her to Milledgeville, they claimed she had been “violent since the [lunacy] trial.”²⁶² She has tried to kill her father by beating him up with a piece of stove wood.” Her husband added that just days before her commitment, “She got a knife and ran after a man, said she would kill him.” Her family resolved: “She will have to be confined in jail if not accepted in the Sanitarium.” She was accepted to the Sanitarium in August of 1924 bearing “several bluish discolored areas where patient has been handled roughly before coming to the institution.”²⁶³ Had Anna Harris not been accepted at the Milledgeville Sanitarium, her family felt they had no choice but to send her to the county jail. Anna was able to bypass the jail for the Sanitarium but many were not so fortunate. Particularly when a woman combined suicidal and homicidal tendencies, her family would seek jail as their final attempt to forestall or to simply wait for placement at the Milledgeville Sanitarium.

Incarcerated in County Jail

After an undisclosed illness, Mandy Chandler’s “mind gradually went bad.” She “tries to hide and at times tries to set the house on fire.” Mandy, a black mother of two, “hit [her] baby with [a] flat iron.” As much as her husband, an ice delivery salesman, must have needed someone to help him supervise her, he had “to work and is not able to pay anyone to stay with her.” While Mandy remained in jail, her doctor provided information to the Sanitarium on behalf of her husband: “This girl has doctor’s attention. Doctors say that the only hope for her is the treatment she will get at Milledgeville. They also say that she is very dangerous and should be put in some safe place under medical attention.”²⁶⁴

²⁶² Ibid. Refer to Chapter 3 for a discussion of lunacy trials.

²⁶³ Ibid.

²⁶⁴ CSH, Box 42, Book 210, pp. 82-91.

Mandy was not the only woman who displayed dangerous tendencies and was placed in jail. In the late summer of 1931, another “colored woman,” Maude Burgess, “got out on the streets... and commenced to abuse and threaten several members of her race.”²⁶⁵ Because Maude was “so violent,” her daughter and brother deemed it “necessary to confine her” to jail.²⁶⁶ Evie Lucas’ situation was similar. Five months after Evie’s husband died of consumption, she was brought to Milledgeville from jail. A widow at 24, Evie was “ill, worried and try (tried) to hurt herself.”²⁶⁷ Still another “colored “woman, Lula Power was found “wandering about,” according to her brother. She “stayed out in [the] pasture all day,” he wrote. More alarmingly, she “lately got hold of a butcher knife and tore off her clothing.”²⁶⁸

Mandy Chandler, Maude Burgess and Lula Power exhibited violent tendencies that alarmed their families to the point where they sought incarceration in county jails. But often, the data suggest no clear reason to place a woman in jail. Particularly for black women, incarceration in jail seemed as likely a response to insanity as watching, guarding or restraining. The data suggest that women were far more likely to spend time in county jail if they were “colored.” Of ninety women committed to the Georgia State Sanitarium from the eight-county area, twenty were “colored.” Of these twenty, twelve women were placed in county jails before coming to the Sanitarium. Of the seventy white women, twelve were jailed before coming to the institution. black women were also the only women in the study who had experienced jail previously, even if not exhibiting signs of mental illness.

Bessie Morris, a 23 year old black woman who arrived at the Sanitarium in March of 1930, described her first jail experience to Sanitarium personnel:

²⁶⁵ CSH, Box 45, Book 255, pp. 178- 191.

²⁶⁶ Ibid.

²⁶⁷ CSH, Box 42, Book 132, pp. 225-236.

²⁶⁸ CSH, Box 32, Book 161, pp. 312- 325.

Sometime during last year or this year, she is uncertain which, she went to Atlanta to visit some of her relatives and got lost and requested the police to carried [sic] her to the station house until she could let her people know where she was. She does not know whether she was in jail a day or a wekk [sic] before her people came for her.²⁶⁹

Maude Burgess also admitted she had experienced jail once before.²⁷⁰ And Ada Pryor was living with her uncle in South Carolina when she spent her first week in jail.²⁷¹

No white women in the study had experienced jail twice before their reception at Milledgeville. White women did go to jail, however. Nelle Mashburn, a widow, was placed in jail at the age of eighty before coming to the Sanitarium where she died after three weeks. Her nephew claimed she was “violent, destructive, and dangerous with fire” and “imagines folks are after her.”²⁷²

Sending women to jail did not require violence on their behalves. Many women, both white and “colored,” went to jail for milder offences. Georgia Oakley’s mother related the reason Georgia went to jail: She began “irrational talking and running spells” after the birth of her third child.²⁷³ According to Ella Mackie’s uncle, her “attack began the second Sunday in May, 1917,” when Ella, age 22, “refused to talk” after her baptism.

She had been inclined to be rather peculiar and dissatisfied, wants to move about from place to place. She has not been noticed in any peculiar acts. Not thought to have any hallucinations or delusions. Probable cause of this attack given she thought she was babtised [sic] at the wrong time. [She] showed considerable worry over this.”²⁷⁴

Physical illness was also a reason for incarceration. According to the sheriff of her community, Willie Franks was “rambling, quit working, [and was] filthy.” When asked her

²⁶⁹ CSH, Box 44, Book 218, p. 368-384.

²⁷⁰ CSH, Box 45, Book 225, p. 178-191.

²⁷¹ CSH, Box 43, Book 212, pp. 228-250.

²⁷² CSH, Box 38, Book 187, pp. 442-253.

²⁷³ CSH, Box 33, Book 163, pp. 370-388.

²⁷⁴ CSH, Box 33, Book 163, pp. 370-388.

occupation, the sheriff wrote she “loafs most [of the] time.” He further divulged that Willie “was found on the street ... having a convulsion which was followed by unconsciousness.” Upon her release from jail, the sheriff drove her to Milledgeville. Another victim of physical illness, Allie Jones, 36, suffered from a toxic goiter which caused her eyes to bulge. She believed “her relatives had her placed in jail because they were afraid of her. She supposes this was because she might have looked dangerous, and refers to the appearance of her eyes.”²⁷⁵

Some women provoked a fear in their families that they would run away, particularly if their tendency to flee was accompanied by delusions. Angie Brown, 44, who spent four days in county jail before going to Milledgeville, explained the circumstances that sent her there. According to Angie “she was put in jail when she was going to her mother’s funeral because ‘they’ said she was running away.”²⁷⁶ Levisy Crump, 65, combined talking too much with a tendency to run away. Levisy was admitted to the Sanitarium in October of 1935 after being confined in the county jail. According to her family, Levisy “cannot stay at home. Talks a great deal. Delusional. Walks the road. Picks up sticks, etc.”²⁷⁷

Delusions accompanying flight were particularly alarming to families. Anna Wyly, 49, was confined in jail before being admitted to Milledgeville along with her sister in 1915. The two were separated as soon as they arrived. Anna’s uncle stated that she was “secluding herself. Expressed the idea that she was hypnotized and someone was trying to kill her.” Anna “spoke of voices, as someone [was] calling her.” And she insisted “on wearing [her] hair down.” Anna

²⁷⁵ CSH, Box 47, Book 235, pp. 93-125. A toxic goiter creates a swelling the neck area and bulging eyes, and is usually caused by too much thyroid hormone.

²⁷⁶ CSH, Box 39, Book 191, pp. 114-129.

²⁷⁷ CSH, Book 243-263 (approximately # 252), pp. 400-408.

admitted “that she and her sister were rather seclusive.”²⁷⁸ She spent two weeks in jail before coming to Milledgeville.

Many women spent time in county jails before coming to Milledgeville, and quite a few spoke of what happened to them while they were there. Some women seemed quite happy in jail. Martha Aiken, forty, went to jail because “she got all worried up and tangled up.” Martha “got so happy she couldn’t do her work. [She] shouted, holloed (hollered), danced, [and] preached day and night and they put her in jail. In jail she continued to sing, pray, preach and dance.”²⁷⁹ Fannie Bush, 48, was also “happy” in jail:

She was in jail two weeks before she was sent here. She was excited, jumped up and down, sang, preached and felt good all the time. The good spirit was with her while in jail. [She] did not sleep well while in jail. Says that the old time religion is the cause of her being happy, and was the cause of her being sent here.²⁸⁰

When asked if she was happy in jail, Fannie told the doctor she was.

Other women had negative experiences while in jail. Ada Pryor, who was in jail for two days, told Sanitarium officials, “she was noisy and ‘tore off her clothes,’ while there.”²⁸¹ And Minnie Dyer, 71,

Was confined for about a week in jail previous to her admission. ...She admits she was rather stormy while in jail. She tells of attempting to throw water on some mischief makers that were teasing her. She did not sleep well and admits she may have been noisy some while confined.²⁸²

When asked if anyone had ever tried to poison her, Maggie Miller, 75, claimed “they tried to poison me to death at the jail because they said I stunk.” But no experience at jail within the data compares to that of Lena Ayers, a thirty year old black cook. When asked if she had ever

²⁷⁸ CSH, Box 28, Book 140, pp. 306-323.

²⁷⁹ CSH, Box 38, Book 190, pp. 445-458.

²⁸⁰ CSH, Box 53, Book 264, pp. 384-410.

²⁸¹ CSH, Box 43, Book 212, pp. 228-250.

²⁸² CSH, Box 32, Book 151, p. 348-364.

been married, Lena first stated “that she had never known a man.” Shortly afterward, however, she revealed the truth.

On further questioning she told the examiner that while she was in jail she engaged in sexual intercourse with a negro man that worked around the jail. She states that the man did this for her own good, hoping to relieve her headache and tooth ache. She also tell [s] of an attempt on the part of her brother to engage in sexual intercourse with her. She is very evasive in the development of her history.”²⁸³

Apparently frightened within her circumstances, Lena told Sanitarium officials: ‘I knew it wasn’t right for me to come to this place but Carrie told me to come. I always was afraid of white people. I don’t know what they will do to me.’”²⁸⁴

Many women had negative experiences while in jail but one woman saw jail as a turning point, a time when she moved from a time of confusion to awareness. Neta Bennet told intake personnel she had “been in jail seven days previous to coming here and while in jail she was insulted and teased by other inmates in jail, and this caused her to become profane and noisy.” Hospital personnel recorded the following exchange between Neta and her doctor:

Doctor: “Is there anything wrong with you now?”

Neta: “Before they put me in jail there would be hours that I would not know what I was doing.”

Doctor: “How long were you in jail?”

Neta: “A week.”

Doctor: “When was your mind wrong?”

Neta: “It was wrong when I was in jail.”

Doctor: “You think you should have been sent here?”

Neta: “Yes.””²⁸⁵

Only one woman alluded to any possible crime in connection to being jailed. In speaking of her own jail experience, Maggie Miller told hospital officials her “sister had also “been locked up in jail for going with men.” Maggie later added that her “sister is now married to a negro man

²⁸³ Ibid.

²⁸⁴ Ibid.

²⁸⁵ CSH, Box 29, Book 141, pp. 441-452.

in South Carolina.”²⁸⁶ But for the women within the study, none engaged in criminal activity. Their emotional behavior elicited the response of being jailed on the path to Milledgeville.

Control and Confinement within the Georgia State Sanitarium

Within the confines of the Sanitarium, women continued to experience gradations of control and confinement. At times, women were isolated for weeks due to “pediculi capitis”²⁸⁷ or contagious illnesses. Lottie Woods, the child who had been treated for hookworm, was “kept in isolation and treated for scabies” from April 8, 1929 until at least April 29.²⁸⁸ Sallie Crews and Destimony Frazier were both placed in isolation due to head lice. According to Destimony’s doctor, “she resents being isolated and insists that she contracted pediculil after coming to the institution...her hair,” he added, “is very thick and long and she objects to same being cut.”²⁸⁹

Other women were confined to bed or placed in restraints. Blanche Bramlett, at 72, was “confined to her bed continuously” for the month of April in 1933. Since October of 1931, “some nurse or good patient remain[ed] in her room practically all the time during the day, to keep her from getting out of bed and falling around.”²⁹⁰ Mary Jo Martin was placed “under mild restraint” during her time at the Sanitarium.²⁹¹ Patients who came to Milledgeville in an “excited,” destructive, or uncontrollable state were often “placed in a pack.” Packs were a form of hydrotherapy popular during this time. Agitated patients were wrapped tightly in either cold or hot wet sheets for varying periods of time.²⁹²

²⁸⁶ CSH, Box 35, Book 172, pp. 356-367. Interracial marriage was illegal until 1967.

²⁸⁷ Head lice

²⁸⁸ CSH, Box 45, Book 223, pp. 1-14.

²⁸⁹ CSH, Book 206, pp. 217-258.

²⁹⁰ CSH, Box 47, Book 232, pp. 186-195.

²⁹¹ CSH, Book 92, pp. 441-446.

²⁹² See Joel Braslow, 39, for an explanation of hydrotherapy and for more on treatments and how they changed over time.

Cleo Kitchens,²⁹³ Allie Jones, and Hannah Waters were all given packs at times. Allie Jones returned to the institution after a furlough in April of 1924. Officials noted:

Her mental condition being very bad. She was out of touch with her surroundings. Seems more or less in a delirium. Would not wear her clothing. Could not be controlled and was resistive. She was given packs some days due to her resistive tendencies and from the fact she could not be controlled. These packs were discontinued after a day or two on account of her exceedingly rapid pulse.”²⁹⁴

“On admission,” Hannah Waters, the patient with the vaginal ulcer, “was placed in a pack where she remained until a very few days before her death. She grew progressively weaker, which was thought to be due to excitement and from a very destructive process that involved the vulva and perineum.”²⁹⁵

Nealie Poole came to Milledgeville in 1923 “very much excited.”

When she came to the ward she was inclined to show violent tendencies towards other patients, and consequently she was placed in a room and in bed. She would not remain in bed, but immediately got up and destroyed some of the bedding, and also she attempted to tear the bedstead up. After this happened she was placed in a cold pack. She seemed to be more quiet after this was done. On the second day after admission she continued excited, and was placed in a pack for the second time. Some hours after this she was found in a state of coma and died in a few hours.²⁹⁶

Placing Nealie in a pack was meant to quiet her. For whatever reason, the treatment hastened her death.

While many agitated patients were placed in packs, patients who displayed “destructive tendencies” were often “kept in the portico,” as was Euphemia Mathis.²⁹⁷ “Portico patients” were most likely to be placed in sleeve aprons or strong dresses.²⁹⁸ In 1919, officials found it “necessary to keep [a] sleeve apron on” Lucy Banks “most of the time to keep her from fighting

²⁹³ CSH, Box 35, Book 172, pp. 180-195.

²⁹⁴ Ibid.

²⁹⁵ CSH, Books 93-128 (approximately book # 115), pp. 406-407.

²⁹⁶ CSH, Books 93-128 (approximately book # 116), p. 20-21.

²⁹⁷ CSH, Box 49, Book 245, pp. 28-44.

²⁹⁸ Presumably the equivalent to a straight jacket.

other patients.” Lucy, who was described as “vulgar, noisy, profane and filthy,” wore a sleeve apron or “strong dress” while at the Sanitarium. Lucy came to the institution at age 55 after “terrorizing the citizens of her small community,” who described her “singing & preaching [in] the streets, carrying with her a long butcher knife & a hatchet and acting strangely and talking nonsense.”²⁹⁹ Other women faced being confined in strong dresses. Mabel Westbrook’s doctors reported in 1912 that the 72 year old woman “used to be destructive and wore strong dresses.”³⁰⁰ In 1916, Lily Strange had “to be kept in [a] strong dress” in the portico, “on account of ... being filthy and untidy.”³⁰¹ Tearing clothing and filthiness (believed to be a lack of attention to cleaning excrement from the body) more than any other quality, led to the use of the garments. “On account of her being filthy, [we] have to keep [a] strong dress on her,” wrote Mollie Merck’s doctor in 1915. Doctor’s notes indicate that Mollie wore a strong dress often from 1913 until 1920. In 1913, Mollie tore up her clothes, “pulls out areas of hair from [her] scalp. Pays no attention to excretions.” In 1919, Mollie began to be referred to as a “portico patient.” “When off as at present, is noisy both day and night,” wrote her doctor.³⁰² By August of 1921, Mollie, still a “portico patient,” was “destructive and filthy and wears a sleeve apron.” Continually “filthy,” her doctor noted in 1923 that “special attention is being given her in an attempt to educate her from filthiness back into cleanliness, but the nurses report that no improvement has been seen so far.”³⁰³

Ruby Word, admitted to the institution in September of 1912, confessed right away that “she is crazy as a bed bug and would like to get well.” Patient records attest that though Ruby was first a portico patient in the fall of 1913, she was not placed in a strong dress until early in

²⁹⁹ CSH, Book 205, p. 162-184.

³⁰⁰ CSH, Box 29, Book 141, pp. 453-460.

³⁰¹ CSH, Box 38, Book 189, pp. 237-253.

³⁰² CSH, Box 31, Book 156, pp. 62-67.

³⁰³ Ibid.

1914. Late in 1914, she had “to wear sleeves apron at times.” By February of 1915, Ruby tore “up clothes as fast as they are put on unless she is restrained in some way.” The notes for August of 1919 reveal Ruby was “violent; destructive; for this reason is kept in portico,” a placement she was to maintain until April of 1924, when she was placed “under a special nurse who is attempting to give her training.” Her doctor noted that “formerly she was destructive untidy and filthy. Since being under the special nurse she has shoen [sic] marked improvement.” But by August of the year, the same doctor noted that “this patient is very meddlesome, goes in other patient’s room[s] and takes things out and hides them, them [sic] will laugh about it.” Ruby continued to “bother” other patients and to steal from them but her case notes reveal that she was not returned to the portico or to a strong dress.³⁰⁴

Lola England, admitted at the age of 26 in 1911, had a long history with physical restraint while at the institution. At home, she had faced only “close watch.” Lola was named a “portico patient” by May of 1913 and remained one until her death in 1933. In March of 1916, Lola was reported as lying “about on the floor, fusses for her meals. Curses and is excited at present...Is vulgar and filthy.” By December of 1916, still “on the floor, [Lola had] rubbed off 1/3 of her hair. Six months later there was little change. “Portico patient, Is filthy, noisy and violent at times, sits on the floor in front of door. Profane and curses examiner. Area where she has rubbed out her hair.” Although throughout this time Lola remained in good physical health, her mental condition deteriorated. In December of 1919, doctors reported that “she tears up blankets and makes dolls.” In May of 1920, they reported again that she “destroys all the linen, etc. in her room; makes dolls.” She became “violent” and “had to be secluded for a time” in August of 1920. Although she continually tore up clothing and linens up until 1924, the first records indicating she wore a strong dress did not occur until January of that year. By the end of the year

³⁰⁴ CSH, Box 33, Book 163, pp. 46-52.

and well in to 1925 she began tying strings about her neck and body. In November of 1926, Lola complained that “something bothers her head sometimes and she cannot hear.” She began scratching her extremities shortly thereafter and although she spent April in the infirmary, she continued scratching afterward. By August of 1927, Lola was “kept restrained most of the time as she scratches and rubs sores on her person, and this [restraint] is done for self-protection.”³⁰⁵ From time to time, Lola seems to have experienced a respite from her agony. Late in 1927, her doctor reported that though she “had pulled out most of her hair,” she was free from restraint at the time. “For a long time she had to be restrained as she picked sores on her person,” he wrote,” but she has not been restrained recently.”³⁰⁶ By April of 1928 she was actively serving her fellow patients their meals and “does not bite or scratch herself as formerly.” In August her improvement continued: “now will wear her shoes and hose,” her doctor reported. By April of 1929, her hair had begun to grow back, but by August of the same year she began pulling it out again and scratching sores on her face and legs, behaviors that she continued for the next several years. Finally, after 22 years within the institution, Lola died of dysentery late in the summer of 1933, finally free of confinement.³⁰⁷

Sterilization—The Case of Babe Tyner

Not often, but occasionally, doctors at the Sanitarium would curb a woman’s capacity to reproduce, a type of confinement on its own. Babe Tyner was the only woman of the ninety who faced sterilization at Milledgeville. Babe was at Milledgeville before sterilization became prevalent at the institution. From the time Babe Tyner was eight years old, she had convulsions. Entering Milledgeville for the first time in October of 1920 at the age of sixteen, Babe had recently tried “to jump in the well.” Her family did not know what caused her trouble, but she

³⁰⁵ CSH Box 44, Book 217, pp. 261-279.

³⁰⁶ Ibid.

³⁰⁷ Ibid.

was “crying, cursing & boisterous” at home. She “was destructive, cut up clothing, bed linen with scissors, knives, etc. Wished to get into the well and drown herself. Would scream and cry.” Babe was “suicidal and homicidal.” She “tried to burn [her] home, threw her watch away. Would burn the house so she would have to leave home.” Although Babe “took patent medicine which controlled her very well while under its influence,” she “lost partial use of her body. Memory said to be impaired.” Early on, after witnessing another patient’s convulsion at the Sanitarium Chapel, Babe told her doctor “I do not have convulsions like these people.”³⁰⁸

In addition to her convulsions, Babe exhibited an early interest in men. Her “inclination towards the opposite sex” gave her parents “much trouble.” She was “very fond of the opposite sex” and loved to “go visiting.” According to Babe, who had been engaged four times, she “received callers” as early as nine years of age, but she wasn’t allowed to date until she was fourteen. Of the four engagements, Babe recalled the “first three were broken up, one when “her father whipped both parties directly concerned.” Her father disapproved of her interactions with young men; so did her mother. Babe informed her doctor her mother “did not want me to go to town so often and go with so many boys so often.” She found a way to be with boys, however, and to persuade her family to satisfy her wishes, even through dishonesty.³⁰⁹

In November of 1920, Babe wrote her family “that she had to sleep on the floor.” When confronted with her lie, she admitted her guilt, but told her doctor “she did this in order to get home.” Her primary doctor at the Sanitarium concluded “she does not seem to have much moral sense. She talks very freely about her relations with boys and men.” Another doctor declared her to be “an institutional case,” due to her lack of hesitation to write “absolute lies” to her father and her tendency towards sexual promiscuity.

³⁰⁸ CSH, Box 33, Book 165, pp. 1-27.

³⁰⁹ Ibid.

Her interest in men did not abate at the Sanitarium. In January of 1921, Babe confessed “of being seduced and that she had an abortion.” By March of the same year, “her conduct for men and flirting was such that she was confined to the ward.” Babe’s patient record includes the following letter; a testimony to her overt pursuit of men. The letter was dated May 3, 1921 and was written by Babe Tyner to a Mr. Finley.

My Dear Mr. Finley:

No doubt you’ll be surprised to hear from me. Never the less if you had any idea how bad I wanted to leave this place you surely would do [sic] some way to get me out. You know I told you I was willing to any thing, and “I mean I will.” I am not going to stay here. Not even thinking about staying. I had planned to leave Friday night. What do you think about it?? What ever you do, please don’t tell no one. Some body told me, that you told one of the nurses on my hall that I ask you would you run away with me, and they locked me in my room. Now if you don’t want to go with me, For God’s Sake tear up this letter and don’t mention it to no one. You can write me, and tell me what you will do whether you will or not, you can send the letter thro [sic] mail. You can put some body else[‘s] name instead of “yours,” and want [won’t] anybody know one thing about it. Let me know at once whether you will or not, For I’m “rareing” to go. And I mean I’m going. Write me, and address it, to me But Just put another name instead of your’s, and whatever you do please don’t tell any one, I hope it will be so you can go—B. Tyner, ans Soon”³¹⁰

It is unclear whether Babe made a successful escape with Mr. Finley but it seems unlikely since this letter was among the documents in her patient file.

