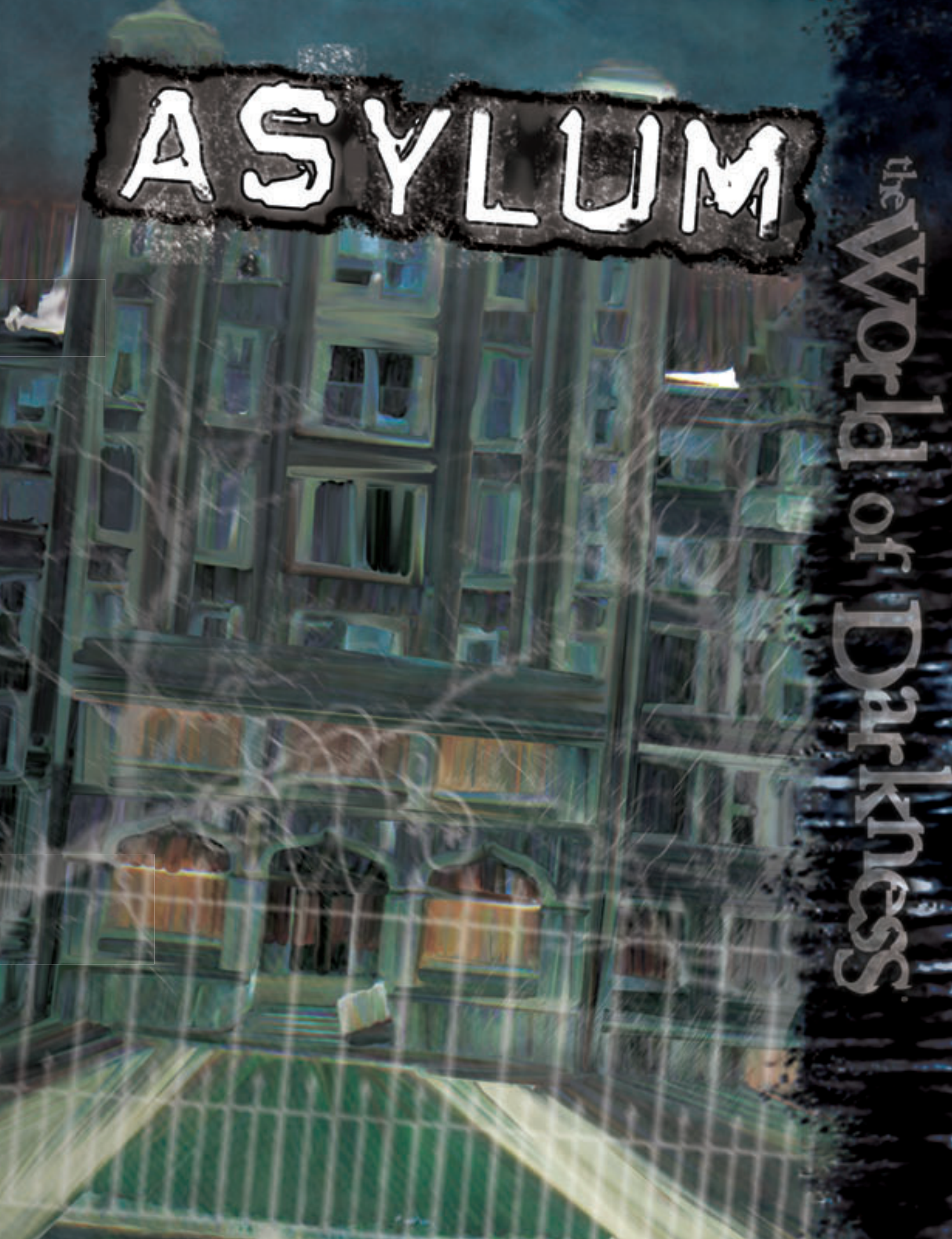


ASYLUM

the World of Darkness



ASYLUM



BRUCE BAUGH | HOWARD INGHAM |
GEORGE HOLOCHWOST | MATT MCFARLAND



WARREN WHALEN MENTAL ASYLUM

(555)555-6257

PO BOX 757

MIDLAND, USA

People helping people are the greatest people in the world.

Patient: Steven Young

Attending Physician: Angela Manning

Case Number: 32448665-75512

Description & History

.....
Diamonds

Does anybody ever really read these things?

Steven looked at what's he'd written on the form, and then pushed his chair back. It was definitely time to quit for the night. He looked around his office and saw paper covering every square foot. Patient reports, session write-ups, insurance forms, consent forms, medical waivers, dispensation forms....

No one reads it all.

Steven stood up and left. He left his pen uncapped in the middle of the paper. He left his coffee mug, still half full, on his desk. He did not plan on returning that night, nor the next day. He did not plan on returning until Monday, even though he would have to come in three hours early in order to finish this week's paperwork before a new crop appeared. On Monday, Steven would curse himself for doing that. When he left his office that night, though, he wasn't thinking about Monday. He was thinking about diamonds.

...

"We're collecting diamonds on a beach. That's all we're doing."

The bartender refilled Steven's drink. He didn't have to ask where Steven worked. He was used to employees from Warren Whalen Asylum coming in here to get drunk. "Say again?"

"Diamonds. Imagine you're on a deserted island and you keep finding diamonds on the beach. They're worthless to you, right?"

The bartender nodded absently and glanced around the place. Slow night.

"You can't eat 'em. There's no way to sell them because you're deserted. On an island. So why pick them up?"

"In case you get rescued, I guess."

Steven knocked back his drink and slammed down the glass. "Right! Just in case. *Just in case*. Motherfucker." He motioned to the bartender for another shot, but the bartender pretended not to see. "Just in case the patient ever improves. Just in case the funding comes through. Just in case the north wing ever gets fixed. Meanwhile, we've got computer systems that are 10 years out of date. We've got new technology that nobody's been trained on using, because there's no budget for CE."

"CE?"

"Continuing education."

"Right." The bartender again ignored Steven's motion toward the glass. This guy, the bartender reasoned, had probably had enough, but better to let him figure that out.





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“So what was I – diamonds. Right. But we’re making all these reports, wasting whole forests of paper, collecting diamonds on a beach. *Just in case* a boat shows up and picks us up, we’ll be rich. But is that *likely*? No.”

“So what should you do instead?”

Steven cocked his head. “On the island? Fuck, I don’t know.” He picked up his glass and shook it at the bartender.

“Think you’ve had about enough, man.”

...

Monday morning, Steven arrived at the asylum at five in the morning. He had a nine o’clock meeting, but all his paperwork had to be done first. He told himself he’d leave early, but some part of him knew that he’d likely be stuck here until at least six that night.

He stood by the elevator and watched the floor numbers light up. The elevators here still used the old plastic-paneled indicators, rather than LEDs. Steven got in the elevator in the parking garage level, and turned his key. Without the key, the elevator would only go to the first floor, the main entrance. Steven’s office was on the fourth floor. The elevator stopped at the first floor, people got on, nodded to Steven, and got off on the second floor.

“Take the goddamn stairs,” he muttered as the doors closed. The elevator whirred to life...and then sputtered and stopped. The lights went out, and Steven heard a loud, metallic *thud* from above him.

The elevator slipped a few inches. “Shit,” he whispered. He felt his heart start to race. He groped out in front of him for the emergency button, but then the elevator lurched to life again. It stopped on the third floor, and Steven hurried out. He took the stairs up to his office and called maintenance.

The guy from maintenance told him to fill out a request form and have it delivered downstairs.

...

“I think we should cut down on paperwork,” said Steven. The meeting was abnormally long that week. Everybody had a lot of business to go over, the minutes from last week were exhaustive and tedious, and the other people there sat behind four-inch stacks of paper.

“Amen,” said someone at the other end of the table. It might have been Tracy, the SLP. Steven hadn’t been looking.

“No, really.” He took a sip of tea and looked at Mr. Tamber, the representative from the hospital’s bureaucracy. “What could we do to cut back a little?”

Mr. Tamber pushed his glasses up the bridge of his nose. “You’ve got a suggestion?”

That was my suggestion, jackass, Steven thought. “Well, how about cutting out the forms for these meetings, for a start? They just get filed without getting read, right?”





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Tamber shook his head. "Sue looks those over to make up the minutes for the meeting." He glanced at Sue, who nodded half-heartedly.

"OK, well, what about the session reports? Could we maybe merge them with the SOAPs and the insurance write-ups, just so folks like Tracy and Dawn aren't filling out three different forms with the same information?" Tracy and Dawn perked up.

"But those forms all go different places," said Tamber. "Different people need to see them."

"Right," said Steven, frustrated. "But they all say basically the same thing, so why not make *one* form, fill it out *once*, and make *three* copies?"

Tamber narrowed his eyes and made a note. "I'll pass it along to the management."

In other words, get fucked, thought Steven. "Thanks."

...

"Thanks for what you did today," said Tracy, leaning into Steven's office. It was almost six-thirty. Steven was considering ordering a pizza; the paperwork was taking him longer than he'd thought.

"You know nothing's going to come of it."

Tracy smiled. "I know. But it was a nice thought." She glanced at the papers on Steven's desk. "You actually going to stay and finish that?"

"I have to. Most of this is from last week. If I let this go I'll be well and truly fucked by Thursday. I can't touch paperwork on Wednesdays, I've got patients back-to-back all day."

Tracy came into the room and sat down in the spare chair. "I know the feeling. That's what Tuesdays are like for me." She glanced at the top of Steven's in box. "You're not going to send this out, are you?" She held up the form he'd started on Friday. It still said *Does anybody really read these things?*

Steven smirked. "Ah, screw it. I don't think anybody ever *does* read them." He stretched. "You working late tonight? Want to split a pizza?"

Tracy stood up. "No, thanks. I've got one more SOAP to do and then I'm going home." A crack of thunder sounded in the distance. "Shit. I hope I rolled up my windows."

Steven didn't respond. He was reading his next form. The ones from the insurance companies were always the worst.

It was eight forty-five when Steven left that night. His wrist hurt so badly from writing reports that he could barely sign out at the front desk. He took the stairs down to the garage. The air had the smell of old oil and new rain, and when Steven pulled his car out of the garage, there were deep puddles on the road. *Must've missed the worst of it,* he thought.

Steven passed four accidents on the way home. The worst of them had snarled traffic for five miles back up the highway, and by the time Steven passed the site, there was nothing but broken glass and sand on the road. The flares were burning out and the cops were just standing there looking shocked. *Must've been bad,* Steven mused, and drove on, glad to be out of the gridlock.

He got home to find a form in the mail from the American Psychological Association. It was time to pay his dues again. He tore the form in half and opened a fresh bottle of scotch.

...



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The next morning, he knew something was wrong even before stepping out of the staircase. The mood at Warren Whalen was somber and silent. Dawn, tears running down her face, caught him as he poured himself a cup of coffee. Tracy had died in a car accident last night. She'd skidded off the road into a tree and been killed instantly.

Steven took his coffee to his office and locked the door. He sat down at his desk and stared at the photos of his family, his cat, his ex-wife. It took him an hour to realize that the accident he'd driven past last night was about the right time and place, and that the dark stains on the road were probably the last he'd see of Tracy.

Steven spent the morning in his office with the door shut, trying to clean the place up. He hated his response to death, because he wound up counseling people through death so often. He knew the probable responses, and he knew that his cleaning instinct was just a way for him to feel active while exerting some control over his environment. He hated that, because it made him feel that, because he understood it, it was not a valid response to the death of a friend.

Tamber called a meeting for the next morning. Steven spent the afternoon seeing as many patients as he could, since he had a feeling the meeting would go all day. That meant that his patients made little progress, since they were out of their routine. Some of them were supposed to have therapy with Tracy that day, as well, and Steven had to explain to them why they wouldn't see Tracy again.

...

One of them was a teenaged girl named Angie. Angie insisted that Tracy had been murdered. Angie was paranoid and probably schizophrenic, but her parents didn't believe in drugs and so hadn't allowed her to get the proper treatment. She'd ended up here after ramming a letter opener through her little brother's cheek and puncturing his sinus. Now she was pacing around the room, talking about Tracy.

"They killed her, they killed her," she said.

"Who do you think killed her?" Steven was going through the motions. It was like filling out a form, just one more bit of paperwork. Without drugs, Angie was never going to improve to the point that this kind of therapy would help her, but he had to keep seeing her anyway. Just one more diamond from the beach.

"The people upstairs."

"There aren't any people upstairs," said Steven. "The fifth floor has been closed for a year, now, and that's the top floor."

"Nuh-uh." Steven hated that whine she used.





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“The sixth floor’s still there. I know they said they took it off, but it’s still there. It’s *five plus one* so if you push the ‘five’ button and then the ‘one’ button, you’ll get there.”

“Angie, there are only five floors here, and the fifth one is empty.” Angie started knocking her knuckles together, and Steven decided to change the topic before she became incoherent. “OK, OK. Who do you think is up there?” In the past, Angie had talked about ghosts and aliens. Steven was expecting something similarly strange.

“The offices,” she said. “The administration.”

Steven looked up from his notebook. “You mean the hospital administration? That’s in a separate building.” *Lucky fucks.*

Angie shook her head so vigorously her glasses fell off. “No, no, no. The administration for *us*. And for *you*.”

“I’m not sure I understand.”

Angie sat down and looked straight at Steven. Steven felt himself start to sweat, though at the time he didn’t know why. “You’re inside our heads,” she said. “You, Tracy, Dawn and everybody who works here. You’re inside our heads.”

“You mean, like, you’re imagining us?”

“No, no, no. I mean, it’s like, you’ve *come* into our heads. You pushed your way in, and now you’re in here, and it’s like a maze. And the only what you can get out is to go back the way you came, and that’s like quitting here, or come out the other side, and then you’d be in here with us.”

“I *am* in here with you,” Steven said before he could stop himself. Angie didn’t seem to realize what he meant.

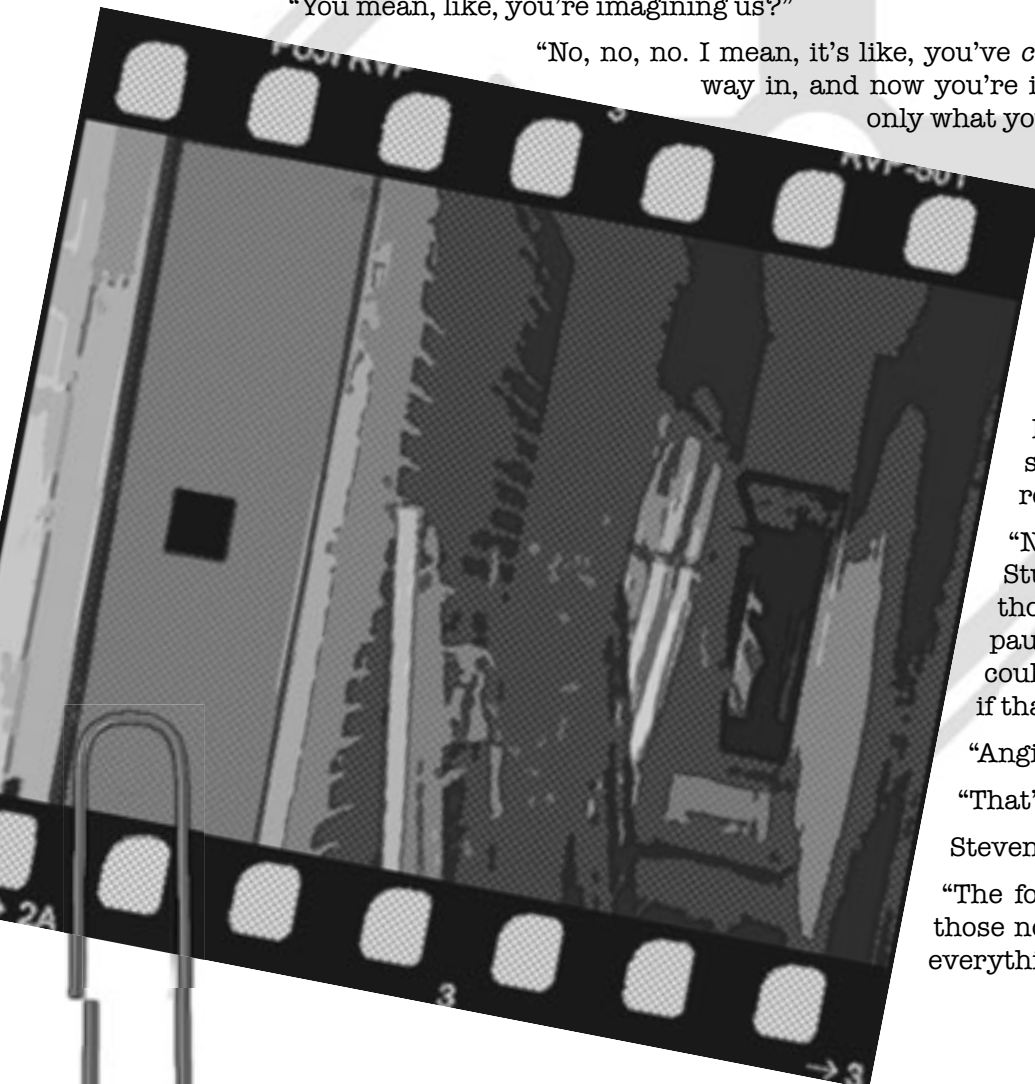
“No, I mean, you’d be like me. Like us. Stuck here answering questions. And those are the only ways to get out.” She paused and pursed her lips. “I guess you could die, too, like Tracy, but I don’t know if that counts.”

“Angie—“

“That’s what all the forms are for.”

Steven put down his pen. “Excuse me?”

“The forms! You all fill them out, right? All those notes and forms and things? You write everything down?”





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“Yes, we have to. We have to keep track—“

“I know.” Angie’s voice grew quiet and conspiratorial. “You have to keep track, because it keeps your place in the maze. When somebody quits or dies, someone else comes in to replace them. And they have to use the forms to figure out where the old person was, or else they’d have to start all over.”

Steven looked down at his notes. “So, who’s upstairs again?”

“I told you,” she said. “The administration. The people in charge.” She glanced up at the ceiling, and then looked back down at Steven and mouthed *they can hear us now*.

On any other day, Steven would have found that funny.

...

The next day, Steven went to the meeting and listened to Tamber drone on about how tragic it was, but that they had to keep seeing patients and don’t forget to do your reports. Also, did anyone have time to help sort through Tracy’s forms so that, when they did hire a new SLP, she could get up to speed quickly? *Find her place in the maze, you mean?* Steven thought, and almost said it out loud, but caught himself.

He left that meeting feeling angry. He was so angry that he forgot that he hadn’t turned in the maintenance form and got on the elevator anyway. It ground to a halt again as it was descending, and Steven heard the *thud* from above him. Instead of being frightened this time, though, he just sat down.

Diamondsonthebeach, hethought. Tracydies, andwe’restillcollectingthosefuckingdiamonds.

He wondered if Tracy had family. He thought he remembered her saying something about a brother in the Navy, but that might have been Dawn who said that. He had heard talk around the office of a memorial service this weekend, but hadn’t heard any firm plans.

Bet the “administration” up on the sixth floor would know, he thought and let out a choked laugh. He stood up and walked to the panel, and moved to press the red emergency button. He stopped, smirked, and press “5.” Nothing happened...but did something move, slightly, on top of the elevator?

Of course not, Steven thought, and just to prove it, he pressed “1.”

The elevator sprang to life, and started carrying him up. The floor indicator showed 3...then 4...then 5...and then a crude, hand-drawn numeral 6 appeared, the light a slightly redder shade than the others.

The doors opened. Steven stepped out. The ceiling was very low, here; it brushed the top of his head as he walked. “Hello?”

A door opened somewhere down the hall. “Who’s there?” The voice was thin, high-pitched, but Steven couldn’t tell if it was a man or a woman.





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“My name is Steven Young. I’m a clinical psychologist. I work downstairs.” Steven walked forward, past doors that seemed too narrow. The light here was dim and reddish.

“Yes, we know you, Steven. But what are you doing up here?”

“Well,” Steven stopped. What was he doing? “I was in the elevator—“

“Oh, hell.” The voice sounded disgusted. “It’s not Wednesday already, is it?” A door opened and Steven heard footsteps.

“Yes, it’s Wednesday. What’s that’s got to do with anything?”

“Tracy died Monday night?”

Steven took a step back. “Who the hell are you?” He looked behind him. The indicator light above the elevator door said that it was on the fourth floor.

“And you had your last session with Angie yesterday?”

“My last—“

A shadow filled the hallway. Something was walking toward him, something too tall for the corridor. “I’m sorry about all this. It’s usually much smoother, but I just can’t seem to get caught up this week.”

...

“This will be your office,” said Tamber, pushing the door open. “Sorry about all the boxes. We’ve been trying to go through Dr. Young’s papers and figure out the status off all his patients, but with both him and Tracy...you know, in the same week and all...”

“I can’t even imagine,” said the new psychologist. She looked around the room and sniffed. “Is it me, or does it...sort of stink in here?”

Tamber walked into the room and looked around the desk. He held up a coffee mug. “Oh, my God. I’m sorry about this. This is what’s doing it. Looks like this has been here since last week.” He opened the window. “You should probably let it air out a bit in here.”

“No, that’s all right. I need to get started if I want to see any patients this week.”

Tamber left the office and the new psychologist closed the door. She sat down at the desk and pulled the top paper from the box. It was a session report, but the words at the top of the page read *Does anyone ever really read these things?*

Of course we do, she thought. She noticed that Dr. Young hadn’t signed it, so she added her signature to the bottom, and then dropped it into a box labeled “Sixth floor.” The files in the box would probably just wind up being stuck in storage after she was through with them, but they’d be kept for a period of years, just in case. The word “diamonds” popped into her head, but she wasn’t sure why.

A knock at the door, and then a pretty blond woman stuck her head in. “Hi. I’m Dawn, the OT. You’re Dr. Manning, right?”

She stood up and went to shake Dawn’s hand. “Yep. Call me Angela.”



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“Angela. OK.” Dawn looked at the office and shook her head. “Wow.”

“What?”

“Oh, nothing. It’s just weird, still.”

“What? Oh, you mean the guy who used to work in here? Dr. Young?” Angela lowered her voice. “I heard they found him in the elevator.”

“Yeah.” Dawn swallowed hard. She’d been the one who had found him. “He chewed his own wrists open.”

“Is he still here?”

Dawn nodded. “For now. They’re transferring him next week. Nobody here can treat him. He still knows everybody, so it’s too weird for us to try and work with him.” She rolled her eyes. “You wouldn’t believe how many forms we had to fill out to convince them.”

“Them?”

“Oh, you know. The higher-ups.” Dawn backed up a bit. The office still smelled funny. “There’s donuts in the kitchen, by the way. Good meeting you.”

“You, too.” Angela sat back down at the desk. She had a few more forms to fill out for the higher-ups, herself.



Credits

Written by: Bruce Baugh, Howard Ingham, George Holochwost, Matt McFarland

World of Darkness created by Mark Rein•Hagen

Developers: Joseph D. Carriker, Jr. and Will Hindmarch

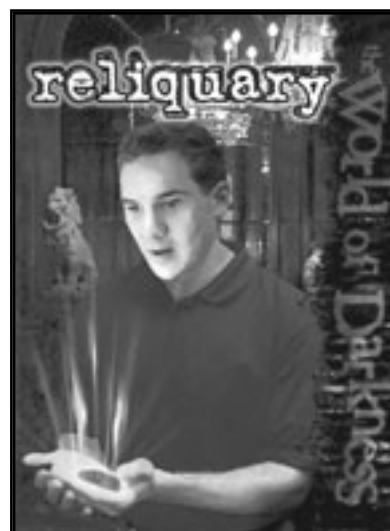
Editor: Scribendi.com

Art Director: Mike Chaney

Book Design: Mike Chaney

Interior Art: Costas Harritas, Mattias Tapia, Ken Meyer Jr, Matt Dixon, James Cole, Jeremy McHugh, Avery Butterwrth ,Mike Chaney. & matt milberger

Cover Art: Becky Jollensten



Coming Next for
the World of Darkness



MOUNTAIN EAST BUSINESS CENTER
2075 WEST PARK PLACE BOULEVARD
SUITE C
STONE MOUNTAIN, GA 30087

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ASYLUM

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Introduction

We know the images. They are familiar in all histories of psychiatry, where their function is to illustrate that happy age when madness was finally recognized and treated according to a truth to which we had too long remained blind.

— Michel Foucault,
Madness and Civilization

Despite the name, this book isn't solely intended to look at asylums in the World of Darkness. In fact, the focus of this book is health institutions of all sorts; it's just *easiest* for the horrors of the setting to come home to roost among the mad.

This book is about playing the dedicated men and women who work to save lives and minds in the World of Darkness, who work to improve the quality of life for their patients despite cold superiors, stifling bureaucracy and their own problems. This book is also about playing those treated by the hospital staff — men and women who have seen too much of the rot at the core of the World of Darkness. Not all of it is supernatural; in fact, most of it is normal, human madness. But in the bleakness of this setting, there is little patience or empathy for those who simply find that they haven't the psychological resources to deal with the world around them.

World of Darkness: Asylum looks at both sides of the one-way mirror, examining the health institution — whether hospital or asylum — and offering useful tools for playing nearly anyone found within.

Madness and the Asylum

This book can serve a variety of uses for the player or Storyteller of a World of Darkness chronicle. Of course, it can serve as a useful sideline resource, providing the tools for an enterprising Storyteller to add his own asylum to his setting, a place where madness and fear are supposedly set away from society, but in truth are gathered to breed and intermix. This book can also serve the player whose character takes an interest in someone who works in such an establishment — or someone who is locked within it. The player may also decide his character is one such individual, whether he is a vampire chosen from the inmate population or a psychologist who Awakened to the howling Pandemonium at the top of the Mastigos Watchtower.

More than that, however, this book can also serve as the core for a chronicle. The game itself might be based out of the asylum proper, with players taking the roles of inmates trying to survive their time within it, or that of the staff working to do good despite the brutality and insanity within. The asylum may be the established hunting grounds of a coterie of vampires in a **Vampire: The Requiem** game, or the site of a powerful — if dangerous — locus defended by a pack of Uratha in a **Werewolf: The Forsaken** game. Likewise, it may be the site of a potent Hallow for a cabal of mages in a **Mage: The Awakening** game, the retreat from society that a throng of the Created retreat to occasionally in a **Promethean: The Created** game or a known point where the Others have punctured the Hedge into the world of men in a **Changeling: The Lost** game.

