PEOPLE, NOT PATIENTS

LIFE STORIES FROM SOUTH CAROLINA'S STATE HOSPITAL

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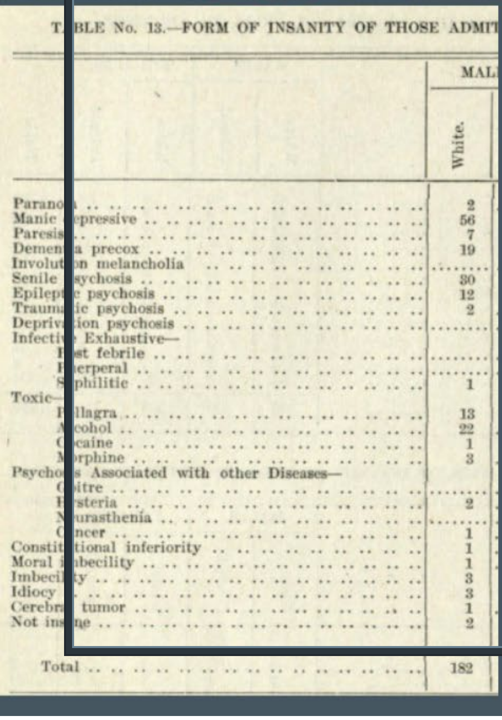

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philitic	1
Toxic—	
llagra	13
cohol	22
caine	1
rphine	3
Psycho s Associated with other Diseases—	
itre	....
steria	2
urasthenia	....
ncer	1
Constit tional inferiority	1
Moral becility	1
Imbecil ty	3
Idiocy	3
Cerebr tumor	1
Not ins ne	2
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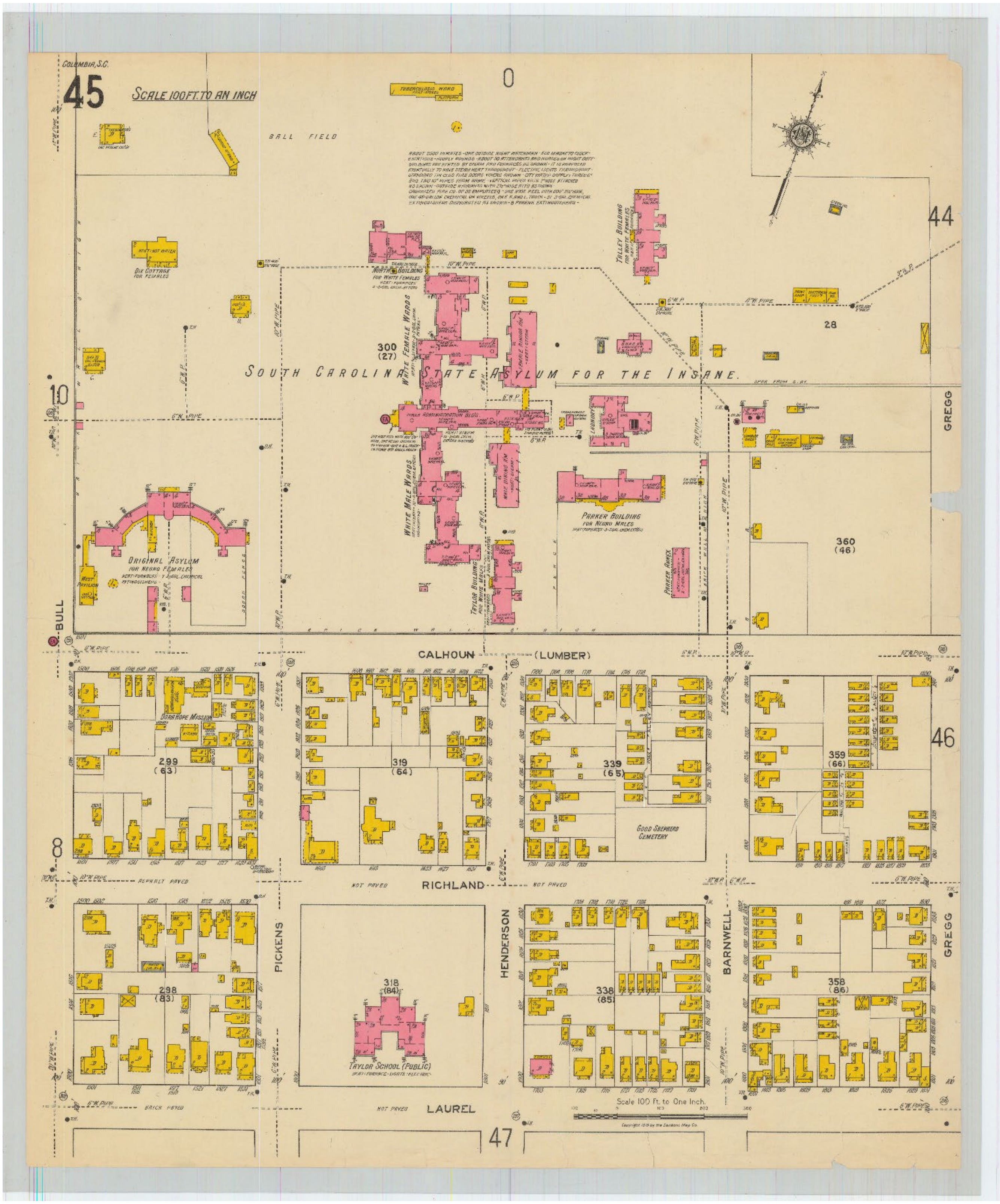

SANBORN MAP OF SOUTH CAROLINA STATE HOSPITAL, 1919. *IMAGE COURTESY SOUTH CAROLINIANA LIBRARY, UNIVERSITY OF SOUTH CAROLINA, COLUMBIA*

DEDICATION

People, Not Patients is dedicated to the individuals who lived at the institution on Bull Street, people who were too often misunderstood, mislabeled, and unheard.

We honor their lives, their humanity, and the dignity they carried, even in the face of profound harm. We acknowledge the pain that occurred, the loss of choice, separation from community, and the impact of systems that failed them. May *People, Not Patients* serve as a reminder that understanding must replace fear, community must replace confinement, and that "Nothing About Us Without Us" is not just a principle, but a promise we must continue to keep.

They were never just patients. They were people.

May their stories be remembered, and may we continue the work to ensure understanding, dignity, and true inclusion for all.

About the cover images:

Portraits of people, past and present, included in this project. Images courtesy *Crush Rush Photography, the American Journal of Insanity, and the The State Newspaper Photograph Collection*

Official diagnoses of patients admitted, published in the institution's annual report, 1909. *Image courtesy South Carolina State Library.*

"Mills Building," painted c. 1900. Historic Columbia is exploring the possibility that this painting, previously owned by the South Carolina Department of Mental Health, was completed by former patient **Edward Lane Spencer**. *Image courtesy Historic Columbia collection, HCF2006.9.1*

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INTRODUCTION

People, Not Patients is a first-of-its-kind collaborative project between Able South Carolina and Historic Columbia, funded by South Carolina Humanities. This project does more than document history; it reframes it. Through a disability justice lens, *People, Not Patients* centers the voices, dignity, and lived experiences of individuals who lived and worked at the South Carolina State Hospital, known to many as “Bull Street”—in Columbia, South Carolina.

MILLS BUILDING, 1904. *IMAGE COURTESY HISTORIC COLUMBIA COLLECTION, HCF2008.4.9.*

The institution was not home to a single population or diagnosis. It housed a broad and diverse cross-section of people with disabilities—individuals with psychiatric disabilities, intellectual and developmental disabilities, neurological conditions, and those who were often institutionalized simply for being perceived as “different,” “difficult,” or outside societal norms. Their stories are shared through audio recordings, photographs, and narrative text, ensuring they are seen not as diagnoses or case files, but as people.

This project captures the true history of life at the institution during a time when people who were misunderstood, mislabeled, or unsupported were removed from their communities rather than provided the services and supports needed to live within them. It tells the story of a system that separated people from their families, autonomy, and opportunities, often without their full consent or understanding, and did so across disability types, reinforcing a broader pattern of segregation under the guise of care.

Since launching this project in 2023, it has become clear that the history of the institution remains deeply incomplete. For generations, the lives of those who lived there have been documented through institutional records filtered through medical, legal, and administrative perspectives, but rarely, if ever, through their own voices or through a cross-disability, civil rights lens. This project begins to fill that gap.

To date, there has been no comprehensive effort to examine the experiences of people who lived at the institution through a framework that prioritizes autonomy, civil rights, and lived experience across disability communities. *People, Not Patients* challenges that absence. It asks critical questions: Who were the people behind the records? What were their daily realities? What choices were taken from them and what resilience did they carry? How did they leave, and what happened next?

By elevating these stories, Able South Carolina and Historic Columbia are not only preserving history, but they are correcting it. This work ensures that the legacy of the institution is not told solely through the perspective of systems and institutions, but through the voices of those most impacted. In doing so, we confront a difficult past, honor the humanity of those who lived it, and build a clearer understanding of how institutionalization has shaped, and continues to shape disability policy and practice.

But this work is not just about the past. South Carolina continues to rely on institutional settings today, with multiple state-operated and private facilities still housing people with disabilities across diagnostic categories, reminding us that the legacy of the institution is not history alone, but an ongoing reality.

If we do not tell these stories—fully, truthfully, and across the breadth of disability experience, we risk repeating them.

The stories that follow offer a starting point for understanding the many lives shaped before, during, and after institutionalization. They remind us that each patient was, first and foremost, a person, and that a return to institutionalization should never be considered an option.

A NOTE ABOUT LANGUAGE:

This document contains historical terminology that is outdated and offensive. These terms appear in direct quotations from institutional records and are preserved for historical accuracy. Such outdated and offensive terms for diagnosis, description, and even nicknames capture how people with disabilities were dehumanized while at the institution. This dehumanizing language is part of the compelling story of lessons learned that led to the deinstitutionalization movement and expansion of disability rights. They do not reflect the values of this project or its partners but are key to telling the whole story of life lived at the institution.

HOW TO USE THIS BOOKLET

This is an interactive booklet that encourages readers to listen to audio recordings, read transcripts, and navigate sections with ease.

You may navigate the document digitally by using the clickable headings in our table of contents.

To listen to audio recordings of interviews, please select the audio icons next to each interview, or use your personal device to scan the QR code. Transcripts are provided within the booklet.

To access additional online resources placed within the booklet, please select the hyperlinked title, or use your personal device to scan the QR code.

A note on the institution’s name: the former South Carolina State Hospital operated under a number of names during its history, including the South Carolina Lunatic Asylum, the State Hospital for the Insane, and the colloquial use of “Bull Street” due to its location on Bull Street in Columbia, South Carolina. For the sake of clarity for the reader, we will refer to this place as “the institution” throughout the booklet.

A TIMELINE OF THE INSTITUTION ON BULL STREET

From the earliest days of the United States, people with disabilities were not supported within their communities; they were separated from them. What began as discomfort and fear from non-disabled society evolved into formal, state-sanctioned systems designed to remove those deemed “unacceptable” or outside societal norms.

One of the earliest manifestations of this was the almshouse system, where people with disabilities, along with others labeled “undesirable,” were housed together and hidden from public life. In these spaces, disability was not understood, but it was managed, controlled, and, in many ways, criminalized.

Following the American Revolution, this approach expanded rapidly. Confinement, not care, became the dominant response, and practices now recognized as harmful and inhumane, such as isolation, bloodletting, and forced interventions, were widely accepted as “treatment.”

By 1821, South Carolina joined this national movement, establishing what would become the South Carolina State Hospital, marking the beginning of the institution’s long and complex role in the institutionalization of people with disabilities in the state.

FROM INSTITUTIONS TO RIGHTS: THE PATH TO DEINSTITUTIONALIZATION

FOUNDATIONS OF INSTITUTIONALIZATION: PRE-1800–1865

PRE-1800

Early institutions for people labeled "lunaticks" emerge in the United States, including the Pennsylvania Hospital (founded 1751), which establish wards for people with disabilities. Similar models develop in Bellevue Hospital and Rhode Island (1752). These institutions introduce a defining idea that would shape the next two centuries: disabled people should be removed from society and managed in separate spaces.

1821–1828 (SOUTH CAROLINA STATE HOSPITAL ESTABLISHED)

South Carolina authorizes and constructs its state asylum, designed by Robert Mills, admitting its first patient in 1828. The asylum was made for "lunatics" and the "deaf and dumb." Institutionalization becomes the default public policy response to disability, rooted in control, charity, and segregation, not rights. Today, "where do we put them" vs. "how do we serve them in the community" is still lingering in practice.

1848

The institution begins admitting Black patients under segregated conditions. Disability systems mirror and reinforce broader systems of racial injustice and exclusion.

1849

South Carolina establishes what becomes the South Carolina School for the Deaf and the Blind and separates from the Bull Street institution. However, this school remains residential and segregated, not community based.

1864–1865

The institution's grounds are used as a Confederate prison camp. These facilities function as tools of state control, not just care.

EXPANSION, SEGREGATION & SYSTEMIC HARM: 1896–1920

1896–1920

The institution expands into a massive, self-contained system, including farms, labor, segregated cemeteries, and separate facilities for Black patients. What is framed as "care" becomes a system of lifetime confinement, forced labor, and social disappearance. The same concept is being discussed by lawmakers today. Why would we go back to something that obviously caused more harm?

1909 INVESTIGATION

South Carolina documents severe neglect, overcrowding, and abuse. Even early on, it was very clear that institutions are not safe, therapeutic, or humane environments.

1918

Creation of institutions for people labeled "feeble-minded" expands confinement to people with intellectual and developmental disabilities. Institutionalization widens, capturing more disability groups under systems of control.

EUGENICS, MEDICALIZATION & CRACKS IN THE SYSTEM: 1927–1965

1927 – EUGENICS LEGALIZED

In *Buck v. Bell*, the Supreme Court upheld forced sterilization. The government formally endorsed the idea that disabled lives are less valuable and can be controlled or eliminated.

1930s–1950s – MEDICAL "SOLUTIONS" EMERGE

Shock therapies, and later psychiatric medications, are introduced. While framed as progress, these approaches often prioritize compliance and control over autonomy and consent.

1935 – SOCIAL SAFETY NET BEGINS

The Social Security Act expands federal involvement in disability-related supports. However, supports are still largely tied to segregated systems.

1963 – COMMUNITY MENTAL HEALTH ACT

Signed by John F. Kennedy after personal and national exposure to institutional conditions, this act marks the first major federal acknowledgment that people should live in community settings, but the system fails to build enough community infrastructure.

1965 – MEDICAID & IMD EXCLUSION

Medicaid is established, but The Medicaid Institution for Mental Diseases (IMD) exclusion limits federal funding for large psychiatric institutions serving adults. This creates a financial incentive to move away from institutions, but without guaranteeing community alternatives, leading to gaps we still see today.

EXPOSURE, RIGHTS & THE BEGINNING OF DEINSTITUTIONALIZATION: 1965–1983

1960S–1970S – CIVIL RIGHTS & DISABILITY ADVOCACY INTERSECT

Advocates like Modjeska Monteith Simkins expose racial and disability-based inequities in South Carolina institutions. Disability begins to be understood not as a medical issue, but as a civil rights issue.

1971 – RIGHT TO TREATMENT

Wyatt v. Stickney establishes that people in institutions have a constitutional right to adequate care. This creates a legal standard that most institutions cannot meet, exposing systemic failure.

1972 – WILLOWBROOK EXPOSED

Abuse at Willowbrook State School in New York is publicly revealed. The nation sees, often for the first time, the reality of institutional life, which is full of neglect, abuse, and dehumanization.

1973 – SECTION 504

The first federal civil rights protection for disabled people formally recognizes disability as a protected class within the Federal government, shifting the conversation from charity to rights.

1975 – EDUCATION RIGHTS ESTABLISHED

Children with disabilities gain the right to public education (later The Individuals with Disabilities Education Act, or IDEA). The idea of segregation as a default begins to break down, starting with youth.

1975 – FREEDOM FROM UNJUST CONFINEMENT

In *O'Connor v. Donaldson*, the U.S. Supreme court rules that people cannot be confined without justification. Institutionalization without cause is recognized as a violation of liberty.

1980 – FEDERAL OVERSIGHT (CRIPA)

The Civil Rights of Institutionalized Persons Act allows federal investigation of institutions. The federal government begins actively documenting and challenging abuse.

1981 – HCBS WAIVERS CREATED

States can now choose to fund services in homes and communities. This is a structural turning point. For the first time, funding can follow the person, not the institution. However, today this program is still optional and significantly unfunded, yet it is half the cost of institutionalization.

1983 – FEDERAL INTERVENTION IN SC

Federal enforcement accelerates the transition of people out of South Carolina institutions. Deinstitutionalization becomes not just policy, but practice.

LEGAL RIGHTS, COMMUNITY LIVING & SYSTEM TRANSFORMATION: 1990–2005

1990 – AMERICANS WITH DISABILITIES ACT (ADA)

Americans with Disabilities Act is enacted, establishing disability as a full civil rights issue across society.

1990S – LARGE-SCALE TRANSITIONS

Thousands of individuals move from institutions into community settings. However, systems are uneven, and many people move into smaller but still segregated settings, revealing that deinstitutionalization is a process, not an endpoint.

1999 – OLMSTEAD DECISION

Olmstead v. L.C. affirms that unnecessary institutionalization is discrimination. This becomes the legal backbone of modern disability rights, requiring services in the most integrated setting.

2005 – CLOSURE OF SC STATE HOSPITAL

The large institutional model officially ends in South Carolina. A symbolic milestone, but not the end of institutional practices. South Carolina still has several state-funded institutions despite the years of evidence that they cause more harm often resulting in abuse, neglect and even death.

While the physical institution closed, many systems of care shifted, not always into true community integration, but often into smaller, still segregated settings, leaving the promise of deinstitutionalization incomplete.

Importantly, the institution didn’t fail because we closed it. It failed because it existed.