Babe was furloughed six months later in December of 1921 and discharged exactly one year later when she had not returned to the institution. By the time she returned to Milledgeville, she was married. Babe explained how this happened. When released home, Babe kept in contact with a patient she met at Milledgeville who was also on furlough. He came to visit her in the Spring of 1922 and they were married just a few days later. “She says they honey-mooned two weeks in Atlanta, a week in Macon and a week at a hotel in Hardwick, after which she spent two months with her husband’s people” in south Georgia. But when she realized both her husband and

³¹⁰ Ibid.

father-in-law drank, Babe became unhappy with her situation and returned to her father's home in northeast Georgia. When she decided to return to her husband, her family refused to allow it. Babe went into a rage. "Between two and three weeks ago she says that she got in a rage, tearing up a book, cursed, black-guarded;³¹¹ got a fire poker and threatened to hit some of them with the poker." The family decided she should return to Milledgeville. In spite of her behavior, Babe insisted that she did not know she was being returned "until after she had passed Athens en route to the institution."³¹²

Perhaps part of her family's concern was that her promiscuity had not abated in the absence of her husband. Readmitted to the Sanitarium in February of 1923, she was examined by her doctor. Babe told him in the examination that she "menstruated three weeks ago," but "after leaving the examination room [the] patient told the ward physician that her menstruation was a week over due, and she feared a pregnancy—admitting illicit intercourse recently." For the next two months, Babe showed "no signs of menstruation," but continued her flirtations. In March, her doctor noted: "she is inclined to dress herself as attractive as possible, and to attract attention of men about the premises. She is also inclined to slip notes to male patients. She admits receiving five dollars from a male patient in the last few days." In April, the doctor virtually repeated himself. "There is a strong possibility that this patient is pregnant," he wrote.

Patient has shown a marked tendency to dress herself as attractive as possible when going out to dances, and going out on every occasion possible, and trying to attract the attention of male patients both in this institution and at Dr. Allen's. She indicated to the ward physician that this was the easiest way to obtain money which she needed very much.³¹³

Apparently, Babe was able to secure a steady income from her liaisons with male patients.

³¹¹ According to the Webster Dictionary, "to talk about or address in abusive terms." www.merriam-webster.com/dictionary/black-guarded

³¹² CSH, Box 33, Book 165, pp. 1-27.

³¹³ Ibid.

No notes exist from April until August of 1923, when Babe was attending “the occupation and reading room.” According to patient notes, “the nurse in charge reported that she didn’t try to make any progress and she was profane at times when visitors were in the room, so she was stopped from attending.” Her liaisons with men intensified. “She wants to be after some man all the time,” her doctor recorded, “and recently it is reported that she planned to slip away from the Picture show with a patient from the Allen Sanitarium.”³¹⁴ In December 1923, doctors noted “it is very difficult to control her on the grounds. She insists on talking to the male patients and has tried to keep up a correspondence with them and with other men loafing on the grounds. Patient would get along well at home,” he added, “if it were not for her attitude toward men.”³¹⁵

In April of 1924, her doctor documented her characteristics: “Hard to control. Unreliable, cannot be depended upon. Slips letters out to the male patients. Has an affair of some kind either with some patient here or with the neighboring institution all the time. Does some work on the ward. Noisy and profane at times. Health is excellent.” He concluded this notation with one more observation: “She is mean.”³¹⁶

By August of 1924, her doctor documented what must have been a frightening intensification of her flirtation: “Clean in her habits, but does not wear her clothing. Will get before the window and strip her clothing off and show herself to any man who may be passing. Talks to the men from the windows. Recently she has been caught talking to the negroes in the yard and exposing her person to them.” Not only was Babe exposing her naked body, but she was exposing it to black men. Perhaps because of this most clear violation of the southern code of conduct, Babe was removed to the infirmary where she was sterilized. No doubt, sterilization calmed the fears of the staff, but it did nothing to calm her promiscuous tendencies. In November

³¹⁴ A neighboring institution

³¹⁵ CSH, Box 33, Book 165, pp. 1-27.

³¹⁶ Ibid.

of 1924, her doctor noted: “She tries to get before the windows next to the boiler room where she can carry on flirtation with anyone she can see out around the doors. Will strip her clothing as near off of her as she can. Recently she encouraged a patient to attempt to run away promising she was going to.”³¹⁷

There is no letter to document this attempt to run away, but conceivably it would be similar to her letter to Mr. Finley. Over the years, Babe’s convulsions became occasional, but her profanity and vulgarity increased, leading hospital officials to curb her privileges. She was no longer allowed “to go out.” Within the walls of the Sanitarium, she continued to “encite [sic] other patients to mischief.” Due to the lack of documentation, we know little else of Babe’s life over the next four years. We do know that Babe died at the age of 24, early in the morning on December 12, 1928 of epileptic convulsions. Her body was taken home for burial.³¹⁸

Suicide

It is perhaps not surprising that some women within the institution would seek to deliver themselves from the captivity of their own lives. Such women sometimes used euphemisms to express a desire for death. Jessie Malone, an elderly patient, both talked and thought “of her people all the time.” Her doctor recorded that Jessie “often wishes to fly away home.”³¹⁹ Flying away home here could very possibly mean a desire for a heavenly home. Upon admission, another patient’s husband described the longing she expressed to him as a desire “to get [the] old body out of the way.”³²⁰ This reference to scripture would have been understood among members of the community as a Christian’s longing for the promised new body that comes with eternal life. At 24, Evie Lucas, a black woman, was admitted to Milledgeville. Married at

³¹⁷ Ibid.

³¹⁸ Ibid.

³¹⁹ CSH, Books 93-128 (approximately book # 125), pp. 558-567.

³²⁰ Author’s Collection of Patient Records on Microfilm, retrieved by Judy Carlisle in 2001.

nineteen, Evie struggled in her first marriage, fighting with her husband, a consumptive, and alternated caring for her husband and leaving him until he finally died after four years of marriage. After he died, Evie “tried to commit suicide by drinking carbolic acid. She did not want to be bothering other people so she thought she would kill herself.”³²¹ And Ruby Bishop, who suffered with convulsions, considered suicide when her husband left her after 25 years of marriage. “Have you wished you were dead?” her doctor asked. “Yes. I was trouble away back yonder when my husband left and got the children torn up and bothered.” Not only had Ruby’s husband left her, but she suffered poor health as well. Ruby told her doctor “sometimes my health is bad and I want to die and get out of it. I haven’t got any money and nobody to care for me.”³²²

Not all women spoke of their previous suicide attempts, but many women entered the institution having attempted suicide already. Of ninety women, 29 had either threatened or attempted suicide.³²³ Based on the number of attempted suicides, it is clear that many women longed to escape their lives.

Allie Jones, who suffered psychosis associated with a toxic goiter, admitted “that she had never mentioned suicide until they had her placed back in jail” but Allie did try to commit suicide:

She attempted suicide on two occasions. A few years ago jumped in the Chattahoochee river [sic], for the purpose of drowning herself, and later made a further attempt by drinking iodine [sic]. Her reason for these suicidal attempts was to get out of this life, and adds that she would commit suicide now, if she had an opportunity. Life is miserable because she never feels well.

³²¹ CSH, Box 42, pp. 370-388.

³²² CSH, Box 28, Book 139, pp. 149-162.

³²³ Twenty-four white women and five black women. This number includes women whose doctors marked the term “suicidal” on their intake form, even if they did not describe the specific threat or attempt.

When asked if she wanted to get better, Allie answered “Sure I do, but I don’t think there is any chance.”³²⁴

Zelda Kesler “thought that she had rather be dead than living. This thought was prompted for the reason that she felt her husband did not care for her.” Her family reported to the Sanitarium actions she did not remember taking.

Doctor: “What are some of the things that they said you did that you did not remember?”

Zelda: “They told me about my begging them to hang me.”

Doctor: “Do you ever wish you were dead and out of the way?”

Zelda: “Yes.”

Doctor: “What makes you want to die?”

Zelda: “I would quit being dragged around to the asylum.”³²⁵

Leola Garrett suffered physically, as well. She longed for the relief of death. Leola had been an invalid for years before she came to Milledgeville at the age of 77, but she believed “her muscles began to ‘perish away’ when she was as young as thirty or thirty-five.” Indeed, her doctor noted “unusual emaciation,” muscular atrophy, and weakness and suspected Raynaud’s Disease.³²⁶ Leola appeared “absolutely helpless,” to her doctor, but he also noted Leola “as that of an individual who is trying to make herself satisfied with her present physical condition.” Leola confessed to him: “I feel like if I should go before sun down it would be all right. It would be a relief.” Leola had not long to wait to die. Her death, by progressive muscular atrophy, came within five months of being admitted to the institution.³²⁷

While some suicidal women expressed physical complaints, sometimes their physical condition was obvious only after death. Until doctors performed an autopsy on the body of Leila Todd, they had no idea she suffered from a brain tumor. Leila, a widowed “washwoman” and

³²⁴ CSH, Box 47, Book 235, pp. 93-125.

³²⁵ CSH, Box 29, Book 143, pp. 245-256.

³²⁶ CSH, Box 46, Book 228, pp. 376-389. Raynaud’s disease appears in the finger-tips as a discoloration as a response to cold or stress.

³²⁷ Ibid.

mother of one, was admitted to the Sanitarium in 1919 at the age of 59. She was sent to the institution because she was “filthy, violent, [and] shooting with [a] pistol.” But once she was there, in some ways she was a model patient. According to her doctor, she immediately made herself useful at the institution, assisting “with the duties on the ward: Rather efficient in looking after some of the sick patients.” Leila was a helpful patient.

Leila was also proud of her affiliation with the Holiness Church. When doctors asked if she felt sad or happy, Leila answered: “Happy, a holiness never gets sad.” Their conversation continued,

Doctor: What makes you happy?

Leila: I am in good health and mind.

Doctor: Were you happy before you came here?

Leila: Yes.

Doctor: Have you ever had spells in which you were very sad?

Leila: I don't get sad.

Doctor: Have you ever been sad?

Leila: Not since I have been a holiness.

Doctor: How long have you been a holiness.

Leila: Over nineteen years.

Leila claimed to be happy, and of “good health and mind,” but she suffered delusions. She claimed to be the “mother of six children, all of which died of tuberculosis, except one boy.” In fact, census records confirm that Leila had borne only two children and no record has been found attesting to her husband's death by tuberculosis. Leila claimed she had been raped three years before coming to the Sanitarium and that local bootleggers were responsible for having her committed to Milledgeville. While at the Sanitarium, she also believed that one of her caretakers had been killed by a group of nurses.

At night, Leila would be noisy “talking out of the window.” Her doctors believed her to be “inferior,” “the moron type,” and “an imbecile,” and one of them stated his belief that “she was sent down here because she was a care to the county.” Indeed, Leila begged “to go [back] to

the poor house.” Although Leila was in the Sanitarium for almost eight years, patient records reveal little that would have caused her to commit suicide.

Nevertheless, in early February of 1927, Sanitarium doctors noted the following:

On the last night of the 31st ult. About 10:45 P.M... the night watch, was making her usual rounds, and on visiting the room of Mrs. Leila Todd, she noticed strings around the transom. On trying to open the door, same was found to be barred. With a pair of scissors she cut these strings and calling assistance pushed the room door open and found the patient apparently dead. The ward physician was called and he responded promptly and investigation showed that she had torn the hem from the side and from the end of a sheet, making long strings which she doubled, passing these strings above the transom and round her neck. She was able to get these around her neck by placing the bed and a chair against the door to make something to stand on, from which she could jump off when the strings were fastened around her neck. When the ward physician arrived he found the nurses giving this patient artificial respiration. The body was still warm, but the patient was dead.

In an attempt to explain her suicide, her doctor noted:

The records will show that this patient was delusional. While she was old, she was being permitted to remain on an upper floor, because she was attached to her room. Recently she had been sick on Ward 28, apparently with a myocarditis, and when she made some improvement she was permitted to return to her old room because she showed such a great attachment to this room. The ward physician recalls that she threatened suicide while on the sick ward in case the ward physician would not return her to her old room.

In fact, Leila committed suicide within her old room. After an autopsy, which revealed a bruised neck from the “mark of the cord,” Leila’s body was buried on hospital grounds. It is impossible to know now if the brain tumor might have contributed to her mental illness.³²⁸

While women like Allie, Leola and Leila had clear physical distress, other women experienced fear and trauma that led to their suicide attempts. Harriett Bruce, 32, came to Milledgeville late in October of 1936, nine years after Leila’s suicide. She was married to an automobile mechanic and was a mother to two young children. In the patient history, Harriett’s

³²⁸ CSH, Book 152, pp. 166-276.

husband explained that not only was her father confined to the Alabama state mental hospital in Tuscaloosa, so were her brother and paternal uncle. Harriett lived in fear of congenital mental illness. “Insanity of relatives here and before mentioned is preying on her mind,” wrote her husband. Although he believed she had a “slight attack” before they were married while she was a telephone operator, she had no further mental problems until the Gainesville tornado of 1936. “She was in [the] center of [the] tornado,” he wrote, and “her condition began immediately following. Harriett was “unable to sleep,” harbored a “constant fear of death,” was “highly nervous,” and showed “loss of appetite and marked weakness.” She “talks constantly of dying,” he explained, and “says she can’t be cured.” Harriett cried when her husband left her, and confided to her doctor that although she had never attempted suicide, she “wished that she had the ‘nerve’ to take her life.”³²⁹

In her first week at Milledgeville, Harriett was “quiet, orderly, and obedient.” Doctor’s notes indicate she was “very pleasant towards everybody.” But the next week, she claimed to feel “empty in her head. She feels like love, hope and charity have gone out of her heart. ‘It seems like I don’t love nobody,’” Harriet told him. On Christmas Day of 1936, her husband arrived to take her home for a furlough. Her doctors allowed her to go, claiming her condition was improved. But when Harriett returned to Milledgeville on January 15, 1937, she had “pulled a large patch of hair from the left side of her scalp.” Two days later, during her examination, she told her doctor “I hate God, I hate my children and everything in the world.” She gave the doctor “no reason for her return, [but] says she pulled out her hair because she knows she has got to go to hell.” No notes exist on Harriett between her January 17 examination and her death in June of 1937, when she was found hanging; her bed sheet tied to [the] window bars and [her] neck.”

³²⁹ CSH, Box 53, Book 264, pp. 58-68.

Although she did not think she had the ‘nerve’ to take her life, she still managed to do so. After death, her body was returned to her husband by ambulance.³³⁰

Summary

This chapter illustrates how families and communities controlled and confined women exhibiting symptoms of mental illness. The women of this time and place experienced many forms of control and confinement on the way to the Milledgeville Sanitarium. For most of them, the form of control intensified along with their illness, from watching to guarding, to restraint, to jail and ultimately to the Sanitarium. As women’s violence towards themselves and others increased, so did the intensity of their confinement.

Mark Finnane’s theory of asylum as a mediator between families and women is a helpful lens through which to view confinement. As the women’s guardians at home grew in desperation, the Sanitarium did indeed become a mediator for them in dealing with their mentally unbalanced member. From the perspective of her family or county, the Sanitarium offered a respite for themselves from the grueling tasks associated with her care. The Sanitarium also offered a situation designed to keep her safe from harm and the only hope many held out for her recovery.

“So often,” writes Finnane, “it is the history of familial relations which is essential to appreciating the decision to commit.”³³¹ The cases of Liza Goode and Babe Tyner are particularly helpful in understanding the familial relations surrounding commitment at the Sanitarium. After the apparent death of her mother, Liza’s family sent her to the Baptist Orphan’s Home for two years before removing her to the home of her uncle. She was but twelve years old when the family first decided to bring her to Milledgeville. The family had tried

³³⁰ Ibid.

³³¹ Finnane, 137.

keeping her at home, but she grew more violent and they felt forced to confine her within her home before bringing her to Milledgeville. Doctors at the Sanitarium decided she was an imbecile and a harmless patient and sent her home by way of the county sheriff. But when she became a threat to her nieces and nephews, the family returned her to Milledgeville, where she remained until her death, no longer a threat or a burden to her family.

Babe Tyner's family had managed her convulsions at home from the time she was eight years old until she was sixteen, when Babe grew violent and began to attempt suicide. Her family also worried about her overt interest in men, a development which occurred long before adolescence in Babe. Appealing to the Sanitarium, Babe's family delivered her to the institution where she continued her flirtations and liaisons with men. When Babe was furloughed, she married another patient, but was soon delivered again to the institution after displaying homicidal intentions toward them. When Babe's promiscuous nature became intertwined with black men at the Sanitarium, officials there stepped in to be sure she would not be able to reproduce. This extreme act of controlling Babe's reproductive capacity was taken by the institution, her guardian in lieu of her family. Her sterilization was meant to protect society from having to support children who might inherit her problems. Finnane suggests that "the discipline of asylum life," ... "functioned after all to hide a family's shame, as well as to control the rebellious."³³² Although Babe's family was initially agreeable to her return home, the intensification of her flirtations may well have increased the level of shame to her family. Babe was more likely to behave at Milledgeville.

Because the Georgia State Sanitarium was free, a family had only to go through the motions of appealing to county officials in order to have their family member committed to Milledgeville. Although this step was a difficult one for many, for families who had faced years

³³² Ibid., 139.

and years of caring for women who continued to decline, the Sanitarium provided the only long-term reprieve possible. Often, families and county officials sought the short-term help of the county jail while awaiting placement at the Sanitarium.

Further study may reveal whether the numbers of women incarcerated in jail are indicative of some aspect of the individual woman's life or to possible overcrowding at the Sanitarium which might have necessitated temporary captivity in jail. Clearly, county jails also acted as arbiters between women and their families. Women who threatened children, threatened to burn houses, threatened themselves and others had to be held apart from those they meant to harm. Families were desperate for intervention. "She will have to be confined in jail if not accepted to the Sanitarium," wrote Anna Harris' husband.³³³ She was, quite simply, too dangerous to keep at home.

While both white and black women experienced all forms of control and confinement, black women were far more likely to be incarcerated in jail, both before and during their illness. It was not uncommon for black people to be jailed, or for black women to be raped in jail, as was Lena Ayers. Leon Litwack writes:

Women made up some 7 percent of the black prisoners, most of them incarcerated on minor charges of prostitution and petty theft ... the conditions they encountered were identical to those of the male prisoners, except that the women were more often the victims of rape and sexual misconduct.³³⁴

Black women in jail were particularly vulnerable to abuse. There is no evidence within this study that black women at the Sanitarium were more vulnerable to abuse.

At the Sanitarium, all women continued to face gradations of control and confinement, whether that confinement was simply the reality of her commitment or of extra layers of

³³³ CSH, Box 33, Book 165, pp. 136-146.

³³⁴ Leon Litwack, *Trouble in Mind: Black Southerners in the Age of Jim Crow* (New York: Vintage Books, 1998), 275-6.

confinement within the commitment. Some women were isolated for contagious illnesses. Others were placed in packs as soon as they were admitted to the institution. Still others became “portico” patients and were placed in strong dresses or sleeve aprons during their residence at the institution. Only one woman was sterilized of those within this study, but incidents of sterilization would begin to grow rapidly in the late thirties. For many, the varied confinements at the Sanitarium must have made it feel like a glorified prison.

Few of the women in this study chose their circumstances. Although the families of middle class women could choose to send them to private sanatoria, the families of rural northeast Georgia had no other recourse but to appeal to the free Sanitarium at Milledgeville. Those who were desperate at the institution sometimes sought to liberate themselves from the confines of the human life at a time when there was little understanding of mental illness and great suffering. Only two of the women were successful in their suicide attempts while at the institution. The Georgia State Sanitarium was effective in protecting the vast majority from harming themselves.

There is great ambiguity in the reality of confinement. Finnane submits, “the asylum was alternately ... beneficent in its protective role but horrible to contemplate in its disreputable face as incarcerator.”³³⁵ While it is ghastly to think of the types of confinement that the women endured, at times it is quite possible to understand why a family or institution might have made the choice to confine a woman, particularly if she was placing someone else in danger. It is even possible to understand why some women might be placed in jail. Within the institution, it is abhorrent to consider the reality of being placed in a strong dress or sleeve apron, but if the alternative was a woman who would continually bathe herself in excrement, the confinement seems reasonable. Some women needed to be institutionalized and some probably did not. Some

³³⁵ Finnane, p. 137.

women seemed to be content in jail and some withered. Most seemed to struggle at the Sanitarium but a few preferred to be there. The majority probably lived much longer in the institution than they would have had they remained at home; but what of their quality of life? The following case study focuses on one woman, Augusta Gordon, who experienced many of the forms of confinement and much of the ambiguity mentioned here.

A Case Study of Confinement: Augusta Gordon:

“I get off sometimes, but I believe I am all right now.”³³⁶

Because Augusta Gordon experienced almost all the types of confinement mentioned in the chapter over the course of her seven trips to the Georgia State Sanitarium, her case is worthy of further examination. Born Augusta Guest in 1883, she was the youngest child of seven born to a farming family in Hall County. She had been baptized as a girl “in Yellow Creek.” She dreamed of “going ‘possum hunting” and claimed she felt happiest when “I just get a book and go to reading it.” When Augusta was sixteen years old, she was engaged to be married and “the date was set.” But three months before the wedding date, she was raped by her brother-in-law, and the rape resulted in pregnancy: “She says that her brother-in-law was drunk and got her to drink some whiskey, but she does not remember anything that happened between them, but she does know that this thing happened because she did not have anything to do with any other man.” Pregnant, and fearful that her fiancé “would find it out and quit her,” Augusta refused to follow through with the wedding. Instead, she “was persuaded to marry” a widower almost forty years her senior, who had just lost his wife. A contemporary of her father, Augusta’s husband-to-be had been married for twelve years and already had five children with his first wife by the

³³⁶ Information on Augusta Gordon is drawn from her extensive patient file, located at Central State Hospital, Book 178, pp. 283-338; microfilm lunacy records from the Hall County Public Library, Georgia Archives Microfilm Medical Case Histories, death certificate from Georgia’s Virtual Vault, and census records through ancestry.com.

time Augusta was born. In 1903, he received Augusta and her newborn son into his household. Augusta inherited the responsibility for her husband's home and the few children who remained at home. Although Augusta told intake officials that "her sexual relations with her husband [had] been congenial," the two did not produce their own offspring, a daughter, for six years.

Augusta's First Trip to Milledgeville, 1911: "been tied"

Two years after the birth of her daughter, Augusta's husband brought her to Milledgeville. She was 22 years old. In August of 1911, just one month since her symptoms appeared, she was admitted to the Sanitarium. On admission, her husband reported that this was the fifth "attack," each previous attack having lasted "about three weeks each." She had been "wanting to run away [and] attempted to drown herself." When asked what kind of confinement had been implemented, her husband wrote simply: "been tied." Before leaving her at the Sanitarium, he added "in case of death or serious illness, [I] want to know."