Theme

In the heyday of the cold war, the Soviet Union established *psikhushka*, or psychiatric hospitals. They were the destination for all manner of social undesirables — nominally those who were insane but also criminals, those who maintained philosophies that the government disapproved of and political dissidents. Thus, our theme for **World of Darkness: Asylum** might best be summed

up as “psikhuska,” the concept wherein a variety of paths may lead to the same frightening place. It also conjures images of the asylum as gulag, a place for outcasts that is utterly separated from the real world to such an extent that even those who work there and are technically free find themselves sharing that exile.

Mood

“Isolation and internal vastness” exemplify the mood of **World of Darkness: Asylum**. The world within the institution — whether hospital or asylum — is massive and vast, utterly impersonal and strange. In such a situation, the best-case scenario seems to be isolation and separation from everyone else within it, because it seems that the only time anyone gets up close and personal is when they’re looking to exercise some kind of depravity that they want hidden. In such a place, the less you know about people, the better. Ignorance truly is bliss, and anonymity is a blessing.

How to Use This Book

This **Introduction** provides a variety of inspirations for the sorts of stories this book will help you tell, as well as providing a handful of useful bits of terminology.

Chapter One explores the history of asylums, institutionalization and concepts of madness, as well as looking at the uncomfortable parts of every era of the asylum — from the filth and neglect of early years to the sterile dehumanization and mandatory drugging of modern facilities.

Chapter Two looks at rules for playing medical characters, an examination of medical procedures in the **World of Darkness** chronicle (including an in-depth look at the **Medicine Skill**), plus a handful of new derangements and Merits.

Chapter Three introduces Bishopsgate Hospice and Asylum, a grand old institution with a history of horrible violations and tragedies. Bishopsgate is designed to be placed in just about any **World of Darkness** chronicle with a minimum of work.

The case studies of **Chapter Four** present 10 different patients at an institution. Each is a mystery in his or her own way, and each is presented with at least two different explanations for the mysteries, allowing Storytellers to choose which applies to the patient — or to use them as inspiration for their own explanations.

Chapter Five is a gallery of useful archetypes for characters that might be found in hospital or asylum — patients and staff alike.

Finally, the **Appendix** takes a look at madness in the **World of Darkness** as it is associated with the myriad creatures of the night. What effect do vampires have on their prey, and what happens to those mortals exposed to the predatory glory of werewolves at hunt? How does the twisting of reality that mages work around them affect the sanity of those who have the misfortune of being nearby? What

are the long-term effects of Disquiet from Prometheans, or of the manipulation of mortal dreams by changelings?

Inspirations

The following books, movies and other pieces of media served the creators of this book well, providing ample inspiration for the creation of a world of institutionalization and madness, of medicine and simple human misery.

Books

One Flew Over the Cuckoo’s Nest, by Ken Kesey. Though the movie by the same name starring Jack Nicholson is great, the novel is absolutely essential for its insight. This book is thought to be a product of the author’s own time working in an asylum, where he not only spoke in-depth with patients but actually received electroconvulsive therapy and took the psychoactive drugs they did in order to better understand their lives. This book is an amazing look at what it was like to live in an asylum, with its own medical petty dictators, twisted inter-relationships and sometimes questionable reality.

Red Dragon, The Silence of the Lambs, Hannibal, Hannibal Rising, by Thomas Harris. Though these stories look at strange manifestations of madness in individuals throughout the series, the asylums as presented in these books are functionally prisons that also happen to offer something in the way of treatment. Ultimately, the level of security in such places makes for difficult roleplaying; **World of Darkness: Asylum** is about institutions that seek to heal but are functionally prisons in their own way.


Taint of Madness, Arkham Sanitarium, for the **Call of Cthulhu** line, by Chaosium. Classic examinations of the milieu — of horror paired with madness. The setting of this material is more appropriate to the kinds of Gothic asylums emphasized by writers around the turn of the century, though: tremendous neglect, torture disguised as treatment and the likelihood of the keepers being just as mad as the kept. Tremendous inspiration for injecting bits of sanity-rendering horror into institutional settings, however.

Movies

Bram Stoker’s Dracula, Amadeus, Fight Club, Hellboy. These are no-brainers, really, with interesting looks at creepy psychiatric environments. You’ve probably seen them. If not, now’s a good excuse.

12 Monkeys. Frankly, Brad Pitt’s performance as a mental patient, combined with the presentation of the institution he was in, is reason enough to see this movie. Gritty and vile, the result of too much bureaucracy without sufficient means to make the red tape do what it is intended to. Just as filthy and depraved as any Victorian asylum, with completely different reasons why that’s so.

Alien 3. Fury 161, with its deco fixtures and grimy tile, is grand institutional chic at its best. Though presented in



an inmates-running-the-prison sort of way, the isolation and sense of people living and working every day in a space so big they only know parts of it is perfect for that unknown that is the core of institution-based horror.

Bubba Ho-Tep. This movie is set in a rest home rather than an asylum, but the institutional regimens overlap a lot. The story, in which two old men who claim to be Elvis and JFK confront a threat to the lives and souls of their fellow patients, is funny as hell, but it also gives them a remarkable dignity. It's also worth watching for a demonstration of how to do satisfying storytelling while leaving a bunch of questions unresolved — it doesn't feel like a cheat, done right.

The Jacket. Don't mistake our inclusion of this movie as a suggestion that it is anything but a forced-march to a gulag of theatrical misery. However, this film does have a single redeeming feature: the visuals. The sets and imagery used in this film are stunning and incredibly inspirational. It's just the rest of the film that is like water torture.

Session 9. This must-see movie was filmed at the real-life Danvers State Sanatorium, which is an archetype for asylums gone strange and bad. The story of something quietly haunting a hazmat crew trying to clean the place up has a brilliant series of unfolding revelations.

Spider. This is a fairly recent but extremely little-known David Cronenberg movie. Ralph Fiennes is in the title role, a man suffering from a well-developed madness and struggling as hard as he can to recover the shattered memories that he hopes would make sense of his life. Absolutely perfect for its portrayal of that struggle, in which there's no reason to trust the evidence that he is successful, and plenty of reason to just assume it's all another turn further down the spiral. It is quiet (with a fantastic score by Howard Shore back in his usual chamber orchestral mode for Cronenberg), intense, and vivid as anything. The DVD is also very much worth listening to the director's commentary, particularly for his discussion of deciding never to say "schizophrenia" in the movie or bind the character's experience too closely to any one clinical model, but instead to focus on "madness" and the intensely personal nature of the misery.

Stay. Thrilling psychiatry. In its way, this movie is a great example of how an audience can be fucked with even when it knows it's being fucked with. The movie is clearly out of sync with reality, and we know that we're being toyed with, but that doesn't mean that we're not still in suspense.

Video Games

Second Sight. This often-overlooked title centers on a protagonist with psychic powers who escapes from a mental hospital and then starts playing through flashback scenarios featuring asylums, spectral children and all kinds of other freakish elements. Unfortunately, the very worst levels are early on, but play through them

and you'll be rewarded. The atmosphere of the asylums is great, and offer up two very different takes on how modern asylums can be scary.

Thief: Deadly Shadows. Another overlooked game, this one features a setting that is tremendously creepy. It's called the Cradle, and it's a run-down orphanage-turned-asylum that caught fire back in the day and burned, killing orphans and patients. It's a triumph of level design. Super, super creepy and worth playing the whole (otherwise uneven, but still good) rest of the game for.

Jargon — Talking the Talk

Just as any specialized field, medicine has its own language. Players taking the roles of medical characters might enjoy the verisimilitude of using some of this lingo in the chronicle, and this section is meant to facilitate that. Please note, though, that different professionals use different levels of specialized nomenclature, and one term might have different meanings for different people.

Also, the medical community loves abbreviations and acronyms. (There is a difference, by the way; an abbreviation that is pronounced as a whole word, such as the "CAT" in "CAT scan," is an acronym, while one in which the letters pronounced individually, such as "TBI" is an abbreviation.) Part of the reason for this is to save time, and part of it is to avoid alarming patients unnecessarily. Using abbreviations and acronyms does make talking to doctors and other health care providers a little dizzying, though.

Many other medical terms are Latin or derived from Latin, and knowing a few of the roots of the words can be helpful. "Peri-," for instance, means "surrounding," and so the "perisylvian zone" of the brain is the area surrounding the Sylvian fissure. Knowing the roots of words can enable even a layperson to puzzle out what a long, cumbersome term means (and even "reverse engineer" such terms, if so desired) without looking it up. For instance, "hypo-" means "under" and "glosso-" means "tongue." Knowing this, a reference to the "hypoglossal nerve" makes a bit more sense; it's the nerve that controls the muscles under the tongue (of course, that nerve is more likely to be referred to as "CN12," rather than by name).

Below are three glossaries. The first contains common terms and how they are actually used within the medical community. The second contains abbreviations and acronyms, and the third contains roots of words that can be used to break down and comprehend longer terms. We don't provide anything like a "complete" list of medical terms here, because such lists fill entire textbooks. If you wish to know more, however, check online for a medical terminology site. Anatomical terms are not included on the first list, partly because there are so many of them, but mostly because they are among the easier terms to look up and understand.

Common Medical Terms

- anesthesiology:** study of how to bring about loss of sensation and consciousness
- anomaly:** any irregularity
- anterior:** located in the front of the body or a structure. For instance, the nose is anterior to the spine.
- antibiotic:** pertaining to anything that works against germ or bacterial life
- anticoagulant:** a drug that prevents blood from clotting; a "blood thinner"
- atrophy:** decrease in the size of an organ; muscles can atrophy due to disuse
- autopsy:** examination of a dead body to discover the true cause and circumstances of death; sometimes called a "postmortem examination" or just a "post" for short
- biopsy:** a test in which living tissue is removed from a patient and examined under a microscope; often used to test for cancer
- carcinoma:** a cancerous tumor
- cardiology:** study of the heart
- cerebral:** pertaining to the head
- chronic:** lasting over a long period of time
- debridement:** removal of diseased or dead tissue from the skin; often performed on bedsores and other wounds caused by long periods of bed rest
- dermatology:** study of the skin
- diagnosis:** the complete knowledge gained after examination and testing of a patient
- diuretic:** drug that causes the kidneys to allow more fluid to leave the body (causing frequent urination); used to treat high blood pressure
- endocrinology:** study of the organs that produce hormones, which enter the blood and travel to organs or glands and increase or decrease their ability to function
- excision:** to cut out or remove
- gastroenterology:** study of the stomach and intestines
- hematology:** study of blood and blood disorders
- hemorrhage:** bursting forth of blood
- incision:** cutting into the body or an organ
- infarction:** area of dead tissue caused by decreased blood flow
- inferior:** located toward the bottom (feet) of the body or a structure; the knees are inferior to the hips
- lesion:** any damage to any part of the body
- necrosis:** death of cells; dead tissue is sometimes called "necrotized"
- neurology:** study of the nervous system and nerve disorders
- obstetrics:** branch of medicine dealing with pregnancy, labor and delivery of babies
- oncology:** study of tumors
- ophthalmology:** study of the eye and its disorders
- orthopedics:** branch of medicine dealing with surgical correction of musculoskeletal disorders
- otolaryngology:** study of the ear, nose and throat and disorders thereof
- pathology:** study of disease
- pediatrics:** branch of medicine devoted to treatment of diseases in children; can be applied to almost any other branch of medicine (pediatric oncology, for instance, concerns tumors in children)

phlebotomy: incision of a vein
posterior: located in the back portion of the body or a structure; the spine is posterior to the ribs
prognosis: forecast as to the probable outcome of treatment
prolapse: drooping or falling of a part of the body
psychiatry: treatment of disorders of the mind
psychology: study of the mind
psychosis: abnormal condition of the mind; serious mental disorder that involves loss of normal perception of reality
relapse: return of a disease after it has appeared to stop
remission: lessening of symptoms of a disease
section: an act of cutting
septic: pertaining to infection
superior: located toward the head on the body or a structure; the shoulders are superior to the abdomen
syndrome: a set of symptoms that occur together to indicate a disease or condition
tracheostomy: opening of the windpipe (trachea) from outside the body; often abbreviated as “trach” (rhymes with “lake”)

Abbreviations and Acronyms

ADL: Activities of Daily Living
CBC: Complete Blood Count
CCU: Coronary Care Unit
Chemo: Chemotherapy
CHF: Congestive Heart Failure
CNS: Central Nervous System
CPR: Cardiopulmonary Resuscitation
CSF: Cerebrospinal Fluid
CAT Scan: Computerized Axial Tomography
CVA: Cerebrovascular Accident (a stroke)
D/c: Discharge or discontinue
DOB: Date of Birth
DT: Delirium Tremens (mental disturbance caused by alcohol withdrawal)
ECG: Electrocardiogram
ECT: Electroconvulsive Therapy (see p. 45)
EEG: Electroencephalogram
EKG: Electrocardiogram
ENT: Ear, nose, and throat; this abbreviation is used to describe an otolaryngologist.
ER: Emergency Room
FUO: Fever of Unknown Origin
GI: Gastrointestinal
HIPAA: Health Insurance Portability and Accountability Act; see p. 39
ICU: Intensive Care Unit
IM: Intramuscular (injected directly into muscle)
IV: Intravenous (injected or inserted directly into a vein)
MI: Myocardial Infarction (heart attack)
MRI: Magnetic Resonance Imaging
NED: No Evidence of Disease
OT: Occupational Therapy (sometimes Occ. Th.)
OR: Operating Room
PE: Physical Examination
Post-op: After an operation
PRN: pro re nata (as needed; in health care, this term refers to a professional who works on a temporary basis, often when the regular employee is out for some reason)
PT: Physical Therapy
pt: patient
PTA: Prior to Admission
ROM: Range of Motion
ROS: Review of Symptoms
RR: Recovery Room
SLP: Speech and Language Pathology (speech therapy)
SOAP: a charting term: subjective data (symptoms perceived by patient), objective data (exam findings), assessment (evaluation of the patient's condition) and plan (goals for treatment)
WNL: Within Normal Limits

Roots of Words

a-, an-: no, not
ab-: away from
-ac, -al, -an, -ar, -ary, -eal, -ic, -ine, -ous, -tic:
pertaining to
ad-: toward
-algia: pain
-ation: process, condition
cardi-: heart
cephal-: head
-cision: process of cutting
con-: together, with
coron-: heart
crani-: skull
dermat-: skin
dys-: bad, pain, difficult
ec-, ecto-: outside
-ectomy: removal
en-: within, inner
encephal-: brain
epi-: upon
gastr-: stomach
-gram: record
hemat-: blood
hepat-: liver
-ia: condition
inter-: between
intra-: within
mal-: bad

myo-: muscle
neo-: new
neuro-: nerve
ocul-: eye
-oma: tumor, swelling
onc-: tumor
-opsy: process of viewing
-osis: abnormal condition
oste-: bone
para-: near, along the side of
path-: disease
-pathy: disease condition
peri-: surrounding
-philia: attraction to
-phren: mind (can also refer to the diaphragm muscle)
-plegia: paralysis
post-: after, behind
pre-: before
pro-: before, forward
psych-: mind
septic: infection
-sis: condition
-somatic: pertaining to the body
sub-: under
sym-, syn-: together, with
vascul-: blood vessel



Chapter One: Total Bedlam

The word “asylum” comes from ancient Greek, and means a place of shelter and sanctuary that cannot be violated. In medieval and later times, the word referred to any place providing for those in need, including what we now call orphanages, hospitals and even theological seminaries (as places of retreat from worldly concern to free the mind and soul for holier concerns). The idea that such different places were actually different *kinds* of places, which should be run differently and treated differently in law and practice, emerged gradually over several centuries. As names such as “orphanage” and “hospital” took on distinct meanings of their own, “asylum” was applied specifically to institutions intended to keep the mentally ill safe from the rest of society (and vice versa) in the 1700s. The older, broader usage lingered on into the early 1900s, but the newer emphasis was already the common practice by the mid-1800s.

Ideally, the asylum is a monument to human understanding, where experts approach the mind’s troubles not as the result of supernatural evil or corrupted souls but as material, subject to scientific study and treatment. The practical reality is usually something less than that ideal, and the complicated tangle of good intentions, malice, simple ignorance and genuine mystery is fodder for drama.

Before Science: Spirit and Magic

In every society that ever was, there have been some people who seemed to think differently from most of their neighbors. These few remember events differently (and may not remember the things others do, or remember events that nobody else does), see visions of people and things others don’t, experience the world in ways that strike others as mysterious. The most common explanations have included the following:

- **Uncaring or hostile powers:** The changes are inflicted on the innocent victims of invisible forces beyond human control. Whether their affliction comes from gods, spirits who simply want to use humans as tools for their own purposes, ghosts or some other inhabitant of the unseen world, there’s no particular blame to the victims most of the time, even when they have to be isolated or confined to protect themselves or others.

- **Spiritual favor and testing:** The changes are a mark of divine attention, for good or ill, with a moral dimension that’s lacking in the first kind of explanation. An angel, god or other power is using the person for his, her or its own ends. The victim may now be a prophet filled with visions of secret truths about the past, present and future, or being subjected to mysterious challenges as the god tests a candidate for future favors . . . maybe with a chance at surviving if the tests prove too much, and maybe not.

- **Punishment:** The changes are retribution for wrongdoing. In some cases, the victim suffers for individual sins and crimes against the moral order, in others for the wrongs of a whole community.

We have much to be judged on when He comes, slums and battlefields and insane asylums, but these are the symptoms of our illness and the results of our failures in love.

—Madeleine L’Engle,
The Irrational Season

If It All Comes True

In the World of Darkness, some or all of the non-scientific interpretations of mental illness may well be true. See the Appendix for advice and rules about this.

Outside Science: Confinement

Throughout history, one of the most common responses to what we classify as mental illness has been to lock up those acting strangely. Custodians with a sense of charity might have tried to keep their captives clean, comfortable and tended to, while others would have treated the inmates more as prisoners or even exhibitions. There was no serious, systematic effort to provide relief from whatever the inmates' problems might be, only to keep them away from the rest of the world until such time as the strangeness apparently stopped. Many such places of confinement have had religious foundations, as monks, nuns and other dedicated believers try to provide some aid to those in obvious but confusing need of help.

Bedlam, the Place and the Attitude

The word "bedlam" has referred for centuries to lunatic disorder. It comes from a particular place: Bethlehem Royal

Hospital, in London. Bethlehem's history includes most of the major developments (for good and bad) in the handling of mental illness, and what Bethlehem's staff do has often been taken as inspiration and authority for asylums all over the world.

Originally, Bethlehem was a priory for an order of monks and nuns, the Order of the Star of Bethlehem. Early in the 1300s, they started taking in patients and providing them with medical care, and late in the century they added victims of mental illness. Whatever good intentions the sisters and brethren may have had, their inmates didn't fare well. Accounts from the next several centuries describe the hospital as full of insane people's shrieks, cries and groans. A lucky few were allowed to leave. Violent cases could be shackled to the walls or floor and kept confined to a single room for years on end. In-between these extremes, most patients had the run of much of the hospital, but without any prospect of relief.

In 1557, the City of London took over the hospital, replacing the monks and nuns with secular overseers. The City authorities assigned responsibility for Bethlehem to Bridewell Place, a nearby facility combining a prison for debtors, a hospital for the poor and workrooms for those assigned to hard labor to pay off their debts. Contemporary notions of pity for those in extreme need were in scarce supply, and Bridewell's principal concern was usually to get the most profit out of inmates' labor while keeping expenses as low as possible. A keeper assigned to



oversee Bethlehem received fees for inmates' expenses, paid by their families, the parish church of their home district or others willing to bear the cost, and many keepers pocketed a lot of that money directly. Periodic inspections would reveal latrines and cells not cleaned for years on end, but there was seldom any punishment for the keeper or his employees.

Bethlehem moved to new facilities outside the City of London in 1675, and early in the new century, the hospital became a tourist attraction. Once each month, visitors could pay a penny admission fee and watch the inmates in their cells and common areas. The visitors could even bring sticks with which to poke and strike the inmates. Right alongside the growth of this circus-like atmosphere, some elements of the modern medical approach came into use, with the inmates called "patients" and separate wards for those deemed curable or incurable, in the first part of the 1700s. The treatment was still a haphazard mix of what we'd now consider something like medical with religious and outright speculative guesswork, often with an emphasis on the idea that insanity was the natural punishment for bad morals.

The hospital moved in 1815, and again (to its modern location) in 1930. Gradually, the ethos of professional responsibility for patients' well-being as well as confinement took hold. The tour days stopped. More systematic diagnosis and treatment crept in, a piece at a time, as doctors and researchers identified recurring patterns of behavior and medical condition. The hospital began treating phenomena such as drug abuse that could alter behavior as well as neurological and other conditions without any direct outside cause.

Within Science: Logic, Mercy, Justice

The high-water mark of belief in hostile sorcery as the cause of mental disturbance was actually the Renaissance. The most complicated systems for casting harmful spells and for detecting and repelling them date from the 15th and 16th centuries, along with the most complicated systems for alchemy and astrology. They flourished right alongside the beginnings of modern experimental science, and in fact many of the scholars of the age studied both kinds of craft without feeling anything contradictory about this.

The emergence of a science of mental health and sickness hinged on several independent processes converging at the right time. One of the most important was the invention and use of better tools: people simply could see more, and analyze it in more ways. Another was the often petty desire to have ideas with which to beat down predecessors and rivals, the classic human impulse not to be like *them*, whoever *they* might be for a particular person or group eager to make their own mark on the world. Since earlier ideas had emphasized outside forces and unseen influences, the focus

Session Report: S.B.

Subjective: S.B. reports no change today, but her behavior suggests otherwise. Her mood is much improved, and she looked out the window during session 15 times with no noticeable anxiety or fear (compare with last session; 2 glances out window, otherwise eyes fixed straight down or ahead, noticeable fear).

Objective: No data collected.

Assessment: S.B. may be holding on to her anxiety in an abstract way, stating that she doesn't see a change because she doesn't have enough perspective to recognize it. She might also be feeling generally stimulated or edgy due to lack of new intellectual material (she enjoyed reading and painting — check psych. orders), or due to meds.


Plan: Next session maybe go outside, or to a room with larger windows, closer to ground floor? Provide paper, pencils, maybe paint? Recommend remove from suicide watch, check w/ doc to cut back dosage.

on material and internal factors was in part a straightforward challenge. The last factor in preparing the way for clinical psychology and psychiatry was the existence of asylums.

Humane Reform and the Modern Asylum

As the history of Bethlehem indicates, modern ideas of humane treatment arrived only recently. The Enlightenment emphasis on the supremacy of reason could and did lead to rationalization of many sorts of cruelty, from the pseudo-medical argument that only diseases polluting the blood could make slaves want to run away to torture of animals (and people) who were after all just biological machines, displaying such symptoms as pain but not really feeling it. In the late 1700s, reformers confronted this detached attitude on many fronts, including the handling of the sick. The moral treatment movement emphasized just what its name suggests, handling patients with compassion and dignity as much as possible.

Some religious care providers had always sought to show mercy to those they tended, and secular arguments based in the idea of universal human rights first appeared in the 1600s. But they didn't gain much attention among those actually running asylums. The reformers of the late 1700s and the following century were more influential in part because they were themselves doctors, nurses, asylum



managers and others within the system. American physician (and signer of the Declaration of Independence) Benjamin Rush at Pennsylvania Hospital, English asylum proprietor William Tuke at the York Retreat, French doctor Philippe Pinel at the asylums La Bicêtre and La Salpêtrière (for women) and others across Europe developed overlapping ideas about how improved treatment of patients might help their recovery. At first they worked independently, but in the 1790s and on into the new century, many exchanged personal letters, essays and pamphlets, and finally full books and journals on their shared interests.

Some of the ideas were very simple, such as reducing the use of shackles and making sure patients could either clean themselves or receive regular cleaning from attendants. Many of these changes did in fact contribute directly to improvement, removing sources of disease (and the ensuing discouragement of being dirty without any way to change it), allowing for regular exercise to build strength, giving patients the many benefits of direct sunlight and so on. Others were more complicated and indirect. Patients treated courteously wouldn't necessarily get better, but they would at least be spared continuing blows to their confidence. The ability to perform useful work and responsibility for the work's completion was, for some patients, the first time in their adult lives that they actually got to function as adults, and some thrived in response.

At the beginning of the 1800s, architects were for the first time systematically designing asylums with humane treatment in mind. Rush, Pinel and others played an active part in this, consulting on the design and operation of new asylums, aiming to make it easy to treat patients well and harder to abuse them. These reformers recognized that anything could be an instrument of vile abuse in the hands of those who determined to use it that way, but good facilities could support good intentions in both patients and care providers. As the moral reform movement matured, ideas about the improvement of prisons, schools and other institutions interacted with those about asylums. One of the crucial advances of the movement was to pay more attention to whether an institution's inmates were actually in the right place, rather than tossed into the closest convenient space that could be used as a cell.

Psychiatry and Psychology

Some of the moral reformers saw themselves as scientists tending to the well-being of the whole patient. Others saw themselves as simply trying to be decent and leaving the science to others. The work of both sorts prepared the conditions in which real sciences of the mind could emerge.

Psychiatry came first, in the early 1800s, as a discipline extending the study of human anatomy and medicine to the biological foundations of thought and behavior. Psychiatry's inventors and promoters included many people working with and in asylums; Benjamin Rush, for instance, was the first American doctor to seriously study the techniques

pioneered by German doctors such as Johann Christien Riel. By mid-century, there were national psychiatric associations in a dozen countries and general recognition of psychiatric doctor and psychiatric nurse as specializations like many others.

Psychology followed in the early 1900s, focusing on the systematic study of mental phenomena without detailed concern for all the medical layers underneath the whole person's behavior. The first psychologists were far removed from asylums and the treatment of the mentally ill, but some of their students took an interest in applying psychological insights to the clinical environment. American psychologist Lightner Witmer was the first to operate a psychological clinic, at the University of Pennsylvania, and founded a journal for clinical psychology in the 1890s. The field grew slowly until World War I, when governments needed to assess the mental state of many thousands and then millions of recruited and drafted soldiers, and then to treat many of them for shell shock and other combat-based mental injury and illness.

Mental hospitals and mental wards within multi-disciplinary hospitals hosted the first combined efforts at treating problems afflicting both mind and body. Very often, research and care took place side by side, and a great deal of psychiatric and psychological lore began with planned or spontaneous analysis of various conditions' causes and remedies. By the 1970s, clinical psychology its application in these practical circumstances had gone from an unpopular fringe movement to the dominant strain of psychological training.

