

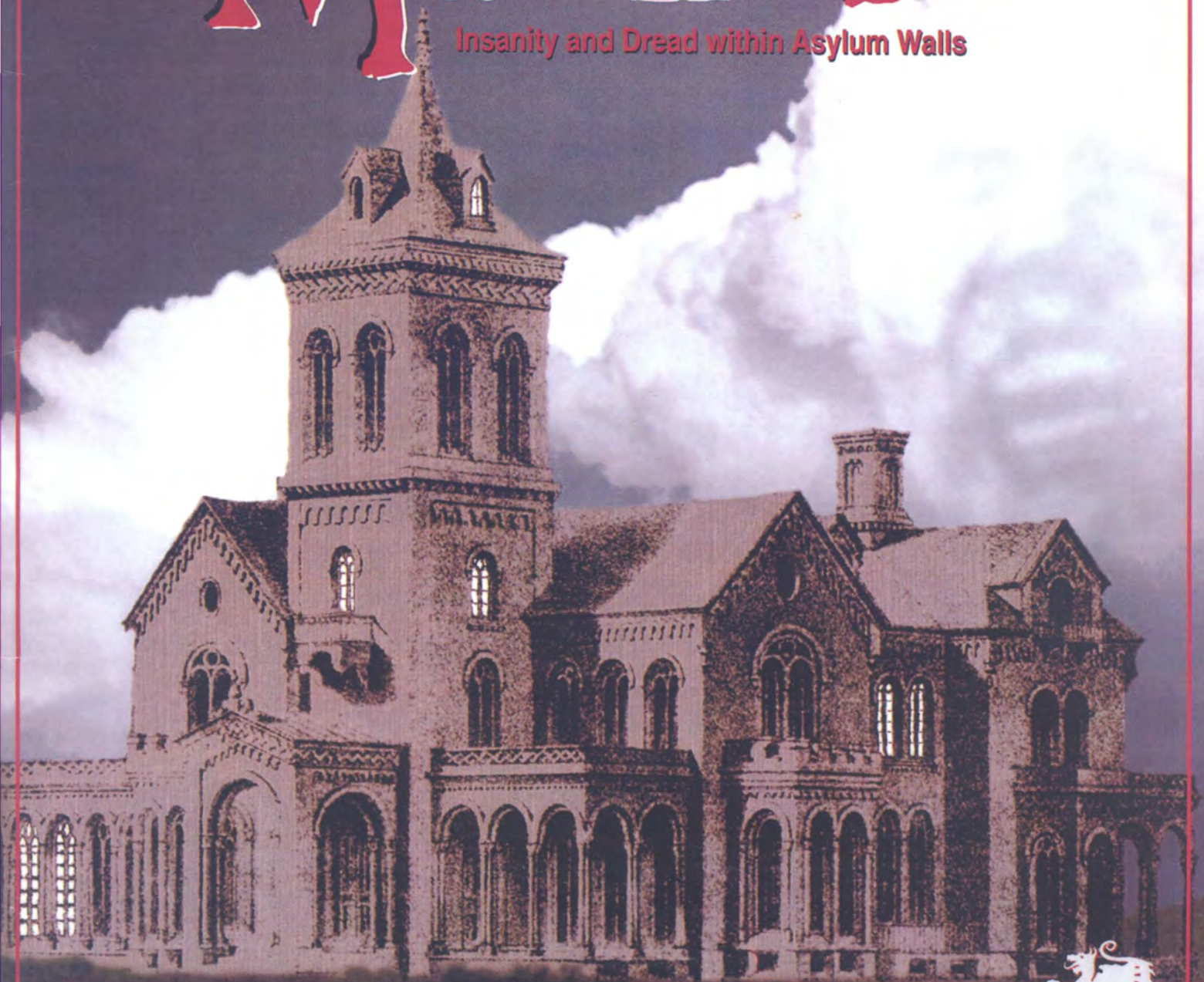
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# Taint of Madness

Insanity and Dread within Asylum Walls

FOR  
**Call of Cthulhu**  
All Eras

with an Asylum  
scenario for  
each era



**Michael Tice, Shannon Appel, Eric Rowe**  
**Dave Carson, Earl Geier, Drashi Khendup, Eric Vogt**



SOURCEBOOK

# Taint of Madness

Insanity and Dread within Asylum Walls



H. P. Lovecraft  
1890-1937



# Taint of Madness

Insanity and Dread within Asylum Walls

A Sourcebook of Sanity, Insanity, Therapies, Asylums,  
and Laws and Procedures Relating to Such Topics

for Call of Cthulhu

with an asylum scenario for each era

by

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Chaosium

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Insanity and Dread within Asylum Walls

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## Note

Institutions change their names over time, and state institutions in the U. S. are particularly likely to be referred to after the town or county in which they are located. Thus the text mentions the asylum in Kankakee, Illinois, both as Illinois Eastern Hospital and as Kankakee State Hospital in different places in the book.

The legal ramifications of insanity change from state to state and nation to nation in their details. The decisions and examples discussed mainly pertain to the United States. Most of the information is nonetheless valid for all places, because the behaviors that prompt such legalities are part of our common human heritage.





# Lunacy

*Being a short history of sane peoples' reactions to the insane, including the rise of professionalism, the evolution of treatment, and the techniques of restraint.*

**S**OME PEOPLE once thought that madmen were divinely guided prophets. Others saw them as fools who might utter wisdom now and then, by divine guidance. In classical times, the insane were sometimes considered blessed by the gods, whether they acted blessedly or not, and sometimes their bewildering sentences were scrutinized for meanings about the future, or the past, or the intentions of God. Lunatics unable to care for themselves might randomly be despised, pitied, or fed, or otherwise aided by personal charity. Often they were seen to be outside the ways of the community, and were ostracized beyond the city walls at night. In the West, no uniform social response has ever existed for the madmen among us.

In the Dark Ages and the Renaissance, Christian mythology helped determine the treatment of the insane. Insanity might still be a blessing or a disease, as in earlier times, but possession by demons might also be a cause. Always in harsh times the insane were thought deserving of nothing, and found no charity though the systematic fostering of charity and mercy was arguably Christianity's greatest social invention. But as hospitals were formed, and then asylums, the insane lost any reverential patina. Even the feeble-minded, once held in awe, became merely village idiots, to be mocked and despised.

In the last two hundred years specific medicines and more humane treatment have appeared. People now generally agree that it is possible for a person not be in control of his or her faculties, or to be in some other way strange and deviant without necessarily being a criminal or a heavenly messenger. Few now think that the insane have simply chosen to behave bizarrely, or that their afflictions are in some way punishment for wickedness. Under-

standing, protections, and certain rights for the insane widely exist. At the same time, the willingness of individuals to personally provide food or shelter for such unfortunates has fallen greatly, both because such sponsors now incur considerable legal responsibility, and because government is popularly imagined to be the proper agent of treatment and care.

In the 1990s, for instance, religious people of good conscience and genuine faith find it possible to demonstrate and agitate for better governmental treatment of the distressed who have wandered from or been cut loose from mental health programs and left to the streets. For various reasons, few find it possible to practice the ordinary personal charity of two thousand years ago, such as offering their own homes for shelter against the night.

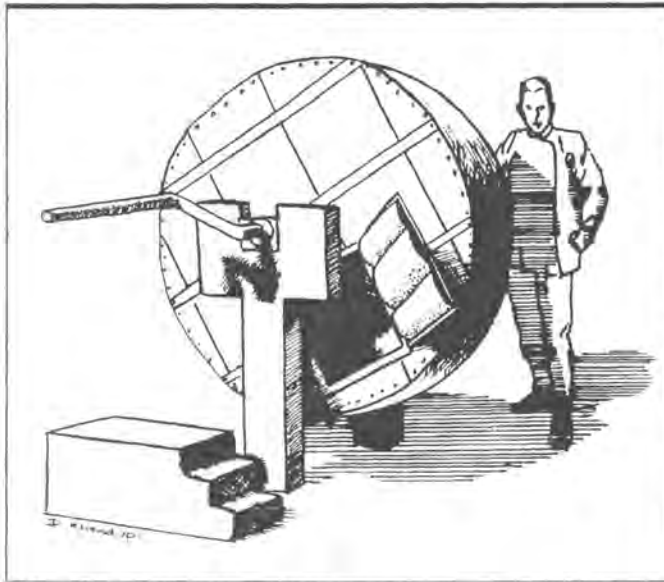
Historically, each seeming advance in treatment for the insane seems also to have represented a corresponding loss of power or status for the insane. Whether the current categories of mental condition represent a logical and rational perception, or are symptomatic of systematic degradation is for the reader to decide.

Broadly speaking, the major legal classifications have evolved to consider two sorts of extreme mental states: insanity and incompetence.

## Insanity

Most dictionaries define *madness* as a non-medical term describing mental illness, derangement, mental alienation, or unsoundness of mind.

Under the law, insanity is any form or degree of mental derangement or unsoundness of mind, permanent or temporary, that makes a person incapable of what can be shown



**"Hollow Wheel".** This early 19th century example and similar spinning or revolving devices were used to calm and control sanatorium patients.

or postulated in a court of law as normal and rational conduct or judgement. As a legal condition, insanity usually implies a need for hospitalization. Specifically excluded from the legal definition are transitory or episodic mental disorders such as traumas, epilepsy, hysteria, and delirium, as well as mental aberrations induced by alcohol, drugs, or fever.

In the United States, each of the fifty states maintains its own legal definition of insanity, defined by statute and by precedent. Similarly, each of the hundreds of nations in the world varies, perhaps in greater degree, in how it treats the legal state of insanity. These definitions are generally similar, since they concern the same sort of phenomena, but the definitions often differ in degree or consequence and, where precedence is important, may spring from different experiences.

However, public observance of the condition of insanity is simple and straight-forward. To most of us, insanity is simply action, manner, or expressed thought that deviates greatly from normal behavior. This is a practical and necessary definition. Faced by a stranger's sudden outburst, few of us are capable of distinguishing the effects of physical disease, or recent emotional trauma, or schizophrenia. We do not need to be medical authorities to judge behavior. Abnormal behavior is all the reason needed to call for police or hospital orderlies: the authorities will then decide what to do, based on their own training and what they see before them.

To most of us insanity is a mysterious and unknowable state, and insanity usually carries with it a stigma of fear or pity. Since we tend to hear only of the most dangerous lunatics and of the most pathetic depressives, the reinforcement of this attitude is understandable. That some of those who have regained their sanity may later relapse into insanity also promotes public wariness and distrust. As a rule, consequently, those who are labeled insane usually bear the brand for life.

## INCOMPETENCE

Incompetence does not have as great a stigma as insanity. We rarely see this state, and when we do it is more often pitiable, and not threatening. Incompetence represents the inability to carry out one's duties and to be unable to act in his or her own self-interest. A man who did not understand court proceedings could be found incompetent to stand trial, while a man who did not understand the significance of binding agreements could be found incompetent to contract.

Most countries allow people to be found totally incompetent: literally, such people are unable to do anything under the law. In these cases the incompetent is placed under the guardianship of some responsible adult. Relegated to the fringe of society, the incompetent rarely is noticed thereafter. Only the guardian can treat with society. The incompetent's loss of power and status is nearly universal.

## MANY MENTAL STATES

But insanity and incompetence are just two of the abnormal mental states that most nations recognize. Among the spectrum of mental states are feeble-mindedness, people who are so incompetent that they are unable to undertake any tasks; the temporarily insane, those who are normally lucid but who have cracked for a while under some extreme stress; and the partially insane, who understand and are responsible for most of their actions, but are somewhat affected by some particular mental disorder. Many more rarely applied notions of mental states also exist.

This non-clinical differentiation was provoked by the existence of large populations. Modern courts need to assess the guilt and innocence of individuals who are personally unknown to them, even by reputation. The terms insanity, temporary insanity, partial insanity, and incompetence have come into use in legal circles, where they are used to weigh and fix differing levels of responsibility for those who are charged with crimes. These classifications are perceptions of insanity. They have no special bearing in the treatment of insanity, though they may well suggest how well an inmate in an asylum will be treated day by day.

## TREATMENT OF THE INSANE

For the mildly insane and incompetent, neither treatment or support is generally necessary. Often, however, a disorder may make the subject dangerous not only to himself or herself, but to the public. For these people, as well as those whose insanities leave them incapable of sustaining themselves in society, asylums are made.

In the past, asylums were primarily hospitals to treat those insane whose insanities had physical symptoms. People with dangerous insanities were generally imprisoned or killed, while people only mildly insane were mostly left to themselves.

At various times, those with insanities that could cause harm might be tortured and chained, while those with even slight mental difficulties might be imprisoned in asylums. As populations grew, asylums became warehouses for

storing those who were different or who could not care for themselves. This tendency to shut away the insane has lasted until the present.

Near the end of the Victorian era, asylums began to change. Patients were unchained and individual treatment became a priority. However, the science of psychiatry was poorly developed and treatments were by and large ineffective. Though more benign, asylums were still places meant to isolate the insane from the public, for the benefit of both.

With the development of modern psychiatry and advances in other fields of medicine, the modern asylum is focused on the curing and treatment of the insane. As with all the rest of history, it seems clear that society still requires the insane be separated from them.

## Theories of Mental Illness

**U**NDER THE IMPACT of formal scientific research and new theories of behavior, the field of mental health changed and grew rapidly at the end of the nineteenth century. Competing for the same patient population, neurologists, psychiatrists, neurosurgeons, psychologists, and psychoanalysts developed separate unique treatments for the various types of insanity then recognized.

Many mental health professionals, especially those with medical training, believed that most, if not all, mental illnesses were the product of abnormal biological processes occurring in the brain or the nervous system of the affected person. This view represents the *organic* or *somatic* viewpoint. In its extreme, this perspective holds that a mental disorder is just like any other medical disease, except that the primary symptoms are behavioral rather than physiological. From this viewpoint an individual's psychology has no relationship to his or her mental disorder; instead, insanity is viewed as a disease that is acquired biologically over time or is biologically inherited. Less extremely, this viewpoint holds that the cause of the behavior is a biochemical process in the brain or elsewhere in the body that has become imbalanced (for whatever reason) and consequently is disrupting the patient's normal behavior.

In contrast to the organic position, the *functional* viewpoint holds that aberrant thought processes and operations of the mind (as opposed to the brain) are responsible for abnormal behavior. A person's activities and life experiences determine the cause of mental illness, not biological factors.

In practice, these two approaches to mental illness were concerned with different types of mental patients. Somatic treatments were mainly used with psychotic patients (those with serious mental disorders) while functional therapies were primarily used to treat patients with neuroses (less severe mental disturbances).

Partly because they were dealing with different patients in different settings, the organic and functional approaches developed independently, each being strongly prejudiced against the ideas and practices of the other. But there were some somaticists who were sympathetic to the functional view, just as there were functionalists who accepted biological explanations.

### The Somatic View

Toward the end of the 19th century, the somatic view was shaped to a large extent by German psychiatrists, particularly Emil Kraepelin. Kraepelin was the foremost authority in neurology during much of the first half of the 19th century. He spent his years tirelessly and meticulously gathering thousands of case histories, from which he evolved a descriptive classification for a number of mental disturbances. While he recognized that neuroses may be caused by life experiences, he was convinced, along with most of his contemporaries, that the psychoses were genetically inherited and developed during adolescence or at least caused by an underlying disturbance of body metabolism. His major work on psychoses, *Lehrbuch*, was first published in 1883 and continued in nine successive editions, including two volumes of 2500 pages published in 1927, the year after his death. Although Kraepelin distinguished over twenty types of psychoses, the two main categories were dementia praecox and manic-depressive disorder.

A patient who had hallucinations and delusions, behaved in a bizarre manner, and tended to get worse was said to have suffered from dementia praecox. Dementia praecox (*schizophrenia* as it was called after 1911) was divided into four types: simple, hebephrenic, catatonic, and paranoiac. Patients were diagnosed with simple schizophrenia after showing profound withdrawal and lack of interest, initiative, or drive. Hebephrenic patients were those whose behavior appeared "silly" and were verbally inappropriate, often giggling indiscriminately. Catatonia applied to individuals who were at times often mute and rigid for hours and violent at other times. Paranoid schizophrenia refers to individuals who had severe delusions of persecution.

The manic-depressive psychoses were manifested by rapid mood or emotion swings in which patients were either so depressed or manic (excited) that they could no longer function in normal society.

Manic-depressives were distinguished from schizophrenics on the basis of prognosis. A patient rarely recovered from dementia praecox, whereas manic-depressive patients were known to improve or at least learn to cope with their illness. Unfortunately, since dementia praecox was a progressive and incurable disease, once that label had been affixed to a person, he or she very often became just a case number awaiting ultimate deterioration into utter madness.

### Functionalism

Some years before Kraepelin, Jean-Martin Charcot, who was the leading neurologist of his day and professor at the University of Paris, carried on his researches at Paris's





famous Salpêtrière hospital. There he became preoccupied with a large mixed group of patients who could not be put into any of the traditional clinical categories. Charcot classified this group as suffering from hysteria (neurosis). Using hypnosis to study hysterics, he developed his own ideas about the way certain hysterical symptoms develop.

Among these symptoms were seizures, paralysis, asthenia (lack of sensation of touch), muscle spasms, choreas (diseases that produced uncontrollable movements in the limbs), mutism, stuttering, hiccuping, and astasia-abasia (an inability to stand straight and walk in a coordinated fashion). He also called those patients "hysterical" who suffered from mental anorexia (disturbance of the appetite), nervous disturbances of the stomach, and polyuria (frequent uncontrollable urination).

One of Charcot's students at Salpêtrière, Pierre Janet, further distinguished two major types of neuroses: hysteria and psychasthenia (the name he used for obsessions, phobias, and other distortions of thought and affect). He also classified what we refer today as multiple personality disorder as a form of hysteria.

As Charcot became convinced by his clinical observations that many forms of hysteria were related to mental concepts, he began to arouse interest in the European medical profession that functional factors may influence mental disorders as well as organic factors. One such physician was Sigmund Freud. Freud was, during the same period as Kraepelin, developing an alternative functional theory of mental illness, *psychoanalysis*. Prior to psychoanalysis, the functional perspective had no coherent explanatory theory of mental illness. Although not accepted initially, Freud's work helped to strengthen the position of the functional viewpoint.

## Developments, 1890-1930, in the United States

Treatment of any kind on mental patients was practically unknown in the United States during the 1890s, at least outside the walls of custodial institutions. Mental hospitals and their therapies were so isolated from the rest of medicine that the doctors who were the superintendents and staff of these insane asylums were referred to as *alienists* by the medical community. (This term lasted until around the turn of the century among academics, a bit later in the popular press, which liked the colorful name.) After this time, these doctors were called what we call them today, psychiatrists.

From 1844-1894, the professional organization concerned with the physicians of institutionalized mental patients was the Association of Medical Superintendents of American Institutions for the Insane. The journal published by them was the *American Journal of Insanity*.

Mental therapy outside the asylums, the little that there was, was performed by neurologists who were often at odds with the psychiatrists in the mental hospitals concerning their care of patients and the lack of access to patients for study. Neurologists were deeply trained in neuroanatomy and neuropathology, and were often professors in major universities or heads of departments of neurology or of

neurology and psychiatry. (There were virtually no separate departments of psychiatry before the 1920s, as it hadn't yet developed into a fully separate medical science.)

So strong was the animosity of the neurologists against the psychiatrists that their professional organization, the American Neurological Association, and its journal, the *Journal of Nervous and Mental Disease*, barred all superintendents of asylums from membership and from publication in their journal.

American psychiatry at the time was largely organic in viewpoint. Therefore, since insanity was to be interpreted as a disease of the brain, neurologists commonly felt themselves to be more scientific than psychiatrists because they knew more about neuroanatomy. In contrast, the alienists (psychiatrists) rarely had specialized training, as few medical schools offered instruction in psychiatry during the 1890s, though psychiatric lectures might be offered as part of a neurology course.

## STANDARDS

In reality, there was little learning or scholarship. Quite often, young untrained physicians were put in charge of entire wards within a few weeks after appointment to asylum staffs. The somatic treatments they used were by personal preference or were dictated by the institution. Ominously, until the 1930s any physician could request that his or her name be listed in the directory of the American Medical Association as a specialist in psychiatry.

The neurologists demanded that psychiatry be more scientific and confine its area of study to the neurological aspects of mental disorders. Neurologists also felt that psychiatry should become part of neurology, so that neurologists could then use the asylums for teaching and research. The psychiatrists claimed that the neurologists wanted to seize the asylums for their own gain.

Whether either side was culpable, the average income of a psychiatrist working in a mental institution exceeded that of most other physicians. In particular, the average income of asylum superintendents was greater than that of all but the most successful physicians. Lacking clear evidence for either viewpoint, quarrels between the superintendents of the mental hospitals and neurologists became politicized, and were fervently debated in the editorial columns of various newspapers.

After a decade of debate, in 1894, on its fiftieth anniversary, the Association of Medical Superintendents of American Institutions for the Insane changed its name to the American Medico-Psychological Association. This was done to show a spirit of compromise with the medical establishment while maintaining separation from the neurologists. Later, in 1921, the American Medico-Psychological Association changed its name again, this time to its present-day title, the American Psychiatric Association. In that same year, the *American Journal of Insanity* became the *American Journal of Psychiatry*. Unfortunately, this did not ease the friction between the neurologists and psychiatrists, and in some ways the schism between psychiatrist and neurologist deepened.

## ADOLPH MEYER

But by the 1920s, American psychiatry had become eclectic, embracing both the organic and functional perspectives. This new emphasis of the functional approach was caused by two things—the rapid adoption of psychoanalysis by American psychiatry and the psychobiological approach of Adolph Meyer.

Meyer, who became president of the American Psychiatric Association in 1927, was open to psychological and social as well as biological causes of mental disorders. Importantly, his impeccable credentials put him above criticism from the neurologists, for Meyer was a trained neurologist and a major figure in neuroanatomy during the 1890s, and he was also a former president of the American Neurological Association.

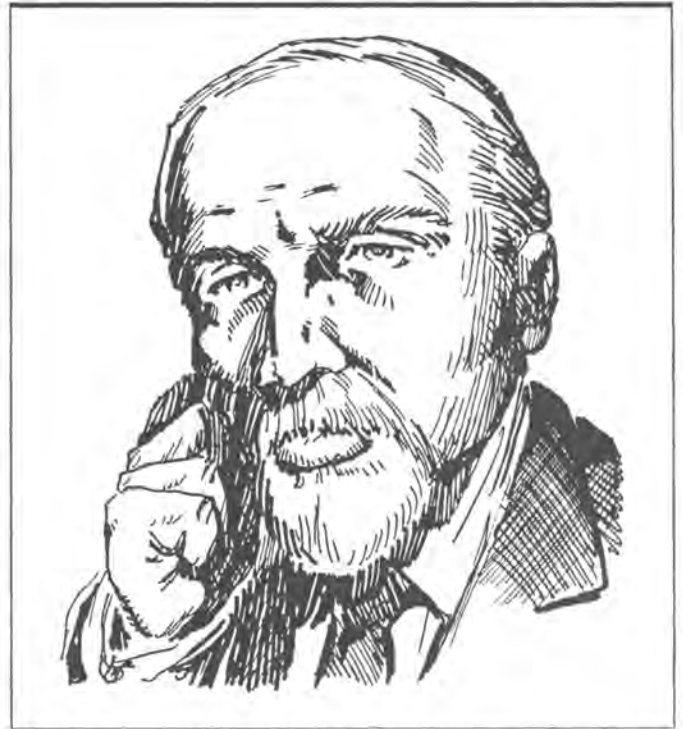
Giving full recognition to the importance of biological factors to mental disorders, Meyer also insisted that the whole person should be recognized. He emphasized the importance of taking complete life histories, for instance, and of keeping accurate and detailed patient records so that information would be readily available if readmitted. Meyer was so influential that he was generally acknowledged as the “dean of American psychiatry” until his death in 1950.

## THE INTELLECTUAL WARS CONTINUE

Psychiatrists weren't the only intellectual adversaries of neurologists. Neurology's traditional supremacy in diagnosing and treating neurological ailments was being nibbled away by neurosurgery. It seemed that neurosurgeons were no longer content to be merely the hands of the neurologists. From the turn of the century, neurosurgeons had helped neurologists by operating on and removing tumors of the brain and spinal cord from mental patients—after these tumors had been diagnosed and localized by neurologists.

In 1920, the Society of Neurological Surgeons was organized in the United States. Each member was an experienced general surgeon, but with no academic background in neurology. Once these surgeons had begun learning about neuroanatomy and neurology, they had found that they could often do their own diagnoses without a neurologist.

The ongoing warfare between neurologists and psychiatrists impeded the establishment of clear standards for physicians treating mental patients. Even in the 1930s, when more psychiatry was being taught in medical schools, few agreed about what constituted sufficient training to treat the mentally ill. On October 20, 1934 at the Hotel Commodore in New York, a compromise was struck and the American Board of Psychiatry and Neurology was established. The compromise called for separate examinations and requirements for certification in psychiatry and certification in neurology. A physician wanting certification in both fields would have to meet two sets of requirements. This was a clear victory for the psychiatrists. Even though any physician was still free to treat mentally ill patients in private practice, this would eventually be restricted to board-certified psychiatrists.



Adolph Meyer (1866-1950). The 'dean of American psychiatry'.

There was a certain irony here. While psychoanalysis and other functional treatments had helped psychiatry to win its political battle within medicine, it had made the field more vulnerable to competition from the rapidly growing numbers of clinical psychologists, social workers, and lay therapists who considered themselves fully capable of practicing various forms of psychotherapy. In private practice, many psychologists and social workers treated patients with psychiatric ailments by the 1920s and 1930s.

Believing that psychiatric problems cannot be diagnosed and accurately treated without the aid of psychiatrists, The American Psychiatric Association of course condemned this practice as unscientific and dangerous. According to them, psychiatry was rooted in medicine while psychology grew out of philosophy and metaphysics. Many psychiatrists felt it necessary to emphasize the medical (i.e., the somatic) bases of mental illness to counter the growing competition.

It was too late. Psychologists were firmly entrenched in American society. Already various universities offered abnormal psychology courses within their psychology departments. Additionally, the National Research Council, with the support of the Carnegie Foundation, had begun establishing psychological clinics to study various types of mental disorders.

The psychologists had their share of infighting and arguments, too. During the 1890s, psychology was growing and breaking way from philosophy by setting itself up as a new scientific discipline. At the time it was harmonious and united without any signs of radical disagreement. Wilhelm Wundt, a German philosopher, had established the first psychological research laboratory in Berlin, at the University of Leipzig which was the then world center for psychology. Nearly every psychologist of this era studied either with or under Wundt.



However changes took place that gradually moved the world's psychological focus from Germany to the United States. By the 1920s, there was a bitter clash between rival schools of thought regarding fundamental principles in psychology. While many of the founders of these movements weren't actively involved in the struggles of the 1920s, their students and followers were.

Of the individuals concerned with mental health, investigators are most likely to encounter psychiatrists in American's asylums, and psychologists as America's private practitioners. Among psychologists, several competing schools of thought, or areas of emphasis, existed.

## STRUCTURALISM

Edward Titchener, a student of Wundt, worked at Cornell University in New York. Building on Wundt's theories and methods, Titchener developed structural psychology. According to structuralists, the subject matter of psychology is conscious experience. Consciousness consists of the basic elements of our experiences as they exist at a given time. The mind is defined as the sum of our experiences accumulated over a lifetime. They are similar except that consciousness involves mental processes occurring at the moment instead of the total accumulation of processes. The structuralist believed that psychology was not in the business of curing sick minds or reforming individuals or society. Animal psychology, child psychology, and their application had no value. For the structuralist, psychology's purpose is to discover facts about the mind using the scientific methodologies of introspection, experimentation, and measurement.

## FUNCTIONALISM

John Dewey and James Angell, professors of psychology at the University of Chicago, first stressed the differences between structuralism and functionalism in Angell's 1906 presidential address to the American Psychological Association. He noted that while structuralism studies conscious content, functionalism studies the operations of consciousness. Where structuralism attempts to analyze the basic elements of the mind, functionalism is concerned with the nature and functions of mental processes with an emphasis on how these processes work. Functionalism doesn't define consciousness as a mere receptacle of experience, but as an actively adaptive reactor to experience. Additionally, the application of psychology was accepted and practiced by functionalists.

## BEHAVIORISM

While functionalists and structuralists may have tried to get along, there was open warfare between behaviorists and the previous two schools. John Watson, who studied under Dewey at the University of Chicago, argued that the subject matter of psychology is human and animal activity and conduct (i.e., behavior). Therefore, the aim of psychology is to predict behavior, to formulate laws about behavior, and to control human behavior. He branded the introspective study of consciousness as illegitimate and declared that

only overt physical behavior can be studied scientifically and objectively. This school was enormously popular with the American public.

## GESTALT PSYCHOLOGY

At the same time in Germany, another school of thought rose up against structuralism, gestalt psychology. Oddly enough, as it matured, gestalt psychology would also oppose behaviorism. While Gestalt psychology accepted the value of consciousness, it criticized any attempt to break it down into elements. Behaviorism, on the other hand, refused to even care that consciousness might even exist. The main idea of gestalt psychology is that the basic elements of an object yield a different result when perceived as a whole. In other words, "The whole is greater than the sum of its parts." This idea, of course, flew defiantly in the face of the established German structuralist viewpoint. Gestalt psychology was developed by Max Wertheimer, at the University of Frankfurt, along with two of his students, German psychologists Kurt Koffka and Wolfgang Kohler.

## PSYCHOANALYSIS

While the other schools grew as a reaction to other psychological schools, psychoanalysis was not developed in response to any of them. While each of the other schools were developed in laboratories and universities and were concerned with topics like perception, sensation, and learning, psychoanalysis was initially developed to provide therapy for mentally disturbed persons. Other systems dealt with the conscious, psychoanalysis deals with the unconscious. Psychoanalysis evolved into one of the most popular forms of psychological thought during the twenties.

According to Freud, the concept of *trieb* (in English, instinct or drive) was the core factor in a person's personality. The fundamental drive is the libido, a violently selfish, aggressive sexual drive which constitutes the id of the personality. The id seeks immediate gratification without regard for the circumstances. Freud called this "the pleasure principle." The ego serves as a mediating agent between the id, the superego, and the outside world. The ego, a representation of reason or rationality, sees to it that both remain in the unconscious, while itself is only partially conscious. The ego uses defense mechanisms such as suppression, repression, projection, sublimation, and displacement to keep unacceptable impulses from rising into the conscious mind. The Oedipus complex, or the unconscious desire for the death of the parent of the same sex and for physical union with the parent of the opposite sex, is among the quandaries which the ego must somehow try to handle. The superego develops in early childhood and represents restriction and self control. It is in constant conflict with the id. Unlike the ego, the superego does not attempt to postpone pleasure, the superego tries to eliminate it all together.

Freud noted that when this balancing act of the ego fails, the result is anxiety. For him there were three types of anxiety. Objective anxiety is caused by the fear of real world dangers. Neurotic anxiety comes from the recognizing the potential danger inherent in instinctual gratification. It is not a fear of the instinct, but of the punishment

that follows. Simply put, neurotic anxiety is the fear of being punished for expressing impulsive desires. The third type of anxiety, moral anxiety, is the fear of the conscience. This is a function of how well developed one's conscience is. The less virtuous a person is, the less likely he or she is to develop moral anxiety.

The task of the ego is complicated even further because the primary focus of the libido moves from one part of the body to another as a person matures. During the oral stage, all pleasure is derived from feeding. Toilet training is the focus during the anal stage, while the genital region is the focus during the phallic stage. From age five to twelve is the latency period when sexuality is totally repressed. Lastly the genital stage occurs during adulthood, when gratification is found through intercourse. If an individual becomes fixated during any of these developmental stages, relationship difficulties, anxiety, or abnormal behavior may result.

During the twenties, all five schools vigorously pursued their respective goals. By the 1930s, however, interest in structuralism and functionalism was almost completely gone.

In addition to the various school vs. school debates, toward the end of the decade, a new division between academic and applied psychology arose. These two types of psychologist rarely collaborated with each other: one group remained on university campuses and the other in factories, hospitals, schools, clinics, and offices.

With relatively little change, this four-way division of labor has continued until the present: psychiatrists in hospitals and asylums, various sorts of psychologists and psychological counselors in private practice, psychologists

(especially behavioral psychologists) in academic departments of psychology, and applied psychologists serving industry and government.

## The Mental Hygiene Movement

Clifford Beers, the spearhead of the mental hygiene movement, was a graduate of Yale who had suffered several severe psychotic episodes and who had received atrocious treatment in three mental hospitals. In 1908, he published a book, *The Mind That Found Itself*, which described the intense suffering of being restrained in a straitjacket and the mental anguish he went through while in custodial care. Beers was able to reach a large audience of average citizens because he spoke to them in their own language, not in the language of psychology or psychiatry.

One year later he had successfully established the National Committee for Mental Hygiene in New York and persuaded the legislature of Connecticut to investigate and improve existing conditions in mental hospitals. An important provision of the Connecticut program was an educational campaign directed at the public concerning the facts of mental disease and its prevention. The public was urged to adopt hygienic measures to avert and control mental illness, just as they were doing for physical illness. Beers emphasized prevention too. To him, cure was a secondary objective. Other states soon followed Connecticut's example.

In 1912, the Public Health Service appointed Thomas Salmon to the position of medical director of the National Committee for Mental Hygiene. He had lost interest in

## Important Theoreticians

### James Cattell (1860-1944)

Cattell was born in Easton, Pennsylvania, and received his bachelor's degree in 1880 from Lafayette College, where his father was president. Choosing Europe for graduate work, Cattell studied with Wundt in Leipzig.

A paper in philosophy won him a fellowship at Johns Hopkins in 1882. At the time, his major interest was philosophy, but during his first semester Cattell became interested in psychology as a result of personal experimentation with drugs. Here he observed changes taking place in his own behavior while under the influence of such substances as cannabis and hashish.

When Cattell returned to study under Wundt in 1883, he made it clear that he would choose his own research project, on the psychology of individual differences, a topic that was hardly central to Wundtian psychology. Cattell also gave Wundt his first typewriter, on which most of Wundt's books were written. Many of the classic reaction-time studies were carried out by Cattell during his three years at Leipzig and he published several articles on reaction time before leaving there.

After obtaining his doctoral degree in 1886, Cattell lectured in psychology at Bryn Mawr and at the University of Pennsylvania. He then became a lecturer at Cambridge University in England, where he met Sir Francis Galton. The



James Cattell

two men had similar interests and views on individual differences and became good friends. As a result of his friendship with Galton, Cattell became one of the first American psychologists to teach statistics in his courses and to stress the statistical analysis of experimental results.

Cattell was also influenced by Galton's work in eugenics. He argued for sterilization of delinquents and defectives and for giving incentives to the

brightest and healthiest people to marry their own kind. He offered his seven children \$1000 each if they would marry the sons or daughters of college professors.

In 1888, Cattell was appointed professor of psychology at the University of Pennsylvania. This was the first professorship of psychology in the world. It represented recognition of psychology's status as separate from philosophy. But Cattell left Pennsylvania in 1891 to become head of the department of psychology at Columbia University. There he remained for twenty-six years.

Because of his dissatisfaction with the *American Journal of Psychology*, Cattell began *The Psychological Review* in

*continued*

trying to help the mental hospitals and sought to broaden mental hygiene at the community level, largely through a series of surveys. This had several beneficial effects, one of which was that the U. S. government began to produce better statistics on the mentally ill. Salmon was followed by Frankwood Williams, who served as director from 1922 to 1930. Through it all Beers continued to promote, to speak, and to raise funds. With the foundation of the quarterly journal, *Mental Hygiene*, in 1917, the movement became international. The mental hygiene campaign was so successful that the First International Committee for Mental Hygiene was held in 1930 in Washington with 3,042 officially registered guests.

After World War II, new appreciations for the realities of insanity and mental instability occurred, and new attacks were launched. As before, the intractability and stigmatization associated with mental problems chewed away at the enthusiasm to combat them.

In the 1950s and 1960s, new humanistic psychologies were developed, the most well known writer in the United States perhaps being Carl Rogers. These approaches often focused upon re-relating the individual and society. In practice these new principles helped guide some of the gender and sexual agitation in the following decades. Perspectives also broadened in this time, so that later therapists were more likely to be more eclectic and draw specific approaches from a wider variety of therapeutic traditions.

In the 1970s and 1980s, the expanding spectrum of psychoactive drugs began to offer quick and reliable palliation of symptoms for many serious emotional disturbances. Except for the criminally insane, the very notion of asylums for the mentally ill began to fade in some states.

But the web of outpatient clinics and support necessary to such an approach was eroded by declining local budgets, and disbelieving national political foes. Once the neighborhood clinics were gone or inundated by lengthy waiting lists, proper drug administration was fractionalized and sometimes trivialized as neighborhood employment programs. A tide of marginal wanderers grew. Though accurate information is hard to come by, perhaps because very few people actually want to know, by the 1990s at least 70% of the new homeless had become so because of mental problems and related narcotic and alcohol dependencies. While those who are homeless for economic reasons tended to rescue themselves after a year or so, evidence of a sizable and unshrinking urban reservoir of madness began to be noticed across the United States.

## Treatment

**T**HE HISTORY of our treatment of the insane is checkered enough that it is not quite possible to distinguish mental therapy from physical restraint, just as it has sometimes been difficult to separate mental therapy from vengeful punishment. Accordingly, some entries in the rest of this chapter are dual.

According to the National Institute for Mental Health, in 1923 there were approximately 266,000 patients in U.S. state and county mental hospitals. The leading textbooks of psychiatry in the 1920s mainly provided illustrative case material for each diagnostic category, but offered very little that was useful in the way of treatments. Science had little to offer. In the absence of recommended therapies, almost any treatment was tried, providing it had the potential for

1894 with J. Mark Baldwin. In 1894 Cattell acquired from Alexander Graham Bell the weekly journal *Science*, which was ceasing publication for lack of funds. Five years later it became the official journal of the American Association for the Advancement of Science. He bought *Popular Science Monthly* in 1900, and after selling the name in 1915, he continued to publish it as *Scientific Monthly*. The phenomenal organizing and editing work required a great deal of time and so Cattell's research productivity dropped.

In 1921 he organized the Psychological Corporation, with stock purchased by members of the American Psychological Association, to provide psychological services to industry, the psychological community, and the public. This organization has grown considerably and is today an international enterprise.

Cattell remained active as an editor and a spokesman for psychology until his death in 1944. He accomplished a lot at a very young age. He was a professor at the University of Pennsylvania at 28, chairman of the department at Columbia at 31, president of the American Psychological Association at 35, and was the first psychologist elected to the National Academy of Sciences at 40.

Cattell is generally credited with influencing American psychology toward practical, test-oriented results. His psychology was concerned with human abilities rather than conscious content, and in this respect he comes close to



**Sigmund Freud**

functionalism, though he was never formally associated with the movement.

### **Sigmund Freud (1856-1939)**

From the age of four he lived in Vienna until Hitler's invasion of Austria, when he moved to England for the last year of his life. After graduating with a degree in medicine in 1881, Freud worked as a researcher, hoping to gain an academic appointment. As this would be difficult to obtain, he

sought to gain additional clinical and research experience in various hospitals and clinics in the event he would have to work in private medical practice.

He married in 1886, while his financial condition was still precarious. It was during the first year of his marriage that he opened his office for private practice as a neuropathologist.

Freud only spent four months in Paris, but while there he came under Charcot's influence and learned hypnosis. When he returned from Paris, he translated the works of both Charcot and Bernheim into his native German, while giving electrical and other somatic treatments to patients suffering nervous disorders. While still in medical school he had made friends with Josef Breuer (1842-1925), who had

over



treating large numbers of patients with a minimum of highly trained staff, a pre-condition for most mental hospitals. This shortage of resources ruled out the slowly-evolving individual approach of the psychotherapist, and made somatic treatments particularly attractive. Of the many somatic treatments introduced in the 1920s and 1930s, few were too radical to be rejected.

## NOTES ON PLAY

In presenting these physical treatments during play, the keeper should be alert to several key areas that most investigators will want described.

First, the doctor might take time to explain to his patient the reason for the treatment, what will happen during treatment, and the sort of outcome he expects. This sort of information and personal respect will help calm the patient, and create less friction with the attendants who will actually be doing the work. If the doctor ignores this sort of attention, and many doctors before the present would as a matter of course, then the patient's anxieties may correspondingly rise. Conceivably a sanity roll might be called for in the middle of a therapeutic session.

The physical setting is also important. The patient may have strong feelings about being enclosed, restrained, being underground, and so on. Is there a dark corner where a monster might hide? Might not a deep one's arm emerge to pull the investigator down the drain of the hydrotherapy tank? If the therapy and a strong phobia clash, damage to sanity is likely.

Similarly, the actual process of the therapy needs to be made clear. Helpful also will be related sounds and smells, indications of normal embarrassments, and so on.

Also consider the patient's relations with the attending doctor and with the orderlies who are administering the therapy. Though the doctor sometimes may be on hand after the first application, he often will be absent, and the investigator will be at the tender mercies of the orderlies, or attendants. The therapy is a chance for punishment and revenge, if the investigator has made enemies of doctors or orderlies, or both.

For each treatment, a few lines of notes following the entry suggest potential game effects.

## A Cabinet of Therapies

### CARBON DIOXIDE THERAPY

In the early 1920s Arthur Lovenhart, a professor at the University of Wisconsin, began various experiments in psychotics, each trying to produce what he called "cerebral stimulation" which would result in increased respiration and metabolism. In his early research, Lovenhart injected patients with small doses of sodium cyanide and was able to show some improvements in schizophrenics. Later, Lovenhart had patients breathe a gas mixture containing 30 percent carbon-dioxide which excited the nervous system. (Normal air has only 0.03 percent carbon dioxide.) Patients were given as many as 150 treatments a day. His first published work on carbon dioxide therapy was in 1929. This form of therapy was used widely into the 1940s as a treatment for dementia praecox, manic-depressive insanity, and forms of melancholia.

also used hypnosis on patients. Breuer had evolved hypnosis into a treatment he referred to as *cathartic* because it was intended to relive tension and anxiety by re-experiencing an earlier traumatic event. For 18 months in the years 1887-1889, Freud used hypnosis and Breuer's cathartic method successfully. By 1892, he introduced his newer nonhypnotic method that was to become psychoanalysis.

Freud's new nonhypnotic method, the forerunner of psychoanalysis, evolved into the method of free association. He apparently never used hypnosis again. After formally renouncing hypnosis in 1896, his new method was becoming well known.

It was not until 1902 that Freud, at the age of 46, received the professorship he had always hoped for. The new title enhanced his prestige and increased the number of his patients. By coincidence, the same year Janet received his professorship at the College de France.

Soon dissension broke out among Freud's followers. The first to defect was Alfred Adler (1870-1937) in 1911; Wilhelm Stekel (1868-1940) resigned in 1912; Carl G. Jung (1875-1961) resigned in 1913. Freud thereafter gained control, established a small committee of the faithful, changed his views from time to time, but expected his followers to accept his new insights. The final defection was by Otto Rank (1884-1939) in 1926, when he left Vienna for America. Freud liked to believe that he did not require

adherence to his own views, but though able to weather the many attacks that others outside the circle made on him, he appeared to be deeply wounded when his insiders disagreed with him. In the end, Freud maintained leadership of the psychoanalytic movement and it prospered with the establishment of institutes of psychoanalysis in many parts of the world.

### Pierre Janet (1859-1947)

Pierre Janet was admitted to the Ecole Normale Supérieure in Paris in 1879. In the terminal examination at the end of the third year (1882), Janet came in second in his class. Coincidentally, this was the year that Charcot delivered his paper before the Academy of Sciences that gave hypnosis scientific status, and Janet had already become interested.

He began to teach at the lycee at Le Havre. There he was able to spend a number of years studying a patient with multiple personalities. Janet also studied a number of hysterical women and wrote a number of papers regarding hysteria. His fame spread, and he had many foreign visitors.

Janet saw that he needed a medical degree to continue the kind of work that he was doing and began his medical studies, working largely under Charcot at the Salpêtrière. Janet graduated with highest honors in 1893. As Janet's career developed, he became a professor at the College de France on a temporary appointment from 1895 to 1902, until a professorship in experimental psychology came open. He competed against Alfred Binet, a longtime

*continued*

*Notes:* the treating physician might present the therapy via a special breathing mask, like a gas mask, or might have built a chamber within which the patient could be secured. Both versions would require that the patient be restrained. Carbon dioxide concentrations above 5% lead to unconsciousness and probably death; 30% carbon dioxide is a lethal level which must be carefully administered and withdrawn. Carbon dioxide narcosis is caused by excessive blood levels of the gas. The subject exhibits a narcotic-like stupor. The proximal cause of death from carbon dioxide poisoning is heart and respiratory system failure. In an autopsy, high acidity of the blood would suggest the actual cause of death.

### DRUG THERAPY: BROMIDES

This was the darling general drug of the twenties. During the early 1900s, physicians found that previously uncontrollable states of excitement could be substantially relieved by the administration of bromide, particularly potassium, ammonium, and sodium bromide, as sedatives. By the mid-twenties many psychiatrists writing in the *American Journal of Psychiatry* were claiming that finally a sedative, bromide, had been discovered that could alleviate serious symptoms of disturbed behavior. The American public, following the lead of physicians, so desired bromides that by 1928 one out of five prescriptions was for bromides. Unfortunately, patients had to be continuously maintained on bromides in order to show improvement, which could make life easier for hospital staffs but did not

much help patients, since bromides accumulate in effect and begin to confuse and disorient patients, as well as to disrupt sleep.

*Notes:* though useful as a sedative, the creation of a



bromide offers plenty of potential for murder since the effects of the bromide depend upon its ratio to chloride in the sedative. The right ratio of bromide to chloride in the mix is 1:4. Higher ratios of the bromide leads to stupor or sleep. If the proportion of the bromide exceeds that of chloride, quiet death will follow.

### DRUG THERAPY: COCAINE

This stimulant drug was introduced in the late 1880s by Freud who experimented on himself with it. He found the exhilaration that he felt after using cocaine within the range of normal euphoria, and felt an increase in self-control and a greater energy for his work. He detected no unpleasant after effects, and none of the craving associated with drug dependency. It was used widely in Europe during the 1890s as he recommended its use to his colleagues, friends, and even his fiancée. By the 1920s, cocaine found its beneficial uses as a local anesthetic, but as a drug used to alleviate mental illness it was disastrous as it had proved to have addictive qualities. Freud was condemned by many psychiatrists for introducing the drug.

*Notes:* in pure powder form, a small amount is easily capable of killing within a few minutes to half an hour. One of the most addictive drugs known. Prolonged use promotes paranoid and psychotic behavior, and hallucinations.

would later develop the IQ test, for this position and was awarded the professorship which he held until his retirement in 1935.

#### Emil Kraepelin (1856-1926)

Even before Kraepelin's graduation from the Wurzburg Medical School in 1878 he was interested in the medical aspects of psychiatry. He spent the summer of 1876 in Leipzig studying under Wilhelm Wundt and shortly afterward he wrote a treatise on "The Influence of the Acute Diseases on the Origin of Mental Diseases." After graduation, Kraepelin studied in Munich for four years and then continued his neuropathological studies in Leipzig and conducted autopsies on patients who had died from organic brain diseases.

Kraepelin studied experimental psychopharmacological and psychophysiological research, again under Wundt, but later returned to clinical psychiatry and for a number of years taught at Dorpat and then Heidelberg. Finally, in 1903, Kraepelin was appointed professor of clinical psychiatry at Munich, where he spent the next nineteen years. In 1922, he retired from teaching to take a position as head of the Research Institute of Psychiatry in Munich.

#### Adolph Meyer (1866-1950)

Meyer was born a few miles from Zurich, where his father was a liberal and public-spirited minister. Meyer's admiration for his uncle, a physician, induced him to study

medicine and particularly neurology. His earliest contact with functional mental illnesses was at home (his mother had frequent depressive episodes) and in helping his uncle treat mental patients.

In 1893 Meyer decided that his professional opportunities would be greater in America than in Europe and came to the United States to work as a pathologist at the Illinois Eastern Hospital for the Insane in Kankakee. The value of patient biographies began to be impressed on Meyer as he noted that the medical staff paid very little attention to accurate history taking. While still at Kankakee, Meyer gave courses in "How to Study the Human Being: for Neurologists and Alienists."

From 1895 to 1910 Meyer was chief pathologist at the Massachusetts Insane Hospital in Worcester and at the New York State Psychiatric Institute and professor of psychiatry at Cornell University Medical College. From 1910 until he retired, in 1941, Meyer was a professor of psychiatry at Johns Hopkins and director of the Henry Phipps Psychiatric Clinic.

In 1902 he married Mary Potter Brooks, who soon became absorbed in her husband's work; in 1904 she began to visit the families of his patients to learn more about their backgrounds. Thus Mrs. Adolph Meyer became the "first American social worker." Meyer more and more emphasized that in order for a psychiatrist to understand a mentally disturbed patient, he had to know about the

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In the 1990s, *crack* is cocaine in pellet form (cut with baking soda or some other extender), to allow it to be smoked rather than to be snorted or injected. Not quite an addict, Sherlock Holmes injected a seven-percent solution of cocaine when he was bored.

## DRUG THERAPY: MESCALINE

When the United States Congress enacted the Harrison Act in 1914, the unauthorized sale of certain drugs became a federal offense. Physicians and pharmacists were forevermore accountable for each prescription they dispensed. Since psychologists weren't legal providers of drugs, they showed little interest in the mental effects of drugs. There were isolated investigations however. For example, in 1928, Heinrich Kluver, a psychologist for many years at the University of Chicago, wrote a book on the effects of mescal (a narcotic drug derived from a cactus plant used by southwestern American Indians). While these drugs produced psychotic hallucinations in non-psychotic testers, he was unable to find a place for these drugs in the therapy of mental conditions.

*Notes:* doubtless very large doses would induce nausea, stomach spasms, and rapid vomiting, but swallowed in normal doses usually produces only gastric discomfort and sweating, followed by sometimes lengthy hallucinations, exposure to which is the goal of the practice. Considering only its hallucinogenic properties, belladonna has a somewhat comparable position in the European pharmacopeia, except that in larger doses belladonna produces a painful and lingering death.

## ELECTROTHERAPY

Pioneered by William Erb, a German neurologist, electrotherapy was a very popular treatment for mild depression (or neurasthenia, as it was sometimes called) and other neuroses. It was believed that applying a low current through the cathode (the negative terminal) would excite the nerves, thus exciting the patient, while mild current through the anode (the positive terminal) would produce sedation. Electrotherapy was a recommended form of therapy as late as 1929. Note that this was very different from Electroshock or Electroconvulsive therapy (see below).

*Notes:* low levels of electricity can be raised to more threatening levels, but only by modifying the circuits in such a device. Not intended to combat serious mental illness.

## ENDOCRINECTOMY

It had been known for some time that a person's mental states and moods could be influenced by hormonal imbalances. It was also known that depression and irritability could be caused by under or over activity of the thyroid or adrenal gland. Women were often labeled as mentally unstable due to the endocrine changes experienced with the menstrual cycle and pregnancy. Due to the alleged link between abnormal behavior and various endocrine glands, during the 1920s, literally tens of thousands of thyroidectomies, ovariectomies, male castrations, and removal of all or parts of other glands were performed on mental patients around the world.

*Notes:* once under their guardianship, psychiatrists were pretty well immune from prosecution for such mutilations. The operations themselves were often more dangerous than

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patient's social environment and to view his disorganized state as a maladjustment of the entire personality rather than the result of brain pathology. In 1907 Meyer met Clifford Beers, who eventually would lead an international organization that Meyer called the "mental hygiene movement."

### Edward Titchener (1867-1927)

While still very young, Titchener received the necessary scholarships to spend five years (1885-1890) at Oxford. During his first four years there he studied philosophy, but in his fifth year began to study physiology and worked as a research assistant. It was at this time he learned about Wilhelm Wundt's new physiological psychology and was so fascinated by it that he began to translate the third edition of Wundt's *Grundzuge*, which appeared in 1887, and determined on his own that he would one day study with Wundt. He took his translation with him when he set off for Leipzig in 1890 but did not publish it, because he found that Wundt was about to publish a fourth edition. After receiving his Ph.D. in 1892, Titchener began his long career at Cornell University, which lasted from 1892 until his death 35 years later.

After only two years with Wundt in Leipzig, Titchener took on some of the characteristics of a German professor and was often thought to be German, even by a visiting English psychologist. He was a unique individual and somewhat out

of place in America. He was born an Englishman, and always thought of himself as living in "the colonies." He was never naturalized.

Titchener's intellectual interests were wide-ranging. Music was an abiding love, and he was "professor in charge of music" until a regular music department was established at Cornell. Even after that he continued to conduct a small orchestra at his home on Sunday nights. His home was a veritable museum. He was a collector of coins and skilled at reading various languages, including Sanskrit and Chinese. He and his wife had a collection of precious and semiprecious stones that was only limited by their income.

He preferred not to participate in the American Psychological Association, although he was influential among its members. Beginning in 1904 he had his own annual meeting of a small group selected by invitation, which he referred to as "The Experimentalists." After his death its focus was broadened slightly and it became the Society of Experimental Psychologists. Many of the leading psychologists of the day belonged to The Experimentalists (as well as to the American Psychological Association). These annual meetings were held at many different universities, with Titchener always the acknowledged leader. Titchener was offered professorships at Clark University (1909) and Harvard (1917), but lived out his career at Cornell. ■



the consequences of surgery, though the loss of testicles or ovaries or spleen was serious enough. A landmark of arrogance and bureaucratic fantasy. The potential for punishment and revenge is obvious.

## FEVER INDUCTION

During the 1920s, inducing fevers by purposely injecting patients with malaria and other fever-inducing diseases was a popular form of treatment for patients diagnosed with general paresis (a psychosis accompanied by paralysis). It was during the First World War that Julius Wagner von Jauregg drew blood from a soldier with high fever from malaria and injected it into three paretics. Once these patients began to run a high fever, he drew blood from them and injected six other paretics. Substantial improvements were seen in the patients whose onset of paresis was fairly recent. Apparently the disease had been arrested. This malarial treatment won him the Nobel Prize in Medicine in 1927. When it was later discovered that it wasn't the malaria but the fever that produced the improvement (presumably because of the body's reaction to the high temperature) various other therapies were tried including: hot baths, hot air, radiotherapy, diathermy, infrared light bulb cabinets, and electric "mummy bags."

Ironically, during the 1890s, general paresis was thought to be a functional disorder. The functionalist explanation of general paresis was the mental strain of a life filled with overindulgence and immorality. Today, or course, we know general paresis as neurosyphilis, or syphilis of the brain. Neurosyphilis was proved to be an organic illness in 1913 when Hideyo Noguchi, a Japanese bacteriologist at the Rockefeller Institute for Medical Research, compared brain tissue slides from patients who had died with general paresis against patients that had died of syphilis. To his surprise, he discovered the same infectious agent, *spirocheta pallida*, in both samples.

*Notes:* the wide selection of apparatus available for fever-induction, as well as the production of heat by electricity, leaves quite a bit of room for subtle torture and "accidental" death. The period of temperature elevation would be partly based on physical condition, but repeated intervals of two to four hours each at minimum would seem likely if the temperature was to simulate at all the effect of a reaction to a viral infection. Such lengthy treatments would demand separate, perhaps private treatment rooms.

## FOCAL INFECTION SURGERY

Henry A. Cotton was the medical director of the New Jersey State Hospital at Trenton. In 1919, he posed the "focal infection" theory, hypothesizing that the toxins produced by bacteria at infected sites throughout the body are transported to the brain, where they are often the cause of mental illness. The evidence for this notion was scant, but in the 1920s he began performing surgery on psychiatric patients and removing the source of these infections. Perhaps because of the controversy and publicity roused by these radical experiments, he was able to convince many others to adopt his methods.

According to Cotton, it was necessary to first locate the site of the infection. Once this had been done, the source of infection had to be removed. He declared that all psychotic patients have infected teeth and that this was the first place to find infection. Any tooth that showed signs of decay or had crowns or fixed bridge work were deemed infected. The tonsils and sinuses too needed to be thoroughly examined for infection. Eighty percent of females were found to have infected cervixes. On the other hand, males were found to have infected seminal vesicles only "occasionally." Twenty percent of psychotic patients were found to have infections of the stomach and or colon. Even though patients that were found to have infected the colon or lower intestine had a thirty percent mortality rate after surgery, Cotton continued these operations for over fifteen years.

*Notes:* the moral depravity or at best the moral vacuum behind these terrible actions speaks for itself.

## HYDROTHERAPY

Hydrotherapy, too, was used a treatment for neurasthenia. It involved the therapeutic effects of baths, douches, wet packs, steam, spritzers, and hoses. For those who could afford it, prescriptions were written for hydrotherapy in combination with "rest cures" (see below) at any vacation spot that offered natural baths at spas. See also hydrotherapy under Restraints, further in this chapter.

*Notes:* hydrotherapy in the 1990s mostly refers to palliative treatment by specialists in physical medicine. Hydrotherapy in the 1920s might refer to courses of immersion in rushing water that might last for weeks, attempting to soothe and tranquilize the patient by physical touch. The potential for torture in lowering or raising the water temperature is obvious.

## HYPOTHERMIC TREATMENT

Hypothermia (cooling the body) while not widely used was one of the many somatic therapies explored as a treatment for schizophrenia. Sedated patients were placed in a "mummy bag" through which a refrigerant was circulated. Even though one patient died from this treatment, the physicians reported promising results.

*Notes:* another stress therapy, apparently adopted with little more evidence than the observation that a cold bath might make a person eager to escape it. Only duration distinguishes this therapy from torture.

## NEUROSURGERY

Evidence of the procedure called trepanning (cutting the skin at the top of the head and perforating the skull to allow matter to escape) goes back to prehistory, and is common in many 'primitive' cultures. This operation was used as early as the twelfth century as a treatment for mania and melancholy. At that time trepanning was imagined to allow the demons that were causing these ailments to escape. While not widely used during the 1890s and 1920s, trepanning did have a small following. As early as 1890, Gottlieb Burckhart, the director of the asylum at Prefarigier, Switzerland is said to have performed operations directly on the brains of at least six patients. In 1899, Clyde Shaw, working

at Bamstead Asylum in England drilled holes in the skulls of paretics and penetrated the dura matter over the motor cortex in the frontal lobes. He hypothesized that patients suffering from "progressive paralysis" have, in this region of the brain, an "elevated intracranial pressure caused by an inflammatory process."