TODAY: THE CONTINUING FIGHT (AND THE WARNING FROM HISTORY)

Institutionalization has not disappeared, it has often been repackaged as group homes, congregate care, or "specialized" disability housing that can still isolate people from community life.

2007–2011

The land is sold and redeveloped, physically erasing the institution. But systems of segregation still re-emerge in new forms.

2020s – ONGOING TENSION

Calls to "bring back institutions" reappear in public discourse. These arguments often ignore decades of evidence showing that:

- Institutions lead to worse outcomes
- Community-based services are more cost-effective
- People with disabilities thrive when given autonomy and support

2026

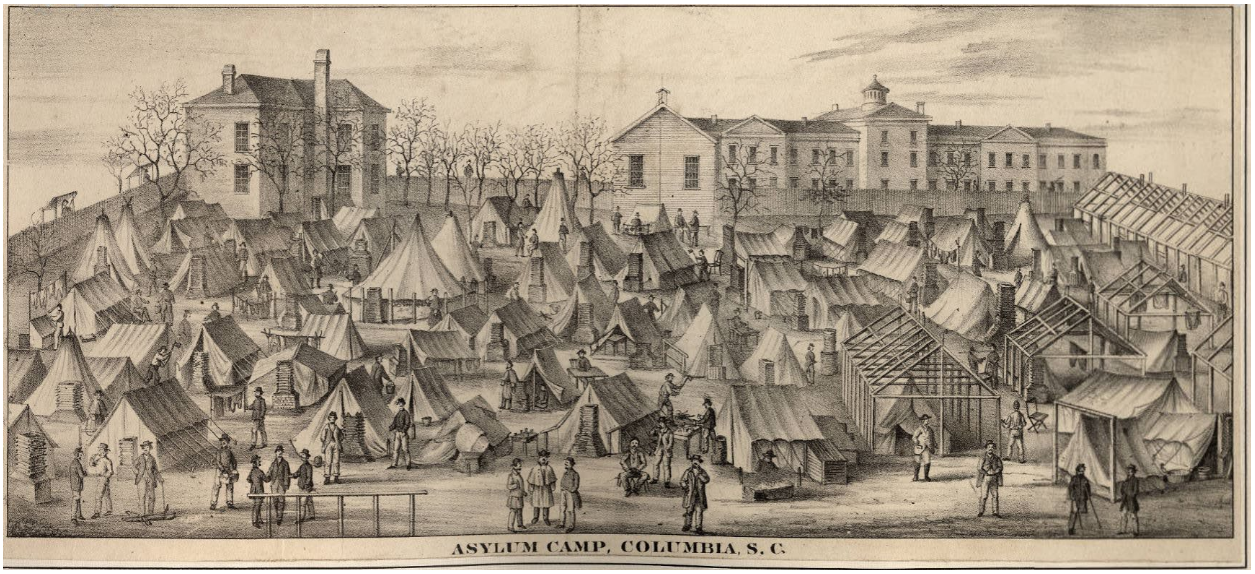
The U.S. Department of Justice reached a settlement with South Carolina after finding violations of the Americans with Disabilities Act and *Olmstead v. L.C.*, requiring the state to expand Home and Community-Based Services and reduce unnecessary institutionalization. More than 25 years after *Olmstead*, federal enforcement confirms that many people with disabilities are still segregated or at risk due to gaps in community supports. This reinforces a critical truth that deinstitutionalization is not complete, and it is an ongoing civil rights obligation.

HOW DEINSTITUTIONALIZATION HAPPENED

Deinstitutionalization is not just about closing buildings; it is about ensuring people are not forced into any setting that limits their freedom, autonomy, or connection to community.

Deinstitutionalization did not happen because systems worked, it happened because:

- Institutions caused harm (documented abuse, neglect, death)
- What was called treatment often deepened harm rather than healing. Courts recognized constitutional rights
- Federal policy shifted funding toward community living
- Disability was redefined as a civil rights issue, not a medical problem to contain



HISTORICAL DRAWING OF "ASYLUM CAMP" FROM THE CIVIL WAR ERA, 1864. *IMAGE COURTESY SOUTH CAROLINIANA LIBRARY, UNIVERSITY OF SOUTH CAROLINA, COLUMBIA*

SECTION 1: HOW THEY GOT THERE

Commitments to the institution rarely began with a simple, unbiased medical decision. They began with a family that could not cope, a judge who relied on a neighbor's testimony, a physician whose biases shaped every form they filled out. Some were requests for help—a boy of about ten or eleven brought in by his father, who had just remarried; two immigrant sisters delivered from a Charleston poorhouse in 1833 with no diagnosis at all; a man who committed himself in 1939, perhaps out of desperation, perhaps out of hope. For nearly two centuries, the path to the institution on Bull Street was paved with poverty, racial injustice, grief, and the failure of communities to support their most vulnerable members. Once inside, most patients were assigned a number, sorted into a ward segregated by gender, race, and sometimes diagnosis—and largely forgotten.

South Carolina State Hospital gate, 1973. *Image courtesy The State Newspaper Photograph Collection, Richland Library*

THE MODERN VOICES

The following modern stories were captured of former patients still living in 2026. The ages at the time of their interviews are mentioned in their descriptions below.

FRANK ANDERSON — FIRST ADMITTED AGE 17, 1976 • SCHIZOAFFECTIVE DISORDER

Frank Anderson is 66. He was just 17 when he first walked into the institution. One of his clearest memories is sitting with a doctor who told him, “Frank, you’ve got a tough road ahead of you. You’re so young.” He doesn’t remember the doctor’s name, but he remembers the weight of those words. Frank mostly attended day treatment since he lived right across the street. For a teenager facing a serious diagnosis, that proximity mattered.

DIANE BILLET — FIRST ADMITTED AGE 29, 1981 • DEPRESSION, SCHIZOAFFECTIVE DISORDER

Diane Billet, 73, was first admitted at 29 and returned five times. “I didn’t think I belonged there,” she says. “I didn’t want to cooperate. I just wanted to do what I wanted to do.”

JESSE BROWN — FIRST ADMITTED AGE 27, 1989 • SCHIZOAFFECTIVE DISORDER

Jesse Brown is 63. When he first entered the institution, he was also diagnosed with what was then called grandiose personality disorder. He describes the environment as “militaristic.” There were lines for everything.

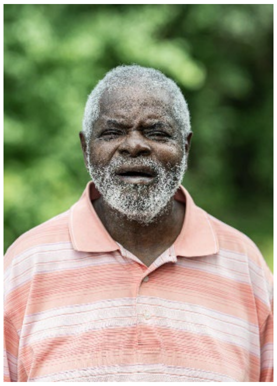
LESLIE DUKES — FIRST ADMITTED AGE 17, 1987 • MAJOR DEPRESSIVE DISORDER, SCHIZOAFFECTIVE DISORDER

Leslie Dukes, 55, was hospitalized at 17, 18, and again in her early twenties. The memories that stay with her most are the harder ones—no privacy, feeling unprotected, and time spent in isolation.

KESHA JONES — FIRST ADMITTED AGE 15, 1987 • AUTISM, ANXIETY, BIPOLAR DISORDER, LEARNING DISABILITY

Kesha Jones was only 15 when she was first committed. Now 53, she lived at the institution on and off for years. She talks about the community she built there and the friendships that helped her survive.

MARVIN MAY — FIRST ADMITTED AGE 30, 1991 • SCHIZOAFFECTIVE DISORDER



Marvin May, 64, was 30 when he was committed. His memories are hazy. What he recalls most is the waiting. The sitting around. Long stretches of time blur together.

ALAN NEWMAN — FIRST ADMITTED AGE 21, 1973 • CHRONIC DEPRESSION • 18 ADMISSIONS

Alan Newman is 73. He was just 21 when he was first admitted and over the years, he returned 17 times. He holds both good and painful memories.

BRYAN WAYMER — FIRST ADMITTED AGE 17, 1998 • SCHIZOPHRENIA, DIABETES • 18 ADMISSIONS

Bryan Waymer, 43, was only 17 when he entered the institution. He remembers the lack of freedom, being handcuffed, and time in solitary confinement. But he also speaks about the relationships he formed.

STAFF VOICES

MARGARET B. — EMPLOYEE ASSISTANCE DIRECTOR, SC DEPARTMENT OF MENTAL HEALTH, MID-1980S TO MID-1990S

Margaret B.'s work focused on supporting employees rather than patients, addressing issues such as transportation difficulties and workplace challenges across the state system. She described the staff as dedicated but burdened, and the organizational culture as highly bureaucratic.

JOHN HALLORAN — COLUMBIA RESIDENT • WORKED FUNERAL HOME RETRIEVALS FROM BULL STREET CAMPUS, 1968 - 1972

John Halloran grew up in the shadow of the institution, a campus he recalls as mysterious and eerie. As part of a team working for a local funeral home, he was responsible for retrieving deceased patients from the campus. It is a haunting reminder that for many patients, death was their only way off the grounds.

It should be noted that John Halloran is the father of Able SC's interviewer, Mandy Halloran.

JOY JAY — RECREATION THERAPIST, SOUTH CAROLINA STATE HOSPITAL, 1978–1982

Joy Jay began working at the institution in 1978 in the Williams Building, where intake occurred and patients typically stayed for short-term stabilization. She shared a deeply personal account of witnessing the involuntary commitment of a family member at just five years old.

SECTION 2: INSIDE THE WALLS

NURSES GUIDE A NEW PATIENT INTO THE INSTITUTION, 1960. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

Once inside the institution, people entered a world where choice disappeared. Days were dictated by rigid routines, long stretches of waiting, and an overwhelming absence of control over even the most basic parts of their lives. This was as true in 1828 as it was at the time the institution closed in the early 2000s.

The details evolved as locks replaced by policies, restraints by medications, ward names by diagnoses, but the experience remained the same: confinement, isolation, and an aching search for human connection in a place designed to limit it.

Across two centuries, the setting changed. The loss of autonomy did not.

HISTORICAL: DAILY LIFE AND LABOR

COMMITTED, ADMITTED, AND FORGOTTEN

In testimony to the General Assembly in 1909, Dr. James W. Babcock stated that the institution was "a dumping ground of every form of humanity that is undesirable in any community." Although founded as a curative asylum eight decades prior, the institution quickly devolved into one that held people in custody for months, years, or decades. Diagnosed with insanity caused by perceived moral (religion, jealousy), physical (pregnancy, idiocy, overwork, paralysis), and “toxic” (alcohol, pellagra) failings, these men, women, and children found themselves committed, admitted, and forgotten, despite needing treatment for “forms” of illness that ranged from paranoia and dementia praecox (schizophrenia) to epilepsy, “imbecility,” and “idiocy.”

Most commitments began with what physicians called an “exciting cause.” For surveyor **Edward Spencer**, this was the loss of his wife, whose death left him “indifferent to everything around him” and prone to drinking too much. He began repeatedly running away from his family and hiding in the woods at night. Despite having two children at home, Spencer could not manage his “acute melancholia.” His family committed him for a fourth and final time in 1896 after he said that “he would kill himself if he could.”

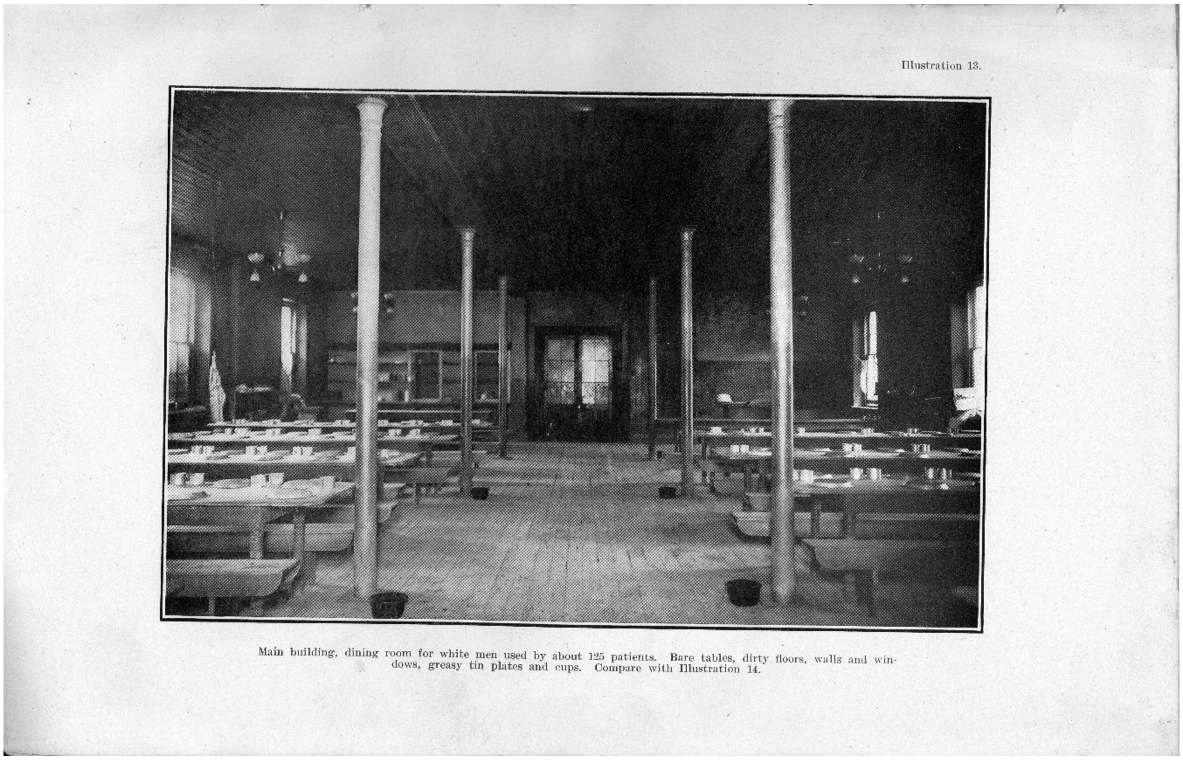


Illustration 13.

Main building, dining room for white men used by about 125 patients. Bare tables, dirty floors, walls and windows, greasy tin plates and cups. Compare with Illustration 14.

“Main Building, Dining Room” from Report of the Legislative Committee to Investigate the State Hospital for the Insane, 1910. *Image courtesy South Caroliniana Library, University of South Carolina, Columbia*

Similarly, domestic worker **Lucy Brown’s** husband died working on the railroad in 1876, leading to an official declaration of insanity; her commitment to this institution two years later followed a “second attack” caused by “disappointment on the night fixed for her second marriage [when] another wife appeared." Physicians considered both these cases "hereditary," with immediate relatives having previously been declared insane. Only Brown, however, was "considered dangerous," after declaring "doctors wish to cut a baby out of her."

Black women like Brown and farm hand **Carrie Taylor** often faced additional discrimination in receiving treatment in the Jim Crow South. Taylor's commitment file, signed by a Richland County probate judge, included testimony given by established planter-physician Herbert Claytor, who stated in 1914 he had seen her personally "abusing and cursing on [a] public highway" and that she "talks disrespectfully" to him. Unlike the other individuals included in this study, Claytor deemed Taylor's original disposition as "frank" rather than "cheerful," her habits "quarrelsome" rather than "industrious," likely indications of racial bias.

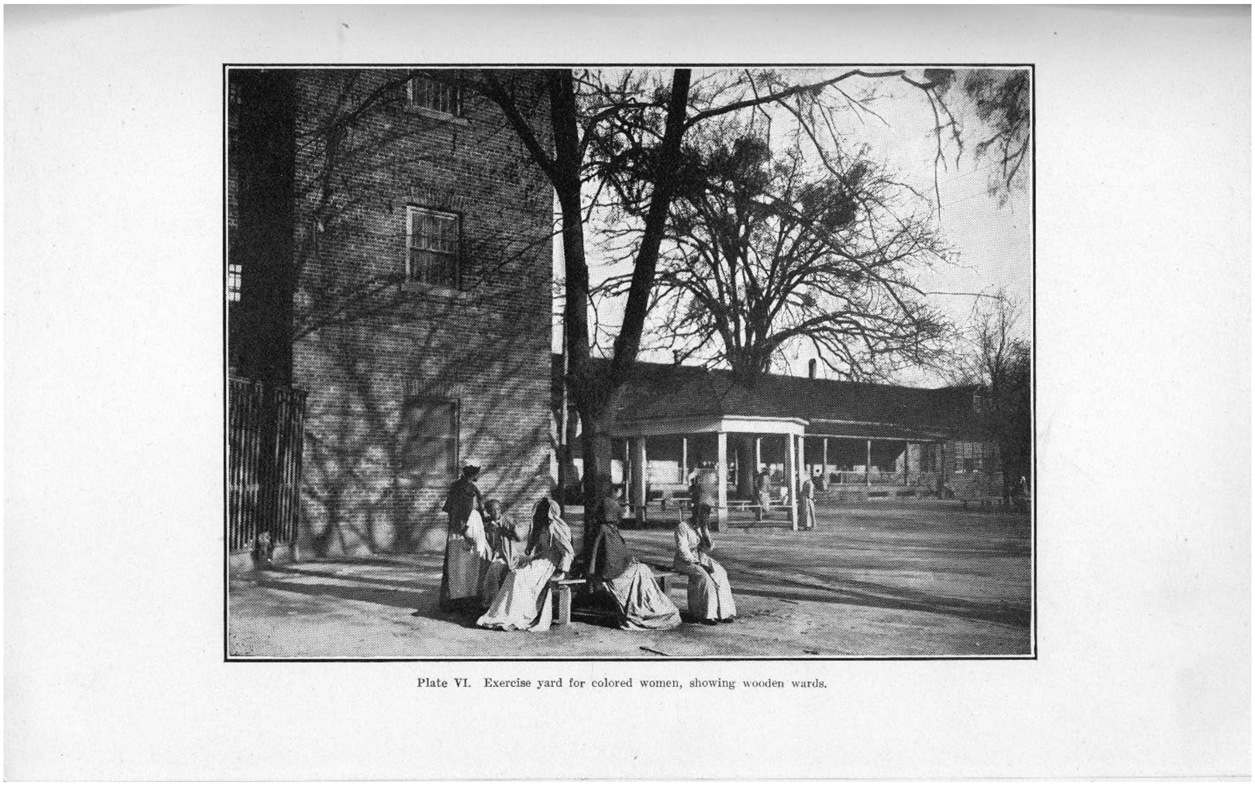


Plate VI. Exercise yard for colored women, showing wooden wards.