At her first examination within the institution, her doctor recorded:

At time of reception patient was very feeble and nervous, showing marked apprehension; had to be assisted to the ward, crying upon the slightest provocation, and seemed to be in fear of being left alone...She came to the examination room with some degree of resistance, took her chair and began to cry...She does not make her own way about the ward readily, and frequently shows a tendency to cry as dictation is being made regarding her.

At ninety pounds, Augusta did express a number of physical complaints to her doctor: "of backache; headache... [she] feels like her teeth have been pulled out; says she cannot straighten up without bending away back." During her physical examination, she admitted to her doctor that "quite a number of her family on both her mother's and father's side has had some mental trouble, or as she expresses it 'had to be sent off to the Asylum.'" Her doctor recorded that "She seems to think that she was sent here because they were not able to feed her at home." When asked why she came to the Georgia State Sanitarium, Augusta stated "My brother brought me,

my father had to send me down here because they were poor and I didn't have anything to live on." When asked if her family thought "her mind was affected," Augusta answered "Yes...because I took sleepy spells and would go to bed. . . .my eyes want to sleep when I hold my head down." Augusta admitted she had the spells "nearly all my life." Augusta did want to come to the GSS. "Yes," she revealed, "I wanted to come it was the first time I ever got crazy. My feet and hands would get cold and I would have to go to bed, and I knew then that something was wrong." Explaining further what she believed to cause her "difficulty," Augusta revealed: "Mamma said for me to take some salts, and I believe that caused me to be wrong all the time...I believe it." She also told the doctor "she knew that she was coming to the Asylum, and wanted to come ever since she had 'cornbread disease.'"³³⁷ Reflecting on her lack of happiness, the doctor noted "she has been seen to smile, but this smile is more automatic, it does not seem to reveal any real spirit of mirth."

Doctors diagnosed Augusta with infective-exhaustive psychosis in 1911. By early 1912, she had "gained flesh and appeared to be in a normal mental and physical condition," but by the spring, she "became agitated, nervous and depressed and lost flesh." In August of 1913, doctors made this note: "Health fairly good. . . .For several months patient has not been anything like normal, and about one-half of the time is confused, negative, refusing to speak or eat for two or three days at a time, removing clothing and disarranging things about her." In spite of this, Augusta was furloughed from the hospital on February 19, 1914 and discharged exactly one year later. Her condition was "improved."

Augusta's second trip to Milledgeville, 1915: "confined in county jail"

Augusta was admitted again, not quite one year later, on January 26, 1915, at the age of 32. Her husband brought her to the Sanitarium, this time in the company of Augusta's father and

³³⁷ See chapter six on pellagra

a neighbor. The men filled out the history form on her behalf. Augusta had borne a third child in September, just five months before her return to the Sanitarium. After the birth, she was “irritable [sic], crying, destructive,” and suicidal. This time, rather than tying her, she was “confined in County Jail.” When asked to write the probable cause of her insanity, her husband stated: “I do not know,” but heredity was a possible reason. “Mother crase,” [sic] he wrote. Next to the space for paternal grandfather and grandmother’s illnesses, he wrote again, “crasey” [sic]. Her husband claimed, perhaps with the input of Augusta’s father, that she had been hard to control as a child. She was “good” before becoming insane; after leaving the Sanitarium the previous time, she was “beter” [sic]. But in August, she began “laffen [and] cring” [sic] and according to them, her head and back continued to hurt. Her husband added his signature to a final note: “I have Done [sic] all I can to the case to help you.”

When the doctor examined her this second time, he found her uncooperative and confused. “During the examination said she hurt all over, but in the beginning denied pains.” Except for telling him that she wanted to go home and that there was nothing wrong with her mind, she gave no answer to any of his questions. When asked why she came back to the Sanitarium, she answered “I don’t know anything about it at all.” Her doctor deemed the examination “useless. ...[she] sits in a rather fixed attitude, gazing at the floor, makes no effort to co-operate.”

Over the course of her second stay, doctors found her alternately cheerful and then depressed. In May of 1915, her doctor noted:

This patient is sociable, pleasant and industrious and seems to react in a normal manner; has given no difficulty whatsoever since being on the ward; knows this is Milledgeville and furthermore is oriented as to time, and person. Does not seem to sense the real meaning of the institution, stating that it is a place to take care of the sick and has not seen any crazy people since she has been here. States she was here once before for a period of about 15 months because of pellagra. States that

her people sent her here for the reason she was out of her mind and did things which she does not remember. Says she feels all right at present. No illusions, delusions or hallucinations developed.

Augusta's doctor claimed she had "one of the most pronounced cases of pellagra seen in the institution at that time," but within weeks, Augusta had improved. She had gained a healthy amount of weight. At 116 pounds, and apparently showing improvement, Augusta was transferred to the infirmary for two reasons: "It was anticipated that she would soon go home" and "in order that she might be help on the infirmary ward." The doctor noted that "The patient got along very nicely on the ward and throughout her residence she seemed to react in an entirely normal manner to her environment." Augusta was diagnosed on her second commitment to the Sanitarium with psychosis accompanying pellagra and was discharged in July of 1915, improved after only five months and seventeen days.

Augusta's Third Trip to Milledgeville, 1916: "Been confined in room at home"

Her third admission was on August 7, 1916. Yet again, Augusta had carried and delivered a baby, her fourth, while home. But this time, she was returned to the Sanitarium only three weeks after the baby's birth. Her husband claimed she was "crying [and] ill and contrary," as well as suicidal since May of 1916 at which point Augusta would have been in her seventh month of pregnancy. She had "been confined in [a] room." Her doctor found little evidence of pellagra this third time. Once again, Augusta was "in an apathetic or confused state, seldom ever speaks to anyone. . . . does not know how long she has been here this time, or who came with her. Says she came in a buggy, [but] was brought in an automobile. When asked if she was sad, said a little bit and cries." Her doctors were unable to come to consensus regarding her diagnosis this time. Their ideas ranged from psychosis accompanying pellagra to dementia praecox (schizophrenia) to infective-exhaustive. Two of her doctors began to consider the implications of

her “inferiority.” Case notes reveal that while Augusta began this turn at the Sanitarium in August refusing to dress or to answer questions, by September she was sleeping well, showing “interest in things going on about her. Calls some of the nurses by name.” Augusta was ultimately once again diagnosed with psychosis accompanying pellagra and was discharged improved after two years, two months, and ten days.

Augusta’s Fourth Trip to Milledgeville, 1920: “Careful Watching”

By the time her husband admitted her for the fourth commitment on October 19, 1920, Augusta was 37. “Your records will show her to have been there three times before this,” he wrote. He further explained that in May of 1920, Augusta began throwing dishes and wanting to fight. Her husband felt the current cause for her most recent attack was a “severe headache [and] irritation of [the] bladder.” According to him, she was both suicidal and homicidal. For the first time, perhaps grasping at straws, he wrote he “suspected” she might have had syphilis. She had borne a fifth child while at home, this time eighteen months before her admission date. Her initial confusion during examination repeated itself:

She cries and when asked why, she says it is because she is at home. At another time she begins to ask the physician questions and laughs. Still again she protests being quizzed and says that it makes her mad. She and her husband have separated. She gives no reason, except to say that [she] just told him that she was crazy. When asked how many children she has, she replies that she does not know and says that she does not wish to talk about such foolishness. Gives her name as Augusta. Has no other name. Never been married.

“Her statements are so contradictory,” the doctor concluded, “that it is difficult to elicit a dependable history.” Still he tried.

Doctor: What is the name of this place?

Augusta: Milledgeville

Doctor: What is it for?

Augusta: Crazy people.

Doctor: Why were you sent here?

Augusta: I just have to talk and I don’t like to say nothing. I don’t like to talk...

Doctor: Do you feel sad?

Augusta: I get a little lonesome sometimes; looks like the windows need washing mighty bad. (Looking up at the window. Cries.)

Doctor: Are you happy?

Augusta: Yes.

Doctor: Anybody ever treated you wrongly?"

Augusta: (No answer.)

Once again, the doctor “abandoned” the examination attempt, and this time, the doctors spoke freely about Augusta’s “constitutional inferiority” within their meeting (to agree upon a diagnosis). One doctor stated that “I don’t think pellagra plays much part in her condition now and probably never did... the history states her parents were feeble minded. I don’t think she would measure up very high.” “She has unstable emotional states,” agreed another, “and she shows evidence of rather inferior intellectual make up. She has a bad family history. Father and mother weak minded and possibly other hereditary taints.” Ultimately, the doctors diagnosed her with psychopathic personality. Very few case notes accompany her fourth stay at the Sanitarium. But in one, dated November 3, 1920, her doctor wrote that “She has reiterated her intention of remaining in the institution and that she is satisfied to remain here.” But in spite of Augusta’s wishes at the time, she was furloughed, and then returned to the Sanitarium two and a half years later, on May 2, 1923.

Augusta’s Fifth Trip to Milledgeville, 1923

When she returned, she gave little information about her time at home. “She is inclined to turn her back and look the other way. She refuses to say whether she has been living with her husband or what she has been doing out of the institution...the ward physician is at a lost [sic] to come to a conclusion in his own mind just what her real mental condition is.” Once again, Augusta improved, was pronounced restored, and was furloughed in September. “This patient will be permitted to go home on trial furlough as soon as her husband comes for her.” After two

years, ten months, and 25 days in the Sanitarium, she was once again released at the age of 39 years on September 14, 1923.

Augusta's Sixth Trip to Milledgeville, 1925: "in jail at present"

Less than two years later, Augusta was readmitted to the Georgia State Sanitarium on July 20, 1925 weighing one hundred pounds. This time she had borne no more children. Her husband claimed she had been engaged in farming and housekeeping while at home. At her admission, he wrote that this decline occurred "about 5 weeks ago," and assumed that pellagra might once again be the reason for her condition. He wrote that she "tries to commit suicide by jumping high and falling on floor." She "is gradually getting worse and her family is getting afraid of her. Believing she will kill someone or herself." Perhaps because of this fear, Augusta was once again placed in the county jail.

But at the time of this commitment, Augusta was different. She no longer offered doctors the confused testimony of the past visits. She spoke with clarity about her family history without delay or confusion. Her doctor wrote that according to Augusta, "One sister died at sixty of tuberculosis in this institution; another died at fifty in this institution. Grandfather died in this institution. Mother has been a patient in this institution. Patient has five children. No miscarriages. Husband living, about seventy-three years of age." Regarding her own life, Augusta offered more than ever before of her story, which the doctor then wrote within a narrative:

Since being at home she says she has never felt right. She really had rather be back in the institution. Her husband is an old man, seventy-three years old, and does not work and lives with his son-in-law, and she does not get along with her husband's first family. They do not like her. She says she really never loved her husband. She was persuaded to marry him.

After explaining the rape of her youth and her broken engagement, Augusta revealed that the fiancé of her youth was now a widower. “This man married,” Augusta explained, “and his wife is dead. She says now she wishes he would come back and marry her.” But Augusta was, of course, already married. According to her, “every time she gets a little mad he [her husband] sends her back here.” Augusta concluded that “she had rather be here.” Perhaps in an effort to return to the institution, in May Augusta began jumping and falling in order to harm herself. “About two months ago she thinks she worked too hard. She was setting out some plants or trees in the garden and she got nervous and excited. According to the commitment history she would jump and fall on the floor and tried to hurt herself in that manner.”

Indeed, the doctor found “bruises on her body . . . that indicate injuries of some kind.” From listening to her during the examination, the doctor decided that heredity “probably plays the greatest factor” in her insanity, but he also believed “the episodes may have been precipitated by her uncongenial married life. She says she does not love her husband and does not get along with his children by his first marriage.” The doctors collectively decided on a diagnosis of manic-depressive, and all but one made a point to highlight her inferiority in the staff meeting notes. “I think we all recognize the patient is mentally deficient,” stated one physician, “whether she is an imbecile or a high grade moron.” At the institution in August of 1925, Augusta was in poor health. “She does work such as shelling peas, [but] owing to her poor physical health, she is not called upon to take up work in the other lines of activity.” In spite of her poor health, Augusta Gordon was furloughed into the custody of her husband one last time after ten months and nineteen days in the institution on June 8, 1926, condition: improved.

Augusta's Seventh and Last Trip to Milledgeville, 1928, "Confined in County Jail"

Her sixth and final admission was on March 16, 1928. Augusta entered the hospital at 45 years old and an emaciated 87 and one half pounds. Her husband reported that Augusta had "tried to fight members of the family" two weeks previously and he once again had her confined in [the] county jail" where she was "treated by the county physician." Doctors found her confused once again. "Does not know whether her husband is living or not." For employment, "she did a little sewing and they paid her for it." Instead of claiming her five children, Augusta told him she had "one child and reckons it is living." When asked if she had ever attempted suicide, she said simply "One time. I was off." When asked "how did you get off?" she responded "Turned weak." When asked "are you crazy?" She replied "I get off sometimes, but I believe I am all right now." Augusta traveled home twice for visits; once with her husband for a furlough on September 8, 1928, and then with her daughter on March 26, 1929. After a debate among the doctors as to whether she might be "an old case of dementia praecox" (schizophrenia) or manic-depressive, Augusta was diagnosed as manic depressive. The doctors reasoned "she probably would have died had some disease caused her commitment every time she had been here." Instead, Augusta lived three more months and finally died of acute nephritis on July 8, 1929 at the age of 43. Her remains were "carried" home for burial.

Summary

The girl that dreamed of possum hunting, loved reading, and who was engaged to be married to a man she loved, had her life altered through an incestuous rape, an illegitimate child and a marriage to a widower before she was even eighteen. Augusta's story illuminates several issues: the common use of confinement, the cycling in and out of the Sanitarium after childbirth

and bouts of malnourishment, and a tendency to be seen by the doctors as inferior, imbecile, or moron when by all indications she was once a “normal” girl. Initially tied within her home, Augusta was placed in county jail three times in addition to being watched and confined within a room at home. By the end of her life, she seemed to prefer the confinement of the institution as a refuge from the confines of a home where she was unhappy in her marriage and with the memory of her youth.

Half of her trips to Milledgeville came immediately following pregnancy and childbirth. She came to the institution five months after the birth of her third child, three weeks after the birth of her fourth, and eighteen months after the birth of her fifth child. For Augusta’s second and third institutional commitments, she was barely home time enough to become pregnant, carry and bear a child before she was returned again. Perhaps because of the number of times she was placed within the Sanitarium, some of her children are not found with her in census records. Her eldest son, the boy who was a product of rape, lived with his mother and her husband in 1910, but with his maternal grandparents by 1920. In the 1920 census, only two of Augusta’s children, her eldest and youngest by her husband were living within her home. Her other two children have not been located within census records.

Records also reveal the confusion Augusta’s doctors experienced in trying to accurately diagnose her illness. Initially diagnosed with infective exhaustive psychosis, she was afterward twice diagnosed with psychosis accompanying pellagra, psychopathic personality, and finally manic depressive. Early on, her doctors entertained the notion of her metal deficiency. By the time she had been to the institution six times, at least one considered her an imbecile or

moron.³³⁸ Admittedly, we will never know with what malady Augusta was afflicted. But her story enables us to imagine the lived reality of one woman who lived and died at Milledgeville.

Augusta was twice diagnosed with pellagra, a disease that ravaged the South in the early part of the twentieth century; it did so because of widespread malnutrition attributed to poverty. The next chapter will explore poverty and pellagra as it was experienced by women like Augusta Gordon at the Georgia State Sanitarium.

³³⁸ Two of these diagnoses are explained in American Medico-Psychological Association and National Committee for Mental Hygiene, *Statistical Manual for the Use of Institutions for the Insane* (no publ. given, 1918). Psychosis accompanying pellagra was the term doctors used to denote “the mental disturbances ... [of] delirious or confused states (toxic-organic-like reactions) arising during the course of a severe pellagra” (21). Manic depressive psychoses were described as “mental disorders which fundamentally are marked by emotional oscillations and a tendency to recurrence”(23). “Idiocy” is defined in Henry Campbell Black, *Black’s Law Dictionary* (St. Paul, Minnesota: West Publishing Company, 1933). as “congenital amentia, that is a want of reason and intelligence existing from birth and due to structural defect or malformation of the brain. It is a congenital obliteration of the chief mental powers, and is defined in law as that condition in which the patient has never had, from his birth, even the least glimmering of reason...” (973).

CHAPTER 6

POVERTY, PELLAGRA, AND PAUPER'S HOMES

The vast majority of women who traveled to Milledgeville from Northeast Georgia were, by today's standards, poor. Poverty, endemic to the South in the post- Civil War years, was the reality for nearly all who were born there until the late nineteen forties. Although Roosevelt's New Deal provided some relief during the 1930's, the South did not experience widespread relief until after World War II. It was so common to be poor that few of the women included in this study ever spoke of poverty; it was the only environment they knew. This chapter will discuss the effects of poverty on the women's work lives, on their health and on their livelihood.

Women's Work

The women in this study rarely spoke of their poverty; they spoke of their work. The vast majority of the women included in the data were farmer's daughters and wives who had worked in the field since they were children. They cooked, cleaned and did field work. Most would describe themselves as hard working women.

Often, women worked alone or with very little help from others. Admitted to the Sanitarium for the second time at the age of thirty, four months after her fourth child's birth in 1917, Mollie Whitlow claimed to have little help running her farm. When asked her occupation, Mollie stated she kept busy "keeping house and working in the field." Her doctor pressed her further: "have you been able to do your work?" he asked. "I done all that *was* done," answered Mollie, whose husband broke his arm and was unable to help her maintain the farm.³³⁹

³³⁹ CSH, Box45, Book 223, pp. 15-31.

Doctors interviewed Maude Burgess, a black woman, early in her stay at the Sanitarium in 1931 about her work. Maude worked hard in the field. She worked so hard she worried she might not be able to persist.

Doctor: Have you been able to work lately?

Maude: I picked two hundred pounds of cotton yesterday.

Doctor: Do you get tired easily?

Maude: No, sir.

Doctor: Do your thoughts come faster or slower than they used to?

Maude: They come slow. I do my biggest studying at night.

Doctor: What do you study about at night?

Maude: I wonder if I am going to be able to go back to work in the morning.

Doctor: Why do you wonder that?

Maude: When I work I work and don't play and I be so tired at night until I just wonder if I will be able to work the next day.³⁴⁰

Some women worked beyond their own homes and fields by taking in the house and fieldwork for others. In addition to her work picking cotton, Maude Burgess was a washerwoman. Sallie Crews also earned a living by “taking in washing” after her husband, a foreman at an apple orchard, died of pellagra. She explained to her doctor that “the property left by her husband has been exhausted.” Unable to make a crop, Sallie was dependent on her own ability to wash, and “on her brothers and son.”³⁴¹

Being able to work was critical for each member of farm households. A disabled member could spell disaster for a family. But the ability of each family member to work hard was no guarantee of making a living for farm families. Between the boll weevil, uncertain rain, and “exhausted land,” farm families lived in constant worry for the future. When asked what she would do when she returned home from Milledgeville in 1924, Neta Bennett responded she would “gather my crop.” The doctor asked “How much cotton are you going to make on six

CSH, Box 45, Book 225, pp. 178-191.

³⁴¹ CSH, Box 30, Book 137, pp. 137-145.

acres?” Neta answered: “I planted for two bales if the boll weevil don’t ruin it.”³⁴² Cash crops were all-important in an economy that saw little cash any other way, but hard work did not always pay off and if a member of the family was sick and unable to contribute, the family situation became much more serious.

Diseases of Poverty

Part of the difficulty of poverty was in its accompanying health problems. Malnutrition was a primary concern in the South and manifested generally as pellagra.³⁴³ The difficulty of achieving appropriate sanitation was another concern. Hookworm became a problem for the South in the early part of the twentieth century. Only two women within the data exhibited evidence of hookworm or tapeworm.³⁴⁴ One of these stories is especially illustrative of the concern surrounding sanitation and disease during the time.

At the age of thirteen, Lottie Woods came to Milledgeville over a year after completing the seventh grade. By the time she arrived, she had already “been treated by various physicians, who have stated that, in their opinion, she has hookworm and perhaps tapeworm. They believe that her condition is caused by one or both.” More specifically, Lottie’s doctors believed her condition was caused by the *treatment* she experienced for hookworm. After the hookworm treatment, Lottie was no longer able to speak. “She cannot talk but makes a whining noise like an animal,” reported her family. The following unsigned letter was written on March 4, 1929, presumably by Lottie’s family physician and handed to the doctor at Milledgeville upon her reception.

³⁴² CSH, Box 29, Book 141, pp. 441-452.

³⁴³ See Chapter 3 for a description of pellagra.

³⁴⁴ The other woman was Ada Pryor, who was diagnosed and treated for “dwarf tapeworm.” CSH Box 43, Book 212, pp. 228-250.

Lottie Woods' condition is as follows:

On July 9th, she got up well and bright. She begun [sic] taking hook-worm treatment, one dose at six o'clock in the morning, one at eight, and one at ten o'clock. By eleven o'clock she was wild and did not know anything. She fell asleep and could not get her aroused until about three o'clock Tuesday morning. She aroused and said she could not hear, then fell asleep again and just aroused enough once in a while to say a few words.

Wednesday morning she aroused and said she had a pain in her head. Then she started having convulsions. She had one after the other all day, each one just about thirty minutes apart. After the convulsions she fell into a stupor and lay that way for about three weeks. Then she begun [sic] licking out her tongue and she would try to chew the bed clothing, etc.

This still continues.

After the convulsions she was speechless, and seems to be yet. In six weeks from the first convulsion she had them again, beginning one evening at seven o'clock, and had them until about twelve o'clock the next day. Then she fell back into the same condition, wanting to chew her clothes. She is still speechless.

Lottie was treated at home first by her family doctor, then she was carried to doctors in Hoschton and Franklin, North Carolina, before a doctor was called in from Atlanta. The doctors agreed "that the trouble was due to the toxine [sic], or poisoning associated with hookworm treatment." At Milledgeville, Lottie was also found to have scabies. The doctors there were puzzled as to how to classify her but finally diagnosed her as an epileptic due to her convulsions. Four years later, in February, 1933, she died at Milledgeville with pneumonia. During Lottie's time at Milledgeville, she also suffered with pellagra, another disease associated with poverty.³⁴⁵

Pellagra

Although Lottie Woods came to Milledgeville in April of 1929 "well-nourished," by December she was "somewhat undernourished" and by August of 1930, Lottie had developed a "marked case of pellagra."³⁴⁶ The four D's of pellagra—dermatitis, diarrhea, dementia, and

³⁴⁵ CSH Box 45, Book 223, pp. 1-14.

³⁴⁶ Ibid.

death—afflicted at least sixteen of the women in this study, either before they came to Milledgeville or while they were there. The stages of the disease impacted first a patient's hands then their mouth, tongue and bowels. Dementia would affect the patient next and if she went untreated, death would soon follow.