Records of trepanning appear in 1895 at the New York State Lunatic Asylum in Utica and also in hospitals in Grand Rapids, Michigan. Later in 1900, Lodivicus Puusepp, an Estonian surgeon and neurologist, tried treating mental patients by cutting the nerve tracts that connected the frontal and parietal lobes. Even though he considered this treatment unsuccessful, Puusepp tried again in 1910 and cut four or five holes in the skull over the frontal lobes of paretics and inserted a cyanide-mercury mixture under the dura matter. This time he produced a "noticeable improvement" in the patient's condition.

In the 1920s and 1930s, Dr. Antonio Egas Moniz experimented with a few prefrontal lobotomies in incurable cases of insanity, with results having implications for the understanding of brain functions.

*Notes:* lobotomized patients did not lose their delusions and hallucinations, as Moniz expected, but they did become more placid, inoffensive, and agreeable; most now would say *zombie-like*. Many state institutions in the United States found the procedure convenient for quelling nuisance or violent patients, and their willingness to adopt such radical surgery has long tainted the institutions and the profession of psychiatry. In many states, this operation is still an option in the arsenal of hospital doctors.

## PSYCHOTHERAPY

While not a somatic therapy, various forms of psychotherapy were used both separately from and in conjunction with organic treatments for mental illness. Very often a somatic treatment was administered to produce a lucid state in psychotics, during which psychotherapy would be attempted.

## HYPNOSIS

The 1890s were the golden age of hypnosis. It was acceptable to medical science and was applicable to a wide range of patients and symptoms. Patients were systematically treated with hypnosis and, while entranced, encouraged to speak about experiences that coincided with their symptoms. Memories recalled under hypnosis were accompanied by the violent expression of emotions that the patient had felt during the original experience but had been unable to express at the time. After several sessions of this catharsis, the patient's neurotic symptoms might disappear.

*Notes:* only an extended course of hypnotic sessions could create new impressions of people and events, and then only if the subject was in some sense eager to deny the old perceptions. But shades of meaning and the implications of events can be, as it were, *renegotiated*, in shorter periods of time if the hypnotist is trusted by the person being hypnotized.

## PSYCHOANALYSIS

During the early twentieth century, psychoanalysis gradually replaced hypnosis in the treatment of neuroses. By the 1920s they were only occasionally using hypnosis and suggestion as aids to their therapy. From the viewpoint of the psychoanalyst, repressed sexual urges are the major causes of neurosis. Using the techniques of free association and dream analysis allowed the patient to uncover and work through these early sexual desires and experiences. Some psychoanalysts with medical backgrounds used sodium amylal as a way to unlock repressed unconscious material and remove the patient's self-censorship.

Adler, Jung, and Rank had a substantial set of followers in the 1920s but their organizations and training centers never became as visible as those of Freudian psychiatrists. Instead of focusing on the sexuality of the individual, Adlerian psychotherapy focused on the life style of the family and how it influenced the life style of the patient so that the patient could modify it in sensible ways according to the patient's goals. Jungian therapists, too, dealt with the patient's problems in their physical forms, but placed an enormous weight on dream interpretation. In Jungian therapy, dream interpretation uses symbols based on archetypes (universal concepts) and mandalas (representations of the universe) instead of the sexual symbols found in Freudian analysis. Otto Rank's therapy (will therapy) involved planned action and was very future oriented. This therapy is based on re-educating the patient with attention to the future rather than the past as with Freudian therapy.

*Notes:* these therapies are discursive and lengthy, and depend too much on the willing and enthusiastic participation of the patient to be of much effect in dealing with incapacitating or criminal insanities. With them, a patient can make valuable personal discoveries, but he or she must be sane at the start.

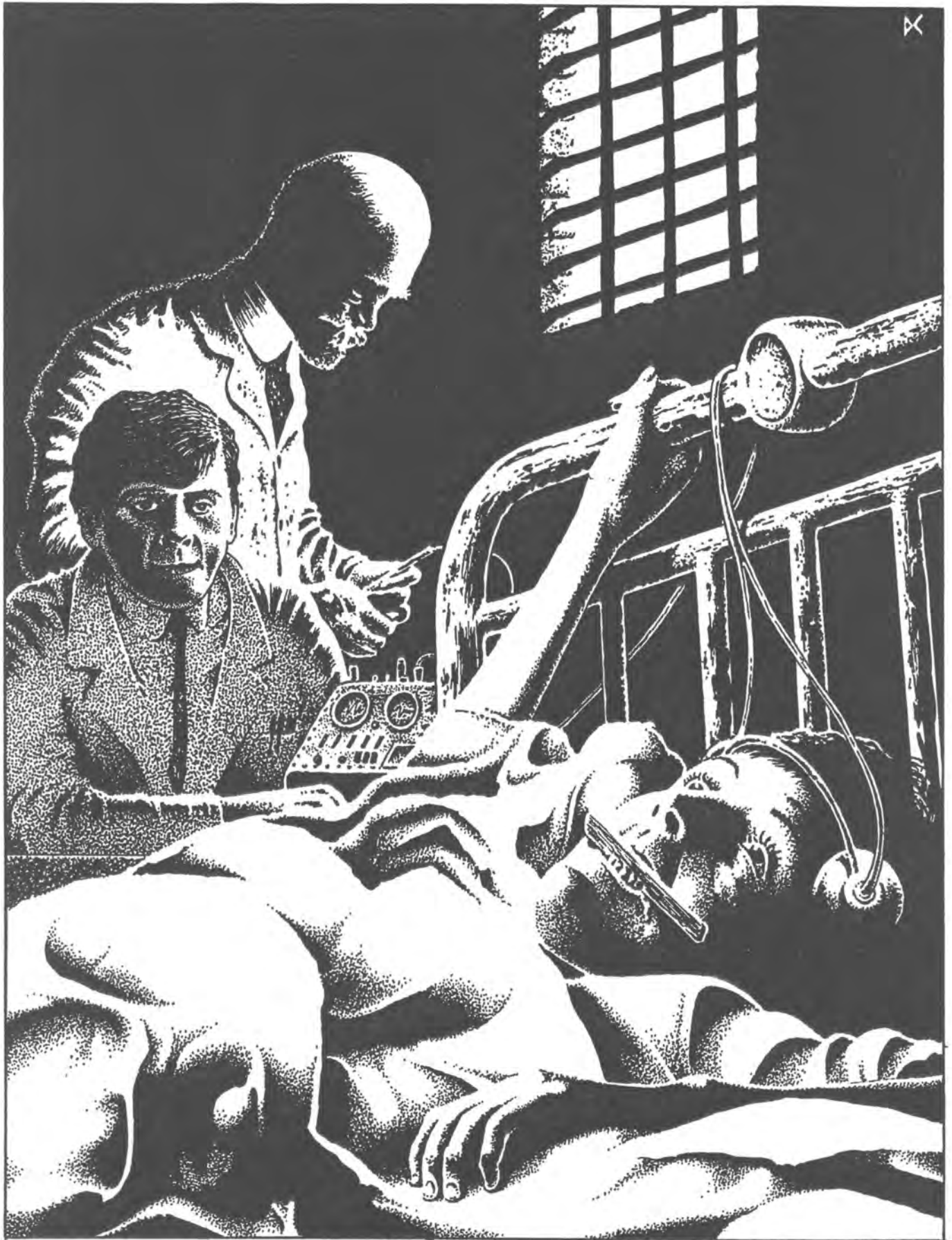
## REST CURES

During the 1890s, rest cures were very popular. These consisted of isolation from family, quiet, special diet, and massage. This was, of course, completely different than the various "mind cures" offered by religious institutions of the day, as rest cures were 1) prescribed by a physician and 2) benefited the patient by building up fat and blood (or so it was perceived by the medical community).

## SHOCK TREATMENT: INSULIN-COMA THERAPY

In the early 1930s, Manfred Sakel, a Viennese physician, accidentally gave an overdose of insulin to an actress he was treating for morphine addiction, causing her to go into a coma. Upon recovering from her coma, he noted her cravings for the drug had subsided, so he started giving insulin to all his drug addicted patients. Eventually he "accidentally" caused a coma in a drug addict who was also psychotic. The patient's schizophrenia seemed to improve after the treatment. Encouraged by this, Sakel began treating schizophrenics at the Neuopsychiatric University Clinic in Vienna by inducing comas through overdoses of





insulin. In 1933, Sakel published his first paper on this technique and claimed that 88 percent of patients showed improvement after experiencing the treatment.

*Notes:* disoriented after waking, the patient needs careful counsel and treatment or feelings of resentment and the perception of exploitation arise.

## SHOCK TREATMENT:

### METRAZOL-CONVULSION THERAPY

Also developed during the early 1930s, this therapy gained wide recognition and acceptance for its success rate. Joseph Ladislas von Meduna, a Hungarian research physician, observed a conflict between the brain cells of an epileptic and those of a schizophrenic. With this in mind he hypothesized that if he could develop a controlled form of epilepsy in a schizophrenic, that the schizophrenia would subside. To do this he injected camphor (a stimulant derived from laurel bushes) which made the patient immediately convulse as if suffering an epileptic seizure. Meduna's first published work on the subject in January, 1935, noted recovery in half of the patients treated. Within a year interest and support for this technique had spread world wide.

Others using the same theory that schizophrenia and epilepsy cannot exist simultaneously tried other methods such as injecting schizophrenics with the blood of epileptics who had recently had a convulsion, and forcing schizophrenics to breathe nitrogen. This technique was later found to be more helpful to manic-depressives than schizophrenics.

*Notes:* camphor can be quite poisonous if injected in higher dosages. Done intramuscularly, it would take effect in ten minutes or so. Headaches, spasms, extreme sweating, vomiting, and so on occur, followed by extreme convulsions and then complete circulatory collapse in less than an hour.

## SHOCK TREATMENT:

### ELECTROCONVULSIVE SHOCK

Italian physicians Ugo Cerletti and Lucio Bini also studied the relationship of convulsions in epileptics and schizophrenics. They, however, tried inducing convulsions by connecting electrodes to the heads of animals and shocking them into unconsciousness. After judging the lethality of several of these experiments, they were able to test it on a human in April of 1938. This therapy too became widely used and was later found to be better suited for the treatment of depression. This is what most people think of as *shock therapy*.

*Notes:* profound disorientation and short-term memory loss are said to be general consequences of the therapy. The convulsions are likely to dismay onlookers.

## SLEEP THERAPY

Sleep therapy or "prolonged narcosis" as it was known in the 1920s and 1930s was a highly-used treatment in Europe for various psychoses. It also had a small following in the United States. In 1922 Jacob Klasi is credited with the recommendation of prolonged sedative-induced sleep be-

cause "excitement was a result of an inflammatory process in the brain that could be relieved through rest." This rest, it was believed, would restore a nervous system to a more normal state.

By means of barbiturates or opium derivatives, Klasi would keep mental patients in comatose sleep from one to two weeks or as long as a month. The patients were generally allowed to awaken sufficiently for brief periods during the day for nutrition, bowel and bladder relief, and routine nursing care. Sleep therapies appeared to have a 70%-80% improvement rate for manic-depressive and schizophrenic patients. It also made the patients more responsive to psychotherapy. Sleep therapy grew out of the popular rest cures of the 1890s and was a precursor to the shock treatments of the 1930s (see above).

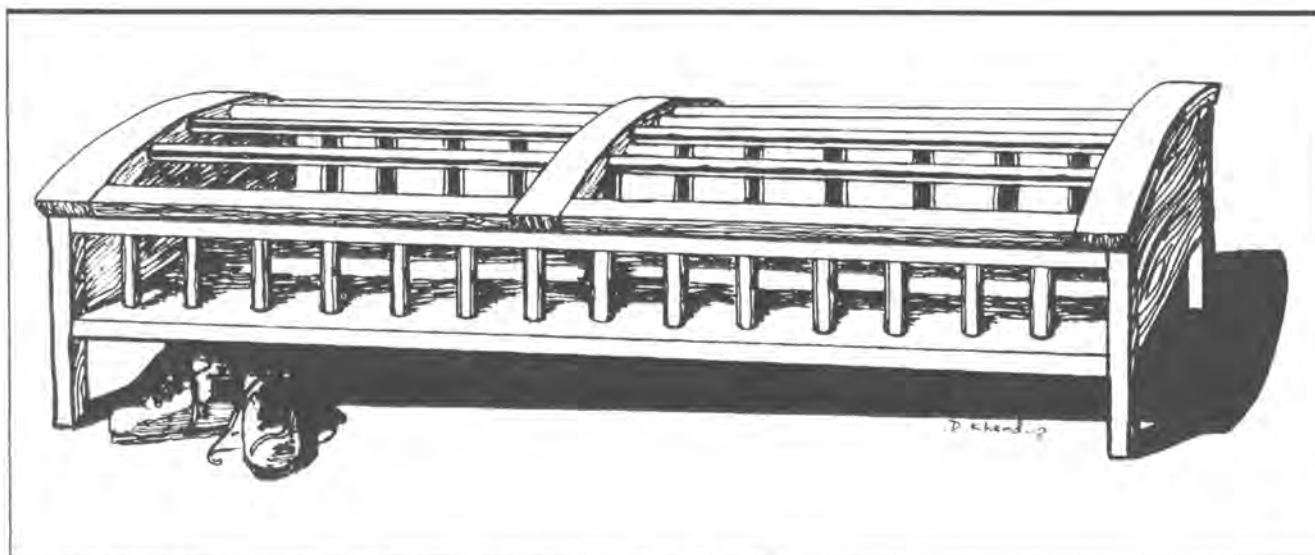
*Notes:* injudicious applications of narcotics could lead to addiction. This course of therapy also assumes a good standard of general hospital care, for such unnatural bed rest has its own physiological complications.

# Methods of Restraint

**P**ATIENTS IN MENTAL institutions naturally present many challenges to the hospital staff. One of the foremost of these is the issue of mechanical restraints or formal isolation. If they are not used, aggressive patients may harm other patients or the attendants. If they are used, they may tend to dehumanize the patient in his or her own mind as well as the minds of the asylum's employees.

Of course, it was not only the violent or excitable who needed to be restrained; psychiatrists described several categories of patients as deserving of such treatment. Those who refused to eat would be held still while force-feedings were carried out, and there was little reason to set them free over the day, as they would only have to be corralled again a few hours later. Destructive patients who tore at their clothes or vented their aggression on the walls and facilities of the asylum were also subdued by restraints. Sexual deviants or frequent masturbators were restrained to save them from the degenerate effects of self-pollution.

In the earliest days of asylums, mechanical restraint was the rule rather than the exception for all lunatics. Before the nineteenth century, the insane were objects of horror to most communities. They seemed to have lost their humanity, and many thought that they had no souls and were harboring only demons. As treatment, the insane were subjected to all manner of mortification in the hope of driving out the evil spirits. Apart from outright torture, they were manacled, locked in cages, and held immobile in innumerable ingenious devices. Even after notions of demonic possession fell into disfavor, it was still believed that the insane were generally insensible to pain or discomfort, so conditions did not alter very much even as mental illness was being recognized for what it was. Those who were unwilling to change, or were far from the groves of academe where the new science of psychiatry was being



'The Crib' and other restraining beds and chairs were still in use as late as 1908.

developed, changed little. Consequently, even well-run institutions might house and use the most barbarous devices. *Call of Cthulhu* investigators will run risks even when treated by enlightened hands.

The introduction of Pinel's moral treatment in the nineteenth century led to the conception of the insane as people suffering from mental illness. No longer would the vanguard of psychiatry allow patients to be treated like demons, to be locked up and shut away. Now, each patient was to be considered a person and varieties of treatments were devised to help cure the mental illness affecting him or her.

Aggressive handling of the mentally ill did not end overnight, but the asylums gradually came to use less strict forms of restraint. Particularly, they eschewed permanent restraints such as cages and manacles. Poor behavior would be met with punishment or removal of privileges; when the patient's attitude improved, he or she would be restored to the freedoms as before.

Gaslight investigators may encounter the gamut of these devices, particularly if they stray beyond western Europe or the eastern seaboard of the United States. The safest place is England, for mechanical restraint (apart from being isolated in a locked room) was eliminated from public English institutions by the middle of the nineteenth century, and private institutions were mostly governed by the same humanitarian spirit.

In the 1920s, Europe and most of the United States will have benefitted from the reforms of Pinel and others, but a few private institutions may prefer the old ways. Dominated by straitjackets, bed straps, and padded cells, most asylums of this period won't directly damage a patient's health. Some of the supposedly beneficial medical treatments offered in the early part of this century are arguably worse than lunacy and shackles combined.

In the 1990s, only backwater nations and industrialized world quacks use the more primitive contraptions. Drug therapy, straps, and isolation are the restraints of choice in most modern hospitals. The mental health care industry in the United States is also obliged to employ the least restrictive method of restraint suitable for the patient. A conse-

quence of this legal advocacy is that dangerous patients who do not respond to psychotropic medicines are often under lax restraint.

The following methods of mechanical restraint are arranged in a loosely chronological order. As noted above, most of the more primitive forms of restraint can be found in later eras in some part of the world, or in particularly backward mental institutions.

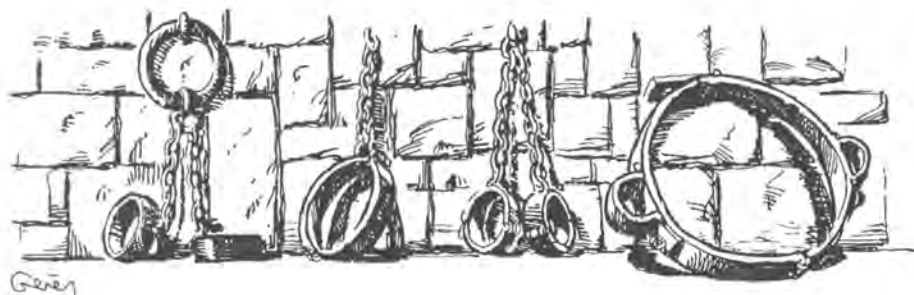
## CHAINS

Early restraints commonly involved chains. Manacles, gyves, or irons could control a disturbed patient as well as any other sort of prisoner. Commonly, several iron bands were affixed to the patient; each band would be hinged and equipped with either a locking clasp like a handcuff or by rings to be connected by padlocks. Such bands would be placed around the neck, the wrists, and ankles. One's freedom of movement was severely circumscribed by the length of chain while the sheer weight of the iron was enough to keep most from attempting to escape or injure another person. The chance of an investigator escaping such bonds is nil, unless he or she has both the talent and the secreted supplies of Houdini.

Often the patients were otherwise free to move as much as they were able. For the more obstreperous, the restriction of the chains would be augmented by bolting them to a wall or sturdy post. The door to the cell could then be safely opened to deliver food. At Bedlam, a particularly homicidal inmate by the name of James Norris was kept in even stricter immobility. In addition to the usual chains, a leather harness about his chest was connected to a short loop of chain which went around a solid wooden post situated next to his bed. The loop gave him enough freedom that he could lie on the bed, sit on the bed, or stand next to the bed, but little more than that. Probably many people suffered this sort of arrangement.

The bed saddle was another variant. The patient would be chained to a cross formed of iron bars, which was laid across a bed for the patient's ease. Except at mealtimes, the patient would spend all his hours in a crucifixion pose. Less severe forms of chains were also popular, and lasted well





into the current century. And, whether for punishment or for staff protection, a patient might very well be secured to his or her bed by means of ordinary police handcuffs or specially made iron bracelets.

## CAGES

The other main early approach to controlling lunatics is perhaps even more stringent: putting them in cages. Even the rather cramped quarters of animals at the zoo were luxurious by the standards of the asylum. Lunatics were kept in cages with dimensions hardly larger than the patients themselves. Imagine a cage seven feet long, three wide, and two and a half tall. That is the extent of the liberty of physical movement allowed by one particular model. Usually, these were of wood frame construction with something like chicken wire forming the walls. Gruel could be poured through the wire into a bowl inside the cage for the inmate's meals. Chamber pots were unnecessary, since the wards would be hosed down every couple weeks whether they needed it or not. In early asylums, the cage would be the patient's last home, sometimes for years, until he finally attained the hardly less capacious accommodations of the coffin.

A slightly more modern incarnation of the cage was the Utica crib, which became popular in the latter half of the nineteenth century after it was introduced at the Utica State Hospital in New York. It resembled nothing so much as a large wooden crib, with the addition of a locking hinged lid over the top. Problem patients would be placed together in a crib room, which resembled an overcrowded giants' nursery. Narrow aisles separated row upon row of identical Utica cribs, each with its own demented occupant. In more modern settings, the patients would be allowed time to eat and exercise away from the cage's confines, but they would spend the remainder of the time encaged. More humane institutions might have cages, but use them solely for punishment and behavior modification purposes.

## MUFFS

Muffs were a relatively humane way to ameliorate the destructive activities of some patients. Made of extremely coarse and padded leather, these fingerless gloves were furnished with tight straps that would lock or tie at the wrists. The rough leather also discouraged masturbation; muffs and their variants were frequently used for that purpose within and without mental institutions.

## CALMING CHAIRS

A gamut of special chairs were also promoted by their inventors as having calming properties. The basic model is the hooded chair, such as the 'Tranquilizer' of Dr. Benjamin

Rush: the patient was strapped in, much as he would be into an electric chair. Then a metal hood was placed over the face. The absence of stimulus was enough to calm most patients.

Inevitably some patients failed to relax, leading to the introduction of new inventions,

such as the gyrotor. The whole apparatus of the gyrotor was rotated rapidly on a stout turntable until the patient lost consciousness. The inventor would point to the extremely calm unconscious patient and the local Lunatic Board would enthusiastically order a dozen. Numerous variations on spinning tables and chairs appeared. By the 1890s, such devices lost their popularity as appreciation grew of the essential humanness of the mentally disturbed.

## HYDROTHERAPY

The many enthusiastic supporters of hydrotherapy delighted in pointing out the calming effects of water. The earliest form of hydrotherapy was probably the dashing of cold water in the face of an enraged patient. Later hydrotherapeutic baths are essentially mechanical restraint systems. In the continuous bath, the patient would be held suspended in a bath of running water. The tub resembled a sarcophagus with a small opening for the head, while the rest of the body was entirely encased in the metal coffin. With time out only for eating and sleeping, patients would undergo a two or three week course of immersion, and hypothetically emerge soothed and acquiescent.

Another variation involved rolling up the lunatic in a cold wet rubber or cloth sheet. The tight winding of the sheet kept the patient from moving a muscle. After an hour, he or she would be unrolled and treated to a hot water spray.

## STRAITJACKET

The straitjacket or strait waistcoat is perhaps the emblem of psychiatry in the first half of the twentieth century. Made of tough canvas and secured by various ties or locks, these garments totally restrict all upper body motion. After a few hours of enforced quietude, most patients regain at least a modicum of composure, and the jacket can be removed. Only in extreme cases would a patient be continuously restrained in such a device.

## ISOLATION ROOM

Another tactic is to place the patient in an isolation room until he or she becomes more sensible. At prestigious institutions, these rooms will probably be padded so that no injury can occur. Surveillance by attendants will be regular or ongoing. At less advanced asylums, the rooms may be bare concrete cells without heat or lighting. Such privation may cause the wanted attitude adjustment, but the sincerity of the contrition is certainly suspect.

## STRAPS

Straps of all kinds form another popular method of restraining the insane. Leather straps perform a function similar to that of chains, but provide several advantages. They are



easy to put in place and remove. The belt-like fastenings are easy to adjust for a safe and snug fit. Straps also can be buckled around any sturdy object.

Early in the century, it would not be out of place to see patients strapped to poles in an upright position. Even as late as the 1940s and 1950s, patients in American asylums were strapped to benches and cots or beds for long periods of time. Strapping the patient into a chair is another possibility. Since the leather straps are built into the furniture, they can be used if necessary, but otherwise the patient can sleep normally.

Two main varieties of leather bed strap can be distinguished. Two-point straps fasten the wrists and chest, while four point straps include the legs as well, effectively immobilizing the patient. Sturdy lined leather cuffs are riveted to strong wide leather straps that attach beneath the bed and pass around the frame and mattress.

## DRUGS

Drugs are the most common way to treat violent behavior today, and drug therapies have been used since the nineteenth century. Early on, institutions used drugs like opium, morphine, ether, and various bromides to sedate patients into sleepy tranquility or unconsciousness. By the 1920s, a large number of sedatives and hypnotics were used to keep order in the wards. These included paraldehyde, chloroform, hyoscine, veronal, chloral hydrate, sulphonal, calomel, and digitalis.

Today there exists a bewildering array of tranquilizing drugs, tailored to specific conditions. Any side effects are well known and predictable. Drugs like valium, seconal, and librium act to relieve the patient's anxiety with useful sedative side effects. Some antipsychotic medications (stelazine, for instance) cause drowsiness in addition to relieving psychotic symptoms. And some antidepressants, such as amitriptyline, have tranquilizing effects.

These serendipitous side effects of psychoactive drugs are frequently used by opportunistic psychiatrists to keep excitable patients under control. The less scrupulous simply dope their charges with powerful sedatives to keep them quiet. Most mental health professionals would classify some of these drugs as *chemical straitjackets* and include them in discussions of restraints. Frequently, these potent drugs alter the personality of the patient so much that they infringe upon the patient's mental freedom. Pharmaceuticals must always be used with care; if they mask symptoms, they delay the patient's eventual recovery.

## LOBOTOMY

Lobotomy is another method of control that essentially acts as a restraint. Touted as a cure for schizophrenia and used widely in the United States before and after the

Second World War, the procedure was later abandoned by the medical community, who concluded that Antonio Moniz's radical procedure did not so much cure as it turned the recipient into such a zombie that any mental illness was no longer noticeable. To his credit, Moniz did not offer the procedure as a cure and was shocked by its widespread adoption in the United States.

## UNOFFICIAL PUNISHMENTS

Last, but certainly not least, there are always a number of unofficial procedures used by attendants and nurses to ensure good order or a quiet ward. Although not sanctioned by the doctors in charge or by any asylum's policies, in most cases responsible authorities ignore these infractions, since they keep the institutions running smoothly. Even if physical abuses result in the death of one or several patients, these illicit procedures may not stop; the particular attendant responsible for the death may be fired, but the abuses will continue.

Though doubtless no such behavior occurs today in any institution, this sort of informal correction might start with warnings and threats. If they continued to be somehow provoked, attendants might perform a quick beating. Key chains, broom handles, a bar of soap in a sock, or a metal pail can deal out pain to the victim without seriously injuring him or her.

Depending on the era and the laws of the particular state, nurses and attendants might also be able to draw upon chloroform, ether, paraldehyde, and other drugs to subdue patients. Though improper administration might result in death to some people, such agents left little evidence of their presence and usually did not require a doctor's signature for their use.

Naturally preferred were methods that left no marks on the patient as evidence. That way, the attendant's job was secure. Tying the patient into his bed using his sheets was a popular method of control. Twisting a wet towel around the neck would squeeze closed the windpipe without leaving telltale purple thumbprint bruises on the neck. Lunatics could drown (or nearly drown) in a hydrotherapy tub without undue suspicion. *Pillowslipping* was an ingenious tactic: a pillow case would be placed over the patient's head, then water would be poured over the mouth, making the saturated cloth impermeable to air, so that the patient had nothing to breathe. Attendants found that nearly dying was an excellent way to scare an obstreperous patient into submission.

Attendants and orderlies were once called keepers, after all, and attendants and Call of Cthulhu keepers will find they have certain mutual interests. Vicious ideas the keeper may devise will probably have been tried out by attendants across history. Even if unoriginal, such notions will definitely personalize the institutional visit.



# Sanity, Insanity and Roleplaying the Investigator

*At the heart of Call of Cthulhu roleplaying is the concept of insanity as a personal shelter to which investigators must retire from time to time.*

**T**HE MAJORITY OF THE INSANE and incompetent are born with mental abnormalities with which these poor souls must deal for their entire lives. Call of Cthulhu investigators, however, are normal people who are driven mad. They become insane as a defensive response to the sheer alienness of what has come to be known as the Cthulhu Mythos. Investigators and other characters in roleplaying adventures share one basic congenital defect: they are human beings.

## SANITY

Sanity is the natural state of conscious existence, the opposite of insanity. It has another specific meaning within the Call of Cthulhu rules. It is basic to all characters in the game, for Sanity represents an investigator's ability to withstand and deflect emotional shock. Those who start with high Sanity characteristics have strong minds. They can rationalize the most unbelievable sights, and repress the most horrible visions. Those with low Sanity characteristics are more fragile, and correspondingly are more easily affected by shocks and thus easier to drive mad.

## WHY THE MYTHOS CAUSES INSANITY

In the game, it is emotional shock that causes insanity. From where does the the shock value of the Mythos come? First, many of the creatures of the Mythos are horrific, blasphemous monstrosities that have no right to live or even to exist, at least within that portion of the universe with which we are familiar. Lovecraft deliberately made his entities as alien and unnatural as his art can create. The more unnatural they are, the greater the shock involved.

The existence of such powers represent a peculiar perception, that the cosmos is not all of one kind, that it is not predictable and understandable by us, and that its true nature cannot be divined by logical scientific thought. Humanity's great inventions of deduction, induction, and rational, timeless doubt mean nothing in the actual universe, which is full of irrational event and unholy fury. Humans cannot begin to understand such an arena until we go insane and open ourselves to the alien horrors at the heart of everything.

Having suggested that all the qualities we honor most—intelligence, compassion, decency, courage, self-sacrifice—all are meaningless if they cannot reflect the universe beyond, Lovecraft goes on to presume that they do not. From this conservative and retiring writer emerged a mockery of humanity in its way as thorough as those of Swift and de Sade.

As yet this terrifying reality is known to only a few. To those who stumble across the knowledge of the Cthulhu Mythos, madness or the threat of madness must follow. In the game, the Cthulhu Mythos skill lowers sanity points. When an investigator gains knowledge of the Mythos, the emotional and intellectual burden of that knowledge reduces his or her maximum possible Sanity by an amount equivalent to the Cthulhu Mythos percentiles gained. The Cthulhu Mythos skill represents true knowledge of the universe, something no amount of rationalization can remove. Since the skill represents truth, psychotherapy, rest, or time cannot remove it. As the Cthulhu Mythos skill increases, maximum Sanity must lower and thus limit current Sanity. Failed sanity checks become more frequent, and Sanity drops yet more. Permanent insanity becomes more and more likely.

## Going Insane

Insanity was an important component in Lovecraft's fiction and is crucial in the Call of Cthulhu game, or ought to be. (The optional rules later in this chapter increase the depth and complexity of roleplaying insane characters, but first the rules as they stand need to be summarized.)

It is emotional shock that drives investigators insane. While many sorts of situations can prompt such shock, the game groups the results into four categories: *continued sanity* (the investigator survives the shock without being diminished), and by *temporary insanity*, *indefinite insanity*, and *permanent insanity*. Each insanity result represents a greater emotional distress than the one preceding it. The type of insanity that results from sanity point loss depends upon the amount of shock received, also measured in sanity points.

### TEMPORARY INSANITY

A sudden, severe shock, represented in game rules as the loss of more than five sanity points at one time, can cause temporary insanity. An investigator with strong mental defenses can readjust to the sudden shock by repressing or rationalizing the experience.

If the mind is not well-protected from the shock, the character goes temporarily insane. For a short amount of time, his or her mental defenses go haywire and the character expresses the effect as one of many possible mental disorders. By definition, all temporarily insane characters heal themselves, snapping out of it after a few hours or up to a few days.

### INDEFINITE INSANITY

When an investigator is subjected to repeated shocks or to some cataclysmic shock such as meeting Great Cthulhu himself, mental defenses may break down completely. This occurs when a character loses one-fifth or more of his current sanity points in a relatively short amount of time, usually about one game hour. In such cases mental defenses have been so thoroughly vanquished by shock that only months of therapy or quiet rest allows restoration of sanity.

### PERMANENT INSANITY

When sanity points reach zero, emotional restraint and intellectual protection disappear. The defenses of the mind have fallen, and there is little hope of rebuilding them, at least quickly. Perhaps only the primal chattering id still exists. Or perhaps the emotions and intellect of a once-complete person are channeled into addiction or monomania, or otherwise so walled away that the personality is inhumanly constricted and humorless.

The state of permanent insanity often ends an investigator's career, since recovery might take years, or never be possible at all. But though madness is the normal state of existence for cultists, an insane investigator does not necessarily become a cultist, as some players and keepers presume.

## Causes of Sanity Loss

The loss of sanity points reduces a character to insanity. Three occasions of mental shock usually contribute to this: emotional shock, the reading and analyzing of Mythos tomes, and the learning /casting of Mythos spells.

### EMOTIONAL SHOCK

Emotional shock represents a blend of fear and disgust. The range of game sanity-point losses goes from 1 or 1D2 chalked up when casting some spells to the potentially cataclysmic D100 called for when encountering Great Old Ones or the dire Outer Gods. Whether "emotional shock" means discomfort or mind-rending terror or

some state in between, the feeling is the most common way to lose sanity points. Examples of small sanity losses are seeing corpses, witnessing bloody violence, or encountering nausea-inducing creatures. Greater sanity point losses occur for instance when people the investigator knows are killed or hurt, or when he or she confronts the reality of the Mythos by viewing something that experience suggests is impossible. The greatest sanity loss occurs when horror and the hyper-reality of the

Mythos are shown to be combined: if an investigator sees something not only blasphemous and disgusting, but also so other-worldly and so impossible that it cannot be believed, and yet must be accepted, then the sanity of any character is in great danger.

### READING AND ANALYZING MYTHOS TOMES

Though conversation and other ways of gaining information about the Mythos exist, by far the most common way is by independent readings of Mythos tomes and other arcane lore. In part this is because of the role Mythos tomes such as the *Necronomicon*, the *Cultes des Goules*, and other such books play in the stories written by the original Lovecraft circle of authors.

As an investigator reads and attempts to comprehend the infernal clues and maddening lessons that outline the true nature of the universe, the mind naturally tries to protect itself against the approaching shock of realization. It never completely manages to achieve this. On average, the amount of sanity points lost from reading a tome is

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### A Relevant Quote

"The most merciful thing in the world, I think, is the inability of the human mind to correlate all its contents. We live on this placid island of ignorance in the midst of black seas of infinity, and it was not meant that we should voyage far. The sciences, each straining in its own direction, have hitherto harmed us little; but some day the piecing together of dissociated knowledge will open up such terrifying vistas of reality, and of our frightful position therein, that we shall either go mad from the revelation or flee from the deadly light into the peace and safety of a new dark age."

— H.P. Lovecraft, "The Call of Cthulhu".



proportional to the amount of Mythos knowledge to be gained from the book or other writing. The amount of Sanity lost in reading and understanding the book is expressed in a dice roll (1D10/2D20 for the *Al Azif*—1D10 to skim it, and 2D20 to read closely enough to locate any spells and understand their general characteristics) and the gain to Cthulhu Mythos is a particular number (+18 for the *Al Azif*). Thus a very lucky person might read and understand even Abd al-Azrad's horrific book with only a twinge of distaste, while an unlucky person might go indefinitely insane from the same experience.

## LEARNING AND CASTING SPELLS

To learn to cast the spells embedded in many Mythos tome takes separate study, as outlined in the rules. Some spells are more horrible than others, and even learning them costs Sanity, since the mind must be intuitively attuned to a variety of hyper-dimensions and non-Euclidean geometries. Other spells cost nothing to learn, but the process of casting them may cost sanity points because the dismaying procedures are indecent, dangerous, or horrifying. Some spells may invoke awful entities and cause them to appear, also costing Sanity for each use. Such situations and the die roll range of Sanity loss are indicated in the individual spell descriptions.

And, in our modern scientific world, the characters already know that magic is impossible. The first time an investigator actually casts a spell, and it works, success in itself also might be a great shock. Most Mythos spells cost some Sanity to cast. Other sorts of magic, such as tribal magic, also exist, and sometimes do not cost sanity points to cast, nor do the spells of other magics usually grant Cthulhu Mythos points.

## Recovering Sanity

The game clearly expects that every investigator will lose sanity points. If the investigator is played frequently, he or she continues to lose points. Without good fortune, the busy investigator's eventual insanity is inevitable.

Fortunately, sanity points can be recovered when some event reassures an investigator that he or she has some control in life, or else convinces him or her that the logical explanation of a recent experience reaffirms an existing viewpoint.

## MASTERING A SKILL

An investigator gains 2D6 SAN each time he or she reaches 90% in any skill except Cthulhu Mythos. This Sanity bonus represents increased self-esteem, and renewed faith in controlling his or her own destiny. The resulting belief is far from the truth, of course.

## DEFEATING MONSTERS

Successfully defeating a monster naturally increases the victorious investigator's self-confidence and attitude. This is especially true when one of the more horrific or unbelievable creatures is defeated. However, the investigator nonetheless has been exposed to the Mythos and even

victory will not remove that fact. The Sanity reward should thus not be more than the Sanity loss for the creature, as shown in the rulesbook entry.

If more than one investigator shares in the victory, then each gets the full Sanity reward.

## MISSION ACCOMPLISHED

When it is appropriate, usually at the end of an adventure, the keeper rewards deserving investigators with additional Sanity points, raising their current Sanity levels. The amounts awarded to every investigator should be the same.

If the investigators survived a particularly brutal and dangerous mission, the awards should be correspondingly large, while smaller risks merit smaller rewards. If the investigators were subject to considerable Sanity losses, but held up bravely, they may deserve several discrete rolls (which makes a higher average gain more likely than a single large roll, such as 1D20).

It is also possible to lose Sanity as a group if the keeper decides that the investigators are particularly demoralized at the end of a mission, but this should be done rarely. What demoralizes investigators also tends to demoralize players.

## PSYCHOANALYSIS

Professional help is always an option. While psychoanalysis cannot cure or reduce the length of insanity, it can strengthen those previously affected by it. And treatment by a professional can restore Sanity points through continued treatment. This is possible because the therapist can succeed in convincing the patient that his encounters have rational explanations, whether as natural occurrences misread, or as unresolved childhood problems expressing themselves in strange visions. Or, even if the patient cannot understand everything that he or she witnessed, that the investigator is not at fault for this. Psychoanalysis assists the patient by revealing the design of his or her personality in a life that may seem chaotic to the individual. It cannot be used to increase Sanity above its original amount.

Though in the game, the Psychoanalysis skill can be the mental equivalent of First Aid, in real life it neither works so swiftly nor so deftly. True madness is impervious to it. Though it may eventually staunch neuroses or other small tricks of personality, "talking it out" takes many months, if not years.

## OTHER PSYCHOLOGICAL THERAPY

In general, psychiatric treatments older than a generation before today usually failed to have effect, and might well be cruel and without scientific basis. Asylums could do some good by shielding patients from the world, letting them feel secure, and keeping inmates from harm, but if healing was possible, time and the patient himself usually were responsible.



# Temporary Insanity

**T**HE PSYCHOLOGICAL state of temporary insanity is occasioned by acute shock. Its debilitating effects take place immediately but last for a limited time, as the term suggests. The nearby tables give a quick way to determine from what the investigator suffers. Choose an appropriate form of insanity, or roll randomly. Most of the effects are self-explanatory, and are well-known psychological reactions. Judging partly by the likely strain that the investigator has been under, the keeper chooses whether the temporary insanity is of short or longer duration.

When the immediate effects are over, a mild phobia may remain as a reminder of the terrible experience.

## TEMPORARY INSANITY OF SHORT DURATION

(4+1D10 combat rounds)

die

roll result

- 1 fainting or screaming fit
- 2 fleeing in panic
- 3 physical hysterics or emotional outburst (laughing, crying, etc.)
- 4 logorrhea: babbling, incoherent, rapid speech
- 5 intense phobia (investigator cannot even flee)
- 6 homicidal or suicidal mania
- 7 hallucinations or delusions
- 8 echopraxia or echolalia (investigator does/says what others around him do/say)
- 9 strange eating desire (dirt, slime, other investigators)
- 10 stupor/catatonia (see fifth edition rules, "Sanity and Insanity")

## TEMPORARY INSANITY OF LONGER DURATION

(10x1D10 hours)

roll

D10 result

- 1 amnesia or stupor/catatonia (see fifth edition rules, "Sanity and Insanity")
- 2 severe phobia (can flee, but sees object of obsession everywhere)
- 3 hallucinations
- 4 strange sexual desires (exhibitionism, nymphomania or satyriasis, teratophilia, etc.)
- 5 fetish (investigator latches onto some object, type of object or person as a safety blanket)
- 6 uncontrollable tics or tremors or inability to communicate through speech or writing
- 7 psychosomatic blindness, deafness, or loss of the use of a limb or limbs.
- 8 brief reactive psychosis (incoherence, delusions, aberrant behavior and/or hallucinations).
- 9 temporary paranoia.
- 10 compulsive rituals (washing hands constantly, praying, walking in a particular rhythm, never stepping on cracks, checking one's gun every ten seconds, etc.)



# Indefinite Insanity

**W**HEN A CHARACTER suffers from indefinite insanity, a random roll on a table of lunacies would trivialize the massive shock to the affected person. Unlike spots of temporary insanity, indefinite insanity affects an investigator for months or years. Since it colors the investigator for such a long time, keepers should always strive to choose an appropriate insanity.

Fortunately, a major mental illness is unlikely to appear instantaneously. The keeper can mull the situation over before acting. In a campaign, the illness might be instituted during the next session of play. That may allow the illness to be even more fitting. A clever keeper can spur the flow of a campaign with a judicious choice.

Since an indefinite insanity has much effect on the personality of the investigator, the descriptions below contain specific information on how to role-play each type of insanity. Make sure the player understands his or her character's insanity. Notice that the symptoms of some indefinite insanities are continuous (amnesia, depression, and obsession, for example), but that other indefinite insanities are transient and only manifest themselves at the right (or wrong) moments: these latter include multiple personality, conversion disorder, intermittent explosive personality, and so on.

The names and descriptions given for the different disorders are those currently used in psychiatry. Alternative modern names are given in *(parentheses)*, while nomenclature suitable for the nineteen twenties is enclosed in *[square brackets]*.

Where applicable, optional game effects are listed under each condition. Not only do these remind the player of the investigator's disability, they also prompt more accurate role-playing of the affected investigator.

In cases such as hysterical blindness, the effect of the malady is obvious enough not to need listing.

## A WORD OF CAUTION

In connection with all the behaviors that follow, keepers might note that these summaries outline degrees of behavior that genuinely interfere with or make impossible normal living. Every human being exhibits dispositions tinted with the reactions and confusions discussed below. The specialist will ask, is the behavior one among many, or something morbidly obsessive? Does the behavior promote personal happiness and character, or does it blight the personality?

Most clinical cases exhibit a degree of intensity not observable in everyday life. A madman is no less human, nor even necessarily less capable than a normal person. The intelligence, wit, or perceptiveness of the insane can be striking and disconcerting to a layman. But the range and flexibility of an insane person's responses and interests may be circumscribed in extraordinary ways. The range of humanity composes a vast spectrum: insane behavior occupies only the furthest edges of that spectrum.

## PSYCHOSES: SCHIZOPHRENIA AND AFFECTIVE DISORDERS

A person with a psychosis has lost touch with reality. He or she generally displays some of the following warning symptoms: delusions, hallucinations, and cognitive problems. The psychoses are generally the most severe forms of mental illness.

**Schizophrenia** (*schizophreniform disorder*) [*dementia praecox, dementia of the young*]: in modern psychiatry, schizophrenia is only diagnosed after the psychotic symptoms have persisted for six months. Investigators who have picked up schizophrenia from a mind-blasting encounter will be labeled as suffering from schizophreniform disorder. Apart from this technicality, the symptoms are the same.

First, the investigator's overall ability to function normally is greatly diminished. Halve all skills that require even a modicum of mental concentration.

Further, symptoms must include one or more of the following:

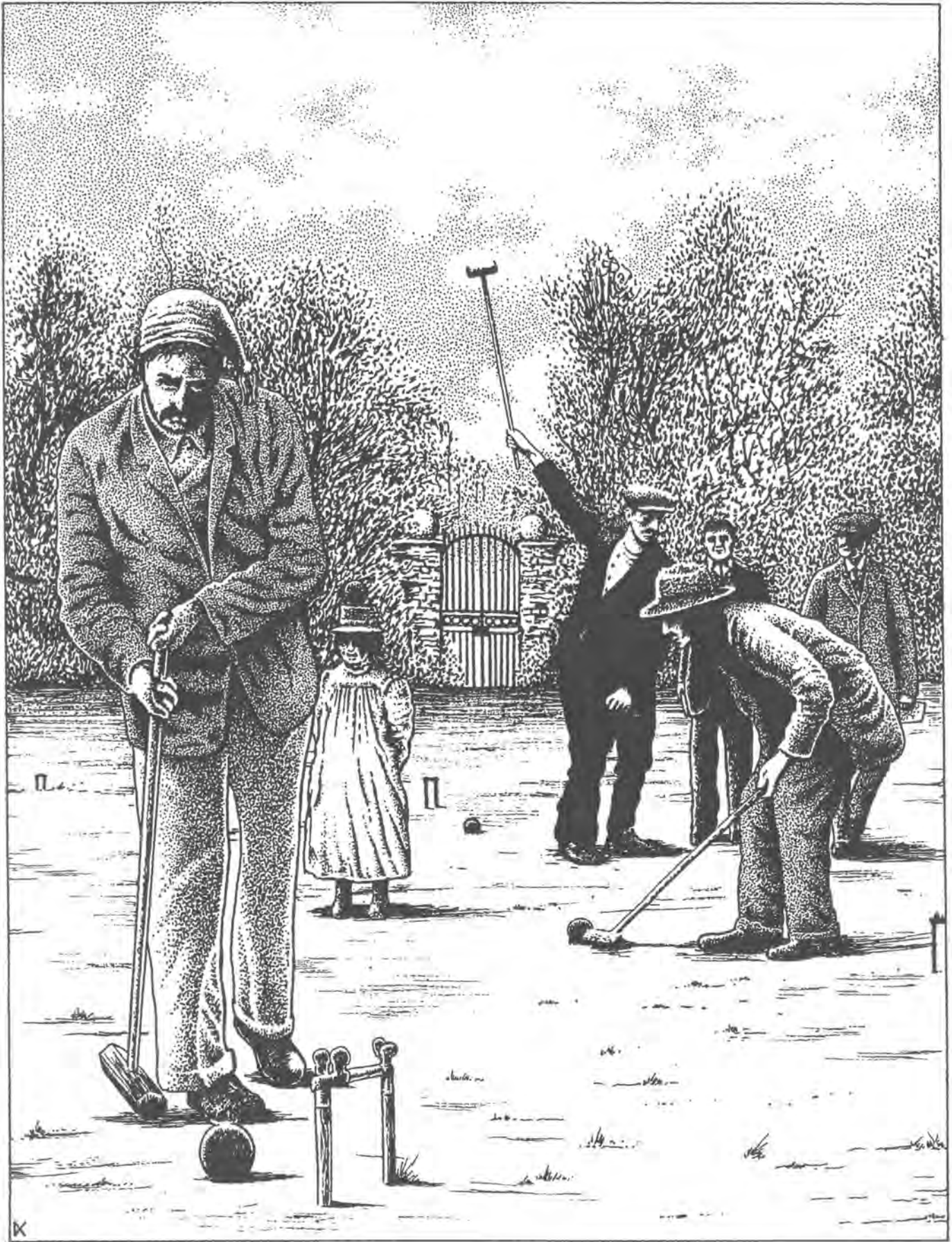
- Extremely bizarre delusions, frequently involving being physically or mentally controlled. "Dr. Morbid is putting thoughts in my head with his tentacled pets." "That book keeps sucking all my thoughts out, leaving only smoke in my head, even when it's far away."
- Other delusions. These may be religious, paranoid, jealous, nihilistic, etc. "I am the true Pope of the Deep Ones." "I have no body; they followed me around until it melted away."
- Auditory hallucinations. The affected investigator may hear running commentaries on himself, or conversations between more than one being. Listen rolls are generally impossible for such characters, they are too distracted by the voices in their heads.
- Incoherence, illogicality, loose associations in speech. Ideas run together without apparent relation to each other. "I was bobo chased by the mushroom from Yuggoth. Where the insects buzz like on Good Friday. But a miss is as good as after a while." Persuade and Fast Talk are simply impossible. Such a character may need a Persuade roll merely to be understood clearly.
- Flat or inappropriate affect. Seeming emotional detachment, or unwarranted giggling, crying, etc. When a schizophrenic is feeling angry, sad, or afraid, his seemingly absent or inappropriate emotions may show through in a manner which generates an uncanny or eerie impact on the observer.
- A strong sense of identity is often missing in the schizophrenic. They no longer feel confident about who they are and what they are, and often believe that they are changing in some mysterious way.
- They are socially withdrawn from others. They act very hermit-like and are totally absorbed in their own thoughts.
- Schizophrenics may exhibit a wide range of plainly bizarre behavior. Running around for no apparent reason, standing rigidly, and making odd facial expressions are all quite common.

Schizophrenia can be further classified.

- Disorganized schizophrenia [*hebephrenia*] is characterized by incoherence, few delusions and blunted, inappropriate or silly affect.
- Catatonic schizophrenia [*catatonia*] is characterized by catatonic stupor, mutism, resistance to instructions, rigidity of sometimes bizarre postures, and/or catatonic excitement (agitated and sometimes dangerous motor activity) Even at the best of times, characters will have minimal physical dexterity.
- Paranoid schizophrenia consists of persecutory, grandiose, or jealous delusions along with matching hallucinations. Spot Hidden rolls always uncover more evidence of the Nefarious Plot.
- Undifferentiated schizophrenia simply doesn't meet any of the above criteria.

**Depression** [*involution melancholia*] is generally applied to an older patient who suffers from a low mood, characterized by a lack of interest and pleasure in anything. This mood is quite persistent, although normal periods occur sporadically. The patient may suffer from several of the following conditions:

- Change in appetite, weight gain or loss.
- Sleeping too much or too little. Insomnia, early morning waking.
- Sluggishness, feeling drained of energy. STR, DEX, and CON are nominally at -2.





- Feelings of worthlessness or guilt, possibly the focus of a delusion. "It's all my fault. If it hadn't been for me, none of this would have happened."
- Slowed thinking, indecisiveness. Effectively lower skills involving concentration by 25%.
- Recurrent thoughts of suicide. Character may make suicide attempts.
- Other signs of psychosis. Hallucinations, delusions, or stupor.

**Mania:** the patient has a euphoric or possibly irritable mood that is fairly constant. Several of the following symptoms may occur.

- Increase in activity (physical, sexual, or occupational).
- Garrulousness. Patient feels pressured to keep talking.
- Flight of ideas. Patient's thoughts race, often pulling the next idea from a word in the previous sentence. "I was in the trunk. The trunk has two legs and two arms. I was trained in long arms. Arms as long as the day is long." Persuade rolls may be required merely to be understood.
- Increased self-esteem, perhaps to the point of delusional egomania.
- Decreased need for sleep.
- Easily distracted by irrelevancies. Skills involving perception or concentration at -40%.
- Willingness to participate in dangerous or imprudent activities.
- Psychotic features. Hallucinations, delusions or bizarre behavior. "I will save the Earth by covering my body with grape skins and sesame seeds."

**Bipolar Mood Disorder** [*maniacal-or manic-depressive illness*]: the patient tends to oscillate every few days between full-blown depression and mania as described above. He or she can be subclassified as manic or depressive depending on the predominant mood.

## PARANOID DISORDERS

**Paranoia:** the patient has persistent delusions of persecution or jealousy. Behavior and emotions are consistent with the delusions. These delusions are not the bizarre, physically impossible delusions found with schizophrenics. They are very plausible and the paranoiac may display unbelievable ingenuity in conveying them and defending them. Spot Hidden, Library Use, and similar knowledge skills yield ever more news of the Great Conspiracy, which always threatens and never lessens.

But the patient has no hallucinations, incoherence, or other psychotic symptoms characteristic of schizophrenia or bipolar disorder. He or she is altogether too convincing.

**Shared Paranoid Disorder** [*folie à deux*]: This is an unusual one which a keeper can spring on a party that already has one (or more) paranoids in it. In this disorder, the patient takes on the delusional system of another paranoid person as a result of being in close contact with him or her.

## SUBSTANCE ABUSE DISORDERS

The affected investigator finds emotional solace in the use of a drug. He or she sooner or later forms an addiction to the substance, and a large part of his or her life revolves around maintaining, hiding, and indulging the habit.

The investigator picks up a taste for one (or more) of the following types of drugs. Withdrawal should cause a reduction in all skills of from 20% to 50%. The effect of intoxication can vary at the keeper's discretion.

alcohol	amphetamines (rare before WWII)
cocaine	hallucinogens (natural only before the 1950s)
marijuana	nicotine
opium	opium derivatives, especially morphine
sedatives	other (glue, PCP, space mead, plutonian drug, etc.)

## PERSONALITY DISORDERS

Unlike many other forms of mental illness, personality disorders are very constant and long-term. The patients do not suffer acute attacks, but their personalities are plainly abnormal in some way. Generally this affects the ability to communicate effectively with others (-25% to Persuade and Fast Talk). Many varieties are recognized.

**Antisocial:** this personality type is characterized by many possible symptoms: inability to maintain a job or relationship, failure to meet financial obligations, involvement with criminal activity, physical aggressiveness, lack of foresight, and habitual lying and recklessness. The main symptom, of course, is antisocial behavior that disregards and violates the rights of others.

**Avoidant:** the afflicted person is over-sensitive to rejection and has low self-esteem. Consequently, he or she is socially withdrawn and finds entering a relationship difficult, despite a strong desire for love and acceptance.

**Borderline:** the patient displays some of the following symptoms: impulsive and possibly self-damaging behavior, intense but volatile relationships, inability to control anger, rapid shifts of mood, fear of being alone, and chronic boredom.

**Compulsive:** difficulty expressing warm emotions, devotion to work, perfectionism, authoritarianism, and an indecisiveness caused by fear of making mistakes are all symptomatic of this disorder.

**Dependent:** lacking self-confidence, the patient wants someone to make all the decisions in his or her life, and also places that person's needs above his or her own.

**Histrionic:** the patient displays overly dramatic behavior, including exaggerated emotions, craving of attention and excitement, overreaction to minor events, and temper tantrums. Onlookers variously perceive the patient to be shallow, insincere, helpless, manipulatively suicidal, or vain.

**Narcissistic:** the patient shows traits of self-importance, fantasies of success, power, or love, craves attention and admiration, and may show indifference or rage in the face of criticism or defeat. Interpersonal relationships are colored by feelings that the patient deserves favors, and a disregard for others's rights and feelings.



**Passive-aggressive:** the individual sabotages his own performance in "passive" ways: procrastination, stubbornness, intentional inefficiency, and intentional forgetfulness.

**Paranoid:** this suspicious personality may have expectations of trickery or harm, hypervigilance, secretiveness, avoidance of blame, jealousy. The individual takes offense easily, and exaggerates the magnitude of an offense. He or she usually appears cold and rational, with no sense of humor.

**Schizoid:** the individual tends to emotional coldness or aloofness, indifference to praise or criticism, good relationships with only a few friends.

**Schizotypal:** the patient displays some of the following symptoms: superstitiousness or belief in own "psychic" abilities, social anxiety and isolation, odd speech patterns (digressive, vague, or metaphorical), cool interpersonal interaction, suspiciousness.

## DISSOCIATION DISORDERS

**Psychogenic Amnesia:** inability to recall important personal information, brought on by some desire to avoid unpleasant memories. The character needs a POW x1 roll to recall any important details about himself or the cause of the amnesia. The keeper may choose to reset Cthulhu Mythos to zero as the horror of the Mythos is the probable cause of the insanity (naturally SAN would stay at the current level).

Distinguish this disease from cases caused by concussion (amnesic syndrome) where the patient has difficulty recalling old memories as well as learning new things.

**Psychogenic Fugue:** sudden flight away from home or work, coupled with inability to recall ones past. Assumption of an entirely new identity frequently occurs after the flight ends.

**Multiple Personality Disorder:** the patient appears to harbor more than one personality, each of which is dominant at times. Each personality is distinct, with its own behavior and social relationships. Keepers might create multiple character sheets, one for each personality.

## ANXIETY DISORDERS

**Panic Disorder [Panic]:** the patient suffers, at a frequency of about once a week, from panic attacks. They are not caused by exposure to some peculiar stimulus (as a phobia). The attacks are characterized by numerous symptoms: difficulty in breathing, palpitations, chest pain, vertigo, feelings of unreality, tingling in the hands and feet, hot and cold flashes, sweating, shaking and/or fear of impending death or insanity. Needless to say, when an attack comes, the character is useless.

**Agoraphobia:** the sufferer avoids being either alone, or in public places where "escape" might be difficult. Increasing restriction of social activity continues until the fears dominate the person's life. The character needs to make a POW xN roll in order to leave his home, engage in social activity, etc. Depending on the severity of the disorder and the difficulty of the task, the keeper should decide on an appropriate multiplier.

## GENERALIZED ANXIETY DISORDER

The patient suffers from a variety of physical and emotional symptoms groupable into several categories.

- **Motor tension:** jitteriness, trembling, aches, twitches, restlessness, easily startled, easily fatigued, inability to relax. Skills requiring agility (e.g., combat) at -50%.
- **Autonomic hyperactivity:** sweating, racing heart, clammy hands, dry mouth, dizziness, upset stomach, diarrhea, hot and cold spells, frequent urination, flushed or pallid face, and high resting pulse and respiration rates (nominal CON at -3).
- **Expectations of doom:** anxieties, worries, and fears, especially concerning anticipated misfortune.
- **Vigilance:** hyper-attentiveness leading to distractibility, inability to focus, insomnia, irritability, and impatience. Skills requiring persistent thought at -25%.

## SIMPLE PHOBIA, OR PHILIA

The individual has a persistent fear (which he realizes is excessive and irrational) of a particular object or situation. This fear leads to a disturbance of the patient's life to avoid the stimulus. In severe cases, the object of the phobia is obsessively imagined to be omnipresent, perhaps hidden. Game consequences run the gamut from nothing at all, to effects similar to those of generalized anxiety, to complete helplessness or frantic flight. Numerous phobias are well known to the Call of Cthulhu keeper, and many are listed nearby.

Phobias (manias) are much rarer, and simply mean that the patient is inordinately fond of a particular stimulus, and will take great pains to be constantly surrounded by it. When the patient's sexuality is involved, it is regarded as a fetish.

These two reactions have been stressed in the Call of Cthulhu rules, partly because they are simple to identify and describe. As this chapter shows, the disturbed human mind is actually a much more luxuriant and bewildering forest of behaviors, symptoms, and concepts.

## OBSESSIVE COMPULSIVE DISORDER

[*Anankastic personality*]. The patient's life is significantly altered due to obsessions and/or compulsions.