"Exercise yard for colored women" from Report of the Legislative Committee to Investigate the State Hospital for the Insane, 1910. *Image courtesy South Caroliniana Library, University of South Carolina, Columbia*

More often than not, a commitment was a request for support from relatives, or even local authorities. First-generation immigrants **Louisa and Angelina Burrel**, sisters previously living in poverty in Charleston, were admitted en masse alongside other pauper patients from the Charleston poorhouse in 1833; neither received an official diagnosis but remained at the institution until their deaths. In 1866, **Samuel Able**, “a boy some 10 or 11 years old,” was presented for admission. Physicians noted that “he was very troublesome to manage at home, and his father thought it best to bring him here.” Able’s father had just remarried and had a baby on the way. Perhaps he believed his three older children, including a similarly disabled sister, were enough to manage at home. Some individuals committed themselves, as **Joseph Smith** did in 1939. Often, these individuals were former patients who had since created lives that society deemed successful. Why they chose to return—the reason for re-commitment—went unrecorded.

Once committed by court order, the institution’s staff completed the intake, or admission, process. Physicians compiled a person’s basic information, including name, age, race, and diagnosis, into hospital logs and casebooks. Presentation of one’s diagnosis to physicians might occur weeks after arrival, as it did for ten-year-old epileptic **Albert McSwain**; disabilities, such as **Samuel Able’s** cleft palate that kept him from communicating upon his arrival, might not be noted in records until years later. Usually, case histories received no updates throughout a patient’s institutionalization.

After being assigned a patient number and “ward” in a hospital building, which were segregated along gender, race, and sometimes diagnosis, each man, woman, and child became another face in a system that would likely fail them.

MODERN VOICES: A NORMAL DAY

WORKERS IN THE LAUNDRY FACILITY, 1957. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

The following verbatim interviews bring together Mandy Halloran (MH) of Able South Carolina with former residents and staff of the institution who lived and worked there in the late 20th century. These are not just recollections, they are lived truths.

Through their voices, we gain an unfiltered look at daily life inside the institution: what it felt like to live there, to work there, and to navigate a system that shaped nearly every aspect of a person’s existence. Their stories move beyond records and reports, offering something rarely captured in history: the human experience behind the walls.

MARVIN MAY (MM)— SITTING, SMOKING & LISTENING

Listen to the conversation

MH: “What do you remember about when you first got there? Like the first day you got there?”

MM: “The staff was nice. The clients was nice. That's all I can remember.”

MH: “How did you feel going there for the first time?”

MM: “I didn't like it to go there, but I knew I had to.”

MH: “So, you didn't want to leave home and go to the hospital but you understood why you were going?”

MM: “Yes ma'am.”

MH: “Okay. All right. What was a normal day like for you at the hospital?”

MM: “Um, I actually, I actually, um, sat down most of the time, smoked cigarettes and listened to what staff had to say.”

MH: “Okay. So, you sat around, smoked cigarettes, and listened to the staff? Yeah. You remember doing anything else during the day?”

MM: “Um, not really.”

ALAN NEWMAN (AN) — A NORMAL DAY

Listen to the conversation

MH: “What was a normal day like for you at the hospital? Tell me about your day.”

AN: “The days were long, it seemed like. They had good food in the state hospital. I had cigarettes and they had a smoke room and that's where I spent most of my time in the smoke room. And I got into several fights in there too.”

MH: “Oh yeah? Tell me about the fights. Was that with other patients or with staff?”

AN: “Other patients.”

MH: “Okay, and what would usually cause a fight?”

AN: “I don't know. When you're grouped up together with a bunch of people, you find ones that you can't get along with. And that was mainly it. We just didn't get along good, and we got in a fight.”

MH: “Yeah, and was that like every time you went there or just in the beginning?”

AN: “Well, every time, not every time that I was there did I fight, but I got into lots of fights and 18 times I was there.”

KESHA JONES — SOME DAYS PLEASANT, SOME DAYS HARD

“Some days it was pleasant, some days it was hard, because I didn’t know what was going on with me at the time. I felt like I just was a loner, like nobody cared. And when the door shut, I got afraid. I wanted to get out of there. I wanted to go home. Then it was nice people that was there and some rough people. Some people would hit their heads on the wall and they would have these helmets on their head. It was kind of scary, and it was kind of fun at the time because I used to paint. They used to give us paint to paint with. I had my ups and my downs.”

KESHA JONES (KJ)— CLEANING BATHROOMS & MAKING A SPECIAL FRIEND

MH: “Did you ever get assigned any jobs or chores?”

KJ: “Yeah, cleaning the bathroom. I liked cleaning the bathroom. I like making things neat and clean.”

MH: “So you cleaned the bathroom. Did you do that often?”

KJ: “Yeah. Well, there is this girl I met. She would always be quiet but she talked to me. And we had similarities. She was Hispanic, I think. But anyway, she was very nice to everybody. I hated when she left.”

MH: “So, you had a close friend there. And I’m guessing there’s not been a way for y’all to stay in touch.”

KJ: “I haven’t seen her.”

MH: “Yeah. That’s special, though, that you had somebody you trusted there.”

KJ: “Yeah.”

DIANE BILLET (DB)— FREE TIME & BEST MEMORIES

Listen to the conversation

MH: “What is the best memory that you have from living there? Something that made you feel good or strong?”

DB: “Exercising and having free time to do what you want to do like ride a bike or go to the game room during free time and the therapies I had.”

MH: “During your free time, what did you do? Did you read books or play cards?”

DB: “I did go up to the library to read and then I did play cards and I did ride a bicycle.”

MH: “Oh, that’s nice. They had bicycles on the property for y’all?”

DB: “Yeah, riding around the property.”

FRANK ANDERSON (FA) — TEACHERS, PATIENTS & COMMUNITY

Listen to the conversation

FA: “I was always one of the teachers and patients. We always got an understanding, you know, with teachers and patients on Marion Street and Bull Street. And they liked me. They always gave me advice. You know, they always gave me advice because I didn't stay that long. I took the classes, I took the classes right, and um, they mostly gave me shots, pulled my teeth, and I ain't never got false teeth. But um, I pulled my teeth, they pulled my teeth, sometimes they gave me x-rays, a lot of x-rays.”

MH: “X-rays? Do you know why?”

FA: “Well, my back was kind of broke. But I never did get that crazy one back again. But after Bull Street, they said the place was going to close down. Had to get rid of the patients. Had to get rid of the students. It was going to close down. I didn't like it.”

MH: “You didn’t like it when it closed?”

FA: “No.”

MH: “What is the hardest or worst memory you have from that time? And you only have to share this if you feel okay talking about it.”

FA: “I didn't have no worst memory.”

JOY JAY, FORMER STAFF — MUSICAL CHAIRS & CIGARETTES AS PRIZES

“We did a lot of activities. We would have—the second day I was there—musical chairs for adults. How stupid was that? I mean, truly, it was. And a lady kept walking around and she thought she was a dog and she bit me on the ass. (Laughter) And we probably made folks smoke more than anything because if you wanted a little outside break, you had to be a smoker. And we handed out cigarettes for prizes or for rewards. I usually bought two or three cartons a week.”

A NURSE SPEAKS WITH PATIENTS PLAYING CARDS, 1960. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

SECTION 3: UNDER CARE — OR NOT

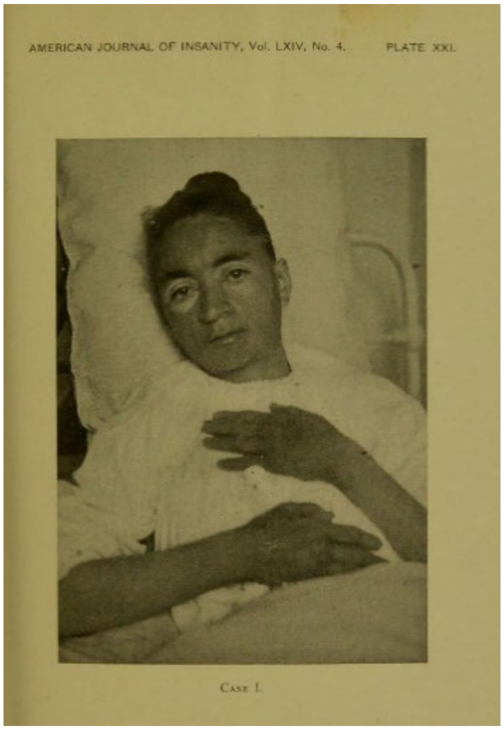
The gap between what institutions called “treatment” and what patients actually experienced was one of the most consistent features of the institution—across every era. Physicians who spent one hour a day on the grounds. Wards where the patients took care of each other because no one else would. Children who were restrained for decades. The words “care” and “treatment” recur throughout the institution’s records—but they rarely matched what the people inside described.

> **“My idea of a square deal to a patient in here is that everything possible should be done to hasten his recovery, and that every possible effort within reason should be made by those in charge to speed his discharge, and I don’t consider I got a square deal.”**
> **— Virgil C. Dibble, Jr., 1909**

DEFINING TREATMENT

Medical treatment at the institution was not compulsory—**Anthony**, an enslaved man, surely received none during his one-month admission in 1850. Physician bias and research interests usually impacted which medical treatments, or lack thereof, each patient received. This was likely the case for Dr. W.E. Fuller, who the General Assembly chastised in 1909 for only "spend[ing] one hour to four hours (more frequently one)" on the institution's grounds each day, and for not making the "specific examination" required upon commitment of the Black women under his care.

Noticeably ill patients might be given basic drugs, such as saline, and some doctors even took proactive action. This was repeatedly the case for Dr. Fuller's colleague, Dr. Eleanor Saunders, who cared for white female patients at the institution from 1907 until 1914. To the dismay of her male colleagues, she began performing the Wasserman reaction, which accurately diagnosed syphilis, and acquired and treated eligible patients from her wards with "606," the first known effective antibiotic treatment for the disease.



MOLLIE CHAMPION AS A PATIENT, 1907. *IMAGE COURTESY AMERICAN JOURNAL OF INSANITY*

Generally, physicians spent more time diagnosing patients than treating them. When **Mollie Champion** arrived in 1907, she caught the interest of Dr. James W. Babcock, who was developing a theory that pellagra was responsible for many deaths in the institution. Champion was already experiencing three of the progressive symptoms that would later define the disease—dermatitis, diarrhea, and dementia—and the fourth, death, would occur approximately ten weeks later.

Babcock included her case history, compiled by Dr. Saunders, in several medical articles. He became consumed with researching the disease, even leaving the institution to study abroad. In his absence, neglect thrived. As **Virgil Dibble, Jr.** noted when describing his room: "I know [killing bugs] is generally pretty hard, but my room had bug nests all over the walls, and I went to Mr. Mitchell to see if he had any whitewash, and he said there was nobody to do the work, that Dr. Babcock was in Europe, and he could not do anything." Dibble was adamant that, while not abused, "the only thing [the institution] did for me was restraint and baseball;" for Dibble, this was not treatment at all.

Although treatments evolved, the use of confinement and bodily restraints remained constant. In 1830, physicians confined **Harriet Gray**, a postpartum mother, in a dark room for an entire month until the isolation left her "mind less furious, or noisy—rather disposed to melancholy and silence." During her second commitment, Gray's hands were bound with a leather muff. In describing the care of Anthony in 1850, the institution's regents noted that "with Anthony it is impossible to give any liberty. It would be dangerous to leave him loose for a moment." One of less than thirty Black people admitted prior to the Civil War, Anthony died of "convulsions," segregated from the other patients. **Mary Hinson**, suffering from child loss and desperate to return home, was held frequently in restraints to prevent her creative attempts at escape, and in 1900 was "held by a muff restraint & kept in close confinement," even as she died of tuberculosis.

> **"You don't have any freedom. You have to live by the, your rights are limited. Anything can happen in a hospital. Someone can relapse and they did. People can get into fights. People can be sexually assaulted. People can steal from you. People can lie. It's not all hunky-dory and everything. It's not like prison, but it's something like it. It's not fun to be in a hospital. People come there to be treated... Every time you go to a mental hospital they put you in handcuffs. I've been in ten mental... I mean 11 hospitals and they always put you in handcuffs. And that's a true statement to everybody that goes to a mental hospital. They put you in handcuffs. The cops don't have mental health training on how to deal with a mental health patient."**
>
> **— Bryan Waymer, 2025**

Restraint was required in conjunction with later treatments as well. The institution introduced shock therapy in 1937 to treat patients diagnosed with dementia praecox (schizophrenia), depressive psychosis (major depression), and involution melancholia (gradual worsening depression among older adults). This therapy was initially drug-induced but later used electricity. All required patients to be physically restrained. **Mary Sandifer** received ninety-three electroshock treatments beginning in 1945, with the final one taking place the day prior to her release. Committed for being “very nervous, [and] very talkative,” Sandifer turned 18 while undergoing this treatment.

Patients did not choose the procedures they received or participate meaningfully in their treatment plan, or lack thereof. This final loss of agency was damaging to those who had already lost everything else.

FOURTH SECTION **The Columbia Record** FOURTH SECTION

Thursday, May 24, 1951, Columbia, S. C.

Shock Therapy For Mentally Ill Proves Effective And Painless

Often Described By Highly Exaggerated Tales Of Horror, Treatment Aids Patient Without Pain Or After Effects

By FELICIA SISK

Shock therapy, today's number one treatment for the mentally ill, is often described by highly exaggerated tales of horror that leap far beyond the bounds of truth.

Reactions resulting from shock have been compared with the fant[illegible] Frankenstein and Dr. Jeykll a[illegible] Mr. Hyde stories.

Doctors at the South Carolina State hospital believe that the over drawn picture of horror stems mostly to the patients, who, with their creative imaginations, have projected grotesque pictures of torture to other patients and relatives.

Yet, it has been established that there is absolutely no pain experienced by the patient during electroshock. This treatment is also amazingly free from after effects.

ECT (electoshock therapy) is said to be a safe method of treatment that is highly effective in depression and in other similar psychoses.

In order to get a more complete picture of the most widely used treatment for the mentally ill, I watched 40 patients receive electroshock therapy one morning at the State hospital.

The patients were brought in one by one, on wheeled litters. They were cheerfully greeted by the doctor in charge and usually returned the greeting.

Prior to the treatment, patients are given only milk to drink for breakfast.

Efficient Nurses

A crew of nurses, with efficient team work, prepared each patient for treatment. The case of a woman patient was typical. A salt solution was smeared on the patient's temples. Two electrodes were then held in place on her temples. A soft piece of rubber was used to prevent the patient from biting her tongue. In cases where the patient has false teeth, a soft sponge is used.

The swtich on the electroshock machine was then pushed and 100 volts of electricity passed directly through the patient's head. Two such charges are given each patient with a *maximum* length of four-tenths of a second each. The voltage and number of shocks given vary with the patient, the average voltage being 100.

The patient's body immediately went into convulsions. "She was out before she knew what happened," the doctor explained. Six trained attendants were used to care for the patient during the shock. They are taught to hold a patient's body in just the right manner during the convulsions so as not to allow him to injure himself.

The doctor in charge said that the convulsions, which last less than a minute, have nothing to do with the actual treatment, but are merely a sign that the current has reached the central part of the brain. The electricity passes directly from one side of the head to the other and does not enter the body.

Patient Awakes Confused

After shock the patient is usually awake in 30 minutes or less and in a confused state. Confusion after shock sometimes occurs, but usually does not last long. Patients are confused in that they forget little everyday things that they would normally remember.

The doctor in charge explained that patients might remember events leading up to the treatment but that they remember nothing about the treatment.

I talked with ten of the patients the day after I had seen them given shock. Though still a bit confused, they talked readily about the treatment. They were questioned one at a time. The general consensus of opinions was that none of them liked getting the treatment but they agreed that shock is doing them good. Some of the patients interviewed had been given shock therapy as many as 18 times. It is usually discontinued after 20 treatments spaced every other day.

It was once required of the hospitals that they get permission to give shock therapy from relatives. Today it is accepted as standard treatment and is given on advice of the staff physicians.

No Cause For Fear

I asked one patient who had expressed her fear of the treatment why she was afraid of it.

"I don't know, but I am afraid," she said.

"Afraid of what?" I questioned.

"I don't know."

"Did you feel any pain?"

'No," she replied, 'but I don't like it."

"Do you think it's doing you any good?"

She nodded. "Yes, I know it is."

Another patient who had tried to commit suicide several times had been given shock about 16 times.

Asked what she thought of shock, she answered, "I don't particularly like it."

"Why?" I questioned her.

"I just don't."

"Did it hurt you?"

"No."

'How much of the treatment do you remember?"

She failed to answer. "Do you remember the doctor telling you good morning?"

"Yes."

"Then what happened?"

"I don't remember," she said.

"Has shock treatment helped you?" I asked.

"I don't worry anymore," she said.

"Were you worried when you came here?"

"Yes."

"Do you remember what worried you?"

"Yes."

"Does it bother you now?"

"No, I don't worry anymore."

One patient stood firm in her statement that shock therapy had not helped her. She entered the hospital in a suicidal state of mind and was considered most destructive. Now, after many shock treatments, she helps on the wards and is considered a desirable "hospital citizen."

This patient "lacks insight" and does not realize that she has been sick. Unfortunately, in certain types of persons improvement is only temporary and treatment must be repeated.

Arguments Against Treatment

In spite of the fact that electroshock therapy is accepted today as the most effective physical agent in the successful treatment of the majority of the affective psychoses, there are still a few who argument against it.

Theoretical objections are so frequently and so violently voiced that ideological differences seem mainly to be the issue.