Scientific Subjugation

Human history includes very few pure success stories of moving from brutal ignorant abuse to wise, kind, informed behavior. The moral reformers encountered skepticism and outright hostility along with favorable reception, and many asylums remained barbaric hellholes even as others evolved into something more humane (and productive). The rise of the mental sciences could be used both to rationalize whatever superstitions one might wish to dress up as science and to develop new tools with which to break down individuals' self-control and sanity to serve the needs of tyrants. Incompetent bunglers can excuse their failures with scientific-sounding rationalizations, hiding their mistakes from all but the most informed observers. But beyond individual failings, there's collective action: terror and cruelty as matters of consciously chosen policy.

Aleksandr Solzhenitsyn gave the name "gulag archipelago" to the Soviet Union's far-flung chain of mental hospitals where "health" was defined as conformity to the state's decrees of the moment and "illness" included all acts of dissent and independent thinking. He documented the routine use of drugs, torture and other abuse against anyone who refused to follow orders. The gulag system included more than mental hospitals, from the courts and police systems arranged to allow for the convenient arrest

Abuse and Cover

In the mid-1890s, Sigmund Freud was studying a mostly female clientele of private psychiatric patients and some patients in mental hospitals throughout the Vienna area. He came to the conclusion that the hysteria and manias afflicting so many of them were the result of sexual abuse in childhood, which the patients had tried to forget. The suppressed truth kept pushing toward the surface again, however, and created mental and emotional disturbances along the way. Just a few years later, however, he decided that what he'd taken as accounts of real abuse were fantasies, and reinterpreted those (now deemed fake) experiences as part of his overall Oedipal model of sexual confusion and conflict within family relations. Psychiatrists and others have argued about it ever since: did he correctly revise his model in light of fresh evidence and reasoning, or did he lose his nerve and surrender so as to avoid opening the upper classes (from whom he drew his private patients) to general scandal and risk of real change?

In reality, widespread conspiracies of abuse, torture-minded cults and the like seem mostly not to exist. In the World of Darkness, that may not be true. How many patients are in asylums not because they're crazy but because they remember the wrong thing? Or, more deviously, how many are locked up and have been given these scandalous false memories to hide whatever really happened to them?

and guaranteed conviction of chosen targets to the remote communities in wild hinterlands where prisoners could be exiled without hope of escape to endure unknown years of waiting for pardon, release or execution. But the mental hospitals were crucial to the system's operation, since it was here that patients could be broken of their will to resist.

The gulags were created in one of Lenin's executive orders less than a year after the revolution that brought him to supreme power, and that's not unusual. The Nazis in Germany, the Maoist movement in China, the fascist government in Spain during and after its civil war, the list goes on and on: a collection of facilities in which the new rulers can put their victims while claiming to be concerned with their mental health is a high priority for many tyrants. Under Lenin, Stalin and their successors, the gulags were kept almost entirely hidden and downplayed — Solzhenitsyn's work was powerfully influential precisely because it connected hitherto scattered and secret data into

a coherent overall picture. That hasn't always been the case, however; some regimes show off their facilities with their gleaming tile and chrome construction, scrupulous cleanliness and broken "model patients" to express their gratitude to Father (or Mother) State.

Civil Rights and Complications

In the 1960s and '70s, scholars as diverse as left-wing French philosopher Michel Foucault and right-wing American psychiatrist Thomas Szasz challenged the very idea of mental illness, with similar critiques. They charged that mental illness is the label defenders of social norms put on any behavior that's inconvenient to the keepers of power, a measure of social disapproval rather than of genuine medical need. Not all critics went so far as to dismiss the entire idea, but it was obvious to most observers that the criticism was true at least some of the time. There wasn't anything like real medical evidence of anything wrong with many people in mental hospitals, and it was no longer widely accepted that people ought to be locked up simply for having a sexual orientation other than heterosexuality, an unusual religious outlook or other ideas that might lead them to act unlike their neighbors.

This reconsideration of mental illness evolved in parallel with the civil rights movement for ethnic minorities, a freshly invigorated feminist movement seeking to formalize equality of the sexes in both law and practice, a gay rights movement operating in public as never before and comparable efforts for other groups who'd been on the losing end of their dealings with social authorities. This rethinking also owed a great deal to advances in medication, which promised to allow the mentally ill to live without the elaborate constraints of asylum life, keeping their symptoms under control even while cures might be a long ways off.

Mental hospitals and the governments overseeing them faced legal challenges both to specific practices and to their fundamental justification. Sometimes the defendants fought back vigorously, but that wasn't always true. The increasingly influential neo-conservative political movement was quite happy to slash mental hospitals' funding and turn inmates out on the street, without making any serious plan for the sort of out-patient supervision the advocates of de-institutionalization had planned to keep former inmates under reliable care. There's continuing argument about the details, but some large fraction of the urban homeless and "street people" of recent decades, even a plurality in some cities, are those who used to be candidates for mental hospital confinement.

It turned out that, exactly as some critics of de-institutionalization had predicted, many of the released inmates didn't stick to their medicines. The idea of simple miracle cures in convenient pill form is a popular one, reinforced by drug manufacturers and accepted eagerly by a public who genuinely do want to believe that such cures exist so that it won't continue to be a struggle to deal with those who have complicated and traumatic illnesses. Alas, in practice



many medications for mental illness produce drastic side effects, sometimes as intense as the original illness itself; depression, short- and long-term amnesia, seizures, insomnia or excessive fatigue, difficulties in eating or getting nourishment from food and many other severe difficulties can afflict those being medicated. These are often so horrible that patients end up deciding the first set of symptoms wasn't so bad. At the other extreme, some medications actually do allow takers to think more clearly, feel more energy and function in society. With these medications, the risk is that the takers will get to feeling so good they decide that the medication isn't needed any more, they stop taking it and the original symptoms return in full force.

For both extremes, champions of de-institutionalization had intended that patients would receive regular appointments with doctors and degrees of supervision short of full-time residence in a care facility but much more than outright neglect. It proved much easier to get just the first step, release, than to get any of the others. In the last couple of decades, much of the work that used to take place in mental hospitals has been performed — with varying attention to quality — in prisons, it being easier to get funding for prisons and laws that criminalize some kinds of deviant behavior than for a network of facilities able to deal with mental health in primarily medical terms. Mental health providers do what they can, but the fundamentals of prison life make it hard to get mental illnesses diagnosed, let alone treated.

It Is Written

The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual* was published in 1952. It was 100 pages long. The current revision to the last edition, issued in 2000, is 943 pages long. Many mentally ill people become obsessed with discovering hidden patterns as clues to what realities others are trying to hide. Granting that even the most paranoid would likely admit there really is more information to write up and finer gradations to be drawn from it about psychiatric conditions, still, in the World of Darkness, what might lurk within and between editions? Are the secret authorities within the APA sending a coded message piece by piece to informed audiences? If so, what are they saying, and to whom? Or might it all be a plot to distract the attention of those who'd otherwise realize some other truth?

When It Goes Bad

Buried deep inside every institution is a simple fact: nobody in the institution now is fully in charge. People do things because they've done things that way in the past, and

because of subconscious drives they've never recognized, and because of conscious obsessions that lead them to disregard current results as just accidents on the way to a better future, and because they're afraid that changes in practice might make them irrelevant, and for a great many other reasons besides feeling that it's the right and appropriate response to the particular circumstances of this moment's situation. They are the inheritors of flawed lessons from equally fallible predecessors, and the recipients of outside pressure to do this and refrain from that. They guess, flounder, drift and cover it up. In asylums, all this happens with people's thoughts, emotions and independence at stake. Here are some of the ways the juggernaut of multiplied human fallibility can turn into horror.

"Medicalization" is a jargon word for approaching problems as medical issues even when that might not be the best approach. In the United States, the classic example is the widespread sense that the physical effects of grief or just unhappiness are best handled through some sort of drug. In principle, medical care for people with peculiar behavior, cognitive disturbances and the like should include dealing with the human level as a matter of course: counseling, help in identifying and resolving fears and angers and so on. Furthermore, some people aren't suffering from anything at all, they're simply living in unusual conditions: happier than most people are when alone, more than usually sensitive to bright light and comfortable being active in low light and late at night and so on. In practice, it's so very easy to start with the medicine and confinement, genuinely intend to get around to the rest and never actually make it past the medical level because new distractions come along. New patients arrive. Existing patients have crises that need immediate response. Administrative or legal changes require the attention of people in key positions. And after all, it can wait a little, can't it? Thus hours and days give way to weeks and years, and only the drugs and confinement remain.

Mental health is necessarily at least in part a subjective matter. A blood test can tell you how acidic your blood is, but there's no simple formula (or even a complex one) to measure your level of happiness or love. Standards evolve over time through observation and tinkering, but are very seldom as objective or clear-cut as they're presented by their advocates. Nor can they necessarily respond gracefully (or perhaps at all) to changing conditions. If a whole class of people are worse off than they were 20 years earlier, perhaps sorrow and discouragement are appropriate reactions and it's the giddy fools among them who are in denial? But in the meantime people have to make decisions about treatment, and it's just easier on everyone except the patient's underlying self to apply the same old standards and let specialists worry about changing the specs. Surely that can't make matters worse, can it? What harm can there be in the long run from having your real needs

denied and glossed over in favor of remedies intended for someone else altogether?


In addition, because the standards of both health and sickness in the mind are partly subjective, it's very difficult to establish reliable guidelines for measuring the competence of those who'd treat the mind (and the person around it). You can measure how many pills they prescribe, how much office time they put in and so on, but how can you measure how good they are at cures? A doctor with a very low rate of released patients might be incompetent, or might be voluntarily working with the most difficult cases and getting as good results as anyone good. A doctor who frequently releases patients after short stays may be doing an outstanding job, cherry-picking easy cases or using drugs and quick fixes to gloss over real, deep problems that will end up in someone else's lap as the patients again suffer from their real complications. It would be hard to tell who's who even with all the information the practitioners have themselves; how can you ever be sure, as a patient or someone concerned about a patient?

This element of uncertainty looms large in the real experience of people abused and mistreated in asylums. Simple evils are easy enough to recognize. Far more traumatic in some ways is living with what feels like mistreatment without ever being sure of it. After all, maybe they're perceiving things wrongly, or there's crucial information that explains it all that happens not to have been given to them . . . and isn't excessive confidence itself a common sign of defective thinking? Everything about institutional life reinforces the message that someone else is driving the vast engine in which the patients all ride, and too much questioning will only delay progress. Just as classic haunting experiences include many details about which witnesses can't be sure, such as the thing flitting at the edge of one's vision and the whisper almost too quiet to hear, so the signs of failure in asylums are often matters of ambiguity and guesswork . . . until it's too late, and the torrent of cruelty and incompetence can't be dammed at all.

Playing Sick

Mental health is a subject loaded with mine fields. Some of your fellow players may have been diagnosed as having some mental illness in the past, and been treated for it. The treatment may have done them a lot of good . . . or it might not have, because the sciences of the mind are far from exact. Some of your fellow players may be trying to deal with mental illness in someone they care about, and just as with physical illness, it's often harder to watch someone who matters to you suffer than it is to suffer yourself. The whole subject is surrounded by layers of folklore and misunderstanding, and can be the source of deep shame along with other complex emotions.

We're not saying, "Don't touch it." We do say, "Touch carefully." Before you make mental illness a ma-



For the next major element of your chronicle, talk some with the other players, and ask if any of this is potentially difficult for them. Likewise, if any of it is likely to be difficult for you, try to let others know when you see it coming up. On both sides, apply some courage, some kindness and some goodwill. Find out what needs to be in or out for the personal well-being of the real people you're playing a game with, and then you can proceed confidently to stick it to the fictional characters.

Says Who?

The concerns raised in this section need to be settled by someone. Who does the settling varies a great deal from one gaming group to another, and sometimes within the same group from one chronicle or act to the next. The test of an answer's appropriateness is whether it results in more enjoyable play for you and the people you're playing with, not whether it's what a particular author or other observer would do in your place, because nobody is you and your fellow players.

If players want there to be secrets that they discover along with their characters, then it makes most sense for the Storyteller to settle most of these questions. The Storyteller may solicit ideas from the players, or simply arrive at conclusions that mesh with other aspects of the chronicle. If players would like some uncertainty without feeling that everything goes, the Storyteller may want to narrow down to two or three options for major issues and tell players that one of them will be true, without saying for sure which it is. Some players feel more confident knowing what the actual answers are and can comfortably separate their own knowledge from what their characters know without it feeling like a burden, and they will do best when they get to help make the actual decisions.

Note that it's not necessary for every player to have the same view on every question. Those who wish to be involved in settling one question may feel fine letting others settle the next.

That's Sick, or Is It?

Definitions of mental illness and approaches to its management are in constant flux. Symptoms once united into a single syndrome become separated in diagnostic manuals when it turns out they may come from entirely independent causes, while others converge as hidden connections come to light in research and treatment. Officials and civilians engage in a perpetual, sporadic debate over what conditions actually impair patients' ability to function as independent adults, and their legal status drifts back and forth. Popular conceptions sometimes shift as easily as fashions in movie-making and clothing design, while other beliefs remain intact for decades and centuries.

Do you need (or just want) an agreed-upon set of truths for the chronicle? Many players and Storytellers do, and it can help to make sure that all the participants are on the same page when it comes to identifying characters as sick, healthy or somewhere in between, whether what the asylum is doing to the sick ones actually helps, and so on. But one of the truths of the real world is that we don't get to peel back the fabric of day-to-day life and see all the hidden machinery that turns the heavens. The harm done by honestly held good intentions is a major thread in the history of all medicine, let alone in the case of mental illness, where key physical mechanisms are so complex and hard to unravel. The World of Darkness expresses this uncertainty when it comes to the origins of supernatural species and modern mysteries of life; the World of Darkness can easily also do so with regard to mental health. If players are amenable, genuine mystery about what's curing or hurting their characters can be a crucial part of the drama.

Science and/or Alternatives

The World of Darkness generally works as the real world does, except insofar as secret forces are pushing it in other directions. How far the hidden truths run is another matter to consider before play begins. The more divergent the chronicle's truth is from what seems to be the case in the real world, the more potential there is for someone trying to trace out implications to run into something that ought to have major consequences for visible human existence. At that point, the group needs to reach a collective decision. Do you want to go ahead and run with the divergence, and make it clear that things just are different? (See, for instance, the discussion in **Vampire: The Requiem** about how the existence of vampires skews popular culture.) Do you want to keep the connection with reality and therefore reel in the extrapolation? Or do you perhaps want to keep the extrapolation but simply not apply every purely logical inference?

The third way is unsatisfying to fans of following internal logic wherever it goes. If you're one of them, and you probably know this about yourself, then by all means, don't choose it. There is no bonus prize round for setting up your chronicle to suit the taste of anyone not there to play with you. Others thrive in a game milieu in which logic itself is unreliable. One relatively popular creator whose works embody the principle in action is film maker David Lynch. His settings and characters are seldom on speaking terms with logic, but to those who enjoy his work, it has the appropriateness and strength of a dream; it's not quite true that everything is up for grabs, it's just that much of what is usually fixed may drift, with or without an explanation. This is a common part of the interior experience of many people dealing with mental illness, so it can be very thematically appropriate.

Three World Views

- **The conventional wisdom:** Mental illness is a condition that that imposes distress or dysfunction on its victim — difficulty in remembering things, for instance, or controlling one's emotions. It may stem from a specific organic failure in the victim's brain or other part of the body, or it may not; psychiatry includes the physical foundations underneath behavior, while psychology focuses on the system of behavior on its own terms. Mental health is the positive ability to use one's thoughts, feelings and physical abilities to serve one's own goals and deal with the obligations of social life. Note that they're not precisely symmetrical. It's possible not to be mentally ill without being in very good mental health.

The treatment of mental illness is a difficult and usually slow matter. It may combine counseling and other therapy with medications and physical treatments such as electroconvulsive therapy. The details may vary widely, and one of the problems for asylum staff is the limitations on their time and resources to treat patients as individuals as fully as they should. Mental illness is almost never *cured* except in lucky cases where there's a specific single problem that can be removed. In the overwhelming majority of cases, it's simply *managed*, reduced in intensity enough so that the patient can lead something like a normal life.

Doctors, nurses, researchers and others can and do disagree on diagnosis, appropriate treatment even when they agree on the diagnosis, the general usefulness of a drug or other treatment and every other aspect of the process. This doesn't mean it's all a matter of taste, either. People building a house may agree on the principles of architecture and aesthetics and on sound techniques and still disagree about the right kind of fastening to use for a joint, how best to hang a window and so on. Applying any large body of knowledge is a tricky matter when it comes to a specific situation.

- **The anti-psychiatric view:** There is no such thing as mental illness. There is organic dysfunction, which is to say, physical illness. If the body is healthy, the mind is healthy as well, no matter how strange the person's thoughts and feelings may seem to others. What's called "mental illness" is simply behavior that social authorities prefer not to endorse, and its treatment is a matter of compelling the patient/victim to give up and adopt the official standard.

Critics who take this general approach disagree as to how much deliberate calculation there is on the part of the mental health establishment and how much muddled good intention shaped by conformist attitudes. In practice, it may not matter a great deal. What matters, in this view, is that the very idea is a tool for those who have (or wish to have) social power to impose their will on others, and to make it seem presentable by

dressing it up as science. The relatively moderate version of the claim is that legitimate science, the biology of health and sickness, is being misused; the more extreme version holds that the whole thing is delusional. The inmates of asylums are, essentially, political prisoners being tortured for their crimes of conscience against the governing regime.

One noteworthy feature of the anti-psychiatric approach is that its adherents tend toward political extremes. French philosopher Michel Foucault, who directly compared asylums with jails as tools of imposed conformity, was part of the Marxist left, while American critic Thomas Szasz is part of the libertarian right. Unlikely alliances are common, and are sometimes used as evidence for counterarguments that this is all about building one's own power base rather than tending to the needs of those the mainstream sees as mentally ill.

- **The religious criticism:** Some groups attack the conventional wisdom for its refusal to take into account important spiritual realities. In some cases, this is fairly temperate, appreciating medical wisdom as far as it goes and simply insisting that there's also more to know and deal with; this is how most Christian denominations and equivalent groups in other large religious traditions handle it. In others, the criticism is much harsher. The Church of Scientology made itself famous in part through its heated assault on the very idea of secular mental health treatment, arguing that everything but Scientology's own therapeutic approach is part of the problem, suppressing the fragile soul in the service of evil ends.

The Lost Children

From the late 1800s until the revelations about Nazi concentration camps at the end of World War II, eugenics — the scientific management of human heredity — was widely accepted as an important element in treating mental illness. Inmates could be subjected to sterilization so as to improve the mental health of future generations. Pervasive grief at lost potential was, and in some places still is, part of the community life of targeted populations, and in the World of Darkness, unsettled emotions can mean much. In the asylums where those sterilizations were once performed, do souls denied their chance at embodiment mourn, too, and need comfort and release? Or do they seek revenge on the staff and patients of still-operating asylums and anyone who comes by ones since abandoned? Do the souls meddle with hearts and souls of the living to try to spare others' suffering ... or ease their own pain by making it worse on a new generation of victims?

Am I the Boss of You?

On the one hand, mental hospitals are like most institutions in needing important things to happen at fixed times, from patient feeding to janitorial work. On the other hand, unpredictability is a crucial part of being mentally ill: the mind's needs are what they are, and the mentally ill suffer surprising reactions to medication, delayed trauma in response to events that happened minutes, days or years ago and other complications. It's not just indulgence for bullies that leads to asylum staff being given great power over patients; it's a practical response to unforeseeable circumstances.

A story in some other medium about people in and around a mental ward would likely include major characters among the patients and the staff. This is potentially very tricky indeed in play, because players generally prefer that their own characters not be subject to thorough command from others. There are exceptions, of course, and they are well-loved by storytellers who like to run chronicles set in armies and other regimented environments, but there's a strong general trend among gamers away from such hierarchies. Ulti-

mately, though, that is one of those decisions that the individual group has to make. If you want to include the radical gap in levels of autonomy, make sure that the other players do as well, or you're very likely to lose someone out of simple unhappiness. Most of the time, you'll find it more productive to play patients or their keepers.

Healing

The complexities of day-to-day life in and around asylums make it easy to forget that there's supposed to be a larger purpose to it all: the reduction of mental illness and the promotion of mental health. The problem is that there's little agreement on what either of those actually mean or how to get at them. Furthermore, this argument isn't just an academic matter for many gamers. Anyone who's been treated for depression, for instance, has been part of the mental health care system, and the diagnosis and treatment may have seemed straightforward and appropriate, but to some critics, both were mistaken, ill-founded or even part of a deliberate effort to impose a doctrinaire conformism on free spirits. All of this is to say that the advice to discuss things with your fellow players before the crisis applies with extra strength

here, and if some of them have reservations, keep in mind that it is not part of the standard Storyteller's role to undertake to debunk others' beliefs or cure their woes.

Except for those who seek miraculous interventions from outside powers, all sides agree that recovering lost mental well-being takes time and effort. For one thing, people who are having problems thinking clearly are likely to develop bad habits that have to be unlearned and replaced, or they'll keep on *acting* sick even when physically well (however wellness is defined). Unless the practitioners working on a patient believe that all mental disorder comes from a single cause, diagnosis takes time, and then it takes time to see if treatment works, and there may well be repeated cycles through diagnosis and treatment when a patient doesn't respond to early efforts. Finally, the physical and mental weakness coming from a first problem may leave the patient open to developing others, just as a body weakened by too-frequent use of antibiotics is at risk for opportunistic infections.

In some dark moods, many mental health practitioners — and many patients — wonder if any treatment ever really works. Maybe it's all just guesswork and luck. . . .

"Outside" by Sadie Brown

Running, running, running.

I thought I could get away.

I thought I was fast enough, so I kept

Running, running, running.

I ran by a little boy.

I ran by a little dog.

I kept running through the playground,

across the path, and I saw the street ahead.

Running, running, running.

And then I looked back and I saw them eating.

I knew I wasn't so fast.

Just a little bit faster.

And they could catch me if they were still hungry, later.



Chapter Two: Putting the Pieces Together

"Of course, Behaviorism 'works'. So does torture"

—W.H. Auden,
A Certain World.

It takes a certain kind of person to enter the medical profession. Yes, many aspects of the medical profession are lucrative, and jobs are almost always available, but the schooling is long and involved (for doctors especially), and extremely expensive. Yes, as a doctor, nurse or therapist a person can do a great deal of good for others, but this attitude is all too quickly crushed under the realities of insurance companies, hospital bureaucracies and the horrors that people inflict on their fellow human beings.

And in the World of Darkness, the supernatural takes a hand, too. Vampires feed on people, leaving them dazed and drained in alleys. Werewolves hunt, leaving any witnesses crazed and fearful. Mages manipulate the thoughts of human beings, often without considering the lasting effects. In all of these cases, the medical staff are the ones who are left to pick up the pieces, to try and make these people whole again. Sometimes they succeed. Sometimes the unfortunate witnesses to the supernatural wind up dead . . . or at a place like Bishopsgate.


This chapter examines the medical profession in the World of Darkness. After reading this chapter, both the players and the Storyteller should have a good idea of what doctors, nurses, EMTs and various types of therapists actually do, as well as some game systems that can be applied to taking on the roles of these characters. Also included are some new Merits, new derangements and even a glossary to help you fake talking like a medical professional.

Before we start, read that last sentence again. We're teaching you to *fake* talking about medical procedures. This book does not provide any true medical knowledge or expertise, even if some of the terminology is accurate or the information factual. Medical expertise is gained through diligent study and schooling, which is time-consuming and expensive (and rightly so). If you want to know how a medical procedure works in the real world, visit a medical school's campus library or do a bit of research online. If you want to know more about psychiatric medicine, the Introduction to this book contains many good starting points. But when reading this chapter, please remember that the information presented here is meant to facilitate a roleplaying game first and foremost, and sometimes (often, really), strict accuracy has to bow before that goal.

With all of that in mind, let's examine those hardy souls who choose to try and heal in the World of Darkness.

Medical Characters

A member of the medical community is a perfectly viable concept for a World of Darkness character, but the term covers a lot of ground. This section discusses some of the various professions within the medical community and talks about the logistics of playing such a character, including the time commitment required for such a job and the rough Resource level one can expect. We also discuss what members of these professions really do, and what effect the World of Darkness has on Morality over time.



Insurance Companies and Other Monsters

Ask a doctor what the biggest problem facing the medical community is these days, and he'll probably mention insurance companies. Doctors must, by law, carry malpractice insurance, and the premiums for this type of insurance are extremely expensive. One of the reasons, of course, that they are so expensive is that when a patient wins a malpractice suit, the payouts are often astronomical. Admittedly, when a doctor commits malpractice, the results can be devastating, even deadly, but the ugly side to the system is that some patients deliberately look for ways to sue doctors, figuring to get rich quick. The result? The insurance companies raise their prices, premiums go up for doctors, health care costs go up and patient insurance doesn't cover as much as it once did.

The other effect is that doctors are leaving certain especially risky fields, finding that the risk of malpractice and the exorbitant premiums aren't worth the trouble. OB/GYNs, for instance, have some of the highest premiums, and in addition to more and more doctors leaving this practice, the rate of Cesarean births remains high because, with a C-section, a doctor has more control over the situation and less is left to chance (also, since it's a surgical procedure, the hospital gets to bill the mother's insurance company more).

Another problem with the insurance/business model of health care is that it's a bureaucracy, and bureaucrats love labels. As any ethical health care provider will attest, a diagnosis and a label can be useful starting points — giving a child the label of “autistic” gives other health care providers a place to begin their research and treatment plans. But the people in administration don't always understand that just because two children have autism, they won't necessarily behave the same, show the same symptoms and (most importantly) respond to the same treatment in the same amount of time. The situation is even worse with mental health disorders, which some states still don't recognize as treatable and serious diseases (which, in turn, means that insurance companies don't cover treatment for them).

What does all this mean for the World of Darkness? Only that health care providers are often frustrated, their hands tied by bureaucratic procedures and nomenclature. In a world where supernatural beings are always looking for desperation and frustration to exploit, the medical profession can provide them in quantity. The truly tragic part is that the professionals who become the most desperate and frustrated are the ones who most want to help their patients to heal.