**Obsessions:** persistent ideas, thoughts, images or impulses that the patient does not voluntarily produce. They generally involve violence or self-doubt and invade the patients consciousness. They are frequently experienced as repugnant to him. He may try to ignore or suppress them with variable success. During times of stress, the character will be unable to focus on mental activity, even if it is necessary for survival. The obsession crowds out all other thoughts.

**Compulsions:** stereotyped and repetitive actions are performed by the patient. These actions are designed to affect the patient's future, although the patient usually understands the senselessness of the activity and may even attempt to suppress it. It is not pleasurable for the sufferer, but may reduce anxiety. During times of stress, the character will be unable to reliably perform physical activity, even

if it is necessary for survival. The need to perform peculiar personal rituals is overpowering and may last for D10 combat rounds.

**Post-traumatic Stress Disorder** [*shell-shock*]: in the wake of a clearly traumatic event, the patient begins to relieve the trauma through persistent thoughts, dreams, or flashbacks. The patient begins to lose interest in normal activities and becomes detached and unemotional.

## PHYSICAL DISORDERS

**Anorexia Nervosa:** the (usually female) patient has an overpowering fear of becoming fat—a fear which does not decrease along with the patient's weight. Frequently, the patient thinks she is fat when she is not: *distorted body image*. Patient loses weight rapidly and refuses to maintain or increase weight. Investigators lose weight (SIZ) and CON at a rate decided by the keeper. Unless some sort of cure is effected, the end result is invariably death.

**Bulimia Nervosa:** the patient eats a large quantity of high caloric food during frequent binges. Binges are often hidden from the outside world. They generally last until abdominal pain or self-induced vomiting. The patient also frequently tries very harsh diet regimens, and body weight fluctuates rapidly. He or she is aware of the abnormal eating pattern and is frequently depressed and guilty following the binges.

**Dysmorphophobia** (*body dysmorphic disorder*): the patient suffers from exaggerated concern over perceived flaws in appearance, usually of the face, but possible of any body part. Behavior can be altered in very strange ways to calm the fears and anxiety of the affected person.

**Hypochondriasis:** the patient believes and fears that he suffers from a serious disease, although medical examination shows no physical cause for the purported symptoms. This belief persists after the patient has been reassured of the truth and is often strong enough to cause trouble in the patient's personal and social life.

**Somatization Disorder:** the patient suffers from a wide variety of physical complaints, from dizziness and impotence to intense pains and blindness. Although there is no medical explanation for these symptoms, this disorder is unlike hypochondriasis in that there is no delusion that the symptoms mean a particular dreaded disease. The patient suffers from a variety of probably psychosomatic ills.

**Pica:** usually a disease of childhood, the patient repeatedly eats non-food substances. Principally these are dirt and clay, but addled investigators may have a sudden yen for slime, ooze, and mucilage.

**Tic Disorders:** the patient suffers involuntary, rapid, and repetitive motor movements that are devoid of purpose. They can be suppressed voluntarily for short periods of time. In Tourette's Disorder, the tics are coupled with many vocal tics, frequently of a scatological or abusive nature.

**Enuresis** (*bed-wetting*): the patient wets his or her bed on a regular basis.

**Encopresis:** the patient voluntarily or involuntarily deposits feces in an inappropriate place on a regular basis. Credit Rating has been known to plummet dramatically.

**Conversion Disorder:** the sufferer complains of a loss of physical body function suggesting a physical disorder, but psychological factors seem to be the cause. Although not under voluntary control, the medical symptoms allow the individual to either avoid some unpleasant activity or gain support and caring from others. Symptoms run the gamut from pain and impotency to blindness and paralysis.

## PSYCHOSEXUAL DISORDERS

**Transsexualism:** the patient feels his/her anatomic sex is inappropriate and wishes to live as the opposite sex. This latter feeling is sometimes augmented by a strong desire to be rid of one's own genitals.

**Impaired Sexual Desire or Functioning:** the patient is unable to become sexually aroused or excited.

**Nymphomania/Satyrism** (*Don Juanism*): the individual has numerous sexual encounters in which the partners are merely used for sexual gratification. No long term relationships or emotional attachments ever form.

**Paraphilias:** this classification refers to disorders in which the primary source of sexual gratification is not intercourse with another adult human being. Although homosexuality has not been considered a mental disease for quite some time, it was regarded as such in the 1920s. Even today, Gender Identity Disorder of Childhood is a rubric sometimes used to help institutionalize and "cure" a minor whose parents cannot deal with their child's homosexuality.

The major paraphilias and their corresponding stimuli are many. A selection follows.

- Coprophilia—sexual gratification depends upon the deployment of feces in some way.
- Exhibitionism—getting sexual thrill by exposing oneself to hapless strangers.
- Fetishism—sexual gratification only occurs with the addition of a certain non-living object, *e.g.*, rubber or leather clothing.
- Frotteurism—sexual gratification is achieved by rubbing against other people, as with a stranger in an elevator or other public place.
- Masochism—the patient requires humiliation, binding, and/or physical harm for stimulation. The torture endured by masochists is rarely life-threatening.
- Necrophilia—death and/or dead bodies provide the sexual stimulus.
- Pedophilia (pederasty)—using children as sexual or fantasy objects.
- Sadism—the sadist inflicts psychological or physical pain on a consenting partner. In rare cases, inept technique or a nonconsenting partner promote severe physical damage, but keepers should ordinarily distinguish between bodily pain and bodily damage. Few practicing sadists seek to incapacitate the sources of their pleasures.
- Transvestitism—the patient (usually male) adopts the clothing of the opposite sex. Initially, cross-dressing may be for sexual gratification, but later it becomes habitual. The transvestite frequently becomes irritable if denied this pleasure.

## List of Phobias

- Onomatophobia — fear of a certain name.  
Rhabdophobia — fear of being beaten.  
Apiphobia — fear of bees.  
Phobophobia — fear of being afraid.  
Merinthophobia — fear of being bound.  
Taphephobia — fear of being buried alive.  
Domatophobia — fear of being confined to a home.  
Helminthophobia — fear of being infested by worms.  
Aphephobia — fear of being touched.  
Henophobia — fear of blood.  
Erythrophobia — fear of blushing in public.  
Batophobia — fear of buildings.  
Carcinomaphobia — fear of cancer.  
Chromophobia — fear of certain colors.  
Trophophobia — fear of change.  
Paedophobia — fear of children.  
Prnigophobia — fear of choking.  
Psychrophobia — fear of cold.  
Cometophobia — fear of comets.  
Peccatophobia — fear of committing sin.  
Dromophobia — fear of crossing the street.  
Nyctophobia — fear of darkness.  
Eosophobia — fear of the dawn.  
Bathophobia — fear of depth.  
Iatrophobia — fear of doctors.  
Cynophobia — fear of dogs.  
Amathophobia — fear of dust.  
Phagophobia — fear of eating.  
Coprophobia — fear of excrement.  
Ommatophobia — fear of eyes.  
Kakorrhaphiophobia — fear of failure.  
Eurotophobia — fear of female genitals.  
Ichthyophobia — fear of fish.  
Anthophobia — fear of flowers.  
Homichlophobia — fear of fog.  
Hylephobia — fear of forests.  
Aerophobia — fear of fresh air.  
Bactrachophobia — fear of frogs and toads.  
Spectrophobia — fear of ghosts.  
Crystallophobia — fear of glass.  
Aurophobia — fear of gold.  
Trichophobia — fear of hair.  
Acrophobia — fear of heights.  
Equinophobia — fear of horses.  
Apeirophobia — fear of infinity.  
Dementophobia — fear of insanity.  
Astraphobia — fear of lightning.
- Herpetophobia — fear of lizards.  
Decidophobia — fear of making decisions.  
Gamophobia — fear of marriage.  
Metallophobia — fear of metals.  
Meteorophobia — fear of meteors.  
Morophobia — fear of mice.  
Catotrophobia — fear of mirrors.  
Chrometophobia — fear of money.  
Motorphobia — fear of motor vehicles.  
Musicophobia — fear of music.  
Nudophobia — fear of nakedness.  
Noctiphobia — fear of the night.  
Acusticophobia — fear of noise.  
Triskadekaphobia — fear of the number 13.  
Numerophobia — fear of numbers.  
Optophobia — fear of opening one's eyes.  
Algophobia — fear of pain.  
Anthropophobia — fear of people.  
Acidiophobia — fear of plants.  
Hedonophobia — fear of pleasure.  
Aichmophobia — fear of pointed objects.  
Hydrophobophobia — fear of rabies.  
Ombrophobia — fear of rain.  
Hagiophobia — fear of saints and the holy.  
Galeophobia — fear of sharks.  
Hamartophobia — fear of sin.  
Acarophobia — fear of skin infestation by mites, ticks.  
Blennophobia — fear of slime.  
Ophidiophobia — fear of snakes.  
Tachophobia — fear of speed.  
Demonophobia — fear of spirits.  
Astrophobia — fear of stars.  
Tomophobia — fear of surgery.  
Laliophobia — fear of talking.  
Ondontophobia — fear of teeth.  
Telephonophobia — fear of telephones.  
Tonitrophobia — fear of thunder.  
Doraphobia — fear of touching animal skin.  
Genophobia — fear of a void.  
Emetophobia — fear of vomiting.  
Aquaphobia — fear of water.  
Chrematophobia — fear of wealth.  
Dinophobia — fear of whirlpools.  
Verbophobia — fear of words.  
Scoleciophobia — fear of worms.  
Ergophobia — fear of work.  
Parthenophobia — fear of young girls.

## Examples of Manias and Fetishes

**Most can be formed by the substitution of -mania or of -philia in place of -phobia. Some potentially interesting examples follow.**

- ballistomania — love of bullets.  
bibliomania — love of books.  
coprolomania — love of foul language.  
demonomania — believes is possessed by demons.  
drapetomania — love of running away.  
edeomania — obsession with genitals.  
egomania — preoccupation with the self.  
gamomania — constantly proposes marriage in odd and elaborate ways.
- idolomania — mania for idols.  
laparatoiphilia — love of abdominal surgery.  
lycomania — belief that one is a werewolf.  
megalomania — grandiose egomania.  
nosophililia — love of sickness, malingering.  
siderodromomania — obsession with railroad travel.  
symmetromania — obsession with symmetry.  
taphophililia — love of funerals, cemeteries, etc.



- Voyeurism (*Peeping Tom-ism*): gratification through watching others engage in sexual activities.
- Zoophilia (*bestiality*)—animals form the preferred vehicle for sexual gratification.

## IMPULSIVE DISORDERS

**Pathological Gambling:** the individual is unable to resist gambling. The gambling erodes the personal and occupational areas of the individual's life.

**Kleptomania:** the individual impulsively steals small objects. Increasing tension precedes the act and relief or pleasure follows it. The stolen items are often given away, discarded, or secretly returned, indicating that the act itself, rather than what it achieves, is more important.

**Pyromania:** impulsive drive to light fires. Tension before, pleasure afterwards.

**Intermittent Explosive Disorder:** the individual is generally impulsive and aggressive, but at times the individual blows up into uncontrollable rages, invariably resulting in assault and/or destruction of property.

## SLEEP DISORDERS

**Insomnia:** patient has difficulty in falling asleep and/or staying asleep.

**Hypersomnia:** patient easily falls asleep. He can and does fall asleep anywhere, usually for much of the day.

**Night terrors (*pavor nocturnis*):** ordinarily a childhood disease, the sleeper awakens after up to three hours of sleep, usually screaming in terror. Pulse and breathing are rapid, the pupils are dilated, the patient sweats and the hair stands on end. He or she is hard to calm down and comfort and the episode is followed by confusion and repetitive motor movements. These fits apparently occur when the patient is not dreaming.

**Somnambulism (*sleep-walking*):** the patient walks in his or her sleep. Episodes last up to a half hour and usually begin in the first three hours of sleep. During the episode, the face is blank and staring and the sleepwalker can be roused only with difficulty. Upon awakening, the walker does not recall any details of the walk.

## OTHER DISORDERS

These are mostly symptoms, or specific cases of diseases already mentioned above. They exist in the fifth edition Call of Cthulhu rules as compact suggestions for psychological states that may make interesting roleplaying. Among them are catatonia, stupefaction, criminal psychosis, panzaism, quixotism, megalomania, and pathological lying.

## Permanent Insanity

No difference between indefinite insanity and permanent insanity exists, except as a prognosis made by an attending psychiatrist (or a judge, in criminal cases). In the real world, all insanity is indefinite insanity, since no one in real life can hope to predict the future as accurately as the rules do for a Call of Cthulhu keeper.

Nonetheless many conditions, especially congenital conditions, offer little hope of recovery. Every keeper must work out what end point of madness satisfies his or her

game. A lifetime of insanity certainly seems to happen more than once in Lovecraft. Whether the utter quenching of a player's feelings and regard for his or her favorite investigator is justified by an appeal to Lovecraft's writings each keeper must judge independently.

But nothing in the rules should be construed to mean that, now and then, a quiet release cannot be made from the local asylum, and that some pale, thin person, almost unrecognizable from the terrors that have wracked his or her soul, cannot walk back carefully into downtown Arkham, or wherever the site is, and once more cast keen eyes about, and attempt to plumb the surrounding darkness....

## Roleplaying the Insane Character

Although the descriptions of the various illnesses presented in this chapter contain a lot of information, mere clinical knowledge is not sufficient for players of Call of Cthulhu. In the art of role-playing, portraying the insane is not a simple task. Merely knowing that one sees things offers little help. However, there are many general rules one can attempt to apply that will add verisimilitude to ones insane characters.

Like Hamlet, many insane people have methods in their madnesses. Illness allows them to avoid reality, gain sympathy, or receive some other benefit they consider valuable. In many cases, exploring these issues for one's own insane character can add depth to the psychic troubles he or she is suffering. For example, Roscoe Winthrop, a private investigator, suffers from clinical depression. An encounter with a nefarious cult of Shub-Niggurath brought about this sad condition. What does he get out of his illness?

Perhaps his depression manifests in part in an increase in weight, stimulated by the remembrance of the bloated idols of the powerful goddess. Mass is strength. His sluggishness and slowed thought are ways to procrastinate, sabotaging his investigative efforts. That could be a defense mechanism designed to ward off any possibility of stumbling upon new cosmic horrors. His general low mood and possible suicidal tendencies reflect Roscoe's shattering knowledge of what the universe is truly like. Who could be happy, or wish to continue his existence, knowing that the human world is a small place lost in a universe choking with alien malevolence?

Also, the care with which the keeper chooses the form of indefinite insanity can be invaluable in aiding the player to connect that insanity with his character. If Roscoe had seen Great Cthulhu and then been told that he suffers from agoraphobia, there is little there for the player to connect the madness to the cause. Agoraphobia should be sprung on a character who has been stalked by members of an ancient cult through the streets of legend-haunted Hyderabad; each robed figure of the thousands milling along the ancient street could be an agent of The Purple Gathering. A climactic battle scene in the midnight streets of the city (with a severe loss of SAN) would be suitable to start the illness. In this case, the cause of the illness is directly related to the form it takes. The player now has an angle into the role-playing: when his palms sweat and his feet

refuse to bear him along, what nameless dread is running through his mind? There must be agents of The Purple Gathering nearby, waiting to exact revenge.

Similarly, delusions, hallucinations, and other cognitive problems (if present) should be tailored to fit the mood and origin of the malady. Far from being quaint and slightly humorous ideas, delusions can be mental shackles on the soul, torturing the mad investigator. If, after having been fed some nightmare drug, an investigator becomes convinced that all food not personally prepared by himself is poison, imagine the effect on his life. Restaurants would be impossible to patronize, grocery stores would resemble houses of death, and an innocent offer of sherry from one's host would be equivalent to the pointing of a loaded gun.

Insanity is a debilitating condition that affects most aspects of a person's life. The player should strive to portray this fact. Speaking, eating, walking, and dressing for the day can be altered by insanity, as can any ordinary or customary behavior. Interpersonal relationships are frequently the first casualty in a person's struggle against mental illness. The investigator may be ostracized by his fellows or his family as a result of his sickness.

At the risk of utterly negating much of what has been said, *Call of Cthulhu* is, first and foremost, entertainment. The commingling of horror and humor that frequently results during an adventure is an acquired taste that appeals to the connoisseurs of strong emotion who enjoy the game. Consequently, insanity in the game need not be limited to an oppressive mood. The use of an insane character as an element of comic relief is well known in drama and should be a well-used narrative tool of the keeper and players as well. However, one must always remember, as one enjoys the ludicrous and rigid mask of comedy, that the stark and leering face of madness lies beneath.

Finally, though the symptoms of an insanity such as catatonia strongly argue against significant game participation, most indefinite insanities do not rule out continuing play in the game. It may be better hypothetically that an investigator becomes institutionalized because of (say) severe alcoholism, but the game makes room for such characters. They can have whatever scope they can seize. If a band of investigators ends up saving the world and becomes utterly eccentric maniacs in the process, such a conclusion will be exactly the sort the game intends.

## Optional Rules

### INSANITY POW

Assign nominal POW values to any indefinite insanities suffered by an investigator. The value should be equal to the total SAN points lost during the fateful hour, or else the amount lost as the last straw. Additionally, the keeper may apply a multiplier from one-half to two if the situation warrants it. If a character takes a 58 sanity-point loss from seeing Cthulhu, one might charitably cut it in half to a mere 29 Insanity POW.

The keeper then requires the player to make a POW against POW roll to keep the investigator functioning in a stressful situation without the insanity becoming more

pronounced or surfacing acutely. This could, for example, gauge the probability that an obsessive-compulsive person would be incapacitated by his obsessive thoughts or compulsive actions. Some disorders may call for daily or weekly checks at the keeper's discretion.

During therapeutic psychoanalysis, critical success rolls reduce the POW of the illness by 1D3. When the POW of the illness has been halved, or after 1D6 months, the effects of the indefinite insanity dissipate. However, should the investigator suffer another attack of indefinite insanity, there is a 5x (Insanity POW) percent chance that the insanity resurfaces, stronger than ever. Add the current POW value to the newly generated insanity POW to give the new strength of the mental illness.

*Example:* Doreen Masterson flees from a shoggoth after failing a Sanity roll at a cost of 13 sanity points. The keeper decides that Doreen suffers from dysmorphophobia, holding the delusion that her skin has blackened and roils and bubbles like that of the shoggoth. The keeper decides that 13 is an adequate strength for the disorder. On bad days (when she fails to overcome the POW of the disease) she takes to wearing long gloves and other concealing garments. Through therapy, Doreen's illness is reduced to POW 6 and ceases to bother her.

Then she is captured by Mi-Go, who perform hideous experiments on her before she is rescued; the harrowing experience causes her to lose 12 SAN. There is a  $5 \times 6 = 30\%$  chance that her dysmorphophobia will return at a strength of  $12 + 6 = 18$  POW.

If it does not return, a new insanity of an equivalent to POW 12 ensues from the tender ministrations of the crustaceous transPlutonian horrors.

### INSTITUTION STATISTICS

See the cure rate/survival rate/release rate expansion notes included with the table **Public Hospitals for the Insane in the United States**, in this book.

### EXPANSION OF MAXIMUM SAN

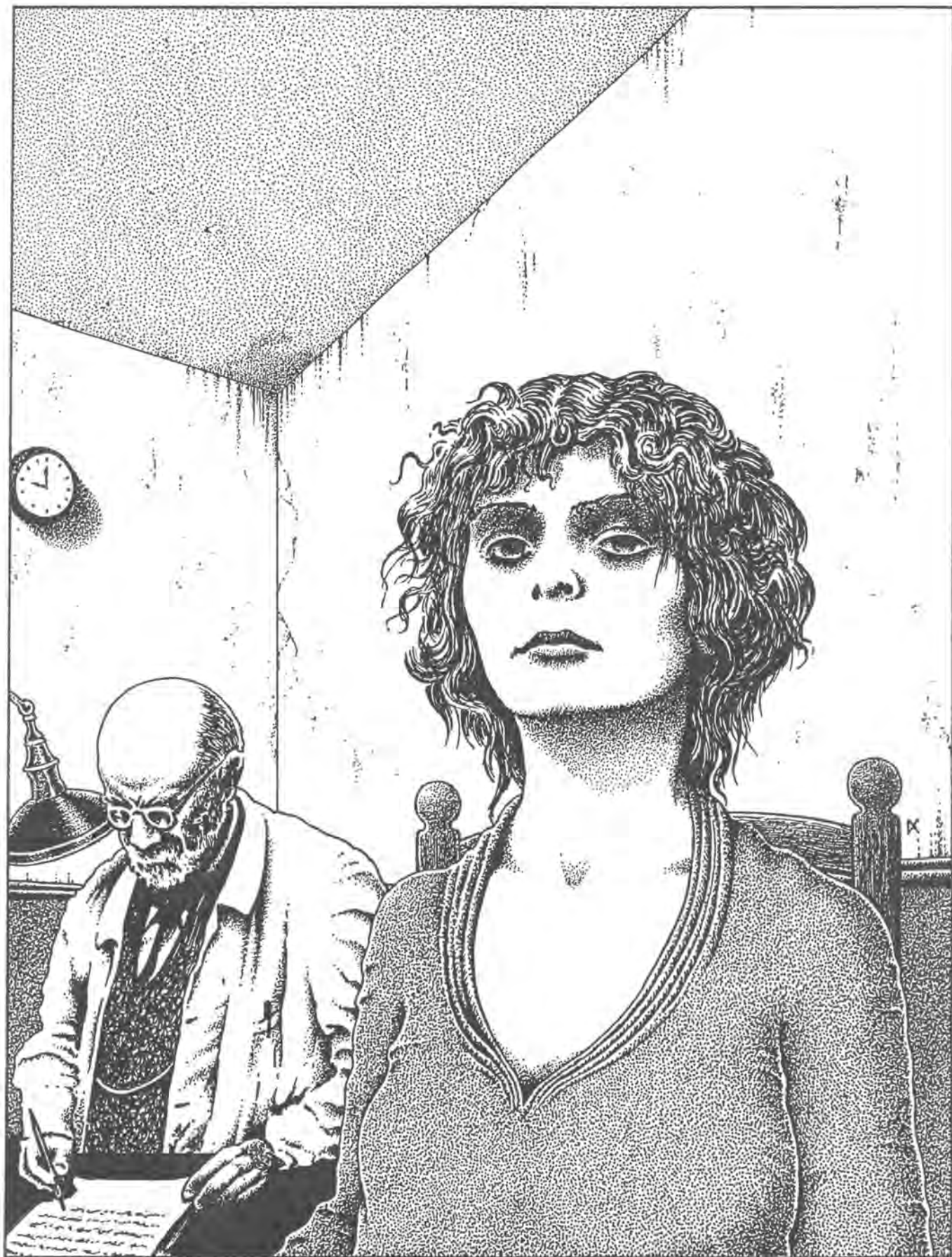
This optional rule in particular is liable to manipulation, and caution is advised.

If an investigator's sanity is at his or her maximum and then something occurs that would otherwise allow Sanity recovery, then increase the maximum SAN. Regardless of this rule, a character's maximum SAN may never be higher than 99.

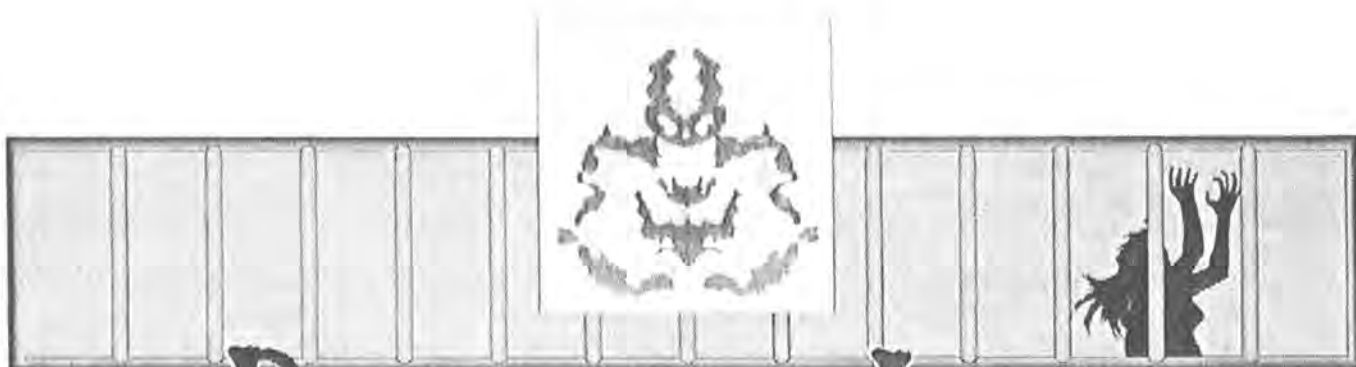
For ways to recover sanity points, see the sub-section **Recovering Sanity** early in this chapter.

### NOT-IN-ONE'S-RIGHT-MIND RULE

This is meant more to play out than to be a rule. During a brief period of temporary insanity, send the player out of the room. When the insanity wears off, invite the player back in and tell him where his investigator is, and what the investigator is doing *now*. Let the other players fill him in on what happened and what he did. If he was alone, he may never understand the significance of the bitter taste in his mouth and his ichor-stained face....







# The Psychiatric Interview

The psychiatric interview represents the gate to freedom or the corridor to the madhouse. But will every interviewee try to put his or her best foot forward?

**W**HEN (NOT 'IF') a *Call of Cthulhu* investigator becomes insane, psychiatric treatment offers the only real hope of even partial recovery. Whether sought out by the affected investigator or mandated by a judge, a psychiatrist will eventually become involved with the case. The rules pertaining to psychoanalysis and recovery from indefinite insanity are vague, and rightly so. Usually roleplaying an individual therapy session is not what most players want as an evening's entertainment.

But the initial psychiatric interview not only offers incidental information about the investigator's particular insanity and how it affects his or her behavior, but there are many occasions in the game where shorter versions of this procedure can be of use. Players with investigators who are by profession psychiatrists will find this section useful in carrying out such duties in the game, and also gives them insight into what in particular their investigators might notice, and why. Psychoanalysts may practice versions of this interview as well, with the proviso that their initial meetings will be less fact-filled and perhaps more aimed at finding an emotional common ground with the patient.

One interesting way to decide what form of indefinite insanity an investigator suffers from is to give the player the interview in the guise of the investigator, allowing player responses to freely occur, and then determining a diagnosis that meets the criteria that he or she has more or less unwittingly outlined. Naturally, this only works well with players who place roleplaying ahead of their own interest in gaining an advantage in the game.

It can also be amusing to analyze sane investigators with this system and then to commit them on the basis of their own damning words. For instance, if someone is arrested by police for dancing naked over a dead cat on top of a century-old crypt in downtown Boston, he may be sent for a psychiatric evaluation. During that interview, he explains his reasons ("I had to do it; otherwise the star gods would take over the world.") Ordinary

investigator paranoia coupled with apparently delusional beliefs and hallucinations of magic and monsters brings on a rapid diagnosis of schizophrenia, which the investigator will find hard to shake. Again, this works best on an investigator who is a bit cracked already and who won't bother to dissemble, even if lying would save him embarrassment or incarceration.

Another plausible benefit involves character development. If the keeper, as psychiatrist, asks many questions about the investigator's past, it may spur the player to come up with more interesting details from the investigator's personal history, fleshing out his or her background and evolving, creating or explaining personality traits of the character.

The following outline of the diagnostic interview describes a very modern method. In the 1920s, much of the same information would be called for, but the psychiatrist would be much more likely to come to snap judgments based on only a brief discussion, rather than taking an entire case history.

Notice also that this version of the interview assumes a relatively peaceful, approachable patient who has a long attention span and who is eager for the interviewee's approval. Not all interviews can be made so easily, nor are all patients cooperative.

## SETTING AND INTRODUCTION

The psychiatrist should conduct the interview in a place that the patient will not find too forbidding and introduce himself in a manner that serves both to lower the patient's anxiety and also to inform the patient of what is going to happen.

*"Good afternoon, Miss X. My name is Dr. Simmons, and I'm here to help you with your problems. To do that, I'd like to ask you some questions for about forty-five minutes. That*

will allow me to understand your problems, so that we can go on to solving them."

The interviewer should be formal and very polite at this opening stage, asking permission to take notes or make an audio recording of the interview. In court-mandated interviews, the psychiatrist should explain the circumstances and legal matters involved, such as the psychiatrist's duty to inform the authorities if the patient is in his judgement a danger to himself or others.

In 1920s criminal cases, according to the law of the state, a stenographer (perhaps hidden, perhaps in view of the patient) might also take down the patient's words for the information of the Court, and this document would become important evidence in any judgment concerning the patient's sanity. It would not have the same weight of evidence as the patient's legal statement concerning the incident about which he or she was accused.

In the 1990s, most states allow the tape recording of the interview, and that recording, or a transcript, would become part of the patient's file.

### THE PRESENTING COMPLAINT

After some rapport has been created, the interviewer should go on to discover just what it is that has brought the patient in. As much as possible, the interviewer should allow the patient to describe the problem in his or her own words. Not only will the psychiatrist avoid the trap of diagnosing the illness too soon, ignoring or refusing other information coming from the patient, but patience and interest increases the patient's confidence that what he or she is saying is of value. The patient will remember this, and be more or less forthcoming in the future, according to the treatment received now.

Gather additional information by very general, open-ended questions: "Can you tell me more about that?" "What happened next?" "How did you feel about that?"



The interviewer should be alert for difficulty in thinking, evidence of drug use, psychotic symptoms, emotional disturbance, anxiety, and social and personality problems, in addition to possible physical causes for mental imbalance.

### HISTORY OF THE PRESENT ILLNESS

Once the psychiatrist has assured himself or herself that he understands the nature of the patient's complaint, the interview can go on to more specific questions concerning the history and development of the patient's current problem. This includes six key areas to be recorded.

- A careful description of each symptom (frequency, severity, engendered feelings).
- Search out other symptoms that the patient may not report (loss of appetite, weight, or sexual interest).
- Instance the consequences that the problems have had in the patient's life.
- Make a chronology of the symptoms, when they appeared and in what order.
- Correlate (if possible) the timing of the symptoms with stressful events in the patient's life.
- Ask about previous episodes or treatment for this mental illness.

### PERSONAL HISTORY

Next the interviewer should begin constructing a sort of biography of the patient. Although Freudians may dwell overlong on this—*Zo! How did you feel about your mother?*—there are many tendencies and mild correlations that may help the diagnosis. Schizophrenics are frequently loners as children. Loss of a parent as a child may lead to adult depression. Lack of a father figure may lead to the formation of a clinically antisocial personality. Information about the following areas will give a well-rounded summary of the patient's life.

- Circumstances of birth, family members.
- Growing up: family life, hobbies, friendships, beginnings of sexual interest.
- Childhood health.
- Academic achievement and school behavior.
- Jobs held by the patient, military history.
- Criminal history.
- Religious beliefs.
- Current living situation, occupation, friends, family, sexual relationships.
- Adult medical history, medication and side effects.
- Patient's self-assessment of own personality.

### LATER INTERVIEW

By this time, a fuller picture of the patient and the illness should be beginning to form. The interviewer must now ask more specific questions geared to making the final diagnosis. These questions are direct, unlike those of earlier parts of the interview. Instead of 'How would you describe your drinking?', the interviewer might now ask

(suspecting alcoholism) 'How frequently do you drink—how many days out of the week?'

## MENTAL EVALUATION

During the course of the examination, the psychiatrist has been searching for signs of mental aberration. Various cues may attract the attention of the clinician during the course of the earlier stages of the exam. Visual and verbal clue types follow.

- **Alertness:** is the patient fully alert, drowsy, in a stupor, or comatose?
- **Clothing:** bright/drab colors may indicate mania/depression. Bizarre dress may imply schizophrenia.
- **Motor activity:** note body language, immobility, restlessness, scratching, tics, or mannerisms.
- **Facial expression:** normal range of expressiveness, eye contact, expression inappropriate to emotion.
- **Affect:** what is the dominant emotion of the patient? Do emotions change too much or too little? Is it appropriate emotion for the circumstances?

Some disturbances of thought can be noticed in the patient's verbal behavior.

- Do the patient's sentences cohere badly (loose associations.)? "My briefcase opened up, up and away down South in the land of cotton."
- Do the patient's answers have little or no relation to the question (tangentiality)?

The previous two conditions are found in psychoses, particularly schizophrenia, but also mania.

- Does speech change rapidly in an illogical manner (flight of ideas)? "I had for dinner, I had some lamb. On the lam. Always running away from his fear. His sphere."

Flight of ideas is typical of mania.

- **Rate of speech:** abnormally fast or slow speech and rate of response point to mania/depression.
- Other peculiarities of speech which may suggest schizophrenia include excessive alliteration or rhyming, repetition, incoherence, and neologisms.

More cognitive aspects of the mental status examination include the following.

- **Delusions**—does the patient cling to a demonstrably false belief in the face of contradictory evidence? The patient should be encouraged to elaborate all the ramifications of the delusion. Is the patient's mood appropriate when discussing the delusion? Mood-congruent delusions are typical of mood disorders; those that have little connection with the emotions are typical of schizophrenia.
- Specific types of delusion are also indicative of particular disorders. Delusions of persecution or reference (the idea that the news, or strangers are talking about you) are classic signs of paranoid schizophrenia.
- **Hallucinations:** if present, the interviewers should find out as much as possible about them. What sense is affected, and how severely, when they occur, etc.
- **Auditory hallucinations,** especially of voices or one's own thoughts are characteristic of schizophrenia. Visual

## Diagnosis Summary

### Psychosis (schizophrenia, paranoia, or bipolar disorder)

- bizarre behavior
- delusions and hallucinations
- poor insight and judgment
- social withdrawal
- unusual speech patterns

### Mood Disturbance (mania and depression, bipolar disorder)

#### Mania:

- increased activity
- elevated or irritable mood
- reduced need for sleep
- flight of ideas
- egocentricity
- distractibility

#### Depression:

- decreased or increased activity
- anxiety
- appetite and weight change
- inability to focus
- depressed mood and interests
- difficulty in sleeping

### Substance Abuse

- legal, financial, occupational, social or medical problems resulting from drug use
- memory impairment

### Personality Disorders

- unusual behavior
- legal, financial, occupational or, especially, social difficulties
- anxiety
- overly dramatic

### Organic Brain Syndrome (tumors, head trauma, disease, senility, etc.)

- odd behavior
- confusion, delusions and hallucination
- memory problems
- shifting affect

### Anxiety Disorders (phobia, generalized anxiety, obsessive compulsive disorder)

- anxiety, fear or nervousness
- obsessions or compulsions
- pain, difficulty in respiration, rapid heartbeat

hallucinations usually result from a physical brain disorder, but also occur in schizophrenia or cases of dementia tremens (pink elephants!).

- Other types (touch, smell, taste) usually stem from an organic brain disorder, not from mental illness.



## Common Diagnoses Of "sane" Investigators

If you accept behaving outside the culturally accepted range of normal behavior as a functional definition of insanity, then most investigators are insane after their first adventure. If such an investigator, for whatever reason, is the subject of a mental competency hearing or a psychiatric interview, he or she risks being declared insane. From what fictitious malady does he or she suffer?

**Paranoia:** a serious diagnosis, but probably correct for most investigators. Suspicion is the watchword of most experienced investigators. Delusions about the Great Old Ones, deep ones, and space creatures that dissolve when you kill them make the symptomatology complete.

**Shared Paranoid Disorder:** if the whole party is investigated, the psychiatrist in charge may salivate at the prospect of endless research papers and professional fame coming from this case. Imagine it, six people, all with the same paranoid delusions!

**Schizophrenia:** another serious diagnosis. Coupled with delusions about the Mythos, investigators may let slip some of their hallucinations of eldritch entities, or descriptions of their bizarre exploits. It is a rare investigator who avoids the paranoid subclassification.

**Generalized Anxiety Disorder:** most investigators display some of the fearful symptoms associated with this disorder.

**Obsessive Compulsive Disorder:** does the character obsess about the futility of all man's actions, or his helplessness in the face of mercurial and alien gods? Or perhaps he compulsively mutters spells to ward off evil?

**Sleep Disorders:** insomnia may plague veteran investigators on those sultry nights when the whippoorwills cry out for passing souls.

**Personality disorders:** many investigators will fit the profiles of some of the various Personality disorders.

**Antisocial:** what investigator keeps up a normal job or marital relationship? And usually they are involved in illegal and violent behavior. Additionally, they frequently have little regard for others.

**Borderline:** violent outbursts coupled with a fear of being alone.

**Paranoid:** suspicion, coupled with hypervigilance and secretiveness.

**Schizotypal:** superstitiousness and belief in ones own magical powers, social withdrawal and suspiciousness.

## OTHER FACTORS TO CONSIDER

**Anxiety, Phobia, Obsessions, and Compulsions:** if present in a patient, the interviewer should determine the severity and other pertinent information about them. The diagnoses in these cases are fairly obvious, if this is the only symptom.

**Insight and Judgment:** does the patient realize he or she has a problem and does he or she have the discrimination to choose an appropriate course of action?

**Mental Status Examination:** Although the former observations help the interviewer to come up with a diagnosis, a formal test of the patient's mental status is also in order. The interviewer attempts to determine how well the brain is functioning, at least as far as the communication and comprehension of information is concerned. This usually takes the form of a brief quiz. The most common disorders that can be uncovered by this exam are organic in origin, although there are many exceptions that can occur as indefinite insanities (amnesia, severe depression, etc.)

**Orientation to Person, Place, and Time:** ask the patient where he is and what day and year it is. If the answers are deficient, he should be asked if he knows who he is.

**Language:** in addition to the wealth of information from the rest of the exam, the patient should be asked to name a few common items, repeat a brief phrase, and read and write a few short samples of text.

**Memory:** name three unrelated items and ask the patient to repeat them immediately, until he or she has them down. After five minutes, ask the patient to recall them. Test long term memory by asking about the patient's past (as in the taking of the history)

**Cultural Information:** ask the patient to name the current and previous President, or to name a few states or foreign countries.

**Abstract Thinking:** ask the patient to interpret a metaphorical proverb, such as "People in glass houses shouldn't throw stones." Or ask him to tell you the difference between two similar objects, like a dwarf and a child.

**Closing the Interview:** after all the necessary information has been noted, the psychiatrist should end the interview by summarizing the results to the patient to make sure there are no misunderstandings and offering support and help to the patient, including a plan for the patient to follow such as more meetings with a therapist, voluntary commission to an institution, referral to a medical doctor or pharmacy, etc.

## MAKING THE DIAGNOSIS

Once the interview is complete, the patient's illness must be classified. For an extremely brief guide, use the nearby summary chart.

## TREATMENT

Once the diagnosis is made, treatment of some sort may commence. Details on the various methods available are described earlier in the sections on treatment.



## Scenario Ideas

This section presents a few ideas that may spur adventure ideas, or ways of using the wealth of material in this volume in a campaign setting.

### A WAY TO RESTORE SANITY QUICKLY

Various therapy modalities may induce entrance to the Dreamlands. Insulin-induced comas, sleep therapy, and hypnotherapy are some obvious candidates. Perhaps the course of the Dreamlands adventure allows the character to face the source of his insanity and defeat it (or be utterly crushed by it), potentially restoring functional sanity.

### A PSYCHIC GIFT

The connection between madness and creativity is fairly well established. In the world of Call of Cthulhu, perhaps other powers are granted to the insane. Many insane people have delusions of having psychic powers, for instance. Perhaps a lucky investigator actually develops paranormal powers as the result of his or her soul-shattering experience. Naturally, the use of such power attracts the attention of other such people.

### BELIEVE YOUR HUNCHES

Jung's idea of the collective unconscious is elliptically touched upon in many of Lovecraft's stories. With the addition of various pre- and semi-human races to the Mythos, investigators may find themselves harboring strange thoughts of unknown origin. Perhaps the a player is told that he shuns a certain glade, finds a certain man of unique physiognomy distasteful, or finds certain corporate graphics wierdly unsettling. These disquieting harbingers may be the legacy of thousands of years of cultural memory, vestiges of a time when knowing how to recognize the spoor of the Mythos was of paramount importance. If only the Hyperboreans' knowledge of how to deal with these ancient menaces survived....

### ENLISTED BY THE MYTHOS

At most asylums in the 1920s, the inmates were used as a source of labor—generally farmwork, but many of the insane were worked in hazardous coal mines and other unpleasant, dangerous jobs. Perhaps the new superintendent has other uses for them: they could be made to walk in strange patterns in the exercise yard, yield magic points or points of POW to some nameless entity, make handicrafts like godseyes that are actually magical implements—or simply be sacrificed (who will miss a handful of out-of-state lunatics?). When the inmate investigator manages to tell his friends on the outside what's going on, the stage is set.

### THE TRAIL OF ITHAQUA

Windigo is an actual mental illness specific to Canadian Indians. Those affected by it suffer from depression combined with the impulse to bite others, a fear of being bitten, and the delusion of being possessed by a flesh-eating monster. The connection between this illness and Ithaqua's confinement to the boreal pole is obvious. Perhaps an investigator at an asylum becomes cellmates with an Arctic

explorer who suffers from such anthropophagy as a result of his explorations. Perhaps the Wind-Walker will make an excursion to recover that escaped morsel of humanity.

### A VISIBLE FEVER

Rampant disease epidemics were another hallmark of the asylum in decades past. Maybe some pitiless madman has somehow contrived to bring a pestilential sickness within the cold stone walls holding an addled investigator. This sickness is an awful manifestation of Azathoth: like creeping mold it spreads from person to person, feeding on both flesh and the remaining tatters of mind and sanity in its victims. How to stop it? Only our resourceful investigators can discover that.

### A DREAM WITHOUT AWAKENING

Many Mythos entities can influence dreams or mental activity. Great Cthulhu's ability to alter the dreams of the sensitive is well-known, but Glaaki, Chaugnar Faugn, members of the Great Race of Yith, insects of Shaggai, Ilogor, and the various Gods of Dream and Outer Gods can affect dreams or the mental state of humans in ways that mimic insanity. Perhaps an investigator is the unlucky recipient of some unwanted attention from one of these beings. Slowly, little mental problems and nightmares appear until the investigator vainly seeks for help in the realm of psychiatry. Perhaps he or she learns the horrible truth while lying hypnotized on a womblike sofa in the doctor's office, convincing the psychiatrist of the need for immediate commitment.

### THE TRUTH AT LAST?

Dr. Cotton, of focal infection theory fame, was always cutting bits and pieces out of human beings. Was he or were some of his followers doing something with those crimson bits? What does one do with hundreds of extracted teeth, yards and yards of large intestine, and the odd ovary or testicle? Make offerings to some antique god? Create a nauseating monster? Cast bizarre and horrible spells? Nothing at all? Some investigators may desperately want to know if fed the right hints.

### A WAKING CONFUSION

Are the delusions and hallucinations that the investigator is experiencing really occurring in the Dreamlands? "What's that, George? You say a twenty-foot tall, four-armed gorilla with a funny mouth is coming in through the window behind me? That's nice. I think it's time for you to take a nap." After several occurrences of this, substitute a real monster coming in through the window, having been drawn here by the investigator's psychic turmoil. Thoughtfully save the investigator, this time, so that he or she can go to sleep, and dream of something new....

### THE ECCENTRIC PROFESSOR

During his last years at Cornell, Titchener only taught during the spring semester and only on Monday evenings. All the rest of his time was spent cloistered in the laboratory at his home. What was Titchener working on all those years at home in his study? And was it actually Titchener? And if it was not, what happened to the real Titchener?



## Sample Interview

**Summary from the patient's medical file:** *Charles Weinstock is a 22-year-old artist who currently resides with his parents in Hartford, Connecticut. He has a younger brother and did very well academically. It appears, from previous familial interviews, that Charles had no psychiatric problems before the event which brought him into our care.*

**Excerpt from transcript of Initial Interview with Dr. Rossmoor (2/13/23)**

*Rossmoor:* That's fine, Charles. Now bring me up to date from college to the problem that brought you here today. Tell it to me in your own words, and in as much detail as possible. That will allow me to get the entire picture so I can help you.

*Weinstock:* Sure, doctor. Like I told you, I've been an artist since childhood. From an early age people recognized my ability to draw. I graduated from Wiggins Prep in June of 1917 having won the R. B. Ogilby Award in Illustration. In 1918, after completing my first year at Middleton Art College, I began work as a freelance artist. That summer I began to get a great interest in photography and so I enrolled in evening courses to pursue this interest. The first class went rather smoothly and my photographic skills were getting better, but during the second class the first ... occurrence took place.

*Rossmoor:* Can you tell me about that?

*Weinstock:* I was in class listening to the lecture and thinking about what photograph I was going to use for my next assignment, when suddenly out of nowhere someone from across the lecture hall blurted out what I had just thought. I was completely amazed and couldn't understand how it had occurred. Then it happened again and again and that evening was the last time I attended that class. I have tried to determine what took place and I think I arrived at the solution. I was not depressed at the time and as a matter of fact had just won a weekend trip to Marthas Vineyard, met several very pretty women and was generally happy with my station. But in the classroom were these two gentlemen that always sat together and I could tell they were jealous of my talents. I'm of the opinion that when a person sets himself up in a good job and his life is going the way he wants it to, that certain people develop added sensory powers. These two individuals may have possessed this ability.

*Rossmoor:* I see — and exactly what is that ability?

*Weinstock:* Through their jealousy, they were able to at first communicate silently to themselves, then with both of their powers combined, they snapped something in my brain, possibly using a form of magnetism to tap my imagination or just threw me a hatred wave, I'm not sure, which consequently influenced certain cells in my brain. In the evenings and nights that followed I noticed it happening again and again, only this time it was with everyone I met and saw. The shopkeeper, the book dealer, the cab driver, all were able to read my thoughts, criticize them, and sometimes they laugh at them.

Eventually the voices would keep me up at night and I had to sleep during the day. This began to drive me mad and started to affect my work and my entire life began to collapse because of this nightly occurrence.

About midway through 1919, I tried to continue my work as an artist, but the voices made it impossible and would dispel my concentration. I tried various jobs through the next year thinking that getting out more would strengthen my brain's *neglow*.

*Rossmoor:* Pardon me? Your brain's ...?

*Weinstock:* *Neglow*. The power of light and clarity, the vanishing point of the soul. Well, in time the voices made the jobs intolerable and forced me to quit each one. By 1921 I was unemployed and unable to work due to the pain of the forced telepathy. At first the pain was merely a dull headache, but eventually it spread down my neck and into my right arm. I was prevented from doing anything and would often stand for hours like a zombie trying every way I could to move, because I knew if I could move that the pain would subside. Then pictures began forming in my head. Faces of people I knew and ones that I didn't know. Each of them raping my mind with their slogith vomit. The disease that was unleashed in my brain is slowly killing me. I know that now. The faces are trying to kill me.

**Excerpt from Doctor Rossmoor's file of same patient:** *Since these episodes began suddenly without any warning, it is not unreasonable to doubt that something was not right with Charles before the first of these occurrences. His family tells me this is not so, but they just may have been unaware of them at the time. Charles describes a number of symptoms that are outside the range of normal human experience and are clearly pathological. He has delusions of telepathy and he believes that others have to ability to "snap" his mind with magnetism or "hatred waves." He also experiences auditory hallucinations. Originally he suffered from audible thoughts, but has now progressed to hearing critical voices that "laugh at him"—no doubt echoing his own self-criticism.*

*Additionally, his account displays a peculiar use of language. He uses words like "neglow" and "slogith." Communication is still mostly fluid and comprehensible, with only minor symptoms of disorganized thinking.*

*Since the delusions are persecutory in nature and there are hallucinations present with peculiar speech patterns, this patient (particularly considering his age) is easily classified as suffering from dementia praecox with strong paranoid tendency. His hysterical paralysis argues against this diagnosis, but it may be due to some delusionary thinking, rather than a true conversion type disorder. This must be kept in mind as the course of the illness progresses. Treatment should start with sleep therapy of no longer than two weeks followed up by psychoanalysis of not less than one month.*

**What's really wrong with Charles? He is being alternatively possessed and tortured by two insects from Shagga!**

For further information, see the bibliography, especially the entries for the American Psychiatric Assoc., Emil Kraepelin, and James Morrison. American Psychiatric Association. *Quick Reference to the Diagnostic Criteria from DSM-III*. Washington : APA, 1980. The DSM (now in its fourth incarnation) is the canonical guide to the descriptions of mental illness. The associated guides offer briefer descriptions that are of greater practicality for the keeper who does not hold a medical degree.



Case No. \_\_\_\_\_ Attending Psychiatrist \_\_\_\_\_ Date of Interview \_\_\_\_\_

**Screening**

*Search for possible incidence of the following, regardless of how the complaint is presented: depression, mania, panic, phobias, obsession and compulsions, psychosis, childhood abuse, drug abuse, suicidal or violent tendencies.*

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**Mental Examination**

1. Visual cues (noted during interview): *alertness, clothing, motor activity, facial expression, affect.*

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2. Speech cues (noted during interview): *loose associations, tangentiality, flight of ideas, rate of speech, other verbal peculiarities.*

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3. Cognitive cues (noted during interview): *delusions, hallucinations, anxieties, phobias, obsessions & compulsions, insight & judgment.*

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**Formal Mental Status Examination**

*Orientation to person, place and time, language, memory, cultural information, abstract thinking.*

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**Diagnostic Impression**

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**Recommended plan for treatment**

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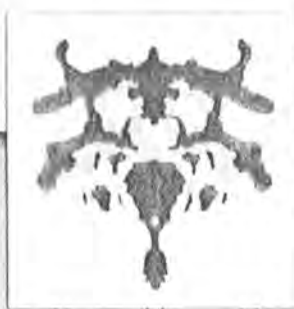
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Psychiatrist's Signature \_\_\_\_\_

Date \_\_\_\_\_







# Insanity, Society, & the Law

*Beset by delusions and uncontrollable impulses, the insane cannot always be responsible for their own actions, and so are protected from unfair prosecution. But society too must be protected.*

**T**HE INSANE CAN be removed from society in many ways. If a lunatic realizes his own mental infirmity, he might commit himself to an asylum, entrusting his care to the doctors there. Alternatively, the state may take action against a lunatic, using any number of civil laws. If the state discovers that a person is mentally ill but does not consider him dangerously so, it might place that person under another's legal guardianship, taking away some personal rights in the process. In the most extreme cases, the state might attempt to have a person civilly committed, forcing him or her to remain in an asylum until the mental condition improves.

## Voluntary Commitment

Occasionally, realizing that he or she is mentally unbalanced, a person will choose to be committed, hoping that the insanities may be diagnosed and repaired. The actual process is relatively simple. A person has to do little more than appear at an asylum, requesting commitment. Very little about the voluntary commitment process changes during the three Cthulhu time periods.

Private asylums will accept almost anyone, if they can pay. Usually, they accept a very limited number of the poor as well. Charity cases that private asylums accept will probably be the minimally insane, who are not a danger to themselves or to others.

Public asylums are another matter entirely. Theoretically, they exist for everyone, but this is not true in practice. Overcrowding usually forces public asylums to accept only limited numbers of patients. This is further complicated by government regulations which place priorities on admitting certain types of people. First priority is usually given to criminals and the indigent, since they would be living upon government funds in any case. Only if these two classes of people do not fill the asylums are others given admittance.

Upon commitment, asylums usually require patients to sign certain agreements regarding their release. Initially, most asylums require a minimum stay, often three to six months in length. After that, asylums will usually allow a voluntary patient to leave at any time, pending written notice. However, there is often a mandated waiting period, usually three to seven days in length, before the patient can actually leave even then. Hospitals may use this time to try to civilly commit a patient if the administering doctor thinks it would be dangerous to release the patient.

Rules and regulations will vary from hospital to hospital, though these guidelines are the norm. It is important to note that a patient who voluntarily entered a hospital may not be held involuntarily for an extended amount of time unless the normal procedures for involuntary commitment are followed.

## **THE 1890s**

In Victorian England, it was quite easy for a patient to gain admittance to a public asylum. However, public asylums were usually simply places of confinement, and a patient would be ill-advised to enter one. Given the money, entering a private asylum was equally easy, and life there was much more comfortable.

## **THE 1920s**

It remained easy to enter asylums in the 1920s. Public asylums faced some crowding, due to criminals and the poor, but few were turned away. Although not cheap, private institutions on average were less expensive than before. Private asylums did provide the best care possible, but public asylums were usually quite acceptable.

## **THE 1990s**

Only in the most recent era has it become difficult for the insane to voluntarily commit themselves. Most public asylums are full, and willing to accept only the criminally

insane as new patients. Private asylums have more freedom, though their costs are beyond the means of many. *Admittance is important.* If admittance to an asylum is obtained, modern techniques are nearly guaranteed to work, and the patient can expect to return to the community as soon as possible.

## Civil Incompetence Laws

Many mentally unstable people are unwilling to submit themselves to voluntary commitment, but not dangerous enough to be civilly committed. The State generally labels these people *incompetent* because they are unable to carry out the normal tasks that society expects of its citizens. The class of incompetents includes several different groups of people, including the insane, the feeble-minded, and the elderly. A number of different laws exist to protect society from the incompetent. For the most part, they have been unchanged for the last hundred years.

Various rights can be taken away from a person on the basis of incompetence. One of the most important of these rights is the right to contract. Almost universally, an incompetent can not make a legally binding contract. This precludes not only business agreements, partnerships, timed payment purchases, and other contracts of that sort, but also marriages. If a person is incompetent at the time, a marriage contract is nearly always null and void. In most states, incompetence is also adequate grounds for divorce.

Another contract that can be invalidated by incompetency is the creation of a will. Not surprisingly, a very specific procedure exists for invalidating a will due to incompetency. This is one of the most well-defined areas of civil incompetence.

In order for a will to be invalidated due to incompetence, it must be contested in a court of law. The arguments and testimony of the petitioner will usually be heard by a psychiatrist. It is the psychiatrist's task to determine if the person who wrote the will had *testamentary capacity* at the time he made the will. A person is said to have testamentary capacity if meeting three criteria: he must have known he was making a will, he must have known the full extent and nature of his property, and he must have known and comprehended the relationship between his potential beneficiaries and himself. After hearing all of the testimony, the psychiatrist testifies to the court whether he thinks the deceased had testamentary capacity when the will was written.

If a person is considered sufficiently incompetent, he can lose more than just his ability to contract. He can also lose his freedom, due to guardianship and ward laws.

Relatives are typically the ones that bring forth petitions to name an incompetent their legal ward. This petition is presented in a court, occasionally before a jury. Usually, it is not contested at all. The potential ward does not even show up in many cases. Only a minimal amount of evidence is needed to get someone named a ward, usually no more than a single physician's letter and the testimony of the petitioner.

Most petitions for guardianship take just a few minutes. When they are done, the new ward is nearly totally without

rights. The guardian becomes utterly responsible for the ward and his actions.

Traditionally, the guardianship process has existed primarily for the rich. The poor have always been at a significant disadvantage, since they are often without relatives, and nearly always unable to pay for a private guardian. Poor incompetents have usually been ignored, left to wander the streets, trying to provide for themselves against the most insurmountable odds.

### THE 1890s

In the 1890s, the civil incompetence laws were harsh. Unequivocally, incompetents could not contract or marry. Guardianship was an easy thing to gain, and the trials were often technicalities. The definition of incompetency was quite wide in the 1890s. Antisocial behavior, such as vicious habits or idleness, or merely advancing age might each lead to a finding of incompetence.

### THE 1920s

By the 1920s, civil incompetence laws were slightly more progressive. The laws of many states recognized the concept of the *lucid interval*, which is a period of sanity enjoyed by a normally incompetent person. Many laws said that contracts could be made during these lucid intervals. However, in other areas of the law, civil incompetence laws were unchanged from the 1890s. Guardianship was still easy to get, and the wards had no real due process. The definition of incompetence was often widened. Some states now included epileptics among the incompetents, as well as the vicious, the slothful, and the aged.

### THE 1990s

The laws of today allow more freedom. Some states recognize levels of competence, realizing that people may be able to engage in some types of contracts and not in others. Due process is much more a part of the guardianship process. Many states guarantee both sufficient notice and a lawyer to the defendant. Further, nearly all the states now offer public guardians to people who have no relatives and insufficient funds to hire a private guardian. Finally, in recent years, courts have recognized that incompetents actually do have some rights, such as the right to education and the first amendment rights of free speech and religion.

## Involuntary Commitment

Occasionally, it is the case that a lunatic is unwilling to commit himself, yet he is too dangerous to leave free in the community. For these situations the laws of civil commitment exist. Though most often used by governments to incarcerate dangerous lunatics, family, associates, or friends may also petition for civil commitment proceedings to be started.

### THE 1890s

The Lunacy Act of 1890 regulated the involuntary commitment of people in England. It attempted to change older precedents put forth in the Insane Prisoners Act of 1840, but most places were quite slow to change. In order to



commit someone, a *Certificate of Insanity*, signed by two judges and two doctors, was required.

The Lunacy Act set some strict restrictions on the judges, saying that they could only take into account evidence presented at a trial and the word of witnesses. These trials were often short, however, and they rarely found against the people seeking involuntary commitment.

When a family came, asking for the confinement of some relative, the laws were even more lax. Most asylums did not require any type of judicial order in this case. Abuses of such power are easy to imagine.

### THE 1920s

For the most part, it was slightly more difficult to have a person committed in the 1920s than it had been in the 1890s. Most states required a combination of medical doctor certification and some type of court hearing, overseen by a judge. States such as Illinois actually insisted upon a jury trial before allowing involuntary commitment. The primary criteria for civil commitment in the 1920s was the *need for care*. If a petitioner could prove that a defendant needed mental care, and followed the proper procedures, the commitment usually followed.

Temporary commitment laws were legislated in many states in the years leading up to the 1920s. These allowed for a person to be confined for a limited amount of time, the range varying from a week to a month, upon the word of a public official such as a police officer. In many cases a lunatic was temporarily committed, and during that time period full commitment proceedings were begun.

The rules in Massachusetts during the 1920s were very close to the norm. To have someone committed, a certificate of insanity had to be signed by two doctors. Then, a court hearing was held. If the judge found that the defendant was insane, he was committed. The Temporary Commitment Law, called Chapter 395, allowed for a ten-day commitment period. This temporary commitment could be obtained by a guardian, a police officer, or a member of the Board of Health, who had to submit a certificate signed by one physician to a judge. No hearing was held to obtain the temporary commitment order.

### THE 1990s

In earlier eras, people could be involuntarily confined for the most arbitrary reasons. In the 1990s, there are only three acceptable reasons for involuntary commitment: *grave disability*, which is defined as the inability to provide for the basic personal needs of food, clothing or shelter, *danger to self*, and *danger to others*.