Psychiatrists agree that there is no adequate theory for electrocoma therapy, but they hasten to add that this is no argument against its application. They conclude that in most psychiatric conditions that the cause of the disease is not accurately known; therefore it cannot be expected that they understand the mechanism of the treatment.

Then the accusation that improvements from electrocoma therapy lead only to temporary improvements is voiced. It is answered simply, "No one objects to insulin treatment in diabetics on the ground that its effect only lasts for hours."

The utilization of this new approach has been responsible for tremendous changes in the ultimate outlook of the psychotic patient. To this patient, it is important in that he can finally place his mental condition in the same position as any other recognized physical illness.

He can now be treated actively and in a relatively short period recover sufficiently to return to his normal environment to carry on his work, without the former fear of stigmatization, and discriminatory legal and social restrictive procedures. In addition, he loses very little time from his work and is able to re-establish himself quickly in his former capacity.

Electroshock has opened an entirely new field to the doctor. It has given him the impetus of curative results instead of prolonged watchfulness with the futility and apathy incident to previous treatment.

Thus there is reawakened interest and study today in state and private institutions on individuals who had previously been classified as progressively deteriorating patients.

Perhaps the most prevalent objection to electroshock is due to the terror created in subjecting a man to high-tension currents. The spectre of the electric chair possibly induces much of the fear.

However, this fear is not valid for in the case of the electric chair 2,300 volts are employed and this high voltage is not only applied to the head but also to the bare skin of the arms and legs. Death here is actually due to the high voltage passing through the body, particularly the heart.

In contrast with this, the shock therapy has a particularly low voltage that passes only through the brain and does not endanger the heart. The current passing through the brain is so minute that it does not appear to damage the brain at all.

It is interesting to note that as far back as 43-48 A. D Largo wrote on therapeutics in which he told of the treatment of headaches by the use of a live torpedo-fish applied to the sufferer's head. The voltage of the discharge of the torpedo-fish is 25-30 volts according to zoologists.

Surprisingly little has been added to the knowledge of the electroshock therapy in the last few years. The standard technique, developed in 1936, is still the technique of choice in electroshock therapy.

The First Experiment

The first experiment with the electroshock machine is said to have been done by Ugo Cerletti. The account of the event follows and is almost identical with the procedure used today.

"A schizophrenic of about 40, whose condition was organically sound, was chosen for the first test. He expressed himself exclusively in an incomprehensive gibberish and since his arrival from Milam by train without a ticket, not a thing had been ascertainable about his identity.

"Preparations for the experiment were carried out in an atmosphere of fearful silence bordering on disapproval in the presence of various assistants belonging to the clinic and some outdoor doctors.

"As was our custom with dogs, Bini and I fixed two electrodes, well wetted in salt solution, by an elastic band to the patient's temples. As a precaution, for our first test, we used a reduced tension (70 volts) with a duration of 0.2 second.

"Upon closing the circuit, there was a sudden jump of the patient on his bed with a very short tensing of all his muscles; then he immediately collapsed on his bed without loss of consciousness. The patient presently started to sing at the top of his voice, then fell silent. It was evident from our long experience with dogs that the voltage had been held too low.

"I, bearing in mind the observation with repeated applications of the day before upon pigs, made arrangements for a repetition of the test. (Cerletti experimented with pigs at the Rome slaughterhouse where pigs were said to be killed by electricity. Actually they were knocked out by electricity and then bled to death. As the pigs were seized by the electric current "they fell on their sides and were soon taken by fits' (convulsed). Then the butcher, taking advantage of the unconscious state of the animals, gave their necks a deep slash, thus bleeding them to death.)

Nervous Onlookers

"Someone got nervous and suggested whisperingly that the subject be allowed to rest; others advised a new application to be put off to the morrow. Our patient sat quietly in bed, looking about him. Then, of a sudden, hearing the low-toned conversation around him, he exclaimed no longer in his incomprehensible jargon, but in so many clear words in a solemn tone, 'Not a second. Deadly.'"

"The situation was such, weighted as it was with responsibility, that this warning, explicit and unequivocal, shook the persons present to the extent that some began to insist upon suspension of the proceedings.

"Anxiety lest something that amounted to superstition should interfere with my decision urged me on to action I had the electrodes reapplied, and a 110-volt discharge was sent through for 0.5 second. The immediate, very brief cramping of all the muscles was again seen; after a slight pause, the most typical epileptic fit began to take place. Later, to the immense relief of all concerned, was witnessed a characteristic, gradual awakening 'by steps'. The patient sat up on his own accord, looked about him calmly with a vague smile, as though asking what was expected of him.

"I asked him: 'What has been happening to you?' "He answered, with no more gibberish: 'I don't know; perhaps I have been asleep.'"

This is how the first epileptic fit experimentally induced in man through the electric stimulus took place. The schizophrenic went on getting better rapidly. Having entirely abandoned his jargon, he was able to supply all the data for his identification.

ELECTRIC SHOCK therapy at South Carolina's State hospital is the number one treatment today for the mentally ill. C. C. Geiger, employe at the hospital, poses for a picture showing the patient's position in the shock therapy. Trained personnel is used to helping the doctor in charge during the treatment. The electric shock machine can be seen in the center of the picture. A nurse is shown holding the electrodes on Mr. Geiger's head. The soft material in his mouth is used to prevent the patient from biting his tongue. (Record photo—Price Studio.)

C. C. GEIGER, South Carolina State hospital employe, is shown posed in a close up demonstration showing where the electrodes are placed in electric shock therapy. Record photo—Price Studio.)

NEWSPAPER FROM *THE COLUMBIA RECORD* FEATURING HEADLINE STORY ON SHOCK THERAPY, 1951. *IMAGE COURTESY NEWSBANK.*

UNDER THEIR CARE

The amount of care shown by physicians, nurses, orderlies, and other staff was as varied as the individual themselves. As **Virgil Dibble, Jr.** noted in 1909, "Some of them [the nurses] were very objectionable. The others were considered pretty good fellows." Yet Dibble also recalled instances of violence, including when a fellow patient began speaking to someone invisible: "He didn't come willingly, started to resist. He was thrown down and choked into submission, although he didn't offer to do any violence that I saw to either of the nurses."

AN EMPTY BED AND SINK IN A PATIENT WARD,1957. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

Dibble's testimony before the General Assembly revealed other truths about the institution. As a white man with no physical disability, he felt he had been treated well overall. He lived on Ward 2, rather than Ward 5, where the "very weak and feeble-minded" were housed, or Wards 4 or 7, where attendants would strip incontinent patients naked and leave them unclean. Baths were given once a week, and often in the same tub of water. **Walter White**, blind and diagnosed with "idiocy," would have been among the individuals on one of these wards beginning in 1898. As Dibble recalled, "a great many of those could not take care of themselves." White, who had tried to kill himself because he felt he was a burden to his family, instead became one of many patients being cared for by other patients like Dibble, rather than the institution's staff.

The way physicians and nurses spoke about their patients also revealed prevailing attitudes about their patients. In 1878, **Lucy Brown**, a widowed Black woman, received an unkind nickname, "Rinktum," upon her admission. Dr. James W. Thompson later recalled: "The nurses continued to call the patient Rinktum, although the right name was entered on the books. Years after, a relative called to see [her], and as they were still calling her by the nickname, we could not give the relative any information about the patient he sought." Fortunately, her relative was able to identify her, and only then was the hospital able to put a face to her original admission record.

Other nicknames given to patients during the twentieth century included "Grease," a disabled white man with greater access needs, and "Dummy" or

"Monkey Head." The latter two monikers were given to Isiah Valentine in 1903 because the staff did not know his real name. Brought to the institution "about 12 or 14," Valentine was a young Black man who was deaf and mute. Rather than search for his relatives, physicians kept him confined to the campus for nearly seventeen years while using him as a type of errand boy.

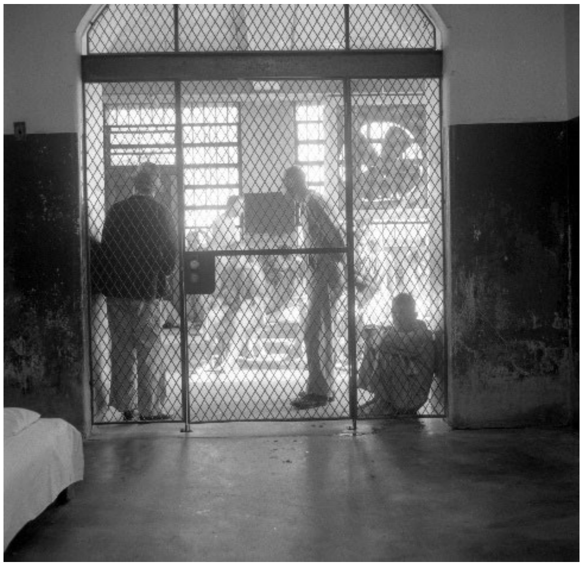
Some staff members did put their patients' care first. Dr. Sarah Allan, the institution's first female physician, recorded that "Mrs. Johnson [is] losing ground today. Not taking nourishment so well." Allan cared for **Elizabeth Johnson** each of her eleven days in the hospital, always granting her and other women the same honorific of "Mrs." in her physician's diary. As Dibble noted repeatedly in his testimony, the staff members who showed kindness were always noticed and appreciated by patients.

Explore A Five-Month Diary Kept By Sarah Campbell Allen, MD During 1900.

While serving as assistant physician of the hospital from 1895 until 1907, Campbell completed many of the patient case histories used in this history. The diary, written in cursive, is transcribed.

MODERN VOICES: HOW STAFF TREATED PATIENTS

The following interviews feature Mandy Halloran (MH) of Able SC and former residents and staff of the institution who lived there during the late 20th century. Their conversations explored their experience with staff treatment of patients.



Patients behind a gate in a ward, 1957. *Image courtesy The State Newspaper Photograph Collection, Richland Library*

BRYAN WAYMER (BW)— FEELING UNSAFE, SEEING & HEARING THINGS

🔊 Listen to the conversation

MH: “Did you feel unsafe?”

BW: “Yes, I did. Because it was my first time going to mental ward, I mean mental health hospital. And I felt unsafe because I didn't know what to expect. I expected, I was doing karate and stuff in there. And I think, I was thinking people were after me. I was seeing all these things in my head and my face and hearing the stuff. I was hearing stuff going on all in my head and trying to relate to people, saying I was schizophrenic and taking all these pills, having side effects, trying to and seeing demons and all this stuff. I was thinking it was the pills were trying to poison me, but Mom was a psychology major and she was a psychologist. She told me to keep taking the pills and get on the right track. But I never stopped taking the pills, but I went through so much.”

MH: “Yeah.”

BW: “And first taking the pills...The first time I got the pills from William S. Hall, they were terrible. The first pill I went on, the first shot I went on was Halidol. And it had a side effect on me. I took four cogentins and I was lethargic and slow. And it had an effect on me when I was disoriented and everything. I didn't like that.”

MH: “I bet, I bet. How did the staff treat you? Did they listen to you and respect you?”

BW: “No, they didn't.”

LESLIE DUKES (LD)— NO RIGHTS

MH: “What would you want people to know, especially leaders and lawmakers, what do you want them to understand about what it is like to live at the hospital versus what it's like to live out in the community?”

LD: “Your rights. Yeah, you had no rights being in the hospital. You didn’t have a choice. You didn’t have a choice of food. You didn’t have a choice of where you slept. You didn’t have a choice of where you were going or anywhere. It’s all that. It’s all your rights.

Now, some of the time, I didn’t want to take my medicine because it would make me not be able to sit still. They gave me a shot and put me in a seclusion room with a mattress on the floor and no sheets or anything. And to lay on the floor, and there was a window in that room.”

MH: “So how often did you have to go into seclusion?”

LD: “Not very often. More than once. Yeah. Yeah, more than once. I’m not going to lie about it.”

LESLIE DUKES (LD) — STAFF PICKING FAVORITES

MH: “How did the staff treat you?”

LD: “Well, they picked favorites for one thing. They picked favorites and I wasn’t a favorite, but when I did good and was quiet and tried to do what they tell me to do—I think they could put themselves in our place.”

JESSE BROWN (JD) — THE RUBBER ROOM

🔊 Listen to the conversation

MH: “Let's go back to when you were 27 and you first got there. What do you remember about your first days there?”

JB: “I mean, I really can't cause I was real psychotic. And I was hearing voices and hallucinating and all that. Until they finally found the medicine that worked for me.”

MH: “Okay.”

JB: “Sometimes they put me in the rubber room.”

MH: “Okay. What was the rubber room?”

JB: “It was I called the rubber room. It was a, it was an isolation like room. Like when you, like the ones that they are too, too psychotic, they will put you inside the rubber room. That's what I saw.”

MH: “How did you, how long did you have to stay in there?”

JB: “Just until the doctor gave me some kind of medicine.”

ALAN NEWMAN (AN) — SECLUSION

Listen to the conversation

MH: “Okay. How old were you when you first went to the state hospital?”

AN: “21.”

MH: “And did you live there only once or did you go back more than one time?”

AN: “I've been there 18 times.”

MH: “18 times. What's the longest you ever had to stay there?”

AN: “30 days.”

MH: “Okay. So, from the, um, let's see, what was your age again? I’m sorry.”

AN: “21.”

MH: “21. Okay. And then, uh, after 21, you went there 18 more times. Okay. Okay. What do you remember about your first days there? What was it like when you first walked in?”

AN: “The first time they locked me in seclusion and left me in there for a couple of days.”

MH: “Okay, what's seclusion like?”

AN: “Seclusion, it's kind of bad. I mean, you just lay there, and you want to be out in the halls with the people but when they put you in seclusion... The first time I went, is the only time they did that. But they put me in seclusion for a couple days.”

MH: “Do you know why you were put there?”

AN: “No.”

MH: “You don't know. Okay. Nobody ever explained that to you?”

AN: “No.”

> **“Now, some of the time, I didn't want to take my medicine because it would make me not be able to sit still. I didn't want to take it and I was angry. They gave me a shot and put me in a seclusion room with a mattress on the floor and no sheets or anything. And to lay on the floor, and there was a window in that room.”**
>
> **— Leslie Dukes, 2025**

KESHA JONES (KJ)— THE ISOLATION BOOTH

Listen to the conversation

MH: “And if you are willing, you don't have to, what's one of the harder or really bad memories you have from your time living at the asylum?”

KJ: “When you spazz out they put you in a room with the walls.”

MH: “So, it's called isolation?”

KJ: “Yeah, isolation booth. I don't know what they call it now.”

MH: “No, I don't know.”

KJ: “Yeah.”

MH: “So, did you have to do that often or?”

KJ: “Sometimes.”

MH: “Sometimes. How long would you have to stay in there?”

KJ: “Until you can control your temper.”

MH: “Okay. Yeah. Is that easy to do? Hard to do?”

KJ: “It was hard at first before I took my medicine or whatever.”

A common practice at the institution was patient isolation, also known as solitary confinement. It is still used today in psychiatric and correctional settings. Many facility leaders believed that isolating someone would calm them or increase compliance. In reality, isolation often heightens distress and anxiety. Courts have increasingly recognized these harms. As one federal judge stated, putting mentally ill prisoners in isolated confinement “is the mental equivalent of putting an asthmatic in a place with little air.”

> **“The memories just make me feel sad. The memories are sad or afraid. I remember I’d just have a meltdown. I didn’t have a meltdown that got me into isolation, I had a meltdown by being in isolation…I thought it was, but it ain't never make you feel better. It didn't make me feel better. It made me feel horrible.”**
>
> **— Jesse Brown, 2025**

JOY JAY — RUBBER ROOMS & SHOCK TREATMENT

“Williams was more short-term—if you could get okay and get on your medicine, you probably left within 21 days. If not, you went to Babcock, which really was a horror show as far as just the facility and the lack of staff. There were a lot of rubber rooms—rubber closets, really. And Babcock was where they also did shock therapy. Occasionally we would have to walk folks up for shock treatment. And I can remember carrying a clean Kotex so they could put it in their mouth.”

A note about electroconvulsive therapy (ECT): ECT is a treatment sometimes used for serious mental health problems like severe depression or bipolar disorder. It works by sending a small amount of electricity through the brain while the patient is put to sleep, causing a brief seizure. It can cause side effects like memory loss, confusion, or headache, and remains a controversial treatment.

BUILDING RESILIENCE

The institution required patients to attend daily “yard hours.” Secured within brick walls and racially separated by wooden fencing, they could walk or partake in some other form of exercise. Some plotted escape. Others adopted a task to occupy their time. **Elizabeth “Lizzie” Burns,** committed in 1850, took care of the yard chickens by creating roosts out of cracker jack boxes. She sold eggs for twenty-five cents per dozen to nurses on staff; by the time of her death in 1897, she had made $75. With no family, the funds went to purchase “pictures” for the wards.

Capable white men were often singled out for more professional tasks. Professor **Robert Manly**, who read multiple languages, translated medical articles for Dr. James W. Babcock beginning in 1906; by 1917, Manly also served as printer of all the institution’s materials. **Virgil Dibble, Jr.** served as the scorekeeper for the institution’s baseball team around 1919 and contributed articles about the games to the newspaper. Other activities included playing cards, attending weekly dances and religious sermons, and crafting.

Other patients, primarily Black men, were made to perform real labor. This included cooking in the mess hall and working on the institution’s farm. **Isiah Valentine** was regularly told to run errands for staff. When recalling the racial disparity, one physician noted that “the white males were somewhat handicapped in their work as it was not customary to have the white and colored males working together[,] and we did not have land enough to have the white males work on the farm, hence they were confined to work mostly in cleaning up the yards and moving trash from about the buildings.”