Professions

The medical field encompasses a wide range of professions. Some of them, including pharmacists and medical researchers, have not been included here, as the focus in this book is staff that treat patients directly. That's not to say that a pharmacist or a tech isn't a viable character concept, just that it's more in keeping with the themes of **World of Darkness: Asylum** to deal with the people who deal with people.

Each profession below includes suggested Traits in terms of Attributes, Skills and Merits that members of that profession would find helpful. Note that these are *not* requirements. It's difficult to get through medical school with below-average intelligence, but it's by no means impossible. Unless otherwise stated, the professions below pertain to members in the United States. Other countries have different protocols for different professions, but in general, these differences tend to show up more in who is eligible for treatment and how much it costs than with the people actually providing the treatment.

The entries below also discuss what level of the Resources Merit would be appropriate for members of that profession. Please remember that Resources indicates *disposable* income, not employment. It's very possible for a character to work 40 hours a week and barely be able to cover his expenses, while someone who works half the hours has a high Resources rating. The rating is determined by how much money a character has left over after meeting monthly expenses, which in turn depends on that character's lifestyle and what else he does for funds.

Licensure

Practicing any kind of medicine requires a license, sometimes more than one. A license to practice comes from the state, though for some fields all that is required for a license is good standing and certification with a professional organization. Licenses aren't free, and the dues can be fairly steep (though some facilities pay for their employees' licensure fees).



It's important to recognize what a license entitles a professional to do. A license only enables a medical professional to act within his *scope of practice*. For instance, a physical therapist's scope of practice includes treatment of pain, injury and conditions that impede movement but does *not* include the ability to diagnosis diseases or prescribe medication (indeed, in many states citizens cannot simply go to a physical therapist and ask for services, they must be referred by a doctor). Acting outside one's scope of practice can result in loss of license, as can ethical violations in medical practice and in research. A character who has lost his license cannot legally provide services, and loses the Status (Medicine) Merit until he can regain his license.

Practicing under a false license is chancy, because professional organizations maintain records of license-holders and these records are available for public viewing (often online). A character who wishes to fake being a doctor had better keep moving or keep his head down, because under a concentrated effort, the charade won't last.

Doctors

Obviously, every hospital or medical facility employs at least one full-time doctor. Most doctors either have a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) degree; both require four years of graduate schooling, plus residencies and internships of varying length. Specialists, including psychiatrists, require additional coursework and residency. Some doctors engage primarily in research or teaching rather than treating patients. To practice medicine requires a license, and to allot certain

medications requires dispensation from the Drug Enforcement Agency. Doctors are expected to keep abreast of current medical trends (whether they do or not is another matter), and obtain continuing education in order to keep their licenses.

Space prohibits a list of all of the possible specialties and areas of focus that a doctor might choose to undertake. Players wishing to take on the role of a doctor might consider doing a bit of research into the scope of practice of their character's field, so as to understand what kinds of patients that character is likely to see. Attitude differs considerably depending on what type of medicine a doctor practices; surgeons, for instance, are regarded as somewhat arrogant, but then, it takes a certain degree of detachment to cut someone open and perform delicate operations with that person's body. A family practitioner sees his patients face-to-face and must explain their illnesses to them, and this fosters a bit more empathy (remember, we're talking in generalities, here — obviously not every surgeon is antisocial and full of himself, and not every GP is kind and knowledgeable).

Doctors usually work full time, and might be on call 24 hours a day, depending on what kind of medicine they practice and how many others in the area do the same. If a doctor is the only vascular surgeon in the area, for instance, she might find taking a night off very difficult.

Trait Suggestions: (Attributes) Dexterity 3 (surgeons), Intelligence 3, Stamina 3, Wits 3; (Skills) Academics 3, Empathy 1, Investigation 1, Medicine 3 (often with a Specialty), Science 2, Socialize 1; (Merits) Contacts (Medical, Business, Legal), Encyclopedic Knowledge, Fame, Holistic Awareness, Retainer, Status

Resources: Varies considerably. A doctor fresh out of medical school is probably in debt up to his ears, and might not have any Resources at all. Likewise, a doctor running her own practice might make good money, but has to pay her staff, her overhead, her malpractice insurance (climbing year by year; see p. 32) and many other expenses. A doctor working for a hospital might have Resources ••, a well-respected and established doctor might have Resources ••• and a famous and highly sought-after surgeon might have up to Resources •••••.

Nurses

Nurses provide medical care under the supervision and direction of doctors. The field is extremely broad, representing a wide range of education levels (everything from an associate's degree to a doctorate) and 200 different specialties in the United States. Nurses perform preliminary examinations on patients, assist in surgery, treat patients in long-term care and handle countless other tasks in a hospital setting. Advanced nursing specialties include clinical nurse-midwives, who can deliver babies (in some states) and nurse-practitioners, who can see patients without a doctor's supervision and can prescribe medication.

Nurses, just as doctors and EMTs, work long shifts and might be on duty at any time.

Trait Suggestions: (Attributes) Intelligence 2, Wits 2 (3 for ER or trauma); (Skills) Academics 1, Athletics 1, Empathy 2, Medicine 2 (3 for Nurse-Practitioner), Science 1; (Merits) Contacts (Medical, Former Patients), Holistic Awareness

Resources: Varies considerably based on experience and specialty. Anything from no Resource rating to Resources ••• might be appropriate.

EMTs

Emergency Medical Technicians (EMTs) are responsible for providing emergency medical care and getting a patient to an emergency room as quickly as possible. EMTs are trained in a wide variety of medical procedures; an EMT might be called upon to administer CPR, start an IV drip, perform a cricothyrotomy (creating an airway directly through the cricothyroid membrane in the front of the throat) or intubate a patient. Various levels of EMS (emergency medical services) training are available, and different states have different protocols for their EMS services. Hospitals might employ their own EMTs, or contract with an independent provider. Some EMTs work on a volunteer basis, some are paid by the state. Firefighters hold EMS training, usually the first responder (minimum) level. Paramedic is the highest level of EMS training, and, similar to nurses, paramedics can treat patients under a doctor's authority.

EMTs generally work 12-hour shifts, volunteer or not. Since emergency services are always in demand, an EMT could be on shift any time of day, any day of the year.

Trait Suggestions: (Attributes) Intelligence 2, Stamina 3, Wits 3; (Skills) Academics 1, Athletics 1, Computer 1, Drive 1, Empathy 1, Medicine 1–3 (depending on the level of EMS training); (Merits) Fast Reflexes, Stunt Driver

Resources: Volunteers obviously have no Resource rating. Paid EMTs might make the equivalent of Resources • or ••.

Medical Examiners/Coroners

A coroner rarely works in a hospital. Rather, he might, but he spends more of his time in the field. Coroners investigate the causes and circumstances of a person's death and declare people legally dead. They also perform a wide range of other duties, depending on the county in which they work. In rural areas, for example, it's not uncommon for the local funeral director to be the coroner as well. In some places, the coroner enjoys the same legal status as the sheriff, and can even stand in for the sheriff is necessary, serving in the same function as this official.

Many American cities have replaced the position of coroner with that of a medical examiner (ME). MEs are doctors, trained in pathology and forensic science. They do not (usually) have the power to arrest suspects or serve process, though, as mentioned, in some places the position does carry these powers. MEs and coroners can enter crime scenes, examine evidence and advise police officers and detectives on the meaning of this evidence. They can perform autopsies and blood and tissue tests on dead bodies, which means that they are useful as Contacts and Allies for the supernatural denizens of the World of Darkness.

MEs work full-time schedules, but don't typically work normal hours, since people die at all hours of the night. An ME or coroner can expect to be "on call" most of the time, and larger cities with high murder rates might employ several such people.

Trait Suggestions: (Attributes) Intelligence 3, Stamina 2; (Skills) Academics 2, Computer 2, Firearms 1, Investigation 2, Larceny 1, Medicine 3, Science 2; (Merits) Contacts (cops), Danger Sense, Eidetic Memory, Iron Stomach

Resources: Coroners might make the equivalent of Resources ••. A coroner who doubles as a funeral director might make Resources •••, depending on local death rates and income. MEs' salaries are similar to doctors' (probably on the low end).

Therapists

Most people hear the word "therapist" and think of psychotherapy, but this profession is covered under "Psychologists," below. The therapists discussed here belong to one of three disciplines: Physical Therapy, Occupational Therapy and Speech-Language Pathology (commonly called speech therapy).

A hospital generally employs all three types of therapist. In most states, becoming a therapist of any of these types requires a master's degree, including a certain number

of hours treating patients and a license issued by the state. Licensure laws vary by discipline and, of course, by state; in a state with a serious shortage of a given kind of therapist, a license might not be required at all. Similar to doctors and nurses, therapists are required to obtain continuing education throughout their careers (the number of hours varies).

There is some degree of overlap between the scopes of practice for therapists, and it's not uncommon for members of all three disciplines to meet to discuss their patients in a given hospital or facility (sometimes accompanied by a social worker, doctor, administrator or other professional). Hospital therapists often work full time, and their schedules are rigorous (generally more than 40 hours in week). They don't work nights, though, and if the pace gets too crazy, a therapist can quit and find a new job within a week. Therapists employed by school systems can take summers off, and therapists can work PRN and set their own schedules (often for higher hourly wages).

Occupational therapists work to help patients develop or regain skills for functional living. For children, this means learning to play. For adults, it can mean skills such as feeding, dressing and other self-care as well as more sophisticated skills such as managing finances. Psychological patients might learn coping strategies, such as developing routines to help them function. OTs also work with the families of patients to teach them to assist in the patients' therapy. Occupational therapy might follow an injury or an illness, or might be required from a young age due to a congenital condition.

Physical therapists help patients develop or regain maximum movement and functional physical ability (as opposed to functional skills, which is the purview of occupational therapy). Physical therapists work with patients following injuries or illnesses, and also treat wounds brought on by prolonged periods spent bedridden. Comatose patients also receive physical therapy; the therapist manipulates the patient's limbs so as to avoid muscle atrophy.

Speech therapists treat disorders of speech, language and hearing. Speech therapy covers a wide range of disorders and conditions: articulation problems brought on by an injury or a birth defect, language comprehensions issues following a stroke and cognitive problems accompanying a traumatic brain injury are all under the purview of the speech-language pathologist (SLP). Modalities for speech therapy depend very much on what's being treated; a swallowing disorder is treated with oromuscular exercises, liquid or thickened liquid diets and careful monitoring during feeding, while a fluency disorder is treated by teaching relaxation and breathing techniques, and strategies for avoiding or pulling out of a stutter.

Unlike PTs and OTs, SLPs do not usually have to take gross anatomy as part of their schooling (though they do have to study the anatomy and physiology of the speech and hearing systems). An SLP who works in a hospital setting is expected to have greater knowledge of medicine

and medical procedure than one who works in a school or out-patient clinic.

Trait Suggestions: (Attributes) Intelligence 2, Wits 2; (Skills) Academics 2, Athletics 1 (PT), Computer 1, Empathy 2, Medicine 2 (Hospital SLPs) or 3 (PT/OT), Persuasion 1, Science 1; (Merits) Contacts (Medical), Holistic Awareness, Language (SLP), Strong Back (PT)

Resources: Therapists are always in demand, though which of the three disciplines is in greatest demand varies year by year. A hospital therapist usually makes the equivalent of Resources ••.

Orderlies/Aides

Not everyone who works in a hospital has gone to medical school, or even to college. Orderlies and aides are responsible for providing non-skilled services: changing bedpans, transporting patients in wheelchairs and gurneys, delivering messages and so on. Nurses aides work with patients a bit more closely, but still in relatively non-skilled ways: bringing them food, helping nurses and therapists transition a patient from a bed to a wheelchair, etc. Being an aide or an orderly isn't particularly glamorous and it doesn't pay well, but it can be a way to get a foot in the door at the hospital while working on a medical degree of some kind.

Working as an aide or orderly can be a full-time or part-time job. Such workers are on shift at all times, but the shifts tend to be shorter than nurses' or doctors'.

Trait Suggestions: (Attributes) Stamina 2, Wits 2; (Skills) Athletics 1, Medicine 1, Stealth 1; (Merits) Strong Back

Resources: Typically none. The work doesn't pay well enough to merit much disposable income.

Psychologists

Clinical psychologists work directly with patients and can diagnose and treat mental illness, though in most states, they cannot prescribe medication. Clinical psychologists normally obtain a doctoral degree in psychology, although some counselors with master's degrees use the job title as well. A clinical psychologist in a setting such as an asylum or prison is likely to see many patients throughout the course of a day, and those patients might have diagnoses ranging from mild bipolar disorder to severe schizophrenia. A psychologist has a long list of potential techniques to use in psychotherapy. "Talk therapy" is a common technique, but it does require that the patient is open and honest with the psychologist about what she is feeling and thinking, and, of course, the psychologist needs the professional acumen to diagnose what the problem is from what information is available. The other problem with talk therapy is that it's slow, and insurance companies only sponsor a certain number of visits per billing cycle (or per year) for mental health. For this reason, talk therapy is often supplemented with pharmaceuticals, which means that the psychologist

Taped Session — S.B.

SB: Patient, age 14. **MH:** Maggie Hyllel, clinical psychologist

MH: I read your poem.

SB: Oh, God. Just burn it. (laughter)

MH: I thought it was good, actually. Spooky, but good. Have you written more?

SB: I did in English class, before . . .

MH: Before it happened?

SB: Yeah.

MH: But nothing else since last week?

SB: (long pause) I started having nightmares again right after I wrote that.

MH: Oh, Sadie. I'm sorry. I thought we had that beat!

SB: Me, too.

MH: Want to tell me about them? Are they the same as before?

SB: Mostly. Only this time I saw the little boy's face more clearly when I ran by. (crying) I just left him. I thought they wanted me. I thought — (inaudible)

MH: Sadie, Sadie, it's OK. Listen to me. Listen. It's OK. You couldn't have helped him. You couldn't have saved him.

SB: I could have. They wanted me. If I'd turned left instead of right at that corner, they'd never have found him.

MH: Are you OK? Do you want to stop for the day?

SB: No. I'm OK. I don't want to back to the common room yet, anyway. (pause, drinks water) I'm getting really good at pool, did I tell you? And I'm halfway through *Pride and Prejudice*.

MH: Yeah? Do you like it?

SB: I liked the movie better. (laughter)

has to be savvy about the effects and side effects of these drugs, even if he can't prescribe them.

Many psychologists work on the academic side of their field as well as the clinical side, teaching or performing research. In a hospital setting, the work is intensive, but psychologists aren't usually on call 24 hours a day (a place such as Bishopgate, though, has a psychologist on duty at all times).

Some psychologists work for government agencies such as police departments, and might be called into to "talk down" a person threatening suicide or debrief officers (or civilians, for that matter) after a shooting. Such psychologists might be police officers themselves, or might simply contract with the department.

Trait Suggestions: (Attributes) Intelligence 3, Manipulation 3, Wits 2; (Skills) Academics 3, Empathy 3, Investigation 1, Medicine 2, Persuasion 2, Subterfuge 3; (Merits) Eidetic Memory

Resources: Varies based on employer. A psychologist in a private practice has the same problems as a doctor (see p. 32) but lower malpractice premiums. Resources • to ••• is appropriate.

Secretaries

It might seem strange to include secretaries (or "administrative assistants," as they're sometimes called) in this list, but they actually wield more power than many

people realize. Doctors, particularly wealthy or respected ones, are generally out of touch with day-to-day activities such as keeping appointments or returning phone calls, and so this duty falls to a secretary. Therefore, a secretary has access to a doctor's schedule, her patient information, her notes and her computer files, and can greatly expedite—or terminate—her dealings with any particular patient. While it's not ethical for a secretary to slow things down for someone because she is angry or disgruntled over how the patient treats her, it does happen (likewise, people who take time to talk with secretaries politely, learn their names and refrain from treating them like automatons often find that their messages don't get lost and the doctor returns their calls promptly).

Duties for a typical medical secretary might include office and clerical work, answering and managing phone calls, keeping a doctor's appointments straight, medical transcription and dealing with insurance companies and/or hospital administrators. Secretarial work at this level is generally a full-time job, 40 hours or more a week, and if the doctor works weekends, the secretary might be expected to do so as well.

Trait Suggestions: (Attributes) Intelligence 2, Wits 3; (Skills) Academics 1, Computer 2, Empathy 2, Expression 1, Intimidation 1, Medicine 1, Persuasion 2, Politics 1, Subterfuge 2; (Merits) Contacts (Medical, Business), Eidetic Memory

Resources: A secretary's salary is commensurate with the salary of the doctor who employs her. A world-famous surgeon might employ several secretaries, each making the equivalent of Resources ●●●. A general practitioner, if he has a secretary at all, probably pays her the equivalent of Resources ●, if that.

Status and Other Merits

Status: At one time, a doctor was unquestionably a well-respected member of the community, almost above reproach, largely because he was unique. But doctors and health care are easier to come by in the modern world (provided one has insurance, of course), and that means that the profession of "doctor" has lost some of its special status. The fact that any layperson can get on the Internet and research his own symptoms, treatment options and prognosis also removes some of the doctor's mystique (this also means that patients can come into doctor's offices with preconceived and sometimes dangerously incorrect ideas about their disorders).

The Status Merit listed on p. 116 of the **World of Darkness Rulebook** is serviceable for medical characters but does require a bit of expansion in light of **World of Darkness: Asylum**.

For instance, having Status (Medical) doesn't automatically grant a character access to crime scenes, patient records and other sensitive areas. As American society has grown more litigious over the years, and after the implementation of HIPAA (see sidebar), access to patients' records

has grown increasingly difficult. Likewise, while a county coroner or medical examiner might have access to a crime scene, most other medical professions probably won't.

Status (Medicine) covers the following, no matter how many dots are purchased:

- **License:** The character has a current, legal license to practice whatever form of medicine is appropriate. This means that the character's name appears on city, state, county and/or national databases, and that the professional organization governing that particular field of medicine knows the character and can revoke the license if need be; see "Licensure," p. 32.

- **Prescriptions:** *Medical doctors and nurse-practitioners* can write prescriptions for medications. This means that the character or the company for which the character works has obtained a registration number from the Drug Enforcement Agency to traffic in controlled substances.

- **Access:** A medical professional has access to areas that other people do not. Operating rooms, record rooms, morgues, crime scenes and storage rooms are a few of the useful places that characters might wish to access and that medical professionals often can. Of course, which areas a character can access with the aid of the Status Merit depend on what the character does; an SLP might work in a hospital, but would have no reason, normally, to enter a morgue or a drug storage room. Simply having an ID badge, though, can open some doors, although for locked areas (psychiatric wards, maternity wards, drug storage, etc.) the character might need a key, a passcode or the right symbol or bar code on her badge to gain entry. Medical examiners, as mentioned, can access crime scenes, and EMTs might have a reason to be at a crime or accident scene as long as their job requires it, but other medical professions don't have this privilege.

Status (Medical) doesn't exactly have limits based on the specific profession that a character holds, but some guidelines exist. A doctor can easily have anything up to Status (Medicine) ●●●●●, and the amount of Status he has is less dependent on his skill and more on how aggressively he maintains his position in the medical community. A nurse might have Status (Medicine) ●●●● or even ●●●●●, while an EMT isn't likely to rise above Status (Medicine) ●●●. Therapists might have Status (Medicine) ● or ●●, depending on the setting in which they work (a physical therapist working for a renowned hospital might even have Status ●●●). Again, profession doesn't specifically limit Status, but profession does provide a good yardstick. Doctors are simply afforded more influence than other medical professionals. That said, the nurse or therapist who has been working at the same hospital for 20 years must defer to a new doctor, but that new doctor, if he knows what's good for him, is *very* polite to the older staffers.

- **Contacts:** One of the advantages to working in a hospital setting, seeing large numbers of patients throughout the course of a week, is that medical professionals meet people. Most patients pass through their rotations without making



too much of an impact, but occasionally medical professionals meet truly interesting people. Medical professionals who provide good treatment often earn their patients' gratitude, and might be willing to provide the character with information in their area of expertise later on. A surgeon might save a child's life following a car accident and discover that her father is a scholar in an obscure field; this is more than enough to justify the surgeon having Contacts (Occult). It needn't be so dramatic, though. A physical therapist who spends hours each week with the same child, teaching her to walk again, is just as likely (or more likely) as the surgeon to earn the scholar's respect and gratitude.

Obviously, anyone who works in a hospital has access to the personnel and resources of that hospital and so could be considered to have Contacts (Medical). The Storyteller could take this Merit as read, or could require the player to purchase it for the character (or to justify why she *doesn't* have it — maybe the character has a bad reputation and the rest of the staff is standoffish and unhelpful).

Allies: In much the same manner as Contacts, medical professionals can find themselves benefiting from favors from former patients. Medical professionals in hospitals, though, are usually disallowed from accepting anything more substantial than a card or a letter from a former patient — gifts, money or other tokens of appreciation are seen as ethically shaky. Also, many patients feel that a doctor or other medical professional who provides health care is simply doing her job, and doesn't necessarily deserve anything in the way of thanks.

All of that said, sometimes gratitude does compel people to offer favors. Consider: A man stumbles into an emergency room in the middle of the night with a wound on his shoulder. Upon examination, the wound appears to be caused by a shotgun blast, but shows evidence of searing as well. The doctor pulls pellets from the wound and watches in amazement as they scorch the man's flesh. Once the wound is cleaned, the man gets up to leave, telling the doctor to keep his mouth shut. The doctor, stunned, cleans the pellets and realizes that they are made of *silver*. If the doctor does indeed keep his mouth shut, he has made a powerful Ally — and he might not even realize it.

Retainer: A doctor who can afford a secretary or personal assistant might have this Merit, but other medical professionals don't generally have the means (or the need) for it. As far as game applicability, though, a secretary or assistant might be able to perform some research, transcription or even errand-running, which would free the character up for more direct involvement with the events of the story. Whether this kind of function is best represented by Merit dots or simply as a "given" for the character to be *able* to participate in the chronicle is up to the Storyteller.

Resources: Medicine can be a lucrative profession, but doctors are hardly rich by default. As the entries above indicate, a doctor just out of medical school is probably so far in debt that no Resources rating at all is merited. Most medical professionals whose fields demand advanced degrees

HIPAA

The Health Insurance Portability and Accountability Act, adopted in 1996, is meant to protect patients' information from falling into the wrong hands. In an age in which a person's medical records are a valuable commodity (unscrupulous thieves can steal a person's identity, accrue tens of thousands of dollars worth of medical care and dump the costs on the hapless individual who now has conflicting and potentially fatally incorrect information in his medical records), the reasoning behind HIPAA makes a great deal of sense. Unfortunately, as is so often the case when bureaucracy tries to make something better, for the most part HIPAA just made things more complicated.

Under HIPAA, medical professionals must keep patient records under lock and key, and if they are transmitted electronically, they must be encrypted. Patient records are limited to authorized individuals, but determining who is authorized (especially if a medical professional from outside a given facility is to be given access) can be difficult. Also, although under U.S. law patients have access to their own records, some facilities have grown downright obstinate in giving out records to *anyone*. The reason for this isn't a desire to obfuscate the records, though. It's simply that HIPAA violations can impose stiff penalties, and so hospitals err on the side of caution.

What this means in game terms is that characters attempting to break into records rooms or hack into patients files might find a much greater degree of resistance than they might expect. Many facilities, in fact, do not store patient records on computers with Internet access at all, making breaking into these files from an outside location impossible.

(which is most of them) are in similar situations, unless they have some way to pay for their schooling without taking out loans. Nurses, for instance, sometimes obtain associate or bachelor's degrees and then go to work for a hospital that pays for further specialty training . . . but then the hospital expects them to remain employed for a period of years, and pay back the money for the schooling if they do leave.

A medical professional's Resources rating depends on how much money he has managed to put toward his debt, his lifestyle and the degree to which he lives beyond

his means, and, of course, his insurance premiums. The player and the Storyteller certainly don't need to draw up a financial portfolio for every character in the medical field, but if a player wants his character to have high levels of Resources, the Storyteller is quite justified in asking where the money is coming from and why it isn't getting spent on other expenses.

Characters in the Medical Profession

For a character to be viable in a chronicle, that character has to have enough free time to devote doing the sorts of things that player-controlled characters do: investigating strange occurrences, getting into fights and so on. Medical professionals' time is generally at a premium, and this can make the other activities (the ones that actually comprise the events of the chronicle) difficult. A character who is also a supernatural being such as a vampire, werewolf or mage can work in one of the above professions and still be a viable character, but it takes some specific circumstances, and such characters can expect to be stretched very thin (which isn't uncommon for medical professionals in the first place).

Taking a simple example, suppose that a mage works as a clinical psychologist. Presuming that she works normal hours, her weekdays from about 9 A.M. to 6 P.M. are taken up in work. Since she needs to prepare for clients' sessions, and that entails extra research, on any given day she might actually work later into the evening. She has responsibilities to her Consilium and her order, as well, if she wants to remain in good standing (maintaining or improving her Status Merit in those groups). She might also have family or other social life, and, of course, she needs to think about continuing education every once in a while. If she performs research, it's probably on her own time rather than during business hours. And all of this is *before* she can think about following her cabal off on some enticing lead. How can the troupe make this sort of character work within the chronicle?

It's not at all impossible. It just requires a little forethought on the part of the Storyteller and the players.

- **Be ready for conflict.** Yes, the events of the chronicle *will* conflict with the character's normal life. That's part of the point. The character might eventually have to choose between the life she has built and the potential for delving deep into the secrets of the World of Darkness, but that's very much in-theme for the game. If the character chooses the real world, can she really afford to "dabble," maintaining a mundane life but sneaking off into the shadows occasionally? Are her compatriots willing to let her do that, or will they leave her behind?

- **The chronicle can intrude on the mundane.** One of the mistakes that players sometimes make is trying to bring too great a degree of "realism" to their portrayal and consideration of their characters. Remember: the chronicle is an ongoing story. That means that anything that happened to the character before the chronicle began



Story Hook — Benefactors

The section on Allies, and to a lesser extent, Contacts, raises an interesting notion. People in health care professions, especially working in emergency services, don't often know who the people they treat are. Thus, a player might take dots in Allies or Contacts and leave the fields unspecified, representing former patients. The Storyteller is then free to work these former patients into the chronicle. Below are several examples of how this might play out.