Pellagra was often suspected by the appearance of a patient's hands. Doctors noted that Lula Power, a young black woman, probably had pellagra solely due to "the appearance of her hands."³⁴⁷ In 1920 and at the age of seventeen, Liza Goode's doctor noted she had "well marked pellagrous eruption on hands symmetrical."³⁴⁸ At 5'7" and 103 pounds in 1935, Vicie Crump told her doctor "she was always healthy until she married, and since then has been run-down and worked to death." Vicie's doctor asked her to explain the reason for her sadness. Displaying her hands for the doctor to examine, Vicie told him "I don't know, unless it is this disease I have. They say it is pellagra. It has been this way going on two years. ... It has worried me down because I am not able to do anything." Her doctor noted, "She prays for the Lord to help her get well of this breaking out and go home."³⁴⁹ But for many women, after "breaking out" on their hands, they suffered with diarrhea and other gastro-intestinal troubles.

There were several symptoms beyond dermatitis common to pellagra patients. Gastro-intestinal symptoms were referred to as problems with mouth, tongue and bowels. In May of 1913, Ruby Word was "returned from the infirmary where she remained several weeks in bed with some gastro-intestinal and other vague symptoms of pellagra, such as sore mouth and discolored skin over dorsum of hands, elbows and knees."³⁵⁰

³⁴⁷ CSH, Box 45, Book 223, pp. 1-14.

³⁴⁸ Ibid.

³⁴⁹ CSH, Books 243-263 (approximately book # 252), pp. 400-408.

³⁵⁰ CSH, Box 33, Book 163, pp. 46-52.

Often, women would exhibit signs of dementia in tandem with the gastro-intestinal troubles. Desimony Frazier, who was admitted to the Sanitarium repeatedly in the late teens and twenties, was diagnosed with “pellagrous insanity,” first in 1918 during what her husband referred to as her “prewar attack.” She displayed “remains of [an old] eruption above the wrists, considered pellagrous.” Her tongue was also “somewhat reddened.” Desimony would “pull off her clothing and wramble [sic]. Probable cause pellagra. Thought she was being chased by germans [sic].” Desimony was released on furlough in 1919. When she returned to Milledgeville in 1924, she described what happened to her while she was home:

She had a sick spell while at home. She had to stand on her feet so much she had trouble with her menstrual periods evidently profuse menstruation. There was no one there but men and she had to do all the work at the house. States she was worked down until she was nervous and could not hold anything still. It seems like they were not going to make anything and she went out and looked at the crop.³⁵¹

Desimony returned to Milledgeville “because she wished to.” She thought “pellagra may have made its appearance” once again while she was home and described to her doctors “that the skin on the back of her hands was black, and her lips were sore, and that at one time her bowels were loose.” After being furloughed once again, Desimony was readmitted for the third time in 1926. She described what her doctors referred to as “a mild attack of pellagra.”

Her husband owns land and runs a three mule farm. States she has five children and she helped to do the cooking and that she patched, sewed and did house work. States she has not done hard work, but that her husband let her do what she could do for fear she would get down in bed sick. States about two months ago her mouth became sore and what ever she ate would run through her, and that she was in bed and could hardly go at all, and it seemed like she had a hot fever. Her teeth bothered her and she believes her teeth had a heap to do with it. Speaks of a breaking out she has had off and on ever since she was a child.³⁵²

³⁵¹ CSH, Book 206, pp. 217- 258.

³⁵² Ibid.

The “breaking out” may well have been pellagra, even though Desimony claimed it was “caused from poison ivy.” Pellagra was known to return in the spring, when families had run out of the vegetables they would have put up for the winter. A diet based on fatback, cornmeal and molasses was low in niacin. Patients who came to Milledgeville in the late 1920’s reaped the benefit of the pellagra study that had been implemented there since 1916. A balanced diet or doses of yeast would soon cure the pellagra, but when a patient returned home, the same cycle would begin again. Plagued with pellagra for the majority of her life, Desimony may well have found relief only in her visits to Milledgeville. In the spring of 1927, Desimony was furloughed for the last time into the custody of her husband. When she returned to Milledgeville, she remained there until her death by pneumonia in the fall of 1932.

Many women suffered with pellagra during this time. Jessie Allen, a 51 year-old married white woman, was diagnosed with “infective-exhaustive psychosis associated with pellagra” in 1917. Although she was unhealthy as a child, she “worked in the field until she married.” When her family brought her to Milledgeville, they wrote that Jessie had no serious diseases “but pellagra for [the] past two years.” Jessie had the following exchange with her doctor, who noted “probable residuals of pellagra in the reddened condition over the elbows and pigmentation extending well up on the wrists.”

Doctor: When did you first show signs of pellagra?

Jessie: Three or four years ago.

Doctor: How did it come?

Jessie: On my hand[s]. They looked red.

Doctor: Your mouth get sore and bowels run off?

Jessie: Yes.

Doctor: Suffer any pain?

Jessie: Yes.

Doctor: Did you have it this spring?

Jessie: Doctor said I had a little touch of it.

Doctor: Ever had any serious illness?

Jessie: Only this pellagra.

Her doctor summarized:

She gives a history of pellagra some two years ago, at which time her hands became dark, the skin was ulcerated, mouth and tongue were sore, and she had a diarrhea. Says a doctor told her she had pellagra, and another physician told her she had the 'dregs' of pellagra last spring. Evidently the patient did have symptoms of pellagra in the spring.

Readmitted eighteen years later in 1935, just a month before her death, doctors concluded she was "an old manic." One doctor stated "I wouldn't be surprised if she wasn't a manic depressive with ingrafted pellagra."³⁵³

Once women exhibited dermatitis and diarrhea, dementia and death were soon to follow if treatment did not come quickly. Black women were more likely to die quickly of the disease. Although Callie Walker, a 32 year old black woman, worked as a cook in a private home, she nonetheless came to the institution in March of 1923 having had pellagra, with her lips and tongue still "inflamed." The doctor prescribed tube-feeding for Callie, but the treatment failed and she was dead within the month due to exhaustion.³⁵⁴

Ina Chambers, a 41 year old black wash woman, was admitted to the Sanitarium in the winter of 1926 and died of pellagra within two weeks of her admission. Her husband, a laborer in the mica mines, reported she became sick in June of 1925, but was unable to give further details. Her home physician recalled: "She for sometime has been afraid. Does not sleep. Screams. Is weak and sometimes falls down. Has tried to set fire to her clothes. Had dress on fire twice. Incoherent, says she is weak and nervous. Every noise she hears she will leap from the bed." He prescribed medicine to help her sleep, and appealed for help by post from authorities at Milledgeville. The physician wrote further that "her husband stays with her and 4 small children that are at home. ...she is a case that needs immediate confinement for safety of herself and

³⁵³ CSH, Books 93-128 (approximately book # 125), pp. 558-567.

³⁵⁴ CSH, Books 93-128 (approximately book # 113), pp. 204- 210.

children. She is getting worse.” Once Ina was brought to Milledgeville, she was confined to her bed. Her doctor at the Sanitarium recorded her condition two days after admission.

This patient was admitted in a very feeble condition. She was immediately placed in bed on the sick ward where a special liquid diet was ordered by tube as she refused to take any nourishment. She has definite symptoms of pellagra. The backs of her hands are roughened and her tongue is red. She has excessive salivation, her breath is foul and she is confused and afraid all the time. She has not replied to any questions asked her. She did not seem to recognize what was meant when she was asked to stick her tongue out. She disarranges things about her in her room, passes her bowel and kidney movements unnoticed. It is necessary to look after all her wants.

The following day, he resumed his notes:

This patient has been confined to bed practically all the time since being in the institution. She has definite lesions of pellagra. She refuses her food. Her mouth is filthy and her breath foul. She is being given a special diet by tube. She is very fearful and seems to be in a delirium.

Five days later, the doctor noted:

She has shown practically no improvement since being here regardless of the fact that she has been taking about two quarts of feeding consisting of milk, eggs, tomato juice and sugar. At the present time there is no yeast in the institution. She is in a delirium. Does not recognize things going on about her. She is untidy and it is necessary to look after all her wants. She will occasionally scream out as if afraid someone was going to hurt her. She has not been heard to say anything that could be understood since being in the institution.³⁵⁵

In just two more days the doctors agreed on her diagnosis: psychosis with pellagra. Brewer’s yeast was the preferred antidote for pellagra, but because there was “no yeast in the institution, Ina was given “quarts of feeding” instead. The feeding was too late. Ina Chambers lived five more days.

Ada Pryor, the third black woman with pellagra, was first admitted to the Georgia State Sanitarium in 1927 at the age of 37 and was diagnosed manic depressive. She weighed 120 pounds. When she improved, her family was requested to “come for her and did not do so.” In

³⁵⁵ CSH, Box 29, Book 141, pp. 99-106.

1928, the Sanitarium made “other arrangements” for her. Ada was placed in the custody of a woman living in Appling, Georgia, where she remained for one year. When she returned to Milledgeville, she exhibited clear indications of pellagra. Ada told her doctor, “She worked so hard [while in Appling] that it cause[d] her to have to come back here. She says they paid her no money for her work.” At just over ninety pounds, Ada had lost almost thirty pounds in her year away. “She gets about slowly,” wrote her doctor, “has sore mouth and red tongue and skin symptoms of pellagra.” Within six months back at the Sanitarium, her health had improved. When her family continued to refuse to come for her, she was furloughed twice afterward, to members of the community, one of whom was the wife of a man who worked in the black kitchen at the Sanitarium.³⁵⁶

Pauper’s Homes

Ada Pryor’s story illustrates not only pellagra, but introduces another aspect of how poverty was handled in the rural communities of Georgia. When Ada’s family neglected to come for her, Sanitarium officials made other arrangements. Ada Pryor was boarded out to a home in Appling County. It was not uncommon at the time for people to agree to take on “pauper charges” in exchange for their labor. But, as historian Elizabeth Wisner suggests, those who took on such charges “could not, in most instances, make a profit or a living for himself except by gross neglect of his charges.”³⁵⁷ Ada’s loss of thirty pounds over the course of a year, her complaints about the grueling work, and her apparent pellagra when she was returned to Milledgeville, suggest that she was exploited for every ounce of labor she could summon. At the point where Ada was physically able to labor no more, she was returned to Milledgeville. Twice

³⁵⁶ CSH, Box 43, Book 212, pp. 228-250.

³⁵⁷ Elizabeth Wisner, *Social Welfare in the South from Colonial Times to World War I* (Baton Rouge: Louisiana State University Press, 1970), 43.

she improved and twice again she was boarded out. Fortunately for Ada, she was not returned to Appling County.

Some pauper's homes might have functioned similarly to the Appling County home, but by the time a woman from a pauper's home was brought to Milledgeville, she was more likely disabled or old and unable to earn her keep in any way. Pauper's homes were an institution common to southern counties before Roosevelt's New Deal. Elizabeth Wisner writes that "where many families had a meager living, the southern poor farm was too often a wretched shelter for the destitute."³⁵⁸

One example of such a "wretched shelter" was the Franklin County Pauper's Home. Stewardship of the Pauper's Home would typically go to the lowest bidder who promised to feed, clothe, and care for paupers of the county. In 1878 in Franklin County, the stewardship went to a man that bid \$3.99 $\frac{3}{4}$ per person, per month.³⁵⁹ Local papers provided regular reports on the number of "inmates" by gender and race in pauper's houses and the status of those homes. But citizens were growing concerned about the condition of the pauper's home in the late summer of 1888, when one local man with "two years experience in the care of a pauper's home," made suggestions for the improvement of the Franklin County home.

Sell a part of the land, as much as may be advisable; build a comfortable dwelling for the steward, a stable, smoke house and corn crib, finish up the present old people house, and buy a good horse, (as a mule is hard to control alone), and a good one horse wagon and harness, also a good cow and calf and put them on the place. Let the Steward and his wife give their entire time to the care of old people, and to putting out of fruit trees, gardening, corn patch and a small grain farm. The Ordinary to see that they have a proper supply of food and raiment, and the county commissioners to visit the farm, at least one of their members, once a month and not on the same day of the month; so there can be a proper oversight [sic] taken of all that pertains to the wants of the Pauper's Home.³⁶⁰

³⁵⁸ Ibid.

³⁵⁹ "Pauper's home," *The Register*, 12 October 1878.

³⁶⁰ "Our Pauper's Home: There Must Be a Change," *Franklin County Register*, 18 September, 1888, 3.

One week later, perhaps in response to the above appeal, the same paper published a report of abuses "at the poor house" in Franklin County. The editor railed "that the poor house should have existed as it is, for a number of years, and in the midst of an enlightened and humane people, is a matter of astonishment." He claimed "great cruelty and inhumanity...mainly in neglect, disregard of the general welfare of the inmates and withholding from them almost everything necessary to a comfortable existence." Among the newspaper's allegations were food "insufficient in quality," bedding "scanty and filthy," a lack of tables "upon which to place their food," and a lack of proper clothing. The paper decried "the plan of letting them [the paupers] out to the lowest bidder" as "unchristian and inhumane." and printed these among several gruesome reports:

1. Abe Banks, colored, passed one winter without shoes.
2. Mrs. Patsy Moss, a very old and infirm, died...she begged for food which was never furnished. During the last hours of her life her mind wandered, but the craving of hunger asserted itself and she continued to call for food. Her last distinct utterance was to call her husband, long since dead, and ask him to make a fire that she might cook something to eat.
3. A man named Isham died there the same year. He died in the night and alone. He complained bitterly of a lack of food as long as he could speak.
4. Sallie Ford died there the present year under very distressing circumstances. She suffered much with cold, for proper food and for want of care. She was beaten by Miss Permelia Poole several times a short time before she died. The keeper says the beating was light, but we believe it was severe. The maggots were in her flesh before death, and at the time of death, and when she was buried, they were teeming inside her body.³⁶¹

By June of 1893, the editor of the *Carnesville Tribune* reported a much improved situation. The ordinary of the county and editor of the paper made the trip to the pauper's home by foot, past "beautiful fat cattle," across a branch, past a "beautiful cornfield" to the home of the steward, Uncle Jed Stovall and "his good wife...one of those good old fashioned motherly kind of women." After dinner, the men swapped war stories and took a tour of the "good old county

³⁶¹ "What shall be done with our paupers: some charges made," *Franklin County Register*, 25 September 1888, 3.

spring,” through the garden—“decidedly the best we have seen this year,” and finally to the “poor, unfortunate” inmates themselves: “5 white women, 1 man and one negro woman.”³⁶²

Clearly, the editor was no longer interested in piquing the public’s interest in abuses at the pauper’s home but in regaling the public with an impossibly idyllic situation. For most women, the pauper’s home, or poor house, was one they were unlikely to choose if given the option of living among family.

Of the women included in this study, six came to Milledgeville from pauper’s homes. At the age of 76, Maggie Miller came to Milledgeville from a pauper’s home. She provided a narrative of her history for her doctor. “When she was a little girl she lived with her mother as her father died during the war and they owned a little land and plowed an ox.” Maggie’s mother, like many women who lost their husbands in the Civil War, “made the crop” alone. Maggie was “sickly. She had rheumatism, dropsy and white swelling and never worked any except to pick a little cotton.” Maggie explained how she would help her family. “When she was little they would sit her in the corner of the fence and pull the bolls off for her to pick cotton.”

Maggie didn’t marry as a young woman and never had children. But when she was fifty-one, “she married a man having known him just two days.” Maggie, who “took in washing,” claimed “her husband did not do anything and nearly let her perish to death.” Regardless of his not being a good provider, she claimed “he was a good man and was a Baptist deacon.” Unfortunately, Maggie’s “husband when [went] with other women and she did not live with him over a year.” She first told her doctor “she has not cared anything for him since,” but then said “I love that man yet.” After leaving her husband, Maggie continued to take in washing. She told her doctor “she washed until she got where she could not see.” But when Maggie could no longer work, “they gave her something to eat and she lived in the poor house a year and a half.” Maggie

³⁶² “A Visit to the Paupers’ Home,” *The Tribune*, 21 June 1893.

did not like living at the pauper's home. She claimed to have been mistreated there: "they would eat up her vittuals [victuals] when she was sick and not bring it to her." She insisted to her doctor "she is not going there any more."³⁶³

The only women who seemed to prefer the pauper's home were those who viewed it as the lesser of two evils. At age seventy, when she came to the Sanitarium in 1923, and "so deaf a personal history could not be developed," Margaret Mize, who had never been married, claimed to have "lived with her mother until she and her mother were both sent to the poor house some years ago." "She states she has been at the poor house herself four years, and came from there here," wrote her doctor. Officials at the poor house knew nothing of her history and she had no relatives. Margaret wandered "aimlessly about" at Milledgeville. "There is no purpose in anything much that she does." For whatever reason, far from expressing a dislike for her previous arrangements, Margaret's doctor recorded she "insists that she wants to go back to the poor house." Four months before her death, he noted she "has no personal pride. She does not wear her shoes. She is untidy and sits about. Takes no notice of anything. She is irritable and shut in, sullen and morose."³⁶⁴ Margaret's body was buried at Milledgeville.

Summary

This chapter reveals the reality of poverty and the effects of poverty among women at the Sanitarium from northeast Georgia. The institution was free to Georgia residents and attracted the impoverished as a result. "It is certainly true that large numbers of 'dependents' were placed in the asylums by their families or by other institutions, very frequently by the workhouses

³⁶³ CSH, Box 35, Book 172, pp. 356-367.

³⁶⁴ CSH, Box 28, Book 137, pp. 154-162.

(pauper's homes),”³⁶⁵ suggests Finnane. Middle class women who suffered bouts of mental illness were more likely to travel outside the state or to Brawner's Sanitarium in Atlanta.

The vast majority of the women worked hard in homes and in fields before coming to Milledgeville. Many of them worked alone because their husbands had died or were disabled. A woman alone was more vulnerable to poverty than a woman who had the protection of a father, husband or son. A large number of the women suffered diseases and illnesses associated with poverty. Lottie Woods' family was similar to many in the fact that they “wavered before the prospect of committing a relative.”³⁶⁶ Lottie's family took her to at least two local doctors, one in Atlanta and one in North Carolina before resorting to Lottie's commitment at Milledgeville, where she finally died. Ophelia Fowler's family, by contrast, had her committed repeatedly, in 1918, 1919, 1924, and 1926. Lottie's husband made a comfortable living and her family's use of the Sanitarium illustrates Finnane's claim that though “the bulk of their [asylums'] inmates came from the rural poor, ... the asylum was quite as subject to the innovative use of the middle class.”³⁶⁷ Ophelia's family made use of the Sanitarium whenever her illness returned.

It is likely that many women who came repeatedly to Milledgeville did so not because their families were working the system, but because their pellagra returned as it did in the spring for many southerners. Black women were more likely to come to Milledgeville with advanced stages of pellagra and to die of pellagra at the institution than white women. Ina Chambers and Callie Walker were two black women, both young, who died soon after coming to Milledgeville. Their pellagra had progressed to the point where it could not be reversed. Ada Pryor, the third black woman who died at Milledgeville with symptoms of pellagra, was unusual in that she was

³⁶⁵ Finnane, 135.

³⁶⁶ Ibid, 137.

³⁶⁷ Ibid, 145.

a young woman but she was placed at a pauper's home. Ada Pryor lost close to thirty pounds over the course of year in a pauper's home because she worked so hard and was fed so poorly.

Most often, women who were left without husbands and children to care for them in their old age found themselves in pauper's homes before they were taken to Milledgeville. Pauper's homes were a last resort before *the* last resort, but they were also a source of potential exploitation, particularly for black women. If a woman could not stay at the pauper's home, the only place left to send her was Milledgeville.

The following case study focuses on one woman, Elizabeth Avery. Though she began her life part of a stable farming family in Banks County, she ultimately found herself in dire poverty, abandoned by her family first to a pauper's home and then to the Georgia State Sanitarium.

A Case Study of Poverty: Elizabeth Avery Dalton:

"I can not always think what I want to say at once but I can after a little while."³⁶⁸

Elizabeth Avery is an example of a woman who was born into poverty and who experienced poverty across the course of her adult life until she was admitted to Milledgeville in 1911. Elizabeth was born in 1866, one of a set of twins, the middle children of six born to a Banks County farming family. Her mother was in poor health and had to be carried in a chair in order to move. Her father was a wholesale grocer who worked the area surrounding Athens, supplying groceries by ox cart. Elizabeth suffered a bout of diphtheria "at the age of nine followed by spinal trouble" which would haunt her for the rest of her life.

In 1882, at the age of fifteen, Elizabeth was married to John Dalton. Her first son was born in 1885. Both her parents died of typhoid fever around this time; her father in 1883 and her

³⁶⁸ Information on Elizabeth Avery Dalton was obtained not only from her patient record, CSH Book 253, pp. 105-125, but also from the Franklin County Pauper's Records, Confederate Pension Records, Census Records, an Atlanta Newspaper archive, and through oral history interviews with her great niece and nephew.

mother in 1886. Elizabeth expected to inherit something from their estate, but her father died intestate³⁶⁹ and her younger sister was the only one to be provided for by law. Elizabeth was John's second wife, the first having died prior to 1880. When they married, John was 42 and his children were twelve and eight. Elizabeth was fifteen years old. Many years later, when she was admitted for the second time to the Georgia State Sanitarium, her doctor asked how she felt about her husband. "Did you care for your husband?" Elizabeth responded: "I cared for him more than he did for me I think, because he drank."

As early as March of 1889 and at the age of 49, John Dalton, Elizabeth's husband of seven years and a confederate veteran, applied for a pension. At Sharpsburg, John suffered a wound from a minie ball which entered his left cheek and lodged below his right ear, "where it was cut out." On John's application, he claimed "to have suffered lock jaw" from a wound to "which he has never fully recovered and his memory and mental powers have never been as strong and clear as before receiving said wound." While his physicians agreed that his speech was impaired, they would "not swear to any [further] disability." John Dalton's application for pension was denied. Perhaps because of this disappointment, combined with his physical and mental condition, the poverty to which he attested and the drinking to which his wife attested, the two had a strained relationship. During the March Term of the Franklin County Superior Court, Elizabeth applied for temporary alimony "for herself and child" pending a divorce law suit. The jury ruled in Elizabeth's favor and her divorce was made final in September of 1889, but John refused to pay alimony or attorney's fees. Elizabeth filed an attachment against John for contempt and the court record for the two ends there. A great-niece of Elizabeth surmised: "whatever befell her caused her divorce and she and her son were in [the] care of her [twin] brother John and his family. . . . and if my grandfather [John] and his twin sister were the only

³⁶⁹ Without a will.

ones left east, he was willing to keep the son and let him grow up with his sons, but he didn't know what to do with her."³⁷⁰

Elizabeth claimed to have borne another son in 1892, but there is no record of the child. In fact, the only record of her life during the 1890's is another Superior Court record. In April of 1893, the State brought suit against Elizabeth Dalton for "Keeping [a] Disorderly House." Apparently, Elizabeth declined to appear before the court and no further record has been found on this matter. However, years later, in an effort to have Elizabeth committed to Milledgeville, her guardians made use of this piece of her history. In 1905, when the superintendent of the Pauper Farm brought Elizabeth to Milledgeville, he claimed she had an "unpleasant married life." He also claimed she was troubled because of the "impure life she has lived, since separation from her husband."

Neither Elizabeth nor her sons were found in the household of her husband John Dalton or her brother John Avery in the 1900 census. John Dalton was living in the home of his married daughter along with her husband and four children. Brother John Avery was living with his wife and children. Elizabeth and her sons have not been located at all. The only record during the early turn of the century was of Elizabeth, who beginning in 1900 was provided for from the pauper's fund of her county.