Further, people who are being involuntarily committed may now expect to have full due process. They have the right to an attorney, a full hearing, and a jury trial. They are also protected from incriminating themselves, just as defendants would be in criminal cases. This means that statements made to a psychiatrist may not be used as the basis of commitment, unlike in earlier eras. For a person to be committed, *clear and convincing evidence* must be given that the defendant meets one of the criteria for commitment.



The Supreme Court has further stated that a person should only be committed to an asylum if there are no suitable, less restrictive alternatives. Juries often will be asked to keep this application in mind when they are making their decision.

However, many temporary commitment laws are still on the books. Thus, despite the due process that is required to gain permanent commitment, the insane can still be temporarily committed and forced to undergo psychological testing, without any real trial.

## Insanity and the Courts

Unfortunately, many dangerously insane lunatics escape civil commitment. Dwelling quietly at the fringes of society, they avoid the scrutiny of civic authorities until at last they appear in court, accused of heinous crimes.

The situation becomes complex. Victims, or friends and relatives of victims, demand punishment, desiring compensation for the wrongs done. The judicial system, however, has a responsibility to ensure that lunatics are not unfairly punished for crimes they could not stop themselves from committing.

The insane have had two main defenses in contemporary courts of law. If a person is moronic or totally insane, and thus unable to understand the charges that face him, the court may find him incompetent to stand trial. In less extreme cases, a lunatic may plead insanity, proclaiming that he was not responsible for his actions at the time of his crime. If a plea of incompetence or insanity succeeds, the defendant will usually find himself criminally committed and labelled dangerously insane.

## The Incompetence Plea

Although it does not receive nearly as much publicity as the insanity plea, the incompetence plea is much more common. A defendant may be found incompetent to stand trial if he is unable to understand the charges that face him or incapable of defending himself. If found to be incompetent to stand trial, the person is typically removed to an asylum. There, he or she remains until the mental state substantially improves. At that time, he or she is returned to the court, to face the original charges.

In many cases, a plea of incompetence is a legal diversion made en route to an insanity plea later in the trial.

### THE 1890s

In England of the 1890s, the differences between incompetence and insanity were very poorly defined. By and far, the majority of attention was placed on the insanity plea. Still, the incompetence plea did exist.

A court might declare a defendant *unfit to plea* if he was unable to understand either the trial or his rights. This could occur if a defendant was deaf and dumb, an idiot, or if he showed a clear *weakness of mind*. However, the courts of England were very strict in their interpretation of the incompetency laws. Very few people were actually found unfit to plea. Many judges preferred to leave decisions of insanity to the juries, and thus raving lunatics might be found competent.

If a defendant was found unfit to plea, he would usually end up in the criminal wing of an asylum, alongside murderers and rapists who had been found fit to plea, and actually been given a trial.

### THE 1920s

By this era, the United States was much more accepting of the incompetency plea than England of the 1890s had been. In fact, the criteria for incompetency was much broader. In some states, any person who was insane at the time of his trial might be found incompetent to stand trial.

As this definition broadened, incompetence became no longer just a defense for the insane individual to hide behind. Many prosecuting attorneys became quite willing to let a defendant plead incompetency. Some district attorneys actually initiated incompetency proceedings, realizing that it allowed them to imprison a defendant without any real trial. The prosecution's newfound zeal for finding defendants incompetent to stand trial came largely from the fact that incarcerated incompetents probably would never be released.

### THE 1990s

Abuses of the incompetency laws have diminished. The reasons for finding a person incompetent are about the same. A person may be found incompetent if he is unable to defend himself in court, due to some mental deficiency. However, prosecutors are now reluctant to allow a defendant to be found incompetent, because the laws governing how long an incompetent patient can be held have changed dramatically. Today only the truly incompetent, unlikely

to ever understand the charges that face them, are likely to be found incompetent by a court of law.

## The Insanity Plea

Although not used as commonly as the incompetence plea, the insanity plea has always received much more publicity. Many people see it as a loophole through which murderers, rapists, and other criminals escape justice. In reality, the insanity plea is a tool of justice. It ensures that the insane are not found guilty for acts which they could not control.

In all three Cthulhu eras, the insanity plea revolves around the M'Naughten Rule, which was formulated in England in 1843. This rule states:

To establish a defense on the grounds of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know that he was doing what was wrong.

This rule is often called the right/wrong test, because it centers around a defendant being able to tell the difference between right and wrong.

When a defendant is found Not Guilty by Reason of Insanity, he is placed in an asylum for the criminally insane. The exact conditions necessary for his release vary widely, depending upon the time period.

### THE 1890s

The Insanity Plea of London in the 1890s was governed solely by the M'Naughten Rule. Only if a defendant met the narrow criteria of that test could he be declared insane. However, a defendant who succeeded at an insanity plea was not found Not Guilty. Rather, he was judged guilty but insane, due to the 1883 Trial of Lunatics Act, passed after an attempt upon the Queen's life.

Since very few criminals were released from asylums in the 1890s, only people who faced capital punishment pled insanity. Several documented cases speak of judges advising defendants not to plead insanity when faced with relatively minor crimes. As punishment, the asylum was considered worse than nearly any other form the court could administer.

### THE 1920s

The insanity plea laws of America in the 1920s were not uniform. In most places, the M'Naughten rule was the basis for the insanity plea. In addition, many states added laws concerning irresistible impulse. These stated that a person might be found not guilty by reason of insanity if the defendant had been "irresistibly impelled to the commission of criminal acts while fully conscious of their nature and consequences." Neither of these two rules was universal in adoption.

California in the 1920s had one of the most extreme variations of the standard insanity plea. After 1925, in order to plea insanity, a defendant had to lodge two separate pleas, not guilty and not guilty by reason of insanity. Then, two trials were held. In the first trial, a

defendant could only be found guilty or not guilty, and no evidence of mental disturbance was allowed. If the defendant was found guilty in the first trial, a second one was held. In that one, evidence of insanity was allowed, and the defendant could only be found guilty or not guilty by reason of insanity. This odd state of affairs continued in California for some twenty-five years.

In its Laws of 1928, Mississippi actually abolished the insanity plea. However, this legislation was quickly appealed and subsequently overturned by the Supreme Court of Mississippi.

## THE 1990s

The Insanity Defense Reform Act of 1984 set the standard for the insanity defense of the present, a slight restatement of the M'Naughten rule. A defendant must prove that

[he] as a result of severe mental disease or defect was unable to appreciate the nature and quality or the wrongfulness of his acts.

In addition, the wording of the verdict has been changed to read "not guilty only by reason of insanity."

In previous eras, when someone was found not guilty by reason of insanity, it was because they had some mental disease, or some defect in their brain. In recent years, this definition has broadened considerably. Courts now recognize that a variety of external stimuli may drive normal people temporarily into the realm of insanity.

The Battered Wife Syndrome is one of the most common insanity defenses. It involves a woman, abused for years, who finally snaps and acts out against her tormentor. Lorena Bobbit, who in the early 1990s mutilated her husband while he slept, was a widely-reported example of a battered wife. The Menendez brothers gave a very similar defense, saying that they had slain their parents because their father had abused them. The lawyers in both cases have stated that their defendants were driven temporarily insane due to years of abuse.

Emotional domination has been another favorite insanity defense in recent years. It is usually pled when the defendant committed illegal acts while being dominated by some cult leader. Some followers of David Koresh, who died along with many others at the end of the tragic siege near Waco, Texas, have said that they were brainwashed, and thus not responsible for their own actions.

Many states, including Michigan, Indiana, and Illinois, have added a new verdict, Guilty but Mentally Ill. This verdict does not replace Not Guilty by Reason of Insanity, but rather supplements it, offering a new middle ground. Defendants found Guilty but Mentally Ill are still sent to prison, but given special psychiatric care. The people found Guilty but Mentally Ill are almost exclusively those who would otherwise have been found entirely Guilty.

Several states also have *diminished capacity laws* on the books. Like the Guilty but Mentally Ill laws, these are meant to give the jury another option besides Guilty or Not Guilty by Reason of Insanity. These laws allow a person to plead that his or her capacity to reason was diminished during the commission of a crime. If the jury believes the

diminished capacity plea, they can find the defendant guilty of a lesser crime.

One of the most far-fetched uses of the diminished capacity law occurred in California in 1979. The previous year, former Supervisor Dan White slew San Francisco Mayor George Moscone and Supervisor Harvey Milk. In court, White pled diminished capacity, saying that the junk food he had eaten earlier in the day had put him into a hyper-active state, and that he had not been in control of his actions when he committed murder. The defense was successful, and Dan White was found guilty of Manslaughter rather than First Degree Murder.

It appears that the insanity defense may soon see major changes. On March 28, 1994, the United States Supreme Court declared that it was constitutional for states to forbid defendants from claiming the insanity defense. Currently, Idaho, Montana, and Utah have all done away with the insanity defense.

## EXPERT WITNESSES

Expert witnesses have long been a staple of trials involving the insane. Psychiatrists, psychologists, neurologists, physicians, and social workers have all gathered in court rooms to explain why a defendant is or isn't insane. Although expert witnesses are forbidden from saying whether or not a defendant is responsible as accused for a crime, such witnesses are allowed to answer many other questions, including:

- Did the defendant know right from wrong?
- Could the defendant control himself or herself?
- Were the defendant's actions a product of mental disease?

Often cases involving insanity have turned into long, drawn-out contests between opposing experts, to the apparent destruction of the notion of justice. Still, the practice continues. In such cases, the present-day defendant would be at an extreme disadvantage without expert witnesses to speak for him.

## THE 1890s

Although the rich could hire expert witnesses in the 1890s, such witnesses at that time were of limited usefulness. Many judges dismissed medical experts utterly or declared such testimony to simply be opinion and hence not to be regarded by a jury. While some expert testimony might be taken into consideration, most was ignored by conservative judges.

## THE 1920s

By the 1920s, American courts gave more respect to medical opinion. In fact, some courts even listened to psychoanalytic rationalizations for a defendant's actions, and then offered reduced sentences, accepting the belief that some subconscious desire had been the true reason behind the defendant's crime. Many poor defendants found their defenses undermined, however, because they were unable to hire an expert witness to speak for them.

Massachusetts tried to make up for this imbalance in 1921 with the passage of the Briggs Law. Under it, defendants who had been convicted of a felony or who were currently indicted for a capital offense were granted a psychiatric examination by a neutral expert witness.



## THE 1990s

Expert witnesses are common in today's courts. Attorneys might parade a half-dozen such witnesses through the court room in a major trial involving insanity. Most states acknowledge this increased importance by either hiring a neutral expert witness or by paying for the defense's expert witnesses in cases involving insanity.

## Reduced Sentences

Sometimes, despite the best argued cases, the slickest expert witnesses, and the most compelling evidence, insanity pleas fail and juries find defendants guilty. Still, the judge may consider the possibility of mental illness when handing down a sentence.

## THE 1890s

The Insane Prisoners act of 1840 gave the Home Secretary the ability to confine criminals awaiting sentencing to a mental institution, following the normal civil commitment laws. During the Victorian Era, many criminals awaiting punishment for a capital crime were certified insane, even though an insanity plea might have failed during the trial. These criminals were thus to exchange their punishments for confinement to a mental institution.

## THE 1920s

In this era, few laws were on the book for reducing punishment due to insanity. Still, progressive or kind-hearted judges took the apparent mental states of defendants into account. Lacking official guidelines for such sentence reductions, the practice varied by judge. At that point the defendant simply was lucky, or was not, in which judge had been assigned to the case.

## THE 1990s

Today, the idea of decreased punishment for the mentally ill is pervasive. The American Law Institute's Model Penal Code says that mental disease which might justify some of a defendant's actions should "be accorded weight in favor of withholding sentence of imprisonment", while Senate Bill 1722 of the Ninety-sixth Congress states that a judge should consider the defendant's "mental and emotional condition to the extent that such condition mitigates the defendant's culpability." Thus today, when a judge lessens a defendant's punishment due to insanity, both tradition and law agree with him.

# Asylums and the Law

**V**IA ONE ROUTE or another, the insane often end up in asylums. Laws regulate the situation here, too. With commitment, many rights are stripped away within the asylum, and the lunatic may not be released until the law mandates that he or she may go free.

## The Rights of Patients

In recent decades, people have begun to demand that institutionalized patients be given the same basic rights as other members of the community. To a limited extent, legislatures and judiciaries have begun to respond to these demands, but the ranges and intensities of mental illness retard attempts to recodify these legal relations. For the first time ever, new laws and court decisions have recognized mental patients as citizens, with full human rights. Because this goal seems to contradict the notion of mental illness as in any sense incapacitating, the rights of an asylum resident are still controversial.

## THE 1890s

Asylum patients had very little in the way of rights in the 1890s. They might be able to expect their Right to Life, but even that was not undeniable, and much devolved to the authorities' senses of the socially appropriate or the politically expedient. If an unremarkable asylum patient died unremarkably, for instance, the police would be unlikely to investigate the matter at all, unless formally alerted to possible foul play by the coroner's office.

## THE 1920s

Patient freedoms were quite varied in the 1920s. For the most part, the government recognized no patient rights, other than the Right to Life. Most hospitals actually went out of their way to deny freedoms to patients, such as receiving visitors. The staff thought that interactions with the outside world would hurt the patients' progress.

However, some progressive hospitals did extend the rights of their patients. In the better ones, patients had some freedom of speech, for instance, and a small ability to determine their medical treatment. However, the hospitals which allowed even minor freedom to their patients were very experimental and quite limited in number.

## THE 1990s

In the last two decades, it has been recognized that patients possess a wide spectrum of legal rights. Today, most asylum patients retain most of their First Amendment rights. They can expect to send and receive letters and phone calls, meet with visitors, and have free access to many of their possessions. In addition, patients are allowed to practice their own religion, and are, in some cases, even able to vote.

Due to *O'Conner v. Donaldson*, asylum patients now have the right to receive treatment. Some states have even granted patients the right to refuse treatment, although this issue is quite unresolved, and varies from state to state. Most states prohibit restraint or seclusion as part of treatment unless the patient is a danger to himself or to others. States are even more specific in disallowing restraint or seclusion as a form of punishment.

Today's mental patients also can expect that their privacy will not be violated, and that what they say to doctors within the asylum will be held in the utmost confidentiality. The only exception to this occurs when a doctor feels that he might be putting others in danger by not revealing what a patient has said.

However, despite the fact that many of these rights are now law in most states, their observation is by no means universal. Individual physicians and staff might choose to ignore these rights on occasion, though in violation of state and federal law, with relative impunity.

## Release from Asylums

Patients who are voluntarily committed usually have little problem getting out of asylums. Within the restrictions of the contracts that they signed when they entered the asylum, voluntary patients may leave when they wish. Involuntarily committed patients face more of a battle.

### THE 1890s

The courts of the 1890s recognized two broad groups of involuntarily committed asylum patients, the criminally insane and the normal lunatics. The normal lunatics were the less dangerous prisoners, usually brought into the asylum by civil commitment. Despite the fact that they were the least deranged of the insane, they still had little chance of returning to society. If they became exceedingly sane while confined, or if relatives begged their release, then some of these people might be allowed to return to society, but only rarely.

The criminally insane, those people sent to an asylum after incompetence or insanity pleas, or transferred to an asylum to escape capital punishment, faced a grimmer future. Only the Crown could initiate their release. The Home Secretary had to receive favorable recommendations from the Commissioners in Lunacy, and from a doctor, before he would even consider releasing a criminally insane asylum patient. According to records, only one in ten such patients were ever released from Victorian asylums.

### THE 1920s

Despite thirty years of advances in medicine, patients involuntarily confined to mental hospitals in the 1920s had little chance of release. Many hospitals were understaffed, and thus doctors and nurses had little time to work with patients, let alone evaluate and nurture their progress. Patients who conspicuously showed sanity or who belonged to wealthy families had some chance for release, but the rest were at the mercy of the asylum.

Involuntarily committed patients and those who had been found incompetent by a court had the greatest chance of release. The asylums felt the involuntarily committed patients were less dangerous, and were thus more willing to return them to the community. Doctors had no scruples about releasing incompetent patients because they would simply be returned to the court, and, in all likelihood, quickly confined again in some jail cell.

However, patients who had entered the asylum due to a verdict of insanity were a problem. Releasing these patients meant returning dangerous people to the community, and most asylums were unwilling to take the responsibility for that action. Thus a patient found not guilty by reason of insanity was quite likely to remain in an asylum for life.

### THE 1990s

In recent years, patients involuntarily sent to insane asylums face a brighter future. A number of Supreme Court decisions mandate that patients must be given due process, as required by the United States constitution.

Civily committed patients are protected by *O'Conner v. Donaldson*. Even if a patient in an asylum has been confined according to correct legal procedures, this decision states that confinement can only continue until the basis for the original commitment is cured. Thus asylums are now legally obliged to regularly review their civil patients.

*Jackson v. Indiana* protects defendants who have been incarcerated due to incompetence to stand trial. This law states as follows:

A person charged by a state with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain the capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal.

If a person is determined unlikely to recover competency, the Supreme Court has further suggested that any charges against him should be dropped.

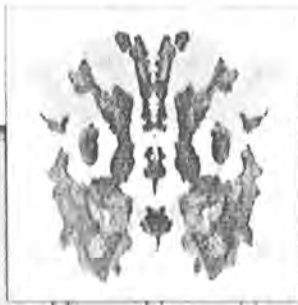
Only the rights of patients being held due to an insanity finding are still in question. For some time, *Baxstrom v. Herold* was the rule. This decision determined that equal protection was violated by indefinitely holding someone determined not guilty by reason of insanity. *Baxstrom*, and other similar decisions, required that an asylum meet the normal criteria for civil commitment in order to hold a patient after an insanity verdict. In some cases, a defendant was actually found not guilty by reason of insanity, and then immediately returned to the streets, because his madness was gone.

But in 1983 a new decision was made, *Jones v. United States*. This reversed the old decision, saying that it was acceptable to commit people found not guilty by reason of insanity indefinitely, if they were dangerous. The Insanity Reform Act of 1984 took even more rights from those found not guilty by reason of insanity. It allows for the "automatic, indeterminate commitment of successful insanity defendants charged with a serious crime."

Today, the laws for releasing successful insanity defendants vary widely from state to state. For most lesser crimes, defendants can expect to face nothing worse than civil commitment. Progressive states even extend this to the greatest crimes, following the older court decisions. In many states, though, defendants who plead insanity to a serious crime may expect to lose their freedom and their right to due process, just as they would have a hundred years ago.







# Asylums

*Modern societies isolate the insane in asylums. A broad overview is given of life in such an institution. Expanded rules discuss cures, survival, etc. Tables of historical institutions are supplied, with appended notes.*

**E**VERYONE NOW spends time in social institutions like schools, offices, and factories. Asylums, like prisons, differ from such situations in that they are *total institutions*. A person normally works in one place, relaxes in another, and sleeps in a third, but the residents of an asylum or prison do all of their living in one location, perhaps spending most of their lives in a few rooms in one enormous building.

This is unusual. Combined with the reasons underlying the existence of an asylum, this situation creates patterns and themes reflected in the bureaucracy that runs the asylum, in the patients themselves, and in the support staff.

## WHY ASYLUMS EXIST

A total institution exists to manage and care for a large number of people in a restricted space. Usually an asylum's expenditures are limited by budget, whether the inmates are voluntary, involuntary, or confined for criminal acts. Needs are quite variable in a mental institution, and patient control and management is a challenge.

A sanitarium must ensure the safety of the public and at the same time provide for the care and treatment of the patients. These tasks must be accomplished with limited resources, and the different priorities of varying asylum officials must be balanced. Each asylum decides where its priorities lie. The style of the decision depends not only upon the resources available, but also on the social climate of the local area, the personal opinions of the people in charge of the institution, and even how up-to-date or conservative the previous administrations have been.

While unique individuals and experimental programs can create asylums that differ from the standard pattern, the standard type of institution is examined here.

## STAFF MEMBERS AND THE ASYLUM

To the staff, an asylum is not a total institution. They always have the option of going out during their off-hours, or going home every evening, or at least of getting vacation or leave time. They watch out for their own safety and make sure that the patients follow the rules—both tasks never quite achievable, as mental patients can be quite unpredictable. Few staff ever feel truly comfortable around them.

Of the staff, the doctors, alienists, and psychiatrists are the most concerned with actually curing patients. Blending old and new techniques, they do what they can to rehabilitate the inmates.

Nurses provide the primary care at asylums. In addition to assisting the doctors, they also administer drugs and medications, and look after the initial complaints of the patients. Wards for the criminally insane or the suicidal generally have nurses on duty around the clock.

Attendants and orderlies, who are non-medically trained, keep an eye on patients when nurses are not available. They are also useful for handling particularly uncooperative patients. They usually serve the food and generally supervise the activities of the patients. They may keep order in the day-rooms, and beat the bushes to prevent sexual dalliance on the asylum grounds. They will be the first to notice if a patient suddenly stops eating or suddenly becomes incontinent.

Finally, asylums need support staff. Clerks keep track of the paperwork that the asylum generates, cooks make food for the residents, and janitors and gardeners maintain the asylum and keep it clean and neat. Members of the support staff rarely are trained to deal with the insane by other than the grim humor of their peers. Often they do not interact with the insane at all.

Turnover of support staff varies in rate, of course, but the unpleasant nature of work in asylums practically guarantees that positions will be vacant. If investigators wish to enter an asylum surreptitiously, being hired as staff is the safest and least suspect way.

## Managing An Asylum

Whether resources are adequate or inadequate, the job of the asylum's superintendent (or chief doctor, warden, hospital administrator, or manager) is ensure the personal safety of patients, staff members, and the public, and also effect without scandal the sanitation, care, and treatment of the residents.

If a manager insists that he or she is solely concerned for the benefit and safety of the patients, he or she will have neglected to add that economics is also a vital consideration of most asylum policies. For example, the institutional clothing that most residents are required to wear may be said to reduce distinctions between patients, and hence reduce possible reasons for conflicts. However, most asylums require standardized clothing because it can all be washed together and then simply reissued by size. Likewise, it is simpler to have all patients eat and sleep at the same times, or to work on the same sorts of projects.

The motivations of superintendents have changed greatly over the last century. In the 1890s, the staff primarily existed to provide surveillance of the residents and the muscle to restrain them. Administrations of the 1920s had the same primary focus, but developments in psychiatry and medicine also suggested beneficial individualized treatments, and great efforts were made to achieve something of this new goal. In the 1990s, the main goals of asylum infrastructure are dual, aimed at effective and sound treatment and care of patients.

Staff members are able to live and relax away from the total institution, but the staff also have power and control over the patients—by the nature of their duties, of course, but also by philosophy. For instance, most asylums deliberately restrict the interaction of staff and patients, so that the staff does not grow attached to patients they may have to discipline and control, but also to decrease physical risk to the staff.

From these differences elaborate levels of social difference evolve, encouraging patients and staff to see each other in the most stereotypical terms. To the staff, patients may be deranged, bitter, secretive, and untrustworthy, while to patients the staff is condescending, mean, uninformed, and arrogant. The staff feel superior and righteous. Patients feel inferior and weak. Both viewpoints reinforce the perception that the patients deserve in a moral sense to be in the asylum.

## The Patient and the Asylum

The patients are the reason the asylum exists. This section explains how patients arrive at an asylum, what they do all day, how they are treated, and what they do to adjust to institutional life. Investigators who enter most asylums will undergo these sorts of experiences.

## ENTERING AN ASYLUM

The arrival procedure is probably the most traumatic part of a patient's existence within an asylum. The general process is called *mortification*. In order to break unwanted and unnecessary ties with the past, most of a patient's possessions are taken away, to be returned upon his or her release. The entrant is issued standard clothing and supplies to replace those taken by the staff. If necessary, the patient is thoroughly washed, and the clothes he or she wore are cleaned before being stored. If he or she is lousy, then treatment is given, and all hair is shorn.

The new entrant is assigned a room or a bed, and a nurse or orderly briefly summarizes the asylum rules that must be followed from now on. In less enlightened facilities, this dehumanization will be enforced by some type of will-breaking—possibly violent—so that the patient is made to understand that he or she has no rights and no hope except to do as the staff wishes.

## INSIDE THE ASYLUM

In the asylum, the patient's life is regimented and strictly controlled. If the patient is allowed contact with the outside world, that contact will be limited and censored. The patient's mail is carefully examined by the staff, for instance, and communications imagined to be upsetting are withheld. Days and times for outside visits are limited. Telephone privileges will be jealously limited, and probably will be denied altogether.

Except for the occasional loner or for the naturally friendless, most asylum residents soon start new friendships within the asylum. Usually a new acquaintance leads the entrant to join a larger clique of inmates. Even if censorship is non-existent, the new friends have more common interests. Communication with the outside world gradually diminishes. Outside friendships fade and die after a few months.

A point of etiquette: as part of the perception of "deserving" to be in the asylum, it is usually thought not proper to ask others why they are incarcerated. Most patients evolve a story or explanation of their problem, and that they willingly share with the other patients and staff. Listeners rarely question these stories, no matter how unlikely the stories seem.

Rarely is there enough staff to guide patients in constructive behavior. In the mid-19th century, most asylum staffs realized time could be well spent in worthwhile educational or skilled pursuits. Among the less progressive institutions, this good idea quickly led to the abuse of patients in factories, almost as forced labor. Recently, work is more tailored to the patient and is often creative in nature.

## PRIVILEGES, PUNISHMENTS

Every total institution develops a privilege system. Residents of good behavior are rewarded for it, from better food and treatment to earlier release dates. Over time, levels of social stratification form, based upon the amount of apparent privilege.

Violating the rules of the asylum results in the withdrawing of privileges—perhaps there is an increase in the

length of confinement and treatment, or perhaps the misbehaving patient is surreptitiously abused and humiliated. For instance, attendants might informally punish a rules violation by not allowing the patient the use of the rest room, resulting in soiling oneself in public.

In every asylum, the staff searches for ways to emphasize to patients that the staff is in control and that all inmates must comply with the rules. This conditioning reinforces the tendency of patients to use deferential speech and behavior toward staff members.

## ADAPTING TO AN ASYLUM

Learning to make one's way about in this controlled world of privileges and punishments does give the entering patient a sense of self and of (limited) control within this new place. But so is a wider realization of his or her situation is also inevitable.

There are common emotional adaptations to total institutionalization. Some people withdraw completely from the situation, or regress emotionally in some way. Others take an uncooperative stance and refuse to obey any orders or rules imposed by the staff. A third type of patient adapts by convincing himself that he has never had it so good. (A poor economic background and good relationships with staff make this possibility more likely, and perhaps true as well.) Finally, some patients take the side of the staff. They agree with everything the staff says and try to live up to the behavior that the staff sees as ideal.

A patient usually adapts in more than one way, to maximize his or her success. For instance, a patient may try to keep out of trouble, but still convinces himself or herself and others that he or she is bucking the system.

Such emotional adaptations help the patient cope better within the institution, and also help to decrease the tension of his or her separation from the outside world. The more control a patient is given or can earn, then the more pleasant living becomes. (If a patient comes from a rough and downtrodden environment, he will have already learned most of the behaviors that patients eventually develop.)

Lastly, most patients need to rationalize that the time spent in the asylum is not wasted. This is easy to do. Healing is one of the goals of commitment to an asylum, as most experts agree. Time spent in activities at the asylum contribute to a better adjustment to the world.

## PATIENT TREATMENT

The quality and quantity of treatment in asylums changes greatly over time. In the 1890s, effective treatment for

mental disorders was extremely rare. Often the cure was more harmful than the actual disorder. Fortunately for patients of this era, most psychiatric specialists realized this and focused on internment and protection rather than treatment and cure.

The 1920s brought the beginnings of psychoanalysis. Patients could have effective treatment if it was given to them.

In the 1990s, laws and regulations make treatment available to all, at the best level possible considering the resources available. However, the lack of resources is often profound, and often limits available treatments to a choice of one. Recent court decisions also make it possible for seriously ill people to refuse treatment that they find inappropriate, which in turn may mean no treatment at all. A majority of the chronically homeless in the United States may be the victims of collapsing outpatient programs.

On the street, the quality and quantity of treatment varies more greatly than it ever has. The tested ability for an effective cure may have to coexist with an inadequate or virtually nonexistent support system. More effective treatments are available during the 1920s and 1990s, but there is no way to be sure that a particular patient actually will be treated. In asylums, the availability of doctors, generally indicated by the doctor-to-patient ratio, seems to be the defining factor. In the 1990s, if the non-congenital patient can get into an asylum, he or she will almost always become more sane and capable.

## RELEASE

In those asylums whose purposes are not simply to isolate the insane and to insulate society, the goal is to attain the patient's cure and release. Once released, patients quickly forget the behavioral patterns they learned in the asylum, and generally ignore the adjustments they made there, because they are busy readjusting to the wide world.

However, the stigma of having been in an asylum must be borne. People react strangely to ex-patients. If the stay was long, the patient may be disculturated to some extent: habits and social graces needed in wider society may have been lost, not learned, or become despised. Patients are often told that doctors and family will notice signs of relapse, and that an ex-patient can easily be returned to the asylum. Though true, this is also an effective warning. And some minor fraction of ex-patients will deliberately fail in the world, so that they can return to the safety to which they successfully adjusted before.

# Using the Asylum Data

The rest of this chapter mostly concerns historical asylums in the United States and abroad. To use the information in the tables, read the rest of this section; it defines ideas like release rate and cure rate, and shows how to use the information.

After the five pages of tables comes a long set of notes, mostly included either to flesh out selected public institution entries, or to supplement them with information about interesting private hospitals, a class which the tables do not include. No survival rates, cure rates, or release rates are



offered in the notes. In general, adequate information was lacking, so that particular numbers would be specious and illusory. The keeper should invent such numbers, if desired. The tone of most entries will be informative enough.

## GENERAL PROCEDURE

The Call of Cthulhu rules concerning institutionalization, like most Cthulhu rules, are succinct and devoid of complicating detail. In them, an asylum is characterized by one number, representing the rate of cure for the institution. The keeper can treat the situation as desired, and move on. For added realism, however, institutions can be better described by three numbers, representing *survival rate*, *cure rate*, and *release rate*. Each affects an inmate once every six months of incarceration.

For each such term, the player must check once to learn if the investigator survives, must check to see if the investigator has been cured, and must check to see if the investigator can be released. Many sane people have been kept inside institutions after they have been cured, and many who weren't cured but who showed improvement have been released when asylums became crowded. No public asylum will be immune from such pressures.

If release from the institution is indicated, the keeper should roll 1D6 to see how many months of the term were spent in the institution. The procedure follows.

- (1) The player rolls D100 against the survival rate for the asylum. With a result equal to or less than the survival rate, the investigator survives. If above the rate, he or she dies. The keeper should be prepared to explain how and why the investigator died. The player deserves this information, and clues in the information may spark new adventures.
- (2) If the investigator survives, then the player rolls D100 against the cure rate. If the result is equal to or less than the cure rate, then the investigator is now sane. If the result is above the cure rate but below 96, then the investigator loses 1D4-1 sanity points. If the result is 96-00, the investigator loses 1D6 sanity points and suffers a relapse or acquires a new form of insanity. Alternately, the keeper may choose an institutional disaster or some form of personal vengeance against the investigator.
- (3) Whether or not the investigator is cured, always roll D100 against the release rate. If the result is equal to or less than the release rate, the investigator is freed. If the investigator is already cured, then automatically subtract 50 percentiles from the release rate roll.
- (4) If the investigator is sane but not released, repeat the procedure next term. This time the still-sane investigator can be affected only by a cure rate result of 96-00, and unless the loss of sanity points or a new insanity now drives the character into insanity, he or she still gets the 50 point bonus in figuring the release rate result. If not released this time either, repeat this procedure in the following terms until released, or until insane once again, or until dead.

## DEATH IN ASYLUMS

On average, about 7.5% of the general asylum population died during a typical year. This number is somewhat skewed by the presence of senile patients, who had a mortality of about 25%. Set the death rate for investigators at 5% per year.

The census figures afford a breakdown of causes for inmate death. Almost certainly the number of murders were woefully under-reported by the state hospitals. Officially, murders accounted for 0.8% of all institutional deaths. Probably many murdered patients succumbed to "other external violence" which sounds better than "murdered by attendant," and suggests that coroner and police politely kept their hands free of such investigations. The actual percentages have been altered to reflect the likely causes of death for young investigators gone batty in the 1920s. Additional homicides also might easily be uncovered in the "suicide" and "unknown" categories.

These causes are little changed for the 1890s. For the 1990s, cancer, suicide, and respiratory ailments will be especially higher, and tuberculosis, pellagra, and syphilis especially lower. Two new categories, *drug-induced/drug-related* and *AIDS*, not instanced in the table, will be in the 1-3% range in some urban institutions.

Choose one of the following or roll D100 for a random result.

cause of death	chance	D100
heart disease	13%	01-13
tuberculosis	13%	14-26
cerebral hemorrhage	10%	27-36
pneumonia	9%	37-45
nephritis	7%	46-52
diarrhea/enteritis	7%	53-59
suicide	6%	60-65
syphilis	5%	66-70
homicide	5%	71-75
pellagra	4%	76-79
cancer	4%	80-83
unknown	4%	84-87
general paralysis	3%	88-90
other	10%	91-00

A variety of rare or horrible potential demises compose the category "other": typhoid, diphtheria, influenza, erysipelas, lethargic encephalitis, purulent infection, septicemia, institutionally-caused diabetes or epilepsy, meningitis, softening of the brain, ulcers, appendicitis, and so on. The category "unknown" also supports creative keepers. This might include unasked-for visits from shantaks or hounds of Tindalos, human sacrifices at the change of the season, unnoticed abductions by saucer-people, and whatever else can be cooked up.

## A FINAL THOUGHT

Albert Deutsch, author of *The Shame of the States*, wrote as late as 1949 that "not a single state mental hospital in the United States meets, or ever has met, even the minimum standards set" by the American Psychiatric Hospital Association.



## Public Hospitals for the Insane in the United States, ca. 1920s

with notes and additional populations for private institutions, by state in alphabetical order.

name	state	area	year opened	# of patients	survival rate (M/F)	cure rate	release rate	notes
Bryce Hospital	Alabama	Tuscaloosa	1861	3,000	95/97	26	15	
Searcy Hospital	Alabama	Mount Vernon	1902	1,300	91/94	3	9	
Arizona State Hospital	Arizona	Phoenix	1879	900	93/96	25	9	
State Hospital for Nervous Diseases	Arkansas	Little Rock	1882	3,600	91/95	0	10	G
Agnews State Hospital	California	Agnew	1888	2,200	93/93	23	9	
Mendocino State Hospital	California	Ukiah	1893	1,600	96/95	22	8	
Napa State Hospital	California	Imola	1875	3,100	95/96	22	8	
Norwalk State Hospital	California	Norwalk	1916	1,900	87/93	46	10	B
Southern California State Hospital	California	Patton	1983	3,200	95/96	17	9	
Stockton State Hospital	California	Stockton	1851	3,400	93/95	9	5	R
25 private hospitals	California	—	—	500	—	—	—	
Colorado State Hospital	Colorado	Pueblo	1879	2,800	94/96	9	3	
3 small private hospitals	Colorado	—	—	200	—	—	—	
Connecticut State Hospital	Connecticut	Middletown	1868	3,000	96/97	42	6	
Norwich State Hospital	Connecticut	Norwich	1904	2,300	93/95	36	11	
9 private hospitals	Connecticut	—	—	600	—	—	—	
Delaware State Hospital	Delaware	Farnhurst	1889	700	96/96	56	5	
St. Elizabeth's Hospital	D. of Columbia	Washington	1855	4,100	96/96	70	4	B,C,R
Florida State Hospital	Florida	Chattahoochee	1876	3,100	93/94	10	4	D,R
Georgia State Sanitarium	Georgia	Milledgeville	1842	5,800	96/96	34	5	C,E
3 private hospitals	Georgia	—	—	100	—	—	—	
Northern Idaho Sanitarium	Idaho	Orofino	1905	400	94/95	5	2	
Southern Idaho Mental Hospital	Idaho	Blackfoot	1886	400	93/94	0	2	F
Alton State Hospital	Illinois	Alton	1914	1,400	95/97	43	5	
Anna State Hospital	Illinois	Anna	1869	1,900	94/94	30	8	
Chester State Hospital	Illinois	Menard	1891	300	98/98	16	2	
Chicago State Hospital	Illinois	Dunning	1912	3,500	90/94	43	10	
Dixon State Hospital	Illinois	Dixon	?	200	94/94	7	4	
East Moline State Hospital	Illinois	East Moline	1898	1,800	94/95	29	8	
Elgin State Hospital	Illinois	Elgin	1872	3,200	95/96	26	13	E
Jacksonville State Hospital	Illinois	Jacksonville	1847	3,100	95/96	28	7	
Kankakee State Hospital	Illinois	Kankakee	1879	3,900	95/96	23	7	E
Peoria State Hospital	Illinois	Peoria	1902	2,600	95/96	28	9	
11 private hospitals	Illinois	—	—	400	—	—	—	
Central State Hospital	Indiana	Indianapolis	1848	1,600	96/96	53	4	H
Evansville State Hospital	Indiana	Evansville	1891	1,100	94/96	4	5	H
Indiana Hospital for Insane Criminals	Indiana	Michigan City	1912	200	99/na	14	1	I
Logansport State Hospital	Indiana	Logansport	1888	1,400	95/98	25	5	
Madison State Hospital	Indiana	North Madison	1910	1,500	95/96	36	4	
Richmond State Hospital	Indiana	Richmond	1890	1,200	95/97	28	4	H
3 private hospitals	Indiana	—	—	100	—	—	—	

NOTES B — good doctor / patient ratio.

C — good nurse / patient ratio.

D — \$30 yearly on food per patient, one-third of national average.

E — poor doctor / patient ratio.

F — poor nurse / patient ratio.

G — overcrowded ~ 50% over capacity.

H — undercrowded.

I — institution for the criminally insane.

R — see also in notes following this table.



name	state	area	year opened	# of patients	survival rate (M/F)	cure rate	release rate	notes
Cherokee State Hospital	Iowa	Cherokee	1902	1,600	95/97	17	6	
Clarinda State Hospital	Iowa	Clarinda	1888	1,700	93/95	17	4	
Independence State Hospital	Iowa	Independence	1873	1,600	95/94	20	4	
Insane Dept., Men's Reformatory	Iowa	Anamosa	(?)	100	98/NA	18	8	I
Mount Pleasant State Hospital	Iowa	Mount Pleasant	1861	1,600	95/97	23	5	
4 private hospitals	Iowa	—	—	500	—	—	—	
Larned State Hospital	Kansas	Larned	(192?)	800	97/98	9	3	
Osawatomie State Hospital	Kansas	Osawatomie	1863	1,600	95/97	25	4	
State Asylum for Dangerous Insane	Kansas	Lansing	(192?)	100	98/NA	3	4	I
Topeka State Hospital	Kansas	Topeka	1879	1,900	94/96	21	4	
7 private hospitals	Kansas	—	—	100	—	—	—	
Central State Hospital	Kentucky	Lakeland	1873	2,100	95/95	1	6	A
Eastern State Hospital	Kentucky	Lexington	1824	1,600	93/93	8	10	A
Western State Hospital	Kentucky	Hopkinsville	(?)	1,900	94/95	0	8	E
3 private hospitals	Kentucky	—	—	100	—	—	—	
Louisiana Hospital for Insane	Louisiana	Pineville	1906	1,400	96/97	28	7	F
East Louisiana Hospital for Insane	Louisiana	Jackson	1847	2,600	97/98	19	2	
1 private hospital	Louisiana	—	—	300	—	—	—	
Augusta State Hospital	Maine	Augusta	1840	1,300	95/95	24	4	A
Bangor State Hospital	Maine	Bangor	1901	800	93/96	35	8	
2 private hospitals	Maine	—	—	100	—	—	—	
Crownsville State Hospital	Maryland	Waterbury	1910	800	93/92	14	4	F
Eastern Shore State Hospital	Maryland	Cambridge	1915	300	87/93	36	7	
Springfield State Hospital	Maryland	Sykesville	1896	2,000	95/97	26	5	
Spring Grove State Hospital	Maryland	Catonsville	1797	1,000	97/96	43	10	
9 private hospitals	Maryland	—	—	1,000	—	—	—	
Boston Psychopathic Hospital	Massachusetts	Boston	(?)	300	97/92	8	86	J
Boston State Hospital	Massachusetts	Boston	1839	2,400	91/94	55	7	
Bridgewater State Hospital	Massachusetts	State Farm	(192?)	1,000	98/NA	16	2	R
Danvers State Hospital	Massachusetts	Hathorne	1878	2,100	92/93	49	8	R
Foxborough State Hospital	Massachusetts	Foxborough	1914	1,000	93/96	53	5	B
Gardner State Colony	Massachusetts	East Gardner	1902	1,200	97/98	43	3	
Grafton State Hospital	Massachusetts	North Grafton	1877	1,600	98/98	34	1	
Medfield State Hospital	Massachusetts	Harding	1896	1,900	96/97	33	2	
Northampton State Hospital	Massachusetts	Northampton	1858	1,600	93/94	39	7	
State Infirmary	Massachusetts	Tewksbury	(192?)	800	95/97	26	1	
Taunton State Hospital	Massachusetts	Taunton	1854	1,700	93/93	49	8	
Westborough State Hospital	Massachusetts	Westborough	1886	1,600	93/94	51	8	
Worcester State Hospital	Massachusetts	Worcester	1833	2,600	94/95	59	7	C
13 private hospitals	Massachusetts	—	—	500	—	—	—	
Ionia State Hospital	Michigan	Ionia	1885	700	98/99	25	1	A
Kalamazoo State Hospital	Michigan	Kalamazoo	1859	2,900	93/95	33	5	A
Newberry State Hospital	Michigan	Newberry	1895	1,300	96/97	33	4	
Pontiac State Hospital	Michigan	Pontiac	1878	1,900	95/96	29	5	A
State Psychopathic Hospital	Michigan	Ann Arbor	(?)	100	93/91	31	92	J
Traverse City State Hospital	Michigan	Traverse City	1885	2,300	94/95	33	3	
4 private hospitals	Michigan	—	—	500	—	—	—	

NOTES A — horribly overcrowded; 50%  
over capacity.  
B — good doctor / patient ratio.

E — poor doctor / patient ratio.  
F — poor nurse / patient ratio.  
I — institution for the criminally.

J — patients under short-time  
observation only.  
R — see also in notes following this table.

## Public Hospitals for the Insane in the United States, cont.

<i>name</i>	<i>state</i>	<i>area</i>	<i>year opened</i>	<i># of patients</i>	<i>survival rate (M/F)</i>	<i>cure rate</i>	<i>release rate</i>	<i>notes</i>
Anoka State Asylum	Minnesota	Anoka	1900	1,100	95/98	4	1	
Fergus Falls State Hospital	Minnesota	Fergus Falls	1890	1,900	96/97	33	6	K
Hastings State Asylum	Minnesota	Hastings	1900	1,000	97/NA	5	1	
Rochester State Hospital	Minnesota	Rochester	1878	1,700	93/95	24	7	
St. Peter State Hospital	Minnesota	St. Peter	1866	2,100	94/93	34	4	
Willmar State Asylum	Minnesota	Willmar	1917	900	98/98	0	1	E
6 private hospitals	Minnesota	—	—	100	—	—	—	
East Mississippi Insane Hospital	Mississippi	Meridian	1885	800	95/97	18	19	
Mississippi State Insane Hospital	Mississippi	Fondren	1851	3,000	93/94	18	9	
State Hospital No. 1	Missouri	Fulton	1849	1,500	95/96	16	6	
State Hospital No. 2	Missouri	St. Joseph	1874	2,200	94/93	10	4	
State Hospital No. 3	Missouri	Nevada	1887	1,600	92/93	12	6	
State Hospital No. 4	Missouri	Farmington	1903	1,000	93/97	22	8	
12 private hospitals	Missouri	—	—	700	—	—	—	
State Hospital	Montana	Warm Springs	(192?)	1,500	94/95	12	8	
Hastings State Hospital	Nebraska	Ingleside	1888	1,800	95/95	41	8	R
Lincoln State Hospital	Nebraska	Lincoln	1870	1,200	93/95	32	8	C,H
Norfolk State Hospital	Nebraska	Norfolk	(192?)	1,000	95/97	27	2	H
1 private hospital	Nebraska	—	—	100	—	—	—	
Hospital for Mental Diseases	Nevada	Reno	1882	200	97/95	51	6	B,H,R
State Hospital	New Hampshire	Concord	1842	1,800	93/95	52	6	
New Jersey State Hospital	New Jersey	Morris Plains	1876	4,000	94/95	55	7	
New Jersey State Hospital	New Jersey	Trenton	1846	2,700	93/93	55	10	B
5 private hospitals	New Jersey	—	—	200	—	—	—	
Insane Asylum	New Mexico	Las Vegas	1891	700	95/93	27	6	H
Binghamton State Hospital	New York	Binghamton	1881	2,900	96/95	21	4	A
Brooklyn State Hospital	New York	Brooklyn	1895	3,700	81/81	48	8	A
Buffalo State Hospital	New York	Buffalo	1880	2,400	93/94	31	5	A
Central Islip State Hospital	New York	Central Islip	1889	6,800	95/96	26	6	A
Dannemora State Hospital	New York	Dannemora	1900	700	98/NA	39	3	B
Gowanda State Homeopathic Hosp.	New York	Helmuth	1898	1,400	96/97	40	7	
Harlem Valley State Hospital	New York	Wingdale	(192?)	1,400	97/98	33	2	A
Hudson River State Hospital	New York	Poughkeepsie	1871	4,400	94/95	34	4	A
Kings Park State Hospital	New York	Kings Park	1896	5,700	96/97	37	5	A
Manhattan State Hospital	New York	Wards Island	1896	7,400	92/93	26	6	A,R
Matteawan State Hospital	New York	Beacon	1859	1,100	97/98	39	3	B
Middletown State Homeopathic Hosp.	New York	Middletown	1874	3,100	96/97	32	3	
Rochester State Hospital	New York	Rochester	1857	2,100	94/94	53	4	
St. Lawrence State Hospital	New York	Ogdensburg	1890	2,500	95/96	35	3	
Utica State Hospital	New York	Utica	1843	2,900	93/95	53	5	B
Willard State Hospital	New York	Willard	1869	2,700	94/94	32	4	
30 private hospitals	New York	—	—	1,500	—	—	—	

NOTES A — overcrowded by half again.  
 B — good doctor / patient ratio.  
 C — good nurse / patient ratio.

E — poor doctor / patient ratio.  
 H — undercrowded.

K — only one doctor on staff; worst doctor / patient ratio in the nation.  
 R — see also in notes following this table.

## Public Hospitals for the Insane in the United States, cont.

<i>name</i>	<i>state</i>	<i>area</i>	<i>year opened</i>	<i># of patients</i>	<i>survival rate (M/F)</i>	<i>cure rate</i>	<i>release rate</i>	<i>notes</i>
East Texas Hospital for the Insane	Texas	Rusk	1919	1,400	93/96	43	5	
North Texas Hospital for the Insane	Texas	Terrell	1885	2,100	96/97	17	5	E
Northwest Texas Insane Asylum	Texas	Wichita Falls	1922	1,300	91/93	51	8	C
Southwestern Insane Asylum	Texas	San Antonio	1891	2,300	95/97	16	5	E
State Lunatic Asylum	Texas	Austin	1857(?)	2,100	96/97	23	3	E,R
5 private hospitals	Texas	—	—	200	—	—	—	
State Hospital	Utah	Provo	1885	800	94/96	0	13	A,O
1 private hospital	Utah	—	—	100	—	—	—	
State Hospital for the Insane	Vermont	Waterbury	1891	900	94/94	50	8	H
3 private hospitals	Vermont	—	—	600	—	—	—	
Central State Hospital	Virginia	Petersburg	1869	2,700	94/96	0T4		E
Eastern State Hospital	Virginia	Williamsburg	1773	1,500	95/95	16	7	
Southwestern State Hospital	Virginia	Marion	1887	1,100	95/97	20	5	D
Western State Hospital	Virginia	Staunton	1828	2,400	95/96	8	7	
2 private hospitals	Virginia	—	—	200	—	—	—	
Eastern State Hospital	Washington	Medical Lake	1891	1,500	95/96	0	4	E,R
Northern State Hospital	Washington	Sedro Woolley	(?)	1,500	93/95	3	5	
Western State Hospital	Washington	Fort Steilacoom	1871	1,900	94/96	21	3	
2 private hospitals	Washington	—	—	100	—	—	—	
Huntington State Hospital	West Virginia	Huntington	1897	400	93/97	21	75	B,C,J
Spencer State Hospital	West Virginia	Spencer	1893	900	90/90	0	1	F
State Hospital for Colored Insane	West Virginia	Lakin	(192?)	300	90/91	0	1	A,E,L
Weston State Hospital	West Virginia	Weston	1866	2,200	93/95	0	2	E
Central State Hospital for Insane	Wisconsin	Waupun	(?)	200	98/NA	39	5	C
Northern Hospital for Insane	Wisconsin	Winnebago	1873	1,100	93/93	45	17	C
Wisconsin Memorial Hospital	Wisconsin	Mendota	(192?)	300	91/91	61	9	C,P
Wisconsin State Hospital for Insane	Wisconsin	Mendota	1860	1,100	96/97	59	29	C
9 private hospitals	Wisconsin	—	—	500	—	—	—	
State Hospital	Wyoming	Evanston	(?)	500	94/97	18	3	H

NOTES A—overcrowded. E—poor doctor / patient ratio. L—colored patients only.  
 B—good doctor / patient ratio. F—poor nurse / patient ratio. O—probably worst institution in U.S.  
 C—good nurse / patient ratio. H—undercrowded. P—serves the best food of all the asylums  
 D—spends about \$30 a year on food per patient; 1/3rd U.S. average. J—patients under short-term observation only. R—see also in notes following this table.



## Public Hospitals for the Insane in the United States, cont.

<i>name</i>	<i>state</i>	<i>area</i>	<i>year opened</i>	<i># of patients</i>	<i>survival rate (M/F)</i>	<i>cure rate</i>	<i>release rate</i>	<i>notes</i>
East Texas Hospital for the Insane	Texas	Rusk	1919	1,400	93/96	43	5	
North Texas Hospital for the Insane	Texas	Terrell	1885	2,100	96/97	17	5	E
Northwest Texas Insane Asylum	Texas	Wichita Falls	1922	1,300	91/93	51	8	C
Southwestern Insane Asylum	Texas	San Antonio	1891	2,300	95/97	16	5	E
State Lunatic Asylum	Texas	Austin	1857(?)	2,100	96/97	23	3	E,R
<i>5 private hospitals</i>	<i>Texas</i>	<i>—</i>	<i>—</i>	<i>200</i>	<i>—</i>	<i>—</i>	<i>—</i>	
State Hospital	Utah	Provo	1885	800	94/96	0	13	A,O
1 private hospital	Utah	—	—	100	—	—	—	
State Hospital for the Insane	Vermont	Waterbury	1891	900	94/94	50	8	H
3 private hospitals	Vermont	—	—	600	—	—	—	
Central State Hospital	Virginia	Petersburg	1869	2,700	94/96	0T4		E
Eastern State Hospital	Virginia	Williamsburg	1773	1,500	95/95	16	7	
Southwestern State Hospital	Virginia	Marion	1887	1,100	95/97	20	5	D
Western State Hospital	Virginia	Staunton	1828	2,400	95/96	8	7	
2 private hospitals	Virginia	—	—	200	—	—	—	
Eastern State Hospital	Washington	Medical Lake	1891	1,500	95/96	0	4	E,R
Northern State Hospital	Washington	Sedro Woolley	(?)	1,500	93/95	3	5	
Western State Hospital	Washington	Fort Steilacoom	1871	1,900	94/96	21	3	
2 private hospitals	Washington	—	—	100	—	—	—	
Huntington State Hospital	West Virginia	Huntington	1897	400	93/97	21	75	B,C,J
Spencer State Hospital	West Virginia	Spencer	1893	900	90/90	0	1	F
State Hospital for Colored Insane	West Virginia	Lakin	(192?)	300	90/91	0	1	A,E,L
Weston State Hospital	West Virginia	Weston	1866	2,200	93/95	0	2	E
Central State Hospital for Insane	Wisconsin	Waupun	(?)	200	98/NA	39	5	C
Northern Hospital for Insane	Wisconsin	Winnebago	1873	1,100	93/93	45	17	C
Wisconsin Memorial Hospital	Wisconsin	Mendota	(192?)	300	91/91	61	9	C,P
Wisconsin State Hospital for Insane	Wisconsin	Mendota	1860	1,100	96/97	59	29	C
9 private hospitals	Wisconsin	—	—	500	—	—	—	
State Hospital	Wyoming	Evanston	(?)	500	94/97	18	3	H

NOTES A— overcrowded. E— poor doctor / patient ratio. L— colored patients only.  
 B— good doctor / patient ratio. F— poor nurse / patient ratio. O— probably worst institution in U.S.  
 C— good nurse / patient ratio. H— undercrowded. P— serves the best food of all the asylums in the nation.  
 D— spends about \$30 a year on food per patient; 1/3rd U.S. average. J— patients under short-term observation only. R— see also in notes following this table.

# Notes on Selected Asylums

## Public and Private Institutions in the United States and Around the World.

In large cities worldwide, mental institutions were fairly common by the 1920s. Information about them is fairly scarce, as asylums were neither photogenic nor tourist spots described in guidebooks, nor did anyone ever brag about being in one. As far as neighboring districts were concerned, these institutions were bizarre and awful places, worse than prisons, places to be hidden away and forgotten.

These notes are neither systematic nor all-inclusive. The longer descriptions present different or unique hospitals, so that the keeper has a variety of sketches upon which to base new hospitals, as needed in a campaign. A handful of shorter entries offer additional locations.

The descriptions usually fit the institution as it was in the 1920s. For 1890s or 1990s investigators, the major difference in the institutions would be the treatments offered, as outlined in previously in this book.

Occasionally a nation's or a city's name has changed. In most cases, name changes for institutions have been disregarded as inconsequential. If you happen to know the right name for an institution in a particular era, make the change.

This information is presented alphabetically for the United States, by state. Then follow sections on Canada, Europe, Africa, and Asia, respectively, each alphabetized by nation.

Particular emphasis is given to the United States, Canada, and Europe. Most investigators come from these countries, and most published scenarios are set there. The entries represent actual hospitals unless noted otherwise.

### DETERMINING RATES FOR PRIVATE HOSPITALS

The preceding tables contain details concerning public institutions in the United States. Private institutions are more difficult to research, and in those tables only the total number of private hospital beds in each state are given. Individual names, staffs, and survival, cure, and release rates must be chosen by the keeper according to his or her needs. But the private hospitals described in this section should offer enough information that they too can become useful to keepers and players.

To determine the game rates used in the tables, set the survival rate at 86+2D6, the cure rate at 5D20-25, and the release rate at 3D10-3. And remember that money can be very convenient:

- As examples for the 1920s, a thousand dollar a month private institution might have a survival rate of 97%, a

cure rate of 10%, and a release rate of 5%, ie SR 97 / CR 10 / RR 5.

- An excellent two-hundred-dollar-a-month institution run by a trained psychoanalyst might have SR 91 / CR 63 / RR 15.
- A twenty-dollar-a-month snake pit might have SR 88 / CR 0 / RR 0.

## United States

### California

#### LIVERMORE SANITARIUM, Livermore

This is a tiny private asylum started by Dr. John Robertson in 1893. Since then Drs. Willhite and Podstata have joined Dr. Robertson in treating the fifteen patients. Each patient has his own nurse to look after him and, for an additional fee, one can stay in a private cottage away from the main building, which is without restraints or bars. The sanitarium will not accept violent patients for any price. The monthly fee of three hundred dollars allows the admitting doctor to be very selective.

### California

#### STOCKTON STATE HOSPITAL, Stockton, Calif.

The oldest and largest institution in the state, Stockton State Hospital first admitted patients in 1851. Its attractive grounds cover some ten city blocks within the city. Brick dormitory buildings enclose ample grassy areas for exercise. A large concrete building serves as the administration and admissions center.

A mattress factory, a broom factory, and a shoe repair shop offer occupational therapy, while weekly dances and Hollywood films provide entertainment. The hospital also owns some six hundred acres of farmlands two miles outside the city where the patients benefit from fresh air, and raise potatoes and beans for the hospital. Although pleasant and free from gross abuses, not much treatment is offered here for the 3400 inmates.

### Connecticut

#### THE HARTFORD RETREAT, Hartford

Built with private funds in 1824, the Hartford Retreat is a small (around 200 patients) but excellent hospital. A square center section of three floors holds the administrative offices, while the two story wings on either side contain the men's and women's wards. Located a couple miles southwest of the State House, the institution is still well into the

country, with lots of space for walking and gardening. There is a chapel on the premises as well as a carpentry shop. Semi-private cottages nestle in the scenic meadows behind the main building. The men have access to a museum and library in their wing, while the women have a sewing room and a bowling alley.

## District of Columbia

### SAINT ELIZABETH'S HOSPITAL

During the 1920s, Saint Elizabeth's Hospital is the foremost in the United States. The care offered here is the best available, practicing the most modern methods of medicine and psychiatry.

The hospital is run directly by the federal government and there is enough money budgeted to provide all the necessities and many luxuries. The superintendent is Dr. William Alanson White, perhaps the foremost American psychiatrist of this era. Dr. White was appointed superintendent in 1903 by President Roosevelt and found the Government Hospital for the Insane in a shocking state. Four hundred patients were sleeping on the floor and many were tied to 'bed saddles,' an iron cross laid atop a mattress. White strove forcefully to alleviate the intolerable condition of the patients, despite the burden of increasing overcrowding. Within a few years, he had changed the place into a humanitarian institution and his blueprint for change affected most hospitals in the country.

In 1907, the first edition of his *Outlines of Psychology* appeared; it went on to become the standard text in psychiatry in America for the next few decades. Later editions included the first widespread airing of Freud's psychotherapeutic ideas. His 1919 book, *Mental Hygiene of Childhood*, offered one of the first introductions to Freudian ideas tailored for the lay audience.

In 1917, the name of the hospital was formally changed to Saint Elizabeth's Hospital, although the name had been in common usage since the Civil War, when it was coined by injured Union soldiers who were sent here for rehabilitation after amputations or blindness. They disliked the label of insanity, when they were suffering physical maladies.

The several buildings are of brickwork, and some date back to the foundation of the hospital in 1855. About half of the patients are members of the armed forces; the rest are from the Washington area. The patients are segregated by race, but otherwise receive equal (and excellent) treatment. St. Elizabeth's was in the vanguard of the hydrotherapy movement, and an excellent hydro building was constructed in 1895. The modern pathology and clinical labs are among the best in the world. An extremely large medical and nursing staff attends the 4100 patients with as close to personal care as possible in such a large hospital.