- A character aids the victim of a vampire attack. The vampire in question, terrified that he might have killed in a fit of hunger, actually delivered the victim to the emergency room. Since the victim survived, the vampire feels that he owes his soul and peace of mind to the character, and resolves to protect her in any way he can.
- An SLP is assigned a stroke patient. The stroke wasn't a natural event, though, but the result of reading a passage in a cursed text. The patient is a mage, but the brain damage from the stroke has left her unable to cast spells. Her cabal discovers that the SLP is making progress, and resolves to help her in any way they can . . . provided that she continues making progress with this patient. Doing so, though, might require a better understanding of what caused the stroke in the first place.
- The longtime patient of a clinical psychologist goes missing one night. Her parents are found dead, torn apart apparently by animals. Two days later, she shows up at her psychologist's home, claiming to have turned into a werewolf. She refuses to demonstrate this power for fear of losing control and killing the character, but asks for help and seclusion. What the psychologist does here could make him a friend for life, or spell his doom. A pack of very aggressive werewolves is looking for this young woman, and they won't take kindly to meddling from a human shrink.

is *back-story*, and anything that happens to the character during the chronicle is *plot*. Therefore, if a particular event in the chronicle seems to be influencing every aspect of a character's life, that only makes sense, from a narrative standpoint. For a cinematic example, consider how Edward Norton's character changes in *Fight Club* after the club really gets going in earnest. He's still working his job . . .

but now, his outside activities leak in. This can happen to your character as well. If the character saw a man change into a wolf last night, how does the character react to the patient who has been talking about having the soul of a wolf for months? Does the character find a newfound respect or interest in what that patient is saying? It might be wise, after a significant event in a chronicle, to play through a few scenes of "everyday life" and think about how the event has affected your character's outlook.

- **Be prepared to lose it all.** Everything that a character has can come crashing down once the supernatural intrudes, or even when the events of the chronicle begin (if the character already had contact with the supernatural). A doctor might lose his practice if he starts missing too many appointments and his patients go elsewhere. A therapist might lose her license if she starts behaving in a way that her professional organization finds unethical. Any medical professional has to keep up with continuing education and the demands of the job, and there are always new grads who will to step in and replace someone who can't do the work anymore. It's not at all inappropriate to present these challenges to players and to force them to make their characters choose between the world they know and the darker world that calls to them.

Then again, some players would rather take it as read that "my character's a doctor" and not go into the considerations of what it takes to maintain a medical license. That's OK, too, if you'd rather a character's profession just be backstory, but medicine requires so much of a person's life, both for schooling and the job itself, that it would hard to imagine a medical professional who doesn't count her job as a large part of her self-identity.

- **Think logistically.** Vampires sleep during the day. They can become active during daylight hours only with great effort, and even then they must stay out of the sunlight or quickly perish. Therefore, any job that a vampire takes *must* have some way of compensating for this affliction, and simply taking "the night shift" doesn't really work because that shift normally runs from midnight to 8 A.M. — which is well past sunrise during most of the year. There are medical conditions that make people vulnerable to sunlight, yes, but they are rare and might have associated effects, so a vampire pretending to have such an affliction and working in the medical community had best know what he's talking about.

Note, though, that none of this means that a vampire *can't* take a job in the medical profession, just that he needs to be careful and thorough. The same is true for any supernatural being. A werewolf needs to be careful around normal people, both because she might fly into a murderous rage with little provocation and because she might attract spiritual interference. Mages do not, intrinsically, have anything that prevents them from living and working as normal people, but as mentioned, they belong to a greater community that demands attention. If a player wishes to make a character who is both a supernatural being and

(for instance) a doctor, the Storyteller should ask how that player balances and manages the mundane and supernatural sides of his life, not with the intent of challenging the concept but with the intent of making the player consider the question. If the Storyteller understands this balance, he knows how to upset it during the chronicle (again, conflict is part of the point).

Morality and Medicine

Doctors are sometimes seen as cold, unfeeling, callous and aloof. Surgeons, in particular, might be described as “arrogant.” And yet, the medical profession is, ideally, dedicated to helping people to heal, so why does this perception persist? And, more to our point, what effect does the practice of medicine have on Morality, over time?

Looking to the first question, the perception of doctors as somewhat emotionless persists for a number of reasons. First, frankly, it's not altogether inaccurate. Doctors often *do* maintain a certain detachment from their patients, but this is necessary for what doctors do. A doctor might be able to treat a close friend for a given disease, but in order to provide efficacious treatment, the doctor needs to remain objective enough to diagnose. If the doctor cannot do that, he should refer the patient. Given this, it's easy to see why doctors don't get too close to their patients.

Another reason, of course, is because doctors see so many patients. Any job becomes routine as years wear on. The first child cancer patient an oncologist sees is tragic. The 200th is just as tragic . . . but the doctor has years of perspective and experience to inure her. Hopefully, this is of benefit, and the doctor has learned over the years which patients might respond better to a given treatment. Another related issue is that patients sometimes don't respond to any treatment, or they refuse to follow the doctor's advice or they die. Medical professionals recognize the inevitability of death long before people in other fields do.

Finally, especially in the United States, the health care industry is precisely that — an industry. Insurance and drug companies, hospitals and other corporations regard the treatment of the sick and injured as another way to make a dollar, and the doctors (and nurses and therapists)

wind up caught between their professional and ethical obligations to their patients and the desires and stipulations of their employers. “Productivity,” the amount of billable time that a professional spends with a patient, has become a buzzword in the health care profession. This results in professionals seeing as many patients in a day as physically possible. This is exhausting for the professional, of course, and leads to (among other things) a loss of empathy for the patients — when there are so many, who has time to get to know them?

So what effect does this have on Morality? In practical terms, not much. A doctor who accidentally kills a patient during a surgical procedure might need to check for degeneration, but even putting a patient through a painful treatment such as chemotherapy isn't going to require such a roll. A doctor's Morality rating might settle at 6 or 7, but it isn't likely to fall any lower than that simply by virtue of the profession. Over time, the rigors of the job might induce certain derangements (especially at a place such as Bishopsgate) but it's just as likely to prohibit increase of the Empathy Skill or simply produce a flat effect or cold demeanor.

At the same time, though, remember that Morality is not the same thing as “goodness.” Morality measures ability to relate to one's fellow human beings and, to a lesser degree, respect for the law. Morality does not measure spiritual purity (not for human beings, anyway), and a lower Morality score isn't indicative of “evil.” It might, however, be indicative of callousness or apathy, and years of desensitization to human suffering *can* produce those conditions. Representing them with a low Morality rating, though, is up to the Storyteller to adjudicate.

Seeing the Supernatural

Supernatural beings are rare, and they have good reasons to keep themselves hidden from humanity. That said, occasionally people see evidence of vampire depredations, werewolf hunts or magic, even if those people have no frame of reference for what they are seeing. Broadly speaking, the two professions most likely to encounter the supernatural as part of the job are law enforcement and medicine.

Minutes of Tuesday Meeting: S.B.

Dr. Hyllel (Clin. Psych.) raises new points about S.B. Recommends removal of medication or severe reduction. Nightmares reportedly getting worse following last session. Dr. Travis (MD Psych.) refuses, wants to increase medication. Agree to make no change for now, reports that spike in vivid dreams is common before “normalization” on current medication. Recommends considering ECT. Dr. Hyllel recommends against it strongly. No ECT at this time.

Slane (OT) and McMillin (PT) report that S.B. can be discharged from both Occ. Th. & PT. McMillin reports that gait is normal, hand strength is returning (reassess in 4 weeks). Slane reports that all skills for ADL are WNL.



Doctors, nurses and other medical staff see the remains of the supernatural and what it does to people. They see huge wounds from a crazed werewolf and are forced to write “animal attack” on a form, despite the odd similarity to a human finger pattern to the claw wounds. They struggle to determine how a healthy person jogging at night could suddenly die of blood loss without a single wound on his body. They see all this, and they have no way to explain it. Even if they know enough about the occult or folklore to think of the words “werewolf” or “vampire” (and most professionals don’t), they certainly wouldn’t actually entertain those theories for very long.

But little by little, if enough coincidences and strange occurrences pile up, they start to guess at the truth. Not in the sense that they realize that vampires exist and belong to clans, or anything so specific, but simply that there is *something out there* that doesn’t correspond to anything in their experiences. Some turn to religion to find comfort and solace, some turn to alcohol and other drugs. A very few seek more knowledge, digging into the literature to find other examples. Professionals who grow too persistent tend to join the supernatural community, often as servants to a more powerful being (but sometimes, by Awakening or being Embraced), or else they get too close to something that values its privacy and wind up dead. Of the handful of professionals who investigate the arcane truths of the world and don’t wind up dead, some might decide that their oaths as healers extend to protecting humanity (see p. 171 for more on this “hunter response”).

Most often, though, once a medical professional learns that the supernatural exists, that’s enough. He now has a handle on the strangeness that comes into his emergency room or his asylum, and might even learn to treat the aftermath of such events, given time. Such characters are by no means happy or well-adjusted, however, because they are aware of the danger that lurks in the World of Darkness. Many of these unfortunates develop derangements such as Avoidance or Suspicion, as well as problems such as alcoholism and insomnia. They know very little, but enough to be terrified, probably forever.

Medical Procedures in the Chronicle

This section discusses game mechanics for medical procedures and situations. Herein, we include new derangements and an in-depth discussion on what a derangement really means within the context of a World of Darkness chronicle, as well as some new Merits to represent various types of medical expertise and experience.

One thing to keep in mind, though, is that doctors and other medical professionals do not “heal” people. They remove obstacles to the human body’s natural healing process, allowing the body’s systems to take over. As simple as that

sounds, the modern medical body of knowledge is capable of some truly impressive feats, including transplanting organs from one body to another, using radiation and poison to kill tumors, repairing gross physical deformities such as cleft palates and even replacing body parts with artificial components. Mental health is somewhat trickier, because the medical profession is still grappling with defining mental disorders in treatable terms, but a few game systems are included here for this arena, as well.

The systems included in this section by no means cover every conceivable medical procedure that a character might attempt. For the most part, we concentrate on the procedures that are most likely to see use in a chronicle. Even if a character is a speech-language pathologist, for instance, systems for articulation therapy probably aren't necessary for the chronicle.

Systems

The systems below expand upon the systems for healing and diagnosis presented on pp. 60–62 of the **World of Darkness Rulebook**. All of the systems presented here are optional, and are useful for troupes that wish to increase the role that medical procedure plays in their chronicles.

Diagnosis

A proper diagnosis is critical for receiving proper medical care. If a patient is misdiagnosed, the staff might waste valuable time using treatment methods that are ineffective. Worse, the wrong treatment, especially with regards to pharmaceuticals, can be fatal.

The roll results provided on p. 61 of the **World of Darkness Rulebook** for diagnosis and treatment are perfectly serviceable for all of the different diagnostic tests discussed here. The dice pools might change, however — and note that not all of them involve Medicine.

Blood test and other lab tests: Most of the time, doctors don't perform lab tests. They send them out to be performed by independent laboratories by trained technicians. Performing the test correctly only requires game mechanics if a player is playing a lab tech or if the Storyteller has some reason to feel that whether a test is performed properly has some impact on the chronicle. In this instance, the test requires a roll of Intelligence + Science. The action can be instant or extended, depending on the complexity of the test and how many different steps it entails. A pregnancy test, for instance, is an instant action (and often performable at a doctor's office, much to the relief of many an anxious couple). Taking x-rays and ultrasounds (but not interpreting them, which is the doctor's job) probably requires an extended action (five successes, 10 minutes per roll).

The doctor's main responsibilities with lab tests are knowing which ones to order in the first place and then interpreting the results. Figuring out which test to order involves a roll of Wits + Medicine; this is an instant action,

made at the end of an examination (see below). Interpreting the results of a lab test is an Intelligence + Medicine roll. This is an extended action (15 minutes per roll; three to 15 successes required, depending on the complexity of the tests, how accurate the information is and how obscure the condition).


Suggested Modifiers — *Ordering tests:* Regular or long-time patient (+1), success on Interview roll (+1 — see below), condition is common (+2), professional keeps current with testing techniques (+2); failure on Interview roll (–1), professional has never seen this condition before (–1), patient is lying about condition (–2). *Interpreting tests:* Good references/Internet access (+1), condition is common (+2); professional ordered the wrong test (–3).

Evaluation: An initial consultation with almost any health care provider, be it therapist, doctor or psychologist, consists of an examination and an interview. This process, which can actually take several visits, forms the basis of an evaluation, after which the professional makes the diagnosis (or, in the case of physical and occupational therapy, forms a plan for treatment). This data collection process is complex, but it is an important part of the job and occupies whole courses in medical and therapy programs. In game terms, the evaluation process comes down to two rolls, one for Assessment and one for Interview.

The Interview comes first. Simply put, the professional talks to the patient, finds out what the trouble is (from the patient's perspective) and what the patient would like out of treatment. If a patient comes to a doctor with a pain in his foot, the goal is fairly obvious: the patient would like the foot to stop hurting. If a non-native English speaker goes to an SLP, however, and asks for accent modification therapy, the goal might be simply to improve intelligibility or to lose the accent completely. During the interview, the player rolls Intelligence + Empathy. This is an extended action, with each roll representing 10 minutes and five successes required. The challenge in the Interview is knowing which questions to ask and putting the patient enough at ease that he is forthcoming and honest about his symptoms and history.

The Assessment includes taking all of the information that the provider receives from the patient, including the patient's medical history, the interview and the results of any tests the character performs (or orders) and synthesizing it into a diagnosis. The Assessment is represented by an extended Intelligence + Medicine roll. Each roll represents 30 minutes. The number of required successes ranges from five to 30, but the character might stop after achieving only a few successes. This doesn't necessarily result in an incorrect diagnosis, just an incomplete one. A doctor might recognize that the patient has an infection in a wound on his side fairly easily, but if she doesn't dig deep enough into the matter she won't discover the fragment of werewolf tooth still lodged in the patient's flesh.

The Assessment can also include behavioral or language tests, depending on what the professional's scope of



practice is. An SLP might administer a test of language, speech, fluency and comprehension or perform an oral mechanics examination to see if all of the organs of speech are intact. A psychologist might ask a series of hypothetical questions, administer a Rorschach or word-association test or simply write down and analyze a patient's normal conversation. Standardized tests have been normed on a given population, and are therefore only applicable within that population. For instance, a language test that was developed and normed for children aged two to nine isn't useful for adults, unless the adult is developmentally and cognitively at such an age.

Suggested Modifiers — Interview: Regular or longtime patient (+1), condition is very common (+2), professional has seen condition before (+2); language barrier between professional and patient (-1), doctor has never seen condition before (-1), patient lies about symptoms (-2). *Assessment:* Good research materials (+2), condition is common (+2); interview roll failed (-2), lab tests were corrupt or misleading (-2), wrong tests ordered or performed (-3).

Treatment

Once a diagnosis is made, the professional can begin treatment. Depending on the problem, treatment might be as simple as taking a few pills and waiting for the problem to clear up, or treatment might require prolonged physical therapy, chemotherapy, several different surgeries or other extensive interventions. We don't have space here to explore all of the possible treatment options, even if we were to limit the problems severely. Instead, **World of Darkness: Asylum** discusses several treatments commonly used in the mental health field and how they might translate to game systems.

Drugs: The first solution, for better or worse, in many cases is psychopharmacology. Prescription drugs are given to the patient in an attempt to help correct whatever is wrong. Although psychopharmacology receives some bad press as a methodology, its basis is sound: all thoughts and emotions in the human experience are represented by chemicals in the brain. A mental health disorder, then, involves some abnormality in brain chemistry, and a drug that corrects this abnormality should fix the problem. Detractors of psychopharmacology feel that some diagnoses are prevalent *because* they allow doctors to prescribe certain medications, which raises the drug companies' profits, which comes back to the doctors in the form of kickbacks and perks, such as plum research jobs. Other critics simply take issue with the idea giving a troubled person a pill instead of helping him solve his problem (though, admittedly, this criticism tends to come from people with a limited view of psychotherapy — psychopharmacology is very rarely the *only* form of therapy given to a patient).

In reality, though, there is no "magic pill" that a person with schizophrenia can take to correct the problem. Drugs *can* help, certainly, and many people with schizophrenia, bipolar disorder, attention deficit disorder and other problems find that the right pharmaceuticals make them much more able to function. However, there are some problems with psychopharmacology,

Outdated Tests

Diagnostic procedures fall by the wayside as they become obsolete . . . for the most part. Sometimes a doctor refuses to abandon the tests that he is accustomed to using, no matter how outmoded and dangerous they are. Sometimes funding for a clinic or hospital doesn't permit new equipment or training. And sometimes, the older tests reveal things that the newer ones don't. Doctors seldom use mirrors to check to see if people are breathing anymore, for instance, much to the relief of vampires, whose reflections appear blurry and indistinct.

One test, used as recently as the 1980s, is called pneumoencephalography. In this test, the fluid surrounding the brain (cerebrospinal fluid, often abbreviated CSF) is drained almost completely and replaced with oxygen, air or helium to allow the brain to show up better on an x-ray. This test was painful and dangerous, and has been supplanted by the CAT Scan. But Bishopsgate still has the equipment for performing this test, and an older doctor might well order such a test out of frustration, obstinacy or just dislike for the patient in question.

even before considering any concerns about the drug industry and the philosophy behind the methodology.

First, drugs work only when you take them. This requires that the patient recognizes that he has a problem, has the desire to correct it, understands (or believes) that taking his meds will help and has the wherewithal to do so. Patients without family support sometimes go off their meds due to forgetfulness, anger or many other reasons, and then the patient can probably expect to relapse.

Second, drugs don't work for everyone. Everyone's biological chemistry is different, and that means that no two people respond to drugs in exactly the same way. Some people find that a few weeks on an antidepressant makes them perfectly able to function, while others find that the drugs exaggerate certain parts of their conditions. It can take time to find the right combination of drugs (called a "cocktail"), and not everyone has that kind of patience . . .

. . . or money, which brings us to the third problem. Drugs, especially in the United States, are extremely expensive. People with insurance can usually afford their meds with only a small "co-payment," but for people without insurance, even getting a good psych evaluation, much less the right medication, can be impossible.

Finally, a drug cocktail has to be reevaluated periodically. A patient's biology changes, and drugs don't have the

same effect anymore, which means the side effects can worsen or the intended effects can disappear. Also, some drugs are habit-forming (sleep aids especially), and a good and ethical health care professional works to prevent this.

Drugs are divided into broad categories based on their general effects, and then further subdivided according to what specific effect they have on brain chemistry, what “generation” they belong to, potency and other considerations. Classes of drugs include *antipsychotics* (used to treat the symptoms of schizophrenia and other psychoses), *antidepressants* (used to treat symptoms of clinical depression), *mood stabilizers* (used to treat mood disorders such as bipolar disorder), *stimulants* (used, among other things to treat attention deficit disorder) and *hypnotics* (used to treat sleep disorders). All drugs have side effects (see sidebar).

Appropriate psychopharmacology increases the effectiveness of “talk therapy” (see below).

Figuring out which drug to prescribe requires a roll of Intelligence + Medicine. *Suggested Modifiers:* Science Specialty in Chemistry or Pharmacology (+1), successful diagnosis (+1); unsuccessful diagnosis (–3). All this roll does, though, is allow the professional to prescribe the right drug. Getting the patient to *take* the drug is out of the professional’s hands, unless the patient is committed to an institution.

Side Effects

The following is a list of a few side effects of psychopharmaceuticals, by type:

- **Antipsychotics:** Restlessness, tremors, cognition problems, dysphoria (a general bad feeling, notable because it tends to cause people to stop taking the meds), seizures.
- **Antidepressants:** Headaches, tremors, nausea, sexual dysfunction, blurred vision, drowsiness, skin rash.
- **Mood stabilizers:** Nausea, vomiting, seizures. Mood stabilizers are often prescribed alongside antidepressants and require frequent monitoring, as they can be life-threatening if used improperly.
- **Stimulants:** Euphoria, insomnia, addiction, loss of appetite.
- **Hypnotics:** Sleep, addiction, lethargy, dizziness.

Different drugs in the same categories have different side effects, and it should be noted that while many drugs have a potential laundry list of side effects, the operative word is “potential.” Very few of the extreme side effects ever show up, but they *might*, and so doctors and drug companies have to advise consumers.

ECT: Electroconvulsive therapy (ECT) is better known as “electroshock therapy.” It involves inducing seizures by applying electric current to the brain, and was developed to treat the symptoms of schizophrenia. Originally, ECT was administered without anesthesia, but current practice is to use both an anesthetic and a paralytic agent before ECT (to keep the patient from self-injury during the seizure). ECT has fallen out of common use because of the proliferation of drugs that accomplish the same things with much greater efficacy, but remains an occasional technique for treating clinical depression.

As might be expected, ECT is controversial, and has been negatively portrayed in the media enough that most people cringe at the thought. Using ECT on an awake and aware person requires a degeneration check at Morality 7.

Patients subjected to ECT don’t take damage from electrocution, but if they are not anesthetized first, they might take damage from the seizure. If an aware and mobile patient is subjected to ECT, she suffers five dice of bashing damage. Successive uses, obviously, can cause a great deal of potential injury.

Talk Therapy: “Talk therapy” is a blanket term for any psychotherapeutic modality that doesn’t require medical intervention. One example is cognitive therapy, in which the patient is directed to change his thoughts (this might seem simplistic, but it’s much more involved than simply telling someone to “think positive” — it involves a long period of treatment and analysis into what thought patterns are harmful to the patient and how they might be changed). Another is expressive therapy, which can incorporate art, dance, music and virtually any creative medium to help a patient express his problems, and thus analyze and confront them. Space precludes discussing the hundreds of different types of psychotherapy here, and players in a World of Darkness chronicle probably aren’t going to detail their characters’ therapeutic approaches, anyway. Keep the following points in mind, though.

Psychotherapy is not quick. It can require months or years of treatment to be effective, and, once again, not everyone has that kind of time, patience or money. Insurance companies, since they are seldom run by health care professionals, don’t often understand why therapy is necessary when drugs are available, and thus don’t authorize many visits with a psychologist (but do authorize payment for pharmaceuticals).

Psychotherapy also depends upon honest and open interaction with the patient. The therapist can be one of the best in the world, but if the patient isn’t cooperative, then progress is going to be extremely limited. Some patients aren’t cognizant enough to realize the point of the exercise, and some *are* aware of it but are savvy enough to manipulate a therapist to their own ends.

Regardless of the specific type employed, game systems for psychotherapy work the same way. The therapist needs to gain the patient’s trust; this can be accomplished with a contested roll (therapist’s Manipulation + Empathy vs.

subject's Composure + Subterfuge). This roll is made once every session, as long as the subject wishes to keep resisting the therapy. If the therapist wins, the patient participates in the therapy, perhaps grudgingly, perhaps only temporarily, but enough for the therapist to make some headway. If the patient wins, he *can* participate if he so chooses, but might lie or remain silent through the session.

The next step is the actual therapy. The therapist presents the patient with the therapy tools, be they conversation, art, play therapy, primal scream or whatever the therapist thinks will work. The therapist's player rolls Manipulation + Medicine. If this roll succeeds, the character has explained herself well enough that the patient can grasp the concepts and employ them. The patient's player might then be required to make rolls such as Wits + Expression (writing a poem), Intelligence + Composure (examining and discussing his own feelings and thoughts) or Resolve + Composure (reliving a traumatic event). If these rolls succeed, the therapy progresses.

At the end of every successful therapy session, the patient's player makes an extended Resolve + Composure roll. When the player reaches the target number of successes, the character stops suffering the effects of a given derangement. The target number of successes varies based on the derangement's severity. A mild derangement requires 10 successes, a severe one requires 20 and an extreme one requires 30.

Note that the derangement does not disappear; the character simply stops suffering the negative effects. No one is ever "cured" of schizophrenia, but it can be put into remission. A traumatic event, a long period of time spent off medication or supernatural intervention can cause a relapse. In such an instance, the Storyteller can have the player roll Resolve + Composure. If this roll fails, the derangement returns, and all rolls involving resisting it suffer a -3 penalty until the character gets back on her meds or has a successful therapy session. The derangement must then be put back into remission, but the difficulty is halved (it remains the same, though, if the derangement returns again later — a mild derangement requires 10 successes to be put into remission the first time and five successes in the future).

Emergency Procedures

The medical procedures that players' characters are most likely to be performing, of course, are in-the-field emergency measures. Wounds caused by gunshot wounds (or claws or fangs), burns from magic spells, damage from falling and so on, are likely to happen when normal medical assistance is too far away to be helpful.

The healing system presented on p. 62 of the **World of Darkness Rulebook** works fine for stabilizing Incapacitated characters, but it doesn't take into account some of the things that this stabilization might mean. Below are some examples of what the Dexterity + Medicine roll to save a dying person's life might represent.

As Long as We're on the Subject . . .

. . . leeches are making a comeback, as well.

Leeches are sometimes used in surgery to drain off excess blood. This prevents it from clotting and blocking arteries. There is some increased risk of infection when using leeches, but this is easily manageable. Similar to maggots, leeches are cheap and effective.

One wonders, then, what kinds of medical marvels a doctor with the supernatural ability to command various forms of vermin might be able to accomplish?

- **Emergency Tracheostomy:** The character's airway is blocked off and cannot be cleared. This might happen because of swelling due to an allergic reaction or sinister magic. In any case, the medical professional must make a hole in the front of the throat to allow air to access the trachea. EMS-trained professionals have surgical tools to accomplish this, but the cinematic example is to use a hollow plastic tube, such as a pen. The danger, of course, is placing the hole incorrectly and puncturing an artery.

- **Stitches, sutures and other blood-loss prevention:** Deep cuts, bullet wounds, savage bites and other injuries that part flesh and spill blood often require stitches or sutures. Properly performed, such procedures can stop bleeding and save lives. A field medical kit contains needles and stitches, but in a pinch, a long sewing needle and thick thread could be used (though this would certainly levy negative penalties). Deep pressure can also be used to stop or slow bleeding, and for untrained people, "Keep pressure on it!" might be the extent of their utility. Tourniquets can also be employed to stop serious bleeding.

- **Infection:** Infection occurs when bacteria enter a wound and multiply. An infected area is referred to as *septic*. Septic areas can be the result of untended, unclean cuts, scrapes, bedsores or other wounds, but can also occur rapidly and seriously if, for instance, the esophagus is severed, allowing stomach acid to spill into the lungs and other cavities. The systems for resisting disease and poison found on p. 49 of the **World of Darkness Rulebook** work for resisting the worst effects of infection, but a successful medical treatment to clean and sterilize the wound, in addition to antibiotic drugs, can add positive modifiers to such rolls.