Although "the law required that any ex-Confederate soldier of the state be provided food and clothing without compelling him to become an inmate of the poorhouse," wives were afforded no such provision.³⁷¹ From 1900 until 1905, Elizabeth, who had no means of support, was found either within residence at the pauper's home or receiving money for her support. For whatever reason, rather than remaining consistently in the pauper's home, Elizabeth moved in

³⁷⁰ Written communication from M.D., November, 2003.

³⁷¹ Pauper's Records, Microfilm, Georgia Archives

and out of the home. From June 11 to September 25, 1900, Elizabeth collected forty cents a day for a total of \$17.30 from the pauper's fund, but lived elsewhere. For the second quarter of 1901, she was listed among 23 other paupers living at the home, for which the superintendent received "\$4.95 per month per head."

In the fall and winter of 1901-2, Elizabeth must have found another residence, for in April of 1902, concerned citizens appealed to the county commissioners to receive her again at the pauper's home. The citizens wrote that Elizabeth "was without means of support and her health is such that she cannot earn a living by her labor." But by 1903, she was boarded out again, given \$1.60 for her care from July 1 to July 22 and another \$1.60 for September 26 to October 5. In 1904, \$.76 was paid for her care for 4 days and she was listed among those within the pauper's home for the remainder of the year. In the beginning of 1905, Elizabeth was in the pauper's home, but by May of 1905, Elizabeth was described as "an ex-inmate of the pauper's home," who had been living within the household of her second cousin once removed for four months. Her cousin's husband reported to the commission that Elizabeth was "now sick [and] not able to work nor buy any medicine and she desires to be taken as an inmate at once." After consideration, the commissioners ordered the steward to "go after" Elizabeth. By the end of July in the same year, her cousin's father and her second cousin, both superintendants of the pauper's home, appealed to have her committed to the asylum at Milledgeville.

At the age of 39, Elizabeth was found to be "a Lunatic from a cut [acute] Spinal trouble and a fit subject for the Asylum." She was committed to the asylum, "until she be again restored to her right reason and sound mind," Exhibiting illness since March of the year, she was received at Milledgeville on August 28, 1905. Her intake records state she was an "inmate of [the] county home" and an epileptic.

Elizabeth spent the next four years at the institution. She was first admitted to Milledgeville in the summer of 1905 and was discharged at the expiration of her furlough in the summer of 1909. Although the records pertaining to Elizabeth's first admission to Milledgeville have been lost, a doctor there remembered her early admission:

Mrs. Dalton was in my care for quite a while and was discharged for not being returned. I do not recall that she ever had any convulsions. She was cross and irritable at times, and sometimes would complain, but otherwise she was quiet in her demeanor, I did not notice any special psychosis about her; she would get nervous sometimes, but other than that she was a normal person.

Perhaps Elizabeth was furloughed because of her lack of her psychosis. After leaving Milledgeville, it is likely that Elizabeth returned to her home community in the late summer of 1908. Her discharge was final on July 27, 1909. The day before her official discharge from Milledgeville, five citizens from her home appealed to have her sent back to the pauper's home: "she has no home, no means of support and is unable to work." Initially, the appeal was denied. Apparently, Elizabeth was staying close enough to the newly formed county line for there to be some question as to which county should claim her. But finally, the appeal was approved and on the ninth day of November, she was returned to the Pauper's Home under the care of the steward.

By the end of April the following year Elizabeth had moved yet again and was living with another local family. But later in 1910, once again, members of the community petitioned the ordinary to receive her, a citizen "in destitute circumstances," to the paupers' home. And on July 26, the ordinary once again placed her at the pauper's home "during good behavior." Elizabeth's behavior was not "good" for long. Four months later, at the age of 44, she managed to slip away from the pauper's home and to board a bus bound for Atlanta, a two hour trip. Although she would live another 25 years, she would never see her home county again. In

December of 1910, an Atlanta newspaper printed the following report:

Dazzled by the bigness of Atlanta, knowing not a single soul in the city, without a place to sleep, and hungry for a sight of the son whom she had come all the way from Claysville to visit, Mrs. Elizabeth Dalton made application late Wednesday evening to the Associated Charities for help in locating her son. She says that his name is Hoyt Dalton that he is 21 years old, and that "he runs an tutermobile or something like that." "He invited me to come and visit him," the mother said, "and I decided to come." She immediately began to make plans for a trip to Atlanta; but, in her gladness, she absent-mindedly mislaid the letter containing her son's address. "But I thought that he would be easy enough to find, because everybody would know him, so I just came along." Her dismay at finding that her search for her son was to be like that of the proverbial needle in a haystack was pathetically comical. After an hour or two of indecision she was directed to the association which provided a sleeping place for the night for her, and which will assist her in trying to find her son. Any information will be appreciated by the old mother, who plainly adores the boy.³⁷²

At 44, the "old" mother found a home in Atlanta for the next three months. When she entered the Georgia State Sanitarium for the second time in March of 1911, she explained what had happened. "I was worried about my children and started on the road." Perhaps because "the oldest one was nervous" she attempted to reach him first. Once in Atlanta, she was placed within a private home where she could provide nursing care. "I had a good home where they took me; they made everything pleasant for me...I was nursing a lady." Her doctor asked for clarification.

Doctor: How did you make a living?

Elizabeth: I stayed with my folks some, and my boys would send me money, I worked when I was able. I was working before I came here.

Doctor: What did you do for a living at home?

Elizabeth: I worked and nursed when I was able and stayed with my people some, my children sent me money.

But when asked to describe why she returned to Milledgeville, Elizabeth first responded: "I can't tell, it just bothers me so much when I try to tell it and study about it." Her doctor noted "she seems to think that the occasion of her return was that she was nursing a woman; she

³⁷² Atlanta newspaper. For more on the work of the Associated Charities of Atlanta, see Georgina Hickey, "Disease, Disorder, and Motherhood: Working-Class Women, Social Welfare, and the Process of Urban Development in Atlanta," in *Before the New Deal: Social Welfare in the South, 1830-1930*, ed. Elna Green (Athens: University of Georgia Press, 1999), 181-207.

received \$3.00 per week; and this work broke her down.” Elizabeth “asked the physician if he knows where her boys are, and then bursts in tears and begins to fumble with the table cover.”

Her doctor continued to probe.

Doctor: Do you think that your mind is affected?

Elizabeth: I hope that it is not, there is something the matter with it, I didn’t want to come back here, but I feel curious and queer.

Doctor: Do you have any trouble in thinking?

Elizabeth: I cannot always think what I want to say at once but I can after a little while.

Early in her second stay at Milledgeville, her doctor wrote down his observations. According to him, she claimed to have “had some nervous fits or swoons.” He noted “a morbid tendency on her part to tell of her own health and children.” He concluded with writing “she is usually sad... She has been seen to cry both by the nurse and the physician.”

Although her early records were not located, doctors did remember her original diagnosis. Most agreed that her current condition was “due to her previous attacks of epilepsy.”

This case was in my care when she first came here, she was evidently an epileptic at that time. She seemed to get better and did not have them [convulsions] for a good while, but I rather think her present condition is due to these previous attacks of epilepsy. She is now in a depressed state, and sometimes borders on hysteria... she has unclassified depression a little unusual from that which you find in epilepsy.

By July of 1912, Elizabeth was described as “hypochondrical [sic], irritable and fussy” with a “peculiar manner.” In 1913, she claimed to have had “attacks since her last child was born, 21 years ago, with her heart, and she would become nervous.” Her doctor noted little change in her over the next two years, but in the summer of 1916, she was witnessed having a convulsion.

“When seen by attendant was sitting on edge of bed with arms flexed and fingers contracted and mimbling [sic] to self. Seemed clouded.” Other than her continual requests to return home, her complaining, and her “neurotic,” “neurasthenic,” and “neurasthenoid” symptoms, Elizabeth’s

doctors noted little of her activity over the next six years. In 1923, she was noted as being “rather quarrelsome and faultfinding...a trouble maker at times.” In 1924, she was recorded as “queer in her conduct,” “seclusive,” and “idle.” In 1925, she wrote letters to her family. Late in 1925, Elizabeth was injured during a fire at the hospital. The staff member writing her accident report recorded,

[Patient] was at the picture show two nights ago and a fire broke out, and she got considerably bruised up in the scuffle. She is quite sore and is being kept in bed. She is quite nervous and unsettled in a mental way and easily upset. She looks after herself fairly well. Has some delusions.

Her delusions continued into 1926. “She feels that she is being interfered with, that people are going to break into her room. She is quite nervous today she states and her head does not feel right.” In April of 1927, she did “fancy work,” and later that year she recollected “having had convulsions during childbirth, and states she has not had any since the change of life.”

In December of 1927, at the age of sixty, Elizabeth had a fight with another patient. Ella Jane Stearns, “knocked Mrs. Dalton down because Mrs. Dalton was cursing her. [Elizabeth was] Hit on [the] side of [her] face with [Ella Jane's] fist.” Elizabeth fell and fractured her left hip in the fray. Ella Jane had warned Elizabeth the week before of “what she would do” if Elizabeth kept “fussing around her.” The doctor recorded Ella Jane's gloating: “I sure got even with her.” After her argument with Ella Jane Stearns, Elizabeth first used a crutch and then limped “on account of a hip fracture.” The limp would remain with her for the remainder of her life.

In December of 1930, her doctor noted that she entered the examination room “crying.” For the last five years of her life, she exhibited growing paranoia, irritability, and delusions. Her last recorded word on herself was spoken and transcribed in April of 1933: “States she used to have fainting spells, but she is not an epileptic.”

Elizabeth Dalton was enumerated at the Sanitarium in the 1930 census and she died there

of pneumonia on December 5, 1936, at age seventy, after nine days of illness and over 25 consecutive years within the institution. Her great nephew, the grandson of her twin, was sixteen at the time of her death. He recalled: "My daddy's aunt was buried down at Milledgeville, down there, my grandpa's sister. And I just didn't never think that was the thing to do. And I been down there a couple of times but I can't never find out nothin' where she's buried. They say they just got numbers down there."³⁷³

Hospital records reveal that Elizabeth's body was indeed buried on hospital premises in a numbered grave thirteen days after her death. Elizabeth's great nephew was old enough to remember the stories of his grandparents. Elizabeth's great niece vaguely recalled hearing her grandfather John, talk about his sister, Elizabeth, but only vaguely. Her own parents lived long enough for her to be able to ask them "deep questions."

My father was as astounded as I was when he looked back and realized [what had happened]. He evidently knew her [Elizabeth's] son, but I don't believe it was a real thing to him, and I believe later as we began asking, and he said 'well honey I don't know *how* papa could have done that' [allowed Elizabeth to go to Milledgeville]... in his mind that was a really terrible thing to *do*.

After speculating about what had happened to cause Elizabeth's misfortunes, her great niece surmised. "It's very possible that [she] suffered some sort of depression from midlife ... the main thing is that they had no support around them."³⁷⁴

Neither great-niece nor nephew was aware of Elizabeth's second son, her purported epilepsy, the criminal charges filed against her for keeping a disorderly house, or her time spent within the pauper's home, on the pauper's roll or in Atlanta. They did know fragments about her

³⁷³ Interview with H.S. by author, August 8, 2002. For an explanation of the debacle surrounding missing grave markers at the hospital cemetery, see Larry Fricks, "The Georgia Story: How to Successfully Restore a State Hospital Cemetery," Atlanta: Georgia Department of Human Resources, Division of Mental Health, Mental Retardation and Substance Abuse, Office of Consumer Relations, <http://www.galileo.usg.edu/express?link=ggpd&parms=action%3>.

³⁷⁴ Interview with M.D. by author, October 31, 2003.

son and grandson, who attended and graduated from a prestigious military institute and made the family proud.

Summary

Elizabeth Avery's case is illustrative of poverty for a number of reasons. At the age of fifteen, she married a Confederate veteran twenty-seven years old than she, who drank. At her marriage, she became step mother to two children, one of whom was just three years younger than herself. Her parents died when she was twenty of typhoid, a disease of poverty, leaving Elizabeth's younger sister well-cared for, but not Elizabeth. She believed she cared for her husband more than he did for her. When she divorced him in 1889, she lost all her own resources and had nothing with which support herself or her four year old son. For whatever reason, her brother agreed to care for her son, but did not take her in. She was accused of keeping a disorderly house before being placed on the pauper's roll within the county. She was then committed to Milledgeville for the first time at the age of 38. Released from Milledgeville, she returned home and was promptly placed back on the pauper's roll in 1909, a destitute woman.

Longing to be closer to her children, in 1910, Elizabeth made her way to Atlanta by bus and after being found and rescued by the Associated Charities, she found work nursing another woman. Elizabeth seemed happy in Atlanta, where she was in proximity to at least one of her sons, but she was returned to Milledgeville just months after her arrival. Seemingly abandoned by her family to pauper's homes and ultimately, the Georgia State Sanitarium, Elizabeth died 25 years later and was buried in a numbered grave.

Although the grandchildren of her twin brother knew of her existence, her own great grandchildren know virtually nothing about her. When contacted about their great-grandmother, Elizabeth's great-grandchildren admitted they had never heard their father speak of her. Elizabeth

Avery is an example of dire poverty, but also of loss. In particular, Elizabeth experienced the loss of her family, her "boys" and of the relationship she might have had with them and with her grandchildren. Loss was a commonality for women who died at Milledgeville. The next chapter will explore the theme of loss among the women in the study.

CHAPTER 7

PUERPERAL INSANITY, MORTALITY, AND ABANDONMENT

Of the 91 records included in this study, at least eleven reflect women's institutionalization during childbearing years due to puerperal insanity.³⁷⁵ Others reflect institutionalization following the deaths of infants and children, and following both real and perceived abandonment by husbands. This chapter describes the situations women faced within their families that led to their institutionalization.

Puerperal Insanity and Infant Mortality

County physicians used the terms puerperal and confinement to delineate specific stages of the childbirth process. Puerperal referred to the period of time surrounding childbirth; puerperal insanity was defined in 1933 as "mental derangement occurring in women at the time of child-birth or immediately after,"³⁷⁶ and could be compared to modern-day postpartum psychosis. Confinement was the period of time some women spent in seclusion before and after the birth of a child.

Patsy Teasley's home physician suggested she was afflicted with "puerperal insanity" less than three months after the birth of her first child in the winter of 1919.³⁷⁷ Mary Jo Martin was admitted just three weeks after childbirth when her family began noticing symptoms ten days after her first baby was born: "wants to pull off clothing, curses, don't sleep." Her intake

³⁷⁵ Six of these women were black and five were white.

³⁷⁶ Henry Campbell Black, M.A., *Black's Law Dictionary* (St. Paul Minnesota: West Publishing Company, 1933), 975. The text continues "it is also called 'eclampsia parturientium.'"

³⁷⁷ CSH, Box 31, Book 156, pp. 247-257.

records suggest the “probable cause” was “confinement. (puerperal insanity).”³⁷⁸ Hilary Marland explained that puerperal insanity was “a disorder that ‘belonged’ to the nineteenth century.”³⁷⁹ The disorder was hard to define, Marland asserted, because “of the difficulties encountered by the medical profession in deciding on its causes and who exactly would be susceptible.”³⁸⁰ But nineteenth century physicians did have some common understanding of the problem:

Women were believed to be particularly at risk shortly after childbirth when they were physically weak and mentally susceptible, but they could also become mad during pregnancy or several months after delivery. It encompassed relatively brief attacks, nervous upsets, violence or delusions, as well as long-term manifestations of mania or deep and protracted melancholia, which could put at risk the life of the mother and child.³⁸¹

It is impossible to know with certainty if a woman’s mental illness was puerperal in nature at the time of this study, but we can assume that women admitted within the year after labor may well have been affected in some way by their child’s birth. Eleven women of the ninety were admitted to the Sanitarium within the year following childbirth. Although Georgia Oakley, a black woman, was not admitted to the institution until just over a year after her third baby was born, her symptoms of “irrational talking and running spells” began within the month after childbirth.³⁸² Zora Hulsey began exhibiting odd behavior two months after her baby was born. Admitted to Milledgeville at the age of 28, Zora, also a black woman, had borne three children, the youngest just four months before. Her father noted his daughter had “not been right since then.” In addition to childbirth, Zora grieved the violent death of her uncle, who was “shot and killed” two months after her baby was born. The incidents together preceded “peculiar acts”

³⁷⁸ CSH, Book 92, pp. 441-446.

³⁷⁹ Hilary Marland, *Dangerous Motherhood: Insanity and Childbirth in Victorian Britain* (Great Britain: Palgrave Macmillan, 2004), 4.

³⁸⁰ *Ibid.*, 3.

³⁸¹ *Ibid.*, 3.

³⁸² CSH, 28, Book 139, pp. 399-404.

on the part of Zora and led her father to bring her to Milledgeville.³⁸³ Catie Osley's husband brought her to the Sanitarium less than six months after her third baby was born.³⁸⁴ And Ennis Poole, the 26 year-old wife of a blacksmith, was admitted to the Sanitarium in April of 1921 after delivering her fourth child the previous October, just a little over six months before.³⁸⁵

About three months after her "last confinement," Cleo Kitchens began manifesting symptoms that alarmed her family. Years before, one of her infants, "an instrumental delivery," had died at only ten days. Cleo had five pregnancies, but did not recover easily after her fifth baby was born in the spring of 1922. Her confinement "was followed by an embolism of the lungs. Her physician said she would die, but after a few months got almost well." But when her "baby was nine months old it began to have convulsions and had several." Cleo "was of a very nervous temperament and this together with the afflicted child made her very nervous. On one occasion the child had a convulsion while in [the] patient's lap and she ran off and left the child." A week before her husband brought her to Milledgeville, "she tried to jump out of the window with her baby." Her husband presented her recent history to hospital officials:

On July 1st, patient had a dream, and in this dream she thought a tree grew up almost to heaven, and her husband seemed in the top of this tree. Just before the tree reached heaven her husband seemed to cut the tree down, as he had an axe with him. She told her husband about this dream. On the next day she carried some water to the field to her husband. She said the Lord had directed her to do this. About this time she passed some water, and it was green and she began to believe she was poisoned. She thought so on account of this dream. She accused nobody of this, however, but sent for her physician. A few days following this she began to have fears, and seemed to be afraid of everybody. Said that everybody about the house would be killed and the house would be burned. She barred the doors for protection. She tried to run off from home, and said she was going to church.

³⁸³ CSH, Box 44, Book 216, pp. 396-412.

³⁸⁴ CSH, Book 203, pp. 410-422.

³⁸⁵ CSH, Book 92, pp. 447-452.

At the Sanitarium, Cleo began to mull over an incident from her childhood. According to her doctor, Cleo claimed to have “caught an old hen and did it wrong. I put her down wrong.” Cleo forgot what she had done to the hen for years until she told her doctor “something come to me.”

Doctor: What came to you?

Cleo: We have had chicken[s] all the time, and one of them had an awful place on her leg and she got to hopping around, and that is one of my troubles, and then is when my trouble began.

Doctor: What did the cripple[d] hen have to do with it?

Cleo: Made me think about things that passed.

Convinced what she had done to the hen had doomed her to “torment,” Cleo spent the last years of her life agonizing over this childhood mistake. “I want to get forgiveness. I am afraid I will not be saved.” For a year from the spring of 1925 to the spring of 1926, doctors noted Cleo walking about “wringing her hands, saying ‘poor Cleo,’ or ‘poor Cleo, if only I had minded her.’ She seems to have some idea of self-condemnation.” Doctors noted Cleo continued to whisper to herself and to cry until her death by tuberculosis in the spring of 1929. She was 35 years old.³⁸⁶

While it was not unusual to have a county doctor suggest puerperal insanity as the reason for commitment, in not one case was a woman diagnosed with puerperal insanity by Sanitarium physicians. Marland explained that by the late nineteenth century,

Explanations for the prevalence of puerperal insanity began to be framed increasingly around the rhetoric of heredity and degeneration, referring to a form of failing linked less and less to maternity and environmental factors. Rather than all women being vulnerable, a particular kind of woman was liable to the disorder, one with a hereditary disposition.³⁸⁷

This may explain why doctors refrained from diagnosing puerperal insanity at all; they were more preoccupied with “heredity and degeneration.” Women who exhibited puerperal insanity

³⁸⁶ CSH, Box 42, Book 172, pp. 180-195.

³⁸⁷ Marland, 202.

upon admission were diagnosed with dementia praecox (schizophrenia), epilepsy, or manic depression.³⁸⁸ Cleo, for instance, was diagnosed with dementia praecox (schizophrenia). Anna Harris is another example of a woman brought in to the Sanitarium after the birth of a baby, who was then diagnosed with dementia praecox. The birth of a baby often led to odd behavior on the part of the mother. Anna Harris's husband explained the odd behavior she exhibited before the family brought her to Milledgeville:

Patient complained of headache and back ache after the birth of her child next to the baby. This was four years ago. About three years ago after the baby was born, she began accusing her husband of running after other women, was very jealous, began talking to herself, would fight, said her husband ran after her mother and sisters all the time, would run away from home, said her husband wanted to kill her, he was mean to her, had no respect for her, and her children.³⁸⁹

Anna went to stay with her father, where her strange behavior continued, noted her family. "She talked all the time about sexual affairs, accusing everybody of being immoral. Was very talkative, laughing, and crying, would play the organ all night." Although her trouble came on the heels of childbirth, once Anna was admitted to the Sanitarium, doctors agreed quickly on a diagnosis of dementia praecox.³⁹⁰

Minnie Dyer was also diagnosed with dementia praecox. The first time she was admitted to Milledgeville was in April of 1886. She was 36 years old. In sixteen years of marriage, she had borne eight children. Two months after her eighth child was born, Minnie suffered an "attack." She recalled "she had spells when she was very crazy. Her mental trouble at that time followed soon after childbirth."³⁹¹

For some women, the postpartum time seemed to aggravate tendencies toward mental illness. And for some, the more children they had, the more they struggled. Bessie Morris had

³⁸⁸ See note 341 on page 117. For more on medical diagnoses, see Chapter 8.

³⁸⁹ CSH, Box 33, Book 165, pp. 136-146.

³⁹⁰ Ibid.

³⁹¹ CSH, Box 32, Book 151, pp. 348- 364.

problems after each of her births. At 23 years of age, Bessie's husband had her committed to Milledgeville in 1930. Bessie had married when she was seventeen. "She was always healthy up until the birth of her first child, since which time, she has not had good health." Bessie had two children, but "since the birth of her [third] baby," she had "not been well and gradually grew worse." Bessie's third child was born in the summer of 1929; she was admitted to Milledgeville at the end of February in 1930. Bessie explained her situation shortly after her arrival that winter:

Says that her mind has been wrong since Christmas. Thinks this is due to a woman poisoning her and putting a spell on her when her last baby was born. This was last June and thinks this woman put something in her food that cause[d] her to act and feel like she does. Has been hearing voices since June of last year when her baby was born.³⁹²

Bessie was diagnosed manic depressive. Although she denied "excitement," she did admit to "periods of depression in which she has felt that she had rather be dead than alive."³⁹³

Mollie Whitlow was also diagnosed manic depressive. She came to Milledgeville in May of 1917, almost five months after the birth of her fourth child. According to the history blank form, she was 30. "A change took place in her one or two months ago. She did not know Sunday from any other day. She could not work or enjoy herself. Could not sleep, was nervous and felt cold at times. Was worried." Compounding her postpartum symptoms, Mollie also grieved over a dead child. At the Sanitarium, Mollie confessed she "cried nearly all the time at home about a cripple[d] child, who had convulsions. Says this child died Saturday before her coming here on Monday." Mollie brought with her "one or two garments belonging to him."³⁹⁴

Infant Illness and Mortality

The women in this study were in a vulnerable state for their postpartum year. All too often, in addition to puerperal insanity, women like Mollie Whitlow faced the illnesses or deaths

³⁹² CSH, Box 44, Book 218, pp. 368-384.