## Florida

### STATE HOSPITAL, Chattahoochee

Originally designed as an arsenal, this facility was first converted to a prison, and then later became an asylum in 1877. This latter change probably necessitated little more than changing the sign outside. The patients are kept

industrious with occupational therapy and spend plenty of time outside in the clement weather. Racial segregation is strictly enforced. Recently, some effort has been made to make this more a hospital than a prison. Iron bars have been replaced by sturdy screens on the windows. On the other hand, the food at this hospital is of particularly poor quality. About 3100 patients are kept here, about half of whom are black.

## Hawaii

### OAHU INSANE ASYLUM, Honolulu

This institution was created by the monarchy in 1862. The inmates reflect the populations of the Islands, including nationals from China, Japan, the Philippines, Europe, and America. Care consists of ample food, fresh air, beautiful surroundings, and a little hydrotherapy. Restraints are not relied on. About 500 patients are kept in the crowded facility.

## Maryland

### SHEPPARD AND ENOCH PRATT HOSP, Towson

One of the many early mental hospitals founded by Quakers, this one owes its existence to the humanitarian gesture of Moses Sheppard who left a sum of over a half million dollars (in 1857) to take care of lunatics and other unfortunates. It took five long years to finish the two buildings, but the sturdy wood and iron beam construction make them worth the added effort. The two buildings are mirror images of each other and have an odd architectural look. Sheppard's will demanded that ample room be set aside for living quarters, employment rooms, and amusement areas. Consequently, the patients received 'modern' care long before occupational therapy and moral treatment were accepted by most public institutions in America. In addition, money was set aside for psychiatric research and to train general practitioners in psychiatry.

In his will of 1896, Enoch Pratt left a great deal of money to the hospital, on the condition that the name be modified to its present title. The change of name, which had to be approved by the government, was nearly obstructed in the state congress by legislators who would have personally benefitted from the banker's estate had the changed been denied. With this additional funding, the hospital built a hydrotherapy building and a marvellous dining facility to replace the inadequate original. The hospital has about 150 patients; the men are held in the East Building, the women in the West.

## Massachusetts

### BRIDGEWATER STATE HOSPITAL, State Farm

Originally designed to hold indigent foreigners, this institution was then a poorhouse, asylum, and a workhouse. In 1883 it burned down. The new buildings (made of fireproof brick and concrete) consist of a prison, an almshouse, and the hospital which has a capacity of one thousand. The hospital has developed a little since then, with the addition of a stronghouse for the criminally insane and a walled enclosure for the free exercise of the patients.

Other than occupational therapy, little curative work is done here. Many of the patients are criminals. If found



guilty of a crime in Massachusetts, this is probably where insane investigators would wind up.

### Massachusetts DANVERS STATE HOSPITAL, Hathorne

This hospital consists of a long line of ten turreted buildings of neo-Gothic architecture, labeled A through J. They were completed in 1878 and complemented by a separate women's building in 1905. There is ample opportunity for exercise in the yards and for industry in the shoe repair shop and the mattress and broom factories. A large garden supplies tomatoes and berries for the kitchen and flower bulbs for sale. Well-behaved patients may be relocated to Grove Hall, a manor house with capacity for fifty patients, who are treated to individual care in a comfortable setting.

The latest methods of psychotherapy are in use here, with excellent results. Modern medical practices are the norm; the administrators are particularly proud of their admissions area, where the initial interview with the patient is recorded by dictaphone and later transcribed into the permanent files. The facility cares for 2100 patients.

### Massachusetts NEWTON NERVINE, West Newton

Dr. Edward Mellus is the sole psychiatrist and proprietor of this private asylum. The twenty patients are divided among four residential buildings in West Newton. Although tended by nurses, Dr. Mellus can't get around to each patient every day, so the treatment is sporadic. No opportunities for exercise exist. This is mostly a caretaking institution.

### Michigan BATTLE CREEK SANITARIUM, Battle Creek

In 1876, ten years after its foundation as the Western Health Reform Institute, this hospital was given into the care of John Harvey Kellogg, a Seventh Day Adventist with a zeal for medical reform. Within the year, he coined the word 'sanitarium' to refer to a hospital where the patients are taught how to lead a healthful and sanitary life through diet and other preventative measures; thus began both the Battle Creek Sanitarium, and the confusion over sanitarium/sanatorium. The latter is the proper term for a mental hospital, although in America, Dr. Kellogg's formation, 'sanitarium,' has practically replaced the traditional term. The Sanitarium was a hospital, but the methods of treatment lent themselves well to handling nervous disorders or other minor mental illness.

Diet and nutrition were two of the consuming passions of Dr. Kellogg, and as early as 1877, he was grinding up digestive, whole grain biscuits for use as a breakfast food. The gravelly substance resembled another medicinal food under the trade name Granula, so Dr. Kellogg named his invention Granola. In 1894, John Harvey Kellogg received a patent for Granose Flakes and the cereal flake making process. The Sanitarium Food Company was created to provide the food for the patients. John's brother, Will Keith, convinced him to manufacture the cereals for outside consumption, and the Sanitas Company was created under



W.K. Kellogg's direction to promote Dr. Kellogg's breakfast foods. Imitators soon arose, such as the 'Battle Creek Breakfast Food Co.' located in Illinois. Will produced Corn Flakes, which became the biggest cereal success ever. In a time of the Sanitarium's financial need, John Harvey sold Corn Flakes to Will Keith, who then started his own company in 1906, and began shipping 'Kellogg's Toasted Corn Flakes' all over the nation with the bold signature of W. K. Kellogg on every box. John Harvey then changed the name of his commercial business to the Kellogg Food Company. Growing friction between the brothers erupted into numerous lengthy lawsuits. Dr. Kellogg lost the right to use his own name, since Will had used it first on Corn Flakes.

Apart from breakfast foods, Dr. Kellogg enforced a large number of other dietary prescriptions at the Sanitarium. Meat was blamed as the cause of cancer, headaches, anemia, and dental cavities among other ills and was totally prohibited. Abstinence from alcohol, caffeine, tobacco, condiments, candies, and chocolate was required as well. One was allowed to eat whole grains, fruits, nuts, and legumes. Dr. Kellogg was initially distrustful of dairy products and eggs, but by the 1920s had adopted their use and became actively enthusiastic about yogurt.

Another of Dr. Kellogg's interests was hydrotherapy. He devised numerous water treatments to stimulate the body or to make a person relaxed and calm. His book, *Rational Hydrotherapy*, became the classic source of information about hydrotherapy, and was utilized by many asylums. To invigorate a patient, short bursts of cold water are used. Wetted sheets are wrapped around a patient to calm him from hysterics or mania. Alternating hot and cold baths are used generically for other patients to keep the body healthful.

Many other unusual treatments were offered at the Sanitarium. Exercise was encouraged, and Dr. Kellogg

even created a gramophone recording of an exercise regimen that resembles a modern-day aerobics workout. Good posture was essential. Kellogg was a foe of the corset, rightly noting the difficulty in proper respiration caused by the device. Sunlight and artificial sun-baths resembling tanning booths were also thought to impart healthy energy to patients. Dr. Kellogg opposed the use of drugs and vaccinations as being unnatural, but grudgingly used them when they were obviously indicated.

Sometime after the turn of the century, Dr. Kellogg joined the eugenics movement and was a member of the Race Betterment Foundation which held important conferences in 1914, 1915, and 1928. He used his position to argue against the use of alcohol and tobacco and for the use of 'biologic living,' his term for his natural methods of sanitary life. He also thought that 'biologic living' could be acquired genetically in a Lamarckian fashion. This tacit acceptance of evolution brought him troubles with his church, which he finally left for a variety of reasons.

The Sanitarium is a long white building with three smaller buildings radiating from the front like rays. In 1923, nearby Battle Creek College first held classes emphasizing biologic living. In 1925, its curriculum diversified into that of a four-year college capable of awarding degrees. Dr. Kellogg initially had great hopes for the school football team: since the team followed biologic living, he reasoned that it should be superior in every way to all other teams. Their disappointing first season was not followed by another, for Kellogg had decided that football was too violent for a healthy life. The College eventually closed in 1938.

John Harvey Kellogg was a fixture of the Sanitarium from 1876 until his death at the age of 91 in 1943. Invariably wearing a white suit, a remnant of the Millerite beginnings of the Adventists, Dr. Kellogg patrolled his domain at all hours and was firmly in control of the treatments offered at the hospital. Investigators who find themselves at this private institution will probably hate the food, and dislike the frequent and uncomfortable baths, but there is some soundness in Dr. Kellogg's teachings.

Little active psychological help is available, unless it be in the Sunday services, but the Sanitarium is a restful place where time can heal without the dreadful abuses found at most mental institutions. Investigators with a religious bent or a fondness for unorthodox ideas may find the Sanitarium to be perfect for them.

## Nebraska

### HASTINGS STATE HOSPITAL, *Ingeside*

This hospital opened in 1889 and is conveniently located three miles west of Hastings on the railroad. Buildings include the overcrowded dormitories and an amusement hall where a variety of diversions entertain the inmates. The patients are also involved with farming and other occupational therapies, including the care of a small herd of Holsteins. Although there is a large percentage of incurable cases at this institution, the state has not turned this asylum into a holding pen. Aggressive medical treatment and large staff give the 1890s patients good care.

## Nevada

### HOSPITAL FOR MENTAL DISEASES, *Reno*

About 250 patients are kept in this rare example of an undercrowded facility. A large T-shaped building, built in 1882, houses the administration and the male patients. A kitchen is located between it and the newer women's facility. There is a thriving hundred-acre farm worked by the patients under close supervision. Although there is little in the way of cutting-edge psychiatric and medical practices, the spacious accommodations seem to generate a healthful atmosphere.

## New Jersey

### NEW JERSEY STATE HOSPITAL, *Morris Plains*

In 1876, this institution opened its doors to patients. The building has a central administration complex with a clock-tower connected to the wings of three stories that lead off to either side for a full length of some 1200 feet. In the 1880s, the conditions were so bad that eight medical officers resigned in two years, while the warden's wife was pressed into service in the capacity of supervisor, since no one else was willing to take the job. However, the turn of the century saw the beginning of a great change in the quality of the institution.

In 1901, new dormitory buildings were constructed to ease the overflowing main building. This E-shaped building has many conveniences for the patients including a game room, billiards tables, and a large auditorium with a motion picture projector. Additionally, many modern medical facilities (dental, hydrotherapeutic, and medical offices) were added to the older building. Two 'temporary' residential buildings, a solarium and an industrial building, were completed in 1915 to house and provide services for even more patients. The industrial building contains equipment for printing, carpentry, and all manner of other occupational therapies. Excellent care is offered here to the 4000 patients. Not only that, but their stay is made much more pleasant by the facilities, the weekly dances and the available equipment for croquet, golf, tennis, and other pleasures.

## New York

### MANHATTAN STATE HOSPITAL, *Manhattan (Ward's Island)*

About 7,400 patients jam this institution, the world's most populous in the 1920s. The Ward's Island site was developed in the first half of the nineteenth century by Bellevue Hospital, to relieve crowding at its facilities. Throughout that century, the treatment offered was very poor indeed, with overcrowding so bad that hundreds of patients slept on the floor or went hungry. Building on the island was continuous, but always far behind the need.

This pressure also caused the administrators to build as cheaply as possible, for the buildings need only contain, not cure, their charges. In 1894, patients kept at nearby Blackwell's and Hart's Islands were transferred to Ward's Island due to even worse conditions there. Luckily, buildings previously used by the Emigration Department were turned over to the asylum to house the influx.

Then, in 1896, the care of the facility was given to the state. The care and treatment offered has considerably improved over the past decades, and the apparent physical freedom offered to the island-bound lunatics elevates their mood somewhat. However, overcrowding haunts the asylum and its success is not as great as some of the smaller institutions in the state.

## **New York**

### **DR. MACDONALD'S HOUSE, Central Valley**

This excellent private asylum is run by Dr. Carlos MacDonald, who bought the property from the nephews of a Dr. Ferguson, who opened the asylum in 1889. Central Valley is fifty miles from New York City on the Erie line. A two-story building houses men and a three-story building is for the women; each has ivied walls and many airy windows. Each patient has a separate room. The total population at the asylum is a mere thirty souls. Three or four well-furnished bungalows cater to wealthy patients seeking a rest cure.

There is a stable and a few cows and pigs, but no other items of occupational therapy. Instead, the paying patients enjoy billiards, dancing, music, and frequent trips to New York, much as if they were visiting a hotel rather than a sanatorium. The patients are free to, and encouraged to, explore the grounds and enjoy the fresh air. Doctors and attendants supply a lot of individual attention, and the kitchen even employs a pastry chef to keep the patients happy. Dr. MacDonald does not accept hostile or noisy patients, but if an investigator can afford the thirty dollar per week fee, he or she will enjoy the comfort of the MacDonald house and the personal and individual care it provides.

## **North Carolina**

### **STATE HOSPITAL FOR THE INSANE, Morganton**

One of the best institutions in the South, this large brick institution was completed in 1883. It is fashioned after the Kirkbride plan (see *Pennsylvania Hospital for the Insane*) and measures some 900 feet across the front. Plentiful treated water and airy wards give this asylum a pleasant feel. Although it holds some 2200 patients, it is actually under capacity.

## **North Carolina**

### **STATE HOSPITAL, Goldsboro**

After the Civil War, there was a widespread perception that the recently freed slaves were more susceptible to mental disease now that they were expected to deal with modern society as a free citizen (a position that many thought them unsuited to handle). Most likely, the slave-owners had 'treated' signs of mental illness in their slaves themselves with the usual implements of their authority. Having a slave committed, even at state expense, was just one less pair of hands to work the master's soil. In any case, the apparent alarming increase in 'colored insane' led North Carolina to build this institution in Goldsboro specifically for African-Americans.

There is a four-story brick administration building flanked by a three-story building to house the patients. Several additions and outlying buildings have been constructed over the decades since the founding of the institution in 1880. The care here is abysmal. Although the building is not too much over capacity with 1800 patients, the state funds for its maintenance are well below the levels of the asylums reserved for whites. The medical staff is overwhelmed, and the African-American attendants have had to take on nursing duties to ease the burden. The annual expenditure per patient on food is \$30, less than one third the national average for mental hospitals. The excellence of the Morganton Hospital offers a striking example of how segregation was hardly the 'separate but equal' institution claimed in the South.

## **Ohio**

### **ATHENS STATE HOSPITAL, Athens**

The first patients entered this Kirkbride plan hospital in 1874. The large brick building is 850 feet long with three story wings and is situated in some of the most beautiful Ohioan scenery. The later addition of an amusement hall, a barn, and an occupational therapy building have added to the comfort and mental activity of the patients. The psychiatric care here is minimal, and the institution is mostly a caretaking enterprise. Nevertheless, they are cared for in conditions free of overcrowding or rampant epidemic.

## **Pennsylvania**

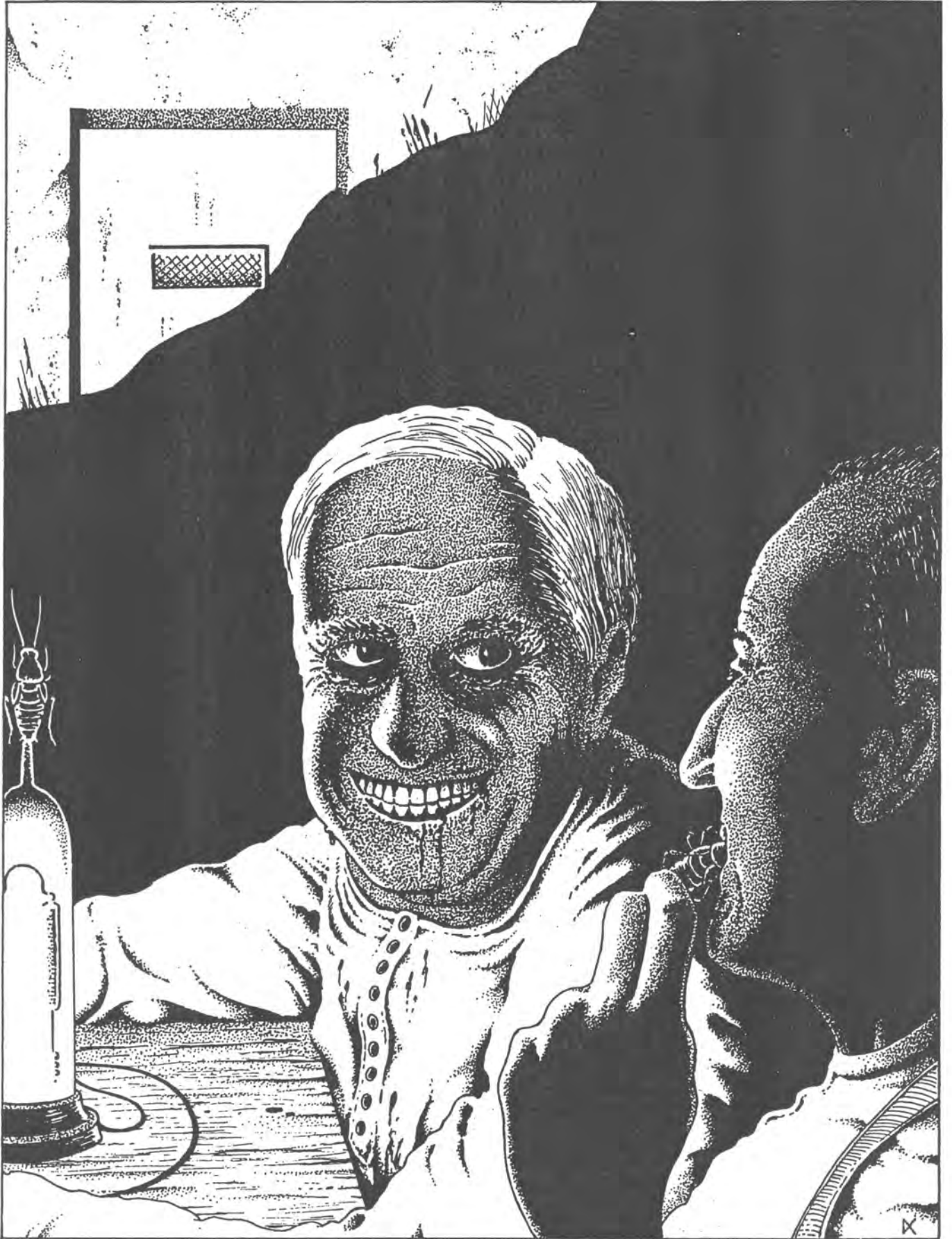
### **PENNSYLVANIA HOSPITAL FOR THE INSANE, Philadelphia**

In 1751, the government of Pennsylvania received a petition urging the creation of a poorhouse and mental hospital. Benjamin Franklin was involved in its successful establishment. After four years in a temporary location, the hospital opened in its Pine Street location in 1756. Dr. Benjamin Rush, the first notable American psychiatrist, was the head physician in the hospital's infancy.

In 1841, a new structure in West Pennsylvania was erected to house the insane. Additional buildings were added utilizing the plan of Thomas S. Kirkbride, who went on to run the hospital for forty-three years. The Kirkbride plan with its wide frontage and wing extensions proved a popular plan for the construction of asylums in America for the next century. Until 1900, nearly constant construction added to the length of the building's wings or connected outlying buildings with corridors.

Innovations at the hospital included a vigorous lecture series with which the patients could occupy their minds, a full gymnasium to occupy their bodies, and a solarium and cottages for convalescent patients. The wide variety of institutional settings allowed designed programs for particular patients. Modern medical facilities have also been established, offering excellent care to the patients, who are cared for out of public charity.





## Pennsylvania

### WOOD LEA SANITARIUM, Ardmore

This small English-style manor house is located at 300 Ardmore Avenue. The hospital caters to about ten female patients, under the supervision of Dr. Grace White, who started the enterprise in 1908. A stable offers riding, an assembly room has a grand piano and a victrola for music, and there is a well-stocked library. The patients also have access to craft activities such as knitting, sewing, embroidery, and gardening. Amusements include croquet, tennis, and hikes through the thirty acres of wooded farmlands.

## Rhode Island

### STATE HOSPITAL FOR MENTAL DISEASES, Howard

In 1870, some ramshackle wooden buildings were constructed to house this small state's incurable insane. As the decades passed, more resources were made available to contain patients in more modern buildings. At the present, the building is filled to capacity, but not overcrowded by 2300 patients. The care here is good and the psychiatric staff has a good chance of improving the mental health of any addled investigators.

## South Dakota

### YANKTON STATE HOSPITAL, Yankton

A huge influx of miners during the Gold Rush in the Black Hills seems to have caused a large increase in the mentally ill in South Dakota in the 1870s. In 1879, this institution opened its doors to a flood of the insane. The site is on a bare plateau that affords the patients a grand view of the surrounding country. The original wooden asylum burnt down, killing five patients. Fortunately, a newer building was nearly completed and took in the rest of the patients. Another disastrous fire in 1899 marked the beginning of more (and safer) construction. Apart from the various wards, a large dairy farm adds to the activities of the inmates. There is a shortage of nurses and the overcrowding is a problem, but reasonable psychiatric care is available here, though it is remote from the centers of American psychiatry.

## South Dakota

### FEDERAL ASYLUM FOR INSANE INDIANS, Canton

Located a half mile from the Big Sioux River in South Dakota, this federal facility is the only one set aside for the care of insane reservation Native Americans. Federal money keeps the twenty small buildings in good repair, and some of the latest therapies are available here for the hundred patients, including a full hydrotherapy room and an extensive gymnasium. The care offered here is better than at Yankton (see above), but not approaching that offered in New York or Pennsylvania.

## Texas

### STATE LUNATIC ASYLUM, Austin

This facility was opened to patients in 1861 and soon filled to its small capacity with people suffering from effects of the Civil War. The main buildings are constructed of local gray limestone, located within a park-like atmosphere of trees and shaded walks. Superintendent Weiselberg was an early advocate of the elimination of restraints except when absolutely necessary. All patients are encouraged to take the air in the shaded courtyards, or visit the bowling alley. Dances and motion pictures are shown to the patients in large, well-attended gatherings, and an annual trip to the circus is a highlight in the institution's programming. About 2100 patients are kept here, including some 600 African-Americans in two separate buildings. The psychiatric care is indifferent, with a small number of doctors overseeing this large establishment.

## Washington

### EASTERN STATE HOSPITAL, Medical Lake

Built in 1890 on the Kirkbride plan, Eastern State Hospital admitted its first patients a year later. Additions to the wings were built soon afterwards to contain the growing flood of insane. Particular wards are devoted to the care of the criminally insane, with the concomitant extra security those patients require. Wards in the newer wings have modern heating, lighting, and extensive medical facilities, including hydrotherapy rooms. The asylum covers over 800 acres, half of which are cultivated by the patients. A dairy farm and chicken ranch offer other occupational activities. Unfortunately, hydrotherapy is practically the only treatment offered by the sorely overtaxed medical staff. The 1500 inmates receive mainly custodial care, but in comfortable conditions.

## Wisconsin

### STATE HOSPITAL FOR THE INSANE, Mendota

Wisconsin actively developed quality public sanitoriums, second only to the great mental hospitals of the eastern seaboard. A case in point is this institution, started in 1860 in a four story building with wings added as capacity demanded. The buildings are located less than a mile from Mendota along the Chicago and Northwestern Railway. A spur line runs supplies to the hospital. Patients arriving at the Mendota station are conducted by automobile to the hospital.

Staff interviews upon admission, careful record keeping and well-equipped medical clinics make this institution a marvel of modern psychiatry. The patients are treated with the ubiquitous occupational therapy in the fields, the barns, and the workshops. Female nurses are the rule in both male and female wards, and they are in enough numbers that the care they offer is as personalized as possible. Concerts, dances, lectures, and other entertainments are offered regularly and contribute to the healthful environment. The institution provides meticulous and effective care. It is one of the most efficacious in the country, perhaps second only to St. Elizabeth's.

## Wisconsin

### OCONOMOWOC HEALTH RESORT, Oconomowoc

The emphasis placed on mental health in Wisconsin has led to the creation of a great many private institutions. Oconomowoc is one such, founded in 1908 on a hill overlooking a lake-filled region of the state. The building is a brick colonial, accommodating 25 patients. The overall effect is of a homelike tranquility, with wooded paths, ducks and chickens, gardens, tennis, croquet, fishing, and other bucolic pastimes. Indoor amusements include billiards and a small reading room. Dr. Arthur Rogers has overseen the psychiatric care of the patients since the resort's inception. Each patient has his own nurse to look after him, and a dietitian prepares meals specific for each patient's illness. Dr. Rogers' training affords a good chance of a cure, and the non-institutional setting does nothing to detract from it.

# Canada

## Alberta

### INSANE ASYLUM, Ponoka

This facility for 550 patients opened in 1911. The youth of the establishment translates into a paucity of medical treatments offered. Although the cross-shaped brick building is new and fully electrified, it is mostly a caretaking facility. Even the recreational opportunities are small; there is soccer ball in the yard, which both the male and female patients frequent, but there being little else to do here. The building is modelled after the hospital in Utica, New York, with the foresighted alteration that the rooms for 'dirty' patients have been relocated to the very ends of the various hallways. The hospital is located near Ponoka on the rail line between Calgary and Edmonton.

## New Brunswick

### PROVINCIAL HOSPITAL, St John

In 1835, a newly built cholera hospital was 'temporarily' turned into the very first insane asylum in Canada. It took a decade for the legislature to provide for a proper institution. In 1847, the cornerstone was laid in Lancaster parish, just outside St. John. This was done with great ceremony including speeches by the Lieutenant Governor of New Brunswick, the provincial Grand Master of the Freemasons of Nova Scotia, and the local clergyman, Rev. Gray, who coincidentally was a Grand Chaplain of the Masonic Order. By the end of the following year, patients began moving into the partially completed building, a central building with four three-story wings. About 700 patients are cared for here.

Additional decades saw extensions built to the wings, as well as many outlying buildings which changed the institution from a caretaking facility to a true hospital, including a hydrotherapy building, a TB center, a building for chronic patients, and a mortuary and medical laboratory. Although the excellent treatment is provided at the expense of the province, each patient is required to pay an

admission fee of twenty dollars to enter—a bargain, but not if you are poor.

## Ontario

### HOSPITAL FOR THE INSANE, Hamilton

Located on the 'Mountain,' a hill overlooking the city and the bay, this hospital was constructed on rocky and wooded ground in 1876. It is a red and white brick building with long wings extended to either side. A serious fire led to the construction of a reservoir, the water being previously pumped up the Mountain. Additional outbuildings were built near the turn of the century when the whole complex was wired for electricity. Fifteen hundred lunatics are given quite adequate care here, with great amusement being provided by, among other things, a large skating rink.

## Quebec

### L'HOSPICE ST. JEAN DE DIEU, Longue Pointe

Informally known as the Longue Pointe Asylum, this institution has a long and interesting history. A merchant and his wife adopted a retarded child after their three natural born children died in infancy. Upon the husband's death, Madame Gamelin endeavored to carry out his wishes that a place be built to care for the poor and insane. Using her large inheritance, she started the Sisters of Providence (Les Soeurs de Charité de la Providence) a lay order devoted to charitable acts. In 1845, their first asylum was located in Montreal, but it was soon relocated to Longue Pointe, five miles from the city.

In 1875, with a government contract to care for the poor and insane in Quebec, a large five-story building was constructed to house the asylum, along with several six-story annexes. The patient rolls swelled rapidly, even though the Sisters were untrained in psychiatry. Conditions there were by all accounts miserable: handcuffs, belts, and straitjackets were the rule. Some cells had only a three-inch transom above the door to allow light from the hallway to spill in. The government appointed a medical superintendent in 1885, but the Sisters pointed out the terms of the contract which gave them full authority to run the asylum. The medical superintendent made suggestions which were most often ignored, and the government bided its time until the end of the contract, when things would be made to change.

Sadly, in 1890, a tremendous fire practically leveled the main building, killing 75 patients (mostly chained in their cells) and five Sisters. New buildings opened in 1894 to receive the remaining patients who had been housed in tents in the interim. In 1897, the contract expired and modern psychiatry made its full entrance into the facility. By 1901, the asylum was fully complete, a large, modern complex of buildings with ample areas for exercise and recreation, medical treatment rooms, and a capacity of 2000 patients. Although still run in the name of the Sisters, the authority passed to government-appointed medical directors, and the care offered here is now of good quality.



# Europe

## Austria (Österreich)

### ALLGEMEINES KRANKENHAUS, Wien (General Hospital, Vienna)

This enormous complex is the largest hospital in Europe. Specialists of all kinds do their training here with the best doctors in the world. Located at Alserstrasse 4 between Spitalgasse and Währingerstrasse, the labyrinthine buildings enclose twelve large courtyards. Originally built in 1500 as a poorhouse by Emperor Leopold I, the buildings were expanded by Joseph II in the 1780s. In 1783, the Narrenturm (Fool's Tower) was built to house lunatics. The tower is cylindrical in shape with a domed roof and caused the locals to christen it 'Joseph's Gugelhupf', i.e. the emperor's Viennese fruitcake, because of its shape.

Construction from the middle of the nineteenth century to the present brought the hospital to its present enormous size. Despite the medieval setting, the doctors were of the finest caliber 1920s, particularly the psychiatrists. Consequently, despite its medieval setting, the Allgemeines Krankenhaus offered excellent care for the insane.

By the 1990s, the Narrenturm no longer housed the psychiatric ward and the staff long ago had lost its 1920s eminence.

## Austria (Österreich)

### SANATORIUM AND NURSING HOME, Ybbs

Situated on the Danube, this scenic hospital cares for 1400 patients.

## England

### BETHLEM ROYAL HOSPITAL, London

The world's oldest institution for the incarceration of the insane is Bethlem Hospital, which has undergone many changes since the initial foundation in 1247 of the Priory of the Star of Bethlehem on the site of what is now the Liverpool Street Station in London. As early as 1377, lunatics were held in the priory's hospital. By 1500, 'bedlam' (and many other common variants of the name) had already become an opprobrious term. When Henry VIII broke with the Papacy and took control of the holdings of the Church in England, he gave the Priory to the City of London (in 1546) and it was soon converted solely to the care of lunatics. In 1675, the hospital was moved to Moorfields.

Throughout the hospital's history, the whips and chains that were the only available treatment for the insane were probably less detrimental to them than the financial scandals which were common at the hospital. Much of the money dropped in almsboxes throughout the city wound up in the

Warden's pocket. Sadly, the best way to help the inmates monetarily was to join the curious throngs that went to gawk at the mad. The visitors were very generous when buying the drawings or poems made by the lunatics, who could spend their money on better food, clothing, or coal in winter.

By 1700, the word 'patient' replaced 'lunatic' and the general treatment of the insane began to improve. By 1770, admissions of the public were somewhat limited by rationing of the number of admission tickets. Although James Hadfield was still selling his poems—one memorable one was a eulogy for his pet squirrel—the monetary situation at the hospital had improved so much that the proceeds were furnishing him with luxuries like tobacco, rather than food and coal. Then in 1815, the hospital moved again, to Lambeth Road. The year 1844 saw the introduction of padded rooms and, shortly thereafter, no other form of physical restraint was used in the hospital. Indeed, by that time brutality had been banished from all of England's asylums.

In 1912, the hospital became truly modern with the addition of a wide variety of medical specialists to the staff. In 1930, the Bethlem Royal Hospital opened in Croydon. Lord Rothermore had purchased the Lambeth Road area and converted it to a public park; the central building eventually became a war museum in the 1930s. The hospital housed perhaps 250 inmates at either Lambeth Road or Croydon.

Investigators incarcerated in Bethlem will find it extremely pleasant. Even if they are troublemakers, in the 1890s and thereafter the worst punishment they will suffer is isolation in a padded room. Otherwise, the building is filled with engaging Edwardian diversions: badminton, billiards, cricket, dominoes, plentiful music, and occasional dances. Inmates are encouraged to keep pets in order to foster responsibility.

## England

### SEWARD'S HOSPITAL, London

A notable fictional asylum of London is Seward's Hospital, conveniently located near Carfax Abbey. Mr. Renfield was under the rather lax care of Dr. Seward in Bram Stoker's *Dracula*. Definitely put investigators here if they need to escape from the asylum.



Bethlem Royal Hospital, as it appeared 1815-1838.

## France

### HOSPICE DE LA SALPÊTRIÈRE, Paris

Originally an arsenal and gunpowder magazine, this building at 47 Boulevard de l'Hospital became a hospital for the poor in 1656. In 1678, Louis XIV built a stronghold for women of loose morals. Subsequently, the building became a pit for all of society's refuse: the insane, the poor, vagrants, and prostitutes. All eight thousand inmates were set to hard labor and treated cruelly. In 1792, the inmates rioted and nearly two hundred prostitutes escaped, while forty-five other were killed. For a few francs, visitors can see where the massacre took place.

John Russell says of the building: "there hangs about it a stench of violence, madness, and decay, which many visitors find forbidding." A massive octagonal domed chapel does nothing to make the place any friendlier. It was at this hospital in the early nineteenth century that Philippe Pinel called for the chains to be struck off the lunatics and demanded the institution of 'moral treatment' for mental illness. By the 1920s, great changes had taken place in the care of the patients and the population had come down to 5000, making a purgatory out of what had once been a hell.

## Germany (Deutschland)

### REGENSBURG HEALING AND TREATMENT INSTITUTION, Regensburg

Fine German care for 1200 patients.

## Ireland (Eire)

### ST. PATRICK'S HOSPITAL, Dublin

This institution is located next to Stevens' Hospital on West Bow Lane, conveniently near the Kingsbridge Rail Station. The St. James Gate Brewery is nearby, filling the air with the smell of Guinness, ironically considering the alcoholism research and clinical work done at the hospital.

St. Patrick's is also known as Swift's Hospital, since it was founded by an eleven thousand pound bequest from Jonathan Swift. Swift's generosity was probably predicated both by a recent visit to Bedlam, which he thought brutal, and his own increasing senile dementia, which afflicted him until his death in 1745. The hospital opened twelve years later.

The building has a granite facade and the sturdy locks on the doors are the original eighteenth-century handiwork of Irish craftsmen. The building holds about 100 patients, and investigators can stay there under excellent care for about five pounds a week. They can stay there for less if they get arrested and committed.

## Norway (Kongeriket Norge)

### DR. DEDICHEN'S CLINIC, Alnabru

A private clinic founded by Dedichen in 1901. In the 1920s, he still presides here over a hundred patients. This is a restful place, but offers little chance of a cure.

## Russia (U.S.S.R.)

### THIRD PSYCHIATRIC HOSPITAL, St. Petersburg (Petrograd, Leningrad, then St. Petersburg again)

Most psychiatric care in Russia is carried out by neighborhood dispensaries where outpatient psychotherapy (Freud with a healthy dose of Marx), hypnotherapy, and drug treatments are available for the citizens. Psychotic patients with little hope for recovery are shipped off to 'colonia' far outside the cities, where they perform agricultural and industrial labor under the care of a medical staff. The worst you can imagine about these psychiatric gulags is probably no worse than the truth. The Third Psychiatric Hospital in Leningrad is much more like the standard institutions of Europe and America.

A thousand patients are kept here in a dozen, overcrowded buildings. The overcrowding is so bad that the patients are encouraged (that is, forced) to spend much of their time outside. The enforced fresh air and relaxation is probably the best treatment available. Successful therapy is also carried out here, but a lot of typically Russian medicine is also practiced. Investigators kept here may be treated to carbonic acid baths, hydrogen sulfide baths, inhaling menthol or ionized air, exposed to electromagnetic fields, static electric charges, or other quackery and sympathetic magic.

## Russia (U.S.S.R.)

### KRAMER INSTITUTE OF PREVENTATIVE NEURO-PSYCHIATRY, Moscow

Clinical setting with some experts in mental hygiene and some crackpots, as often encountered in Russian medicine of the time.

## Scotland

### ROYAL CORNHILL HOSPITAL, Aberdeen

Originally founded in 1800 to accompany the medical hospital at Woolmanhill, this asylum offers excellent care to its patients. Although the conditions were characterized as 'grotesque' in the mid-nineteenth century, the officials of the hospital began buying manor houses in the countryside surrounding Aberdeen. These manor houses then housed a large proportion of the patients at the hospital in comfortable surroundings with plenty of fresh air and honest work. The main hospital was also improved with the addition of good food and better sanitation by the turn of the century. In the 1920s, the main building housed some 800 patients, while the half dozen mansion houses held up to a hundred in each. One of the manors is ominously named the House of Glack, located in Inverurie. Excellent and modern psychiatric care is available here.

## Scotland

### BILBOHALL HOSPITAL, Elgin

This institution suffers badly in comparison to the previous one. Built to accompany Dr. Gray's Hospital, the asylum was named the worst in Scotland in 1859. New accommodations built in 1865 did little to alleviate the problems.

From its inception in 1835 until 1949, there was never a full-time medical officer in attendance. The asylum offers nothing more than custodial care for 200 patients, in cramped quarters.

**Sweden (Konungariket Sverige)**  
**LLERÅKERS HOSPITAL, Uppsala**

Founded in 1766, this hospital holds 1500 patients.

**Turkey (Turkiye Cumhuriyeti)**  
**BAKIRKÖY AKLIYE VE ASABIYE HASTANESİ**  
**(the Bakirkoy), Istanbul**

No descriptive reference found. The Bakirkoy might be poorly run, reflecting the poverty of the region, or might be excellent, reflecting the natural grace and hospitable charity of the people. Keeper's choice.

## Africa

**Botswana (Bechuanaland Protectorate)**  
**THE SANITARIUM, Kanye.**

The first modern hospital in Botswana was founded in 1921 by Seventh Day Adventists in the town of Kanye, a little north of modern-day Gaborone. The philosophy and treatment resembles that offered at the Sanitarium in Michigan.

**Rep. South Africa (Cmnlwth. of South Africa)**  
**SUNFOLD SANITORIUM, Johannesburg**

On Louis Botha Ave., in Kew. A private institution with 20 beds. Before Mandela, it likely had a whites-only policy.

**Rep. South Africa (Cmnlwth. of South Africa)**  
**POLOKO SANITORIUM, Thaba 'Nchu**

East of Bloemfontein, in one of what would be for a while 'tribal homelands.' Traditional tribal treatment for insanity is offered here for resident blacks.

## Asia

**China (Zhonghua Renmin Gonghe Guo)**  
**JOHN KERR REFUGE FOR THE INSANE,**  
**Fong Tsuen, near Canton in Kwangtung**  
**(Guangzhou) Province**

This private asylum was founded by John Kerr, a Presbyterian minister from Ohio who was involved in missionary work in China. For 25 years, he attempted to get a mental hospital built in China, and finally, in 1897, he succeeded. The building has two stories with plenty of airy balconies on all sides. Many ingenious wooden devices as well as small cages of chicken wire were used to restrain the patients. Europeans would be expected to pay for their stay

here; poor and indigent Chinese are kept here at government expense. In 1927, the refuge was deeply in debt and the government stepped in to take control of the hospital.

**Hong Kong**  
**HONG KONG SANATORIUM & HOSPITAL**

2-4 Village Road, Happy Valley. Founded in 1922. Hong Kong is a colony of the British Crown until 1997. Then the Peoples' Republic of China is sovereign.

**India (Bharat)**  
**PRESIDENCY HOSPITAL, Calcutta**

This is the place to come for simple medical treatment (if you are European, of course) In 1758, the British purchased this private garden house on Lower Circular Road and converted it into an airy and beautiful hospital with 150 beds after the addition of another building in 1901. Here in 1898, Sir Ronald Ross discovered the link between malaria and the anopheles mosquito, a fact commemorated by marble plaques at the hospital. A small mental ward is located fifty yards north of the newer building, near a contagion ward. The peaceful surroundings are probably the only treatment available here, but the 10-20 rupee daily fee is reasonable.

Non-Europeans can go to the Mayo Native Hospital, originally founded by Governor Sir John Shore who wanted to help the native Indians, particularly "the labouring part of them."

India is a commonwealth of the British Empire until just after World War II.

**Singapore (Malaysia, Malaya)**  
**NEW LUNATIC ASYLUM**

In 1885, this institution replaced an older asylum, built in 1862. The new building is located at Sepoy Lines in Singapore. It was here, in 1891, that 'amok' was first described in the native Malay population. The conditions at the hospital are fairly bad. In 1907, the death rate for patients was 60%, mostly from beri-beri, dysentery, and tuberculosis. By the 1920s, changes in diet eliminated beri-beri as a hazard, but the other diseases were still rampant in the wards. Nearly two thousand patients are kept here, with bare boards for beds and wooden blocks for pillows. Despite its drawbacks, investigators may choose an alternate local treatment: *cannabis sativa*.

In 1927, the asylum transfers its patients to the newly built Mental Hospital, located on the grounds of the Trafalgar Estate, on Yio Chu Kang Road. Although quite an improvement, the Mental Hospital is still of low quality compared to institutions in Europe and America.

Singapore dissociated from Malaysia in 1965. In the 1990s, its mental health facilities are modern and complete.

**Thailand (Siam)**  
**BANGKOK SANITARIUM & HOSPITAL, Bangkok**

Located at 430 Pitsanuloke Road in the city; with 200 beds total.







# Bethlem, Arkham, Bellevue

Three asylums, one for each era, two historical and one fictional, accompanied by appropriate scenario ideas and a short scenario.

**T**HERE ARE six sections in this chapter, in this order: 1890s Bethlem, "Turnabout" (a scenario set then in Bethlem Hospital); 1920s Arkham Sanitarium, "The Curse of Anubis" (a scenario set then in the Sanitarium); and 1990s Bellevue Hospital, and "To Wake, Perchance to Dream" (a scenario set in the contemporary Bellevue).

Statistics for scenario and asylum are grouped together between the asylum writeup and the respective scenario, for the sake of utility.

Most of the information in this chapter is self-explanatory, but the summaries of the hospitals deserve some comment.

The *type of hospital* could include Criminal Asylum, Private Hospital, State Hospital, and Women's Only Institution. More than one category may apply.

The *number of doctors* includes alienists, medical doctors, psychiatrists, and conceivably psychologists. These people need not be certified practitioners as long as they are regularly using some method to try to better the mental welfare of their patients.

All other asylum employees are counted under the *number of staff members*. They are mostly concerned with the welfare of the asylum itself and the maintenance of the patients' bodies.

The *number of patients* does not include patients who spend only a portion of their time at the asylum.

The amount of proper sleeping space available to the patients varied less than the number of patients. Consequently the *number of beds* and the number of patients may or may not be anywhere near the same.

The *survival rate*, *cure rate*, and *release rate* are as per the preceding Asylums chapter.

## Bethlem

*an 1890s asylum*

### Bethlem Royal Hospital ("Bedlam")

Lambeth Road, London

Type: Public Hospital  
9 Doctors  
52 Staff  
250 Patients  
300 Beds

Survival Rate 95/95  
Cure Rate 35  
Release Rate 16

**B**ETHLEM'S long history began in 1247, when it was established as a hospital by the Bishop of Bethlehem. Though it was put under the control of the city of London in 1546, Bethlehem remained in close contact with the Church for several centuries. Its early existence was largely due to indulgences paid to aid in the hospital's upkeep.

The first mental patients were admitted to Bethlehem in 1377. Slowly, their numbers increased until it was solely used as a sanatorium. Since the Reformation, when it became Bethlehem Royal Hospital, it has moved twice, in 1676 and 1815. It will move again in 1930, to Croydon. Its later twentieth century name is Bethlem Royal Hospital and the Maudsley Hospital.

Bethlem's history is not one of exemplary service to the mentally ill. Over the centuries, Londoners truncated *Bethlehem* to *Bethlem* and pronounced it *Bedlam*. That formation came to stand for the disarray, confusion, and

## BETHLEM ROYAL HOSPITAL PERSONNEL

### MEDICAL STAFF —

*Resident Physician and Medical Superintendent:* Robert Percy Smith M.D., F.R.C.S.

*Assistant Medical Officer:* Theophilus Bulkeley Hyslop, M.D., F.R.C.S.

*Pathologist:* Clement Lovell, M.D. (Lond.)

### CONSULTANTS —

*Surgeon:* Arthur Evans, M.D. (Lond.), F.R.C.S.

*Anaesthetist:* Cecil Hughes, M.B., B.S. (Lond.)

*Aurist and Laryngologist:* W. Mayhew Mollison, M.A., M.C. (Camb.), F.R.C.S.

*Ophthalmologist:* J. Francis Cunningham, F.R.C.S.

*Gynaecologist:* Thomas G. Stevens, M.D. (Lond.), F.R.C.S.

*Dental Surgeon:* Frederick Todd, M.R.C.S., L.D.S.

*Chaplain:* Rev. Johnathon Simpson Vaughan.

### ADMINISTRATIVE STAFF —

*Steward:* Arthur Henry Martin, Colonel A.S.C. (Territorial Force.)

*Matron:* Gladys S. Bettinson.

*Head Attendant:* Ernest Gordon Clark.

*Clerk and Receiver:* John Lade Worsfold.

disorder which characterized most of the asylum's early years. Even during the majority of the Victorian period, the patients at Bethlem were treated abominably, often being viewed as exhibits by touring London citizens. Several major scandals involving inhumane treatment finally led to better conditions and regulation. The first padded rooms were added in 1844. In 1846, the church chapel and dome were built. Finally, in 1853, Bethlem was registered for periodic inspection by the government.

By 1890, conditions at Bethlem had improved even more. The criminal patients had been removed to Broadmoor Hospital in the 1860s. Since then, paupers and other lower class patients have also been redirected to other institutions. In recent years, the administration of Bethlem has promoted it as a hospital for the upper class. The corresponding increases in the wealth of patients and their benefactors have allowed great improvements in the physical welfare of the patients.

Currently the curing of patients is almost secondary to ensuring that they are happy and content. The doctors rarely use the treatments standard for the 1890s, which manage both to be upsetting and ineffective.

Dr. Robert Percy Smith replaced the previous medical superintendent in 1888. He is a socialite who uses his position to raise his status among London high society. While a competent surgeon, Dr. Smith does not care enough about his patients to be of much help to them. The assistant medical officer, Theophilus Hyslop, joined Bethlem at the same time as Dr. Smith. He is a better

surgeon and administrator, but his overly large ego controls his actions. Knowing that he is superior to Smith, Dr. Hyslop bides his time, waiting to take over the hospital. The rest of the doctors on staff are primarily specialists, recently hired to give improved primary medical care to the patients.

Other important staff members include the steward, who sees to the comfort and treatment of visitors to Bethlem, the clerk, the chaplain, the matron, and the head attendant. The matron and head attendant oversee approximately twenty nurses and twenty attendants respectively. Of the staff, only the chaplain has no real authority. However, his personality and goodwill have made him the actual focus of advice for both staff and patients.

Despite the lack of effective treatment for mental disorders, the life of a patient in Bethlem is quite pleasant. There are dances and parties on holidays, and cards are available for whist daily. Every day, the patients spend several hours in the sunny courtyards out back. There team sports such as cricket are common. Inside the hospital, the wards are well lit. Comfortable sofas and chairs line the corridors. Guests are commonplace, so contact with the social scene in London does not seem so far away. The chaplain is currently thinking about starting an asylum newspaper to be called "Under the Dome."

## The Hospital Grounds

**Gardens:** expansive and elegant gardens make strolls through the grounds a pleasant experience. They are kept up well by the female patients who get to garden as a hobby during their outside times.

**Cricket Oval:** Dr. Smith has had the central lawn converted to a small cricket oval. He hires a special gardener to take care of it and keep it well groomed.

**Kitchen:** this large building was once a workhouse, wherein men occupied their time making mats, paper bags, and felt slippers. It has since been converted into an institutional-sized kitchen. The staff here are overseen by the matron. The laundry is also run in this building. Most of the cleaning and cooking is done by female patients.

**Tennis Courts:** the tennis courts were built during the original construction of this facility and have been used primarily by the female patients.

**Superintendent's Residence:** this comfortable two-story residence houses the current medical officer, Dr. Smith. In years past, the basement of this building was used as the kitchen for the whole facility.

**Visitor's Residence:** visitors have not used this building for many years. Its current residents are the assistant medical officer, Dr. Hyslop, and the steward, Colonel Martin.

## Main Building and Criminal Wards

The main building is an impressive construction with three palatial floors topped by a large dome. Two long, single-story wings extend southward from the back of the building. The male and female criminal wards no longer contain criminals, but have been made normal wards and will be



discussed with the main building. Each of the former criminal wards is four stories in height. An extensive basement links the main building to the criminal wards and extends under the cricket ground.

## First Floor

**Entry Hall:** an expansive, carpeted entry hall greets all those who enter Bethlem. Here the clerk/receiver has made his office and can disperse information and instruction to visitors.

**Patients' Rooms:** of standard construction throughout the hospital, these patient rooms are quite small, measuring a little over 2 by 3.5 yards. There is room for a bed and a small chest for personal belongings. Since there is not much space here, the staff do their best to see that patients have free access to the nearby corridor and day room.

**Day Rooms:** the day rooms are comfortable combinations of parlor and dining room. Three times a day, meals are served here. At other times, the day rooms become a social setting where papers are read and whist is played.

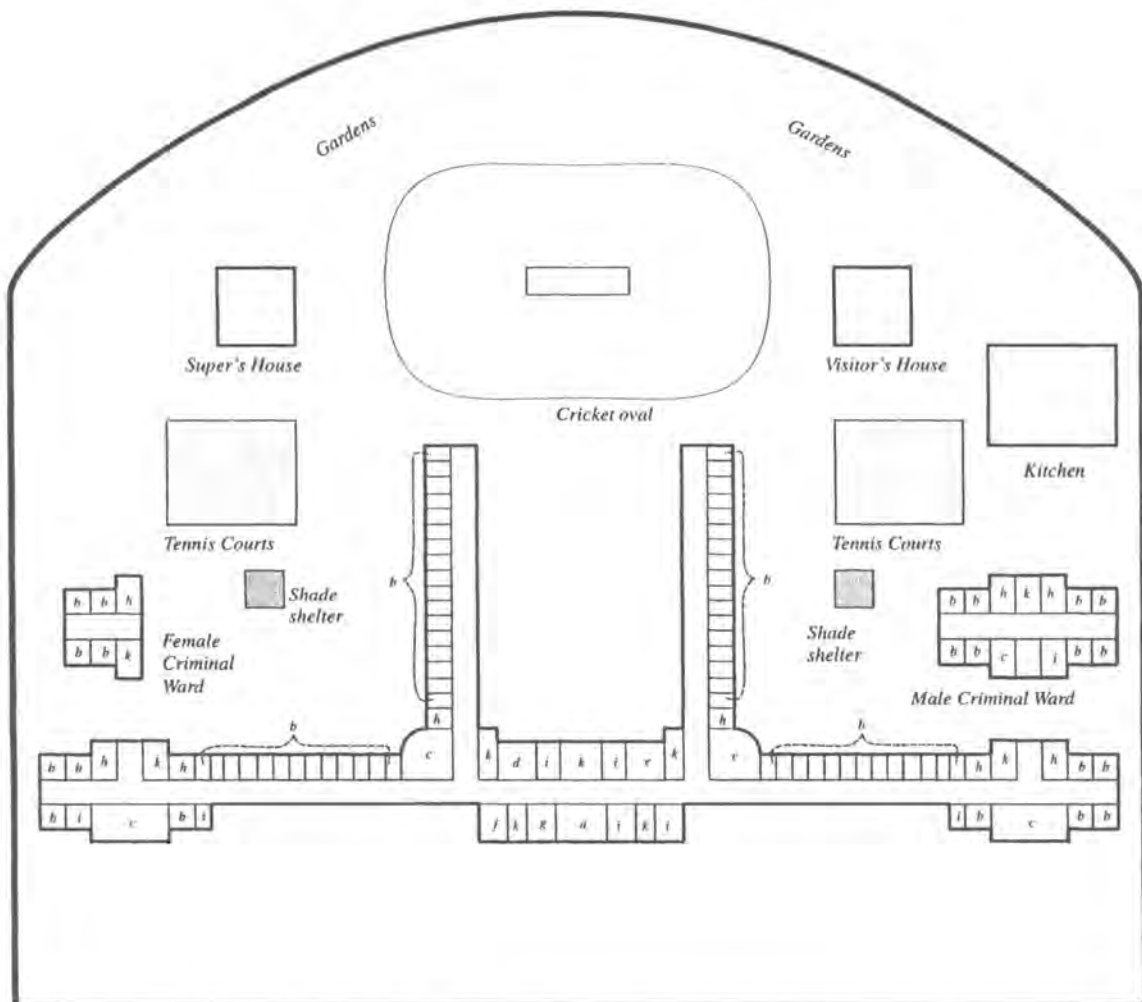
**Physician's Room:** this is the only room in the hospital where treatment and examinations occur. It contains a collection of medical instruments and devices thought to aid in recovering sanity. If drugs are to be administered, that is done in this room as well.

**Visitor's Room:** this friendly room is for guests of the hospital patients to wait in while the steward makes arrangements for their visits.

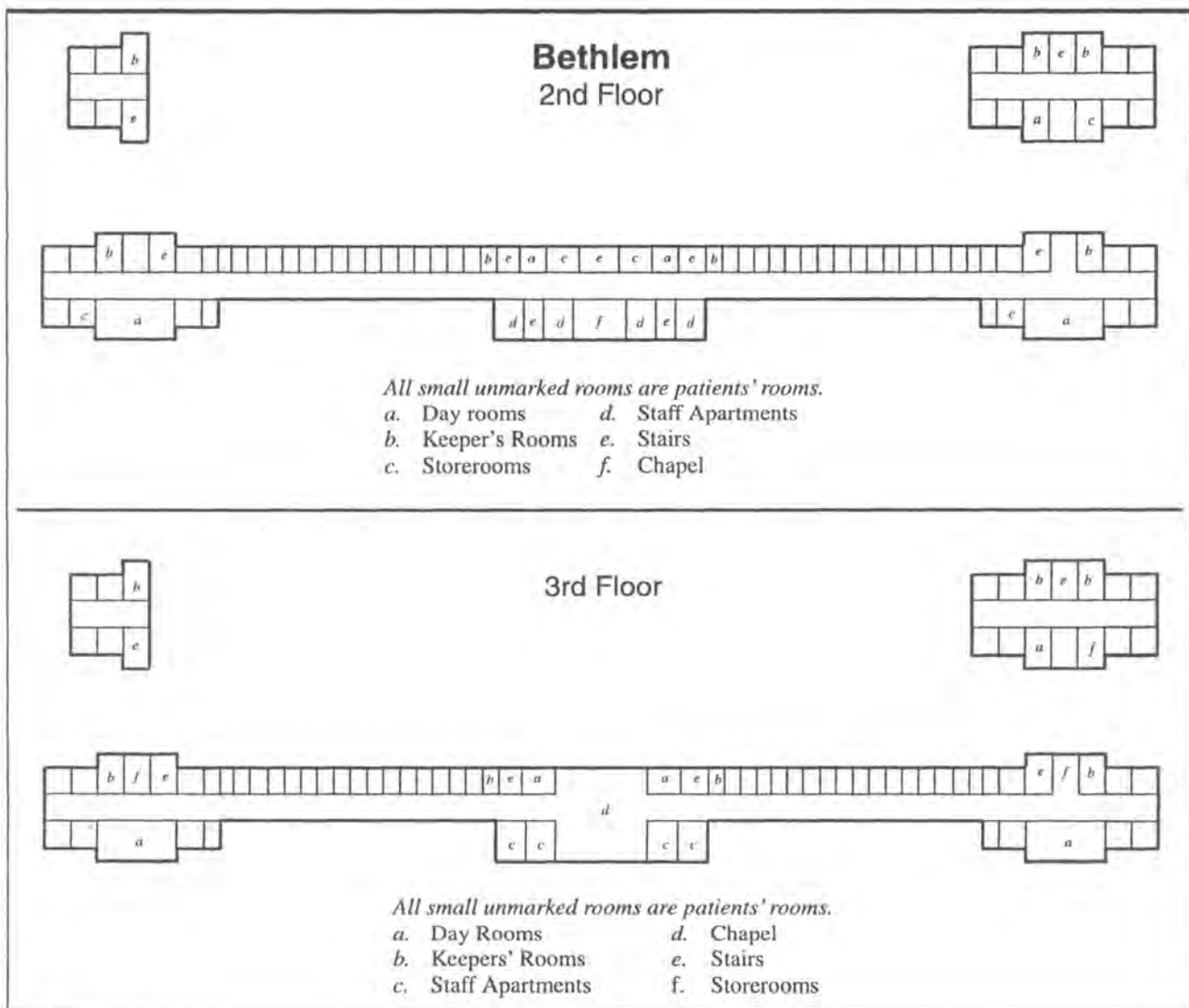
**Steward's Room:** the office of the steward, it contains records of all the patients and staff of the hospital.

**Pharmacy:** this room stores the drugs that are sometimes used to sedate or improve patients.

**Bethlem**  
First Floor & Grounds



- |                     |                   |
|---------------------|-------------------|
| a. Entry Hall       | f. Steward's Room |
| b. Patient's Rooms  | g. Pharmacy       |
| c. Day Rooms        | h. Keeper's Rooms |
| d. Physician's Room | i. Storerooms     |
| e. Visitor's Room   | k. Stairs         |



**Keepers' Rooms:** for the attendant in each ward. They contain supplies to meet any special needs of the patients in the ward.

**Storerooms:** the storerooms on the first floor contain supplies for the wards as well as supplies for the administration of the hospital.

## Second Floor

**Patients' Rooms:** identical to the first floor patient rooms.

**Day Rooms:** identical to the first floor day rooms.

**Keepers' Rooms:** identical to the first floor keeper rooms.

**Storerooms:** these contain general supplies for the nurses and attendants to see to the patients.

**Staff Apartments:** rooms are provided for the medical consultants when they wish to stay at the hospital. Each contains a bed, drawers, and a desk, so that personal belongings can be kept here.

## Third Floor

**Patients' Rooms:** identical to the first floor patient rooms.

**Day Rooms:** identical to the day rooms on the first floor.

**Keepers' Rooms:** identical to the keeper rooms on the first floor.

**Staff Apartments:** these are the apartments for the non-medical staff, including the matron, the head attendant, and the chaplain. As these staff are on premises full time, the quarters are furnished to a greater degree than those of the second floor.

**Chapel:** the chapel and dome were constructed together. The chapel has room for the attendance of up to thirty worshipers at a time. Three separate services are usually run by the chaplain every week.

## Fourth Floor

**Patients' Rooms:** the patient rooms on the fourth floor are reserved for the younger and healthier patients who can make the long climb.

**Keepers' Rooms:** the fourth-floor attendant rooms are the prize assignments for the staff. The patients on this level are friendly and there is a great view.