Once flesh is infested, it might start to die, becoming necrotized. Necrotized flesh needs to be removed; it cannot be healed. This might result in amputation of a limb if the wound is serious enough, but for smaller wounds, *debridement* is enough. Wound debridement usually involves

scraping the dead flesh away, leaving pink flesh behind (if it's got blood flow, it's not dead). In some cases, though, live maggots are applied to the wound. The right species of maggot eats only dead flesh, does not burrow under the skin and does not pupate in the wound, so apart from the disgust a patient might feel at having live maggots eating part of him, the little creatures are a superb (and, as it happens, economical) method of wound debridement.

The Medicine Skill

The Medicine Skill, presented on p. 60 of the **World of Darkness Rulebook**, mentions that one or two dots of the Skill translate roughly to first aid and other low-level training, while three or more dots is more akin to what a doctor or surgeon might possess. Below is an expansion of what each dot of the Skill might cover. Since real-life medical acumen is a combination of talent, intelligence and training, there is no way to make all possible forms of medicine fall into five neat little categories, but this breakdown should at least provide a rough idea of how much Medicine to give a character.

One dot: A character at this level has probably taken classes in human anatomy and physiology (which might or might not include cadaver dissection), and might know CPR, the Heimlich maneuver and other simple lifesaving procedures. A character who works in a hospital might pick up enough information by observation to qualify for a single dot in Medicine, regardless of what field she works in. Medical professionals who work with patients in low-medical settings (some psychologists, SLPs) might have Medicine 1.

Two dots: This level implies a greater degree of schooling and experience. A character with two dots of Medicine might have been a combat medic in the military, or might be an EMT with below paramedic-level training. Most nurses are at this level, as well, as are physical therapists. A medical student in a residency or fellowship might also be considered to be at Medicine 2. Such characters might know how to perform a wide variety of diagnostic evaluations, and even know, in theory, how to deliver babies or perform some surgeries, but not have very much experience in applying this knowledge.

Three dots: At this level of skill, a character might be a general practitioner with a few years under his belt, a surgical nurse (or nurse anesthetist, nurse-practitioner or other specialized nurse), a paramedic-level EMT or a medical professional in a therapy field with a great deal of experience and theoretical knowledge. Such characters are competent to perform complicated activities within their scopes of practice (deliver babies, perform lifesaving surgery, treat known mental disorders), but, as has been mentioned, scope of practice differs from field to field (even the most expert occupational therapist isn't going to perform brain surgery).

Note that at this level of skill, the next step is usually to gain a Specialty, rather than a fourth dot in Medicine. Specialties are discussed below.


Four dots: A medical professional at this level probably has at least 10 years of experience in his field, stays abreast of current research (or performs such research himself) and if he continues to practice, enjoys a strong reputation in his field. Other professionals in the area know his work and refer patients to him. At this level, a character can perform extremely difficult and complex activities within his scope of practice (joint replacement, open-heart surgery, rare or delicate mental disorders). Such doctors are usually very expensive. Professionals other than doctors at Medicine 4 are rare, and such acumen implies an incredible devotion to the job, independent study and probably additional schooling, and a great deal of natural talent as well as years of experience.

Five dots: Laymen might recognize the names of doctors at this level of skill; they have become household words (and thus, some level of the Fame Merit is appropriate). Doctors such as this are often published and cited in multiple journals, sought after all over the country (and perhaps the world) for their skill, and only treat the most complicated and challenging patients within their scopes of practice. It is extremely rare for professionals other than doctors to reach Medicine 5.

Specialties: As mentioned above, when a medical professional reaches Medicine 3, it is much more likely that she will gain a Specialty than progress to Medicine 4. Any of the fields listed in the glossary beginning on p. 15 (cardiology, oncology, etc.) might be an acceptable Specialty. For purposes of game mechanics, fields such as Speech Therapy, Physical Therapy, Occupational Therapy and even Psychology or Psychiatry might be considered Specialties, although there are numerous smaller fields within those arenas that would make sense as well. A speech therapist might specialize in voice disorders, for instance, but it probably makes more sense from a game mechanics perspective to buy the Specialty in Speech-Language Pathology.

Long-Term Effects

Roleplaying games, *World of Darkness* games included, are usually written with the assumption that some form of magical healing takes place. This is a simplifying technique. If magical healing *doesn't* happen, then a character can look forward to being out of the action for months of bed rest, treatment, surgery, recovery, therapy (physical, occupational, possibly speech if the mouth or throat was damaged) — and all of that assumes modern medical facilities. Modern medicine has made fantastic advances in rehabilitation techniques, but heavy damage to the human body still leaves lasting effects. The *World of Darkness*, for the most part, glosses right over them. Once a character is “healed” and the boxes on his sheet are empty, he's right back where he started. For some characters, this makes perfect sense. Vampires and werewolves are, by their nature, not subject to the same problems as normal people. Mages are, but they can heal magically in a more complete way than any normal person can. But what if your character



is a normal person with no access to magic? How can you simulate the deleterious effects of serious injury?

For one thing, before implementing any such system, make sure it's what the troupe wants. While adding effects of injuries to your chronicle might make for slightly more "realism," and certainly might have the effect of acting as a deterrent to wantonly jumping into combat, such a system adds more bookkeeping to the game and might remove a dimension of non-reality inherent to characters in a story (rather than people in real life). If the players and the Storyteller agree that injuries shouldn't just fade away, though, below are three methods of handling them. We don't list specific injuries and their effects, because we don't have that kind of space and because two people might be injured in the same manner but wind up with completely different lasting effects. If your character is stabbed in the back, she might wind up with trouble breathing (collapsed lung), walking (severed nerve) or just massive blood loss and scar tissue.

- **Narrative:** The lasting injury has no game effects, but players are expected to portray their characters with an eye toward old complaints. Maybe a character's knee flares up when the weather turns cold following a broken leg. Maybe another character has trouble remembering details following the car accident. Maybe a character is still grappling with a nicotine addiction following surgery for a tumor on his lung (obliquely related, but related nonetheless). The Storyteller can, if he chooses, award experience for good roleplaying.

- **Flaws:** A simple method for representing ongoing effects of injury is simply for the character to take a Flaw. The system listed on pp. 217–219 of the **World of Darkness Rulebook** can easily be applied to the results of serious injury, and can allow a player to garner some additional experience (which softens the blow a bit).

- **Reduction of Traits:** A harsh, but appropriate, method of representing injury is to remove dots of Attributes or Skills from characters. Physical Attributes and Skills are probably the most likely targets — people who spend months in a hospital come out weaker than they went in. Stamina, Strength and Athletics are the most appropriate Traits to be reduced, but Mental Attributes and Social Skills might be affected if the character suffered brain damage. Merciful Storytellers might wish to translate the lost dots into experience points, which then might be spent on Traits that the character might improve while in the hospital. For instance, a character is shot in the back and loses a great deal of blood. He winds up bedridden for months. The Storyteller rules that he loses a dot of Stamina from the ordeal, dropping him from Stamina 3 to Stamina 2. Since Stamina 3 would normally cost 15 experience points to purchase, the player receives 15 experience points to spend. He buys a dot of Medicine (three points; he pays attention to what's around him and talks to the doctors and nurses), a second dot of Academics (six points; nothing to do but read), a dot of Contacts (two points; he takes a

shine to his physical therapist) and saves the other four to put toward rebuilding his Stamina.

Note that some Merits have prerequisites that might be lost under this system. The Merit isn't gone for good, though — just until the character rebuilds his lost Traits.

Derangements

An important point to note about derangements is that they are not the same thing as mental illness. A derangement, as defined by the **World of Darkness Rulebook**, is "[a behavior] that occur[s] when the mind is forced to confront intolerable or conflicting feelings, such as overpowering terror or profound guilt." A derangement might mimic the symptoms of schizophrenia, bipolar disorder or any other diagnosed psychological problem but is not necessarily the same thing.

Why do derangements come about? Most often, they are behavioral changes that result from "sins" against Morality. Calling the actions that can cause Morality to fall "sins" is misleading, though (if evocative). "Sin" implies some religious transgression, and while many religions do indeed prohibit killing (or at least regulate it to certain circumstances), you'll notice that violating the precepts of one's religion does *not* appear on the list of sins against Morality on p. 91 of the **World of Darkness Rulebook**. That list is written with the idea that people hold to a certain level civilized of behavior and that deviating from that results in behavioral (if not psychological) problems.

Morality is a tricky concept in the real world — philosophers, epistemologists, theologians and even scientists try to nail down what it means and whether or not there is a universal human standard for behavior, whether from a supernatural or natural source. The Morality system in the **World of Darkness**, then, isn't an attempt to state anything about the way the world "really is," but simply to make a workable system for measuring how much the terror and desperation of the **World of Darkness** has poisoned the mind of a character. A derangement is a symptom of that poison, and should be understood as nothing more than a game term (i.e., you won't hear characters talking about "derangements").

From the perspective of a psychologist, a derangement, regardless of what form it takes, might well be diagnosed as post-traumatic stress disorder, since it is a change in behavior following a significant and probably trying event in a person's life. When designing new derangements, it might be helpful to consider them from an empirical point of view rather than an etiological one. That is, *what* exactly is happening? What are the behavioral quirks? What changed in a character's outlook? (An etiological perspective would examine *why* it is happening, what the underlying pathology is, and as far as derangements go, we know why they arise.)

Below are a few new derangements. Again, these aren't meant to represent real-world psychological disorders,

because such disorders arise from problems with brain chemistry, for the most part, not from sudden exposure to the supernatural or committing actions that society considers morally wrong.

New Derangements

The first four derangements are adapted from the **Vampire: The Requiem** supplement entitled **Ghouls**, because they are generally applicable. The rest appear for the first time in this book.

Fetishism (mild): Your character formulates an irrational, pleasurable association with an object or situation. To fully enjoy himself, so to speak, he needs to duplicate the situation or be in the presence of the object. This can lead to some truly bizarre behavior, often triggering a cycle of gratification and guilt that's extremely difficult to break. If your character experiences something that reminds him of the event or object he's fetishized, roll Resolve + Composure. If the roll fails, your character focuses on re-creating the situation or coming in contact with the object in question. For example, an orderly who fetishizes licking female patients' feet when they are restrained might see an attractive woman sunning herself by a pool and feel compelled to indulge himself.


Masochism (severe): Your character is no longer satisfied with the presence of the object or duplication of the situation. He must now be hurt by it in order to enjoy himself. The effects of fetishism apply, but the character must also suffer an amount of bashing damage at least equal to his Stamina during the compulsive activity in order to be satisfied. Without the interference of an outside agent, he won't stop until the damage is inflicted in full.

Insomnia (mild): Your character has trouble getting the required amount of sleep, and not just occasionally. It happens more often than not, and leaves her feeling tired, irritable and unable to concentrate. Any time the character is engaged in a stressful situation (Storyteller discretion), roll Resolve + Composure. Failure means that your character is unable to sleep properly and suffers a -2 penalty on all rolls the following day. Each day thereafter is considered "stressful" and requires a similar roll until the character succeeds and gets a full night's or day's rest.

Cataplexy (severe): Your character has so much trouble resting that her body is beginning to fail her. Whenever the aforementioned sleep roll fails, the character suffers from bouts of overwhelming feebleness throughout the following day. Any circumstance resulting in an intense emotional reaction such as laughter, anger or fear requires a Stamina + Composure roll. Failure means that the character slumps to the ground, paralyzed with weakness for a full turn even though she remains fully conscious.

Repression (mild): Your character has blocked out the memory of the event that caused this derangement.





She might not remember pulling the trigger and killing that man. She might remember walking into the old house, but have no recollection of the horrors she saw there. In any event, only through intense therapy or memory-altering supernatural powers will she regain those memories. The character is aware that *something* happened, and is potentially open to discovering what, but cannot call up the memories herself. In addition, if she finds herself in a similar situation, the player must roll Resolve + Composure or else the character blocks out the memory of that scene as well.

Denial (severe): Your character not only represses the memories that trouble her but has constructed a potentially elaborate scenario to replace them and grows hostile if someone tries to persuade her otherwise. Whenever someone tries to educate the character as to the truth of what happens, the character's player rolls Resolve + Composure. If the roll *succeeds*, the character's delusion remains intact, and the character becomes irate and refuses to discuss the matter. If the roll fails, her internal commitment to the safety of the delusion weakens a bit, and she is at least willing to listen.

Supernatural Fascination (mild): Your character, usually following a supernatural event, has become convinced that the supernatural influences every facet of life. "The supernatural" here is defined by the character in question. He might become devoted to a particular religion, and see the hand of whatever God he chooses in every aspect of life. He might believe that aliens or secret government masters control everything. In any event, he believes that the world has a secret set of rules and codes that, if he abides by them, he will go to Heaven/have good luck/be safe from harm/etc. At least once a scene, and more often if significant events occur during a scene, the player must roll Resolve + Composure. If that roll fails, the character must perform some action appropriate to his beliefs. He might utter a brief prayer, mumble into his wallet (which he's sure contains a communication device), line his hat with tinfoil to prevent the aliens from reading his mind and so on. Because this derangement is so pervasive, it shouldn't cause major disruptions to the character's life, but its effects are almost constant.

Zealotry (severe): Your character has decided that his spiritual or supernatural beliefs are so important that *everyone* should share them. He proselytizes to everyone he meets, given only a few minutes of conversation. He might ask people if they have accepted Jesus Christ as their personal savior, or he might simply warn people engaging in "sinful" behavior that they are bound for Hell. He might snap pictures of agents of the government conspiracy and warn other people to "stay away from *them*." He might occasionally curse while looking at sky, as though expecting the aliens to arrive any moment. The game system for this derangement works similar to Supernatural Fascination, but the effects are more extreme, as described.

New Merits

The Merit listed below are designed and described with medical characters in mind, but nothing says that other characters can't take them as well.

Mental Merits

A Little Knowledge ,(•)

Prerequisite: Mortal (non-supernatural)

Effect: Your character has either had a brush with the supernatural or been in a field that has regular casual contact with the supernatural (such as medicine or law enforcement) to know that something else is out there. While he doesn't know anything specific (i.e., this Merit doesn't give any bonus to Occult rolls or offer any frame of reference), your character doesn't suffer negative penalties when trying to identify or diagnosis conditions for which there is no easy medical antecedent.

For instance, a doctor with this Merit sees a patient in the ER with long, vicious bite marks. The doctor knows that no animal short of a bear could have made those wounds, and he knows that there are no bears native to the area. Normally, this would negatively affect his treatment — he might waste valuable time trying to shoehorn the evidence into his own experience. With this Merit, though, he takes it as read that *something* made these bites and treats them.

This Merit also offers a +1 bonus to any roll made to recognize a strange or otherworldly situation. If the character ever becomes a supernatural being, including a ghoul or a Sleepwalker, he loses this Merit.

Emotional Detachment ,(••)

Prerequisite: Resolve ••

Effect: Your character can distance himself from the pain, grief and suffering of his fellow human beings long enough to help them. This might make him seem somewhat aloof, but it also means that he doesn't second-guess himself when performing delicate surgery. The character ignores penalties stemming from stress equal to his Resolve rating. For instance, if an EMT is trying to perform an emergency tracheostomy while in a moving car with a werewolf on the roof, the EMT might normally suffer a -2 penalty from sheer emotional pressure. If he had this Merit and his Resolve were 2 or higher, he would take no penalty at all.

Good Time Management ,(•••)

Prerequisite: Academics, Medicine or Science ••

Effect: Years of working with demanding corporations have served your character well. She can make effective use of her time, provided that she's not relying on anyone else who might slow her down. Each roll in an extended action has the time requirement reduced by one quarter. For instance, if the character is translating

Letter from S.B. to Mrs. Holly Ulrich

Dear Mrs. Ulrich,

I don't think you'll ever get this letter. But I'd like it if you did. I think you should know what really happened. Maggie says she won't open this letter and if she doesn't open it and it never gets sent, there's no reason I can't say what really happened.

OK. What really happened was that I got into this little club at school with these three other girls and one boy. And we did some really stupid stuff. We cut ourselves with razors and mixed the blood together, and one night we all got naked together, and the boy and I did it. I know this all sounds sick, but you need to know what really happened and why.

So this had been going on for a month, and one morning I woke up and it really hurt when I went to the bathroom. And I told my mom and we went to the doctor and he said I had herpes. So since I only ever did it with one boy, I knew he had to have it, too, and I called him up and told him that he needed to get checked out and tell the other girls because I was pretty sure he'd done it with them, too. And he said that I'd better not go telling the other girls, and I said I would if he didn't, and he said he'd call up the Hounds if I did that.

When I got to school the next morning, the other girls wouldn't talk to me, and they all had big cuts on their hands. I knew that they'd done something pretty big to use that much blood, and I tried to tell them about the herpes, but they wouldn't listen. I was walking home after school, and I heard a noise like barking behind me, but

a text and each roll would normally require one hour, a character with this Merit only requires 45 minutes for each roll. Characters using Teamwork (see p. 134 of the **World of Darkness Rulebook**) cannot benefit from this Merit, or characters relying on machines (such as lab equipment).

Good Time Management applies only to mundane actions. It does not apply to magical rituals of any kind, though it does apply to researching such rituals.

Physical Merits

Tolerance for Biology (●)

Prerequisite: Resolve, Stamina or Composure ●●

Effect: Some people see blood and pass out. Some people hear another person throwing up and get queasy. Your character can watch medicinal maggots being massaged into open, blackened wounds and feel nothing except a bit of curiosity. He never

feels nauseated due to unpleasant things he sees in a medical setting, and receives a +2 bonus to any roll to keep composed when offered scenes of violence or carnage, or when exposed to horrific smells.

Social Merits

Bureaucratic Navigator (●●)

Effect: Bureaucracy has a pattern, and your character has learned to recognize it. Within any given bureaucratic system, be it a hospital, a government agency or a corporation, he has learned whom to talk to get results, which rules he absolutely must follow and which ones he can ignore because no one pays attention. You receive a +2 bonus to all Social and Mental rolls made to navigate, manipulate or work within a bureaucratic system. Note that this Merit doesn't accomplish the impossible. Your character isn't going to get a permit for a heavy assault rifle if such weapons are illegal in his city, no matter how much he flirts with the ladies at the country courthouse.



Chapter Three: Bishopsgate— Built on Secrets

Years passed and no one in our town, no one I could name, allotted a single word to that great ruin which marred the evenness of the horizon. Nor was mention made of that darkly gated patch of ground closer to the town's edge. Even in days more remote, few things were said about these sites. Perhaps someone would propose tearing down the old asylum and razing the burial ground where no inmate had been interred for a generation or more; and perhaps a few others, swept along by the moment, would nod their heart's assent. But the resolution always remained poorly formed, very soon losing its shape entirely, its impetus dying a gentle death in the gentle old streets of our town.

— Thomas Ligotti,
Dr. Locrian's Asylum

We often forget that the ground on which we stand has more history than we know. The land has been here longer than our nations, than our institutions. It will outlast us.

The Psychiatric Hospital at Bishopsgate is an example of this. It has stood for barely a century and a half, but the hospital's grounds carry a history of madness and violence that predate its building. Terrible things have happened on this land, and they've been happening for longer than anyone alive today can know. The question is, why?

Perhaps the earth is sick. Perhaps it is sour. Perhaps the people who do these things to one another, year after year, are the helpless, the victims of an ancient malevolent power from beneath the earth that dooms them to repeat the same atrocities generation by generation, manipulated like toys until they break. Perhaps the people in the asylum do what they do because they want to, because the opportunity is there to do it and they do it anyway, because that's what people do, one generation traumatizing the next, over and over, until there aren't any people to do it.

This cycle of murder, madness and abuse flares up over and over. A sickness seeps into the fabric of the building, into the minds of the people, both those who came here to recover, and those who should be working to help them. Perhaps, ultimately, it doesn't matter. Whether they do it themselves or some external agency forces them to do it, well-intentioned people grow cynical and hateful, and people suffer.


So What's Worse?

In stories set in a world where the supernatural is real, sometimes it can be easy to forget that ambiguity can be just as creepy, if not more so, than direct revelation. The Storyteller shouldn't feel forced to settle the question of what's under the Bishopsgate (although the following chapter offers plenty of options to that mystery). Maybe it's more frightening if the people in the asylum do what they do because the Thing under the earth makes them. Maybe it's more frightening if they do it as the result of choice. Human beings sometimes do the wrong thing because they can, and they do it surpassingly, horrifyingly well. That's the cold, awful truth. That's all there is.

But then, maybe it's more frightening if the source of Bishopsgate's evil is no more than hinted at, left open enough that the people who face it could conclude that there's something down there . . . but not definite enough that anyone could make any real conclusions. Feel free to pick the one that works best.

A History of Madness

In Bishopsgate's short history, the hospital has seen more than its share of incident. It's good to know the past. Sometimes, the past carries lessons. Sometimes, the past carries warnings. Always, the past gives shape to the present. The documents that sit in county, city and hospital archives give some clue as



to the shape that the Bishopsgate Hospital's history has taken. They speak into the present.

The Mound (1674)

From Daniel Shepherd's Journal:

17th October, 1674. Having sent Moshola ahead to treat with the native Indians, our party encamped in an open, sparsely wooded area not far from the river. The Weather for much of our Journey has been clement, and the Families have been in high Spirits.

Moshola returned with three dignitaries from the local Tribe; a Group of Savages wilder in Demeanour and Dress could scarcely be imagined. The Man who Moshola indicated to be their Chief, whom I guessed to be aged about 50, was of a particular striking Aspect, clad all in Feathers, Bone and Hide, but yet spoke mildly and offered Friendship, indicating his Company, who laid three head of freshly-killed Deer in our midst.

Relations were cordial in the extreme; at no point did our conversation prove any less than pleasant. Our estimable Guide, through well-chosen Words and the proper Obeisances, maintained good Relations with the Savages.

After we had duly reciprocated in the Giving with two sacks of Beads and three Muskets, I communicated to Moshola our Intention to settle here, and begged Moshola to assure the dignitaries that as Neighbours we would prove no trouble; Moshola conveying this Sentiment to the Chief, the Chief proved amenable; the only Proviso, said the venerable Indian, was that we make no permanent Settlement in the close Vicinity of certain Mounds; the nearest and largest of which, Moshola explained, was a flat area some half a mile of the River Bank on which had been built a Grave.

These Mounds, Moshola explained, were a source of Fear to the Indians, and to build near to them was an Offense to their Superstitions; even to go near for any Reason was a Source of Trembling for the most courageous Savage. The Indians said that they had not built the Mounds, claiming that they had been built by those who had preceded even the Indians' Coming to this Land. They said that one could become lost in the Mounds, for there were Doors through which evil Spirits from deep within the Earth could leap out and snatch the unwary Trespasser away. They said that under the Mounds were Tunnels, which led down to the deepest Regions.

I saw no Merit in their Superstitions, but gave my Assent to this, as a trifle. This agreed, the Chief gave his free Assent to our Settlement. . . .

18th October, 1674. Having taken the Opportunity to Walk around what will be the Perimeter of our new City, I came across what must surely be that Mound which occasioned so much superstitious Fear among the Savages. I saw only a broad, flat grassy Clearing, central to which was a narrow Tumulus of Earth, some Seventy Paces in Length and Fifteen Paces in Breadth. I felt no Evidence of there being any Malignancy here, and purposed to build here when Necessity demands it. . . .

Story Hooks: Under the Mound

The mound once lay where the East Wing of Bishopsgate Hospital now stands, and the upper level of tunnels now makes

up some of the so-called Labyrinth of passages and sub-basements under the hospital. Those tunnels go down a very long way, spiraling further down toward the depths than anyone knows. What's down there?

- **Ruins.** Someone or something once lived down here.

Tunnels give way to vaults and huge, ornate buildings that contain the relics of a civilization. Strange wrecked machines, incomprehensible writings, artwork that represents things incomprehensible and smashed furniture designed to hold people of a very different shape and size from people of the present. The inhabitants are gone, but some of the things they made still have energies, and bringing them to the surface could have terrible consequences: dreams of horrors long gone, ancient plagues, mutation, possession, psychoses above and beyond anything experienced by a patient.

- **A Living Culture.** A previously unknown pre-Columbian civilization still survives deep in the tunnels below the hospital. They're insular and hostile to outsiders. Perhaps they resemble the highly advanced but amoral people of H.P. Lovecraft's short story "The Mound." Maybe they're closer in looks and intention to the "Deros" of 20th-century folklore: malevolent, deranged creatures with the power to influence the emotions of the people above. Maybe the beings down there are monstrous in other ways: flesh-eating Morlocks tending vast mechanisms of indeterminate purpose; pale, bloated beings responsible for three centuries of disappearances, who engage in revolting feeding rituals and who croon and titter hymns to gods better left undisturbed; boneless worm-like beings who use some of the doctors in the hospital as agents in order to obtain the human blood and offal they need to survive; or something just as bad. It doesn't have to be ancient, either: when James Teesdale's house burnt down, many of his "friends" vanished with him. The blind, bloated inbred cannibal descendants of James Teesdale's original black coven (see p. 57, below) could yet survive, only making occasional sorties into the sub-basements of the hospital in order to find food.

- **A Contagion.** Danger from the earth can take other forms. It doesn't have to be visible straight away. Isolated from the world above, all manner of plagues could wait in the depths for an unwitting intruder to take the infection and bring it to the surface. An alien plague could have evolved into something entirely outside human experience over thousands of years. Who knows what lives and multiplies down there in pools of water, stagnant for millennia? Or worse, it might be a biological weapon, created by a lost civilization — or a surviving one. A disease can be one of the most terrible enemies anyone could ever face. A hospital, quarantined, becomes a prison. People die terrible, painful deaths. Those who would treat them begin to fall apart. Some seek to save themselves. Others become paranoid, seeing illness even when there is none and lashing out in fear and horror. Others try to escape, maybe even unwittingly taking the contagion elsewhere. Symptoms could manifest in any number of ways. They could be realistic — wasting, diarrhea, vomiting, bleeding and the like. First symptoms could be psychological — hallucinations and delusions (in a madhouse,

who'd notice if someone goes mad?) Or they could be bizarre, leading to mutation, evolutionary shifts or random disappearances of partial or whole humans — it could be like the Jigsaw Disease from the old Judge Dredd comics, which causes chunks of flesh to vanish one by one until there's nothing left, or the ghost-plague that has people turning into shadows burned onto the wall, as in the Japanese film *Kairo* (Pulse). A plague from beneath the earth could lead to another kind of survival horror as well, as the plague causes its victims to fall prey to homicidal rage, cannibalistic urges or, worse, resurrection after dying, as in any number of zombie movies (but especially *28 Days Later*, which has a bio-engineered disease as its rationale).