³⁹³ Ibid.

³⁹⁴ CSH, Box 45, Book 223, pp 15-31.

of their infants. Losing infants was hardly unusual at the time. Alice Ewing was about twelve years old when the Civil War commenced. She “plowed four years [during the war].” Afterward, she “lived on at home with her people until she married [at the age of 42.] After she married, her husband came to live in the family with them.” Perhaps because Alice Ewing married so late in life, both her babies died right after they were born.³⁹⁵ Lola England, a married woman of 26, delivered her first baby eight months before her mother brought her to Milledgeville in the summer of 1911. The baby died. Six days after returning home, her mother posted a letter to the Superintendent of the State Sanitarium in order to explain her daughter’s situation. “The first trouble with her was her periods / She had a long spell of sickness taken with spasms and her mind was wrecked / at that time she was in her 18[th] year when she took sick / and about 18 she came monthly and she got in good health and her mind was good though she was always nervous and we was very careful with her.”³⁹⁶

Lola agreed with her mother. Even before she married and had a baby, she was troubled. She told her doctor that “She was born with a veil over her eyes,” explaining that “people who have this can see things any way.” She explained “her impaired gait as being caused by having been injured by a snake bone while walking in the field.” She also told her doctors at Milledgeville that she had a “spinal affection in 1904” during which time she was “despondent,” and she had “convulsive attacks all of her life.” She specifically remembered an incident that occurred just a couple of years before her baby was born, an incident recorded carefully by her doctor. “It seems that my mind is more thick than it used to [be]. We had a little dog that went mad three years ago and I went to having them spasms again; Mamma said for me to get a treatment of medicine and some said to go to the madstaone [madstone] just once [it]wouldn’t

³⁹⁵ CSH, Box 35, Book 171, pp. 417- 428.

³⁹⁶ CSH, Box 44, Book 217, pp. 261- 279. Because this letter was written without punctuation, I used the slash mark to separate what I believed to be the author’s sentences.

cost much, they thought I was a mad woman.” A madstone was a “stone” found within the belly of a deer that was thought to cure the bite of a rabid dog. The fact that “some” said for Lola to go to the madstone indicates her behavior was similar to that of a mad dog. Clearly, Lola was troubled before she married and bore a child. In spite of their being “very careful with her,” marriage and childbirth aggravated her condition. Her mother’s letter continues:

The first of last year she married / in a short time she seemed confused / in last may she gave birth to a child and her baby died and her mind grew worse. Every day I think she hurt her self during confinement / we could not keep her quiet after her baby died / it lived 8 days / the docters here says it is her nervers and spines / I believe she has female trouble to / please do all you can for her / that I may soon get some word of hope I pray / if there is any other question about her I will be glad to answer / I hope you will write me your opinion about her very soon / respectfully³⁹⁷

At Milledgeville, Lola was diagnosed with dementia praecox. In addition to all of her difficulties in life, when her doctor asked what sin she might have committed,³⁹⁸ Lola answered “[my] worst sin was [getting] married when I was weak minded.” Her marriage was difficult for her, as illustrated by the following exchange recorded by her doctor:

When an effort was made to develop who she is she states in an abstract way who she was before she was married and afterwards who she married, here she turns away from the physician in a rather animated way and said: “Jim didn’t stay at home very well on account of the fact that Lola didn’t cook as well as some other women.” She says the neighbors told her she ought to make biscuit with flour bread [bread flour] and see if it would not help hold him.³⁹⁹

Ultimately, Lola was not successful in holding on to Jim, who abandoned her to the Sanitarium in 1911. Neither was his abandonment of her uncommon. For men who faced a future with women plagued with mental illness, abandonment of one sort or another appeared to be the route taken. The women in this study, ensnared in mental illness, often felt abandoned by their husbands. Abandonment of any sort by a husband meant a frightening vulnerability for women

³⁹⁷ Ibid.

³⁹⁸ This was a standard question among doctors in the initial mental examination of their patients.

³⁹⁹ Ibid.

who had so few resources of their own. When Lola's doctor asked her about the part her husband played in sending her to Milledgeville, he also recorded a response that reveals the tone of the times.

Doctor: "What did your husband say about sending you here?"

Lola: "He said that would be the way of it."

What a husband said *was* the way of it in Lola's day. There is no record of Lola's husband ever contacting the Sanitarium or of taking her home for a furlough. Lola lived twenty-two years at the Sanitarium and finally died of dysentery in 1933 at the age of 46.⁴⁰⁰

Abandonment as a Prelude to Institutionalization

For the women in this study, abandonment occurred in a number of ways. Some men stayed away from home as much as possible, some were verbally, emotionally and physically abusive to their wives, some found other female companionship, while others disappeared. The remainder of this chapter will identify the ways in which women experienced abandonment and were abandoned by their husbands before they faced commitment to the Georgia Sanitarium.

Husbands who stayed away from home left their wives feeling vulnerable and abandoned. When W. P. Carson brought his wife Ina to Milledgeville in September of 1927, he claimed she had hit him "in [the] head with a rock...been violent for [the] last two weeks." Ina's doctor recorded her response when he inquired about the incident. "When asked if she did not strike Mr. Carson with a rock she said, 'I certainly did because he tried to run over me. He left me with so much work to do.'"⁴⁰¹ According to Ina, he was not home as much as he should have been. Apparently, Mr. Carson left her alone with her children too often. "I did not like to stay by the road side with the children when a cloud come up. I thought a man ought to be there," she

⁴⁰⁰ CSH, Box 44, Book 217, pp. 261-279.

⁴⁰¹ CSH, Box 36, Book 178, pp. 104-116.

said. Clearly, Ina needed the security of her husband's presence, particularly in stormy weather.⁴⁰²

Zelda Kesler faced a similar problem with her husband. Zelda, who was diagnosed with dementia praecox, returned to Milledgeville for the second time in the spring of 1923. She explained what had happened after leaving the institution the first time in September of 1920. As reported in the doctor's notes,

Patient states she left here ... and went to her home in Hall County with her husband. A child was born to her in July 1921. She got along fairly well for a time, but her husband got to where he did not seem to care for her. He would stay [away] from her all he could and come in late at night. There seemed to be a change in him. He did not seem to care to talk much.⁴⁰³

Zelda worried about why her husband avoided her and what her husband did when he was out so late at night. "She thinks she was sent here for the reason that her husband did not care for her and wanted to get rid of her. She seemed to be imbued with the idea that her husband took up a good deal of time with other women, and set her aside for this reason."⁴⁰⁴ In spite of her worst fears, Zelda would "not accuse her husband of anything further than not caring for her." In order to cope with her sadness, she admitted to her doctor "that she has crying spells at times. She cries because she gets relief by so doing."⁴⁰⁵

Much like Zelda, Fannie Bush believed she was brought to Milledgeville because her "husband wanted to get shed of me and was tired of me and wanted somebody else over the children." Fannie thought "he sent her here so he could marry a 'yellow gal.'"⁴⁰⁶ But unlike Zelda's husband, Fannie's husband was abusive. The first time Fannie Bush left Milledgeville

⁴⁰² Ibid. While it is impossible to know whether or not Ida was being metaphorical in her statement, I have chosen to read her statement literally.

⁴⁰³ CSH, Box 29, Book 143, pp. 245-256.

⁴⁰⁴ Ibid.

⁴⁰⁵ Ibid.

⁴⁰⁶ CSH, Box 53, Book 264, pp. 384-410. It is unclear why Fannie would worry that her husband wanted a "yellow gal." A yellow gal would probably be a light-skinned black woman. Fannie's husband was white. If he did indeed prefer black women, it would be unusual for his wife to speak openly about his preference.

for home was in March of 1918 after fourteen months and eight days within the institution.

Fannie stated she “was brought here [the first time] because she was happy, and that caused her husband to whip and abuse her.” Fannie left the Sanitarium with her husband in 1918 and they went home. Once at home, she did “house and field work.” She was glad to be home, but all was not pleasant. “At times [Fannie] did not get along well with her husband. He would whip and abuse her, and that would cause her to cry.”

She was happy and felt good at times, had the good spirit with her. She read the new testament, would sing and preach to her children. She blessed the table every day. When her husband would curse her and abuse her she would cry, and would tell him that she would pray for him secretly. Her husband told her that her prayers were not worth a ‘hell damn’ to him. He also told her fifty or a hundred times that he wished she was ‘in hell with her back broken.’

In spite of this abuse, Fannie told the doctor “she loves her husband.” She stated “she would be happy if her husband would treat her right [but] she thinks her husband is trying to throw her away because she is cripple[d].” By 1929, when her husband brought her to Milledgeville for the final time, Fannie was 55 years old. “When asked if she had ever been here before, she replied, ‘nine times, honey, my old husband has put me here.’”⁴⁰⁷

Although abuse was not common among the women in this study, it did occur. When Ina Carson’s husband was home, she claimed he would “scold” her “if I don’t answer him as quick as I ought to.”⁴⁰⁸ Scolding was a relatively mild form of abuse compared to what some women endured. Cleo Kitchens, for one, had a hard situation with her husband. She explained how she worried over her own “disobedience” where he was concerned.

Cleo: My husband was a good man but I did not obey him.

Doctor: In what way did you disobey him?

Cleo: A lot of things. One of my little girls got sick one night, and I got up to see about her, and went to put her back in the bed, and leaned over, and he said,

⁴⁰⁷ CSH, Box 53, Book 264, pp. 149-162.

⁴⁰⁸ CSH, Box 36, Book 178, pp. 104-116.

‘damn you, get off of me.’ I never got down when he told me to, and he knocked me down with his fist.

Doctor: How did you do wrong?

Cleo: When he told me to get up I ought to have done so.⁴⁰⁹

It was a husband’s prerogative to beat his wife at this time in Georgia, particularly if she did not “obey” him, but some husband chose to leave their wives, rather than remain with them. While leaving a wife rather than abusing her might seem merciful, a wife left without the protection of a husband at this period in history meant she was defenseless. If her family would not allow her to live with them, she likely faced institutionalization.

Dementia Praecox and Abandonment

Husbands of women with dementia praecox were faced with watching their wives in a slow, irreversible cognitive decline. What we now know as schizophrenia was then completely untreatable. When Minnie Dyer’s husband left her, he very well might not have had the courage to face his future had he remained with Minnie. Minnie Dyer was first admitted to Milledgeville in April of 1886 at the age of 36. Although her original patient records are lost, she recounted her earlier experiences to doctors at the institution when she was readmitted some forty years later. Married at nineteen, Minnie had borne eight children in sixteen years. Her trouble began with “the birth of her last child.” She recounted “spells when she was very crazy” during this time and her doctors diagnosed her as an epileptic. While she remained at Milledgeville for twenty-one years, not leaving the institution until November of 1905, her husband was remarried before the end of 1886. He went on to father at least 9 more children with his second wife before divorcing her and moving to Oklahoma.⁴¹⁰

⁴⁰⁹ CSH, Box 35, Book 172, pp. 180-195.

⁴¹⁰ CSH, Box 32, Book 151, pp. 348-364. Insanity “at the time of marriage” was grounds for a total divorce in Georgia. See A.W. Cain, Jr. “The Georgia law of insanity,” *Georgia Bar Journal* 3, no.4 (May 1941): 44.

Minnie was discharged twenty years later in 1906 but her condition at the time was unimproved.

She left the institution in the custody of a sheriff and went to her uncle's home. She staid [sic] there a few months when she went out west where she remained until three or four years ago when she returned to her home in Georgia. While out west she lived with relatives, and denies she was committed to an institution during the time she was there.

As late as 1920, Minnie still lived in Arkansas with her brother, but by the time she was readmitted to Milledgeville in 1924, she had been living with her older "half-brother" back in Georgia. One month before coming back to Milledgeville, the two had an argument.

He criticized her conduct. She admits this made her mad, and she stormed at her brother, whereupon he threatened to have her sent back to the Sanitarium. Soon after this she ran to a neighbor's house to prevent being sent back. They soon came for her and she was returned home.

Eighteen years after leaving the institution the first time, Minnie returned. After three years back in the Sanitarium, she died of cancer at the age of 74.⁴¹¹ Minnie was first diagnosed with epilepsy, but was ultimately diagnosed with dementia praecox. Of the women in this study, none faced harder situations of abandonment than those with epilepsy.

Epilepsy and Abandonment

Ruby Bishop was fifty years old and suffering from convulsions when she entered Milledgeville in 1925. Her doctor recorded a synopsis of her life to that point, including her "falling spells," which she later referred to as "smothering spells."

A few years after her marriage and about the time her first living baby was born she began to have falling spells and has had them since. She states she will average one spell ever [sic] two or three weeks. She exhibits several scars on her hands and arms where she was burned by falling against a stove. She states she has bitten her lips and tongue on these occasions. She feels that her mind has been affected by having spells and insists she has no memory.

⁴¹¹ Ibid.

After a 25 year marriage when her boys were in their late teens and Ruby was 42, her husband left her. By 1920, her youngest son lived in the household of his father and his father's new wife. In 1925 she explained to her doctor that her husband "deserted her seven years ago running off with another woman. This was a great shock to her and she has been dependent upon her sons since that time." Still, she longed to have her husband back.

Doctor: "Do you want to live with your husband again?"

Ruby: "I reckon I would if I could."⁴¹²

Ruby's husband not only married the woman for whom he left her, but fathered three children by this second wife. His leaving her appeared to be the defining event of her life.

Doctor: What year were you born?

Ruby: I have forgotten.

Doctor: The date of your marriage?

Ruby: I have forgotten.

Doctor: What month was your first child born?

Ruby: I have forgotten.

Doctor: What months was your last child born?

Ruby: I have forgotten.

Doctor: How long has your husband been dead?

Ruby: Seven years.

Ruby's husband was not dead; but he might just as well have been dead for all the good he was to Ruby. Ruby died suddenly after a hospital hysterectomy the same year she was admitted to Milledgeville.⁴¹³

Lizzie Duncan was another woman who suffered with epilepsy and faced abandonment. Lizzie's convulsions began in 1905 when she was seventeen, around the same time her only child was born. She went on to raise this daughter with the help of her sister, who lived within her home. Lizzie was thirty years old when she became the conduit of a family tragedy. According to her family, in "about 1915 she was nursing her brother's baby and had one of her

⁴¹² CSH, Box 28, Book 139, 149-162.

⁴¹³ Ibid.

spells and dropped the baby and killed it, the fall bursting the baby's skull." Lizzie's family never divulged her responsibility for the accident. Just a year after the baby's death, Lizzie's husband "got into trouble by selling some mortgaged property, and to avoid legal proceedings, left the country." Lizzie's sister, who lived with them, disappeared at the same time. The family explained they had no contact with this sister, they only knew "that she left the country at the same time that [the] patient's husband ran away, and it is believed that perhaps she may have gone with him."⁴¹⁴ Lizzie was left with an eleven year old daughter and the help of her family. She lived with her mother until her mother died of cancer in 1921. At that time, she began to move from relative to relative, but she felt her family did not treat her well. "They don't treat me much; that's why I am down here. No sir, after mother died, I had to live and went to my brother's and then he died." Lizzie's brother died in 1925 with pneumonia.⁴¹⁵ After his death, Lizzie "just had to go here and yonder, until I told them I was tired of just going here and yonder." She told her doctor her family "mistreated" her. "I don't know how to say hardly; they just treated me so it was a wonder I have sense enough to get on with." Her doctor noted "that her simple ideas of mistreatment are based on her idea that they "just wouldn't keep her." Not only was Lizzie tired of moving from place to place, in the two years before her family took her to Milledgeville, she became violent. Her family claimed "she would fight her sister-in-law" and Lizzie agreed "that they were afraid of her because she had these fits. Her family described her convulsions to intake officials at Milledgeville."

These spells strike her suddenly, and informants say that if she is noticed as being unusually smart or active you may know that she is going to have one of these attacks. Informants say that when they strike her she is 'just like a baby.' Passes her urine in her clothing and sometimes passes her bowels; froths at the mouth and jerks. Her head draws aback to the left side, or shoulder. She always falls if

⁴¹⁴ A relative posted on Genforum (An online Genealogy database) claiming the two "ran away" together and suggests "they probably changed their names."

⁴¹⁵ CSH, Box 35, Book 171, pp. 313-327.

attack occurs in daytime. These attacks last sometimes for only about 5 minutes, and then again, they will last all day. Some days she won't have any, and some days she will have 3 or 4 in the same day.

Just as her husband abandoned her years before, her family ultimately abandoned her to the Sanitarium. Lizzie died of pneumonia less than three years after entering the Sanitarium. Neither her husband nor her sister was ever heard from again.⁴¹⁶

Summary

This chapter illustrated women's experiences with numerous losses, or in modern-day language, stress. Mark Finnane suggests that "stress of many kinds, economic, social, emotional, was so commonly known to working people and their families that sudden signs of failure to cope were likely to be of some surprise."⁴¹⁷ The women in this study suffered the stress of puerperal insanity and abusive husbands and the losses of infants, children, family members, and husbands.

Oddly, Finnane writes further that the "experience of bereavement or job loss or poverty would be shared by the family: [but] the accumulation of a family's hardships might appear of only passing relevance."⁴¹⁸ Indeed, the data suggest puerperal insanity, infant and child death and the abandonment of husbands were often precursors to women's commitment to the institution. And yet, Sanitarium doctors rarely mentioned any of these stresses or losses within patient records. Hillary Marland suggests these doctors increasingly viewed mental illness through a frame of heredity, causing them to pay less attention to the special stress and loss of women's reproductive years.

The data further suggest abuse and abandonment by husbands was not uncommon for women at Milledgeville. An abused woman had no legal protection from her husband. And a

⁴¹⁶ Her husband and sister could not be found in the 1920 or 1930 census.

⁴¹⁷ Finnane, 140.

⁴¹⁸ Ibid.

woman's diagnosis may have played an integral part in her abandonment. The cyclical nature of manic depression, the slow cognitive decline of dementia praecox, the advancing senility of old age and, more than any other, the neurological problems of epileptic women, took a toll on the marriages of those included in the study. According to patient records, epilepsy could cause convulsions that left a woman in a state of complete incapacity. Few could bear to remain with women in such a condition.

In all probability, husbands trying to deal with schizophrenic and epileptic wives would have struggled. While some women sensed their husbands did not "care for" them, some men simply stayed away from their wives, as did Zelda Kesler's husband. Others would find companionship with other women. In either case, the wife would sense abandonment. What women perceived as abandonment could also be their own delusions. Although Zelda Kesler died in 1926 still convinced that her husband might be involved with another woman, the census records do not uphold her suspicion. Her husband lived on alone with his three children until at least 1930 as a plumber in a local cotton mill.⁴¹⁹

The following case studies explore the situations of two women. Although neither experienced puerperal insanity, both experienced the loss of children and one additionally experienced the abandonment of a husband.

Two Case Studies: Leila Ward and Neelie James

Two women exemplify the issues of loss and abandonment. Although neither woman suffered puerperal insanity, or what we now refer to as postpartum psychosis, both suffered the deaths of children. One woman suffered the abandonment of her husband in her lifetime; the other lost her husband through his death. Additionally, each makes a useful case study because a

⁴¹⁹ 1930 census.

family member wrote the institution on their behalf, securing background knowledge otherwise lost to history.

Leila Ward

Leila Ward is an example of abandonment and loss, but also an anomaly because she did not suffer from poverty as did the vast majority of the women within the study. Her family was middle class. After exhausting other means to restore his wife's health, her husband turned to the Sanitarium at Milledgeville. In spite of her relative affluence, she is included here. Just as every other woman within the patient records Leila ended her days at Milledgeville. And she suffered the loss of a child and the abandonment of her husband, which makes her an illustrative case study of loss.⁴²⁰

Leila Ward was born Leila Little in 1868, the second child and only daughter of a country storekeeper and his wife. Her father, a native Georgian, served as a second lieutenant for the Confederate Army in the Civil War where he suffered the paralysis for which he was discharged before the war's end. Her parents had married in 1853 and had one son together. By the time Leila was born in 1868, her father, who was still disabled, kept a country store, her mother kept house, and her brother was in school at fourteen years of age. As an child, she was boarded out to a "maimed" Confederate veteran and his wife in Gainesville where she attended private school. Her parents remained in the country where her father worked as a waggoner⁴²¹ and farmed. Her brother went on to study medicine, marry, and to move to Arizona.

After earning the equivalency of a high school diploma, Leila taught school until she was married to a physician and the eldest son of a New York postmaster in the spring of 1889. Leila's father died in 1893 and her first and only child was born in 1894. By 1900, Leila's brother, still a

⁴²⁰ Information on the life of Leila Ward was taken from her patient record, CSH, Box 32, Book 151, pp. 196-211; her husband's Confederate pension record, census records and case histories at the Georgia Archives.

⁴²¹ Driver of a wagon.

practicing physician, had returned to Georgia from Arkansas with his second wife and children. Leila lived in Athens with her husband (also a physician), her daughter Beatrice, and her mother. In March 1901, Leila's mother applied for a Widow's Pension, claiming she was helping her "sick daughter keep house." She managed to support herself "By the aid and kindness of kindred," but confessed neither her daughter nor son had much to spare: "son has a very little & daughter none."

In 1909, Leila's brother died with the flu. By 1910, her mother had also died and Leila's small family had moved to Atlanta, where her husband worked as a postal clerk. At that time, her daughter Beatrice was sixteen, but she would live only two years more. Years later, in an effort to describe her history, Leila's husband explained what happened to their daughter in a letter to an "old [medical] school friend" who happened also to be a physician at the Georgia Sanitarium in Milledgeville:

Our only child, a girl of 18, died nearly 12 years ago, after about 50 hours illness with meningitis. Had never had even a headache. Her death practically finished my wife, whose hair turned exactly as you can see it now, that night. She went down from then on. Her brother, who was about 15 years older than her, helped her into the morphine habit.

Because her brother had died before her daughter did, it is hard to know if he really "helped her into the morphine habit," but she obviously had an addiction. By 1920, the couple had moved back to northeast Georgia and Leila's husband had resumed his work as a physician. But early in 1920, Leila's husband "had a stroke of paralysis—or as Dr. Downey of Downey Hospital in Gainesville said, "a nervous break-down from overwork & worry about my wife." He was hospitalized for a month, then sent home to die within two weeks. "I'm still here though," the doctor wrote his colleague, "with only a dragging left foot to show for it."

