

William Whitney Godding and the Concepts of Asylum and Therapeutic Community

Michael B. Knable, DO

ABSTRACT

St. Elizabeth's Hospital in Washington, DC, was built in 1855, and now, despite its designation as a historical site, it is currently being renovated to house the Department of Homeland Security. The hospital's buildings, grounds, and philosophy of humane care were greatly enhanced during the administration of William Whitney Godding, MD, the hospital's second superintendent. Prior to joining St. Elizabeth's, Godding had leadership roles at other public hospitals in New Hampshire and Massachusetts—hospitals that have also been drastically reduced in size and mission. This article discusses Godding's career and contributions in light of the drastic reduction in the availability of psychiatric beds in the United States, and also the decline of the concepts of "asylum" and "therapeutic community." [*Psychiatr Ann.* 2015;45(1):45-48.]

Michael B. Knable, DO, is the Executive Director, Sylvan C. Herman Foundation.

Address correspondence to Michael B. Knable, DO, Executive Director, Sylvan C. Herman Foundation, 617 West Patrick Street, Frederick, MD 21701; email: mknable@clearviewcommunities.org.

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Since at least the time of the Industrial Revolution, and perhaps since medieval times, the societal role of large institutions for the care and housing of the persistent mentally ill has been debated. Over the past several decades we have witnessed the abandonment of the many public psychiatric hospitals created in the 19th and 20th centuries in the United States, and have debated how to provide long-term care in the community in the face of “deinstitutionalization.” The subsequent rise in the numbers of homeless or incarcerated mentally ill has been frequently described. St. Elizabeth's Hospital in Washington, DC, one of the largest and

most renowned public psychiatric hospitals in the United States, is currently undergoing a radical transformation. In the midst of the ongoing debate, I thought it prudent to recall the good and charitable intentions that accompanied the founding of St. Elizabeth's, and the work of William Whitney Godding, MD, who tried to create a humane asylum (“place of safety”) during his tenure there.

HISTORY OF ST. ELIZABETH'S

In 1855, the Government Hospital for the Insane was opened to care for the mentally ill of the District of Columbia, the US Army, and the US Navy. It was the first federal hospital designed for the

care of the mentally ill, and its founding largely depended on the efforts of Dorothea Lynde Dix. In 1916, the hospital was officially renamed St. Elizabeth's Hospital, after the tract of land on which it is located that had borne a similar designation since colonial times. The hospital was administered by several federal agencies, including the Department of the Interior, the Federal Security Agency, and the Department of Health and Human Services, until it was taken over by the District of Columbia Department of Mental Health in 1987. In 2004, the General Services Administration assumed control of the West Campus of St. Elizabeth's, and the property is currently being redeveloped to house portions of the Department of Homeland Security and other government agencies.

As I reflect on the former beauty of the grounds of St. Elizabeth's, the many patients I have seen there, and the many influential professionals who have worked there, I am reminded of the difficulty involved in the creation of a "place of safety," or of a "therapeutic community," where patients and caregivers are aligned in purpose and philosophy. In combination with rapid de-institutionalization, we have experienced a period in which biological reductionism became the dominant paradigm in psychiatry, the methods for reimbursement of psychiatric services were drastically altered, and the various elements of treatment for those with persistent mental illness were fragmented and separated from each other. The idea that a "continuum of care" could be constructed using separate institutions offering short-term hospitalization, residential treatment, partial hospitalization, and outpatient psychotherapy and psychopharmacology visits, which would replace the "asylum" in both public and private sectors, seems to remain a distant goal. It is my contention that for patients to become as independent as possible, to overcome social anxiety, and to continue with edu-

cational or vocational goals, a special interpersonal environment needs to be created.