**Day Rooms:** identical to other day rooms in the facility.

**Dome:** this great construction stands out proudly on the London skyline. Its expansive windows provide excellent lighting for the chapel below.

## The Basement

**Patients' Rooms:** patient rooms in the basement are much more secluded than the patient rooms on the other floors. Many of them contain equipment that is used to prevent patients from injuring themselves or others. An investigator who was physically resisting admission to Bethlem would be placed in one of these rooms.

**Day Rooms:** day rooms in the basement contain the same furnishings as regular day rooms. In addition, there are supplies and equipment for bringing food directly to the rooms of restrained patients.

**Storerooms:** the basement storerooms contain supplies for the nearby wards as well as relics of previous administrations. This includes all sorts of torturous restraints that are not currently being used.

## Staff

The following staff members represent just some of the more important employees at Bethlem Royal Hospital.

### DR. ROBERT PERCY SMITH, age 39

STR 11 CON 12 SIZ 13 INT 14 POW 10  
DEX 12 APP 12 EDU 20 SAN 34 HP 13

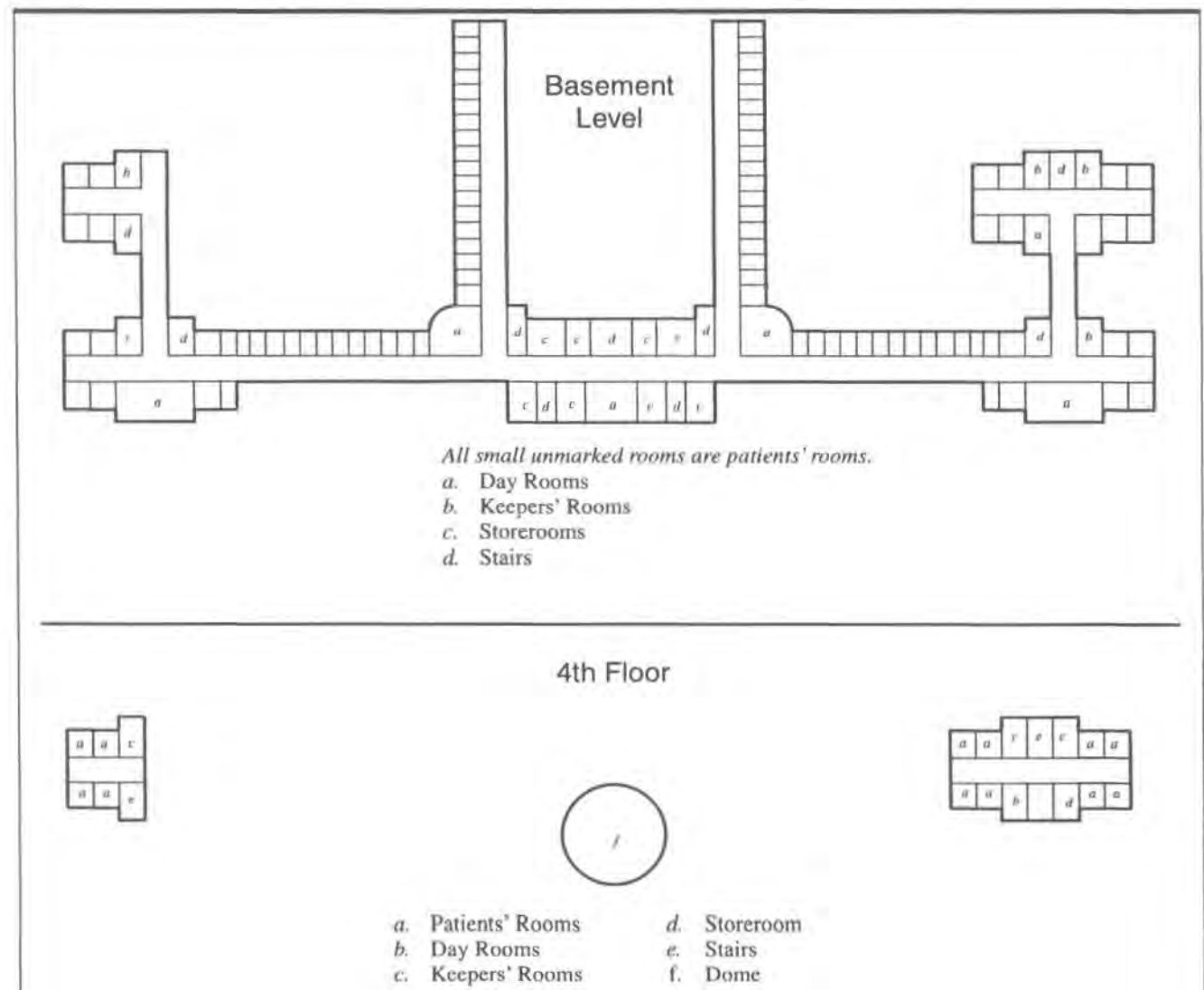
**Damage Bonus:** +0.

**Weapons:** Cane 44%, damage 1D4+db

**Skills:** Credit Rating 60%, Cricket 65%, Geology 30%, History 54%, Latin 35%, Library Use 70%, Medicine 85%, Natural History 40%.

**Quote:** "I say, quite a stunning match at Lord's today."

Dr. Smith has been in charge of Bedlam for just two years. The place is beginning to show the signs of his neglectful administration. Staff members arrive late, patients are not cleaned regularly, and only the front rooms are kept in order. Among other things, Dr. Smith is a cricket fancier and player. He has the gardeners keep a well-groomed wicket between the rear gardens. Here, he forces patients to participate in cricket games, giving him a chance to relive his glorious early sporting years while on the university team.





**DR. THEOPHILUS BULKELEY HYSLOP, age 35**

STR 10 CON 11 SIZ 13 INT 15 POW 12  
DEX 13 APP 11 EDU 21 SAN 48 HP 12

**Damage Bonus:** +0.**Weapons:** Derringer 40%, damage 1D6**Skills:** Credit Rating 30%, Latin 50%, Medicine 80%, Persuade 55%, Pharmacy 30%, Psychology 40%, Scheme 68%.**Quote:** "Some day, I'm going to run this place."

The assistant medical officer has grand plans for himself in the world. He is competent, relatively young, and his boss is utterly inept. Theophilus plans to let Dr. Smith's lack of concern for the hospital build to a dangerous level, so that he can step in and replace him. Whenever a government examiner arrives, Dr. Hyslop is always sure to point out all the problems and what he would do to fix them.

**REV. JONATHAN SIMPSON VAUGHN, age 60**

STR 5 CON 4 SIZ 9 INT 12 POW 17  
DEX 6 APP 8 EDU 12 SAN 71 HP 7

**Damage Bonus:** -1D4.**Weapons:** none.**Skills:** Bible 55%, History 70%, Natural History 52%, Occult 30%, Oratory 85%.**Quote:** "Yes, God blesses you too my son."

The old reverend is rumored to be retiring due to poor health soon. He will be missed, for he has been a fixture at the hospital for almost thirty years and all the staff and patients look to him for kindly, well-thought-out advice, both spiritual and mental. In three decades, Vaughn has done much to make Bethlem a cleaner and more pleasant institution, without the rabble or the poor and criminal elements. Vaughn leads services in the chapel every Sunday. He has an additional service every Tuesday and Thursday evening. On other days, he visits patients who have asked to speak with him.

**GLADYS S. BETTINSON, age 51**

STR 13 CON 14 SIZ 15 INT 11 POW 13  
DEX 8 APP 10 EDU 10 SAN 62 HP 15

**Damage Bonus:** +1D4.**Weapons:** Writing Board 50%, damage 1D4+1D4**Skills:** First Aid 40%, Listen 72%, Nag 92%, Persuade 55%.**Quote:** "Look sharp, ladies, we have a distinguished visitor today."

This large woman is the matron of the hospital. In her mind, Gladys runs the whole place and isn't afraid to let others, such as the head attendant, know it. She extends this overlordship to the lesser staff as well.

Officially, Gladys is there to ensure that patient activities run smoothly. She does so well, making sure her patients are having fun whether they like it or not.

## Resident Patients

The majority of patients in Bethlem have mild forms of Dementia Praecox (schizophrenia) or some type of manic-depressive disorder. Many others are also old, feeble-minded, or have no better place to go. This latter group includes alcoholics, addicts, epileptics, and simple morons. The patients below are a few of those whose disorders make them worth noting.

**WINSTON HUDDLESTONE, age 32**

STR 11 CON 10 SIZ 12 INT 13 POW 9  
DEX 13 APP 14 EDU 16 SAN 31 HP 11

**Damage Bonus:** +0.**Weapons:** none.**Skills:** Art (Painting) 65%, Credit Rating 85%, Fast Talk 60%, History 50%, Natural History 40%.**Quote:** "There's been some terrible mistake."

Winston Huddlestone has been a model resident for three years now. A severe alcoholic, he was committed to Bethlem after he began ranting about unbelievably strange rituals he had seen during a drinking binge. Now, he constantly ingratiates himself to the staff and visitors in an attempt to win his freedom. He insists his brothers had him committed to get his money and he promises great financial rewards to whoever assists in his release.

**HARRIET FITZHUGH, age 33**

STR 13 CON 12 SIZ 14 INT 11 POW 14  
DEX 9 APP 10 EDU 10 SAN 32 HP 13

**Damage Bonus:** +1D4.**Weapon:** Mop 55%, 1D4+db**Skills:** Clean Floors 92%, First Aid 30%, Spot Hidden 63%.**Quote:** "Of course you're a boor, but in that you're not charmless."

An overly protective mother and a deep need for affection have left Harriet a hypochondriac. She has multiple personalities and all her personalities have mental problems of their own. Her two most common personalities are Mary, who cleans floors and windows and doesn't talk, and Louise, who is an extreme paranoid and best avoided. The staff never know who Harriet is at any given time.

**DAVID JOHN SWEET, age 25**

STR 14 CON 15 SIZ 16 INT 9 POW 10  
DEX 12 APP 15 EDU 16 SAN 0 HP 16

**Damage Bonus:** +1D4.**Weapons:** Handgun 45%, but possesses no weapon.

Rifle 35%, but possesses no weapon.

**Skills:** Art (Acting) 73%, Art (Disguise) 67%, Bargain 55%, Cackle Menacingly 86%, Cthulhu Mythos 22%, Occult 40%, Persuade 60%, Sneak 47%.**Quote:** "If necessary, I will strike you repeatedly until your sobbing bloody body goes limp."

Committed by the authorities after being found knee-deep in chicken entrails, David has convinced himself that Bethlem holds a world of opportunity for a young cultist like himself. He is generally harmless, but always willing to let others in on his current set of plans for destroying the world.

### COLONEL LYSANDER STARK, age 42

STR 13 CON 9 SIZ 13 INT 15 POW 12  
DEX 12 APP 11 EDU 14 SAN 46 HP 11

**Damage Bonus:** +1D4.

**Weapons:** Revolver 60%, damage 1D8  
Martini-Henry Rifle 56%, damage 1D8+1D6+3;  
Rapier 48%, damage 1D6+1+db

**Skills:** Art (Counterfeiting) 78%, Credit Rating 47%, First Aid 60%, History 40%

**Quote:** "Curses, foiled again."

The Colonel is as sane as any criminal mastermind. After a recent narrow brush with the law, he had himself voluntarily committed to Bethlem for its relative security and comfort. He is currently trying to devise ways to set up a new counterfeit ring or some other ingenious criminal activity, to occupy his time spent in hiding. In person, the Colonel is quite pleasant, but in his arrogance makes it clear that he thinks himself superior to the mental defectives who surround him.

### TYPICAL BETHLEM ATTENDANTS

	#1	#2	#3	#4	#5	#6	#7	#8
STR	14	14	16	12	13	12	15	16
CON	10	15	11	12	14	13	10	12
SIZ	15	11	14	14	12	15	11	14
POW	7	10	9	9	9	10	11	10
DEX	10	12	8	10	13	11	9	10
HP	13	13	13	13	13	14	13	15

**Damage Bonus:** +1D4.

**Weapons:** Fist 70%, damage 1D3+db  
Grapple 45%, damage special  
Head Butt 30%, damage 1D4+db  
Club 50%, damage 1D6+db

**Skills:** Dodge 40%, Listen 45%, Persuade 30%, Sneak 40%.

### TYPICAL BETHLEM NURSES

	#1	#2	#3	#4	#5	#6	#7	#8
STR	13	11	10	9	9	11	11	8
CON	15	10	15	15	13	14	13	11
SIZ	10	12	10	11	11	9	10	12
POW	10	12	8	12	11	9	12	11
DEX	13	12	10	11	12	11	13	13
HP	13	12	13	13	12	12	12	12

**Damage Bonus:** +0.

**Weapon:** Fist 50%, damage 1D3

**Skills:** First Aid 50%, Medicine 25%, Persuade 30%, Pharmacy 20%.

### TYPICAL BETHLEM PATIENTS

	#1	#2	#3	#4	#5	#6	#7	#8
STR	7	12	12	9	8	14	10	9
CON	9	9	11	11	6	10	8	8
SIZ	16	8	10	15	16	8	14	15
POW	9	11	8	8	9	11	9	9
DEX	15	9	7	12	8	9	12	10
HP	13	9	11	13	11	9	11	12

**Damage Bonus:** +0.

**Weapons:** Bite 30%, damage 1D2  
Claw 35%, damage 1D3  
Butcher Knife 35%, damage 1D6  
Club 35%, damage 1D6

**Skills:** Cry Randomly 33%, Drool 21%, Quote Poetry 21%, Recite Obscure Fact 74%, Scream 57%.

**Insanities:** generate 1D3 insanities from the Indefinite Insanity chart in the Call of Cthulhu rulesbook, or choose alternates from among the information in this book.

### SWEET'S CO-CONSPIRATORS\*

	#1	#2	#3	#4	#5	#6
STR	10	11	10	11	11	10
CON	9	17	14	8	12	10
SIZ	12	9	13	10	9	16
POW	11	9	10	13	8	7
DEX	12	8	15	6	7	9
HP	11	13	14	9	11	13

**Damage Bonus:** +0.

**Weapons:** Bite 45%, damage 1D2  
Claw 45%, damage 1D3  
Club 55%, damage 1D6

**Skills:** Appear Menacing 31%, Brag 91%, Butcher Chicken 67%, Cackle 52%.

\*Their respective insanities; follow:

Richard (#1) — Multiple Personality (alternatively benevolent and malicious), Amnesiac (sometimes).

John (#2) — Iatrophobic (especially afraid of Dr. Smith).

Henry (#3) — Hematophobic (faints if he sees his own blood), Obsessed with keeping his clothes clean.

Arthur (#4) — Agoraphobic, Claustrophobic.

Brute (#5) — Paranoid (doesn't trust anyone but the Sweet conspirators), Necrophobic, Zoophobic.

James (#6) — Delusional (believes that he is a well-to-do nobleman living in his summer mansion).

### TYPICAL LONDON CONSTABLES

	#1	#2	#3	#4	#5	#6	#7	#8
STR	12	13	10	17	13	17	16	11
CON	13	11	10	9	12	13	10	11
SIZ	15	12	15	12	12	13	15	15
POW	9	9	13	12	12	9	13	11
DEX	13	13	15	11	12	13	16	16
HP	14	12	13	11	12	13	13	13

**Damage Bonus:** +1D4.

**Weapons:** Fist 60%, damage 1D3+db  
Grapple 45%, damage special  
Nightstick 50%, damage 1D5+db

**Skills:** Dodge 35%, First Aid 35%, Hide 25%, Law 45%, Listen 35%, Persuade 25%, Sneak 25%, Spot Hidden 35%.

## Scenario Ideas

### THE CRICKET PLAYERS

Dr. Smith has had a sudden inspiration. He will form and captain a hospital cricket team to tour and compete with other institutions. He is rounding up any staff or relatively sane patients who show even the slightest athletic ability. Can Dr. Smith put together a team? If he does, can the staff keep disasters from happening as it goes out on tour? If the plan is a disaster, how will it affect Dr. Smith and his reputation, let alone his own sanity? This scenario has the potential for bringing interesting characters to London for some pub hopping when they give the staff the slip. The escapees could run into a great many adventures outside the sanatorium, even if they stay with the team. Isn't it odd that grunts from the fast bowler for the nearby prison's team sound a bit like Glaaa...kiii?

### THE INVOLUNTARY WITNESS

A barrister has contacted the investigators about a small matter. It seems his client, a Winston Huddleston, is being held against his will in Bethlem, after being involuntarily committed by his younger siblings. The barrister is offering a large sum to anyone who can manage to prove that Winston is sane. This will require considerable effort, as Winston's brothers have many witnesses to his drunken excesses and visions. Perhaps the investigators can find other witnesses to the strange rituals that Winston claims to have observed, or discover physical evidence that they occurred. Excellent communication skills and proper respect for the Bethlem medical officers will also be required to gain Winston's release. A new cricket bat for the Medical Superintendent probably wouldn't hurt either.

### WORK THERAPY

The investigators have been called in to help on a criminal case. Counterfeited archeological artifacts have been pouring into London. The only clue that the authorities have so far is the word of an ex-inmate of Bethlem. He told them that someone is using inmate labor to forge these items behind the backs of the staff. Several people are needed to enter the asylum as patients, to uncover the source of this activity. The staff will be aware of their cover. Of course, this scheme is being run by the master criminal Colonel Lysander Stark. What Stark doesn't realize though, is that one of his workers, David Sweet, has plans of his own. Recalling instructions from an ancient occult tome, David is crafting special items with obscure powers. Since the project has begun, several notable collectors of artifacts have been found dead, lying on their beds in pools of their own blood. There have also been odd changes in the behavior of some of the patients who have been working for Stark. Even if the investigators uncover Stark, if they do not also discover David Sweet, then the source of the strange deaths will remain, perhaps requiring another visit to Bethlem.

### TOO MANY MURDERERS

The headlines of the London papers have finally disturbed the serenity of Bethlem. The horrible crimes of Jack the

Ripper have spawned a large number of false confessions. Scotland Yard has ordered the majority of the confessors to Bethlem for watching over. Only confessors who have no chance of being the actual culprit have been sent, but there are still dozens of fresh patients in Bethlem, all claiming to be the famous mass murderer. To make matters worse, a false rumor is passing through the wards that one of the confessors is really Jack. The source of the rumor is actually Dr. Hyslop, but that should be difficult to discover. As it is, Dr. Smith needs to hire some private investigators to prove that Jack isn't really a patient at Bethlem. The investigators will need to talk to Scotland Yard to get information and then to enter the asylum to question the inhabitants. Most of the suspects should be easy to eliminate, but some should seem to be viable possibilities. Problems could occur in the asylum when various inmates are questioned, and when provoked, some of the confessors may try to prove their story by violent actions. The whole goal of the investigators is to squash the rumor. This will be made even more difficult by Dr. Hyslop if he thinks he can hinder the investigators safely.

### ODD BEHAVIOR

Something has happened to Reverend Vaughn. His sermons are growing increasingly violent and are upsetting the patients. There are also some strange new books in his library, ones that are written in an undecipherable ancient tongue. Unknown to all, a malignant creature from the Dreamlands has eaten the Reverend and taken his place. Who knows what its motives are? All that matters is that the investigators must discover and stop the creature before the patients become violent, guided by Vaughn's evil commands. His control over them is almost magical and will be hard to break.

## Turnabout

### *an 1890s scenario*

**T**HIS ADVENTURE is set entirely in London's Bethlem Hospital. Have the players assume the roles of insane residents of the asylum. They will confront the machinations of a cultist, David Sweet, who is attempting to drive the hospital staff mad.

Unlike some Call of Cthulhu villains whose identities remain secret until the end, the investigators will be living in the same building with him, and will see him daily. Sweet is crazy, but charismatic, and very intelligent. His character is crucial to this adventure, and keepers can think about it with profit. Since he makes every effort to appear normal, Sweet spends a lot of time in the Day Room. He is phenomenally lucky at cards... or does he cheat? When he starts to lose at chess, does he act gracefully, or become enraged? Does he flirt with the ladies? Does he enjoy a stroll in the gardens? What foods does he like, and what happens when he is served something he doesn't like? These are only small examples of how the investigators might form impressions of David Sweet.



## KEEPER'S INFORMATION

Several months ago, David John Sweet was researching cultist material when he came upon a moldy tome that had been bracing up a crumbling bookshelf in an antiques shop. He scanned it briefly and purchased it from the bemused owner. Most of the pages had been damaged beyond repair, but one section held the secrets to an ancient ritual that would have been better left unrecovered. Excited by his discovery, Sweet rushed out at once to try it.

Several hours later, Sweet entered Hyde Park with a small crate full of live chickens and waited until just after sunset. When several particular stars were visible in the night sky, Sweet began his ritual, offering sacrifices so that he might partake of the knowledge of the dark god, Nyarlathotep. Unfortunately for Sweet, a constable from the nearby Hyde Park Police Station came across him, brutally subduing him before taking him away.

Between the dead fowl that surrounded Sweet and the arcane signs that he had traced in blood, there was no real question about Sweet's sanity. Civil commitment proceedings were immediately begun. Within days, Sweet was confined to Bethlem.

Since being admitted, Sweet has acted the model patient, friendly and courteous to the staff, even offering to help them with simple tasks. Sweet has been watching everything carefully, learning all that he can about Bethlem, so that he can use his current situation to his advantage.

Sweet now has a plan. He realizes that Bethlem is poorly administered, and that many of the staff members are demoralized by the deteriorating conditions. Sweet wishes to drive the asylum staff over the edge, into madness. He plans to then step in and take over, making the hospital a base for cult activities.

## THE INVESTIGATORS

The investigators should begin as patients in Bethlem Hospital. They might have entered the hospital voluntarily or have been committed by the government. This adventure serves best as either an introductory or stand-alone adventure, but any long-running campaign may have built up enough lunatics to enable them to participate.

Characters generated for this adventure should be given a number of insanities. Let each player pick one to three insanities from the Indefinite Insanity table in the *Call of Cthulhu* rulesbook. These insanities should have major effects on the character's behavior throughout the adventure.

As resident patients of Bethlem Hospital, the investigators should be familiar with the hospital's layout and personnel. Supply them with a copy of the Bethlem floor plan as well *Player Aid #1*, the Bethlem Hospital Staff Listing.

## David Sweet's Cunning Plan

Ever since his arrival in Bethlem Hospital, Sweet has been developing his master plan to control the asylum. Always alert for signs of weakness, Sweet quickly noticed that most of the staff members were badly stressed by the poor

## Bethlem Hospital Staff Listing

DR. ROBERT PERCY SMITH, the Medical Superintendent of Bethlem, interacts with the patients infrequently. Occasionally, he calls a few of them out to the back green, to join him in a game of cricket, but apart from that he remains far from the eyes of the asylum residents. Some of the other staff members speak very disparagingly of Dr. Smith, saying that he is an incompetent administrator bent upon destroying the asylum.

DR. THEOPHILUS BULKELEY HYSLOP, the Assistant Medical Officer, seems to believe that he'll be the next superintendent of Bethlem. When only patients are listening, he sometimes mumbles about how he plans to take over the place. Although Dr. Hyslop occasionally walks through the wards to examine the current conditions, he never seems to do anything to improve them.

DR. CLEMENT LOVELL, the pathologist at Bethlem, is the doctor who actually tends the patients. He is usually quite brisk with them, and it is obvious that he doesn't particularly enjoy his position as an asylum's doctor. However, he is competent and thus tolerated.

REVEREND JONATHAN SIMPSON VAUGHN, the chaplain, is the kindest staff member at the asylum. Nearly everyone likes the friendly, good-natured man, and they turn to him for all manner of advice.

GLADYS S. BETTINSON, the matron of Bethlem, is the one who actually runs the asylum. The steward, the head attendant, and all of the nurses look towards her when there is a problem. It is Gladys who ensures that all of the patients follow their daily regiment, if they like it or not.

COLONEL ARTHUR HENRY MARTIN, the steward of Bethlem, is only seen by the patients when he is showing the asylum to the public. The Colonel is rude and arrogant, and thus generally disliked.

ERNEST GORDON CLARK, the head attendant of Bethlem, is a middle aged man who never expresses opinions of his own. He always turns to Gladys whenever he is forced to make a decision. Even the patients are able to manipulate Clark, often convincing him to obey their insane whims.

IN ADDITION, there are about twenty nurses and twenty attendants at Bethlem. For the most part, their morale is low, due to Dr. Smith's poor administration. Recently, there has been an abnormally high turnover rate among these staff members.

administration and deteriorating working conditions of the hospital.

The first step of Sweet's plan has already been accomplished. He has convinced five of the more deviant residents of Bethlem to join him in his plan. They have begun to annoy and sabotage the staff and disrupt their routines. Appointments are missed or rearranged, offices have been broken into and disorganized, fictitious problems and staff orders have been generated, and even the cricket pitch has been wet down.

## Shadow of Nyarlathotep, a new spell

Learning this spell costs 1 POW. To cast the spell, the caster needs a pint or more of human blood, and three live chickens. The spell costs the caster three magic points and 1D3+1 Sanity points. The blood may come from anyone, but it must be fresh and warm.

After disemboweling the chickens and intoning dread words to Nyarlathotep, a large, shadowy form appears, the shadow of one of Nyarlathotep's thousand forms. Here we use the form worshiped by the Cult of the Bloody Tongue, in Africa, but any aspect could be chosen if held as an image in the caster's mind

The shadow then walks to its intended target, where it springs out at and dismays the person it haunts in dozens of unexpected ways. There is about it a curling dread and strange coldness that make it impossible to ignore. Even Gladys Bettinson loses Sanity points to it, no matter how hard she tries to stay calm.

Those seeing the shadow at a distance lose 1D6+1/1D2 SAN. If a person comes close to the shadow, or if it approaches in a place where it cannot be avoided, the target can make out the clawed appendages and the blood-red tentacle where a face should be. Those seeing the shadow this way lose 1D20/1D6 SAN, for this is a true visage of the Crawling Chaos.

The shadow follows the commands of the caster for one hour before fading away. It can frighten, horrify, and unnerve those who see it, but it cannot affect viewers physically, nor move things or make attacks. Common physical symptoms of such a scare include nightmares, excessive sweating, and incontinence at night.

The ritual can also be done with dead chickens, but then a weaker, smaller version of the shadow appears. This only causes 1D6/1 SAN loss upon viewing and only obeys the caster for five minutes before fading away. The sanity cost to the caster is the same.

Any version of the shadow is dispelled by strong light directed at it, such as the nearby presence of large fire or the headlights of automobiles, but ordinary electrical lights in a room do not chase it away.

With staff unhappiness at an all-time high, the next step of Sweet's plan involves all his insane helpers saving their dinners every Wednesday evening, when chicken is served.

On Wednesday night, Sweet then bleeds one of his helpers and casts the Shadow of Nyarlathotep spell. After the frightening shadow makes a quick visit to one of the staff, the plan is greatly advanced. When chaos finally erupts, Sweet can take over, running the asylum as the greatest center of cultist activity in London.

This scheme may seem insane, but what more can be expected from the plan of a madman? The keeper should play up the aspect of insanity; keep the investigators off-balance by quick scene changes, frequent non-sequiturs, and the insane behavior of the other residents.

## INVOLVING THE INVESTIGATORS

Let the investigators become involved shortly after David Sweet's harassments begin. They will notice that the unhappy staff members have begun to grow short-tempered, and that the quality of care has lowered.

Introduce the investigators to the adventure by explaining the generally utopian environment of Bethlem, where the inmates are commonly given free-run and treated quite well. End the monologue by telling the investigators that recently, conditions have begun to decline. Playing out a short scene with each of the investigators will emphasize this, and also give them a rough idea of the asylum and its residents:

- One investigator, who likes Reverend Vaughn and often helps him with simple tasks, accidentally drops a few books that he was carrying for the Reverend. Despite his normally calm demeanor, the Reverend loses his temper, and begins deriding the investigator before suddenly apologizing, and then hurrying off in embarrassment.
- An investigator hears Dr. Hyslop and Matron Bettinson arguing in loud voices in the Doctor's office. If the investigator eavesdrops, he learns that the Doctor is accusing the Matron of stealing one of his texts.
- Dr. Lovell misses a whole set of appointments one morning, and if he is confronted about it, blames the investigators, claiming that they never made the appointments.
- If one of the investigators is a troublemaker, one day an attendant becomes physically abusive with him, yelling and screaming until two other attendants come in and drag him away, to calm him down.
- Dr. Smith calls one of the more athletic investigators to his office one morning. He explains that he knows what the investigator has been doing, and begins to blame the investigator for wetting down the cricket greens. If the investigator continues to stubbornly deny this allegation (as assumedly he will), Dr. Smith will end up shouting "The Ball won't bounce true! It won't bounce true!" before demanding that the investigator leave.

While this should all cause the investigators some puzzlement, and an even greater wish to be freed from Bethlem, they will have very few clues to work with at the start. This condition changes as Sweet's plan progresses.

## The Daily Meeting

Alert the investigators to the conspiracy by the existence of their daily meetings. Every afternoon at two, the patients from the men's wards are scheduled to exercise in the East Courtyard, and it is not unusual for a group of patients to gather in the shade of the shelter there.

Now the same individuals meet there every day, looking conspicuously furtive and conspiratorial. David Sweet is their leader. The rest are entranced by the brilliant words pouring forth from his mouth, in an endless stream.

If an investigator tries to join Sweet's select group, or even attempt to lounge about the shelter, Sweet will attempt to chase them off. If his demand that the investigator leave

is refused, Sweet threatens physical violence. His conspirators are ready to fight. If he gives the word, a melee will erupt, and the investigators and the conspirators will fight for 1D3+3 rounds before attendants break up the battle. If attendants become involved, all those concerned are sent to bed without dinner.

## The Shadow Strikes

By this time, investigators may want to know what is going on. See the sub-section **Other Investigations**, below, for some of the paths that the players might take. Meanwhile, Sweet begins the second stage of his plan, described here.

Every Tuesday evening a large shipment of chickens arrives at the asylum kitchen. The next morning, they are killed and cleaned for the Wednesday late meal. Sweet has instructed his followers not to eat their Wednesday night meal, but instead to sneak it into Sweet's room, for use in his spell. Thus, the Shadow is summoned and each Wednesday night one of the staff receives a visit from it. Below is the order that Sweet intends for these visitations. They should begin soon after the adventure starts.

**1. Reverend Vaughn:** the moral and spiritual backbone of Bethlem cancels his worship services for a week after being visited by a 'demon.' The week is spent in silent prayer before he returns to work. He describes the demon if questioned.

**2. Gladys Bettinson:** the matron has a great fright, but her strong presence of mind quickly chooses to see the visit as a prank by one of the inmates. For the next few weeks, less food is served as punishment. She denies any knowledge if questioned about strange shadows.

**3. Colonel Martin:** the Colonel is so uptight that he can pretend he saw nothing. Keeping a stiff upper lip, he never mentions it.

**4. Doctor Lovell:** the doctor, who never liked Bethlem anyway, resigns and lets everyone know the place is haunted by monstrous shadow creatures.

**5. Ernest Clark:** this poor man was withdrawn and dull. After seeing the shadow, he becomes a model patient at the asylum. He gladly describes his insane visions to those who ask.

**6. Doctor Hyslop:** the doctor reacts by alerting the civil authorities to horrible irregularities at the hospital. After a brief visit by men in uniforms, nothing is done.

**7. Doctor Smith:** quite shaken, Dr. Smith moves to a residence well away from the hospital grounds.

The staff may not be attacked except in this order. Others such as attendants who get in the way may be attacked between the main staff incidents. Some of the patients might also glimpse the Shadow, go insane even further, and babble incoherently about what they saw.

The investigators should feel the results of these visitations as they continue their investigations.

### ACCELERATION

At some point Sweet will find a way to increase the quantity of chickens ordered, and find a safe place (perhaps in the basement) to hold them. When that happens,

the Shadow can prowl nightly. When the night staff ceases to be responsible, Sweet and his group will rule the nights at Bethlem.

Discovering Sweet's chicken supply can be a curious and useful clue for the investigators to ponder, and following the doomed fowl to their rendezvous should make everything clear.

## Other Investigations

As the investigators look into the behavior of David Sweet's group, they may notice other irregularities as well. The most likely paths of investigation are noted below.

### CHICKEN PARTS

The investigators may realize that reports of the shadow always originate from a Wednesday night. They might also notice that on every Thursday morning, one of Sweet's followers can be seen digging in the Garden. If the area is examined, several small burials are found. Each hole contains the remains of the chicken parts used in one of Sweet's spell.

### SWEET SECRETS

If investigators are particularly nery, they may decide to search Sweet's room while he is out. At first glance, it seems to be the residence of a model patient. However, if an investigator makes a Spot Hidden roll, he will notice some strangely blood-stained shirts hidden down beneath the rest of Sweet's garments. In addition, crumpled up and discarded papers reveal rough sketches of what is clearly the creature that the Reverend described.

### THE BRAGGART FOLLOWERS

The investigators may decide to question Sweet's followers. At first, they are either quiet and taciturn or threatening. However, if the investigators persevere and act encouraging, all of Sweet's followers will eventually brag about, and therefore expose, Sweet's entire plan. If the investigators try to dissuade the followers from such a course, they are in for a fight.

### LATE NIGHT ANTICS

Investigators who are willing to sneak out of their rooms after the official bed time may notice that Sweet's followers have likewise snuck out if it is a Wednesday night. If the investigators reveal this out to the attendants, they will likely get into trouble for being out themselves. However, if they do manage to get the attendants to investigate what is going on, Sweet arranges a distraction by releasing one of the more violent patients of Bethlem, and Sweet's followers will slip into their rooms during the ensuing uproar.

## Confrontations

Eventually the investigators directly confront Sweet and his followers. Use the two following interludes when investigators have figured out most of what is going on. If either seems inappropriate, exclude it.



## BLOOD BROTHERS

As Sweet's plan concludes, his followers may grow wan and weak from frequent donations of blood. Sweet decides to grab one of the investigators and use his or her blood. Late one Wednesday night, several of Sweet's followers grab a random investigator to drag to Sweet. He gives the investigator a small cut and then bleeds him or her for a pint. The woozy investigator is then released and ordered not to mention this event.

If the investigator reports the incident, the staff will not believe it. The small wound could have been caused by anything, and there are no other witnesses to back up the very odd story.

## THE INVITATION

Sweet eventually realizes that he needs additional assistance to assure success. He therefore may approach one of the investigators (not one from which he took blood), and invite them to join him. He will explain his plan, and offers incentives, but even an insane investigator will reject this plan. Sweet then warns the investigator not to mention their conversation to anyone, promising that he will deny it, and threatening murder. Will the staff believe the investigator or Sweet?

There is a chance that the investigators may decide that escape has become their best chance. The keeper should allow this if they insist, and finish the scenario with random inmates as the foil to Sweet and the investigator's evil plan.

## The Chicken Raid

As Sweet's plan succeeds, he realizes that the investigators are trying to thwart him. This should occur after the two confrontations discussed above. When this occurs, Sweet will speed up his plan, preparing to raid the kitchens late Tuesday night, so that he may finish things with three Shadows (all that Sweet's magic points allow) rampaging all night in the hospital. Perhaps, in fact, he has taught his spell among his followers, and shadowy horrors will be lurking everywhere.

On Tuesday, Sweet and his followers behave strangely. They slink about and avoid the investigators as much as they can. This should be a clue that something is up. Investigators notice that Sweet and his followers all sneak out just after bed-time.

The investigators may follow Sweet themselves, or they may try to alert the staff.

Following Sweet leads them to the kitchens. Here the investigators discover an unconscious watchmen and many cages of chickens missing. The back door is open. Sweet and his followers have gone to the cricket pitch, there to cast spells.

When the investigators arrive, Sweet is in the middle of disemboweling several chickens and splashing their blood on his followers while chanting unintelligible words. Attempting to stop Sweet causes all his followers to attack.

Whether the followers are winning or not, the staff is alerted by all the screaming, and soon attendants are out in the field tackling patients as fast as they can.

If the fray is large enough, the keeper can call in London constables to the scene as well.

If the investigators instead choose to alert the staff, they have chosen a difficult task. Staff members will be unlikely to accept tales of diabolic summonings without evidence. However, if the insane investigators are able to come up with a story that demands attention (fornication on the cricket pitch, for instance), several orderlies will accompany them outside to see what is going on. The attendants immediately take Sweet to the basement when they see what he and his group are doing.

A large melee and the death of many chickens results.

The investigators may try to take advantage of the mass confusion and flurry of feathers to escape the asylum. This is likely to be successful, but the authorities will be notified. That little matter of sanity will have to be cleared up sooner or later.

## Conclusion

### WHAT IF SWEET SUCCEEDS?

Sweet's plan might actually succeed. If the investigators do not intervene, and have in no way brought the issue to the authorities, the following occurs.

One or more Shadows of Nyarlathotep rampage through the asylum all night, driving some of the staff insane. Sweet slips out of the hospital, returning a short time later in a fine suit, with official-looking papers naming him the new Superintendent of the Hospital. Perhaps he has imprisoned Dr. Smith, or worse. Perhaps Hyslop has gone north, to speak in Scotland. Sweet's papers are clearly forged, but the remaining staff members are really too far gone to notice. After having taken control of the asylum in this way, Sweet will proceed to use it as a base for his cultist activities, the first to be to spread confusion and apparently-accidental death through the hospital's governing board, consolidating his position in the meantime.

By this time, no doubt Sweet has learned about Col. Stark. The Colonel would make an excellent partner-in-crime and enforcer, if convinced that Sweet is up to his part of the job.

If the investigators were adversarial to Sweet, they will no doubt face a very unpleasant environment at Bethlem.

### WHAT IF SWEET FAILS?

It seems much more likely that Sweet's plan will fail spectacularly. Once Sweet and his minions have been properly sedated and confined, each of the investigators should gain 1D6 sanity points. The staff may release some or all who helped stop Sweet, especially if they are showing mental improvement. Those that are not released might still become trusted patients at Bethlem, giving them chances for better treatment and quicker releases.

# Arkham Sanitarium

## a 1920s asylum

### Arkham Sanitarium

225 E. Derby Street  
Arkham, Mass.

Public State Hospital  
3 Doctors  
14 Staff  
44 Patients  
50 Beds

Survival Rate 95/95  
Cure Rate 35  
Release Rate 20

ORIGINALLY OWNED by Tom and Paul Pickering, in the early nineteenth century the three-story Georgian mansion that is now Arkham Sanitarium was converted into a hospice for aging veterans of the Revolutionary War. Over the years, it has slowly changed its clientele. Today, it treats only the mentally ill. It is financed by public funds, paying patients, and the Pickering Foundation.

The facility is currently headed by Dr. Eric Hardstrom, who runs the Sanitarium with help from two other doctors. Hardstrom has been in charge for almost ten years now and has become a capable hospital administrator. His likely successor, Dr. Bradley Harcourt, handles admissions and also keeps an eye out for likely bequests from local families. The other doctor, Harry Dunbar, oversees the physical health of the patients. This leaves Dr. Hardstrom plenty of time to spend with the patients he cares so much about. Several Arkham-area doctors have staff status at the sanitarium, but rarely spend much time there.

Also on staff are eight nurses and four orderlies who assist with the patients. A gardener, janitor, and part-time handyman round out the staff. All the staff live off premises, but round-the-clock care is still provided. The night watch consists of two nurses and an orderly.

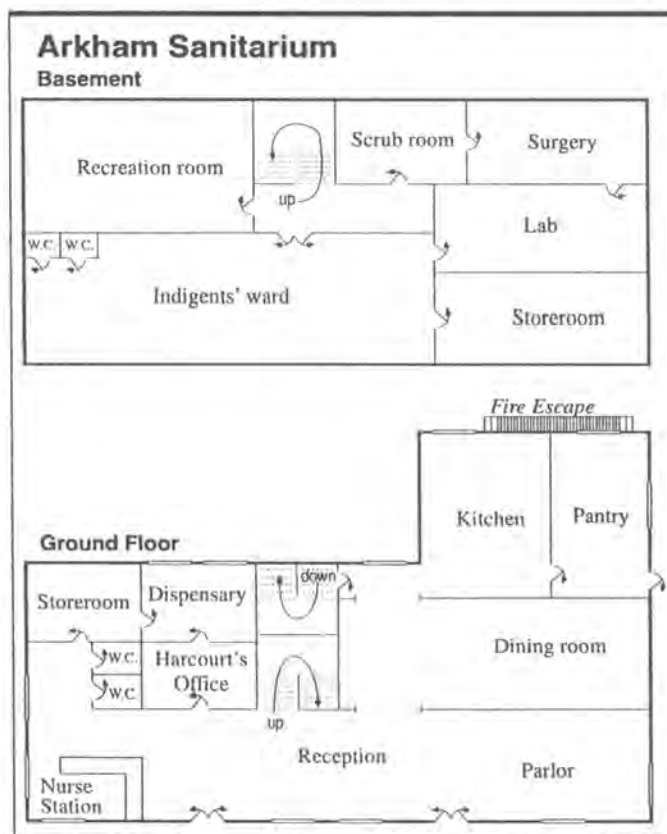
When Dr. Hardstrom took over the sanitarium it was a place more likely to harm its patients than aid them. Hardstrom, full of youthful idealism, initiated a complete overhaul of the treatment system to bring it to the cutting edge of psychiatric theory. A devout Freudian, Dr. Hardstrom spends the majority of his treatment time experimenting with the newly developed psychoanalytic techniques that have found some success in Europe. Drs. Harcourt and Dunbar are left with the psychiatric treatments, including drug therapy and hydrotherapy. Experimentation with new drugs and psychoanalytic techniques is encouraged. Dr. Hardstrom often invites other psychiatrists to spend time at the asylum, trying out new concepts.

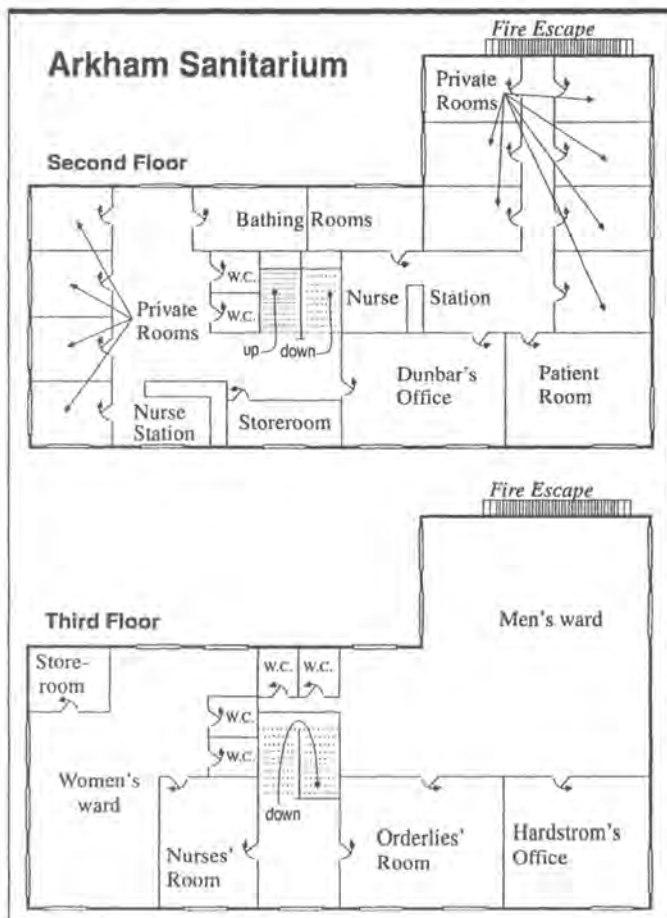
Thanks to Dr. Hardstrom, the patients have been unchained. Even humane restraints such as straitjackets are rarely used, though the windows remain barred. Patients

are drugged only when behavior grows reckless or dangerous. The most common prescriptions are for sleep-producing and sleep-alleviating drugs, and anti-depressants. Simple dietetics have shown improvement in some cases. Lacking adequate funds, though, the amount of treatment received at the sanitarium is sadly proportional to the amount paid for treatment. Indigent patients are lucky if they get a full medical examination and treatment once a month, while patients in private rooms get at least one or two treatments a week.

Dr. Hardstrom has also attempted to create more similarity between the world outside and the institution. This has taken several forms. Some of the old cells have been converted to a large recreation room (the interior of the old house has been rebuilt twice, accounting for its peculiar floor plan). Patients mingle, under supervision, and read current papers and magazines to keep in touch with the outside world. Creative projects are also encouraged by Dr. Hardstrom. Several patients have artistic projects under construction in the recreation room. Finally, Dr. Hardstrom has introduced an institutional newsletter, the *Pickering Paper*. This is administered by Dr. Harcourt and allows verbally creative patients to express their views and keep the other inmates informed and entertained.

Normal in-patient care costs \$110 per month. This pays for food and lodging in one of the open wards as well as treatment and necessary drugs. A private room costs double this, and also ensures greater access to treatment. Paupers may be admitted if space allows, and their needs are paid for by public funds. They are not guaranteed treatment, although their physical needs will be well taken care of.





## Ground Floor

**Reception Area:** a large, well-lit open room with several comfortable sofas and pleasant wall paintings. The carpet shows wear, but the area is, in general, scrupulously clean.

**Parlor:** contains several small tables with chairs and a large, upright piano.

**Nurse Station:** here are various supplies and papers needed for the reception area. This is where the assistant to Dr. Hardstrom is stationed. All official paperwork and appointments must go through the assistant first.

**Storeroom:** this storeroom is primarily for stationery and forms.

**Dispensary:** this contains all the regular and psycho-reactive drugs used in the hospital. Anti-depressants and local concoctions of the staff are stored here. The drugs are dispensed by Dr. Harcourt and stocked by a local pharmacist.

**Dr. Harcourt's Office:** cluttered with piles of files, paper work, and partially full drug bottles, it is barely possible to walk through this office to the dispensary. If one can locate the doctor, they will find him as untidy as his room. Despite the appearance of incompetence, Dr. Harcourt is an outstanding physician who never loses anything.

**Dining Room:** contains enough small tables to seat half the residents at a time.

**Kitchen:** spacious and orderly, it fits the needs of a large institution. The door to the basement stairs and the fuse box to the building are in this room.

**Pantry:** This small unlit room is full of shelves with jars and cans of food. Sacks of flour and potatoes line the floor.

## Second Floor

**Nurse Stations:** there is usually one nurse stationed at each of these areas, serving the private patients. Each area contains extra towels, soap, linens, snacks such as raisins and nuts, and other supplies to keep the patients happy.

**Private Rooms:** for those with money, this is the way to go. Each private room has a single bed, dresser, desk. There is space for personal belongings and a small bell on each desk for summoning the nurse. The rooms on the left side of the floor, closest to the stairs, are usually reserved for women while those to the right rear of the building are for men. All the rooms are currently full.

**Storeroom:** this small room contains supplies for the water closets and extra materials for the private rooms.

**Dr. Dunbar's Office:** Dr. Dunbar is in charge of the patient's physical health. He sees them all on a regular schedule that gives obvious preference to paying patients. In all respects, his office is ordinary, except for his collection of prosthetic devices.

**Patient Room:** this is the room where Dr. Dunbar does his regular physical examinations. Standard medical instruments and supplies like bandages are stored here.

**Bathing Rooms:** the residents of the private rooms get full use of these two facilities. Patients on other floors are herded here in groups once each day. One room for each sex.

## Third Floor

**Nurses' Room:** there is a single cot and desk in this room. Wall shelves are stuffed with bed linens and gowns. At least one nurse is stationed here day and night. The desk is beside small windows that survey the entire ward. Going through this room is the only way to get to the women's ward.

**Women's Ward:** this open room contains ten simple beds along the walls. There is a small locker for personal belongings near each bed. Only two of the beds are unoccupied at present. Easily movable screens give some privacy to the residents.

**Men's Ward:** a larger version of the woman's ward, this room contains twelve beds, of which ten are currently filled.

**Storeroom:** linens and medical supplies needed for the men's and women's wards. It also contains personal possessions that patients are not allowed to keep with them.

**Orderlies' Room:** There is a single cot and a desk and chair. Smoking is forbidden here, because of the fire hazard, but sometimes occurs. Going through this room is the only way into the men's ward. At least one orderly is in attendance day or night, at a desk that surveys the entire ward through small internal windows. Fresh bed linens and towels line one wall. Connected to Hardstrom's office, the orderlies chosen for this post are usually literate, and may also assist the doctor in his paperwork when their duties allow.



**Dr. Hardstrom's Office:** as prim and proper as the doctor himself, this room practically shines. Small piles of paperwork dot the surface of the two large desks in the office. There is no art or ornamentation of any kind in the room. One shelf contains all the latest writings in psychiatry, including a collection of Freud's and his followers' recent papers, nearly all in German.

## Basement

**Recreation Room:** this room contains tables and paraphernalia for cards, cribbage, chess, and other amusements. There are magazines and local newspapers. Here you can find several of the latest copies of the *Pickering Paper*. One corner of the room is reserved for art projects under construction and currently there are some poor quality water colors and clay sculptures here. Patients are allowed here only during approved hours and under supervision.

**Indigents' Ward:** eighteen narrow iron cots with chipped and peeling paint are crammed into this room. Tattered curtains are draped between beds for limited privacy. There are currently eight men and ten women filling the room, separated by the orderly's desk. Narrow windows at the ceiling let in the only natural light.

**Scrub Room:** a small room with sinks and cleaning supplies, as well as a line of coat hooks and extra gowns.

**Surgery:** a moderately equipped operating room for taking care of the medical needs of the patients. It has the usual table, lights, trays, and instruments.

**Laboratory:** the clinical lab. Contains microscopes, incubators, an autoclave and various other pieces of analytical medical equipment. The shelves are full of medical and pharmaceutical reference books. Test tubes, beakers and chemical storage bottles cover the lab tables. Each of the three doctors loves to spend some time each week experimenting with various drug combinations to cure various disorders.

**Storeroom:** houses various materials needed by the sanitarium. Cots, towels, medical supplies, janitorial gear, massive cans of food, and straitjackets make up the bulk of this room's contents. Personal belongings left behind by patients eventually make their way here. Who knows what strange items have accumulated over the last half century?

## Staff

The following staff members represent just some of the more important employees at Arkham Sanitarium.

### DR. ERIC HARDSTROM, age 45

STR 11 CON 12 SIZ 13 INT 17 POW 14  
DEX 12 APP 11 EDU 21 SAN 70 HP 13

**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** Credit Rating 45%, Bore Listener 37%, German 60%, Medicine 78%, Persuade 51%, Pharmacy 48%, Psychoanalysis 70%, Spot Hidden 35%.

**Quote:** "Would anyone like some tea?"

Dr. Hardstrom is a boring, dedicated, and hard-working man who cares. He personally gets to know all his wards and does all that he can to better their condition. He tries to use the most modern treatments available and is not adverse to newer, experimental treatments. Dr. Hardstrom is a follower of the new school of psychoanalysis and is currently planning a trip to Vienna to study with Sigmund Freud.

### DR. BRADLEY HARCOURT, age 31

STR 12 CON 11 SIZ 15 INT 16 POW 17  
DEX 12 APP 10 EDU 21 SAN 75 HP 13

**Damage Bonus:** +1D4.

**Weapons:** none.

**Skills:** Bureaucracy 66%, Medicine 76%, Pharmacy 53%, Psychoanalysis 32%.

**Quote:** "Please fill out these papers while I talk to Dr. Hardstrom."

Dr. Bradley Harcourt has only been at Arkham for a year, and is already thinking of leaving, because Dr. Hardstrom has overburdened him with dull paperwork. Harcourt would already have left if not for the presence of nurse Trudy Houghton, for whom he has developed a great affection. He is very shy and has not yet broached the subject of romance with her, but she has seen the signs and is a patient woman. Hardstrom would be quite distressed that he had burdened the young doctor, and if it is ever brought to his attention, will quickly correct the situation. Young Harcourt does keep the asylum running smoothly.

### TRUDY HOUGHTON, age 23

STR 10 CON 9 SIZ 12 INT 13 POW 14  
DEX 14 APP 14 EDU 13 SAN 60 HP 11

**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** First Aid 69%, Gossip 80%, Medicine 35%, Pharmacy 25%.

**Quote:** "I'm afraid the doctor is busy. Take a seat please."

Trudy is the receptionist for the asylum. She went into nursing to find a handsome young doctor to marry. While Dr. Harcourt isn't very handsome, Trudy couldn't help developing feelings for him, but does not want him to see her as forward. She is friendly and chatty. She will be happy to converse with those waiting to see one of the staff or patients, and is a good source of information.

### BILL FILIOS, age 62

STR 8 CON 9 SIZ 11 INT 10 POW 13  
DEX 6 APP 12 EDU 10 SAN 51 HP 10

**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** Cthulhu Mythos 10%, Listen 83%, Sweep Floors 92%, Taste Beer 57%.

**Quote:** "This is the best beer I've had all day."

The old janitor has been working in the sanitarium as long as anyone can remember. He does his job competently, but the years of close contact with the insane have affected him. Often, Filios can be heard mumbling about some horrible

tale or other he has overheard from the patients. He is a chronic alcoholic.

## Resident Patients

The majority of patients at Arkham Sanitarium are less extreme than the few listed below. The following patients have been chosen because they may be of interest to any players visiting or residing in the asylum. Most Arkham patients are victims of mild schizophrenia or some type of manic-depressive disorder. There are also some cases of paranoia and paralysis due to cerebral syphilis. Other patients are senile or feeble-minded.

### TROY BANKERT, age 27

STR 13 CON 13 SIZ 11 INT 14 POW 10  
DEX 12 APP 12 EDU 16 SAN 35 HP 12

**Damage Bonus:** +0.

**Weapons:** Fist 66%, damage 1D3

**Skills:** Fast Talk 79%, Glare Angrily 56%, History 34%, Persuade 60%.

**Quote:** "How can you not see that?!"

He was committed two years ago, after killing a man in a pub brawl during an argument about what beer was best. While Troy Bankert is generally harmless, the staff are under orders to quickly restrain him when he starts arguing with someone. The topic is irrelevant; he will be convinced he is correct and if he is unable to convince his victim, he quickly works himself into a dangerous rage. Attendants and nurses keep a close eye on Bankert because he resides in the men's ward and has plenty of opportunities for conversation.

### CHRISTOPHER CLEOWN VAN HORN III, age 87

STR 6 CON 7 SIZ 11 INT 12 POW 13  
DEX 4 APP 10 EDU 14 SAN 46 HP 9



**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** Arabic 23%, Aramaic 44%, Archaeology 75%, Credit Rating 95%, Fast Talk 67%, Geology 25%, Hebrew 45%, Latin 11%, Occult 20%, Turkish 49%, Spot Hidden 83%, Whine Annoyingly 64%.

**Quote:** "I am not whining."

Mr. van Horn is a well-known archaeologist who grew rich finding and importing rare artifacts from the Holy Land which he sold to United States collectors. After he began having horrible visions, hearing and seeing things in his mansion that were not there, his bickering and greedy children had him involuntarily committed. When van Horn does not get his way, he whines until he does. He is an intelligent man, but cursed with an abrasive personality that frequently makes people go out of their way to dislike him. He is currently in the private room closest to the Patient Room.

### ELIZABETH CAROLINT, age 19

STR 10 CON 10 SIZ 11 INT 6 POW 15  
DEX 17 APP 13 EDU 6 SAN 75 HP 11

**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** Art (Fingerpainting) 38%, Giggle 88%, Hide 43%.

**Quote:** "Oooo... Can I have some too?"

Elizabeth (Lisa to the staff and other patients) never made it past the mental age of six. She passed from one public institution to the next until finally finding a home in Arkham. While not technically insane, Lisa is incapable of caring for herself and has no relatives willing to support and care for her. Her friendly, childlike personality is one of the few bright spots in the indigent ward. As a pauper, Lisa is not due any actual treatment, but Dr. Hardstrom is intrigued by her case. He therefore spends a little time each week trying to ascertain whether her condition is purely physical, or if some horrible shock or secret is keeping her adult mind locked away.

### CLIVE, age 30?

STR 10 CON 10 SIZ 11 INT 14 POW 12  
DEX 15 APP 8 EDU 13 SAN 24 HP 11

**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** Forget Trauma 92%, Hide 45%, Play Piano 15%, Sneak 80%.

**Quote:** "Is the piano free?"

Clive is an amnesiac who was found wandering the streets of Kingsport in a bewildered daze (see H.P. Lovecraft's "The Festival"). He has remained a mystery since that Christmas in 1922. One of the staff named him. Totally harmless, Clive is often found in the parlor playing the piano badly. The doctors consider Clive a lost cause. He is no longer under any treatment plan. He is supposed to stay in the indigent ward, but the staff have grown so used to him that they often let him wander about freely and give him access to the piano as long as he closes the door to the rec room.

## Scenario Statistics

### Detective RAY STUCKEY, age 43

STR 15 CON 15 SIZ 15 INT 15 POW 11  
DEX 15 APP 12 EDU 9 SAN 45 HP 15

**Damage Bonus:** +1D4.

**Weapons:** Fist 65%, damage 1D3+1D4

Grapple 55%, damage special  
Nightstick 50%, damage 1D6+1D4  
.45 Revolver 55%, damage 1D10+2

**Skills:** Dodge 54%, Drive Automobile 45%, Fast Talk 55%, Law 25%, Sneak 20%, Spot Hidden 50%, Track 15%.



## THUGS, ages 16-25

	#1	#2	#3	#4	#5	#6
STR	17	15	14	15	16	14
CON	12	14	14	11	18	9
SIZ	15	17	17	14	15	13
POW	14	11	11	9	10	14
DEX	9	8	14	14	11	11
HP	14	16	16	13	17	11

**Damage Bonus:** +1D4.

**Weapons:** Fist 65%, damage 1D3+1D4

Head Butt 30%, damage 1D4+1D4

Kick 50%, damage 1D6+1D4

**Skills:** Curse 31%, Dodge 40%, Intimidate 57%.

## ROBERT VAN HORN, age 28

STR 9	CON 8	SIZ 12	INT 9	POW 11
DEX 11	APP 16	EDU 12	SAN 55	HP 10

**Damage Bonus:** +0.

**Weapon:** .45 Revolver 25%, damage 1D10+2

**Skills:** Credit Rating 25%, Fast Talk 15%, Law 15%, Persuade 25%.

## GHOULS

	#1	#2	#3	#4	#5	#6	#7	#8
STR	18	16	16	18	18	14	17	14
CON	14	11	14	13	14	14	8	11
SIZ	10	16	14	12	13	17	15	18
POW	16	13	17	15	13	14	13	11
DEX	16	17	14	10	14	11	15	14
HP	12	14	14	13	14	16	12	15

	#9	#10	#11	#12	#13	#14	#15
STR	19	12	16	16	15	17	17
CON	8	10	16	15	12	11	16
SIZ	13	13	14	13	12	16	12
POW	13	12	13	13	13	15	11
DEX	16	16	13	17	11	16	13
HP	11	12	15	14	12	14	14

**Move 9**

**Damage Bonus:** +1D4.

**Weapons:** Claw (x2) 30%, damage 1D6+1D4

Bite 30%, damage 1D6 + automatic worry

**Armor:** firearms and projectiles do half of rolled damage.

**Skills:** Burrow 75%, Climb 85%, Hide 60%, Jump 75%, Listen 70%, Scent Decay 65%, Sneak 80%, Spot Hidden 50%.

**Sanity Loss:** 0/1D6.

See the ghoul description in the *Call of Cthulhu* rules for more information.