While he was being treated for paralysis, Leila's morphine habit must have escalated. Her husband wrote his school friend that he had "gotten her out" of the morphine habit "3 or 4 times." Ultimately unsuccessful in breaking her habit on his own, in 1921 he sent her to Brawner's Sanitarium in Cobb County for a month, and assured Milledgeville's officials she had no morphine since then. "But" he wrote "she has to take barbital every night to sleep at all."⁴²²

In October of 1923, Leila's husband took her to Milledgeville. "She has tried to kill both herself & me several times--& for 2 months was rapidly growing worse, so I had to get her to Sanitarium." He concluded his letter with an appeal:

Will you kindly write me fully as to her probably [sic] chances of coming back home & every thing about her. She had grown to hate me so thoroughly for the last year, I don't know if I ought to write to her at all for a few months or just get news of her through you or supt. [superintendent] Ever[y] week or so. Please advise. I find it some different prescribing for my own wife [than] for others.

His explanation to hospital intake officials was condensed. He claimed Leila exhibited "growing worry over [the] death of [our] only child 12 years ago." [But] she "seemed to get worse suddenly" and "recently tried [to] jump in [the] well."

Above patient lost her only child about 12 years ago, and since then her mind has been affected. She was cared for at home until about 30 or 40 days ago, when she seemed to lose all reason, and at times threatened to kill herself and others. Attacked her husband and tried to jump in well, and is now guarded day and night at home.

At Milledgeville, Leila was "quiet, orderly and obedient. Cleanly and tidy. Friendly and sociable." She was clearly unusually intelligent from the vantage point of her doctors, "in splendid touch with her surroundings." Her body was "well developed, [though] very poorly nourished." Accustomed to "house and fancy work," Leila contributed little to the work of the ward. By December, she was in a "hypo-manic state," but by July of 1925, her doctors concluded she was "not a fit subject to be here." She was "in [a suitable] condition to go home provided she

⁴²² Barbital was a common barbiturate at the time.

has a home to go to.” Leila told her doctor “she would like very much to go home if her husband could keep her home going. She does not know whether he could do that or not, however.”

Leila’s perspective varied somewhat from her husband. Although their marital relations were “congenial,” Leila “did not approve of his business management. He was always in debt.” Leila told Sanitarium officials she “had plenty up to three years ago. At which time her husband had a physical break down.” Her doctor explained her situation further:

She is devoted to her husband although she says he has always been a poor manager and he ran through with what they had. About four years ago her husband had a nervous break down or a stroke of paralysis. He evidently was paralyzed because Mrs. Ward says he drags one foot in walking.

But according to Leila, even before his paralysis, Mr. Ward’s behavior was odd. “Her description of his conduct prior to this illness and after it does not seem to show that he was normal himself. He would leave home and not tell her where he was going and she was likely to hear of him locating in some other county trying to practice medicine or some city.”

Leila realized “there was something wrong with her and says she worried so much about her husband and was run down waiting on him so much during his illness.” She confessed her drug addictions to hospital officials. In addition to the use of snuff, Leila had recently been addicted to morphine, but she defeated her addiction at Brawner’s in May of 1921, although at the time she came to Milledgeville, she was using hypnotics “to make her sleep.”

There is no record of Leila’s husband visiting her at Milledgeville. Her doctor recorded her emotional instability and a tendency to “magnify her complaints. She wants to take medicine all the time especially aspirin.” The last notes on Leila, written in December of 1926, record she “complains rather frequently of severe headaches [but] she looks after herself and her conduct is good.” Leila died at Milledgeville of a cerebral hemorrhage in the summer of 1927. She was 57 years old. Her husband followed her in death just three months later. At the time of his death, he

lived in a home they had not known before. He died practicing medicine in the mountains of Georgia.

Neelie James: “I was the mother of nine but the last one is dead.”

Neelie James is another example of a woman who lost her children and her husband before being sent to Milledgeville. Unlike Leila Ward, however, Neelie was far more representative of the other women in the study, in terms of her family’s economic status. She was born Neelie Susanna Cleveland in 1852, the eldest daughter of nine children born into the home of Tom Cleveland, a cooper, and his wife Esther.⁴²³

Tom Cleveland was apt to move around. He was born in South Carolina, but moved first to Georgia and then to North Carolina as he started his family. He lived in Habersham County with his family immediately before the Civil War. He fought for the Confederate Army and was captured and sent to Camp Douglass in Chicago where he remained “to the end of the war.” Neelie, nine years old at the outbreak of war, most certainly spent her childhood helping her mother with younger siblings. She married Edgar James in 1868 and by 1870 had her first child. Neelie and Ed lived for a time in the mountains of Georgia, close to both sets of parents and siblings. By 1880, Neelie had borne five children and the family had settled in Hall County.

When Neelie’s father, Tom Cleveland, applied for his Civil War pension in 1896, his family lived in Hall County. His wife was still living, though an invalid. He relied on his “four girls, aged 34, 32, 22 & 20 years, and [a] son 41 years,” in order to make a living. “We are all poor folks,” he wrote. We “live by farming our rented land.” Tom’s fellow soldiers corroborated his story. “He ought not to work at all,” one wrote. He was able to support himself only “by

⁴²³ Information on Neelie James was taken from her patient record, CSH, Box 44, Book 217, pp. 387-404; case notes, census records, death certificates and her father’s pension application.

what little work he could do, and by the help of his daughters.” After their parents died, Neelie’s four sisters lived on together, taking on a boarder to help farm the land.

In 1900, Neelie and Edgar were still living in Hall County, but of the nine children born to them, five had already died. Ed worked as a day laborer, presumably helping out on nearby farms. By 1910, Neelie and Edgar had moved to Brooks County in south Georgia, along with one of their two living children, a daughter who was then 21. Their second living child, another daughter, moved with her husband and child to live as neighbors to her parents. And all of Neelie’s living sisters were there, as well, one of them having married the boarder who provided their farm labor after their father had died.

Neelie James was brought to Milledgeville the next year, after her husband and last daughter died. Her sisters moved back to north Georgia. Neelie, her husband Edgar, and her daughter were taken to the Brooks County Pauper Farm. Mr. Thompson, the superintendent of the farm, was the person responsible for bringing Neelie to the Sanitarium, claiming she had been “nonsensical” since he knew her. “[I] don’t think she ever had much sense.” The county ordinary added the following.

This patient came to Brooks County from North Ga a little over a year ago and last year lost [her] husband and daughter by death and while she is not a raving maniac she seems to have lost her sense and is not capable of taking care of herself even when a home and board is furnished her and some one has to look after her all the time.⁴²⁴

Neelie had an exchange with her doctor shortly after being admitted to the Sanitarium in the winter of 1911:

Doctor: “Why did they send you here?”

Neelie: “I don’t know, only my girl died at Mr. Thompsons’s; they said they would take me back up yander to North Georgia. Eddy, my old man, died and that is why they fotch me here. I stayed at Mr. Thompson’s ever since my gal, Laura,

⁴²⁴ CSH, Box 44, Book 217, pp. 387-404.

died; I think she died in September, and we moved to Mr. Thompson's in July. I declare I spent the loneliest time that I ever spent in my life."

Doctor: "Have you ever seen angels?"

Neelie: "Yes, if Laura went to heaven I have seen one... I thought Laura would live until morning."

Doctor: "Tell me who you are right now?"

Neelie: "I seem to be a widow, just the same as when Eddy died."

Doctor: "Are you married now?"

Neelie: "Lord me no."

Doctor: "Have you any children?"

Neelie: "No, I was the mother of nine, but the last one is dead."

Doctor: "Is there anything the matter with you?"

Neelie: "Nothing, I was sent here because I was without a home."

Neelie's doctors differed over whether she was naturally inferior, senile, or an imbecile. "The fact that she has been to the poorhouse," suggested one doctor, "rather implies this stage [imbecility]. Usually when a person is so poor they cannot make a living I think there must be some mental defect." The team of doctors determined to "try to straighten her up, and see if we cannot find out more about her before she came to this place." One month later, Neelie's sister Martha, eight years her junior, wrote to the Sanitarium in an effort to provide her sister's history.

Dear Sir i will try to answer your request the best I can. She was alright when she was a child & young woman. up till about 6 years ago. when her first child died. She was about a month. she acted strang like she would lose her mind then she got all right again. She had 9 children. they are all dead. ever time one would die. she would be crasey for some time. then she would get better for a while. last year her Husband & 2 last children died. she she has been crazy ever since. Please write me how long she has been at Milledgeville & how she is getting along. is she crazy all the time yet or does she know any thing at times. i would be glad to hear from her.⁴²⁵

There is no record of the doctor's reply. Over the next fifteen years, the doctor's notes rarely varied from "quiet. Compliant. Tidy. Conduct good." Sixteen years after she arrived at Milledgeville, her doctor recorded "Patient has her hair down. Will get in the bath tub with her clothes on. The nurse states she has these spells which last about two months. She is somewhat excited at present." A year later, the doctor again recorded she "gets somewhat excited at times

⁴²⁵ CSH, Box 44, Book 217, pp. 387-404.

and will pull off her clothes and refuse to wear shoes.” Neelie continued to “disarrange” her hair as the year wore on. In the spring and summer of 1930 and 1931, her doctor noted she “uses a rolling chair most of the time” and “walks by pushing a chair.” By April of 1933, she stayed “in bed most of the time due to general feeble condition.” After an illness of about one month, Neelie died at Milledgeville of heart disease in the fall of 1933. She was one month shy of her eighty-third birthday and had been widowed and childless for twenty-two years.

Summary

These case studies exemplify the losses endured by two women as representative of common loss endured by women of this period. Leila Ward, a woman of relative privilege, lost her only daughter to illness. Her decline led from hastened aging to drug addiction to private sanatoria and finally to Milledgeville. Leila’s husband was afflicted as well, and lacked the ability or willingness to “keep her home going” as she had hoped. Although he exhibited his own struggles with mental illness, a situation that seemed to intensify her struggle, he was somehow able to escape the institutionalization she experienced.

Neelie James lost seven children, though we do not know the details. After moving with her family to a pauper farm in south Georgia, her last two children died along with her husband and Neelie was taken to Milledgeville. No doctor ever mentioned Neelie’s losses. Neither did the superintendent of the pauper farm. If not for her sister’s letter, we would never have known that she lost every one of her nine children.

A clear schism existed at the time between women’s issues and their male doctors, when the impact of pregnancy and deaths of children did not warrant even a comment among them. Clearly, loss was common, but doctors rarely mentioned the losses of women once they became patients at the hospital. It was as though painful life circumstances did not matter. But such

circumstances clearly did matter. Loss by death and abandonment was often a precursor to institutionalization at the Georgia State Sanitarium.

CHAPTER 8

CONCLUSION

The purpose of this study was to examine the relationship between rural women from northeast Georgia and the Georgia State Sanitarium in Milledgeville from 1886-1936. The following research questions guided the work:

1. What can we learn about northeast Georgia's rural women through the prism of the patient records of those who died at the Georgia State Sanitarium from 1886-1936?
2. What kinds of circumstances precipitated the institutionalization of women from northeast Georgia?
3. What role did the Sanitarium play in the lives of northeast Georgia women?

The themes generated in the study reveal the centrality of confinement, the prevalence of poverty and the pervasiveness of loss in the lives of the women who went to Milledgeville. Broader themes at play include gender, race and class. The following chapter frames these themes within the findings of similar studies and overarching theory, addressing consistencies as well as contrasts.

Confinement and the Vulnerability of Women

While it may not be true that all Georgia's women experienced physical confinement, women during this era experienced a metaphorical confinement. Not only were they constrained from making choices about their own lives (Anna Wyly "insisted on wearing [her] hair down."),⁴²⁶ but without a man—be it father, husband or brother—they were vulnerable. Some of

⁴²⁶ CSH, Box 28, Book 140, 306-323.

them were vulnerable even with a husband. Women who married older widowers, like Elizabeth Dalton and Augusta Gordon, faced what appears to be an oft-strained relationship with the children from his first marriage. “His [her husband’s] family did not like her,” confessed Augusta,⁴²⁷ but she was still persuaded to marry him.

Women within this study all experienced actual confinement, from being guarded at home to being incarcerated in county jail. Whether white or black, women on their way to the Sanitarium experienced levels of confinement which intensified with their level of violence. Women who were dangerous to their families or themselves were often tied up at home, in chairs or with handcuffs or to trees. Many faced incarceration in county jails, and a greater percentage of those were black women. While it does not appear that more black than white women were sent to Milledgeville, a greater number of black women certainly did find themselves in jail. More black women than white, like Lena Ayers, were vulnerable to abuse and rape while they were in jail.

More quantitative studies are needed to provide detailed findings about the exact numbers of women, white and black, who faced incarceration before institutionalization at the Sanitarium. The degree to which overcrowding at the Sanitarium frequently led to incarceration in jails is another topic for further study. Newspaper accounts of the era suggest that this is the case, but if so, who would be more likely to be incarcerated and who would receive a bed at Milledgeville?

The Sanitarium also confined women. While such confinement is hard for those of us who live within the age of pharmaceutical constraint to imagine, the Sanitarium from 1886-1936 lacked alternatives. Using strong dresses and sleeve aprons seemed one of the few choices the institution had for women who were “filthy.” Sterilization was experienced by only one woman

⁴²⁷ CSH, Book 178, pp. 283-338.

in the study; a woman who exhibited sexual promiscuity and the temerity to show her white body to black men. This exhibitionism seemed the final straw to asylum officials who promptly had her sterilized. The fact that she was probably carrying a child at the time was not addressed in patient records at the point of her sterilization. Further study might yield information about what became of the pregnancy or of the child.⁴²⁸

One third of the women in this study came to the institution suicidal. The fact that 29 of the ninety women in this study were suicidal as they entered the institution provides another obvious possibility for further scholarship. The rural women in this study were most inclined to attempt suicide by jumping in wells or in nearby rivers, although others set fire to their clothing, drank carbolic acid or iodine, jumped from heights and attempted to hang themselves. It would be useful to focus only upon the women attempting suicide in order to observe what most contributed to their desperate attempts to end their lives.⁴²⁹

Confinement remains ambiguous. Some women clearly needed to be institutionalized while others probably did not. As repugnant as the means of their confinement is to us now, we must remember the options were far more limited during the time of this study. Where we might now prescribe a medication in order to calm a woman, the homes and sanitariums of the past had no such option. A measure of confusion also pervades the use of labels for patients of the era. The diagnoses themselves are problematic because they do not translate to modern clinical categories. Women were diagnosed “infective exhaustive,” “psychosis with pellagra,” “dementia praecox,” “old manic,” and other terms that have either shifted in meaning over the years, or have become archaic. Psychology was still a relatively new field at the time of this study and its practice was very much centered on the asylum. Not until 1918 was the clinical terminology

⁴²⁸ Central State Hospital does maintain obstetrics records within its archives. These might yield answers to such questions.

⁴²⁹ This statement assumes suicide is a logical response to suffering, one that many may find problematic.

codified in the *Statistical Manual for the Use of Institutions for the Insane*,⁴³⁰ leading to standard terms and procedures for the nation's asylums.

Terms of intellectual disability are similarly problematic. The women in the study were referred to as “mentally deficient,” “moron,” “high grade moron,” “the moron type,” “imbecile,” “inferior,” “constitutional inferiority,” “feeble-minded” and “tainted” by heredity. Doctors, who were at a loss to diagnose women's illnesses, often seemed to label the women with these terms. More study needs to be done in order to make sense of these terms in reference to these specific women.⁴³¹ My initial questions, however, center on whether more poor women were labeled with intellectual disabilities than their middle-class contemporaries. Because the Sanitarium was free to Georgia residents, it attracted a majority of poor women. Those who had money would go to Brawner's in Cobb County or to other private sanitarium. The data in this study suggest that a poor woman was more likely to be labeled as intellectually disabled than a middle-class woman. In fact, one of Neelie James' doctors stated “when a person is so poor they cannot make a living, I think there *must* be some mental defect.”⁴³² Leila Ward, the wife of a doctor, was educated in private school and became a teacher before her marriage. She delighted her doctors with her “splendid” level of awareness and articulation. Such effusive praise on behalf of physicians at Milledgeville was rare indeed. The intellectual disability labels were not rare in the least among the women in the study. Labeling, as well as poverty, pervaded the institution.

⁴³⁰ American Medico-Psychological Association and National Committee for Mental Hygiene, *Statistical Manual for the Use of Institutions for the Insane* (New York: no publ. given, 1918). Edward Shorter chronicles the development of the DSM (Diagnostic and Statistical Manual of Mental Disorders) from this manual. See Shorter, 298.

⁴³¹ Richard Fox has done the most extensive work on intellectual disability in United States asylums. See Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978). See also the work of Edward Larson.

⁴³² CSH Box 44, Book 217, pp. 387-404.

Poverty and the Vulnerability of Women

The majority of women who came to Milledgeville were poor. They worked hard in the fields and in their homes before coming to the Sanitarium. And they worried. Women admitted worrying, or “studying” about whether they could keep working so hard, about their “exhausted” land, and about their husbands “getting down.” They worried about their crops, whether they were going to make anything and the boll weevil.

Poverty paved the way for disease. Poverty necessitated inexpensive, seasonally available food. The pellagra’s diet of cornmeal, meat, and molasses was the food most southerners ate, although not all developed pellagra. Other diseases associated with poverty were also a constant threat: hookworm (also known as “ground itch), typhoid, and tuberculosis among them. Southerners at the time did not always understand the etiology of the diseases they encountered, but often their doctors did. As scientists, many from the North, began to study the diseases of the South, many southern doctors rejected their findings, embarrassed to be found lacking in sanitation and nutrition. The result was delayed relief for the South. Though doctors knew the reasons behind pellagra and hookworm, poor southerners spent decades entrenched in the grip of disease. The Sanitarium provided a place for women who suffered from pellagra to heal, at least temporarily. For a group of women in this study, like Desimony Frazier who had the “breaking out [of pellagra] off and on ever since she was a child” and was admitted three times,⁴³³ the Sanitarium allowed them to cycle in and out as their symptoms reoccurred each spring. The women’s weight fluctuated, as well. Emaciated women came to the Sanitarium for treatment. Well-nourished women went home, only to return thin and emaciated a year or two later. Black women, who were too often admitted beyond the point where they could be cured, suffered the most from pellagra. A greater number of black women than white came to the institution with

⁴³³ CSH Book 206, pp. 217-258.

pellagra and a greater number of them died from pellagra. Further study may reveal why it is that black women were kept from treatment longer than white women.

In the era before welfare, many who had no family to care for them found themselves in pauper's homes, particularly those of old age. According to Peter McCandless in writing about South Carolina's asylum, "many families thought it a greater disgrace to have a relative in a poorhouse than in an asylum."⁴³⁴ Six women in this study came to the institution from such houses. The care they received varied. Black women were more likely to be exploited for their labor at such homes. Whether black or white, women were ill-treated in pauper's homes. Maggie Miller complained that people at the pauper's home would "eat up her victuals,"⁴³⁵ but not all had bad experiences at pauper's homes. Some women wished to return rather than to stay at Milledgeville. This study has found that the poorhouse, asylum, and the practice of boarding individuals "out" into the care of others were three means of managing those who had no home, no family, or whose family knew not what to do with them. The three were often intertwined, but the Sanitarium was for many a place of very last resort; when family was gone, when the pauper's home was unwilling, the Sanitarium, a free institution, became home for many.

Loss and the Vulnerability of Women

The women in this study suffered overwhelming losses. Tanja Luckins writes "an asylum is traditionally a place of loss—of memory, sanity, identity and stability."⁴³⁶ But the women of this period, even those outside of the asylum, often suffered more tangible losses, in particular, the deaths of children on a scale that modern-day women and men would find inconceivable.

⁴³⁴ Peter McCandless, *Moonlight, Magnolias, & Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill: University of North Carolina Press, 1996), 262.

⁴³⁵ CSH Box 35, Book 172, pp. 356-367.

⁴³⁶ Tanja Luckins, "Crazed with grief? The asylum and the great war in Australia," in *Madness in Australia: histories, heritage and the asylum*, ed. Catharine Coleborne and Dolly MacKinnon (St. Lucia, QLD: University of Queensland Press, 2003), 170.

Postpartum issues, combined with high infant and child mortality rates and the abuse and abandonment of husbands meant many women suffered losses they may have been ill-prepared to bear. Mark Finnane elaborates:

A common category of ‘causes of insanity’ in early asylum statistics was ‘disappointment’. The word was used commonly to describe the experience of women who had been jilted or cheated by men, but it might as readily summarise the position of many, both men and women, who found their lives falling apart through social, emotional or economic upset.⁴³⁷

A woman who recently bore and suffered the death of a child but who still had to work in the field, at a time when making a crop was hardly guaranteed, might very well feel her world was falling apart. Such losses were far more common at the time of this study than they are now. What is it that enabled some women to cope with the enormity of such loss and others to succumb to illness?

Oddly, doctors seemed to take very little note of women’s recent experiences, childbirth among them. Hilary Marland explains that by the time of this study, puerperal insanity as a serious diagnosis was losing credibility. “The rich emotional landscape of fear, despair and misery, which marked much of the discourse on puerperal insanity throughout the [nineteenth] century, was obscured by the gloom of hereditary insanity, the separate existence of the disorder denied by many.”⁴³⁸ More doctors were concerned with heredity and degeneration than with postpartum needs, therefore, not all women were perceived as vulnerable during the postpartum period, but only those whose heredity made them vulnerable. If Marland’s findings hold true for the Georgia State Sanitarium, a analysis of patient records could reveal a change in thinking among staff physicians over time. Records do exist for at least twenty years prior to this study;

⁴³⁷ Finnane, 140.

⁴³⁸ Marland, 209.

an interesting possibility would be to explore those records for treatment of women in their postpartum year.

Most often, doctors' and staff notes leave unspoken the reality of a woman's losses, implicitly negating the significance of loss. Elizabeth Dalton grieved over the loss of relationship with her sons and her inability to "hear from them," a grief most women would understand, but her physician described her grief as a "morbid tendency to tell of her own health and children." There was clearly a disconnect between women's losses and their male doctors. There was no recorded reaction or even acknowledgment of the enormity of loss Neelie James endured with the deaths, one at a time, of her nine children. Neither was there a recorded response to the experience of Lizzie Duncan, whose husband reputedly ran away with her sister and was never heard from again, or to Zora Hulsey, who grieved over the violent death of a beloved uncle.⁴³⁹ Mollie Whitlow brought the clothing of her dead child to the Sanitarium, but even this did not warrant any response. Trauma was also discounted by the doctors. The experience of Harriet Bruce, who survived being in the center of the Gainesville tornado of 1936, warranted no written reaction from her doctors. Whether this lack of recorded response is due to a move toward viewing all mental illness as hereditary and degenerative, as Hilary Marland suggests, remains to be seen.

Another area of common loss is apparent from the patient records. Prior to, and sometimes during their confinement at the Sanitarium, a number of women appear to have been separated from their children. Augusta Gordon's children do not all appear in census records even when she was home with them. And Elizabeth Dalton could not locate her second son; this son remains completely unknown by Elizabeth's descendants, as does she. Further study will reveal what happened to children whose mothers went to Milledgeville. Certainly some remained

⁴³⁹ CSH Box 44, Book 216, pp. 396-412.

with fathers or taken in by family, but other might have been placed in homes. Mark Finnane found evidence that some women could be persuaded to relinquish their children to children's homes if the relinquishment lightened the economic burden on the family.⁴⁴⁰ Pursuing records of Georgia's children's homes might yield more information on this topic.