WILLIAM WHITNEY GODDING

William Whitney Godding, MD, was the second Superintendent of St. Elizabeth's Hospital.¹ During his tenure, he presided over a large expansion of the facility and worked diligently to elaborate the concept of asylum. In reading Godding's writings, and the reminiscences of those who knew him, one obtains the impression that he was a kind, gentle, and well-rounded scientist-scholar who himself benefited from the solitude and contemplative life that St. Elizabeth's offered at the time:

"But, though unbidden, and not mentioned above a whisper, the spectre is never wanting at our feast; step by step, keeping pace with our ever advancing civilization, still stalks the growing shadow of brain decay, with its attendants, apoplexy and insanity. We lock up our insane man in the hospital, and think that we are rid of him; vain is our selfish hope; we cannot thus shake him off, for is he not our neighbor? nay, may he not be our brother? worse yet, at the next turn, what shall prevent that the insanity may not happen even to ourselves?"²

Prior to joining St. Elizabeth's Hospital, Godding served in two other institutions that later became large state hospitals and whose stories were integral parts of the debate concerning appropriate care for the persistently ill in previous generations.

Godding was born on May 5, 1831 in Winchendon, Massachusetts. His parents were pious pillars of the local community. His father, Alvah Godding, was a respected country doctor and his mother, Mary Whitney Godding, was descended from an English family that had been in Massachusetts since 1635. He obtained his medical degree in 1857

from the Medical College at Castleton, Vermont, which existed from 1818 until 1862 on the site of the present Castleton State College.

After graduation, he briefly went into general practice with his father, and in 1859 took a position as Assistant Physician at the State Hospital for the Insane at Concord, New Hampshire, where he worked until 1863. The State Hospital for the Insane at Concord, now known as the New Hampshire State Hospital, was established in 1842 as the 17th hospital for the mentally ill in the United States. Like many state hospitals, it became drastically overcrowded during the 19th and 20th centuries, and by the 1970s the hospital had approximately 2,700 long-term patients.³ During the rapid de-institutionalization of the 1980s, the New Hampshire State Hospital was redefined as an "acute care facility" and now has a capacity of only 152 beds. Despite the reduction in available beds and services, the New Hampshire Hospital did begin a notable collaboration with Dartmouth Medical School during this period in order to improve the recruitment and retention of physicians, to improve the reputation and quality of care at the hospital, and to establish a site for research on psychiatric rehabilitation. The Psychiatric Research Center, under the direction of Robert Drake, MD, was established and produced important publications regarding evidence-based practices, supported employment, and other aspects of psychiatric rehabilitation. In 2006, state funding for the Psychiatric Research Center was reduced, along with an overall reduction in funding for psychiatric services. Subsequently, patient and family groups have mounted a class action suit against the State of New Hampshire, which has been joined by the US Department of Justice, regarding the decreasing availability of adequate services.

From 1870 until 1877, Godding served as Superintendent of the State

Hospital for the Insane at Taunton, Massachusetts. The main buildings of Taunton State Hospital were in operation from 1854 until 1975, but these beautiful structures were later allowed to deteriorate and were ultimately demolished in 2009. Although the hospital still exists in other structures, the State of Massachusetts is considering its permanent closure and the possible use of the grounds for a casino or other commercial enterprises.⁴

Godding served at St. Elizabeth's on two occasions. From 1863 until 1870 he was Second Assistant Physician Charles Henry Nichols, MD. In 1877, Nichols resigned his post to take charge of the Bloomingdale Asylum in New York City, and Godding returned to St. Elizabeth's to take over as Superintendent. In a manner similar to the hospitals in Concord and Taunton, St. Elizabeth's was constructed with the idea of utilizing the harmonious combination of impressive architecture, a beautiful natural environment, and the compassionate or "moral" treatment of patients to help create a therapeutic community. At the end of World War II, there were 7,460 patients at St. Elizabeth's, but now there are only approximately 400.

In 1877, the West Campus of St. Elizabeth's had three buildings that housed about 700 patients. This number of patients was more than three times what had been envisioned in original plans for the hospital. By the time of Godding's death in 1899, there were more than 60 buildings and about 2,000 patients. The West Campus of St. Elizabeth's was designated as a National Historic Landmark in 1990. Of the 70 buildings that were constructed there, 62 will be renovated as part of the historic preservation effort, although they will no longer house agencies or facilities having anything to do with mental illness.