> **“I remember they were treated differently. Some white people were treated differently than Black people I think it was favorism [sic: favoritism]. They were treated like, how should I say, prejudicially wise. Some white people got more privileges than Black people... They got to stay up longer...And they got to do more things. They got on a higher level because they were writing a letter. And one boy in particular, he was allowed to leave off the campus...You see this one Black dude, he did something wrong. I don't remember what he did. They locked him up in an isolation unit. And they put him on, put chores on.”**
>
> **— Bryan Waymer, 2025**

When faced with inadequate funds to build wards for Black male patients, such as **Robert John Palmer**, the institution decided that the patients could do the work themselves. This scheme continued with the construction of the segregated State Park campus that began in 1911 and continued through the 1930s.

At various points in time, the institution relied on all physically non-disabled patients to perform tasks that were considered wage work. Working in facilities, including the bakery, laundry, mattress factory, farm, and dairy, kept patients busy. Although not strictly occupational therapy, physicians and administrators counted it as such while also factoring related profits into their annual reports. This mistreatment would continue for most of the institution’s history.

MODERN VOICES: STAFF WHO MADE A DIFFERENCE

The following interviews feature Mandy Halloran (MH) of Able SC and former residents and staff of the institution who lived there during the late 20th century. Their conversation explored their experience with staff treatment of patients.

JESSE BROWN — SPECIAL SMOKE BREAKS WITH STAFF

"Yeah, they did. Because I used to pull up with one particular female staff, and she would take me out to a special smoke break. Yeah, and we'd go there and we'd sit and she'd tell me about how she went this place and that place. I remember she said, "You want to talk to me? So talk." And then I actually got stage fright or something. When she said that all my thoughts went out my head."

JESSE BROWN (JB) — MENTAL HEALTH AIDS & CLIENTS KEEPING THINGS CALM

MH: "Do you feel like they listened to you and respected you?"

JB: "They treated me like one of them. The mental health aids."

MH: "Why do you think you were one of their favorites?"

JB: "Because I got the gift of gab. I would walk over and start talking to them. I'd talk to them sometimes the whole smoke break."

MH: "What about the people that you were in there with?"

JB: "There was a couple of them that were knuckleheads that wanted to fight, but there were other ones that wouldn't let nobody bully nobody."

MH: "So they kind of kept things calm?"

JB: "Yeah, the actual clients kept things calm."

> **"They were real racist... They were real racist. They were showing favoritism to white people. And black people, they were showing stigma to. They're looking at people's mental illnesses and judging them... They show more favoritism with people who had depression than schizophrenia. And they were judging people by their mental states."**
>
> **— Bryan Waymer, 2025**

MARGARET B. (MB) — STAFF OVERWORKED

🔊 Listen to the conversation

MH: “Was there ever a time… [when you went to administration to talk about overworked conditions at the institution]?”

MB: “Wait a minute, I did.”

MH: “Oh, okay. Tell me about that.”

MB: “I did. And I went to Dr. Bevilacqua and he did not know it was going on. It was the only time I ever went to him about a personal grievance that I had that was going on at mental health because I wasn't in that open niche, you know. And I had talked to some of them, but he didn't know. But the kitchen helped. They used to cook for all these facilities, and they would get there at six o'clock in the morning, and then they would stand out under the tree from about 8:30 to 10:30, and then they'd come in and do lunch, and then they'd go stand out under the tree and smoke and come back and fix supper, and they were paid for eight hours. And they were standing, they were there 12 hours. And most of them rode the buses and had such a hard time. And I went to Dr. Badvalaqua, and it took everything in me to do it, but I said, I don't know if you know that we are running a sweatshop at the Department of Mental Health in the kitchen. And nobody's telling you that, and I just wanted you to look into it. Yeah, so I did, you know.”

MH: “Yeah, I love that. I love that. Did he make changes?”

MB: “He did make some changes. That's great. Because these people should have been on shifts.”

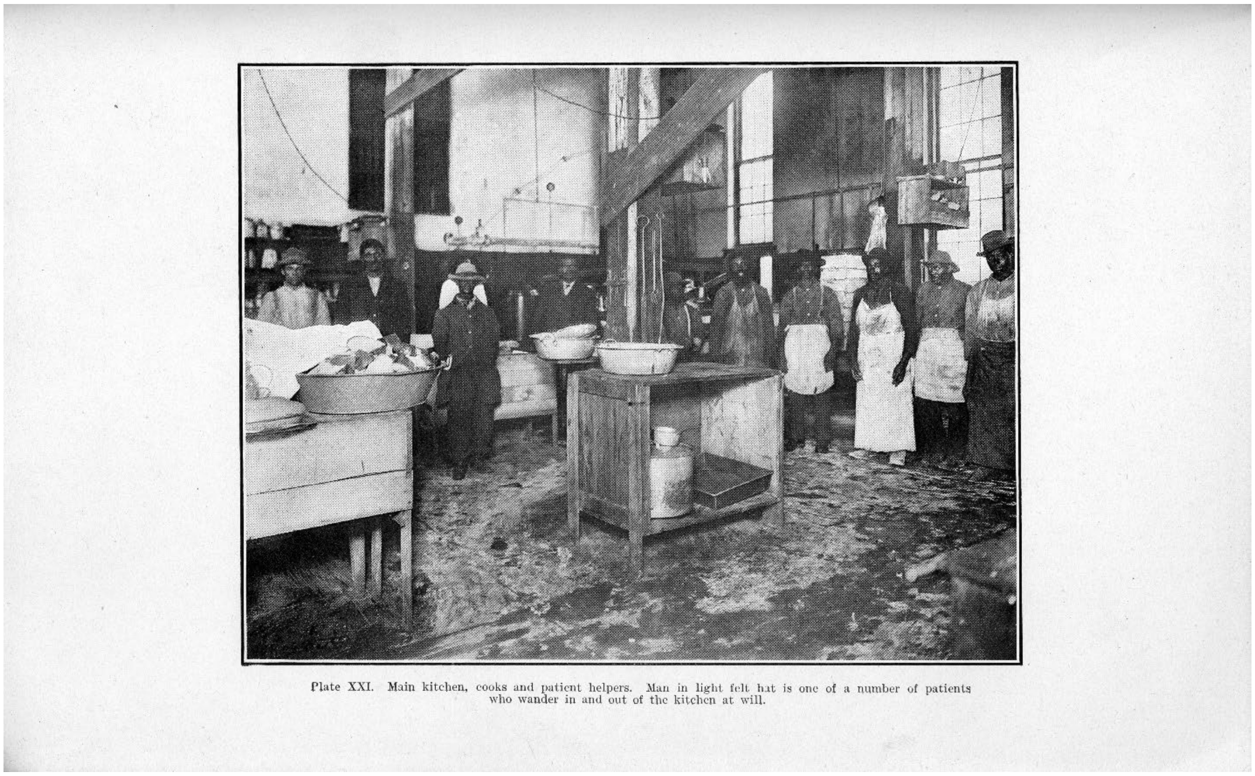


Plate XXI. Main kitchen, cooks and patient helpers. Man in light felt hat is one of a number of patients who wander in and out of the kitchen at will.

"Main kitchen, cooks and patient helpers" from Report of the Legislative Committee to Investigate the State Hospital for the Insane, 1909. *Image courtesy South Caroliniana Library, University of South Carolina, Columbia*

MARGARET B. (MB)— PATIENTS EATING NAKED & MAKING CHANGES

🔊 Listen to the conversation

MB: “Yeah, I mean, I think something that really stands out to me is a mental health specialist that came to me with tears. She'd been sent there because she'd been late three times, and she had no transportation, and she said to me, she said, ‘I powders my ladies and keeps them so nice, and that doesn't even count.’ And that has stuck with me for 30 years. You know, I said, these are the people that need help. It's not the big dogs here, you know. But there were a lot of dedicated people that worked with me.”

MH: “Yeah, yeah. You mentioned before we turned on the recorder that Dr. Bevilacqua came on board and made a lot of changes. What was that in response to? There were some disturbing things going on?”

MB: “Yes, he found that some of the population was being fed with no clothes on. They were absolutely naked and eating with their fingers.”

MH: “Do you know why?”

MB: “Well, it was because they threw food. And, you know, knives and forks could poke out eyes. And so they had to learn a different way to work with these patients.”

JOY JAY (JJ)— ACTIVITIES & LACK OF PREPARATION

🔊 Listen to the conversation

MH: “You mentioned your first days there getting bit. (*Laughter*) Do you remember anything else, like when you first got on campus, those first few days or weeks, what your impressions were out the gate?”

JJ: “I definitely was not prepared. I was not. I had done an internship at a place called Brewer's Porch, which was an adolescent unit in Tuscaloosa, in Alabama. And it was so horrible. I mean, it really was. And so I guess I was prepared for more violence. There was a lot of violence. And so, I was scared when I went in. I really was. And Marion, who's still my best friend, you know, is the one who really helped me. And she was like, you know, ‘These folks aren't violent.’ I mean, she bit me, but she really did think she was a dog.”

MH: “Yeah, she wasn't trying to be violent.”

JJ: “She wasn't trying to be violent. Yeah. So, yeah, I think it was just, you had a lot of lockdown then, a whole lot of lockdown. And it's still the same way at Bryan Hospital now. I mean, I think going into Bryan right now [in 2026] is scarier than any building I went to in at State.”

> **“One guy that really stood out for me, his name was George. He had been in, when I came in ‘78, he had been there since 1960. And he had a crippled arm and a crippled leg. The story they told, which could never be validated, was that he actually jumped off a roof in Greenville, where he grew up. And that's why they put him at State Hospital. George was one of the smartest guys I've ever come across. I mean, he read everything. So, George was always on my case list, because I would take him to the library first, get him books. Again, some of the stuff that we did seems so silly now.**

> **It's like, we played games and, we sang songs and— Very childlike.”**
>
> **— Joy Jay, 2025**

SECTION 4: WATCHED, DISPLAYED, FORGOTTEN

The institution on Bull Street was never invisible. The ten-foot wall surrounding the institution kept patients in—but it also made them an object of fascination for the city outside. Visitors strolled through the wards. State Fair booths displayed patient-made goods. Newspapers named the mentally ill in headlines. And the community learned to use “Bull Street” as a threat. The stigma that followed patients home was part of their institutionalization too.

A COMMUNITY ON DISPLAY

Governor Hollings visits patients at the State Hospital. The mental health patients are undergoing recreational therapy in Benet Auditorium, 1959. *Image courtesy The State Newspaper Photograph Collection, Richland Library*

The ten-foot-tall brick wall that surrounded the institution did not isolate patients from the outside community. In fact, the gates remained open to visitors regardless of whether they had relatives or friends in treatment. During her 1831 visit, tourist Anne Royale reflected that “from the top of the building, you have a perfect view of those unfortunates. I stood and looked at them sometime, they seemed to be very happy….” Similarly, in 1850, state representative Benjamin F. Perry, visiting with other legislators, “passed through all the buildings, saw all of the inmates & walked over the grounds & garden & green house, all of which are interesting.”

Perry also “saw old Mrs. Alston. [sic] She looked comfortable & happy. In one room a sitting room or parlor I saw fifteen or twenty women, all neatly dressed & well behaved. No one would have supposed that they were crazy." **Mary Allston** felt differently about her institutionalization. Despite paying for comforts such as her own room, private nurse, and special food, Allston told relatives that she would “now rather suffer the most excruciating death than be confined here.”

The institution found other ways of exhibiting its patients—and therefore its own benevolence—to the public. Each year during the State Fair, the institution became "the most sought after place in Columbia," with "a line of visitors [that] could be seen beyond Main Street on Monday afternoon…and continued until the gate was closed." Visitors were primarily relatives wanting to see family or speak to doctors, as was the case with **Lucy Brown's** relative, but anyone could visit and stare at patients taking exercise on the grounds.

The State Fair provided other avenues for curious onlookers. For several decades, the institution maintained a booth to showcase the wares created by patients under the guise of occupational therapy. In 1893, **Edward Spencer's** painting of the "Old Building" won a five-dollar prize; the institution's exhibit that year also featured various fancy sewing work and two taxidermy Ivory Bill woodpeckers mounted by a patient. According to one physician, "the contents of the booth were things made by the patients, naturally they were considered relics, and so many visitors wished to possess one or more." The money made at the fair returned to the institution's coffers. Patients were also granted free admittance each year, over time they began attending alongside the public.

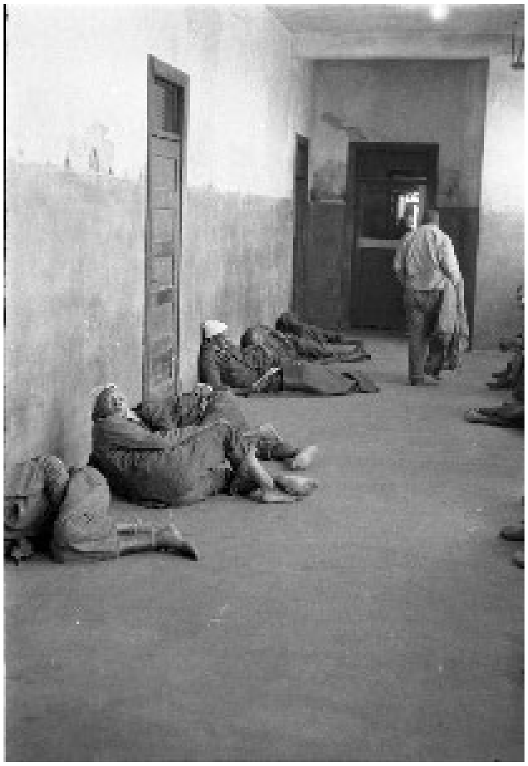
Staff acknowledged that outside visits became an opportunity for society to stare but failed to understand the harm this caused. The same physician also recalled, "The institution had a large wagonette, called the 'Asylum Lunaphone' which would hold 10 patients and two nurses. When the patients were out riding people would stop and gaze at the vehicle with a great deal of curiosity. The patients enjoyed the rides very much." Similarly, patients attended "parades of every kind." At these events, "those who had money were allowed to purchase fruit, peanuts, lemonade, cakes, etc." Of course many had no money to spend.

BEDS IN A PATIENT WARD, 1960. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

More intrusive and socially damaging were the public headlines identifying a person as insane. Such was the case with Rev. **McSwain and Belle Attaway**, a "sad story of [a] minister and his wife" who newspapers declared had been "driven insane by poverty" in 1893. Physicians disagreed, noting that the wife had been "rambling over country at night disturbing [the] neighborhood," and that her husband encouraged her behavior and "thinks God orders everything he does." In 1908, newspapers announced that successful tailor **Robert John Palmer** was "demented" and "pursued by hallucinations." An extremely wealthy Black man, Palmer's report to city police that he had been cheated out of some property may have had some basis in truth. Regardless, physicians diagnosed him with "acute melancholia" and kept him confined for more than a year. His business and health never fully recovered.

Isolation from society felt like a punishment for some, but a balm for others. Interactions with the community had the potential to be positive, but the "othering" of patients ultimately always intruded.

NEGLIGENCE IN MANY FORMS



PATIENTS LAYING ON THE FLOOR OF A WARD,1957. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

In his 1909 testimony before the General Assembly, **Virgil Dibble, Jr.** noted "they [the institution] surrounded me with unhealthy conditions and left me to struggle and get well the best way I could in spite of them." In addition to general disinterest from medical staff and a lack of therapeutic activities and treatments, patients faced constant overcrowding. This led to the transmission of communicable diseases like tuberculosis, which killed **Elizabeth Johnson** and contributed to **Edwin Syfan's** death following his release.

Some wards were more unhygienic than others, especially if their occupants could not clean and care for themselves. But even physically non-disabled individuals in "the best wards" endured bed bugs, lice, and parasites like roundworm, inadequate clothing and bedding, few opportunities to bathe, and violence by staff and other patients. Within the Parker Building, which housed **Robert John Palmer** in 1908, 236 Black men died during a five-year period "for the lack of proper care and a fit building to live in."

All the institution’s buildings, beyond being unsanitary and poorly ventilated, kept doors and windows locked and used an open-flame heating system that was a known fire risk. In 1909, the General Assembly concluded: “Not only does the State fail to provide proper or adequate treatment for insanity for the patients there held, but its custodianship is a menace to the health and life of these afflicted citizens.” This echoed concerns from physicians dating back decades.

In 1918, disaster finally struck: the East Pavillion, a one-story wooden structure housing the most vulnerable white male patients “of the idiot and imbecile class, and by those whose minds had so deteriorated as to be practically helpless,” caught fire in the middle of the night. Eighteen patients, ranging in age from eleven to seventy-two, died, among them **Albert McSwain**, a child suffering from epilepsy, and **Walter White**, who was blind. As it had in the past, and would again, inaction by the institution resulted in unnecessary deaths.

These deaths, like the thousands of others that occurred across two centuries, generated recommendations from physicians but little follow through. Surviving negligence sometimes came down to luck, although physical health, race, and an outside support system mattered, too.

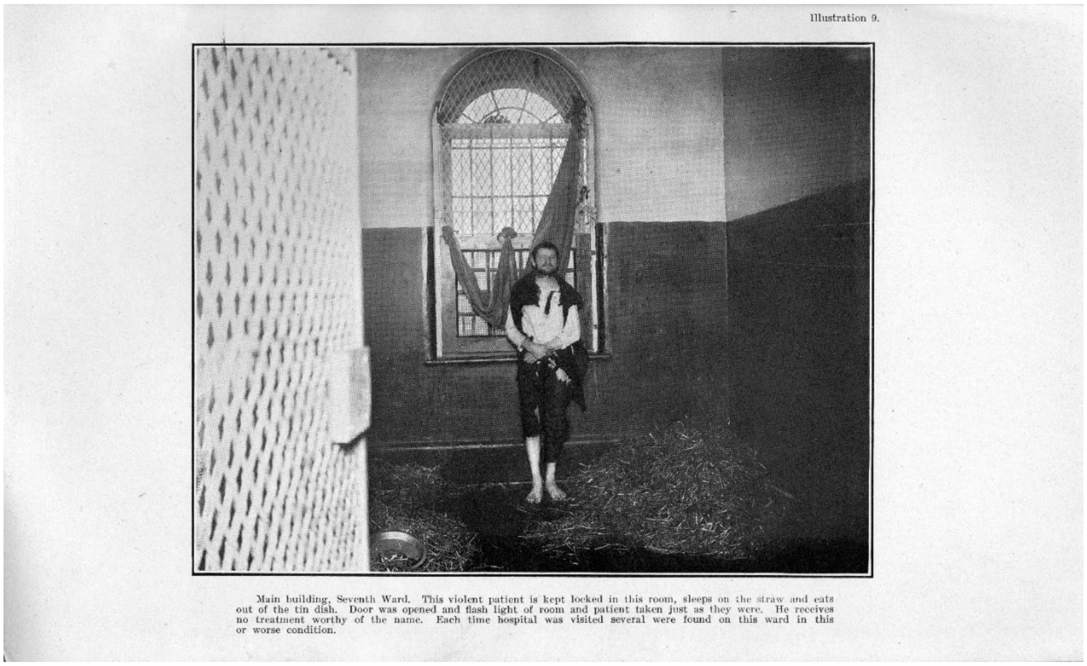


Illustration 9.