## Scenario Ideas

### THE MYSTERIOUS STRANGER

A stranger has arrived in town, and wants the investigators to determine the true identity and background of Clive, an amnesiac in the Arkham Sanitarium. Perhaps he is a cultist looking for others, and expects Clive to lead him to new friends. Then again, he might be a government agent investigating cultist activity in the area. Even if he is just a

friendly philanthropist with Clive's best interests in mind there should be something interesting to be found. See H.P. Lovecraft's "The Festival" for more information. A trip with Clive back to Kingsport would probably be helpful, but will the hospital agree to let him leave? And if so, what will happen if Clive's memory does return? There may be people in the area who do not wish to see Clive back in Kingsport, at least not alive.

### THE MUMMY'S HAND

Dr. Hardstrom has a problem he needs investigated. One of the patients in the men's ward had his personal belongings rechecked recently. In his bag, the staff found something that was not present when he entered the facility, a mummified human hand. This is probably a job for the police, but Dr. Hardstrom would also like this problem cleared up without public exposure if possible. He has informally alerted the police through Chief Nichols, who has given him ten days to clear up the matter before the police get involved. Where did the hand come from? Did the patient sneak out and get it, did a strange visitor bring it in or is there an even more sinister answer? Dr. Hardstrom will use drugs and psychoanalysis to help in questioning the patients, but he hasn't had much luck yet.

### THE FAITHFUL GRANDDAUGHTER

The young granddaughter of Mr. van Horn is convinced that her relative is not insane, and does not belong in Arkham Sanitarium. She has come to plead with the staff or anyone else that she can convince, begging them to help prove his delusions really occurred. As she is due to inherit a large part of van Horn's fortune, she can offer rewards as necessary. What is going on in Mr. van Horn's mansion? Is it really haunted, or are other sinister forces at work? Talking to Mr. van Horn may help a little, but he is long past his prime.

### THE ODD INDIGENT

There's a new patient in the indigent ward with some decidedly odd behavior, even for Arkham. Troy Bankert has a theory, though, and is happily conveying it to the staff and other patients. Troy thinks the new patient is some kind of space creature and will describe in graphic detail the monster's real appearance. Is Troy right? Is there another explanation for the new inmate's behavior? Why are the doctors not concerned? Perhaps this creature has some type of mental powers. Then again, Troy has a pretty active imagination.

### THE INVESTIGATION

The last drug inventory by Dr. Harcourt came up alarmingly short. Is someone stealing the drugs? Dr. Hardstrom hires some investigators to get to the root of this problem. Is it the mysterious new patient in the indigent ward? Perhaps one of the staff is having problems with gambling debts and is selling supplies. The janitor may know something, but he's not talking sense. He keeps mumbling about zombies and ghouls and how smart patients shouldn't go to sleep in the wards at night.



## THE MIRACLE DRUG

Dr. Hardstrom has been experimenting again. This time, he has created a seemingly perfect miracle drug that cures almost any mental aberration. Many patients have been released since their cures, and Boston psychiatrists have begun to take an interest in Hardstrom's panacea. Unfortunately, Dr. Hardstrom has just discovered that his cure is very temporary. Nonetheless, there may be a Nobel Prize in it for Hardstrom, since even a temporary cure is vastly more useful than no cure at all. But the investigators need to track down the "cured" patients before the drug wears off, or Hardstrom's reputation will be ruined. And if they find the newly-released patients, will the no longer insane patients believe that they must return to the hospital? Some of those released patients may be a danger to themselves and others when the drug wears off.

## A DIRE COMPLAINT

Bill Filios, the janitor, has quit the Sanitarium and is drowning his sorrows in alcohol at the local pub. He is telling all who will listen of the horrors that made him quit, but who would believe such horrors could happen in such a reputable establishment? His tale may be of strange experiments, or of bizarre creatures that wander about the hospital. How can Dr. Hardstrom remain so staid and calm with all this going on? Any investigator with some Cthulhu Mythos skill will recognize some truth in Bill's rambling. This had better be looked into before something terrible happens!

## CATS' PAWN

When ex-patients leave personal belongings at the Sanitarium, the items eventually end up in the basement store-

room, tagged and cataloged. One of the nurses happened to notice a small black idol in one of the corners while getting supplies, and placed it upon the desk in the indigent room as a paperweight. Since then, the indigent patients have been remarkably well-mannered. There has also been a vast increase in the number of cats in the neighborhood. And who is that robed person seen skulking around east Derby Street? What is going on here?

# The Curse of Anubis

**I**N ARKHAM SANITARIUM dwells Christopher van Horn, an aged archaeologist who has been confined by his own family. Van Horn swears that he still retains his sanity, but van Horn's children keep him locked away. The Sanitarium's staff do not believe him, for he sometimes raves about ancient curses that have been set upon him by long-dead Egyptian priests. When the investigators arrive in Arkham, they find truth in van Horn's ramblings. He, or rather things that he owns, are being stalked by awful subterranean creatures.

## KEEPER'S INFORMATION

Retiring from active archaeological life, Christopher van Horn continued to fund expeditions to the Middle East. Hundreds of artifacts recovered by these expeditions now line shelves in his home. The most successful of these expeditions was a dig in British Palestine just four months ago.

When van Horn was brought the Phoenician items from this latest expedition, he was elated. Among the artifacts were a medallion, a figurine, and a clay bottle. The figurine depicted a crouched man eating the flesh from a human arm. The bottle and medallion, both bore certain ancient Egyptian symbols connecting them with a cannibalistic religion that he had seen previously expressed in the ruins of Bubastis, an ancient Egyptian city.

Van Horn dispatched another expedition, hoping to be able to trace the spread of the religion. van Horn realized that it might be decades before the pieces were finally put together, and that he would likely die long before then. He rewrote his will. Deciding against giving money to his greedy, bickering nephews. He created a trust to continue the study of the macabre Egyptian religion forever.

Christopher van Horn was not the only one interested in the recent recoveries, for the items sent visions among the ghouls of Arkham. The three artifacts had been ceremonial to the Egyptian Cult of Ghouls. As the sands covered Bubastis, the cult of the ghouls dwindled and fled. The ghouls moved on as well, to fresher graves. Though someone held the artifacts, a priest of the cult perhaps, belief died out in Palestine, and the items were lost and forgotten. But in the Arkham area many ghouls wander, and some of them now sensed the ancient power of van Horn's artifacts, and of them a hesitant few dimly sought the source of these atavistic dreams. In this they were mostly baffled, for van Horn kept the bottle at his home,



the medallion with him in the Sanitarium, and the figurine in a safe deposit box at Arkham First Bank. The dreams persisted, and some ghouls were left restless and chittering even when burials were plentiful.

Van Horn then had bad news from Palestine. Several members of the expedition had been slain, and rumor said the digsite was cursed. When van Horn began to see the shapes and hear the noises of the prowling baffled ghouls, he came to believe that the curse had descended upon him. A few nights later, van Horn peered out his window and saw a bestial, inhuman face staring in at him through the glass. Grabbing his shotgun, van Horn fired wildly into the darkness.

When the police arrived, van Horn raved about the jackal-headed followers of Anubis who had come for him in the night.

Very shortly, the police told of Christopher van Horn's odd behavior to his eldest nephew, Robert. Robert had been the primary beneficiary of Christopher's old will. Now promised only a pittance, Robert saw an opportunity to regain that wealth. Moving quickly, he had his uncle involuntarily committed, proclaiming that he was clearly a danger to both himself and others, using the police report concerning the shotgun blasts. When Uncle Christopher dies, Robert believes that he can successfully contest the revision, since the old man was committed to an asylum soon after he altered his will.

## The Investigators

In order to get the adventure rolling, the keeper needs to convince the investigators to help Christopher van Horn prove his sanity. Optimally, one of the investigators could be an old friend or trusted relative of van Horn. The investigator will receive a letter from van Horn asking him to come to Arkham.

Or the investigators could be hired by Melissa van Horn, Christopher's grand-niece. She has recently received a letter from her grand-uncle and believes his claims of sanity. However, she doesn't think that she can be of much aid, and thus she hires the investigators to help her grand-uncle out.

In either case, the investigators should be given Christopher van Horn's letter (*Player Aid #2*). Shortly afterwards, the players should be headed for Arkham Sanitarium.

## Arkham Sanitarium

Arkham Sanitarium will likely be the investigators' first stop in Arkham. The reception area is a clean, well-lit room. There, the investigators will be greeted by Trudy Houghton, the receptionist. She will be quite happy to answer the investigator's questions about Mr. van Horn, but will refuse to let the investigators see him. She'll explain that it is against Sanitarium policy for any patient to receive visitors, and that exceptions to this rule can only be made by Dr. Harcourt. With some encouragement, Trudy can be convinced to ask the doctor to come out and speak with the

October 13

Dear \_\_\_\_\_,

*Let me apologize in advance for imposing upon you, but I am afraid that I have found myself in the most dire straights.*

*I am now confined to Arkham Sanitarium, surrounded by doctors who constantly tease and torment me, proclaiming the whole time that I am insane, and the horrors that I have faced in recent months are all hallucinations.*

*I am afraid to put pen to paper, and recount my trials, lest you think me as insane as the doctors here. So please, let me beg you, come to Arkham, and I will explain everything. I desperately need someone to prove my sanity, else I will be confined to this asylum for the rest of my days.*

*Sincerely,*

*Christopher van Horn*

investigators. It will take Dr. Harcourt some fifteen or twenty minutes to tear himself away from his current work.

Ms. Houghton knows the public facts of the van Horn incident. She is happy to explain to the investigators that he went mad on October 3rd, and started firing his shotgun. When the police came to speak with him, he proclaimed that jackal-faced servants of Anubis had been harassing him. He had seen one peering into his window, and he had shot at it, hoping to slay the beast. A few days later, Christopher van Horn's eldest nephew, Robert, had him committed.

If the investigators do not all know each other, it is a good time for them to meet while waiting for Dr. Harcourt to arrive.

Eventually, Dr. Harcourt emerges from his office, looking disheveled and harried, apologizing profusely for delaying the investigators for so long. Dr. Harcourt asks their reason to see van Horn. Unless the investigators can give an extremely convincing reason, proclaiming that vitally important legal matters require them to speak with van Horn at once, or something similar, they then will be asked to wait again, while Dr. Harcourt goes upstairs to speak with Dr. Hardstrom, whose patient van Horn actually is.

When Dr. Hardstrom arrives, he explains that van Horn has been upset and excited since his commitment, and that he needs unbroken rest. If the majority of the investigators receive successful Credit Rating rolls, or happen to have

psychoanalytic or psychiatric expertise, Hardstrom will waive his fears, noting that the investigators are obviously responsible, prudent people who will provoke no new incident. Lacking that, Hardstrom carefully interviews the investigators. If they admit that they want to prove van Horn's sanity, Hardstrom tries to discourage them, saying that van Horn's progress might be hindered if others accept his delusions as truth. However, unless the investigators seem overly dangerous or suspicious, Hardstrom eventually brings them to see van Horn.

## A TOUR OF THE ASYLUM

Hardstrom is proud of the work that he's doing at Arkham, so once he allows the investigators into the Sanitarium, he'll insist upon a tour of the whole facility. The tour will include the medical facilities in the basements, the recreation room, and the various wards. As they tour the wards, the investigators will get a chance to meet the most interesting inmates, among them the resident patients for whom statistics were given earlier.

During the tour, Dr. Hardstrom gives long, detailed explanations, the keeper perhaps reading in a drone from the **Lunacy** chapter, hopefully boring the investigators. If the investigators ask Dr. Hardstrom to bring the tour to an end, and to take them to van Horn, he is slightly offended, but does so.

## Christopher van Horn

At the door to Christopher van Horn's private room Hardstrom reminds them not to upset van Horn, and then leaves,

telling the investigators to report to the nurse's station when they're done.

Van Horn is immensely pleased to see the investigators and chats comfortably with them, to convince them of his sanity. (A successful Psychology roll establishes that he has been under unusual stress, but that he is completely sane.) When he is sure that they accept him, van Horn moves on to the issue at hand.

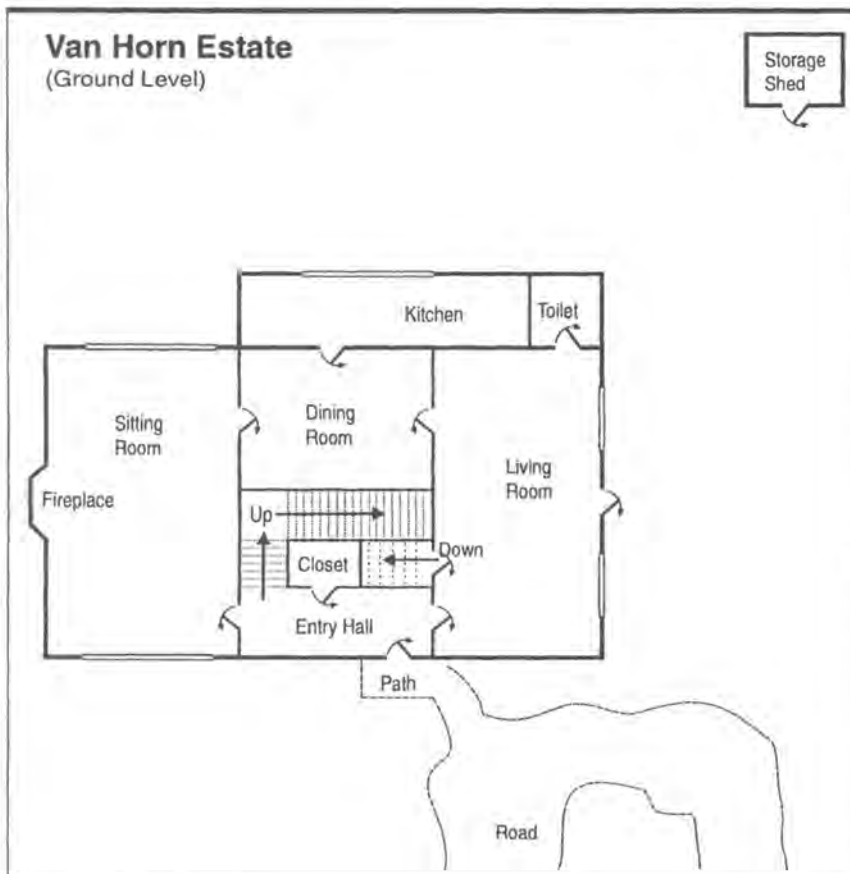
He summarizes the events surrounding the Palestinian expedition, and mentions the importance of the three Phoenician artifacts. If the investigators seem interested, van Horn spends considerable time talking about the flesh-eating cult of Bubastis, and explains how important it might be that artifacts of the same cult were found in faraway Palestine.

As he talks, van Horn will reach into his shirt and pull out the medallion which hangs around his neck. It is one of the three artifacts from Palestine. Van Horn will also carefully describe the clay bottle and the figurine, the first of which is in a display case above his fireplace. Under no circumstances will van Horn give up his medallion. He will explain that it is the only thing that keeps him sane, reminding him that what he saw was real, and not some delusion, as Dr. Hardstrom suggests.

Then came the letter from Palestine, written by Carter Keezar, the young man overseeing the Palestine dig. Keezar was frantic. It said that a curse had befallen the expedition, and that two of the workers had been killed, each slain by a wild beast that had broken their bones and gnawed away their flesh. Keezar advised van Horn to destroy the three artifacts at once. If asked for the original, van Horn replies that Keezar's letter is in the top drawer of his desk.

It was about then that van Horn occasionally heard things moving outside at night. Once something got into a storage shed, and knocked its contents all about. Van Horn's pet dog, Lizzy, got out one evening and was found the next morning, ripped apart. When van Horn saw the jackal-faced creature peering in the window, he felt both terrified and confirmed. He shot it once and is sure that he hit it, and then fired several more times out into the darkness for good measure, but upsetting the neighbors no end. He chides himself for not lying to the police.

Van Horn closes by talking about his treacherous nephew, Robert, who had him locked away. He'll whine tediously for a while about the lack of family loyalty in the younger generation. Van Horn will be happy to answer questions. He's quite convinced that he has been cursed for unearthing the Phoenician artifacts, and that servants of Anubis truly tried to slay him.





## Van Horn's Country Place

The investigators will probably decide to head out to van Horn's residence, to look for evidence of the jackal-faced creature, and to see Keezar's letter for themselves. There should be plenty of evidence to suggest that all is not right.

Van Horn tells them his nephew has probably locked up the place tight as a drum, and won't be interested in cooperating with them. He says that a key is hidden in the foundation of the storage shed. "Never locked the place ever, until I started hearing them things skulking around. Then I got out the keys, sure enough, and oiled the locks to boot!"

Located several miles north of Arkham, the van Horn estate is removed from even the placid pace of life in Arkham. The entire area is secluded, almost abandoned, with many groves of young trees reclaiming old farms one by one.

### THE GROUNDS

Trees cover most of the grounds of the van Horn place. A couple of times a year, a gardener comes to cut back limbs and bushes that are overgrowing the house, but the trees beyond are not touched by human hands.

If an extensive search of the grounds is done, the players should attempt Track rolls. Any successes will result in a discovery of another cloven hoofprint in soft soil near the house. The print looks like it could have been made by a large deer, but hunters among the investigators will know that it looks more like the mark of an improbably large goat.

If the outside of the house is examined, the players should make Spot Hidden rolls. Successes reveal that in several different places the paint on the outside of the house has been scratched away by sharp points, sometimes three or four points together, like a garden claw.

The front window of the sitting room was shattered. Buckshot and glass litter the ground in front of the window, but nephew Robert's workmen have boarded up the window itself. A successful Spot Hidden roll reveals dried blood on some of the shards of glass. Though the blood is now old and weathered, of dubious value, tests done upon it suggest that it is not human.

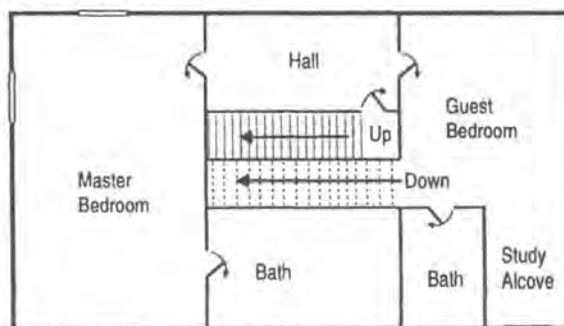
A bit to the rear of the house sits a storage shed. The door lies to the side, ripped from the hinges. Inside the shed are various gardening supplies, thrown all about. Some of the gardening tools are broken and useless. The spare key to the house is hidden in a cranny in the stonework beneath the door.

### THE HOUSE

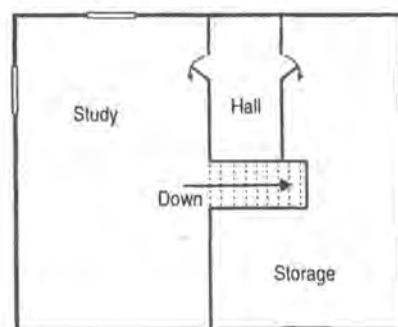
Only the most interesting of the rooms of van Horn's house are detailed below. The rest of the rooms contain opulent, somewhat dated furnishings, but nothing unusual. An investigator going through van Horn's house should have no doubt that he is well off, though the home itself is quite ordinary.

## Van Horn Estate

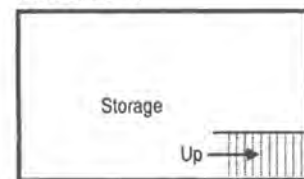
### Second Floor



### Third Floor



### Basement



### THE SITTING ROOM

Here van Horn displays many of the treasures won from various archaeological digs. Shelves line the back wall, to both sides of the fireplace. Artifacts of all shapes and sizes sit upon them. Most of the artifacts are from Egypt and Palestine. Van Horn's most valuable artifacts sit in a display case on the mantelpiece. In it is the Egyptian bottle that van Horn described. Several other items are in the case, including a beautiful Egyptian sculpture of a golden cat.

As noted earlier, the front window of the sitting room has been blown out by a shotgun. The shotgun still sits in the room, next to a chair.

### THE STUDY

The study is the most crowded room in the house. Floor to ceiling bookshelves line every wall, filled with books of every description. Investigators interested in archaeology and the Middle East will find plenty of interesting information. If the investigators make a Spot Hidden roll while searching the book shelves, they will find a copy of *The Ghoul Cults of Bubastis* written in archaic English. It describes the practices of an ancient Egyptian cult that

Player's Aid #3  
Letter From Robert van Horn

September 3

Dear Uncle Christopher,

*I spoke with your lawyer a few days ago and must say that I am most distressed. Saltonstall told me that you had recently changed your will, and are planning to spend nearly all of your fortune upon some scientific project in Phoenicia. I am astounded that you could care so little for your own family, and can not help but wonder if you are entirely aware of your actions. Could we please get together some time and talk about this?*

Sincerely,

Robert van Horn

Player's Aid #4  
Letter From Carter Keezar

September 18

Dear Christopher,

What I write in this letter may seem fantastic, but I beg you, please heed my warnings. Over the last two days, two workers on the Palestine expedition have been slain. Their deaths were brutal, too awful to describe. It looked like some huge animal had got at them, rending them limb from limb.

Even before I sent you the artifacts that we had uncovered so far, I had heard it said that a curse would fall upon any who disturbed the graves of the dead. I ignored it at first, but now I can no longer. Just as the natives predicted, the vengeance of the dog god had fallen upon us. I plan to walk out to the desert tonight, carrying the items that we have uncovered. I will leave them there, on the cold sand, to be covered once more, by the winds. I hope it will be enough, that I will be allowed to escape this damned place alive. I beg you, abandon the three items that I have already shipped to you, lest your life be put at risk too!

Carter

worshiped flesh-eating beasts. The book is worth +2% Cthulhu Mythos and costs 1D4/1 sanity points to read. There are no spells.

On the front wall sits a huge hardwood desk. Cluttered papers cover most of the desk surface and fill the drawers. Investigators searching the desk will find any number of useless letters and notes as well as: Christopher van Horn's current will, a letter from Robert van Horn (*Player Aid #3*) and a letter from Carter Keezar (*Player Aid #4*).

The will, dated August 10th of the current year, leaves almost all of Christopher van Horn's money to the Palestinian Archaeological Trust, a financial arrangement created to continue fund work van Horn thinks valuable, even after his death. Very little money is left to Christopher van Horn's surviving relatives.

## STORAGE ROOMS

The storage rooms are piled full of boxes, papers, and every manner of strange and bizarre objects. Although there is nothing in the store rooms pertaining to the current case, if the keeper wishes to introduce some odd artifact for a future scenario, this would be an ideal place.

## Encounters

Robert van Horn is not too happy about the investigators trying to prove that his uncle is sane. Thus, when they begin nosing about the van Horn estate, Robert will do what he can to run the investigators off the land. He'll try to do this first by sending Detective Stuckey, and then a band of thugs out to the estate. These two encounters should be separated by about a day.

## MEETING THE LAW

Shortly after the investigators show up at the van Horn place, Detective Ray Stuckey arrives in an Arkham police car. He'll tell the investigators that they're trespassing, and that they have to leave the land. Stuckey smiles if he's told by the investigators that they have Christopher van Horn's permission to be on the estate. Confined in an asylum by a guardian, the elder van Horn has no legal rights.

However, if one of the investigators is a relative of van Horn, or can prove that he has the permission of a relative, Stuckey will relent, since he is simply doing a favor for a well-known member of the community. He will be very interested in the investigators if they are new to the Arkham area, and may do some checking on them when he returns to the office.

If the investigators strike Stuckey as being decent sorts (one successful Credit Rating roll), he mentions casually that trespassers have been a worry in Arkham, too, both around Arkham Sanitarium and around Arkham First bank for several weeks. "Some folks claim to have seen big things sniffing around, like dogs but on two legs—and they clatter when they run," Stuckey laughs. With a successful Idea roll, the investigators remember that the three sites contain the three artifacts that van Horn found significant to the flesh-eating cult of ancient Bubastis.

## THUG ATTACK

If the investigators are still hanging around the property on the following day, a group of six thugs arrives to drive away the investigators. They'll do their best to intimidate the investigators, and perhaps rough them up, but aren't dumb enough to do serious injury or damage to property. After all, each guy is only getting a sawbuck for the job.

## Arkham

During the adventure, the investigators might decide to follow up leads in the city of Arkham. Following are some of the places in Arkham that investigators are likely to visit.

### ROBERT VAN HORN'S RESIDENCE

Robert van Horn lives in the Uptown district of Arkham, near the corner of West Street and West Miskatonic Avenue. The investigators might pay a visit on Robert if they believe that he is behind the weird night visitations at the van Horn place, as part of an elaborate scheme to reclaim his inheritance.

While Robert is greedy and heartless, and he does hope to use his uncle's misfortune to his advantage, he is not nearly intelligent enough to concoct such a plan. He will be astounded at such an accusation. Robert will do his best to convince the investigators that his uncle is totally insane. If that fails, he will turn nasty, and begin threatening the investigators with all manner of reprisals.



Robert van Horn

### ST. MARY'S HOSPITAL

If the investigators are looking for a mundane solution to the strange night movements at the van Horn place, they may come to Arkham's only hospital to learn if anyone was treated for shotgun wounds on October the 3rd. The nurses at the hospital will not open their records, but say without hesitation that no shooting victims were treated since July, when young Cabot Jenkins shot himself in the foot with his .22 rifle.

### MISKATONIC UNIVERSITY LIBRARY

At the Miskatonic University Library, the investigators may find information on the Egyptian cult of flesh-eaters which van Horn believes has cursed him. They find nothing of particular interest in the main stacks.

Dr. Henry Armitage maintains a restricted set of Mythos books. The investigators need to convince him to let them have access. After the Whately incident, Armitage is quite nervous about letting people see the books. If the investigators seem like good, honest people (a successful Credit Rating roll will do), they convince him. Learning that the investigators are trying to help a poor old man prove his sanity would probably be sufficient to convince Armitage to allow access to these rare books.

If the investigators gain access to the restricted collection, they should make Library Use rolls. Success will

reveal many interesting passages in Miskatonic's copy of *Cultes des Goules*. Although the book is mostly about necromantic practices in France, it traces the history of the race of ghouls, starting in ancient Egypt, where they were worshiped by some as gods. The book also talks about certain items of power that the cults of ghouls used. The items were covered by the same runes which adorn the pot and medallion that van Horn shipped back from Palestine.

## Night at the Estate

Although there are many interesting things to investigate at the van Horn Estate during the day, it is only at night that a ghoul or two might stalk the area. If the investigators see a ghoul, then they at least will be sure of van Horn's sanity. This would be a good chance to rig a flash camera, to gather some evidence.

### THE FIRST NIGHT

The first night that the investigators remain at the van Horn place, they should receive hints of the horror that lurks outside. They hear steps and snapping twigs outside and see a shadow now and then moving about in the darkness. Perhaps the investigators might chase a shadowy figure through the woods for several miles before it escapes. In the morning, long scratches might be found on cars, bicycles, or other vehicles.

When morning dawns, the investigators should believe that something is out in the woods, but they should not know what it is unless they have made a careful plan to encounter the thing. (If they do, it might turn out to be a black bear, or an itinerant looking for shelter.)

### THE SECOND NIGHT

The second night that the investigators spend in the van Horn house should start off quietly. After the sounds and skulking shapes of the previous night, investigators may become worried by the oppressive silence.

As the night wears on, the investigators will be disturbed by shifting and groaning sounds from within the house itself, as though the structure itself was in pain, or perhaps displeased. Then the creaking and squeals from the timbers and foundations stop, and all seems right. For a moment, there will be silence again.

Then, from the basement, a slow clatter of hooves will be heard. And then sharp footsteps mount the stairs. The ghouls finally have a clear vision of what has dogged their dreams, and three (up to fifteen, as the keeper thinks appropriate) come up the stairs. Their goal will be to retrieve the be-runed bottle that has been calling to them. They stumble about almost like sleepwalkers, for they are searching for something they can only dimly sense. At last they zero in on the display case above the fireplace, and smash it. Chittering among themselves, the ghouls bob and sniff over the artifacts within, like grotesque parodies of human connoisseurs. One squeals in glee, and then another, and at last they agree upon the bottle, seize it, return to the basement, and disappear into the catacombs with which the basement now is linked.



If the investigators get in the way, the ghouls will be happy to deal with them. They are always a little hungry, but just now are actually intent upon the bottle, and otherwise will leave. This is one time when fainting will be a secure defense.

If fighting begins, so that the ghouls' blood is up, each surviving ghoul will carry away one dead or unconscious investigator. Once in their maze of burrows, the ghouls will easily escape surviving investigators. At the keeper's option, pursuit fails to find the lost comrades, who are shortly devoured.

## To The Sanitarium

After the battle with the ghouls, the investigators should probably realize that Christopher van Horn's life is in deadly danger. If the ghouls retrieve one artifact, they will come to retrieve the other two. Van Horn holds the medallion, probably the most powerful item.

If the investigators don't seem ready to rush back to the asylum after meeting the ghouls, the keeper should feel free to prod them in that direction. Remind them of the medallion that van Horn possesses. If the investigators don't head out on their own initiative, have them receive a visit from one of the asylum staff members, bringing word that van Horn has begun shouting that "they're coming for him tonight!" The staff member hopes that the investigators will return to the asylum, to help calm the old man, who is reacting badly to sedation.

Van Horn is entirely right. The ghouls are coming for the medallion he wears around his neck. Shortly after the investigators arrive at the asylum, a new band of ghouls enters, also through the basement, behaving blindly, almost contemptuously of human interference or resistance. If the keeper wishes, the battle in the asylum can involve any number of asylum patients and staff members, in addition to the investigators and the ghouls. This would be especially appropriate if the investigators are outnumbered during the battle. The whole time, van Horn will be at the heart of the battle, trying to retain his medallion.

If the ghouls retrieve van Horn's medallion, they'll try to escape. Otherwise, they will fight to the death.

## CONCLUSION

After the battle with the ghouls, the doctors at the sanitarium will have little reason to doubt van Horn's sanity. If the investigators are willing to speak for van Horn, he will be released in a few days, despite his final outburst. Otherwise, it will be several months before van Horn is freed.

The affair at the Sanitarium is kept quiet by all parties. If the investigators conduct themselves well in the eyes of the authorities, add 1D10 points to each investigator's Credit Rating skill. If that happens, Detective Stuckey becomes their friend, and can help them with information and suggestions around Arkham in the future.

Van Horn might have been killed in the final battle. In this case, investigators might instead find themselves involved in the court battle over his will, trying to prove to a judge that van Horn really was being harassed by ghouls.

Whether or not the investigators defeat the ghouls, if van Horn is not killed, each investigator gains 1D10 SAN. If one or more ghouls as well as van Horn was killed, reduce this gain to 1D6-1 SAN. If the ghouls slay van Horn and no ghouls die, there is no Sanity award.

# Bellevue

## *a 1990s asylum*

**Bellevue Hospital**  
462 1st Ave & East 27th Street  
New York, N.Y. 10016

Public State Hospital, Psychiatric Clinic Section  
45 Doctors  
350 Staff  
300 Patients  
300 Beds

Survival Rate 91/93  
Cure Rate 59  
Release Rate 26

**B**ELLEVUE is one of the oldest medical institutions in the Western hemisphere. It was founded in 1736, as a six-bed infirmary atop New York City's first almshouse. In the 1800s, it was moved several times. The hospital was named after its final location in 1825, Bellevue Place, the name coming from its magnificent view of the East River. Subsequent expansions have grown outward from this site.

In early times, Bellevue operated as a general assistance facility. These services were slowly eliminated, until in 1848, Bellevue operated solely as a hospital. The next year, a permanent medical board consisting of outstanding physicians was established, and political manipulation and factionalism were removed from Bellevue. The board added a medical college in 1861 and eventually merged with the New York University College of Medicine in 1898.

In 1887, the journalist Nellie Bly entered the hospital disguised as a patient and wrote a sensational account of her experience. This led to a common belief that Bellevue was solely a repository for the insane, and a poor one at that. In actual fact, Bellevue has had an excellent history of treatment and care for the mentally ill. Not only has Bellevue been a national leader in many typical medical services, but it was also the first to incorporate a child psychiatry in-patient unit, in 1923. Another first occurred thirteen years later when Bellevue became the first to use insulin shock therapy for the treatment of mental illness. Bellevue was also the first U.S. center to study autistic children and to train child psychiatrists.

Bellevue's primary reason for existence is the care of New York City's sickest and poorest residents. Each year, Bellevue's outpatient services help about 400,000 people. The 1,232 beds handle about 25,000 inpatients each year as well. Of this, about 300 beds and seven floors are dedicated to the psychiatric clinic. As a public hospital,

Bellevue remains dedicated to the belief that anyone, regardless of race, religion, nationality, or ability to pay is entitled to accessible, quality health care.

The main hospital building, an impressive 23-story construction, is Bellevue's most recent addition. Two large, older, multi-story buildings flank the main building and contain most of the hospital's outpatient services. This includes outpatient psychiatric care, which consists mainly of the dispersal of drugs and advice. The main psychiatric clinic resides in seven floors atop the main building. Most rooms have two beds each, and these are generally full, especially around holidays. There are several larger wards as well. When the clinic is overcrowded, fold out beds are set up here with break-down partitions for privacy. These quarters, of course, cost less on the final bill, and are only used for patients with mild and treatable disorders.

Like most large modern public institutions, Bellevue is burdened with over-administration. There are over 6,000 total employees. The hospital has a total operating budget of \$360 million. While just a small part of the overall hospital, the psychiatric unit shares this bureaucratic nightmare. Dr. Henry Martingale is the Chief Administrator and Head of Clinical Psychiatric Research at the hospital. Under his able leadership, the clinic runs smoothly and everyone has a lengthy, important-sounding title.

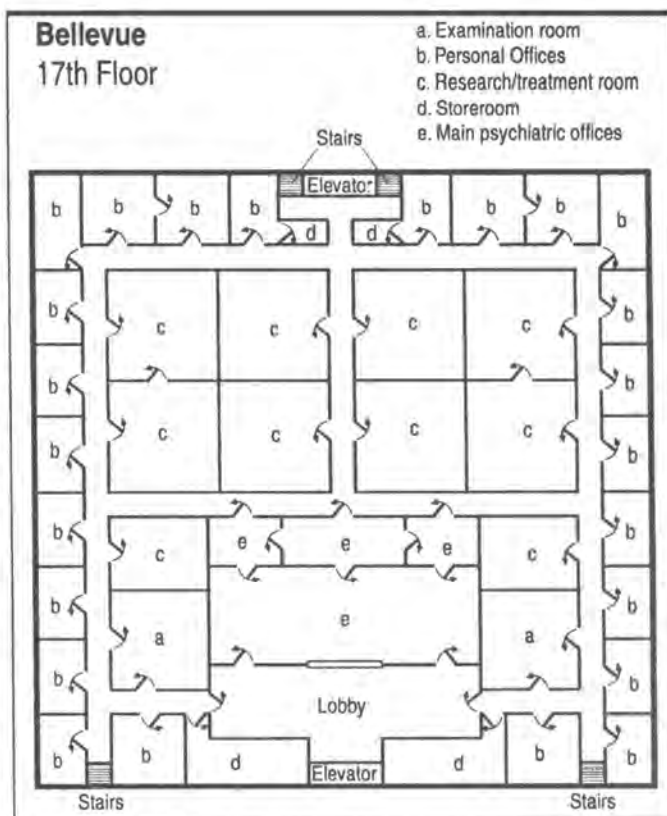
Treatment in Bellevue is primarily done through a combination of advanced drug-therapy and psychiatric review. Treatments are individually tailored to each patient to achieve a cure as quickly as possible. In general, these are the safest and most modern treatments possible. Little actual experimentation is done on the patients, although recently electroshock therapy has seen limited use for special cases.

Only severe problems get inpatient care. Demand is so great that if a mental health problem can be taken care of on an outpatient basis, it will be.

Patient life is highly regimented and all the benefits of modern technology are available to enforce it. Remote cameras are in most rooms and hallways to ensure proper and correct behavior. There are strict rules to keep staff-patient interactions to a minimum. Usually, the only interaction occurs during treatment or when attendants lead patients to their meal, work, and recreation areas. This is especially true of the top floor, which houses the criminally insane and extremely dangerous.

The actual life of a patient, while regimented, does leave them many choices regarding how they spend their free time. Most patients have specific activities prescribed by their doctors. Those who don't can spend their time watching television, reading, or in some other allowed hobby. As patients are effectively separated into wards dealing with specific types of disorders, patients' day rooms allow plenty of supervised personal interaction. Anyone who has visited a modern hospital will notice that the mental health facility in Bellevue is very similar to any regular hospital area. The patients in mental health are not treated in any way which would stigmatize them or lessen their humanity.

More information on Bellevue can be obtained from *The Bellevue Sun*, the hospital newsletter. It is published by the



public affairs department and will be sent to those who request the latest copy.

## 17th Floor

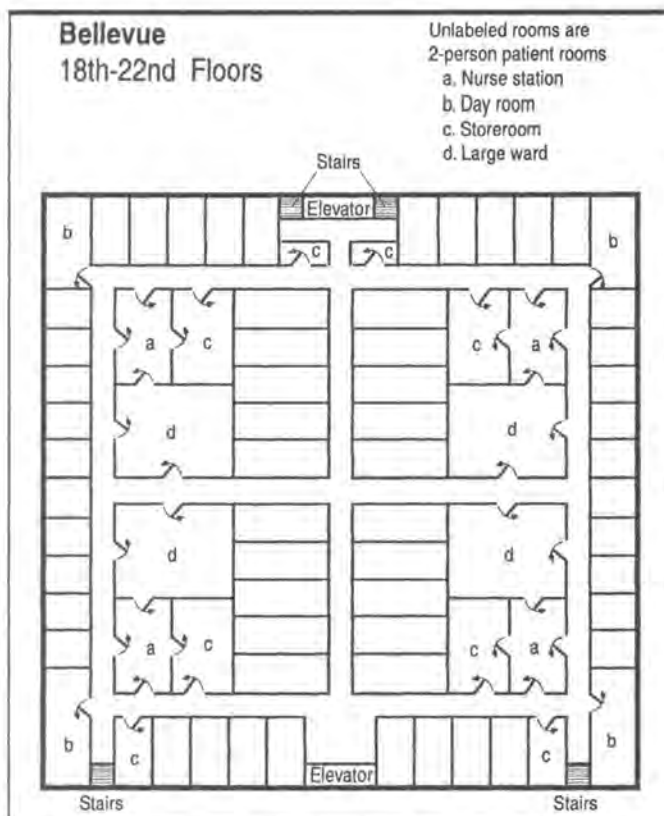
**Lobby:** a comfortable lounge and waiting room for those with appointments and those who are waiting to visit patients. Several vinyl couches line the walls and central area. The wall opposite the elevators contains the service window. Several desk nurses at this window answer questions and serve the public. Even at night, there is at least one nurse present.

**Main Psychiatric Offices:** it consists of several smaller rooms. The service area has a window into the lobby. Here, the desks hold modern computers for use by the nurses on lobby duty. The computers have access to all the hospital's information, from patient histories to doctors' salaries. The back rooms consist of the employee lounge, the main clinic office, and a changing room.

**Examination Rooms:** these are the rooms used for examination before admittance into the inpatient wards. They are also the rooms used for routine examinations of continuing patients. These spartan rooms contain few medical supplies.

**Personal Offices:** individual offices for all the psychiatrists are on this floor. Each one is comfortable, modern, and equipped to allow the doctors to psychoanalyze patients in their offices if necessary. Most doctors' offices also contain personal effects as well as excellent collections of texts on medicine and psychiatry.

**Research/Treatment Rooms:** there are several rooms full of impressive monitoring devices such as CAT-scan and magnetic resonance imaging equipment. There are also several chemical labs where drug therapy research is done.



Current patients are not used for research. Proper controls and volunteers are taken from the general public. Patients who require extreme treatment such as electroshock or insulin shock therapy are treated in these rooms.

**Storerooms:** the store rooms on this floor contain supplies for the offices, the research and treatment rooms, as well as regular janitorial supplies. Often, extra pieces of medical equipment get lost in these rooms for years.

## 18th to 22nd Floors

**Nurse Stations:** each station has one nurse on duty 24 hours a day. Each specific station is supplied with drugs and others supplies needed for the patients in its zone of responsibility. This zone covers a quarter of each floor.

**Day Rooms:** For resident patients who are allowed the privilege, there are common day rooms with games, cards, and televisions. Most patients are allowed to use the day rooms. In fact, many are allowed to eat at the main cafeteria on the first floor.

**Storerooms:** the regular storerooms on these floors contain no medical supplies. They have linens, gowns, pillows, and other items for the patient rooms. One storeroom on each floor for janitorial supplies.

**Large Wards:** these rooms are generally empty or used for storage of large items. When the hospital isn't crowded, they are also used for parties or other special occasions. In times of crisis or overcrowding, the wards can be filled with fold-out beds to increase hospital capacity. Some of the larger wards are already laid out for patients and can be used by those not needing semi-private or private rooms and who want a lower bill.

**Patient Rooms:** the standard patient room has two beds and several chairs for visitors. A curtain can be drawn between the beds for privacy. Some rooms are tailored specifically to patient type. For instance, manic depressives have sharp objects removed from their rooms. There is room for some personal possessions for each patient. As with the rest of the hospital's higher floors, windows do not open.

## 23rd Floor

**Lobby:** the lobby of the 23rd floor is similar to the main lobby of the psychiatric clinic. Here, the service window usually has one nurse on duty to answer questions. In addition, one hospital policeman is always on duty here.

**Police Office:** the police office consists of several officers who police the hospital, managing everything from hospital security to parking tickets. The administrative office and employee lounge are also in this area. Special restraints and equipment for handling hostile patients are found in the office storeroom.

**Nurse Stations:** much like the nurse rooms on the other floors except that a police officer is usually stationed in each room as well.

**Patient Rooms:** the patient rooms on this floor vary a great deal. They range from rooms that resemble the standard patient residences on the other floors, to simple padded cells. Many of the rooms have restraint systems for the patients. On this floor, one person to a room is the rule.

**Storerooms:** identical to the storerooms on the other floors.

## Staff

The staff members listed below are just two of the many doctors employed at Bellevue.

### DR. ELLIOT WARREN, age 50

STR 10    CON 9    SIZ 13    INT 17    POW 14  
DEX 11    APP 10    EDU 18    SAN 60    HP 11

**Damage Bonus:** +0.

**Weapons:** Revolver 45%, damage 1D10

**Skills:** Chemistry 50%, Computer Use 65%, Computer Games 72%, Dream Lore 6%, Library Use 80%, Medicine 68%, Pharmacy 70%, Psychoanalysis 82%.

**Quote:** "Just relax, everything is going to be fine."

When Dr. Warren isn't playing computer games in his office, he is a very competent psychiatrist. He has the highest cure rate of any of the staff doctors in the sanatorium. His specialty is autism and several of the patients in the facility are here specifically to be treated by him. In some of his recent research though, he has begun to uncover some strange connections in some of his patients' dreams. It is beginning to concern him and has cut into his game playing; he has not been able to play *Myst* for several days. Dr. Warren's official title is Assistant Executive Supervisor in Charge of Psychiatric Care.



**DR. MICHAEL STEWART, age 42**

STR 13 CON 11 SIZ 11 INT 17 POW 9  
DEX 12 APP 10 EDU 17 SAN 37 HP 11

**Damage Bonus:** +0.**Weapons:** none.**Skills:** Chemistry 82%, Medicine 48%, Pharmacy 76%, Psychoanalysis 61%, Sinister Laugh 90%.**Quote:** "Bwahahahahaaaaa..."

Dr. Stewart is not your typical mad scientist. He has no plans to destroy the world, create life or make himself the most famous scientist in the world. All he wants to do is learn a little about the way the mind works, to satisfy his own twisted curiosity. As with most insane scientists Dr. Stewart is very intelligent and no one suspects the true motives behind some of his experimental therapies and treatments. His ultimate goal is to prove the existence of the Dreamlands and their connection to this world through peoples' minds. Dr. Stewart's official title is Associate Director of Psychiatric Research and Attending Psychiatrist.

**Resident Patients**

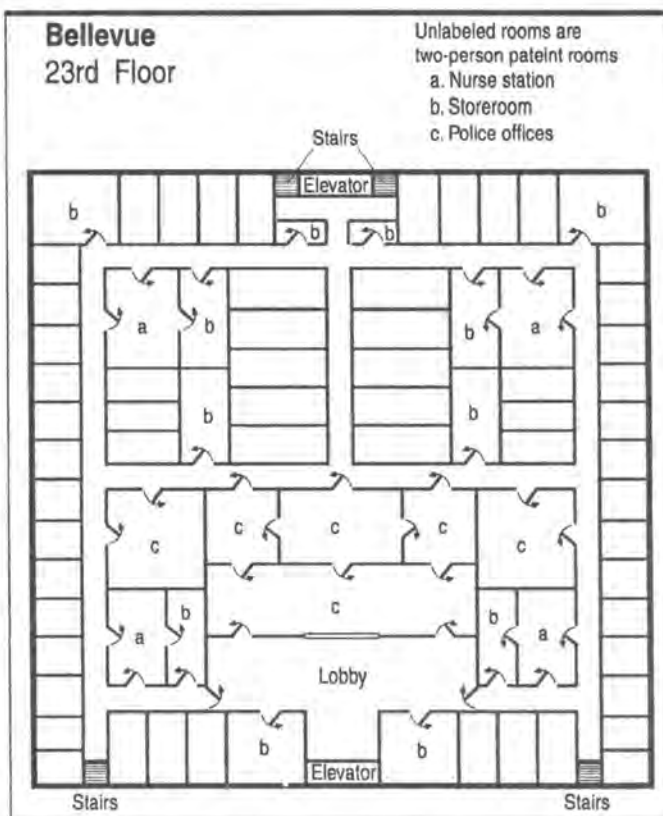
As with the other asylums in this book the residents listed here are extreme versions of standard patient types. The 1990s mental institution no longer imprisons the epileptic, nor the elderly and feeble-minded. The majority of genuinely insane patients remain the same types, however, with schizophrenics and manic-depressives the most common. A high number of hysterical paralytics are inpatients as well. To have a room number starting with 23 means the patient is either criminally insane or extremely dangerous.

**DAVID WOO, age 21**

STR 12 CON 12 SIZ 11 INT 13 POW 16  
DEX 10 APP 13 EDU 8 SAN 48 HP 12

**Damage Bonus:** +0.**Weapons:** none.**Skills:** Confound Analysis 57%, Dreaming 35%, Dream Lore 24%.**Quote:** "Eh?"

David Woo is a quirky autistic with few moments of rationality and a world of almost complete silence. He spends the majority of his time in trivial pursuits that do not disturb his daydreaming. Sometimes, he gets so lost in his own strange dream world that he must be fed by the staff. In his lucid moments, he is cooperative, but is unwilling to share his dreams. His Dreamland's persona is Jarantel the Wise. In the Dreamlands, David is well known for his far travels and great knowledge. Many consider him one of the greatest of the wandering sages. He can normally be found in room 2013.

**MARK SPENCER KUNITZ, age 45**

STR 13 CON 9 SIZ 14 INT 12 POW 11  
DEX 10 APP 14 EDU 14 SAN 36 HP 12

**Damage Bonus:** +1D4.**Weapons:** none.**Skills:** Art (Sing) 78%, Art (Imitation) 67%, Fast Talk 40%, Listen 52%, Occult 44%, Persuade 30%, Physics 70%.**Quote:** "I'm gonna break on through to the other side."

Mr. Kunitz believes himself to be the lizard king, Jim Morrison. His breakdown occurred during his oral examinations for physics in graduate school. When asked to give a complete listing of sub-atomic particles, he broke into a medley of Doors' songs. Ever since then, he has been writing bad poetry and trying, through the mail, to convince the rest of the band to get back together again. Mark's singing and knowledge of Morrison's songs is incredible. He can be found in room 2011 or the nearby day room, where he often performs.

**ROBIN BULLOCK, age 25**

STR 10 CON 11 SIZ 9 INT 13 POW 16  
DEX 14 APP 13 EDU 12 SAN 48 HP 10

**Damage Bonus:** +0.**Weapons:** none.**Skills:** Conceal 60%, Hide 72%, Sneak 45%, Speak Irish 90%.**Quote:** "If I could just find me pot-o-gold, I'd buy my way out of here."

Robin Bullock is an excitable young woman who was convinced during a hypnosis act that she was a leprechaun. She has never snapped out of it. If something goes missing,

the staff asks her first, if they can find her. She insists she hid her pot of gold in New York City and is just waiting to get it. If you take the time to notice, she has a very slight frame and an elfin nose to go along with her red hair and unpredictable behavior. Odd that. Ms. Bullock is assigned to room 2025, but she keeps popping up in other rooms as they go vacant.

**JOHN DRAKE, age 28**

STR 13 CON 14 SIZ 13 INT 16 POW 12  
DEX 14 APP 14 EDU 15 SAN 28 HP 14

**Damage Bonus:** +1D4.

**Weapon:** 9mm Automatic Pistol 90%, damage 1D10

**Skills:** Computer Use 45%, Demolitions 70%, Drive Auto 82%, Hide 68%, Listen 65%, Pilot (Civil Prop) 44%, Spot Hidden 77%, Swallow Microfilm 95%.

**Quote:** "Whose side are you on?"

John Drake is a secret agent, or at least he insists he is. He is convinced that he has become enmeshed in a tremendous plot against secret agents everywhere, and that he and his fellow secret agents are all being kept drugged and restrained in this fake hospital while the fake doctors try to extract information with their drugs and interviews. John's constant escape attempts make him quite a security problem for the staff. This is made worse by the fact that John always tries to convince others to help in his mad escape plans. Whenever a new patient enters John's ward, he will attempt to determine which side the new inmate supports. Despite John's escape attempts he has not yet been moved to Floor 23 and currently resides in room 2006.

**EDDIE WALSH, age 33**

STR 12 CON 10 SIZ 13 INT 12 POW 14  
DEX 11 APP 10 EDU 12 SAN 36 HP 12

**Damage Bonus:** +1D4.

**Weapons:** none.

**Skills:** Listen 85%, Scream in Terror 94%, Spot Hidden 62%

**Quote:** "Aaaahhhhhlll"

Eddie Walsh is a raging paranoid, literally afraid of his own shadow. The staff do their best not to frighten him, as his screams disturb the other patients. Eddie is the best source of information available to the staff and other inmates. His ears and eyes are always open in order to alert him to the ever-present danger of those nearby. He is always willing to talk about what he has learned, as long as you promise not to hurt him. Due to his problem Eddie is always given his own room, currently it is 2021.

**COURTNEY BARNES, age 19**

STR 11 CON 10 SIZ 12 INT 13 POW 11  
DEX 13 APP 14 EDU 12 SAN 33 HP 11

**Damage Bonus:** +0.

**Weapons:** none.

**Skills:** Fast Talk 45%, Persuade 60%, Vomit at Will 36%.

**Quote:** "If you do that I'll kill myself."

She is a manic-depressive suicide risk. A broken home and early drug use led to a troubled youth. Courtney has been involuntarily committed by the state for her own protection

and is kept under close supervision. In her manic stage, she is quite friendly and outgoing. However, when Courtney is depressed, she becomes totally uncooperative. Large doses of drugs are used by the staff to control and minimize these swings. Counseling is having some beneficial effects on her eating problems, but not enough. She can usually be found in room 2030, or else snacking in the day room.

**Additional Statistics**

**DREAMLANDS CATS**

*A cat can attack three times in a round. If both claw attacks hit, it will hang on and continue to bite, and rip with the hind legs from then on.*

	#1	#2	#3	#4	#5	#6	#7	#8
STR	1	1	3	2	1	2	3	1
CON	4	7	7	9	5	3	4	8
SIZ	1	1	1	1	1	1	1	1
INT	17	17	9	13	17	15	12	12
POW	15	16	11	17	14	13	17	16
DEX	29	30	31	33	31	28	34	30

**Damage Bonus:** -1D6.

**Weapons:** Bite 30%, Damage 1D4-1D4  
Claw 40%, damage 1D3-1D4  
Rip 80%, damage 2D3-1D4

**Skills:** Dodge 80%, Dream Lore 60%, Purr 97%, Recognize Friend 99%.

**PARSLEY FREESON, age 52**

STR 10 CON 11 SIZ 18 INT 16 POW 15  
DEX 8 APP 10 EDU 8 SAN 75 HP 15

**Damage Bonus:** +1D4.

**Weapon:** Sword Cane 64%, damage 1D6+1D4

**Skills:** Dodge 21%, Dream Lore 27%, Fast Talk 71%, First Aid 43%, Persuade 58%.

**SPEAR-WIELDING MANIAC (Man of Leng)**

STR 13 CON 12 SIZ 16  
DEX 11 APP 6 SAN 0  
INT 8 POW 7 HP 14

**Damage Bonus:** +1D4.

**Weapon:** Spear 51%, damage 1D8+1+1D4

**Skills:** Art (Dance) 85%, Gibber 51%, Laugh 82%, Occult 8%.



**TYPICAL BELLEVUE PATIENTS**

	#1	#2	#3	#4	#5	#6	#7	#8
STR	10	9	8	9	11	11	12	11
CON	9	12	9	9	11	8	12	11
SIZ	14	12	16	11	13	13	9	9
POW	12	8	10	7	8	12	8	10
DEX	10	13	11	9	9	12	7	12
HP	12	12	13	10	12	11	11	10

**Damage Bonus:** +0.

**Weapons:** Bite 30%, damage 1D2  
Claw 35%, damage 1D3

**Skills:** Appear Sane 27%, Bargain 43%, Persuade 39%.

## ELEPHANT

STR 46 CON 28 SIZ 40 INT 4 POW 13  
DEX 7 HP 34

Move: 10

Damage Bonus: +4D6.

Weapons: Trunk 50%, grapple  
Trample 50%, damage 5D6+db vs. downed foe  
Tusk 25%, damage 1D6+4D6

Armor: 8-point thick hide.

Skills: Smell Intruder 54%, Listen 61%.

## TYPICAL BELLEVUE ATTENDANTS

	#1	#2	#3	#4	#5	#6	#7	#8
STR	12	15	16	12	16	13	12	14
CON	9	16	14	9	13	13	10	10
SIZ	16	10	11	14	16	16	15	11
POW	11	10	11	11	11	12	11	12
DEX	12	16	17	10	18	16	12	14
HP	13	13	13	12	15	15	13	11

Damage Bonus: +1D4.

Weapons: First 40%, damage 1D3+1D4  
Grapple 75%, damage special  
Head Butt 30%, damage 1D4+1D4  
Club 35%, damage 1D6+1D4

Skills: Dodge 40%, First Aid 35%, Listen 55%, Persuade 40%, Psychology 20%.

## Scenario Ideas

### THE POSSESSION

A reporter who knew Jim Morrison recently visited the hospital and swears that Mark knows things that only the real Jim could have known. Now, the paper wants answers and they are willing to hire people on the inside or on the outside to get them. A little research will confirm that Mark went mad on the same day Morrison died. Is it possible that Morrison has reached out to possess Mark? Is it true possession by a ghost or just the imagination of a shattered mind? More importantly, if spirits of famous people are possessing the insane, then which impersonator is the real Elvis?

### THE TREASURE HUNT

Robin Bullock has found a way to escape. Now, she needs other patients to aid her and help recover her pot of gold. She claims to have hidden it somewhere in New York's Central Park. Of course, only seriously disturbed individuals would believe Robin and accompany her on her mad venture, but that's why the investigators are locked away in the first place. Can the patients successfully escape and make their way to Central Park with the authorities hot on their trail? And, what strange object was actually buried in the park by Robin, such that she insists it can only be dug up at midnight?

### A RESEARCH PROJECT

Dr. Warren has uncovered some startling facts during his treatment of David Woo. He has advertised in the paper for volunteers to aid him in additional dream research. It pays

well, and how hard can it be to just sleep and dream? Through the use of weak mind-altering drugs, the doctor will enable the investigators to enter the Dreamlands. Where do the investigators appear when they arrive? While in the Dreamlands, the investigators should meet David Woo in his Dreamlands persona. Will he aid them or try to slay them to protect his private world? If the players do survive, will Dr. Warren believe them? Will anybody else?

## THE SELF-ACTUALIZING MAN

John Drake has determined that the investigator inmates are on his side. Now, he needs their help to escape this retirement community for secret agents or to destroy the place. Even with his considerable skills, he can't do it alone. How many of the other imprisoned secret agents will help him? There is also the matter of counter-intelligence. John is sure some of the other patients are plants from the governments that control this institution. What can be done about them without alerting the staff?

## A VISION SHARED

In a startling recovery, David Woo has come out of his shell of silence to talk with a few chosen patients. He reveals what he knows about the Dreamlands and the wonders that can be had therein. The investigators are invited to accompany him. Does he have some nefarious purpose for bringing them in or has he just grown lonely and in need of human companionship? What will happen when a bunch of insane people find themselves roaming about the Dreamlands?

## THE VANISHED

Some of the patients have disappeared. Have they escaped or has something evil occurred? The investigators are called in to try and determine what has happened. Eddie Walsh seems to know something, but he's too afraid of the players to talk to them. Can they win his confidence before he too disappears? Will they be able to track the missing patients to Dr. Stewart and his mad experiments? The doctor has some new theories to test, but they require fresh brains.

## PARENT AND CHILD

Something is making the patients more depressed than usual. This is very troubling to the staff, especially since the manic-depressive patients are becoming fully suicidal in their depressive stages. Round the clock duty is mandated for all patients, and investigators, preferably staff, are asked to look for the source of the problem. Careful investigation will lead to the discovery that one of the manic-depressive patients, Courtney Barnes, has had an almost full recovery and is not affected by the waves of depression affecting the rest of the patients and beginning to affect even the staff.