Where women's husbands and fathers, and most certainly sisters and mothers, would refer to trauma and loss in background forms, the information was rarely picked up by Sanitarium officials. This finding is in direct contradiction to that of Catherine Coleborne, who found the background information given by families at asylums in Australasia *did* surface time and again among hospital staff within their case notes. Coleborne, in fact, found families helped to construct asylum communication.⁴⁴¹ But at the Georgia State Sanitarium, background information given by families did not advance beyond the woman's intake records. There is very little evidence that families helped shape asylum discourse as they did in Coleborne's study.

While physical abuse of women was not common among the data, such abuse did exist. Women were raped and beaten, sometimes by drunken husbands. They were also sometimes exploited for every ounce of labor they could provide, particularly if they were black. Fannie Bush's husband whipped and abused her because she was "happy." It is possible that Fannie was not so much "happy" as she was manic and her husband might have been engaging in some misguided notion that he could rid her of her conduct by beating her.⁴⁴² A few husbands in this study physically abused their wives, but more of them took their leave.

Women were abandoned by husbands all too often. Husbands who left their wives forced other members of the family to care for them. In some cases a woman would be passed around to

⁴⁴⁰ Finnane, 141.

⁴⁴¹ Coleborne, *His Brain*, 52.

⁴⁴² CSH Box 53, Book 264, pp. 384-410.

various family members, what Lizzie Duncan described as going “here and yonder.”⁴⁴³ Often, women whose families tired of the situation or were frightened of their ill relative would in turn, abandon her to the Sanitarium.

The Sanitarium served a number of roles for families and women in Georgia. Scholars point to the work of Mark Finnane in turning from viewing patients at asylums through a narrow lens of social control to a broader lens that encompasses the family of the patient. Finnane found the asylum not only a custodial institution, or a “dumping ground,”⁴⁴⁴ but also a sanctuary, refuge and place of protection. “The significance of familial relations in the histories of the incarcerated remains,” writes Finnane. Furthermore,

Among those for whom we have something more than the standard social information (age, sex, marital status, religion, occupation) which accompanied any committal there is plenty of evidence of the domestic conflicts, the pressures, the disappointments, frustrations and anxieties which preceded committal. In letters from relatives or friends, for instance, we can see rehearsed (or reflected in afterthought) assumptions about normality and health which lay behind decisions to commit.⁴⁴⁵

This study concurs with that scholarship; the family and their perspective, was as central to understanding the women as the words of the women themselves. For women whose words were not recorded, the family provided the only prism available with which to understand their situation. Patient history forms completed by family members provide much of the information we know of the women’s lives. In a small number of cases, letters written by family members also yield revelations about the lived experiences of the women. Family members often explained the circumstances that led them to commit their wives, mothers and daughters, sometimes revealing their exasperation: “I have Done [sic] all I can to the case to help you,”

⁴⁴³ CSH Box 35, Book 171, pp. 313-327.

⁴⁴⁴ Finnane, 141.

⁴⁴⁵ Finnane, 139.

wrote Augusta Gordon's husband, as he turned her over to the care of the Sanitarium.⁴⁴⁶ As usual in this study, the will of a male relative determined the fate of a woman.

The Sanitarium offered a place for families to be relieved of the responsibility of caring for their women. For some of the women in this study, the Sanitarium was a place to be forgotten and for all of the women in this study, it was ultimately a place to die. And yet, many women no doubt lived much longer within the walls of the Sanitarium than they would have lived had they remained in other situations. For all its faults, there was a measure of medical care, regular meals, the company of others, and a shelter over their heads, items that were lacking for many in Georgia during this time. Some in this study, like Augusta Gordon, are similar to those in Anne Shepherd's study; they found life in the asylum preferable to being home because the asylum life was more comfortable for them. Not only did women have a more healthful diet than at home, they did not have to prepare the meal; the meal was provided for them. Neither did they have to suffer abusive husbands or the rigor of house and farm work. The women of this population were also similar to those of Marjorie Levine-Clark's study, whose struggles had to do with the pressures involved in the daily difficulties of their lives.

This study fills a gap in the literature by honoring the experiences of the many ordinary women who lived and died at the Georgia State Sanitarium. Unlike many elite and middle-class women of the South, these women did not write their memoirs; neither did they leave many letters or diaries behind when they died. But those who witnessed the struggles of women who went to Milledgeville, like Ellen Hooper and Mary Dean, offered their stories in oral history interviews. Archival work, particularly in the patient records at Central State Hospital, provided a glimpse, though not of the specific women I sought who had gone to Milledgeville, of many more whose experiences were illustrative. This study joins other studies in a methodological

⁴⁴⁶ CSH, Book 178, pp. 283-338.

move to “lower the historical gaze onto the sufferers”⁴⁴⁷ by accessing patient records that record their voices and those of their families.

This study uncovers the relationship and roles of the Georgia State Sanitarium to rural women in northeast Georgia. But it is also a useful tool for “analyzing moments when historical time and personal circumstance converge.”⁴⁴⁸ In her study of loss during the Great War in Australia as it intersected with women and the asylum, Tanja Luckins found “the asylum moves outside its own walls, and its archival sources become part of a broader social context, making the writing of new histories apparent.”⁴⁴⁹ This dissertation presents a “new history” of Georgia’s rural woman. By making visible what was invisible; the voices and experiences of Georgia’s rural, poor women through the lens of patient records, this study rectifies an historical oversight: the experiences of rural women from northeast Georgia who lived and died at Milledgeville.

⁴⁴⁷ Roy Porter, “The patient’s view: doing medical history from below,” *Theory and Society* 14, no. 2 (March 1985): 192.

⁴⁴⁸ Luckins, 169.

⁴⁴⁹ Luckins, 169.

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Morrow, Georgia

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APPENDICES

APPENDIX A: PATIENT INDEX CARD

Name		ACME 4204-6		County		Hospital No.	
						39289	
Nativity	Age	Sex	Race	Occupation			
Ga.	50	Female	White	Housewife			
Civil condition		Duration		Cause			
Married		7 years		x			
Diagnosis							
Epileptic psychosis.							
Symptoms							
Homicidal and suicidal. Violent and destructive.							
Admitted		Furloughed		Discharged		Died	
9-14-25						-25	
Cause of death							
Embolism. Post operative. Hysterectomy for fibroid. 5.10 PM							
Name of Guardian or relative				P. O.		Telegraph	
				Ga.			
Name of Patient		County		Folio		Ward	
						1926	

APPENDIX B: RECORD OF DEATH

149

NAME Mrs. [illegible] COUNTY [illegible]
 Color white; Sex Female; Age 50
 Received 9-14-25; Died -25
 Cause of Death Embolic, Post operative, hysterectomy for fibroid
 Form of Insanity Epilepsy
 Duration of Last Illness Several days
 Disposition of Body [illegible]
 Remarks Patient had a Jan hysterectomy for fibroid uterus 12/10/20. She has had a little fever 37 and on, ranging from normal to 101 1/2 F. She had a gastric ulcer, she had to be coaxed to eat since operation, she never voided herself. Neither did her bowels move, she has had considerable distension pituitary extracts and enemata failed to give relief. Yesterday afternoon at 5:10 o'clock she suddenly began gasping for breath and died right away.
U.S. - [illegible]

APPENDIX C: PATIENT HISTORY FORM

MAKE ANSWERS TO QUESTIONS AS DEFINITE AND COMPLETE AS POSSIBLE

Have Blank Filled Out By Family Physician Whenever It Can Be Done.

150

Date Sept 7 - 1935

From (white) (State whether WHITE or COLORED)

County, Ga., Native of Ga If not a native of Georgia

How long has patient resided in this State? all life Age? 50 Married, single or widowed? married

If female, state the number of children born and date of last birth 7

Occupation Housewife

Religious belief Baptist Give as near as possible date of first symptoms of this attack seven years ago → 1918

What symptoms of insanity were manifested? Temporary mania

State in full the probable cause of this attack Gradually progressed to point of insanity

Is this first attack of insanity patient has ever had? yes Give number of previous attacks and duration of each Continuous

Is the patient an epileptic, or ever had convulsions? yes If so at what age did they appear? 4.5

Did patient show any evidence of scrofula, or other constitutional disease when a child? no State if patient is blind? no

Deaf? no Paralyzed? no Able to walk? yes State in full what relative of patient if any and whether paternal, or maternal, have ever suffered from any of the following diseases: Insanity? ?

Epilepsy no Idiocy no Deaf Muteism no

Alcoholism no Apoplexy no Weak-mindedness no

Paralysis no Drug Habit no Consumption no Congenital Deformity no

Moral Degradity no Has patient's marital relation been congenial? no

Has patient ever received an injury to the head? no Has patient ever had any serious disease preceding the development of this attack, if so, what disease, and duration of same? no

Has patient ever had syphilis? ? Has patient ever been suicidal? If so in what manner? yes

Has patient ever been homicidal? yes

Has patient ever been addicted to the use of spirituous liquor or tobacco? no

Has patient ever been addicted to the use of morphine, cocaine or chloral? yes

Has patient been violent? yes Has patient been destructive? yes

Has patient been filthy? yes Has patient been disposed to do mischief with fire? no

Has patient been eating and sleeping satisfactorily? no

What treatment or confinement has been employed? Forced Confinement at home

Give FULL NAME of RELATIVES to be addressed in connection with case:

POST OFFICE ADDRESS [redacted]

TELEGRAPHIC ADDRESS same

REMARKS: This patient has gradually grown worse until she has now become unmanageable. Has to be forcibly confined.

N. B.—Ordinary will kindly impress the following facts upon the family of the patient: The Sanitarium authorities will only write in answer to inquiries, except in cases of serious sickness. When communicating with authorities, the patient's full name and county should be given. If remains are to go home, in event of death, the charges have to be borne by the family and must be arranged in advance through the express company. The State furnishes a plain coffin, but if a nicer one is desired, the patient's family must bear the expense.

APPENDIX D: GENERAL EXAMINATION

EXAMINATION BY DR. [REDACTED] SEPT. 15th, 1925.

MRS. [REDACTED]

[REDACTED] COUNTY.

ADM. SEPT. 14, 1925.

FAMILY HISTORY: By distant relative.

Father died very old of dropsy. Mother is in very good health.

One brother died of fever. Three sisters in good health.

One sister insane. one sister died in childhood.

PERSONAL HISTORY: By distant relative.

Patient is fifty years old. Born and raised in [REDACTED] County.

Schooling limited, but she seemed of average intelligence.

Married when twenty. Marital relations very ^{un}congenial.

Husband deserted her five years ago. Three children in good health. After her marriage she lived a number of years in

[REDACTED] County. Has been dependent on her children since she separated from her husband five years ago.

Mrs. [REDACTED]

15.2

PRESENT ILLNESS: By distant relative.

Her present illness dates back about five years and about the time her husband deserted her. Informant states he heard something of patient having falling spells. She has done no work in several years. Has been homicidal and threatened people with knives. She has no interest what ever in her surroundings. She gets mad without provocation. She goes no where.

APPENDIX E: PERSONAL HISTORY

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PERSONAL HISTORY: By the patient.

Patient states she is fifty years old. Her schooling was very limited. States she learned to read, but was never able to write. She never had a chance to advance much, but states she supposes she did very well for the time she was in school. She is healthy as a child and never had any serious illness. She states she married at about seventeen. Is the mother of three children, all in good health. States she had two miscarriages which happened some where about full time; one being born dead and the other lived about two weeks. She states the first few years of her married life her her marital relations were congenial, but her husband neglected her in later years. He deserted her seven years ago running off with another woman. This was a great shock to her and she has been dependent upon her sons since that time. She states a few years after her marriage and about the time her first living baby was born she began to have falling spells and has had them since. She states she will average one spell ever two or three weeks. She exhibits several scars on her hands and arms where she was burned by falling against a stove. She states she has bitten her lips and tongue on these occasions. She feels that her mind has been affected by having spells and insists she has no memory. When her husband deserted her it was a great shock to her and she has never been able to do much since. She is inclined to attribute her not doing anything on physical grounds.

APPENDIX F: PHYSICAL SUMMARY

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MRS. [REDACTED]

PHYSICAL SUMMARY.

Only fairly well nourished white female weighing 109 lbs., and five feet and six inches in height. Forehead very low, narrow and receding. Teeth show much decay and a few absent. Complexion is sallow. Mucous membranes rather anaemic. Muscles soft. Tanniculus loose. Complains of aching pains of limbs and body, and of being cold. Expression is dull. States that at one time she had an anaesthetic area near the left axilla. Hand grips weak. History of convulsions. Blood pressure 100-165. Cervix is lacerated. Uterus is retroflexed.

Urine; Sp.gr. 1.021. Alb. faint trace. Many leukocytes and few epithelial cells.
Blood Wassermann negative.
Feces negative.

APPENDIX G: ATTITUDE AND MANNER; MENTAL SUMMARY

MRS. L.

ATTITUDE AND MANNER:

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Patient is not clear as to her surroundings here. has manifested no interest in anything. She has done nothing further than dressing herself. As a rule she has to be directed about the ward and to her meals. She complains greatly of being cold all the time. She wants to sleep under blankets at night. She has not been observed in any convulsions. She is inclined to sit about with her head drooped. She appears ill at ease and seems to be suffering some physical discomfort. In the examining room she was quiet, but inclined to complain. Stating she was cold and aching all over.

MENTAL SUMMARY.

patient realizes a change in her feelings. She states she has cold feelings and at times she does not know anything. She came here to get warm and get better if she could. She mentions having had smothering spells or convulsions. Thinks these have effected her mind. She is unable to say anything right; Has no memory. Has not been doing any work as she was not able to. Feels that her health is bad and at times wants to die and get of it all. (She has no money and nobody to care for her. She has not done wrong. Has been more or less troubled since her husband deserted her. She denies making violent attacks upon anyone. Got along with her sons all right. has no enemies. she insists she has heard voices from heaven. Her father has told her to come on and be buried

APPENDIX H: MENTAL SUMMARY; TENTATIVE DIAGNOSIS

Mrs. [REDACTED] mental summary. 2. 156

by him. her grand mother asked her to come on to heaven. She states sometimes she feels that she sees her father and talks to him. She is oriented for the year, but only approximately so for the date of month and day of week. Grasp for recent events shows some defect, quite defective for remote events. Retention is nil after three minutes. Fund of general information is quite defective. She calculates only in small numbers. Writing is very primitive. She miscalls many of the words and was slow in reading. Could not write her name in a legible manner. She seems to have superficial insight. Judgment is defective.

Diagnosis- I am inclined to a diagnosis of epileptic psychosis. We have a fairly clear history of convulsions with scars on the patient resulting from burns on these occasions. We have some evidence of hallucinations and loss of memory and mental reduction.

Treatment is dietetic, symptomatic and out door exercise.

APPENDIX I: PHYSICAL EXAMINATION

Mrs. [REDACTED]

PHYSICAL EXAMINATION.

GENERAL TYPE AND APPEARANCE:

Head regular. Teeth show much decay and a few absent. Forehead narrow and receding. Complexion sallow.

NUTRITION:

Only fairly well nourished. Muscles soft. Panniculus loose. Ht. 5 ft. Wt. 109 lbs. Mucous membranes anaemic. Scar on the dorsal surface of right forearm two inches long, about one inch wide, resulting from a burn. Rather extensive scar tissue on left index finger resulting from a burn. Com

NERVOUS SYSTEM:

Complains of limbs and body aching and of being cold.

EYES:

Expression is dull. Pupils equal, regular and react.

CUTANEOUS SENSIBILITY: Undisturbed though patient gives a

h history of having an anaesthetic area in the left axilla.

REFLEXES:

Elbow and wrist normal. Quadriceps and knee jerks absent.

MOTOR FUNCTIONS: Undisturbed.

TREMORS: None.

SPEECH: No defect.

CONVULSIONS: History of convulsions.

THORACIC ORGANS:

Chest is very well developed. Heart normal in position, no murmurs. Blood pressure 100-165. Lungs negative.

ABDOMEN: Negative.

GENITO-URINARY ORGANS:

Cervix lacerated. Uterus retroflexed.

APPENDIX J: MENTAL EXAMINATION

Mrs. [redacted]

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MENTAL EXAMINATION.

STREAM OF MENTAL ACTIVITY:

Why did they send you here? "I come here to get warm and get better if I could."
What is wrong with you? "I have cold feelings and at times I don't know nothing."
When is it you don't know nothing? "When I have them smothering spells."
Do you call the fits smothering spells? "Yes."
Have these spells affected your mind? "Yes."
In what way? "I can't say nothing right."
Do you act like a crazy person sometimes? "They say I do. Walking around and standing around."
How is your memory? "I can't recollect."
Have you quit work? "Yes."
Why did you quit work? "I was not able to work."
What was wrong with you? "I hurt and was not right."
Do you have imaginations? "Yes."
What do you imagine? "I imagine sometimes my health is bad and I want to die and get out of it. I haven't got any money and nobody to care for me."
Don't your sons care for you? "Yes, but I just feel that way."
Do you feel that you have done wrong? "No."
Have you ever tried to kill yourself? "No."
Have you wished you were dead? "Yes. I was trouble away back yonder when my husband left and got the children torn up and bothered."
Have you attempted to harm anybody with a knife? "No."
How did you get along with your sons? "All right."
Have you got any enemies? "No."
Has anybody tried to do you any harm? "No."

GENERAL MENTAL ATTITUDE:

How do you rest at night? "Some nights I rest good if I don't get bothered up and ache and hurt."
Are you worried about anything else besides your discomfort? "No."
Do you ever hear voices when you are alone? "No."
You never hear voices from heaven? "Yes."
Who have you heard? "That old lady that lives with us."
Is she dead? "No. My wife works in the cotton mill and this old woman stays there and keep house."
Who do you hear from heaven? "My father says come on and be buried by him. My grand mother said come on to heaven."
Did anybody speak and tell you that? "I can't say."
Have you seen things? "Sometimes I think I see my father and talk to him."
What else have you seen? "I don't know."
Have you seen anything? "I don't reckon I have."
Has anybody tried to poison you? "No."

Smile

APPENDIX K: MENTAL EXAMINATION, CONTINUED

Mrs. [REDACTED] . Mental. 2.

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ORIENTATION:

What year is this? "1925."
What month is it? "About the 20th of . ." (15th.)
Day of the week? "Wednesday." (Thursday.)

MEMORY FOR RECENT EVENTS:

What day did you come? "Monday."
How did you come? "In a car."
How many were in the car? "Four."
How many hours were you on the way? "We left home at seven o'clock
and got here twenty minutes of eleven."
Name some of the towns you came through? "Buford."

MEMORY FOR REMOTE EVENTS:

What year were you born? "I have forgotten."
The date of your marriage? "I have forgotten."
What month was your first child born? "I have forgotten."
What month was your last child born? "I have forgotten."
How long has your husband been dead? "Seven years."

RETENTION:

25 Broad St. 8 10 o'clock A.M., white house.
After three minutes- nil.

GENERAL INFORMATION AND SCHOOL KNOWLEDGE:

How many months in a year? "Twelve."
How many days in a month? "30, 31, 32."
Which is the shortest month? "October."
When is Christmas day? "25th of December."
Why do we celebrate Christmas? "I don't know."
How many days in a year? "I don't know."
How often does leap year come? "I don't know."
What county you live in? "I don't know."
What county is Atlanta in? "I don't know."
What is the capitol of Georgia? "I don't know."
Who is the president? "I don't know."
How many inches in a foot? "I have forgotten."
Spells house, bridge. Misspells hospital, biscuit and scissors.

COUNTING AND CALCULATION:

5 + 4? - "9."
6 + 7? - "13."
7 + 8? - "14."
7 - 3? - "4."
15 - 6? - "I don't know."

APPENDIX L: MENTAL EXAMINATION, CONCLUDED

Mrs. [REDACTED] Mental. 3. 160

READING:

Patient's reading is very primitive. She miscalls many of the words and was slow in reading.

WRITING: She could not write her name in a legible manner.

INSIGHT AND JUDGMENT:

Do you think you are insane? "No. At times I don't know anything. I have had so much trouble."
What is your greatest trouble? "About my husband."
Do you want to live with your husband again? "I reckon I would if I could."
What are your plans? "Nothing much."
Can you make a living like you are? "I am not able to work."
What is wrong with you? "My health is bad."
How long do you think you will be here? "Not very long."
Where are you going when you leave here? "Back to my sons."
Why were you sent here? "They did not send me. I took a notion to come and look about and stay awhile."
What is the name of this place? "A hospital."

APPENDIX M: STAFF MEETING NOTES, CASE NOTES

STAFF MEETING NOTES.

MRS. [REDACTED].

Oct. 1, 1925.

History read by Dr. [REDACTED].

Dr. [REDACTED] I agree.

Dr. [REDACTED] I agree.

Dr. [REDACTED] I agree.

Dr. [REDACTED] I agree.

Dr. [REDACTED] I agree. it is rather late in life to have epileptic fits to come on.

21784
MRS. [REDACTED] COUNTY. ADM. SEPT. 14, 1925.

Diagnosis- Epileptic psychosis.

Sept. 22, 1925. Note by Dr. [REDACTED]

Patient has not been observed in any convulsive seizures though she has something to say about having had some. States she does not rest well at night. She has chilly sensations. Complains that she has no strength and cannot do things right. She needs some assistance in dressing and undressing. She finds her way about the ward.

Sept. 29, 1925. Note by Dr. [REDACTED]

Patient is very quiet on the ward. She takes but little interest in things about her and talks but little. Never spontaneous. She is tidy and looks after her personal wants. Finds her way about. Since last notes were taken she has been observed in two unconscious seizures. On both of these occasions she was at the table. It seems that she was unconscious about two minutes. She quit eating for that time and seemed totally oblivious to her surroundings. The nurse reports that her muscles were somewhat drawn. This seemed to be more or less general. After the attack she was confused, laughing, reaching out and throwing things about on the table in a rather promiscuous way. She had to be taken from the dining room.

Patient has been removed from 1st reception ward.

APPENDIX N: IMPLICATIONS FOR ACTION

An extraordinary database exists at Central State Hospital in Milledgeville, but the database faces deterioration each day. Original patient records hold the voices and experiences of a generation of Georgians who lived between Reconstruction and the Depression. The records, were they made more easily available, could provide scholars with studies on medical history, social history, women's history, and southern history, among others.

The patient records, while safe and in relatively good repair, are beginning to crumble. The microfilm, in particular, may well be beyond repair. But with the knowledge of preservationists, there is some possibility that some part of the microfilm could be digitalized, making the patient records more accessible for scholars.

By moving all records to the Georgia Archives, they would be spared further deterioration. The Archives provides temperature-control as well as a trained staff who can repair old documents and who can make the decision of whether or not to handle fragile documents, preserving them for future scholars. Furthermore, the archives are well-equipped to enforce the strict confidentiality required in using the records in order to protect patients and their families. It is my sincere hope that the State Department of Behavioral Health & Developmental Disabilities will see fit to pursue the preservation of these records before any more are lost.