• **A God.** Somewhere far, far below the ground, there is a deity, a vast, horribly ancient being that looks at best on the humans as a disinterested and slightly cruel child with a magnifying glass looks on ants. This god can sense walking above its resting place. Once upon a time, the deity was an object of worship for a lost civilization. Or a surviving culture still worships it. Maybe there wasn't anything that worshipped the deity in this world, and long ago the god was imprisoned here for some reason that no one will ever know. Fans of H.P. Lovecraft will find it easy to imagine Really Big Monsters with unpronounceable names, toad-like outlines, tentacles and huge numbers of eyes and mouths, but even Lovecraft himself would have considered that description inadequate. Whatever it looks like — and it doesn't have to have anything like a consistent appearance — this alien god is material, alien and abstract at the same time. It's a cosmic personification of some abstract concept. Some mathematicians and philosophers are of the opinion that some of the more conceptual areas of higher mathematics (calculus, imaginary numbers and the like) always existed in their own intellectual non-space, waiting to be discovered. What if emotional abstracts such as hate, anger, fear and inevitably madness were also things that weren't artifacts of human consciousness but instead were cosmic, Platonic realities that humans simply accessed? The Thing sleeping so far under the earth feeds on and propagates the emotion. It personifies, perhaps sending equally conceptual but no less real servants (or "children") to the hospital above, the better to bring about the destined time when It awakens fully and eats the world. The best a human could hope for is to delay the inevitable, passing on the danger for another generation to deal with. If we're really as insignificant as all that, that's still something of a triumph. Certainly, actually seeing the god from beneath the mound could only mean defeat of a permanent, eternal kind, defeat for the entire world.

• **Nothing.** There's nothing down there apart from some lizards, some burrowing animals, a whole load of bugs and worms. And that's it. They're a natural feature of the stone and soil making up this region, and if anyone or anything ever really lived down there beyond the first few levels, they're long gone. They're unstable and bleak, however, and lend themselves to claustrophobia and paranoia. Perhaps it's down here that one of the orderlies is hiding the bodies of those patients whose hearts and eyeballs he ate. Perhaps the doctor whose abuses at the

asylum are at risk of being uncovered takes flight from his more righteous colleagues down here. Perhaps this is where one of the nurses keeps a brutalized harem of scared, filthy patients, forcing them to fulfill her urges. A multitude of sins can be hidden down here, and it seems to go down forever.

The Burning of Squire Teesdale's Mansion (1714)

From *A History of My Family and Country, or A Memoir of A Peaceful Life*, by Joel Walker Shepherd:

It was shortly after the Thaw of that year that I witnessed the Burning of James Teesdale's Mansion. The cry went up suddenly; Squire Teesdale's youngest Son, Edwin, unique among his Brothers for his Attendance at the Methodist Hall and thus familiar to us, came to my door at Two O'Clock in the Night, shouting and making the most terrible Commotion, and crying out, "Master Shepherd, please attend, for the sake of your Aunt and her husband!"

Having discovered the cause of his Excitement, I pulled on my Breeches and Boots and took to rousing the Militia. Within a Half an Hour, we had reached the house; we near drained the River in our Exertions, but our most strenuous and determined Efforts came to Naught, for the Fire had taken the Foundations of the House.

The Roof came down with the greatest Crash I have heard, and the Walls of the House collapsed soon afterward, collapsing into the ground with a speed I would have thought impossible, had I not seen it myself. I fancied that there were great Hands pulling the Walls inward and downward into the Earth, and thought that I had heard something like unto a great Shriek from some Voice I dare not name. I concluded that I was tired. It was but a Fancy.

The Squire, his two elder Sons, who had been visiting, and his other Guests, of whom there were ten, perished in the Fire. It fell to me to tell his Wife, his Daughter, and Edwin, who was now his only surviving Son and through this tragedy heir to Squire Teesdale's estate, such as it was.

These sad Duties went as could be expected, but for the Response of Squire Teesdale's Widow, my late Father's Sister, was singular. I approached with grave Countenance and told her that her husband was lost. She set her mouth firmly, and said only this: "He has surely returned to his rightful Place; I shall not weep for him."

Last Entry (1857)

From the journal of Reverend Bodycombe

July 3rd: The Holy Ones came to me again

WOL
ASYLL



last night. They told me that I had done well. They said to me, “Well done, thou good and faithful servant,” and I saw them clearly for the first time. It’s the eyes, you see. It’s the eyes. No matter how fair the angel may appear to be, a man can see the truth of an angel’s soul through its eyes. Their voices, too — they mocked me. They were laughing at me, and as the scales fell from the eyes of the Apostle as the light was withdrawn, so, too, did they from mine.

They had hidden their eyes from me until now. They had hidden in the light. They had hidden in the light, and their faces had been obscured by a thing I had thought to be the light of divinity. But last night I saw them for who they were, and I realized my sin. For I have fallen prey to error, God help me. I have fallen so far and I have led all of these sheep into error with me.

And now I alone, and it is my duty to face the truth of what I have done and to report it to the world, to present a truer Gospel than the Gospel hitherto preached.

Were I a strong man, I might be able to do it; but I am not a strong man. And I am alone. I passed on the promise of the angels to my lambs, that they would pass from this world and find a new world of joy and peace, if only they would drink, I made them to drink, and they drank

joyfully and willingly, and I stayed behind to await the angels, to watch as they ushered my flock into perfection.

But I caught them in a lie. I denied them Heaven, and now they lie cold and dead, and I must face the consequences of what I have done.

I cannot. I am not a strong man, and I deserve far worse an eternity than that to which I have consigned my lambs.

May God have mercy on them. And on me.

Story Hooks: Angels and Devils

The cycle of madness and death that predates the hospital, but that doesn’t mean that it can’t have its implications even today.

- **Angels:** The angels that Rev. Bodycombe say may have been the true inhabitants of the tunnels. They may have been ghosts or spirits. They may have been psychic projections of the true inhabitants under the earth, or they may have been the products of psychic machines left by a long lost civilization. They might also have been a product of Benjamin Bodycombe’s imagination — or the result of an instable mind. Whatever they are, what happens when present-day patients in the hospital begin to experience the same kind of theological delusions that Bodycombe did? What happens when a patient with no knowledge of the hospital’s history begins to repeat the same channeled sermons the unfortunate minister received 150 years ago,

James Teesdale and the Witches

When James Teesdale arrived in Bishopsgate and built his house on the mound, it didn't take long for the rumors of witchery to circulate. He kept to himself, he owned a huge and ill-tempered black dog, he had a large library, which he wouldn't allow the local minister to visit, he had come in haste from the witch-craze in Massachusetts with little explanation, he consorted with several of the less reputable people in the town and he always made sure there were 13 at dinner.

It might have been that he was just a misanthrope, who enjoyed the company of other less-than sociable individuals, whose hatred of the church came from entirely reasonable sources — he'd seen the witch-hunts firsthand, and he had nothing but contempt for the superstitious, laughing at them and provoking them with his sacrilegious antics. Of course, he wasn't going to let the Vicar of Bishopsgate see his library. He just detested the man.

On the other hand, he could just have easily been a magus of some kind. Was he an Hermetic experimenter? A pentacles-and-Black-Mass balls-to-the-bloodied-wall Satanist? Or just a deluded dabbler with a desire to shock?

Owners of **Mage: The Awakening** shouldn't have any trouble imagining a scenario in which Teesdale, an Awakened and anti-social worshiper of the Abyss, left behind artifacts and books in the catacombs under Bishopsgate. Maybe he left other, more active things, too. Spirits and demons can wait a long time.

word for word? And what happens when half a dozen others do the same?

• **Hauntings:** In a world where the Restless Dead really do exist, it's inevitable that a place that has played host to much more than its share of untimely deaths would spawn a few ghosts. According to some traditions, suicides are denied the afterlife, a condition made more acute by the denial of hallowed ground for their remains. The mad, vengeful ghosts of more than 30 suicides swarm through the hospital, playing havoc, first quietly, as things move, patients begin to act and speak strangely, and then more decisively. Bizarre phenomena take over the hospital, as the ghosts, driven endlessly to repeat their final days, seek to drive every single human being in the hospital, doc-

tor and patient alike, to share their fate. Or the shades of James Teesdale's coven take over the hospital instead, trying to complete whatever it was they were doing when the mansion burnt down — and speaking of that, why did the mansion burn down? Why did Elizabeth Teesdale get out perfectly safely when her husband and his coven died in the blaze? And why did no one ask any questions about the cause of the blaze? An angry ghost's unfinished rite may prove the solution, a solution to which the only escape could be a repeat of what Elizabeth Teesdale (maybe) did 200 years ago.

• **A Relic:** James Teesdale's grimoire or Benjamin Bodycombe's revelation turns up, in a used bookstore, or in the cellar of one of the doctors' houses or in one of the sub-basements, just sitting there, waiting to be found, as if it had been just put there the day before. The more someone reads it, the more he begins to find the peculiar phenomena described in the book happening. Angels appear and grant visions, or alien entities appear just outside the edge of the retina, preying on the patients or subtly changing them somehow. Only the owner of the book can see it. Maybe it was always happening; maybe the character just never noticed it. Maybe it's not happening at all, and the finding of the book was coincidental — the character, who is himself ill, is unconsciously using the contents of the book to fuel his own delusions.

Timeline. 1674–1857

Unknown past time – Undefined pre-Columbian civilizations builds mounds in area that will one day become Bishopsgate.

1674 – (October) City of Bishopsgate founded by English settler Daniel Shepherd.

1675 – (January) Death of Daniel Shepherd, of fever.

1695 – Arrival of James Teesdale, late of Massachusetts, along with his two sons, by a now-deceased wife. Although he left Massachusetts in some haste, Teesdale arrives with a sizable fortune, and is soon established as the richest man in the region. Teesdale secures an advantageous marriage with Elizabeth Shepherd, 14-year-old granddaughter of the city's founder. The marriage is evidently not a happy one, although they have seven children, two of whom survive past the age of seven, including another son, Edwin.

1697 – Completion of Teesdale's mansion, built over the largest of the mounds in the region, notwithstanding the warnings of the local Native Americans. Teesdale fells much of the surrounding forest in order to cultivate the grounds, which will prove to be unsatisfactory in their fertility. By the end of the year, the last of the Native Americans have left the immediate area of Bishopsgate. From now until the last Indian is forced to leave the district, no Indian comes within a radius of roughly 10 miles from Bishopsgate, centered upon Teesdale's home.

1714 – (March) James Teesdale's house burns down. Teesdale's family escapes, but Teesdale's body is never found. Elizabeth Teesdale will later cause a minor scandal

by refusing to wear mourning dress. Although not yet 40, Elizabeth Teesdale does not marry again.

1841 – The last Native Americans leave the county, having been “encouraged” to do so by State Government under the Removal Act.

1851 – The land, uninhabited since James Teesdale’s day, is sold by Teesdale’s descendant Elliot Teesdale to a religious splinter group led by Rev. Benjamin Bodycombe. The Teesdales have owned the land for more than a century, but have never lived on it. The group builds a subsistence community on the grounds of the old Teesdale mansion, in which they intend to pursue Bodycombe’s idiosyncratic brand of Protestantism. Bodycombe, only one of many self-proclaimed prophets of the 19th century, encourages among his followers a communal pool of wives and a strict regimen of vegetarianism. These teachings, along with his outright denial of Nicene Trinitarianism, led to the ejection of Bodycombe and his followers from the Episcopalian church in Philadelphia. Although not strictly welcomed (and the subject of declamatory sermons in the local Methodist Hall over the next five years), Bodycombe’s sect causes no trouble, and receives none in return.

1857 – (January) Rumors of deviant practices lead to increasingly fraught relations with the main community of Bishopsgate, and, finally, the complete withdrawal of Bodycombe’s sect from society. Neither Bishopsgate nor any of his adult followers will be seen alive again.

1857 – (July) Bodycombe’s sect commits mass suicide. Thirty-seven men, women and children willingly swallow fatal doses of arsenic. Bodycombe shoots himself through the mouth with a .303 rifle. It is a week before anyone finds out what has happened. There are two survivors, both children under the age of seven. Although taken in by families of the community, neither of the two girls seems to get over the trauma, and both are dead within the year.

Lay Me Down, (1863)

From a letter stored in a small town museum archive, in a town near Bishopsgate

My Dearest Lily,

I guess it’s time I wrote to you and I’m thinking I’ll never see you again, and I want to say I’m sorry and I miss you. I’m sorry for all those things I said, Lily, I’m sorry I went to war and I’m sorry that I’m never going to come back home.

I need you to forgive me, Lily. The Padre says that it’s only the Good Lord who does the forgiving, but I seen too many things that lead me to assume that the Good Lord’s done with forgiving and all he’s concerned about is laying a deal of wrath down upon the world. You’re all there is that matters now. You’re all there is that’s forgiving.

I saw a man roll over and die yesterday. He just turned over and let out a sad kind

of sigh, like he’d been told the dogs were loose and he’d have to round them up, or some such other minor annoyance, and then he went quiet. Atkins went over and looked, and he said he was dead, and we hollered for the doctors, but they didn’t come, and we spent the night with him just lying there. I began to see things in the dark. Figures coming out of the trap-door in the floor like Lucifer and his cronies from the Bad Place, wandering around the ward, and smiling and laughing like they’d have us all.

I woke up in the sun this morning, and the dead man was gone, the doctors took him away I guess, but I got awful scared. I know I dreamed all that with the Devil and all, but it made me scared. When they cut off my leg, they didn’t stop the gangrene. I can’t get rid of the smell now and it don’t even hurt anymore, and I figure that I’m a goner soon. And I don’t want to go to Hell, Lily. You got to forgive me for going to war and doing what the generals and the colonels made me do, because God ain’t the forgiving kind anymore.

Maybe they’ll send me home. Don’t mourn me, Lily. Go to the chapel and say a prayer, Lily. Lay me in the ground and say goodbye and forget me. Go find yourself a man who’ll treat you good and not go off to war and get his dumb self killed. But please, Lily, forgive me. I saw the face of the Devil himself last night, and I don’t want to see him again.

*Yours forever,
Malachi*

A Denial, (1891)

From Bishopsgate documentary archives, stored on microfiche

24th February 1891

Dr. Gamble,

It is the opinion of the Bishopsgate’s director that pandering to patients’ fears is deleterious both to the therapeutic intent of this hospital and to the morale of your colleagues.

I feel obliged to remind you that you are a professional, and you should recognize that as such, your taking seriously patients’ fancies concerning the foundations of this building is neither useful nor desirable.

It need not be said that your request to gain access to the sub-basement levels of the East Wing cannot be indulged, and I advise that should you persist in these inquiries, Dr.

Screams (1906)

Sworn statement of Rebecca Lowe:

Not Looking for New England?

Of course, having a settlement at Bishopsgate in the 17th century limits the geographic location of the hospital, given that it took quite a bit longer than that for the Colonies (as they were then) to shake off the control of the mother country and even longer still to settle the entire continent. Storytellers who wish to place Bishopsgate elsewhere in the United States shouldn't feel that they need to change too much.

Perhaps the first settlers were Spanish or French. Maybe instead of befalling Benjamin Bodycombe's Protestant extremists, the mass suicides happened at a Jesuit mission. Perhaps the occultist whose home burnt down was a Frenchman who went there as a missionary, or a pioneer in the West, who retreated into unexplored territories rather than survive in society. The mound itself could be anywhere: a 17th-century Spaniard could have just as easily come across the place as a Pilgrim. The town could be called something such as "Las Tumbas" or "San Eustochio" (giving a reason for one of the carved saints on the hospital's fascia).

The further west the hospital is, the less history there is has to play with, and a Storyteller will likely need to make some choices as to which historical events (and their modern-day implications) best suit the chronicle. Did the occultist's house burn down in 1811, leaving a blank piece of ground on which the hospital will one day be built? Or did the religious suicides happen a little earlier? If the hospital is west of the Mississippi, does that mean that there may still be a Native American community in the region? The answer depends on what works best for the chronicle.

Hopper shall, regretfully, be forced to ask for your resignation, nor will he feel obliged to supply you with a good reference.

Dr. Hopper considers this matter to be closed.

Dr. A. X. Cave,
on behalf of
Dr. I. K. Hopper,
Director, Bishopsgate Asylum

I had been trusted with the mop. I wasn't dangerous so they let me use the mop. On the floor. I wasn't going to do anything with it. So they trusted me with the mop. I'd been making progress. They said I was making progress. So they give me a mop and bucket and they let me clean the wards.

I was washing the floors in the corridor. The one north of Cave Ward. Just above the stairwell. And there was this screaming and commotion like you never heard in your life, and there was this big fella, and three orderlies dragging him downstairs and he was hollering and kicking and swinging back and forth and suddenly he gets free and he's running down the corridor at me like a bull my pa had on his farm that got free and I just stood there and he pushed me to the floor and snatched away my broom and then he did things with the broom and the two orderlies, they weren't moving no more.

Then he ran away past me, and me, I didn't know what to do, so I ran out of the ward and ran upstairs banged on the door of the office and got Doctor Marvin and told him and he locked the door again but with me out of it and he ran to get help and I sat in his office for a bit and then I heard screaming and shouting and things and ran into the corridor and I looked into a ward and it was full of people and it was on fire and the door was locked and they were hammering on the door and I tried and tried and I shouted fire, fire, but no one was listening.

An orderly, Mr. Holmes it was, came running down the corridor toward the stairs, and there were a couple of orderlies and nurses I didn't know and I tried to say, help, let them out, but he pushed past me, and I grabbed his arm and he pushed my head against the wall and I passed out and when I came to, it was hot and I could hardly breathe, and I could hear screaming. It was the worst sound I ever heard. They'd left the mad people there. They were dying and they'd left them all there. I went to the ward and tried to open the door and the handle was red hot and burned my hand and I could see the faces of the people and I didn't even have my bucket of water and the smoke was so bad I had to run out of there, and I ran out, and there were men trying to put out the fire, so I ran to some of them and told them there were people dying in there, and no one listened, and they just let them die.

Resignation (1907)

From Bishopsgate documentary archives, stored on microfiche

18th June 1907

Dear Dr. Brake,

It is to my regret that I must write to inform you that Hoyle and Shepherd will no longer be able to continue in our current role as contractors, effective immediately.

I attach a copy of a deposition from one of my men concerning his discoveries in the sub-basement level of the East Wing as was; I trust that this should in itself prove adequate to explain his unwillingness to continue in this capacity.

Please also find attached an invoice for work done to date. I would be thankful if your payment was tendered as soon as possible.

Yours sincerely,

A. D. Hoyle,
Chief Foreman,
Hoyle and Shepherd.

Also from the microfiche archives, directly following the preceding archival

20th June 1907

Dear Mr. Hoyle,

Please find enclosed a banker's cheque covering your work to date, along with an additional sum for your expenses, as agreed yesterday.

Yours sincerely,

Dr. E. K. Brake,
Director, Bishopsgate Hospital

A Note (1920)

A note discovered in the late 1920s, which has reappeared periodically every few years since.

It is in the walls. I would like to kill it, but it has whispered to me that I cannot and I know that it is right. I prised back one of the panels; an eye stared back at me from a fusion of brick and pale flesh.

I had no choice, then. I stopped Roe, I broke him I broke his neck and he won't do what the building tells him to do anymore, they won't. He didn't know I could see what he really was but I knew. I can see and heard that beats beneath this place. My third eye opened wide open and I can see the truth in all things and I

can see that it's here, living through the walls in strands of flesh and gore. It whispers to people and they become its slaves and lovers and they're not warders and orderlies, they're just disguised as the warders and the orderlies and I can't get them all. But I got their leader. I got the monster who leads them. He won't put his fingers in my head anymore he won't pull any of my thoughts out.

It can't stop me any more. I'm going someplace where they can't find me ever.

Laurence Merrigan

Dr. Gorlay's Notes (1929-1930)

Project 311/312

May 17th, 1929

Patient 1142: Male, aged 19, delusions of religious nature;

also Patient 1139: Male Negro, aged 16, cretinism

Being fortunate enough to be able to oversee sterilization, I decided to take the opportunity to perform the transference of reproductive organs with those of patient 1139, who had also not yet been sterilized. Having restrained and anesthetized both subjects, I began the operation at 2.14 pm. Aside from some hemorrhaging on the part of 1139, the experiment was initially a success. I have decided to postpone sterilization of both subjects until the results of this experiment have become apparent.

Postscript, June 12th 1929. 1142 died this morning. The wound appears to have developed gangrene. 1139, to my surprise, appears to at least be in somewhat higher spirits, although having had him brought before me for inspection today, I note that the injury has also become infected. I expect the subject is not likely to live much longer than 1142. This is something of a disappointment. I shall have to try again.

Project 353

July 29th, 1929

Patient 1199: Female, aged 25, erratic behavior (post-natal)

RE: Personnel Changes
Date: Friday March 9, 2007 9:58 am
From:bmccclusky@bishopsgate.com
To:allstaff@bishopsgate.com

Gary Pilcher is no longer employed at Bishopsgate

My intention was to duplicate the famous experiment of Dr. Sarles. The subject, who is dolichocephalic, is subject to episodes of inappropriate behavior. Dr. Sarles discovered that certain incisions in the forebrain of a patient could, if carefully executed, remove negative emotional extremes in a subject. After restraining and anesthetizing the patient, I shaved an area of hair and proceeded to make a circular incision through which I extracted a small amount of tissue.

Postscript, September 12th 1929. 1199 has responded well to the treatment. Although somewhat listless, the subject is co-operative and responds well to all given treatment.

Project 401

October 12th, 1929

Patient 1213: Male, aged 32, fits and periods of loss of reason

Performed a posterior sympathectomy. During resection of subject's ribs, I slipped and damaged the subject's right lung. Bleeding was impossible to stem; subject died on the operating table. I am somewhat disappointed. I shall have to wait until a similar subject arrives.

Project 492/493

January 17th, 1930

Patient 1199: Female, aged 25, erratic behavior (post-natal);

also Patient 1116: Female, aged 16, Mongolian idiocy

Following experiment 353, I decided to extend the Sarles technique to transplantation, re-opening skull and removing greater section of forebrain from 1199 and transplanting tissue to brain of 1116. Operation a success.

Postscript, February 23rd, 1930. 1199 is significantly more docile and more listless. Ability to make decisions altered. 1116 has begun to experience seizures; three to date on January 26th, February 1st and February 18th. No improvement in condition.

Timeline: 1862-1934


1861 - Dr. Ignatius Hopper, a moderately celebrated freethinker and progressive physician, obtains the land on which Bodycombe's farm stands in auction. No one else bids. It costs him one dollar. The Bishopsgate and County Examiner reports Hopper as being "utterly unmoved by superstition, and positively convinced of the medicinal powers of the region." Hopper arranges the demolition of Bodycombe's farm and submits to the City Council blueprints of a new sanitarium, built on the Kirkbride Plan, to be erected in its place. Perhaps in relief that the building is this time for what seems to them a more wholesome purpose, the Council approve the plans without alteration. Hopper designs the sanitarium with the help of local architect Jonathan Teesdale, whose personal touches include the sculpting of six saints over the front face of the building.

1862 - (February 28th) Bishopsgate Sanitarium opens. It does little business, as fighting between Confederate and Union forces spills over into the local county.

1862 - (June 9th) Forces holding Bishopsgate requisition the Bishopsgate Sanitarium as a military hospital. The military holds the hospital up until the end of the war.

1866 - Hopper and his staff regain control of Bishopsgate Sanitarium.

1868 - A brief spike in profits and a number of canny investments allow Hopper to acquire several neighboring properties. Hopper uses connections in East Coast cities to secure a number of prestigious patients. Hopper sanctions the construction of a number of extra buildings, mostly as homes for the director and doctors, although Hampden House was originally purposed as a spa. The others are Whitehall House, Brochart House and Maxwell Gymnasium. They are named after Hopper's investors. Hopper's own office is in the East Wing of the sanitarium, in one of the upper floors.



1870 – (September 26th) Hopper experiences what appears to be some sort of breakdown. He takes a leave of absence from Bishopsgate without notice. A letter from Hopper received at the sanitarium a week later cites “nervous exhaustion.” His departure is extremely sudden: this causes something of a stir among the staff, amid claims that the director was carried out of the building screaming. There is no obvious structure in place to deal with Hopper’s absence. Hopper’s own need to be responsible for the management of every aspect of the Sanitarium’s management leads to a crisis, ended after a month by Dr. Albert Cave, one of the more senior staff members, who volunteers himself as caretaker director. Cave, an outspoken critic of Hopper’s management, begins to re-establish order in the sanitarium according to his own preferences. One of his first acts is to dismiss without notice three younger doctors whom he identifies as being responsible for the rumors concerning the disturbing manner of Dr. Hopper’s removal.

1871 – (January 19th) Hopper returns to Bishopsgate. The Bishopsgate and County Examiner reports on his appearance: his hair, once black, is now white. Hopper names Dr. Cave as his deputy, leaving Cave in effective control of the Sanitarium. In the next five years, Cave will dismiss most of the staff, replacing them with staff of his own. He will gradually steer the sanitarium toward specialization in treatment of the insane.

1876 – (March 27th) Bishopsgate Sanitarium is renamed Bishopsgate Asylum for the Insane. Dr. Cave institutes a two-tier system of treatment. Patients who can pay (or whose families can pay) receive full hospital care on the upper floors of the hospital’s main building. Less wealthy patients earn places in the lower and basement wards, where “treatment” includes isolation, physical restraint, beatings and the withdrawal of basic human comforts, such as food, water and clothing.

1881 – Building of Chesterton Hall and Potomac House; also renovation of barn.

1894 – (June 16th) Albert Cave is trampled to death on the front path by a draft horse pulling an arriving carriage containing a wealthy patient. No one can ascertain what spooked the horse. Cave dies before anyone can offer treatment. He is 49. Dr. Edward Brake, one of Cave’s own assistants, takes Cave’s place as deputy. A ward in the East Wing is renamed in Cave’s memory.

1898 – Ignatius Hopper dies in his office, apparently of a heart attack, aged 68. Edward Brake becomes the director of the asylum. Brake commissions a statue of Hopper, sculpted by Frank Teesdale. It is erected on the grounds to one side of the main drive. The statue still stands in the same place today.