Main building, Seventh Ward. This violent patient is kept locked in this room, sleeps on the straw and eats out of the tin dish. Door was opened and flash light of room and patient taken just as they were. He receives no treatment worthy of the name. Each time hospital was visited several were found on this ward in this or worse condition.

"Main building, Seventh Ward" from Report of the Legislative Committee to Investigate the State Hospital for the Insane, 1910. *Image courtesy South Caroliniana Library, University of South Carolina, Columbia*.

MODERN VOICES: THE STIGMA OF BULL STREET

The following interviews feature Mandy Halloran (MH) of Able SC and former residents of the institution who lived there during the late 20th century. Their conversation explored their lived experiences with stigma towards patients.

JOHN HALLORAN — THE STIGMA OF BULL STREET

“Growing up in Columbia, there was a stigma associated with it. Older folks, especially people in my own family—even though there was an aunt, an uncle, and then later one of my close cousins who spent 35 or 40 years working in maintenance at the state hospital—there was a stigma about what the state hospital represented. And where I grew up, it was my major thoroughfare. I had to go right by there every day, wondering what was behind those walls.”

JOY JAY (JJ) — PEOPLE ARE JUST PEOPLE

MH: “Is there anything you think people in South Carolina should know about the time when the asylum was open?”

JJ: “I guess it’s just that mentally ill people are just people. And I think we really did a disservice by locking people away, having that big old gate, that just made it so scary. And then the fact that it was just called Bull Street. Getting sent to Bull Street. ‘If you don’t straighten up, I’m going to send you to Bull Street.’ I had an aunt who went to Bull Street several times. She would walk for days, just walk and talk to herself. I remember one time them coming to get her and putting her in a straitjacket on the front porch. And unfortunately, she hung herself in the upstairs at home. She was at home.”

BRYAN WAYMER (BW)— THE LEVEL SYSTEM & LONELINESS

🔊 Listen to the conversation

BW: “We used to do arts and crafts and watch other stuff, but there was a level system. And being in the ward by yourself makes you lonely, makes you feel unwanted. Instead, you had to be on a level system, level two, level three. You see everybody was on a level three or higher. I was at level one, so I had to stay on the ward and had to be by myself and stay there while they do extracurricular things and have to earn my way to get up there and I felt lonely and tiresome. When everybody comes back, they're laughing and giggling around. I want to know how to get off the ward. It's boring up there. It's tiresome. It's troubling. Because I want to get off the ward, too. Staying on the ward, it bothers me.”

ALAN NEWMAN (AN) — VISITATIONS & GIRLFRIENDS BRINGING CIGARETTES

Listen to the conversation

MH: “What is the best memory, something good that you have from living there, something that made you feel good or strong?”

AN: “My visitations.”

MH: “Visitation, so family and friends would come see you?”

AN: “Yeah.”

MH: “What would y’all do during a visit? Was it just a plain room or did y’all go outside?”

AN: “Most of the time they came to bring me cigarettes.”

MH: “Okay, your visitors did?”

AN: “Yeah, and I had several girlfriends in that time and they would come and visit me and stay all that they possibly could.”

BRYAN WAYMER (BW) — HOOKING UP & GOOD FOOD

Listen to the conversation

BW: “It was my first time coming because that's what made me feel unsafe. The staff made me unsafe. I panicked. It's my first time so normally I would feel unsafe. It was the staff that made me feel scared and they had a system where you had to go from level one, level two, level three, level four. You had to write letters to go out. Level four, you had to write letters to go to level four, one, four, two, or four C, or whatever it was. And when I first got there and went to groups, I was all alone and that made me feel like they left me out. I felt alone. That made me feel sick.”

MH: “I bet. Okay, what is the best memory you have from living there? Something that made you feel good or strong?”

BW: “The best memory now is when I was hooking up with the girl.”

MH: “(*Laughter*) Okay, I love it.”

BW: “And going out to groups. After I went to level three, I could get off the campus and they had good food too.”

MH: “Did they?”

BW: “Yeah.”

MH: “Say more about the food.”

BW: “The food was good.”

SECTION 5: THE FIGHT TO GET OUT

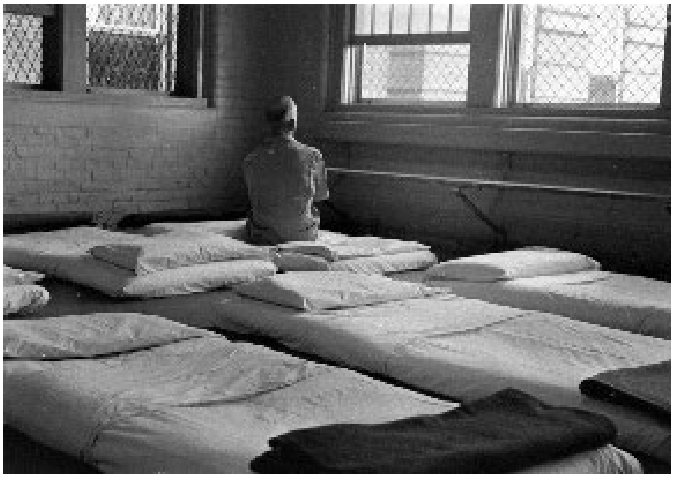
Leaving the institution was rarely an act of freedom; it was a battle, a waiting game, or a door that never opened at all. Some patients spent years pleading for a doctor’s approval that might never come. Some fought through the courts. Some risked everything to escape—only to be dragged back behind the same walls. And some never left at all, their lives ending in the very place that had taken them.

For those who did make it out, freedom was not a clean break—it was a fragile, uncertain beginning in a world that had already decided who they were. They stepped into communities that remembered their label more than their humanity, forced to rebuild lives from the fragments institutionalization left behind.

That struggle, the ache for dignity, for autonomy, for belonging threads through time, binding **Jane Moody** in 1884 to **Alan Newman** in the 1990s.

> **“I would hear about people actually escaping… because one of my cousins who is probably in his mid to latter sixties when he was working in maintenance, said they had to actually chase some people down… but of course during that era, it wasn't really reported on the news.**
>
> **…Unless you had somebody housed there as a loved one, or you had someone who worked there, you didn't really know. The inner workings of what, what was really going on behind closed doors, it seemed like. So it was mysterious, very mysterious, very desolate, very isolated almost, even though it's right in downtown Columbia.”**
>
> **John Halloran, 2025**

LONGING FOR AND OBTAINING FREEDOM



PATIENT ALONE ON A BED IN A WARD,1957. *IMAGE COURTESY THE STATE NEWSPAPER PHOTOGRAPH COLLECTION, RICHLAND LIBRARY*

"I have not herd [sic] from any of you this year what has become of you all or have you forgotten me….I want to know for certin [sic] if I have to make this my home…it is very hard for me to give up every thing…it is hard for you to keep me in this place so long why will you all not let me come back home."

When **Jane Moody** wrote these words to her brother in 1884, she was one year into her institutionalization. She clearly wondered if doctors would ever decide to release her. Moody was not alone in desiring freedom. **Edwin Syfan**, despite suffering from bowel incontinence, dedicated himself to securing his release in 1908. He recalled "I went to the steam laundry and worked like a man, and showed them that I was sufficiently able to make my living, and I went on the farm and I took the lead row there." Syfan eventually had to hire an attorney to secure his release, as his wife and brothers would not answer his letters or come to visit. His testimony noted that it was common for patients to "walk after the doctor….and curse him" for not granting their release. Having an outside advocate was often the only path to freedom.

Other patients chose to escape, and if caught and returned, to escape again. Isiah Valentine, known as "Dummy" by the institution's staff, escaped at least three times in 1919 and 1920. His final elopement drew the attention of his father, who secured his release the same month. **Carrie Taylor**, a transient farm hand, escaped twice in 1915; the second time she was not returned. One of **Mary Hinson's** escape attempts was almost successful. She and another patient followed the railroad track to the town of Killian, more than ten miles outside of town. Hinson shared with physicians that she "intended to pick cotton & make money enough to get home" and would "try to escape again at the first opportunity." As she neared the end of her life, sick with tuberculosis, Hinson did not stop trying. In 1900, she was found hanging out a third-story window from a bedsheet; she only halted her descent when she realized the sheet would not hold her weight. Her physician noted that she “was always in mysterious possession of an implement to cut belts or escape, had hollowed out of the wall a place for spoon handle and plastered up the handle with paper, bread crumbs & water, rubbing coffee for discoloration. The wall being flakey & many colors, we were completely deceived.” Despite her ingenuity and ironclad will, Hinson died while still institutionalized. So too did “mischievous” **Samuel Able**, who physicians later nicknamed “Sammy.” He ultimately grew up in, and later died at, the institution.

Patients who were released, or retrieved by relatives, sometimes returned and remained for the rest of their lives. This was the case for the still-grieving widower **Edward Spencer**, family man and hospital worker **Arthur Smith**, and even accomplished man-about-town, **Virgil Dibble, Jr.**, who remade his life several times over. Others, like eighteen-year-old **Mary Sandifer**, gave every outward appearance of having moved on permanently from their institutionalization.

UNMARKED GRAVES

Death did not discriminate inside the institution—if a patient did not escape or was not released, they died during their commitment. Patients of all races, ages, and social classes died from communicable and hereditary diseases and all forms of neglect. In 1832, wealthy planter **John Mathewes Flud** “had struck his eye against the Iron bannisters on the back steps one or two days before,” but received no care until he began bleeding an hour before his death. However, the epitaph upon his elaborate tombstone, which survives today, named his as a “Tender Husband and kind Parent, a dutiful son and sympathizing friend possessing the love and esteem of most who knew him,” who ultimately suffered “under great bodily disease” from “a series of afflictions seldom occurring in the same mortal." Similarly, **Edwin Syfan's** brothers, who cared for him from his release in 1908 until his death four years later, remembered him lovingly in a subsequent obituary: “He was gentle and unassuming, with a quiet and easy manner that brought around him scores of friends. He was self-sacrificing and always ready to lay aside his own pleasure and comfort for that of his friends. As a friend and companion, he was genial, big-hearted kind and true.”Flud, and other patients who could afford burials, often left a physical legacy divorced from their institutionalization.

But for more than 9,000 people buried in the institution’s cemeteries, there was no sacred ground. Internments initially took place in one of Columbia’s potter’s fields, both of which are now desecrated. Beginning in 1856, white patients were buried in “Square 41” of Elmwood Cemetery. This is where mother and son **Sarah and Johnathan Newton, Lizzie Burns, Elizabeth Johnson, Mary Hinson, and Mollie Champion** were laid to rest. Unfortunately, the 1909 legislative investigation found that the institution had desecrated these graves as well, through a reburial scheme:

> “When the space for burial in this lot was exhausted, the contractors were ordered by the Hospital authorities to bury between the graves, thus going over the lot a second time. The space thus indicated was found too small, the graves on either side being dug into. Finally, these grave diggers simply dug down into the old grave instead of digging between the two, the remains of the person previously buried were thrown out and another body buried in the same grave.”

This reburying of bones occurred until about 1908, when outrage from deceased patient’s families halted the practice. The institution next interred white patients “in a corner of one of the lots in which the Hospital’s hogs are kept,” just north of the Confederate Soldier’s Home on Bull Street. Today known as Geiger Avenue Cemetery, many of its graves are also unmarked, despite records that indicate that McCormick Funeral Home buried more than 1,400 individuals here from 1909 until at least 1959 and gave many small slate markers. Among them are all eighteen victims of the 1918 fire, including **Albert McSwain and Walter White.**

Until 1908, Black patients continued to be buried at the potter’s field adjacent to the Congaree River, or at “Square 80,” an inferior lot in Elmwood Cemetery located far from the entrance. The institution next used the far eastern corner of its property that abutted the Booker Washington Heights neighborhood. Referred to as “Farm Cemetery,” “Negro Cemetery,” and later Slighs Avenue Cemetery, this burial ground contained mostly unmarked graves. Although Black patients were relocated to the State Park facility beginning in 1911, Slighs Cemetery remained in use. It was leased to a golf driving range in 1963 and has since been erased by the construction of the James E. Clyburn Golf Center.

For many patients, death and an unmarked grave became their legacy. The few records that survived thanks to dedicated archivists ensure some small record of their lives survives.

Illustration 3.

Burial ground for white patients. New graves are seen along wire fence. No care is taken of this ground. The lot has been used for burial for eighteen months, and at present and for five years as a hog lot. Hogs were in the enclosure when this picture was taken.

“Burial ground white patients” from Report of the Legislative Committee to Investigate the State Hospital for the Insane, 1910. *Image courtesy South Caroliniana Library, University of South Carolina, Columbia*

An index of nearly 9,000 people interred by the hospital:

Identifies names, race, burial location, and date and cause of death. Note that there may be slight discrepancies between this transcription and the original records.

MODERN VOICES: DEPARTURE AND FREEDOM

The following interviews feature Mandy Halloran (MH) of Able SC and former residents of the institution who lived there during the late 20th century. Their conversation explored their feelings about departure from the institution.

Alan Newman (AN)— Free at Last

MH: “Do you remember feeling better or worse when you got released?”

AN: “When I get released, oh I was happy to get out. Back into the good life.”

MH: “You said you were always happy the days that you left the asylum. It felt good to get out?”

AN: “Oh, yeah. Yeah. Free at last.”

MH: “Now that you live out in the community instead of the asylum, how does that feel?”

AN: “Wonderful.”

DIANE BILLET (DB)— GOING HOME

MH: “What did you like about home versus the hospital?”

DB: “I could express my feelings better at home and do more of what I wanted to do than what the doctor wanted me to do. And I did conform to that and got better and got released.”

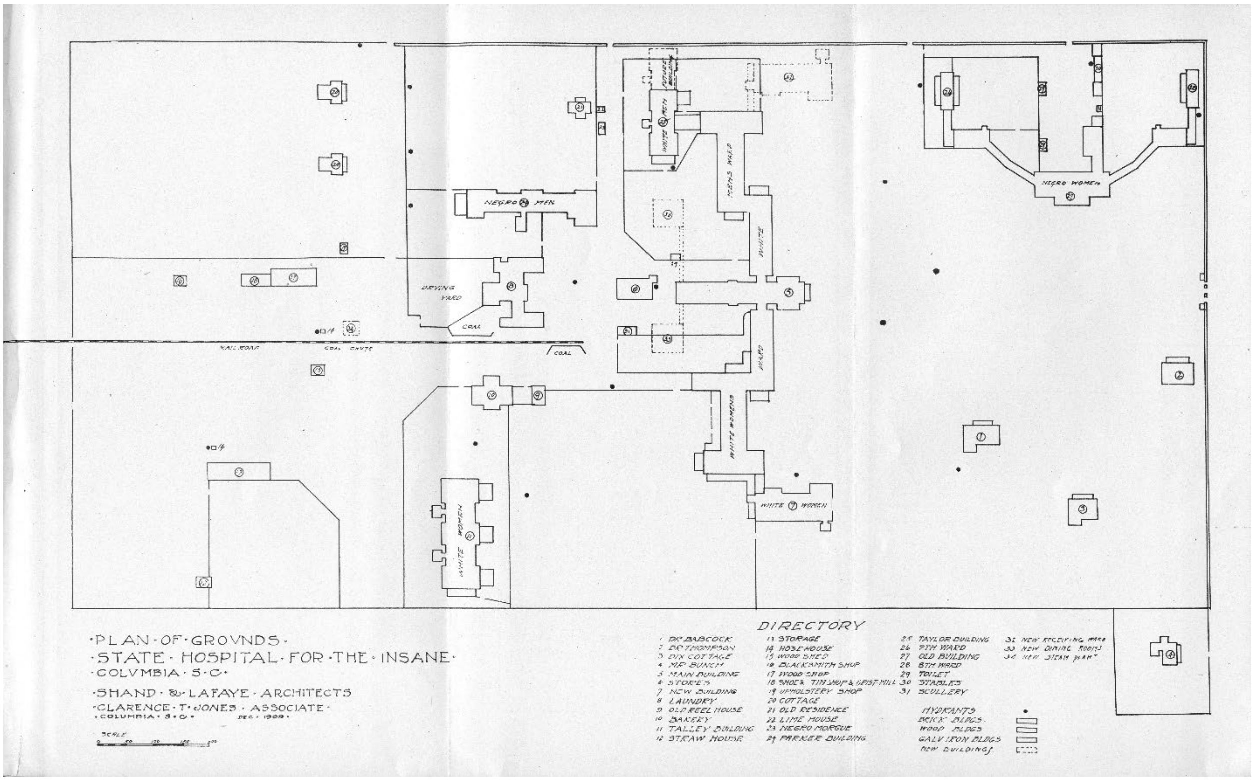
JOHN HALLORAN — ESCAPES & MYSTERY

“I can’t recall people escaping to the state hospital, but I guess it did occur. One of my cousins who was working in maintenance said they had to actually chase some people down. But during that era, it wasn’t really reported on the news. Unless you had somebody housed there as a loved one, or you had someone who worked there, you didn’t really know the inner workings of what was really going on behind closed doors.”