Unknown to anyone, on a recent visit to the hospital, Courtney's mother, a cultist, enchanted a ritual on her daughter to cure her depression. It does so by draining those nearby of their positive energy. Careful questioning and examination of medical and visitation records should lead the investigators to the cultist mother. They must then



convince or force her to dispel the ritual before people start killing themselves.

## To Wake, Perchance To Dream

**T**HIS ADVENTURE, set entirely in Bellevue Hospital, leads the investigators into the strange world of dreams. Faced with bizarre manifestations in the waking world, the investigators will eventually track this odd phenomenon to David Woo, an autistic. Only then will they learn that one of the Hospital's staff is actually the source of poor Woo's problems.

### KEEPER'S INFORMATION

For years, Dr. Michael Stewart has been obsessed with the world of dreams. Through interviews with certain insane subjects, Dr. Stewart has come to believe that some people reach another plane of existence, as real as the earthly one, while they sleep.

When David Woo was first brought to Bellevue, Dr. Stewart ignored him. Then, while reading through Dr. Warren's psychoanalytic notes, Dr. Stewart realized that Woo was a very strong dreamer.

By this time, Dr. Stewart has begun to work towards proving his theory. Woo unwillingly became Dr. Stewart's test subject. In the last months, Dr. Stewart has tried many different methods to increase the potency of Woo's dreams, including hallucinatory drugs, hypnosis, and even shock therapy. He believes that if he makes Woo's dreams strong enough, then that other plane of existence, the realm of dreams, might touch upon ours for a time.

However, Dr. Stewart is now close to giving up on his work with Woo. Although Woo's dreams have seemed to increase in intensity, Dr. Stewart has never seen any physical manifestation of them. However, that is about to change. Four days ago, when Dr. Stewart last worked with Woo, he gave him a mixture of several drugs of his own creation. There was absolutely no effect, and Dr. Stewart wrote the mixture off as another failure. In reality, the mixture lay dormant for four days and is just becoming active now.

### INVOLVING THE INVESTIGATORS

This adventure works best if the investigators are all staff members at the hospital. Attendants, nurses, doctors, clerks, stewards, and any number of other hospital employees are all possible characters.

If the keeper wishes to use this adventure as part of an ongoing campaign, the investigators could be called in by Dr. Warren to help deal with the strange problems that have begun to crop up. In this case, skip the first section of the adventure. The investigators should arrive at Bellevue just in time for The Staff Meeting.

### INVESTIGATOR INFORMATION

Provide the players with the basic floor plan of Bellevue Hospital. Other basic information on Bellevue, such as staff listings and patient listings, will probably not be needed for this adventure, but can be given to the investigators if the players request them.

### Strange Happenings

For months, the residues of various chemicals have been building up in Woo's body. Four days ago, when Dr. Michael Stewart gave a new drug to Woo it acted as a catalyst for these various residues. Dormant for four days, the effect is just now becoming active. As a result, the world of dreams has begun to cross into the world of reality.

While going about their normal duties at Bellevue, the staff members will begin to notice strange occurrences. The keeper should face individual players with the following encounters, to help give the players a sense of the odd things that are happening at Bellevue.

#### THE DISAPPEARING CAT

A strange cat is seen inside one of the large wards at Bellevue. He wanders through the ward, going from bed to bed in a very systematic manner, as if he were looking for someone. The cat's actions seem very intelligent, almost human in nature. If anyone tries to chase the cat away or hurt it in any manner, it will dart into the shadows, disappearing totally.

#### SOUNDS IN THE NIGHT

In the middle of the night, the sounds of loud argument erupt from one of the private rooms. The argument quickly becomes violent and turns into a brawl. Any investigator rushing to the area will find all of the patients asleep in their cells. If an investigator makes a successful Listen roll, he will be sure that the noises came from a private room that is currently empty.

#### THE MYSTERIOUS VISITOR

An odd visitor shows up at the seventeenth floor lobby. The man is tall and gangly, dressed in noble silks that might have been in style during the late Middle Ages. He announces himself as Parsley Freeson, and demands to be taken to Jarantel the Wise. If asked to describe Jarantel, Parsley will say that he is a small dark-haired man from the unknown lands far to the east who possesses a noble bearing and a great intelligence.

Parsley eventually fades away, just as the other manifestations have. This should occur when he is removed from everyone's view, perhaps after he is locked away in a cell, or after he has left the hospital in frustration.



Parsley Freeson

#### OTHER VISITATIONS

Keepers should feel free to add other visitations. None of them should be too far from the norm for Earth, and they

should all be seen by only a few people. Each of the visitations will vanish while out of the view of others.

## THE STAFF MEETING

After a few days of strange happenings, Dr. Warren calls a staff meeting, asking all of those who have had strange experiences to attend. This group should include all of the investigators. Dr. Stewart is invited as well, but he declines to attend. By this time, he has not worked with Woo for about a week, and so has no reason to believe that these strange occurrences have any relation to his experiments. Dr. Stewart assumes that any bizarre happenings can be explained as part of the general neurosis of the Bellevue clinic.

Dr. Warren, however, is quite concerned. He isn't quite sure what to make of recent events, but he's more than happy to listen to theories from the staff members. The keeper should allow the investigators to talk for a while, discussing what might be going on at Bellevue.

When conversation dies down, Dr. Warren will ask a special favor of the investigators. He wants them to temporarily put aside their regular tasks in order to look into this problem. He suggests that the investigators search through the wards, talk to the patients and, in general, do what they can to solve the mystery. He also asks that they be as subtle as they can, so as not to upset the entire hospital.

## Tracking Down the Dreamer

While the investigators are tracking through the hospital, trying to learn more about the odd manifestations, the keeper should take the chance to introduce the patients at Bellevue (see the statistics section for instances). There are also any number of schizophrenics and manic-depressives which the investigators might meet, or who can be made up on the spot to relate later clues and red herrings.

As this portion of the adventure progresses, the manifestations of dreams should become slowly stronger. Alien creatures only seen in the Dreamlands might suddenly appear or disappear right in front of the investigators. Strange transformations could occur, as items change to their medieval counterparts—flashlights becoming lanterns and guns crossbows, for example. As the adventure begins to reach its conclusion, the atmosphere should become entirely dreamlike, as spatial distances and time become confused.

Some of the manifestations which the investigators encounter should eventually lead them to Woo as the source of the problems. Many of the creatures from the Dreamlands are searching for Woo. The investigators should eventually realize this, and begin to wonder if Woo may somehow be at the center of things. The following encounters exemplify the types of problems that the investigators might face during their investigation.

## ESCAPED PATIENTS

Word comes that a foppish swordsman has been seen on the top floor of the hospital, releasing dangerous madmen from their cells. When the investigators arrive on the top floor, they will find utter chaos. The guards have all been

overcome. Some are tied up, while others have been rendered unconscious. Their keys have been taken from them, and many of the least sane lunatics have been freed. No doubt, the investigators will have their hands full trying to return the madmen to their cells. If the investigators talk to any of the lunatics, they will learn that a man dressed in silks and carrying a sword did indeed free them, screaming the whole time, "Jarantel has proclaimed that all must be free!"

## MADMAN ON THE LOOSE

As the investigators turn a corner, a screaming patient will slam into them, falling to the ground. Chasing him is a large man dressed in loose Arabic clothing and a turban. As the large man closes on the investigators, he gibbers, drools and laughs at random times.

The large man carries a dangerous looking spear in his hands. It is clear that the tall man intends to slay the patient if the investigators don't intervene. It is likely that a fight will quickly result. If the investigators knock the tall man's turban off while they fight with him, they will see horns beneath the man's shaggy hair, for the tall man is actually a man of Leng. This will cost 0/1D5 SAN.

Eventually, the maniac will either succeed at his grisly deed, or be slain, and he will then fade away.

## ELEPHANT ON THE TWENTIETH FLOOR

From near Woo's room, the investigators will hear a loud trumpeting and feel the floor vibrating horribly beneath them, reminding them that they are high in the air. When the investigators arrive in the north-eastern day room on the twentieth floor, they will find an elephant there, trying to force its way through the western door. Woo's room lies halfway down that corridor. It will take considerable work to calm down the elephant and get it into the freight elevator. On the way down, it slowly vanishes.

## OTHER ENCOUNTERS

The keeper should feel free to include as many other encounters as they wish, using the varied creatures and people of the Dreamlands. Many of the people will be looking for Jarantel the Wise and many of the creatures will be heading towards Woo's room on the twentieth floor.

## THE CAT COMES BACK

If the investigators don't end up at Woo's room during their own investigation, the cat which earlier began the scenario can be brought back. He will be trotting straight towards Woo's room, a determined look upon his face. The cat can lead the investigators straight to Woo's room.

## WOO SPEAKS

When the investigators close in on Woo, they will hear two voices coming from his room. If any of the investigators have heard Woo speaking during one of his lucid intervals, they will recognize the first voice as his. The second voice sounds like it belongs to a young woman. As the investigators move towards Woo's room, they will hear the following conversation.

*Woman:* Jarantell! It is you! I can scarcely say how happy I am to see you, so long has it been since we last met.

*Woo:* It is good to see you as well, Tana. I had never thought I would see you in this realm.

*Woman:* It seems that things have been strange of late, and that dreams have begun to walk the world of man. I had hoped that you could explain it, oh wise one.

*Woo:* I am afraid that in this matter, I am ignorant, my lady. I wish that I knew more, but it is beyond me.

When the investigators burst in the room, they will find Woo sitting alone in his room, as silent as ever.

By this time, the evidence should all point towards Woo being the center of the problem. The investigators will now need to decide what exactly to do with him.

## Dealing With Woo

When the investigators entered the room, Woo returned to his normal autistic state. He will not acknowledge the investigator's presence, but rather ignore them completely. Outside, dreams will continue to manifest in the asylum, growing ever stronger. If Woo is sedated in some way, the storm of dreams will slowly abate. Otherwise, they will continue full strength, until the drugs burn their way out of Woo's system, in about a day.

An investigator who examines Woo closely will realize that he has been subjected to some various extreme treatment lately. The marks of numerous needle injections and the burns of electroshock therapy will be easily visible. It should be clear to the investigators that Woo's recent treatment has been unethical and probably illegal.



David Woo

## INVESTIGATING WOO'S TREATMENT

Although the adventure could conclude with the investigators tracking the problem to Woo and sedating him heavily, so that he does not dream at all, most investigators will probably want to discover who is responsible for Woo's extremely harsh treatment.

## SPEAKING WITH THE PATIENTS

If the investigators speak with patients rooming near Woo, they will learn that Dr. Stewart has been paying a lot of attention to Woo in recent months. He even occasionally removed Woo from his room, taking him elsewhere to do testing. Of course, the investigators will have to deal with the patients' insanities in order to gain this information.

## CONFRONTING DR. WARREN

If the investigators don't already know that Dr. Warren is Woo's regular doctor, they can learn this at once by speaking with the administrative staff. The investigators might confront Dr. Warren, assuming that he is the one who has been experimenting on Woo. Dr. Warren will angrily claim

that he had never done anything but speak with Woo, using psychiatric techniques to try and lessen Woo's autism. Dr. Warren knows nothing about Dr. Stewart's secret experiments on Woo, and he will do everything that he can to try and find the person responsible for Woo's abuse. Once shown the condition of Woo's body, Warren is shocked and outraged, and gives the investigators every aid. The next day an official investigation of Dr. Stewart begins.

## Investigating Dr. Stewart

Dr. Stewart has been none too careful about covering his tracks. Several patients and staff remember seeing Dr. Stewart leading Woo through the halls, taking him away for some treatment. By correlating different reports, the investigators will eventually conclude that the two were headed towards the hospital's western wing, an older building used primarily for outpatient care. Once in the western wing, Dr. Stewart took Woo down to the largely unused basement. There are no official records of any of Dr. Stewart's treatments of Woo. The administrative staff at Bellevue will know nothing about it.

If the investigators begin to carefully look through the hospital's administrative records, however, they may learn some other valuable information. Records will show deliveries of certain equipment and chemicals to Dr. Stewart over the last few months. Clerks and other administrative staff may remember that Dr. Stewart had the deliveries left in the basement of Bellevue's western wing. The equipment largely consisted of components necessary to put an electroshock therapy machine back into working order. A successful Electrical Repair roll can determine this fact. The chemicals were used by Dr. Stewart to make certain hallucinatory drugs. A successful Medicine or Pharmacy roll can determine this fact.

Other facts may point towards wrong-doing. Certain drugs have gone missing from an area accessible only to doctors in recent months. Electrical usage in the western wing has been quite high recently, and Dr. Stewart has ascribed some of the excess to his research budget, so that administrative staff would not have to worry about it.

## Horrors In The Basement

Eventually, the investigators may find themselves in the basement. For the most part, the basement seems relatively normal. Boxes are piled all about, and dust lies heavy everywhere. However, a successful Spot Hidden roll reveals a heavily tread path in the dust. It leads to a pile of boxes set up against one wall. The boxes are actually all empty, and can be easily moved. A door is concealed behind them.

Beyond the door is a small room that has been very used frequently lately. A lab bench sits against the back wall, set up for organic chemistry. Some vials are labeled with phrases such as 'Compound 3172'. They contain hallucinatory drugs of various strengths, as careful analysis will show. A pile of note books reveal Dr. Stewart's goals, and the results of his experiments so far. The note books are quite dry reading, as they are mostly just notes on Woo's



reactions to various drugs and treatments. The procedures for making the various compounds on the lab bench are explained in the note books.

In the center of the Dr. Stewart's lab is a long table with restraining cuffs. A generator sits just under the table, wires from it dangling all about.

## Confronting Dr. Stewart

As the adventure comes to a close, the investigators will no doubt want to confront Dr. Stewart. Dr. Warren and several higher authorities in the hospital, as well as the hospital police, will no doubt want to be there too.

By this time, Dr. Stewart will have realized that his experiments are at the heart of Bellevue's problems. Things have grown too strange for there to be any other rational explanation. However, Dr. Stewart is not worried about his unauthorized experiments being discovered. Rather, he is elated, for his theories have been given definite, physical proof. The investigators will find Dr. Stewart in his office, happily working on an article explaining his theories, his experiments, and the results.

If the investigators begin accusing Dr. Stewart of experimenting on Woo, he will gladly admit it, saying that Woo has helped to prove that there are "worlds beyond our world, places in the realms of dream as alive as our own, places where the dreams themselves are alive, full of their own substance!" As Dr. Stewart babbles on, it should be quite clear to the investigators that he has gone around the bend. Fortunately, there also will be attendants very near by, happy to take Dr. Stewart to a nice padded room.

## Conclusion

Within a day, Woo will have burned Dr. Stewart's drugs out of his system. For a few days yet, occasional inter-dimensional manifestations might still be seen in Bellevue, but they will be quite minor and entirely harmless.

Dr. Stewart's sanity will not return to him, and in all likelihood, he will be confined to Floor 23 for the rest of his life.

Although Dr. Stewart's final article is mostly gibberish, his earlier notes contain quite extensive documentation on his experiments. With careful work, another might be able to duplicate his experiments. However, this would not be an entirely sure thing. Woo's dreams only began to manifest upon the world after the residue from many different drugs had collected in his system. Since Stewart's research belongs to Bellevue Hospital and the City of New York, as part of the commitment process, the Court is wisely able to order these items of evidence sealed for the lifetime of Dr. Stewart.

The investigators who took part in the case will probably be asked to keep quiet about the whole episode. Bellevue would look quite bad if the public realized that one of their doctors had gone mad and begun experimenting upon the patients.

For successfully concluding this affair, grant each investigator 1D6 Sanity points, a one-step increase in their civil service grade, and a letter of commendation in each person's file.



Commonwealth of Massachusetts

# Certificate of Insanity

This document does hereby serve notice that

\_\_\_\_\_

has been certified  
**Legally Insane**  
by the Commonwealth of Massachusetts on this date of

\_\_\_\_\_

Whereby the above named has become a Ward of the State  
to be committed to an appropriate Institution of Mental Hygiene  
to receive treatment for the condition of

\_\_\_\_\_

For a period of six (6) months or more, as care shall require,  
or until sufficient cause can be shown as to warrant release.

*Francis Ellis M.D.*

Attending Psychiatrist or Physician

*Roland B. Fournier*

Judge, District Court

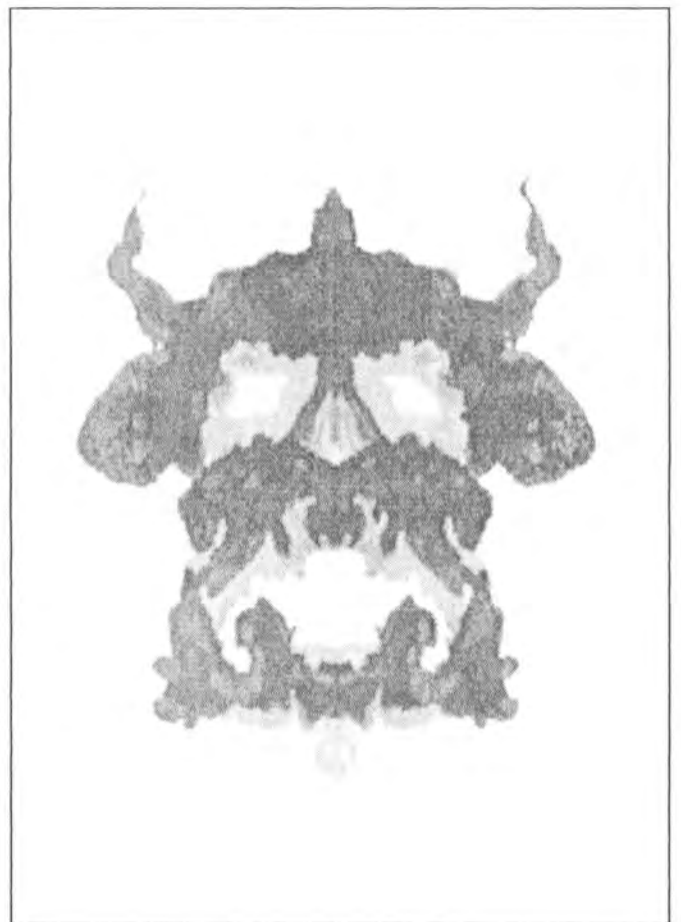
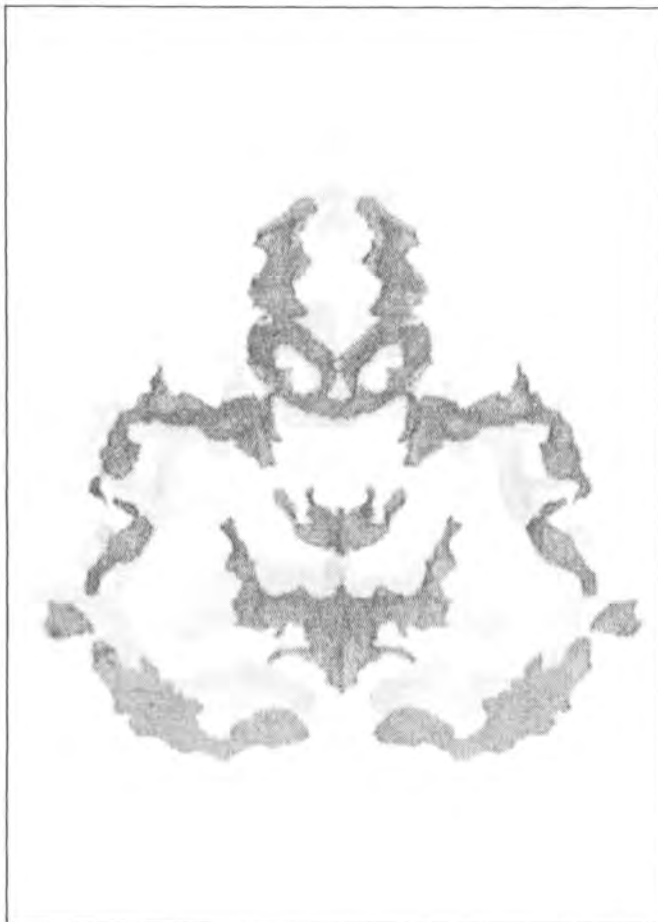
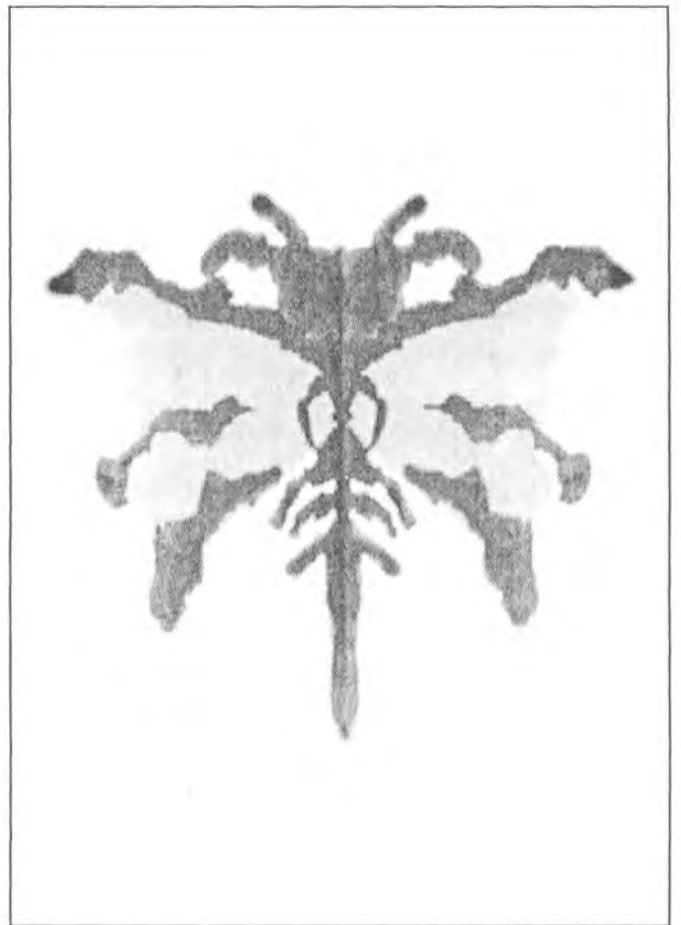
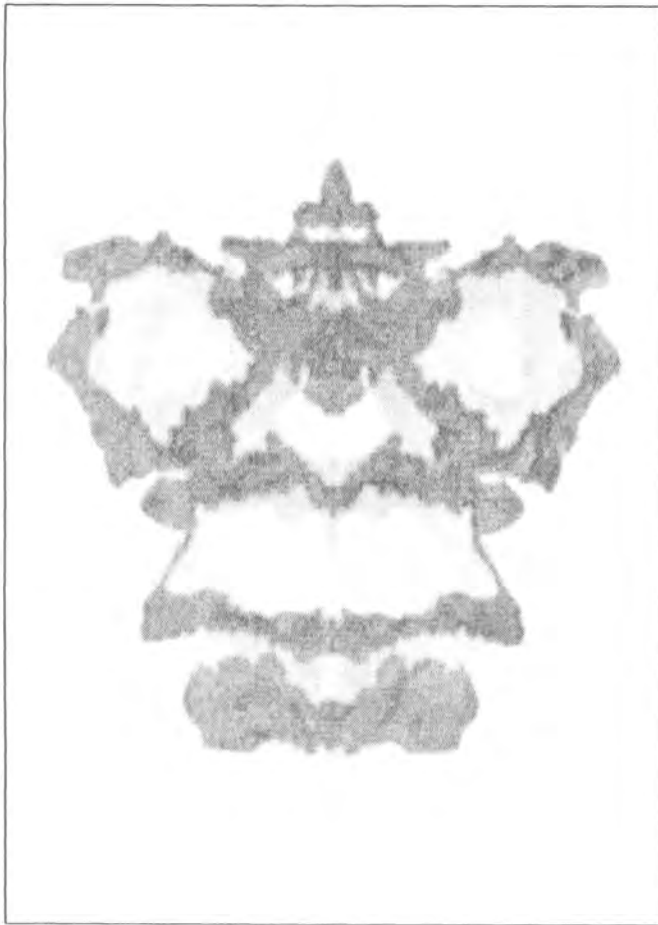
*Eric Herdstrom M.D.*

Superintendent of Institution

*Keegan Randall*

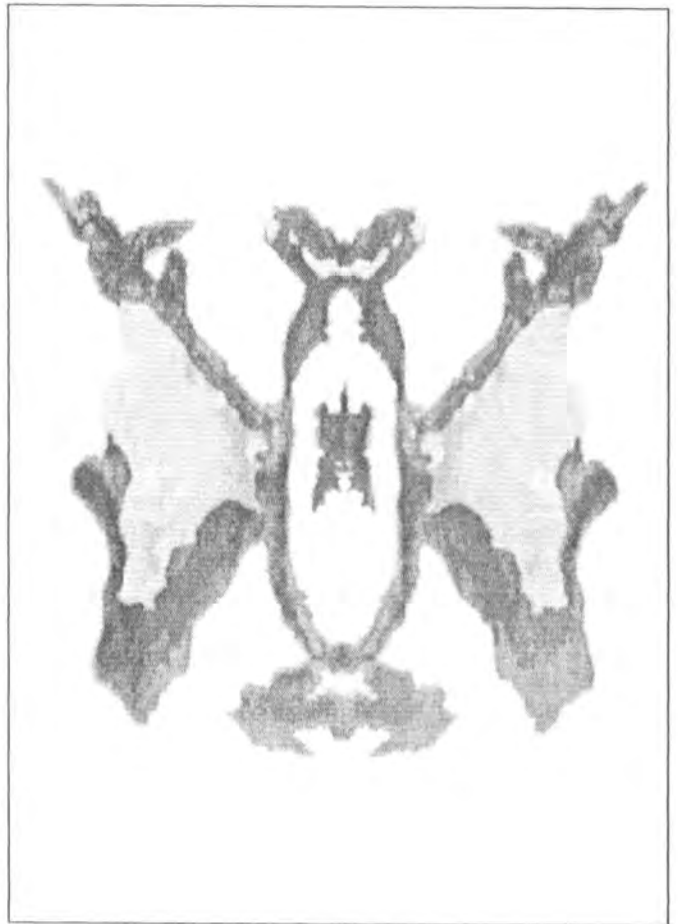
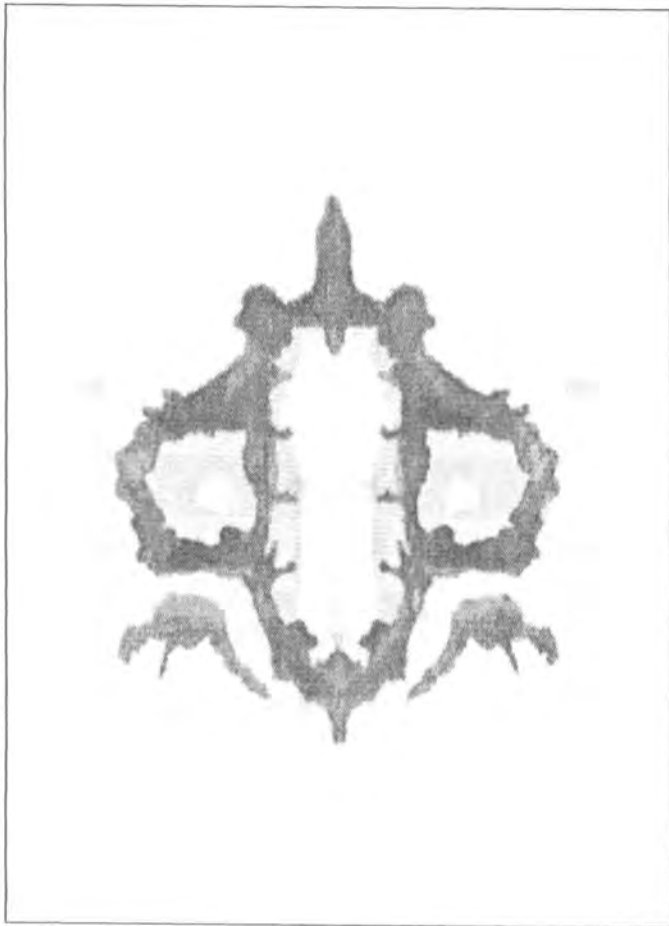
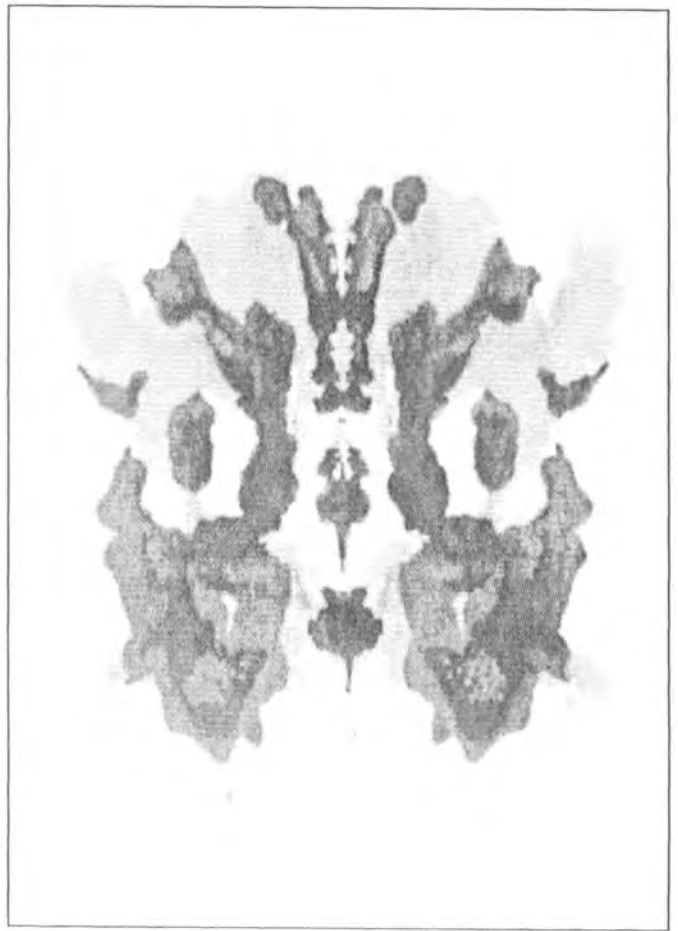
Judge, Municipal Court





*Singularly suggestive examples of Rorschach test inkblots.*





*Singularly suggestive examples of Rorschach test inkblots.*

# Alternate Asylum Ratings and the Recovery from Indefinite Insanity

**T**HESE RATINGS do not correlate with the information given in the Asylums chapter of this book, but do offer simple and effective ways to present important information.

If a keeper does not wish this modest additional detail, use the Overall Asylum Rating for the cure rate of the asylum, as per the Harsh Treatment Rules in the Call of Cthulhu rules.

## OVERALL ASYLUM RATING

Indicates the general quality of the institution, philosophy, physical plant, staff, finances, and so on. The rating is a percentage.

**101%+** — A superb asylum, one of the best in the world. Nothing is put ahead of the mental health of the patients. Only the most modern techniques are used.

**76-100%** — An excellent asylum. Doctors are genuinely concerned about the mental health of the patients.

**51-75%** — A good asylum. Although there is probably concern about the patients, other problems interfere. There may be overcrowding, insufficient doctors, or poor psychiatric techniques.

**26-50%** — An average asylum, usually more concerned with confining and maintaining patients than with helping them. Patients are usually offered either little or no treatment.

**1-25%** — An abysmal asylum, likely to do patients more harm than good. Physical conditions are usually sub-standard and treatments detrimental.

## ADDITIONAL FACTORS

The overall rating can compare different institutions, but investigators need more information to fit into the game. Use the following three factors:

**Recovery:** how quickly patients are cured. A percentage.

**Mental:** how well patients are treated emotionally and intellectually. A percentage.

**Physical:** how well the patients are treated physically. A percentage.

## Procedure

To recover from indefinite insanity, a player must determine the Recovery, Mental, and Physical scores of the asylum in which his investigator is confined. Ordinarily, these will be provided by the keeper. Then the player rolls against each of the three scores.

The Recovery roll determines how quickly a patient is released from an asylum. After making the recovery roll, consult the following table.

<i>roll</i>	<i>result</i>
critical	1 month
success	1D6 months
failure	1D6+3 months
fumble	1D6+6 months

The Mental roll determines how well the patient stood up to the psychological stresses of the asylum. Although good asylums benefit their patients, using psychiatric techniques and some psychoanalysis to allow broken psyches to heal, many use fear and pain as weapons to control their patients. After making the mental roll, consult the following table.

<i>roll</i>	<i>result</i>
critical	patient gains 1D6 SAN
success	no SAN change
failure	patient loses 1D6 SAN
fumble	patient loses 1D6 SAN and 1D3 INT

The Physical roll determines condition of the patient's health during his stay in the asylum. While good asylums may be clean, and patients well-cared-for, some madhouses are absolute cesspools. After making the physical roll, consult the following table.

<i>roll</i>	<i>result</i>
critical	patient gains 1D3 CON
success	no effect
failure	patient temporarily loses 1D3 CON
fumble	patient permanently loses 1D3 CON

Regain temporarily lost CON at the rate of one point per month. At the keeper's discretion, an investigator might alternatively lose APP, DEX, or STR, to reflect other possible adversities.

## AVERAGE CARE

If you don't need a hand-tailored place in which to stash a glassy-eyed investigator, the following numbers may do just fine. The comparisons between modes of care speak for themselves.

### 1890s

<i>location</i>	<i>overall</i>	<i>recovery</i>	<i>mental</i>	<i>physical</i>
home	47%	40%	10%	90%
priv. asy.	30%	30%	10%	50%
pub. asy.	12%	20%	5%	10%

### 1920s

<i>location</i>	<i>overall</i>	<i>recovery</i>	<i>mental</i>	<i>physical</i>
home	67%	60%	50%	90%
priv. asy.	50%	50%	30%	70%
pub. asy.	33%	30%	20%	50%

**1990s**

<i>location</i>	<i>overall</i>	<i>recovery</i>	<i>mental</i>	<i>physical</i>
home	85 %	80%	80%	95%
pri. asy.	70%	70%	70%	70%
pub. asy.	47%	50%	40%	50%

**ASYLUM RATINGS FOR THE SCENARIOS**

Here are the numbers for the three asylums discussed at length in this book.

**Bethlem Royal Hospital (Bedlam)**

Lambeth Road, London  
 Type: Public Hospital  
 9 Doctors  
 52 Staff  
 250 Patients  
 300 Beds  
 Overall Asylum Rating 25%  
 Recovery 20%  
 Mental 5%  
 Physical 50%

**Arkham Sanitarium**

225 E. Derby Street  
 Arkham, Mass.  
 Public State Hospital  
 3 Doctors  
 14 Staff  
 44 Patients  
 50 Beds  
 Overall Asylum Rating 45%, 20% for indigents.  
 Recovery 40%, 20%  
 Mental 50%, 10%  
 Physical 45%, 30%

**Bellevue Hospital**

462 1st Ave & East 27th Street  
 New York, N.Y. 10016  
 Public State Hospital, Psychiatric Clinic Section  
 45 Doctors  
 350 Staff  
 300 Patients  
 300 Beds  
 Overall Asylum Rating 75%  
 Recovery 75%  
 Mental 90%  
 Physical 60%



## Glossary

**Affect** — the emotional state or mood of a patient, or the external manifestations of these internal emotions.

**Akathisia** — restlessness and fidgeting, often the side effect of medications.

**Akinesia** — difficulty in performing voluntary movements.

**Alienist** — originally, a court or immigration psychiatrist; later, another term for analyst.

**Amimia** — inability to make or understand gestures.

**Amnesia** — memory loss. In *anterograde amnesia*, the patient cannot recall events after a significant event. In *retrograde amnesia*, the patient cannot recall events before the mind-numbing event.

**Amok** — homicidal mania; a culture-specific syndrome of Malaysia.

**Anal personality** — a person characterized by orderliness and obstinacy.

**Analgesia** — absence of pain sensation.

**Anankastic personality** — same as Obsessive/Compulsive Neurosis.

**Anesthesia** — absence of sensation.

**Anhedonia** — inability to experience pleasure.

**Anorexia nervosa** — an eating disorder in which the patient has a distorted body image, fear of obesity, and life-threatening weight loss.

**Anticholinergic effects** — dry mouth, blurred vision, constipation and urine retention caused by neurotransmitter imbalances, frequently as a side effect of psychoactive medications.

**Antidepressants** — a class of drugs that alleviate depression. Two major varieties are the *tricyclics* and the *MAO* (Monoamine Oxidase) inhibitors. Side effects include anticholinergic effects and heart arrhythmia.

**Antipsychotics** — a class of drugs that alleviate psychotic symptoms. Thorazine is the prime example. Side effects are wide and varied, including tardive dyskinesia, Parkinsonism, anticholinergic effects, tics, akathisia, etc.

**Antisocial personality disorder** — sociopathic personality: criminal, impulsive, irresponsible and sexually deviant.

**Anxiety neurosis** — hyperactivity and irritability brought on by stress.

**Aphasia** — deficit in language production. In Broca's aphasia, the patient is aware of the deficit and struggles to produce speech. In Wernicke's aphasia, the patient appears unaware of any problem, but the fluid speech that emerges is nonsensical.

**Aphonia** — inability to produce the sounds of normal speech, to be contrasted with aphasia, where linguistic ability is impaired.

**Arrhythmia** — alteration of the rhythm of the heartbeat that is of functional or organic origin.

**Aura** — a subjective flash of light experienced by someone about to suffer an epileptic seizure, migraine headache or other mental disturbance.

**Autism** — a disorder that develops early in life in which the child withdraws from reality and has severely impaired social ability. Other symptoms include echolalia, mutism and a need for sameness in the environment. Autistic savants (idiot savants) are rarer cases in which the autistic person has an extraordinary ability in a narrow area of specialization, such as mathematics, music or chess.

**Bedlam** — madness or chaos; corruption of Bethlehem Hospital in London.

**Bestiality** — paraphilia characterized by the need for animals to produce sexual response.

**Bipolar disorder** — modern alternate term for *manic-depressive* illness. This is a serious psychosis, subdivided into manic, depressive, and mixed, depending on the predominant state of the patient.

**Bleuler, Eugen** (1857-1939) — psychiatrist who described and named the condition of schizophrenia.

**Borderline personality disorder** — inability to maintain normal social relationships, fear of loneliness.

**Bruxism** — grinding of the teeth.

**Bulimia** — eating disorder characterized by excessive eating followed by purging through vomiting or severe dieting.

**Catalepsy** — trance-like state characterized by lessened response to stimuli.

**Cataplexy** — loss of muscle tone.

**Catatonia** — rigidity or inflexibility of the body. In agitated catatonia, violent and dangerous spasms of the muscles accompany the rigidity.

**Causalgia** — a sensation of burning pain.

**Cerea flexibilitas** — "waxy flexibility" of catatonic schizophrenia. The patient's limbs may be arranged, and they will remain as positioned like a wax doll.

**Compulsive personality disorder** — workaholic; obsessed with hobbies, work, or rituals.

**Conversion disorder** — loss of sense or paralysis with a symbolic meaning, usually a defense against a subconscious wish. If you wanted to hit someone, your right arm might become paralyzed.

**Coprophagia** — eating of feces.

**Coprophilia** — paraphilia dependent upon feces for sexual gratification.

**Countertransference** — feelings engendered in the therapist about the patient, such as anger at a hypochondriac.

**Culture-specific syndromes** — forms of insanity peculiar to particular societies. See also *Amok*, *Koro*, *Latah*, *Piblotko*, and *Windigo* as examples of these.

**Delirium** — general term for temporary loss of cognitive functioning due to disease or other organic brain syndrome.

**Delirium tremens** — alcohol withdrawal. Symptoms include hallucination, seizures, and crawling skin. It is a severe medical problem and may result in death.

**Delusion** — a false belief which is held to strongly, even in the face of proof.

**Dementia** — irreversible loss of cognitive functioning, usually due to an organic brain syndrome.

**Dementia praecox** — "Youthful dementia." obsolete term for schizophrenia, coined circa 1860, but still in use in the 1920s.

**Dependent personality disorder** — lets or forces others into running one's life. Indecisive, low self-esteem.

**Depersonalization neurosis** — feelings of unreality or estrangement from one's self or body.

**Depression** — lack of interest, sluggishness, suicidal tendencies, low sexual drive, low mood. Often there are problems with normal appetite, sleep, or concentration. When linked with mania or psychotic symptoms, it becomes bipolar disorder.

**Depressive neurosis** — neurosis characterized by depression.

**Dix, Dorothea (1802-87)** — reformer active in America in the 1840s who called for many of the same improvements as Pinel.

**Dyslexia** — impaired reading ability.

**Dysphagia** — difficulty in swallowing.

**Dystonia** — muscle spasms of the face and neck.

**Echolalia** — repetition of others' vocalizations.

**Echopraxia** — repetition of the movements of others, occasionally seen in catatonic schizophrenia.

**Ego** — Freudian term for the conscious self, the part that interacts with the real world.

**Egomania** — pathological preoccupation with the self.

**Electroconvulsive Therapy (ECT)** — shock therapy. Invented by Cerletti and Bini in Italy in 1938.

**Encopresis** — defecation during sleep.

**Enuresis** — Bed-wetting.

**Epilepsy** — particularly in temporal lobe epilepsy, the symptoms of this disorder may mimic those of schizophrenia or mania.

**Erotomania** — pathological preoccupation with fantasies.

**Euphoria** — emotional 'high.' Characteristic of the manic phase of bipolar disorder.

**Exhibitionism** — desire to expose one's self for sexual gratification.

**Exorcism** — early therapeutic technique involving shouting at the afflicted, making noise, ducking in water, potions, whippings, starvation, and exposure. Of dubious value, but better than being burned at the stake.

**Explosive personality disorder** — characterized by emotional instability leading to occasional outbursts of aggression, anger, or affection.

**Flagellation** — self-torture by whipping. Usually, but not always, for sexual gratification.

**Flight of ideas** — unstructured thought characteristic of mania.

**Folie a deux** — rare disorder in which a paranoid delusion is shared between two people.

**Formication** — the feeling that insects are crawling all over you. Often experienced in delirium tremens or cocaine intoxication.

**Freud, Sigmund (1856-1939)** — founder of psychoanalysis and its many related topics, such as psychosexual development.

**Fugue** — a breakdown characterized by amnesia coupled with physical flight from the cause of the personality dissociation.

**General Paralysis of the Insane (GPI)** — also called *general paresis*. Paralysis of the insane, a common disorder resulting from syphilitic infection.

**Gilles de la Tourette syndrome** — disorder characterized by involuntary tics, grunts, and shouted expletives.

**Glossolalia** — speaking in 'tongues'.

**Hallucination** — apparent sensation; usually auditory or visual, but all the senses are possible.

**Huntington's chorea** — late onset disease characterized by lurching and jerking movements. Progressive psychosis ensues.

**Hypnogogic** — referring to the period just before sleep, as in hypnogogic hallucinations.

**Hypnopompic** — referring to the period just after awakening.

**Hypnotics** — see sedatives.

**Hypochondria** — imagined health problems. Preoccupation with health and disease.

**Hysterical neurosis, conversion type** — blindness, deafness, or paralysis caused by stress.

**Hysterical neurosis, dissociative type** — amnesia, fugue, or multiple personality disorder brought on by stress.

**Hysterical personality disorder** — personality characterized by dramatic overreaction, craving attention.

**Id** — in Freudian terms, the seat of unconscious biological desires.

**Impotency** — male sexual dysfunction.

**Insomnia** — inability to sleep.

**Involution melancholia** — middle age depression. An obsolete term, used in the 1920s.

**Kirkbride, Thomas S. (1809-83)** — 19th century doctor who published a highly regarded treatise on how to plan and build mental institutions. Most American asylums built in the 19th century are modeled after the Kirkbride plan with central facilities connecting long wings divided into separate wards.

**Kleptomania** — the urge to steal; often small, inexpensive items.

**Korsakoff's dementia** — problem associated with alcoholism and severe memory impairment. To cover memory lapses, total fictions are created by the sufferer.

**Kraepelin, Emil (1856-1926)** — psychiatrist who at the turn of the century devised a classification scheme of mental illnesses that was essentially the same as that used today.

**Koro** — morbid delusion that the penis is contracting into the abdomen. The sufferer believes that his death will occur when the penis fully disappears; a culture-specific syndrome of SE Asia.

**Lability** — a state of unstable, shifting emotions.

**Lapsus linguae** — a slip of the tongue. Interpreted by Freud as an outlet for the silent id.

**Latah** — a culture-specific syndrome of SE Asia characterized by suggestibility and echopraxia. Similar to Voodoo zombies.

**Lethologica** — temporary inability to remember a proper name.

**Lithium** — medicinal treatment effective for the manic phase of bipolar disorder. Side effects include nausea and diarrhea. High dosages can be very toxic leading to stupor and coma.

**Lobotomy** — a procedure in which connections in the brain are surgically severed, usually in the frontal lobes. Invented in 1935 by Egas Moniz, who received the Nobel Prize for his work in 1949.

**Logorrhea** — unceasing talking.

**Loose associations** — speech characteristic of the disjointed thought processes of schizophrenia. Unrelated concepts follow each other.

**Mania** — hyperactive, euphoric state often found in bipolar disorder. Rapid speech and loss of concentration. Hypersexuality, social intrusiveness, and disturbed sleep.

**-Mania** — as a suffix, shows pathological preoccupation with something, as in pyromania.

**Manic-depressive illness** — now bipolar disorder, which see. The term manic-depressive was used exclusively in the 1920s, and is still commonly heard today.

**Megalomania** — delusions of power.

**Moniz, Egas (1874-1955)** — neurologist and psychosurgeon, developer of the prefrontal leucotomy (lobotomy), winner of the 1949 Nobel Prize.

**Monomania** — obsession about something; one-track mind.

**Moral treatment** — movement started by Philippe Pinel, involving an end to cruel or dehumanizing treatment, careful record keeping, and a pledge to not make any mental problems worse through treatment.

**Münchhausen syndrome** — feigning an illness to receive attention. Also, Münchhausen syndrome by proxy, in which one makes another ill (frequently a mother and child) to receive sympathy and attention.

**Narcissistic personality disorder** — obsession with the self, characterized by vanity, self-love, setting unrealistic goals, and overestimating own abilities.

**Narcolepsy** — feeling strong emotions causes loss of motor tone, uncontrollable drowsiness in the day, waking paralysis, and hypnagogic hallucinations.

**Necromania** — pathological preoccupation with dead bodies.

**Neologism** — a compound word invented by a psychotic, meaningless to the hearer.

**Neurasthenia** — constant weakness and fatigue. Lowered ability to laugh and experience pleasure.

**Neuroleptics** — see antipsychotics.

**Neurosis** — a maladaptive way of coping with stress. Anxiety.

**Nihilistic delusions** — delusions of the nonexistence of an object, a part of one's body or one's entire self.

**Nymphomania** — pathological preoccupation with sex. Usually applied to females; the male form is satyriasis.

**Obsessive/Compulsive Neurosis** — neurosis characterized by obsessive/compulsive behaviors. Obsessions involve constant unwelcome thoughts, or attention to minute details. Compulsions involve ritualistic, impulsive behaviors that are frequently repeated over and over.

**Organic brain syndrome** — general term for diseases, drugs, endocrine imbalances, heavy metal poisonings, or other physical problems that masquerade as insanity.

**Paranoia** — psychosis in which the patient has highly structured delusions. Affect is suspicious. If hallucinations are present, then the patient is schizophrenic.

**Paranoid personality disorder** — displays suspicion, but not linked to full-blown psychosis.

**Paraphilia** — orgasm is conditional on some unusual stimulus, such as an inanimate object, an animal, personal humiliation, pain, or an unwilling partner.

**Parapraxis** — a blunder or memory lapse.

**Paresis** — incomplete paralysis.

**Paresthesia** — creeping, tingling sensations.

**Parkinsonism** — symptoms reminiscent of Parkinson's disease seen in antipsychotic medicine side effects: shuffling gait, hand tremor, inexpressive face, muscle rigidity.

**Passive/aggressive personality disorder** — aggression displayed through passive means, such as procrastinating, stubbornness, intentionally forgetting things, etc.

**Pathomimicry** — same as Münchhausen syndrome.

**Pavor nocturnis** — "Night Terrors," usually experienced by children. The sufferer wakes up screaming from the early stages of sleep in which no dreams occur.

**Pellagra** — disease that results in the four D's: diarrhea, dermatitis, dementia, and death.

**Personality disorders** — unconventional behavior not linked to more serious symptoms like hallucination that would lead to a diagnosis of a serious mental illness.

**Phantom limb** — sensation of pain in an amputated or nonexistent body part.

**Phobia** — irrational fear of some stimulus or condition out of all proportion to the physical danger.

**Phobic neurosis** — phobia brought on by stress.

**Piblotko** — a culture-specific syndrome of the Eskimo characterized by crying and screaming fits and running naked into the snow.

**Pica** — eating disorder in which the patient eats non-food materials, usually dirt or clay.

**Pinel, Philippe (1745-1826)** — French doctor who advocated moral treatment for the insane, rather than keeping them in chains.



**Post-traumatic stress disorder** — a neurosis characterized by anxiety, bad dreams, flashbacks, and aggression. Follows extremely stressful events such as wartime service.

**Projective test** — psychological test with a loose structure; used to determine a subjects' personality. The Rorschach test is one such.

**Psychoanalysis** — a therapeutic theory that seeks to probe the unconscious sources of conflict that cause emotional problems. By exposing these urges, the patient's mental health improves.

**Psychosexual development** — Freud's idea of the development of the mind through various stages: oral, anal, phallic, Oedipal, latency, and genital.

**Psychosis** — severe mental illness in which the patient breaks from reality. Symptoms include disturbed thoughts and emotions, disorientation in space, time and identity, delusions, and hallucinations.

**Psychotherapy** — techniques for the treatment of mental illness.

**Psychotropic medications** — medicines that ameliorate symptoms of mental illness.

**Pyromania** — pathological preoccupation with fire.

**Rorschach Test** — A psychological test using inkblot designs that the subject describes in terms of what they see in them. Named for Hermann Rorschach (1884-1922), Swiss psychiatrist who devised the test.

**Satyriasis** — male nymphomania.

**Schizoid personality disorder** — eccentric personality that avoids social contact, remains aloof and cool.

**Schizophrenia** — a general term for a variety of psychoses characterized by delusions, hallucination, emotional disturbance, gaps in logical thinking, withdrawal, flat affect and loose association in speech. Also false ideas of reference, such as thinking that strangers or TV announcers are talking about you. There are four major varieties:

**catatonia schizophrenia** — catatonia interspersed with agitated catatonia, 'waxy flexibility'.

**chronic undifferentiated** — not in any of the other categories. Usually an emotionless affect. Stress increases impairment.

**disorganized schizophrenia** — inappropriate affect, silliness. Previously called hebephrenia.

**paranoid schizophrenia** — delusions of importance or persecution, suspicious affect.

**There are also some other categories —**

**acute schizophrenia** — sudden onset following a stressful incident.

**childhood schizophrenia** — patient is prepubescent and withdrawn

**latent schizophrenia** — Schizophrenic symptoms but no psychosis

**residual schizophrenia** — latent after one psychotic episode

**Schizophreniform disorder** — same as acute schizophrenia.

**Shizotypal personality disorder** — Displays a mild bizarreness in thought; unusual word usage, but no loose associations.

**Scotoma** — figurative or literal blind spot.

**Sedatives** — a class of drugs that help reduce anxiety. Librium, Valium, and Xanax are common today.

**Shell shock** — WWI term for post-traumatic stress disorder.

**'Shock' therapy** — a variety of procedures involving the injection of drugs such as metrazol or insulin to induce seizures in mental patients. See also Electroconvulsive therapy.

**Sociopath** — someone suffering from antisocial personality disorder

**Strophosymbolia** — the reversal of letters or numbers in reading or writing.

**Stupor** — a state in which one is unaware and unreactive to one's surroundings. Sometimes the person is aware, but is totally paralyzed.

**Superego** — Freudian term for the part of the self that contains the moral values of the patient's culture.

**Tardive dyskinesia** — protruding or writhing tongue, chewing motions and rocking. A common side effect of psychotropic medication.

**Transference** — emotions that a patient develops for his or her psychotherapist. Often the analyst becomes a father/authority figure or the focus of sexual feelings.

**Transvestism** — dressing in clothes appropriate for the opposite sex. Sometimes a paraphilia.

**Trepanning or trephining** — primitive psychosurgery performed in many ancient cultures. Holes are bored in the skull, possibly to allow evil spirits to escape. The release of pressure on the brain could possibly have been of value in certain circumstances.

**Trichotillomania** — pathological preoccupation with pulling out one's hair.

**Voyeurism** — being a Peeping Tom. Sometimes a paraphilia.

**Wagner-Jauregg, Julius von (1857-1940)** — winner of the 1927 Nobel Prize in medicine for his work on fever therapy as a cure for GPI. Instrumental as one of the first objective cures available to psychiatric medicine, even despite the dangers of the treatment.

**Windigo** — syndrome characterized by agitated depression, biting impulses, fear of being bitten, and the delusion that one is possessed by a flesh-eating monster; a culture-specific syndrome of Canadian Indians. Or is it?

**Word salad** — apparently disjointed speech characteristic of schizophrenia.

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Grob, Gerald N. *Mental Illness and American Society, 1875-1940*. Princeton, N.J.: Princeton University Press, 1983. Excellent historical description of the treatment of the insane.

Hurd, Henry M. (ed). *The Institutional Care of the Insane in the United States and Canada*. Baltimore: Johns Hopkins Press, 1916. Available in a reprint edition from 1973, this massive four volume work is invaluable in describing asylums in approximately the era of *Call of Cthulhu*. The first volume has general notes with a wealth of detail, while the remaining three cover U.S. and Canadian institutions. Some photographs of the hospitals show them to be dreadful Victorian monstrosities.

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Valenstein, Elliot S. *Great and Desperate Cures*. New York: Basic Books, 1986. A depressing book which details the many bizarre psychiatric "cures" proposed over the ages.

## Films

For less bookish keepers, several films have a particular connection to madness and institutional care. Most are widely available on videotape.

*Asylum* (1972). A tense British film based on four Robert Bloch short stories. The sanatorium provides the framing device for the anthology.

*The Cabinet of Dr. Caligari* (1919). It's unfortunate that the poor quality of the film stock doesn't allow a better look at the eerie sets that were designed for this film. Still, an aura of madness broods over this German Expressionist masterpiece. The ending, although quite abrupt, is chillingly effective and sends the whole story swirling into insanity. Probably not for people who want their MTV, but if you can handle this silent film, it'll leave your jaw hanging with stupefaction at the end.

Also noteworthy is *Dr. Caligari* (1989) in which not only the characters, but the director and the studio also suffer from debilitating insanity. One can only say... chinchilla, chinchilla, chinchilla!

*Dracula* (1931). Tod Browning's version is still the best. Everyone's favorite insectivore, Renfield, is played with gleeful insanity by Dwight Frye. Renfield is kept in Seward's Sanatorium, which apparently has locks of a very inferior quality as Renfield is always lurking about the place.

*Love Crazy* (1941). An excellent screwball comedy. Myrna Loy plays a woman convinced that her husband (William Powell) has had an affair, and decides to divorce him. He feigns insanity in order to forestall the proceedings until a lunacy commission examines him. Not only is he unsuccessful in getting his wife to take him back, but he is found insane and institutionalized in a private asylum. The film provides some good scenes with the psychiatrist and attendants that might come in handy to confront investigators who protest their incarcerations.

*One Flew Over the Cuckoo's Nest* (1975). The film version of Ken Kesey's novel swept all five of the big Oscars, the first film to do so since *It Happened One Night* and the last until *Silence of the Lambs*, another excellent film with elements of the insane.

Jack Nicholson plays McMurphy, a criminal placed in a mental institution for examination. McMurphy inspires rebellion among the other inmates and earns the enmity of the authorities who want nice, quiet patients.

*Shock Corridor* (1963). A newspaper reporter decides to get the inside scoop on insane asylums and publish a lurid expose, as many journalists really have over the past century. As he grows closer to solving a murder that occurred at the institution, he slowly goes mad himself.

*The Snake Pit* (1948). Olivia de Havilland plays a newlywed who suffers a nervous breakdown and is sent to Juniper Hill State Mental Hospital for treatment. She was nominated for the Best Actress Oscar for her brilliant portrayal of someone suffering from mental illness. Just watch her self-conscious smile as she goes in for the first staff evaluation. The film displays hydrotherapy, electroshock therapy, hypnotic therapy, and a slavish devotion to Freudian analysis, ponderously explicated while Sigmund watches from a picture on the wall. Adapted from Mary Jane Ward's autobiographical book of the same name.

*Titicut Follies* (1967). Although Frederick Wiseman made this documentary in 1966, it didn't see the light of day until 1991, when Wiseman won the right to show it. The film is about the mental institution in Bridgewater, Massachusetts, and the state was so embarrassed that it had the film banned for twenty-five years. Wiseman's hands-off style lets you form your own judgment about the institution, its patients and the employees.

Despite the state's reaction, don't expect whippings and manacles. At worst, the patients are dehumanized by indifferent attendants, being kept naked, and being forced to watch the yearly talent show that provides the title of the film. Still, it's hard not to believe Vladimir, a paranoid patient, when he insists that the place is making him worse. Note the foreign psychiatrist—imagine him forty years earlier, in 1926, fresh out of med school in Vienna and ready to practice on American patients.

The film gives a good idea of the hopeless and depressing character possible in a mental institution. The authenticity of the illnesses presented make it much more emotionally disturbing than the almost humorous depictions in other films.



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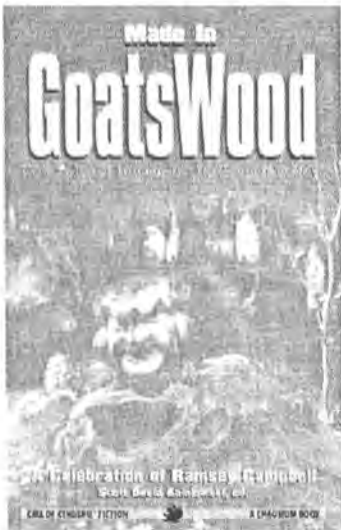
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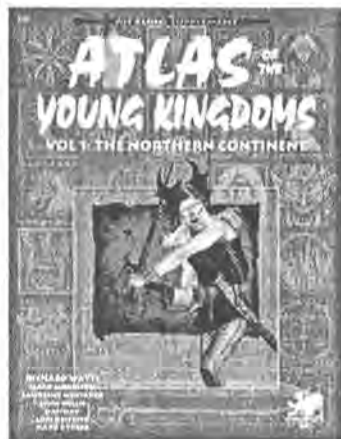
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— H.P. Lovecraft

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