Godding originally decided to build according to a "cottage plan," in which smaller home-like structures were built

near the Center Building to house patients requiring less supervision and that were integrated with agricultural aspects of the hospital such as orchards, vineyards, and facilities for livestock. Later construction included larger buildings for patients and also structures related to the infrastructure of the hospital, such as a bakery, an ice plant, greenhouses, a

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reservoir, and numerous artesian wells.

Godding's son Alvah was raised on the grounds of the hospital. Alvah was an amateur horticulturalist who procured more than 170 varieties of exotic trees for the hospital campus and also served as superintendent of the grounds until his death in 1949.

In addition to the building projects that Godding supervised, his other notable achievements include the construction of the first pathological laboratory in a mental hospital and the construction of Howard Hall in 1891, one of the first facilities for the criminally insane. He served as President of the Association of Medical Superintendents of American Institutions for the Insane (which later became the American Medico-Psychological Association and then the American Psychiatric Association), and was Professor of Psychological Medicine and Medical Jurisprudence at the Columbian University (later George Washington University). Between 1933 and 1943, during the time that Winfred Overholser, MD, was superintendent, several buildings for long-term and geriatric care were constructed on the East Campus of St. Elizabeth's and were named after Godding. These buildings also now stand empty and in poor repair.

CONCLUDING THOUGHTS

Does one not instinctively mourn the passing of the early life of St. Elizabeth's? The staff of the hospital and their families lived on the grounds, priority was given to the aesthetics of the buildings, the patients were given an opportunity for purposeful work with plants and animals, and the grounds were decorated with beautiful vegetation and exquisite views of the Anacostia and Potomac Rivers. Along with St. Elizabeth's, does one not also mourn the passing of the New Hampshire State Hospital, the Taunton State Hospital, and other similar facilities about which Christopher Payne⁵ has observed:

... the idea of self-contained communities that grew their own food and made their own shoes fascinated me and seemed to speak to a more environmentally sensible way of life.

In a forward to Payne's book, Oliver Sacks, who began his career as a neurologist in a large state hospital, noted:

...by 1990 it was very clear that the system had overreacted, that the wholesale closure of state hospitals had proceeded far too rapidly, without any adequate alternatives in place... We forgot the benign aspects of asylums, or perhaps we felt we could no longer afford to pay for them: the spaciousness and sense of community, the place for work and play, and for the gradual learning of social and vocational skills.

To further highlight the excessive rapidity of de-institutionalization efforts, the Treatment Advocacy Center of Arlington, VA, recently published an analysis of hospital bed numbers available for the persistently mentally ill.⁶ They estimate that the average number of public psychiatric beds available in the United States in 2010 was 14 per 100,000; the same ratio

that was present in 1850 at the start of the asylum movement. The authors of this report recommend that the necessary ratio for “minimally adequate” treatment is 50 per 100,000. For comparison, the ratio in the United Kingdom in 2008 was 63 per 100,000 and the ratio in the United States in 1958 was 300 per 100,000.

Despite the standards of current practice and of “managed care,” I must conclude that patients with persistent mental illness, especially young adults in the beginning stages of illness, require a period of “asylum.” They require the creation of a healing environment, frequently separate from the family of origin, that slows exposure to the stimuli and stresses of the world but that encourages and fosters independence. If given this environ-

ment, many will recover and lead productive lives. Such treatment is currently available in private settings but is very rare in public settings or in settings financed by third-party insurers. Although we seem to chronically lack funding for such efforts, we must ask ourselves how did we afford this before? Why is it a lower priority now?

Godding died while working at St. Elizabeth’s on May 6, 1899, at a time that preceded the discovery of psychotropic medications, psychoanalysis, electroconvulsive therapy, and most of the techniques that we now employ. Nevertheless, he seemed content with his work and with how his patients fared. Why did he, members of his family, and the staff that worked for him not appear to tire of their work? Without the availability of therapeutic

communities, do we not increase fragmentation and dissatisfaction in the lives of our patients, and also in our own lives as caregivers?

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