> **“It was not uncommon in this era to make four or five trips in one day, just picking people up who had died there.”**
>
> **— John Halloran, 2025**

JOHN HALLORAN — THE MORGUE

“We would go to the admin building, sign out, get a transit permit, then go down to the morgue—a brick building with a loading dock. There were between 24 and 32 drawers. You’d open a drawer, pull out a stainless steel tray, and foot first would be the decedent. They always wore a toe tag. It was not uncommon in this era to make four or five trips in one day, just picking people up who had died there. For those with no family to claim them, they were held sometimes 30, 60, to 90 days. Then transferred to a burial site in Upper Richland County on a quarterly basis.”



MAP OF THE STATE HOSPITAL FROM REPORT OF THE LEGISLATIVE COMMITTEE TO INVESTIGATE THE STATE HOSPITAL FOR THE INSANE, 1910. *IMAGE COURTESY SOUTH CAROLINIANA LIBRARY, UNIVERSITY OF SOUTH CAROLINA, COLUMBIA*

THE PATIENTS LEAVE FOR GOOD, DEINSTITUTIONALIZATION

Deinstitutionalization at the South Carolina State Hospital did not happen in isolation, it was part of a hard-fought, national civil rights movement led by people with disabilities and their allies, demanding an end to segregation, abuse, and lives hidden behind locked doors. Beginning in the mid-1950s, the introduction of antipsychotic medications like Thorazine created the first real possibility that people could live beyond institutional walls, but it was advocacy, not medicine alone, that pushed those doors open. Federal action followed the voices of those demanding change, including the Community Mental Health Centers Act of 1963, which promised a future rooted in community, not confinement. South Carolina mirrored this shift by establishing the Department of Mental Health in 1964 and opening the Columbia Area Mental Health Center in 1967, the first in the Southeast, yet even then there were warnings: releasing people without real community supports would simply trade one form of harm for another. The lack of community support is common even today.

By the 1970s, the country could no longer look away. Survivors, families, journalists, and advocates exposed the truth of institutional life. In 1972, the horrors of Willowbrook State School were broadcast into living rooms across America, igniting outrage and fueling a growing disability rights movement that declared these conditions not just unacceptable, but unlawful. That same wave reached South Carolina. A 1976 investigative series by *The State* revealed abuses at the institution, and by 1978, the state was forced to publicly confront patient rights. The passage of the Civil Rights of Institutionalized Persons Act (CRIPA) in 1980 gave the federal government authority to investigate and in 1983, that authority was used to intervene at the South Carolina State Hospital. This was not a quiet policy shift; it was the result of relentless pressure, of people refusing to accept that institutionalization was care.

Through the 1980s and 1990s, the hospital’s population declined as more people were moved into community settings, but the promise of community living was never fully realized. Advocates had always been clear: freedom without support is not freedom at all. And yet as people were discharged, the systems meant to support them lagged behind—underfunded, fragmented, and inconsistent. By 1993, many former residents had been dispersed into residential programs across South Carolina, and in 2005, the hospital finally closed its doors.

But closure was never the end of the story. The movement that led to deinstitutionalization was rooted in dignity, autonomy, and the right to live fully in the community, not merely exist outside of institutions. Decades later, that promise remains unfulfilled. Community supports are still too often inadequate, leaving people with psychiatric disabilities navigating systems that fail to meet their needs. The walls of the institution may be gone, but the fight that closed them, the fight for real inclusion, real investment, and real justice—continues.

> **“It's not the way to go because you ain't gonna help nobody. All you're gonna do is isolate people. They're going to get scared and frightened. They're going to be like, “Why we need to go somewhere that's not loving, that's not pleasant or positive.” You need to be in a positive place where you can share and you can care for the needs of others like they care for you. Some people care, some people don't.”**
>
> **— Kesha Jones, 2025**

SECTION 6: WHAT SHOULD NEVER COME BACK

The narrators in this project were asked a direct, urgent question: *What do you think about bringing back institutions like Bull Street?* Their answers came without hesitation—and without doubt. Institutionalization did not heal them. It did not protect them. It confined them. It warehoused them. It stripped them of choice, connection, and identity, reducing their humanity to something conditional—something that could be ignored, managed, or erased.

What they endured was not care. It was control.

And what they know through lived experience, not theory, is that the path forward cannot lead back to locked doors and forgotten lives. It must lead toward community. Toward peer support. Toward dignity. Toward a world where disabled people are not hidden away, but seen, heard, and valued as whole human beings.

> **"It felt like I was in a prison."**
>
> **— Bryan Waymer, 2025**

MODERN VOICES: REFLECTIONS

The following interviews feature Mandy Halloran (MH) of Able SC alongside former residents of the institution who lived there during the late 20th century. Together, they speak not only about what life inside the institution was like, but about why we must never go back.

KESHA JONES (KJ) — WE FIT IN TOO

MH: "What if they came back and said, we're putting you folks with mental illness back in these facilities?"

KJ: "I don't think that's right. Because everybody has a big struggle of who they are as a person. And they're fighting to live a life that's normal to other people like everybody else."

MH: "Yeah, yeah."

KJ: "Because we fit in too. Just because you have a mental illness doesn't mean that you're that person that they think is cuckoo, crazy. We have feelings too."

MH: "How would you approach that instead of institutions?"

KJ: “I think that you have more clubhouses where we go get our medicine, where we learn about everyday life and how it teaches you how to be an individual that can help others come out whatever they’re going through. Peer support. Stuff like that.”

MH: “Why do you think bringing back big institutions is not the way to go?”

KJ: “It’s not the way to go because you ain’t gonna help nobody. All you’re gonna do is isolate people. They’re going to get scared and frightened. You need to be in a positive place where you can share and you can care for the needs of others like they care for you.”

BRYAN WAYMER (BW) — IT FELT LIKE PRISON

Listen to the conversation

BW: “It felt like I was in a prison.”

MH: “Uh-huh.”

BW: “We couldn't do what we wanted to do. We had to listen to what they had to say. We had one tight ship. We had people watch us while we were sleeping. In all my mental health hospitals only hall was watching people, was watching us when we were sleeping. 24 hours, I mean 12 hours at night. When we were going to sleep. They used to watch us during the day. We didn't have total freedom. We used to take our pills. Everybody used to take the pills at a certain time. Instead of... We ate lunch at a certain time. Instead of when we would get hungry.”

JESSE BROWN (JB)— WAREHOUSING PEOPLE

MH: “You weren’t challenged?”

JB: “At all. We felt like we was outside society while we was there.”

MH: “Tell me more about that.”

JB: “Sometimes when we went for a walk, we could see cars passing by and all that. It felt like we was in prison.”

MH: “How is prison better than Bull Street?”

JB: “Prison had more social interaction. Prison had work release programs. But people on Bull Street didn’t have the opportunity to engage. It’s like warehousing people, just warehousing people and leaving them there. And then hopefully society forgets about them. But society can't forget about them. Because mental illness is a definite force in the world."

> **"I mean, I think going into Bryan [Hospital] right now [in 2025] is scarier than any building I went to in at State."**
>
> **— Joy Jay, 2025**

CLOSING STATEMENT: PEOPLE, NOT PATIENTS

This project began with a simple but powerful belief: that the people who lived and worked inside these walls deserved to be seen, heard, and remembered as full human beings, not as diagnoses, not as case numbers, and never as curiosities hidden behind a ten-foot wall. Bull Street does not need to erase or soften this history to move forward; it must honor it fully and truthfully, by recognizing the lives of the people who were confined there and ensuring their experiences are never forgotten or repeated.

What we uncovered is not easy to accept. This history is marked by confinement, neglect, ableist mindsets, racial injustice, and the systematic stripping away of choice, voice, and dignity from people who had no say in what happened to them. It is a history shaped by silence where lives were controlled, stories were erased, and humanity was too often overlooked. And yet even in that silence, people resisted. **Lizzie Burns** sold eggs to bring beauty into the wards. **Mary Hinson** climbed out of a third-story window on a bedsheet, determined to find her way home. These are not just stories. They are acts of defiance, reminders that even in the most restrictive environments, the human spirit refuses to disappear.

Many of the people who lived here left behind little documentation and even less control over how their stories would be told. We have done our best to honor them, not as subjects of history, but as people who deserved more than what they were given. What makes this project different, and what we hope stays with you, is that these are not only stories from the past, they are voices that are still with us. **Kesha, Jesse, Leslie, Diane, Alan, Marvin, Bryan, Frank, Joy, Margaret, and John** trusted us with their truth. They shared what it meant to live inside those walls, not as distant history, but as lived experience. Some memories made them laugh, others were difficult to say out loud, but every story shared was an act of courage and trust. To each of them: thank you. You are the heart of this work.

And this is where the story turns back to us, because the institution on Bull Street is not just history—it is a warning. There are still voices today calling for a return to institutions, for segregated settings repackaged as "care," and solutions that separate rather than support. We must be clear: we have already seen where that road leads. We have walked those halls, and we have listened to the people who survived them. Segregation is not safety. Isolation is not care. And institutions—no matter how they are renamed or redesigned—are not the answer.

At Able South Carolina, we are part of a national movement grounded in one unshakable truth: that people with disabilities belong in their communities—with choice, dignity, and the full right to direct their own lives. This work is not finished. It lives in the policies we fight for, the systems we challenge, and the spaces we build where disabled people lead, belong, and thrive. We ask you not to let this history sit quietly on these pages. Carry it with you. Talk about it. Challenge the narratives that romanticize the past or minimize its harm. Stand with us to ensure that what happened here is never repeated, not in new forms, not under new names, not ever again.

We are deeply grateful to our partners—South Carolina Humanities, Historic Columbia, Mental Health America of South Carolina, Bridges Clubhouse, and the University Libraries at the University of South Carolina—whose commitment, expertise, and care made this work possible. Because of them, stories that were nearly lost are now part of our collective memory. And memory matters, because remembering is how we protect the future. We have been vigilant. We are vigilant. Together we will stay vigilant.

— Able South Carolina

APPENDIX: HISTORICAL BIOGRAPHIES

The following biographies document individuals whose lives intersected with the institution throughout its history. Their stories are drawn from institutional records, legislative testimony, and archival sources.

HISTORICAL BIOGRAPHIES

SAMUEL ABLE, COMMITTED: MARCH 1866 – FEBRUARY 7, 1886 (HIS DEATH).

Committed around “10 or 11 years old” by his father, he was “a stout, active boy,” with a malformation of the mouth that prevented him from communicating. Physicians noted that “he was very troublesome to manage at home, and his father thought it best to bring him here.” In 1874, they diagnosed him with a cleft palate. Despite recognizing his speech was limited by physical impediment, physicians did not judge him to be intelligent. The 1880 U.S. Census listed Able and his sister, Olivia, as part of the “Defective, Dependent, and Delinquent” population. Able remained institutionalized until his death. By 1877, physicians called him “Sammy.”

MARY PYATT ALLSTON, COMMITTED: 1848 – 1853 (HER RELEASE).

Committed at age 65 by her politically connected relatives, she was “deposed to religious enthusiasm.” She believed that God demanded she separate from her husband and “left her house some time ago.” As a paying patient, she received a private room and nurse but still begged to be released: "My poor weak shattered Nerves are truly harassed and tortured by being in a Madhouse or perfect Bedlam! [I] would now rather suffer the most excruciating death than be confined here."

ANTHONY, COMMITTED: MARCH 29 – JUNE 2, 1850 (HIS DEATH).

Committed at age 50 by his enslaver, future South Carolina Supreme Court Justice Franklin J. Moses, Sr., (1804-1877), he was only the second Black man officially admitted to the institution. He would have lived in a wooden building constructed within "the courtyard of the whites." Its location meant he had nowhere to exercise, a problem physicians recognized but did not solve. He lived just two months before dying of convulsions.

AQUILLA BEARD, COMMITTED: NOVEMBER 7, 1877 – MAY 5, 1878 (HIS DEATH).

Committed at age 46 by a nephew, he was a single man who physicians noted as “a wandering imbecile all his life.” His father had previously made provisions, including income from the hiring out of enslaved persons, for Beard’s lifelong care. Following the Civil War, and with the death of Beard’s mother, his remaining family recommended his commitment as a "pauper” patient. Physicians noted that medical treatment was “not required.” Beard died six months later of “a fit.”

ADNEY MCSWAIN ATTAWAY, COMMITTED FEBRUARY 2 – MARCH 9, 1893.

Committed at age 35 by neighbors, he was a Methodist minister who local reports claimed had been “driven insane by poverty.” Physicians noted his “peculiar religious views,” but believed his insanity was a reaction to his “wife [Belle] being insane,” and that both ailments were religious in origin.

BELLE HARRIS ATTAWAY, COMMITTED FEBRUARY 2 – MAY 2, 1893.

Committed at age 30 by neighbors, she was a wife and mother of young children who local reports claimed had been “driven insane by poverty.” Physicians noted a specific "religious experience” that had caused her change in temperament, as well as the extremely poor diet maintained by the family of seven. Her brother, however, noted that she had previously simply stated, “I will leave my husband, for God does not require me to live with a man who will only give me corn bread to eat.”

LUCY ANN BROWN, COMMITTED: APRIL 9, 1878 – AUGUST 19, 1887 (HER DEATH).

Committed at age 30 by a probate judge, she was a widowed domestic worker who lost her husband in a railroad accident two years prior and then suffered romantic “disappointment” after her new fiancé's legal wife appeared on the eve of their marriage. Immediately upon Brown's arrival, nurses renamed her “Rinktum” for an unknown reason. When a relative came to see her sometime in the 1880s, staff could not identify Brown; the relative walked through the wards until they found her. At this time, physicians were able to rediscover Brown’s identity.

ELIZABETH “LIZZIE” BURNS, COMMITTED: APRIL 19, 1850 – OCTOBER 25, 1897 (HER DEATH).

Committed at age 30, she was an Irish immigrant with no known diagnosis. As an old woman, she began caring for the institution’s chickens and was allowed to sell their eggs for money.

ANGELINA BURREL, COMMITTED: FEBRUARY 16, 1833 – MAY 29, 1837 (HER DEATH).

Committed at an unknown age from the Charleston poorhouse, she was a French immigrant who had been ill for many years but was "good humored" and "deposed to accommodate herself to all about her." She remained confined until her death from "a sudden and violent hemorrhage from the uterus"—perhaps a miscarriage.

LOUISA BURREL, COMMITTED: FEBRUARY 16, 1833 – JUNE 7, 1864 (HER DEATH).

Committed at about age 31 from the Charleston poorhouse, she was a French immigrant confined alongside her sister, Angelina. She "enjoyed uninterrupted health" following her arrival but was later considered by physicians to be "the most irritable being."

MOLLIE CASH CHAMPION, COMMITTED: DECEMBER 7, 1907 – FEBRUARY 12, 1908 (HER DEATH).

Committed at age 30 by her husband, she was a married housewife and mother who suffered from depression for at least two years before being admitted with the diagnosis of "pellagra." She was already experiencing three of the progressive symptoms that would later define the disease—dermatitis, diarrhea, and dementia—and the fourth, death, would occur approximately ten weeks later. She spent her time at the institution confined to a bed, although physicians noted she managed to assault her roommate, "an old woman," and needed to be watched. Just prior to her death, hospital superintendent James W. Babcock presented her case alongside two others as evidence of pellagra's existence in the state.

VIRGIL CORNELIUS DIBBLE, JR., COMMITTED: OCTOBER 24,1900 – NOVEMBER 16, 1901 (HIS RELEASE); OCTOBER 24, 1906 – OCTOBER 27, 1908 (HIS RELEASE); SEPTEMBER 9, 1912 – APRIL 11, 1913 (HIS RELEASE); OCTOBER 15, 1915 – SEPTEMBER 15, 1919 (HIS RELEASE); JANUARY 22, 1926 – AUGUST 16, 1933 (HIS RELEASE); AUGUST 20, 1940 – JANUARY 24, 1947 (HIS DEATH).

First committed here at age 23 by his father, he was a young schoolteacher whose diagnosis throughout his repeated admission at this institution were always some form of "acute melancholia" or "manic depression." His delusions were religious, even believing at times "that he is dead and that his spirit cannot get away," or that "every one of the billion or more souls in the world would be lost if I did not do certain abnormal, distasteful or excruciatingly painful things." Dibble's primary physician took a special interest in his recovery, but in testimony given after his second release, Dibble felt that the institution had performed no real treatment except “restraint and baseball.” His examination in 1912 revealed that he still believed “to have died twelve years ago” and that his existence was due to his having “committed the unpardonable sin.” During a period of health beginning in 1919, he co-founded the Columbia Builders’ Exchange and was manager of Allison Lumber Company, an accomplishment echoing his early success in 1903 when he served as superintendent of Bennettsville’s schools. He married in 1921 and had one son, but later voluntarily committed himself in 1926. In between his final commitments, he served on the Columbia Merchants Association board. Dibble was an extremely popular man who was clearly missed while institutionalized.

JOHN MATTHEWES FLUD, COMMITTED: MAY 5 – AUGUST 23, 1832 (HIS DEATH).

Committed at age 33 by his wife, he was a wealthy planter who did not receive an official diagnosis. Beyond multiple baths a week to combat his “uncleanness,” no treatment was noted. Like other paying patients, he would have had his own room, and one month before his death he received a large shipment of clothes from his wife. Flud died suddenly, just two days after hitting his head on an iron banister on the back steps of the original asylum building. His only son was born one month later.

HARRIET JANE GRAY, COMMITTED: APRIL 5 – SEPTEMBER 14, 1830 (HER RELEASE); MARCH 8 – OCTOBER 6, 1832 (HER DEATH).

Committed at "about 34 or 35 years of age” by her husband, she was a wife and mother of three who had given birth just a few months prior. As one of the institution’s few paying patients, physicians kept extensive treatment records for Gray. She endured everything from a month of complete isolation in a dark room to medical treatments including bloodletting and the ingestion of calomel (liquid mercury) and Fowler’s solution (a type of arsenic tonic). According to physicians, “she “complains of nothing – talks coherently but manifests undue feelings of distress and grief at her situation and especially on account of her children." Perhaps suffering from postpartum depression, Gray repeatedly requested to see her children during her institutionalization. Her husband removed her against physician advice but brought her back after 18 months. Her health, already bad when recommitted, continued to decline until her death.

MARY JANE HINSON, COMMITTED: JULY 7, 1897 – JUNE 27, 1900 (HER DEATH).

Committed at age 38 by her husband, she was a wife and mother who suffered the death of two of her children several months prior. She became unstable, and her husband reported that she had threatened her own life and his with both a knife and a gun. When in custody at the county jail, she attempted to escape. Hinson begged to be sent home from the institution and was known by the staff for her single-minded focus on escape—for example, she once created a sharp implement to cut her restraints and kept it concealed inside her body. Hinson escaped once with another patient after breaking through some latticework and climbing down four stories. They hid in the institution's cornfield and then followed the railroad tracks to the north towards Killian, where they were found. Hinson told staff that she "intended to pick cotton & make money enough to get home," and would "try to escape again at the first opportunity." Her final months were spent in "close confinement" in a muff restraint before dying from "Phitusis" (tuberculosis).

ELIZABETH JOHNSON, COMMITTED: JANUARY 4, 1900 – JANUARY 15, 1900 (HER DEATH).

Committed at age 51 by her brother, she was a married, childless housewife who "worked very hard all her life in the field & has recently been troubled over money matters." Her behavior changed suddenly; she began acting "wildly," looked "like a maniac," and continuously spoke profanely and incoherently that Black people were going to kill her. Johnson, who physicians diagnosed with epilepsy, was repeatedly restrained to her bed and unsuccessfully force fed. She died of "exhaustion [from] acute melancholia" after eleven days.

ROBERT WHITFIELD MANLY, COMMITTED: JANUARY 3, 1906 – JANUARY 30, 1945 (HIS DEATH).

Committed at age 47, he lived and worked at the institution prior to his admission, but physicians diagnosed him with "Paranoia" after he began hearing voices and noises at night. A former professor who spoke multiple languages, Manly "was quite intelligent and fond of reading." He translated foreign medical articles on pellagra for the 1907 National Conference on Pellagra, held at the institution. He became a "model patient" with "special privileges" who staff permitted to "attend church in the city, also to go and come outside of the Institution as he wished." By 1917, Manly served as the institution's official printer. Despite physicians noting his stable mental health, Manly remained committed until his death in 1945; his obituary highlighted his education and translation work but made no mention of his decades’ long institutionalization.

ALBERT LEE MCSWAIN, COMMITTED: JULY 23, 1917 – MAY 29, 1918 (HIS DEATH).

Committed at about age 10, he spent just over ten months in the institution before dying in a preventable fire alongside seventeen other men and boys with diagnoses of epilepsy and idiocy. Almost no documentation survives about his life or time at the institution. Despite arriving in July, McSwain’s case was not presented to staff until October 31. The physician’s case history gave his patient number and a diagnosis of “epilepsy - congenital defect with excitement.” McSwain is buried in Geiger Cemetery alongside the other victims of the fire.

JANE ANN MOODY, COMMITTED: JUNE 9, 1883 – JANUARY 23, 1885 (HER RELEASE).

Committed at age 51 by her brothers, she was single and childless. Following her parents’ deaths, her brothers could not “obtain any Female attendants to minister to her comfort and wants,” which primarily seemed to include insomnia and melancholy, as well as being “suspicious of the intentions of friends” —perhaps rightfully so, given her brothers’ actions. Physicians noted “uterine derangement” (likely menopause) and speculated it might have been “generated by celibacy.” A surviving letter to one brother indicates her strong desire to come home. Upon release, she moved to Florida to live with another brother.

JONATHAN A. NEWTON, COMMITTED: MARCH 19, 1869 – CIRCA 1870 (TRIAL RELEASE); MARCH 1872 – CIRCA1875 (TRIAL RELEASE); DECEMBER 1, 1877 – OCTOBER 13, 1901 (HIS DEATH).

First committed at age 25 by his parents, he returned to the institution several times. During his second commitment, physicians noted that he spent all his time living in the hallway, laughing and talking to himself and no one else, and had also become “addicted to that foul sin, masturbation, for the cure of which all means have failed.” Despite having known him as a child, the assistant physician struggled to communicate with Newton and considered his “a hopeless case.” During several trial releases, he continued his father’s sign painting business in Columbia.

SARAH A. NEWTON, COMMITTED: NOVEMBER 26, 1894 – JANUARY 16, 1897 (HER DEATH).

Committed at age 73 by a well-known citizen with no known family connection, she was a middle-class widow and mother who had “always been eccentric” but likely faced additional hardship following the repeated commitments of her only son, Johnathan. Her extensive financial affairs, including rental properties, were managed by a third-party until her death.

ROBERT JOHN PALMER, COMMITMENT: JANUARY 11, 1908 – JUNE 11, 1909 (HIS RELEASE).

Committed at age 59 by City of Columbia police, he was a wealthy tailor diagnosed with "acute melancholia." He acquired property downtown beginning in the 1870s, when he served as a city councilman. Physicians noted that he "went to sheriff for protection from mob violence without cause. Thinks he has been cheated." This may have had some basis in truth, as Palmer had recently sold his most valuable lot on Main Street. He lived in the institution's Parker Building, which a 1909 investigative report determined as "in worse condition than any of the others."

MARY EMMA SANDIFER, COMMITTED: OCTOBER 19, 1945 – OCTOBER 23, 1946 (HER RELEASE).

Committed at age 17 by her father, she was a high school student who suddenly became "very nervous, very talkative." Her examination revealed that she had "hallucinations" and "delusions." Her mother was previously a patient at the institution. Diagnosed with Dementia Praecox (schizophrenia), she was an ideal candidate for electroshock therapy. She received 93 of 94 prescribed treatments—more than triple other women being treated. This might be attributed to her three "relapses" noted during her eight-month confinement. Released the day after her final treatment, her later struggles, if any, are unknown. She married and had children.

JOSEPH ARTHUR SMITH, COMMITTED: JUNE 10, 1910 – NOVEMBER 10, 1920 (HIS RELEASE); JANUARY 18 – MARCH 18, 1939 (HIS RELEASE); APRIL 28, 1940 – JULY 6, 1962 (HIS DEATH).

Committed at age 28 by his mother, he was a single farmer diagnosed with "manic depression" who felt he was lost, could not be saved, and "dreamed that he has been in hell." Prior to his admission, one of his eyes was damaged by a briar, and he felt that was when his "nervous trouble" began. The institution gave him a glass eye. He requested to have one arm restrained at night, as he feared his own actions. This fearfulness of something bad happening to him slowly lessened, Smith began working at the institution. Although released in 1920, he was kept on as a driver and given room and board in addition to a salary. He married in 1925 and had two children. He voluntarily committed himself in 1939 and 1940 and remained as a patient the rest of his life.

EDWARD LANE SPENCER, COMMITTED: JULY 11 – NOVEMBER 19, 1889 (HIS RELEASE); AUGUST 6, 1893 – OCTOBER 31, 1893 (HIS RELEASE); MARCH 14, 1896 – MARCH 27, 1919 (HIS DEATH).

First committed at age 35, he was a widower and father who suffered from repeat episodes of depression, "acute melancholy," and suicidal thoughts, all brought on by the recent loss of his wife and exacerbated by alcohol use. Physicians described him as suffering from "hereditary" insanity. A surveyor by profession, nurses enlisted him to paint their likenesses, and in 1893 he painted the "Old Building" (Mills Building). The painting, which won a $5.00 prize at the South Carolina State Fair, hung in the hospital superintendent's office until at least the 1930s. Spencer's two sons were raised by his family, as he spent brief periods "out on trial," before being institutionalized for the last twenty-three years of his life.

EDWIN MARSDEN SYFAN, COMMITTED: APRIL 27, 1905 – MAY 29, 1905 (TRIAL RELEASE); FEBRUARY 12, 1906 – NOVEMBER 23, 1908 (HIS RELEASE).

Committed at age 39, he was a married father diagnosed with "acute mania" after a sudden change in behavior following a consultation with a "faith cure" doctor. Physicians described him as raving, cursing, and threatening to others. They noted his recent surgery for rectal cancer, but Syfan later testified that they "left me in my filth" on the bare floor for "hours and hours," as he had no control of his bowels. He resorted to paying an attendant "twenty-five cents a week to bring me water and bathe me oftener," and over time he regained his strength. He spent his time bathing other patients, changing their bedding, and whitewashing rooms, and later, working on the farm and in the laundry. He was able to hire a lawyer to secure his release, as none of his family would visit or respond to his letters. He returned to his native Abbeville but remained in ill health, having also contracted tuberculosis while living in the institution. When he died in 1912, the local paper noted that he had "been living in a tent in order to better get fresh air, and it was there that he died." His brothers, who stood by him at the end of his life, remembered him lovingly in a subsequent obituary: "He was gentle and unassuming, with a quiet and easy manner that brought around him scores of friends. He was self-sacrificing and always ready to lay aside his own pleasure and comfort for that of his friends. As a friend and companion, he was genial, big-hearted kind and true."

CARRIE TAYLOR, COMMITTED: AUGUST 8, 1914 – AUGUST 31, 1915 (HER ESCAPE); SEPTEMBER 21, 1915 – OCTOBER 10, 1915 (HER ESCAPE).

Committed at age 35, she was a widowed farm laborer with four children seen "abusing and cursing on [a] public highway" and making threats to unknown individuals. Somewhat unusually, this behavior was witnessed by lower Richland County physician Dr. Hubert Claytor, who also noted Taylor "talks disrespectfully." Taylor likely worked for Claytor or one of his neighbors. Her case history does not include a diagnosis, but one logbook noted she had "manic depression." Taylor escaped from the institution twice within sixty days and was not sent back, indicating she may have left the county completely. Record keeping in the second half of 1915 was minimal, with Taylor's return on September 15 not noted in several admission books.

ISIAH VALENTINE, COMMITTED: JULY 17, 1903 - OCTOBER 29, 1920 (HIS RELEASE).

Committed at "about 12 or 14," he could not communicate with staff. Despite being deaf and mute, "he had a way of understanding fairly well what was said to him." Staff, who initially thought a family member would come to retrieve him, began calling him "Dummy" and "Monkey Head" because they did not know his name. Although technically a patient for seventeen years, he mainly performed errands for staff and helped in the dining hall. He escaped at least three times in 1919 and 1920. Several weeks after his final escape, Valentine's father came from Orangeburg to retrieve him, at which point Valentine's name is recorded for the first and only time in records. His life upon release is unknown.

MICAJAH VAUGHN, COMMITTED: FEBRUARY 5, 1835 – DECEMBER 6, 1835 (HIS DEATH).

Committed at an unknown age from the Kershaw poorhouse, he suffered from epilepsy. One physician noted ten days after his arrival that, "*I have been examining him daily, no prospect of curing him, his mind seems to be utterly broken down."* Doctors documented a few of Micajah's "fits," or seizures, throughout 1835, and over time claimed he had lapsed into constantly talking in "a language known by school boys as gibberish."

WALTER WHITE, COMMITTED: JULY 27, 1898 – MAY 29, 1918 (HIS DEATH).

Committed at age 30 by his parents after attempting suicide, he was blind and had "a simple way of expressing himself," leading to a diagnosis of idiocy. Previously "tied and confined" at home and suffering from melancholy, White confided in physicians that he was a burden to his family. After nearly two decades at the institution, he died in a preventable fire alongside seventeen other men and boys with similar diagnoses.

APPENDIX: A NOTE ON SOURCES

Uncovering narratives for this project was a circular process, with each type of source being consulted multiple times for each patient selected. Historic Columbia's work is indebted to published research that identified potential individual narratives or cited relevant primary sources. These include:

1. Berry, Aimee Renee. "'An Asylum is a Sad Prison House': Insanity, Commitment, and Community in Late Nineteenth-Century South Carolina." MA thesis, University of South Carolina, 1999.
2. Bryan, Charles S. *James Woods Babcock and the Red Plague of Pellagra.* Columbia, SC.: University of South Carolina Press, 2014.
3. Fowler, Catherine Alison. "Commitment, Care, and Control: The Treatment of the Black Insane at the South Carolina State Hospital from 1900-1963." MA thesis, College of Charleston, 2012.
4. McCandless, Peter. *Moonlight, Magnolias, & Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era*. Chapel Hill: University of North Carolina Press, 1996.
5. Tuttle, Steven D. *Admitted into the Asylum: Abstracts of Patient Treatment Records at the South Carolina State Hospital, 1828-1880*. [Columbia, S.C.]: Steven D. Tuttle, 2024.

FOR A MORE RECENT HISTORY NOT INCLUDED IN THIS PROJECT:

1. Buchheit, William. *The South Carolina State Hospital: Stories of Bull Street.* Charleston, S.C.: The History Press, 2020.

MOST UTILIZED REPORTS

1. *Report of the Legislative Committee to Investigate the State Hospital for the Insane.* Columbia, S.C.: Gonzales and Bryan, State Printers, 1910.
2. *Testimony Taken Before the Legislative Committee to Investigate the State Hospital for the Insane at Columbia, April 28, May 4, 6, 7, 18, 19, 20, 1909.* Columbia, S.C.: Gonzales and Bryan, 1910.
3. *Report of the Proceedings of the Special Legislative Committee on the State Hospital for the Insane and State Park, January 1914.* Columbia, SC: Gonzales and Bryan, State Printers, 1914.
4. Trinkley, Michael, and Debi Hacker. *McCormick Funeral Records for the SC State Hospital: African American Patients between March 1915 and 1935 and*

White Patients between March 1915 and 1959. Chicora Research Contribution 395, 2004. https://www.chicora.org/pdfs/RC395%20-%20McCormick%20vol%202%20State%20Hospital.pdf

5. *Annual Reports of the South Carolina Lunatic Asylum* (until 1894-5, thereafter *Annual Reports of the South Carolina State Hospital for the Insane*)

DIARIES AND MEMOIRS

1. Allen, Sarah Campbell. "Diary from SC State Hospital, 1900." Waring Historical Library.
2. Thompson, James L. *Of Shattered Minds: Fifty Years at the South Carolina State Hospital for the Insane.* Columbia, S.C.: South Carolina Department of Mental Health, 1989. A close reading of Thompson's Of Shattered Minds provided anecdotes about everyday life for patients in the hospital. Although names are not given, each anecdote included a date of admission and county of residence.

ARCHIVAL RECORDS

Records from the institution are held at the South Carolina Department of Archives and History as part of the State Department of Mental Health collection. From 1828 until 1950, the institution assigned more than 58,000 patient numbers. These patient numbers are the entrance point to most other records about each individual. Some records were not preserved.

ADDITIONAL RESEARCH SOURCES

- Extensive searches of *The Columbia Record* and *The State* provided additional context as well as new individuals for inclusion.
- Research using Ancestry.com helped locate burial locations and build family trees.
- Historic Columbia also used its own extensive research files.

APPENDIX: RESOURCES AND FURTHER READING

1. Buchheit, William. "New Book Provides Inside Look at Iconic S.C. Mental Hospital." *The Columbia Star*, 2011.
2. Jones, A. *Psychiatry, Race, and Asylums in the U.S. South.* Southern Spaces, 2021.
3. Metzner, J. L., & Fellner, J. "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics." *Journal of the American Academy of Psychiatry and the Law*, vol. 38, no. 1, 2010, pp. 104–108.
4. Mayo Clinic. *Electroconvulsive Therapy.* Mayo Clinic

5. Richland Library, The Walker Local and Family History Center. *Digital Collection.* Richland Library
6. Rosenbaum, S., & Shin, P. "Frontline Health Care Workers: Labor Inequities in Care Roles." *Health Affairs*, 2021.
7. South Carolina Department of Mental Health. "A Brief History of Patient Rights." South Carolina Department of Mental Health. https://www.scdmh.org/patients-and-families/patient-advocacy/a-brief-history-of-patient-rights/
8. South Carolina Department of Mental Health. "Institutional History of the South Carolina Department of Mental Health." South Carolina Department of Mental Health. https://www.scdmh.org/about/history/
9. South Carolina Encyclopedia. "South Carolina State Hospital." South Carolina Encyclopedia, consulted 2026.
10. U.S. Department of Health, Education, and Welfare. *A Study of Psychiatric Aides in State Hospitals.* ERIC Document ED023829, 1963.
11. University of South Carolina, Digital US South. "Digitizing Bull Street: The Story of the South Carolina State Hospital." University of South Carolina

SUGGESTED READINGS:

1. Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. Anchor Books: New York.
2. Gonaver, W. (2019). *The Peculiar Institution and the Making of Modern Psychiatry, 1840-1880.* The University of North Carolina Press.
3. Louis, D. M. (2025). *Colored Insane: Slavery, Asylums, and Mental Illness in the Nineteenth Century.* Columbia University Press.
4. Nielson, K. E. (2012). *A Disability History of the United States.* Beacon Press.
5. Payne, C. (2009). *Asylum: Inside the Closed World of State Mental Hospitals.* MIT Press.
6. Reiss, B. (2008). *Theaters of Madness: Insane Asylums and Nineteenth-Century American Culture.* University of Chicago Press.
7. Rembis, M. (2024). *Writing Mad Lives in the Age of the Asylum.* Oxford University Press.
8. Shorter, E. (1998). *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac.* Wiley Press.
9. Sitton, S.C. (2012). *Life at the Texas State Lunatic Asylum, 1857-1997.* Texas A & M Press.

ABOUT ABLE SOUTH CAROLINA

Able SC is a disability-led organization seeking transformational changes in systems, communities, and individuals. Since 1994, we've remained a consumer-controlled, community-based, cross-disability nonprofit that seeks to make South Carolina a national model of equity and inclusion for all people with disabilities. To learn more about Able SC's programs and services, please visit www.able-sc.org or call 803-779-5121.