1906 – (November 10th) Early in the morning, violence erupts: several patients in the lower wards revolt against cruel treatment. By the end of the day, the escapees have claimed the lives of three staff members and have set fire to the building. Although local fire teams eventually get the fire under control, the East Wing, where the trouble

originated, is gutted. The fire claims the lives of 17 staff and 116 patients, most of whom were unable to escape, being locked in and in many cases tied or chained down.

1907 – (February) Brake begins a program of renovation of the entire hospital, beginning with the demolition of the remains of the East Wing and the building of a more modern facility. He begins with basements and sub-basements. With the help of plans drawn up by Frank Teesdale, Brake bases the new sub-basements on pre-existing tunnels, and oversees the building of a new Medical Center. However, when building is complete, Brake himself orders that the lowest sub-basement be sealed up.

1908 – (January 16th) Dr. George Marvin and orderly Harold K. Holmes, who were both accused of allowing the deaths of most of the inmates in the East Wing, are acquitted of criminal negligence in a trial in the State Court.

1917 – Brake’s body is found hanging by his belt from a light fitting in his office. Dr. Donald Roe, Brake’s assistant, takes over. Weaver discovers that Brake overstretched the asylum’s financial resources during the period of renovation and placed the hospital in severe debt. Over the next year, Roe is forced to make many economies. He dismisses nearly half of the staff. The quality of treatment in the hospital begins to suffer.

1919 – Six patients in basement wards are found starved to death. No staff members are ever blamed; no compensation is ever paid to the families of those patients who have died.

1920 – (October 23rd) Laurence Merrigan, a patient suffering from delusional psychosis, escapes from his ward and strangles Roe in his office. Merrigan then cuts his own throat with a scalpel. The bodies are not found for at least nine hours. The board of trustees finally view the Bishopsgate’s accounts, and begins to search for a means to keep the institution afloat.

1921 – (March) After three months of uncertainty as to the future of Bishopsgate, Farnsworth W. Weaver, director of Weaver Pharmaceuticals, Inc. steps in as director. Weaver is not a doctor, and so takes on as the Head of Medicine one Dr. Matthew Gorlay.

1922 – Weaver renovates Hampden House, which has been unused for some 10 years, and is in a dilapidated condition. He moves his office there. Weaver turns the office space in the East Wing into private rooms for wealthier patients. Gorlay, an outspoken and enthusiastic eugenicist, begins to use patients as test subjects for his experiments in transplantation and psychosurgery.

1926 – Gorlay institutes systematic compulsory sterilization of patients.

1927 – (April) William Lovell, an orderly, is tried for managing an illegal still in one of the sub-basements. He pleads guilty. The state court imprisons him for two years. Lovell’s spirit is distilled using denatured pharmaceutical alcohol pilfered from the asylum stores. He is caught after selling measures to patients at a dime a glass, causing permanent blindness for 15 patients and death for another six. Although the families of some of the patients complain, the

Compulsory Sterilization

Before the Second World War, eugenics was a widely supported field of study. One of the tools of eugenics was family planning, and often countries supported sterilization of criminals, ethnic minorities, the “feeble minded” and the insane. The first country to support a program of compulsory sterilization was the United States. Hitler’s Germany would follow in 1933; a book by two Californian eugenicists who actively supported forced sterilizations proved highly influential to the Nazi administration, as evidence that a widespread system could work. Canada and Sweden adopted similar programs (Sweden’s lasted until 1976).

Although there was never a federal sterilization program, 33 states eventually passed eugenics laws. These statutes empowered medical professionals in asylums, hospitals and prisons to sterilize individuals without their consent, and often without their knowledge (performing the operation under the guise of another procedure). Mostly, this was done by vasectomy in men or tubal ligation in women (although some states, such as Oklahoma, used castration). Between 1907 and 1981, tens of thousands of prison inmates, psychiatric patients, people with mental disabilities and even Native Americans underwent surgery to take away their ability to conceive children. Most of these operations happened between the late 1920s and early 1960s, after which most states allowed sterilization laws to fall out of use. Doctors in the state of California performed more of these operations than in any other state.

Was Bishopsgate Asylum in a state that allowed for compulsory sterilization? In a sense, it doesn’t matter, since during the period when the asylum was sterilizing its patients as a matter of course (1928–1933), it was seen as a reasonable thing to do and a patient would have had a difficult time taking Bishopsgate to court. Having said that, if the asylum were in a state where no such laws existed, the program could well have been another charge on F.W. Weaver’s rap sheet, since, no matter how therapeutic the procedure was thought to have been, his doctors were performing the procedure illegally.

asylum administration pays no compensation and makes no apology.

1930 – A patient riot in the lower East Wing, apparently incited by one of Gorlay’s experimental subjects, takes the lives of 17 patients and five staff. Weaver offers generous compensatory payments to the families of all those who lost relatives. The matter goes no further.

1933 – James Sercombe, a 21-year-old patient with “Mongolian idiocy” (now normally known as Down syndrome) dies of a brain hemorrhage. Since Dr. Gorlay is out of town on a lecture tour, Dr. Thomas Werner, a recently appointed member of staff, performs the autopsy. He discovers that the unfortunate young man had been the subject of at least 14 surgical procedures over the last year, including three separate operations on the brain. The last of these, a second exploration into the forebrain, was the direct cause of death. Although ordered by Weaver to cover it up on threat of dismissal, Werner takes his findings to the state representative of the AMA Committee on Ethics, which orders an investigation. The investigators discover that Gorlay’s now-celebrated research comes at a cost: although he’s well-known for dozens of groundbreaking surgical techniques, Gorlay has covered up the deaths of nearly 300 patients over the last 12 years, and has caused permanent and needless damage to another 150 or more. Many

advocates for eugenics and proponents of the efficacy of psychosurgical techniques come to Gorlay’s defense. Doctors across the United States mount a letter-writing campaign on Gorlay’s behalf, stressing the major contributions Gorlay has made to the field of psychiatric medicine. In the end, however, no one can escape the fact that Gorlay is guilty of medical fraud, and it is fraud, not malpractice, for which he is indicted. During the investigation, it transpires that Weaver, who is aware of Gorlay’s coverup, has been embezzling Bishopsgate’s profits since 1926, for a total of \$96,000.

1934 – Weaver receives a prison sentence of three years for fraud and embezzlement. Gorlay is struck off the register and sentenced to five years, although he commits suicide in prison after two weeks rather than live on in disgrace. Thirteen other staff members receive prison sentences of between one and three years. The Bishopsgate Asylum is shut down, and its patients are sent elsewhere. Those staff members who survive with reputations intact (notably Thomas Werner, whom the press treats as something of a hero) attempt to find other employment in hospitals across the state. Most, including Werner, whom no hospital administration will touch, don’t succeed and are forced to make ends meet by whatever means they can during the lean Depression years.



The 18th Amendment

In some U.S. states, Prohibition — the outlawing of intoxicating liquor — was enacted as long ago as 1908, but it was in 1920 that the Volstead Act brought in federal Prohibition. Alcohol was still legal for sacramental purposes with a permit, and was legal in the industrial and pharmaceutical sectors, although industrial and pharmaceutical alcohol had to be denatured with methanol. Illegal distillers who used industrial alcohol as a base of their spirits risked methanol poisoning, which can cause vomiting, seizures, blindness and death. Many distillers knew exactly what they were doing — and didn't care. A glass of illegal moonshine might contain as much as 50% methanol.

By the mid-'20s, illegal stills had cropped up all over the United States. The production of illegal liquor only tailed off when Prohibition was repealed at the end of the decade.

Story Hooks:

Strait-Waistcoats and Padded Cells

- **The Cursed Room:** The front upper room of the East Wing is cursed. That's it. It has to be. Why did Ignatius Hopper's hair turn white? What did he see that September night that caused his breakdown? What about his heart attack, which again happened in that same room? He's not the only one to have faced an unfortunate fate in the upper offices of the East Wing, particularly after its rebuilding. Edward Brake committed suicide there. Laurence Merrigan strangled Donald Roe there. F. W. Weaver, meanwhile, compromised his reputation, company and career for the sake of \$96,000. What's to say that the curse of the room has ended? It's used as a private room for patients now; how many of them have died or committed suicide? What causes it? Is the room a focal point for the malevolent energies of the Labyrinth beneath? Did Jonathan and Frank Teesdale know what they were doing when they placed the office of the director in the same precise point? Has the room taken the malevolent ghosts of the dead into its material structure? What secrets lay behind the wall panels of the room? Maybe there is a narrow passage in the thick outside wall leading down into a secret corner of the Labyrinth. Maybe something terrible and dead (or alive) lurks behind the walls, and the upper room has, behind its century-old wooden panels, the sensory

apparatus of something terrible and huge. The madness that infects the inhabitants of the room could have to do with mouths in the walls, mouths that speak and influence the course of the madhouse. Why did Albert Cave repurpose Bishopsgate Sanitarium? What impelled him to do so?

- **If These Walls Could Speak:** The fabric of Bishopsgate is literally alive, a vast complex web of flesh. Tendons run through cavities in walls. Nerve endings and blood vessels thread through narrow fissures in the mortar and brickwork. Eyes and ears sit behind glass panels, and in the lowest sub-basement, at the head of the so-called Labyrinth, a vast maw waits to be fed. Was this always the way? Was this the intention of the asylum's original designers? Or has the thing that lived below grown into the walls over the years? Worse: What if Matthew Gorlay had an occult plan? What if it were he who threaded the flesh into the fabric of the building, making the madness of the dead into a living personification of madness that projected its own madness into the patients and doctors who lived here. But then, what if the thing isn't real at all? What if it's a delusion, a quasi-Jungian representation of the centuries of tragedy that have defined this place? If a character starts dreaming about eyes and ears and whispering lips that run through the body of Bishopsgate Psychiatric Hospital, what can it mean? Is she going mad, or is she simply being the recipient of revealed truth, and if so, what does the thing in the walls want with her to reveal itself to her so? Is this why Matthew Gorlay killed and tortured so many people on the operating table? Reports of the fire talked of the screams of the patients, rising up together, but what if those screams belonged not just to the patients but to the building? The arsonists might have discovered the living fabric of the building and tried to kill it. Could that happen again? Alternatively, it could just as easily be that the flesh inside the building is all that is left of the patients who died in the fire, abandoned to die in chains and straps and masks and padlocks. They want retribution, and the institution and all who support it are their targets for the justice they feel they deserve.

- **The Lost Closet:** Somewhere in the bowels of the hospital are a number of store-rooms, dating from between the early 1920 and the late 1950s. A room dating to before World War II contains a rack of strait-jackets with stiff leather straps. In wooden boxes on the shelves that line the room are truncheons, leather gags and facial cages. Another room contains more straitjackets, a restraining chair and a rack of chains, manacles and straps. Another store closet contains surgical instruments, cloudy bottles of trichloroethylene, jars containing pickled fetuses and brains and a box of oddly-shaped metal plates, bolts and butterfly nuts. A closet untouched since about 1955 contains




wooden cases containing surgical saws and scalpels. Three small cases contain small ice picks, leucotomes and orbitoclasts (picks and hammers designed for use in performing transorbital lobotomies). A case with a strap contains a portable electrical anesthetic device. Somewhere down in a sub-basement is a room containing three restraining chairs and an ECT machine that is capable of producing voltages far in excess of the maximum available to contemporary ECT devices.

In an establishment as labyrinthine as Bishopsgate, it perhaps is easy to lose things — but why would they turn up now? What would lead someone to uncover a potentially lethal ECT machine or a set of pristine lobotomy equipment right now? Perhaps whatever malevolent force exists beneath the hospital has chosen now to reveal these objects. Perhaps the objects themselves are malevolent, either because they are anchors to the vengeful ghosts of their victims or the hungry ghosts of their users. Perhaps they are simply possessed of a desire to be used, an overwhelming need that overtakes anyone who owns them. They might just be objects, neutral metal, cloth, wood and leather. Whatever power they really hold, whether symbolic or supernatural, the most important question is what the discoverer of these things might do with them. A doctor whose frustration with the patients and opposition to the other medical staff leads to a desire for revenge, a need to cause pain, takes patients down one by one,

confining them, lobotomizing them, poisoning them and electrocuting them, picking off patients — and maybe doctors, too — with cold, methodical precision. An orderly discovers them after having taken a wrong turn in the Labyrinth and although he fights the temptation, eventually succumbs to the desire to use them. A patient who escapes into the tunnels stumbles across them and uses them as weapons against the pursuing staff, picking them off one by one. Maybe it's a malevolent force that drives the finder to do these things . . . but it just as easily might not be.

On the other hand, maybe there's no human hand involved at all. Ghostly orderlies drag the unwary into long-forgotten treatment rooms and perform ghastly surgeries on them. Blades fly through the air. Straps and fasteners, saws are pulled back and forth and switches pulled by invisible hands. Screaming faces surround the ECT machine, taking turns to deliver shocks, again and again, long after the man in the chair has begun to smell like cooked meat. The contents of the lost closets may, on the other hand, make their presence known in more subtle ways: objects turn up in unexpected places. A doctor finds a baby pickled in formaldehyde in his locker; a case full of ice picks end up on another doctor's desk. A trail leads a group of determined investigators to a truth from decades ago: a death, a birth, a coverup, a mind lost, a secret kept so well it's long lost.



• **Gorlay's Experiments:** Matthew Gorlay performed his experiments on a lot of people. He was adept at hiding his failures — an easy thing to do in an institution that had come to exist, at least partly, for the purpose of consigning people to be forgotten about. Because of that, he became quite celebrated as a therapeutic innovator. Hundreds of his failures came to light in the fallout following Thomas Werner's discovery of his malpractice. But the experiment numbers had gaps. There were at least 50 experimental subjects who could not be accounted for. Perhaps Gorlay simply killed them, and their bones, quiet or unquiet, yet wait to be found under one of the sub-basements. Or, worse, he kept them caged and chained up, feeding them and performing ever more outlandish experiments on them until they ceased to resemble something human. Gorlay couldn't bear to bring them to light. Perhaps he had initially wanted to create perfectly healthy people through surgery, instead coming up with a Frankenstein creation that refused to die.

Perhaps he began to enjoy the tortures he wrought on these creatures as he remade them, continually altering them just because he could. Realizing that he could never let them go, he clammed up about the missing subjects and allowed their secrets to die as they starved to death. It's the most logical conclusion to that story, and certainly, there's horror plenty in a trail of clues leading to the discovery of the subjects' miserable bones and the disclosure of truth after 70 years or more. But then, what if they didn't die? What if they survived and became the inhabitants of the tunnels? Underneath the Labyrinth, they could persist as a tribe of wizened but strong beings made of transplants and stitches and wiring and electrodes living under the ground, bearing children whom, in rites to Gorlay, their cruel creator God, they alter to be like them. On the other hand, Gorlay had most of the patients sterilized, and it could be that in order to persist, they must steal patients or staff from the hospital and make them into one of their own, cutting into brains and organs and limbs to create the creatures of urban myth from scratch.

Gorlay and the Divine Fire

Promethean Storytellers shouldn't find too much difficulty in imagining Matthew Gorlay as ideal demiurge material. A Frankenstein (or more unique) Promethean could waken beneath the ground and live in the tunnels right up to the present day. His very presence could be the reason for the sickness of the earth.

A Compulsion (1939)

From a letter buried in a small county library historical archive

My Dearest Josephine,

I miss you very much. I hope the boys are being good for you.

I'll be down in Bishopsgate for a few more days. Weaver's records were fully as dull as I imagined them to be. Still, he was responsible for an impulse on my part. You'll never believe what I have done. Let me tell you: I bought Bishopsgate.

I paid a dollar for it. They were holding an auction. Old Weaver had died intestate and without an heir. So they laid it open. I didn't even know the auction was going on when I came down. I saw the sign on Saturday; I was passing. I went out of curiosity. I suppose that I wanted to know who was going to own the place, and how much they thought it was worth. The auction house in Bishopsgate was a strange little place, and there were only seven or eight men there. There were some other lots, and the other men bid for them. They were mostly won by a short, middle-aged man in a grotesque check suit. Bishopsgate came up fourth.

The auctioneer started the bidding at a dollar, and no one bid. He called three times, and do you know, Josie, it was the strangest thing: I felt a compulsion to put my hand up and bid that dollar. It was as if something was whispering in my ear to buy the place. I had this cold feeling down my back. But there it was: my hand was raised, and it was as if I had no choice in the matter. No one else bid, and so there it is. I handed over a the five-dollar bill I had in my pocket and got four bucks back and went away with the deeds.

I imagine that you're thinking, "Why on earth should my Thomas want anything more to do with that terrible place?" To be honest, I'm thinking that myself. I don't know why I bid. Still, what harm can it do? Maybe I can, at some time, put the place to some use. Or perhaps I can sell the land to someone back home, who doesn't know the reputation the place has. I can imagine some of the families back in DC who would love the grounds for a big white house with balconies and wings. It could be quite desirable. I'm sure we shall find a use for it.

There's little I can say to match that in novelty, I'm afraid, and in fact little else of any real interest has happened. Jameson

and his wife send their regards; so does Mrs. Amstruther. The weather is clement, mostly, although somewhat rainy for this time of year.

Tell the boys I love them. You know I love you. I'll be back by Tuesday.

All my love
Tom

A Veteran's Dream (1945)

From a journal found at an estate sale

Somehow I can hear the voices of two people — men, with the air of some kind of authority — communicating, by radio or something. I realize that they are approaching my mother's house, where I am staying, and that they want to arrest me or kill me.

They are, they say, as they communicate their whereabouts to a superior, down the street. I rush upstairs and look through the window. I don't see them, but hear them — they have become aware that I know they are coming.

One voice tells the other to 'change shape,' and it dawns on me that my pursuers are not human. I find myself in the kitchen with a shotgun and an electric torch, sitting on the floor, paralyzed with terror, as I hear them come to the door. I wake up, and I am still in the VA hospital. It is dark. The moonlight filters through the blinds, and I begin to breathe more easily.

And then the voice in my head says, Quiet, now, he's awake, and the handle on the ward door turns, slowly.

Jerry Moorcock's

Memorandum (1973)

From a tattered piece of typewritten paper, found in the occult collection of a small-town suicide

Four years since man first landed on moon — has it brought lasting peace and security? 1. Eisenhower — controls moon from Earth; 2. Luke 21: 25 Signs in Moon — Jeremiah 21:25 not for man to govern — James 4: 1-3 cause of conflict

Men speak about reducing the ARMS STORE — Bible foretells complete end to all armaments Micah 4:3, 4 — Men speak about bringing CRIME under control — Bible foretells the wiping out of all sources of crime Psalm 37: 8-11 — Men speak about progress in medical research — progress in psychiatric research to IMPOSE CURE FOR ALL SICK/OLD/MAD — Bible foretells how GOD'S GOVERNMENT brings

LASTING HEALTH and even overcoming AGING and DEATH Revelation 21: 3, 4

Psalm 146: PUT NOT TRUST IN PRINCES — Luke 21: 25 SIGN in MOON — Micah 4:3,4 END ARMS RACE — Psalm 37:8-11 END of CRIME — Revelation 21: 4 END of SICKNESS and OLD AGE — Psalm 146: 3 TRUST NOT MEN — Jeremiah 10:23 not for men to govern the moon — Matthew 6: 21, 33 KINGDOM FIRST — Matthew 6: 9 Lord's Prayer about Kingdom — Daniel 2: 44 kingdom a CERTAINTY
THE KING IS COMING BACK — THE MOON IS THE KEY — THE MOON BELONGS TO GOD ALONE — GOD WILL RETURN AND THE MOON WILL BE THE SOURCE — THE MOON HAS BEEN THE SOURCE — HERE IS THE DESTINATION — IT IS HERE — THE KINGDOM IS HERE

Innocence (1992)

A business memo, misfiled in the document archive at County Medical

MEMO FROM: K. N. D.

TO: J. R. B.

RE: Interview Process

Further to the interviews for Bateman's replacement, it seems that the likeliest candidates are McClusky, Robson and Baxter.

In my opinion, Robson is highly competent. He was well aware of the standard of treatment. He showed a great deal of interest in the structure of the building during the tour.

Baxter is very impressive indeed, in terms of qualifications and talent. He also had done no small amount of research into the history of this institution. His questions were highly perceptive, betraying an impressive breadth of knowledge as to the way things have in past years been done at Bishopsgate.

McClusky is by no means as talented or qualified as the others, and seemed almost entirely unaware of the historical background behind Bishopsgate Hospital. She answered questions directly but with little imagination.

McClusky, then, is the only obvious choice. I recommend you contact her immediately.



Motivation (1993)

Statement of Adam Barker, March 6th, 1993:

AB: I didn't have a choice. They knocked me out. With a box. An electrical box. They got me while I was in bed and held me down and put the electrodes on my head, and they knocked me out. It was like I was dead. They carried me to the stairs, feet first, one holding my arms, one holding my legs. I remember thinking that the carpet was the color that blood would be if blood were green and not red. And then I wanted to laugh at myself, but I couldn't, because I couldn't move. Like I was dead. I could only stare at the floor. One of them said, "Fuck, he's heavy," and that would have made me laugh, too, because they weren't like people, they were too tall and thin and they had this black leathery skin and round empty eyes and no noses or mouths, but they still said "fuck" like us humans do.

They took me down to the cellar, and then two floors below that, and

then they strapped me into a machine and they made me look at movies and lights and they cut open my head and put things in my brain. Like a little machine. They showed me what they could do. They could talk to me through my head without talking, like they could beam words into my head. And they could beam thoughts into my head. They could make me think about being hungry or happy or sad or lonely or horny or wanting to kill someone, and they did, all in a row like they were playing a game with me. And they could even, if they wanted to, flip a switch and switch me off and I'd be like a little robot and I'd do anything they made me, and I wouldn't know or remember or anything like that. And I'd walk under a car or off a cliff or something and that'd be the end of me. So I wasn't allowed to tell anyone.

That's why they let me out of the asylum. I pretended that there wasn't a chip in my head and that the Deros weren't putting thoughts in there and transmitting messages and things.

They promised me that if I did what they said and didn't fight them I could have money and girls and stuff. They said they'd get me a girl and put a machine in her head, too, and they'd give me the controls so I could make her do whatever I wanted.

And they did. They did. Out in Seattle. She did whatever I said, but they lied to me. They had a control box, too, and they flipped the switch and they changed the channel when there was someone walking past the hotel room, so they made her scream, but not real screams, robot screams, aah-aah-aah screams. But it was enough and they made her get the police on board, and they sent me to court and sentenced me and she told the court what the Deros wanted her to in her robot voice. I'm not back at Bishops-gate, I'm here because I wasn't going to tell because I didn't want them to switch me into a robot and make me walk under a truck or stick my head in an oven or sit in a car and gas myself or eat a .45.

I was pretty happy here. They stopped talking to me in my head. Until the Doctor came in. Then they started again. They said they'd made him kill someone and they thought he was going to talk and I had to kill him and I could choose: I could do it myself or they'd switch me off and make me and then they'd make me die. And it'd be all right. I wouldn't feel anything. But I said, I'd rather do it myself if it's all the same, and they beamed hateful thoughts into my head so they'd help me do it.

So when I saw the Doctor I hated him, so I had to kill him and that's why I killed him.

I don't care if I die now. The Deros can do with me whatever they like. I killed a man, and I deserve all I get.

The Empty Room

Dream (2008)

From Tucker Jenkins' dream journal

I sit in an empty room somewhere in the East Wing, I think, judging by the


decor, the walls. I don't know. It's not the same without the patients. I've never looked at the walls.

There are three other men with me. I don't know them. We exchange names, but I forget their names as soon as they tell me. Conversation turns around to what is happening outside: Is there anybody left? Are we alone?

One of the men slips a finger through the blind, prises the slats apart. I gain a glimpse of blasted earth, a black sky streaked with flames. He lets go of the blind quickly, flinches, jumps back from the window.

The second man says, "Did it see you?" We have an internet connection, a PC in the corner of the room: logging in, we check out site after site, all of which - no matter how frivolous - have now been twisted so that their focus is on the evil that is eating the world outside. A gossip site talks about a Hollywood star you've heard of and her marriage to the Great Chaos from the Earth, as if she were an item with some other actor and they were seen together at a party. Every profile we can find on MySpace has some sort of prayer of praise to the new Master of the World. Religious websites - Christian, Muslim, Hindu, Jewish - are despairing or defaced. All the atheist and humanist websites I can think of are gone entirely, barred from entry: Error 404. The White House and the CIA urge co-operation with the new Lords of the Earth. A medical site describes mutations and atrocities of the most stomach-churning kind as if they were normal and nothing to worry about. We can't find a site that was updated more recently than maybe three days ago. We look away after a while. The third man turns back to the screen and cries out.

And then there is nothing on the computer screen but an eye, huge and green and black and yellow, looking right back at us with amused malevolence.



I lunge forward and pull the power cable from the socket. The computer judders to a halt; the eye is still there. I sweep the monitor off the table, and the flat screen falls face down on the ground.

No one moves to pick it up.

And we know, in the way that you know facts and histories in dreams that are not the case in waking, we know that the endless scream that fills the world outside will soon come within, and we know – I know – that we are the last people, and that It has allowed us, allowed me to see what it has wrought. It knows we are here and It has always known, because this is Its home, this ground beneath my feet. And I know that this has happened to the world because of something I failed to do – and this is the worst thing of all.

I wake up. For a few seconds, I wonder if I am still the last man alive.

Timeline: 1939–present

1939 – F. W. Weaver dies of stomach cancer in prison, aged 58. He dies with no heir and no will. His assets are liquidated. Thomas Werner buys Bishopsgate Asylum for a dollar at auction.

1944 – Thomas Werner pushes for the re-opening of Bishopsgate Asylum (now Bishopsgate Hospital) as a recovery center for veterans. With a grant from the U.S. Army, Werner successfully opens the West Wing of the asylum. Cast as a restful setting for the recovery of wounded veterans, the building once again receives a coat of paint and an influx of mostly military staff. In the city of Bishopsgate, the hospital becomes known as “The Purple Heart,” a sobriquet that sticks until the early 1970s. Werner has particular success in dealing with sufferers of “exhaustion” (the condition now known as combat stress reaction).

1946 – After the numbers of wounded veterans decline, Bishopsgate Hospital is closed again. In July, the city of Bishopsgate gives Werner the Key to City. One month later, Werner receives the Commander’s Award for Public Service. Werner’s reputation restored, he takes up a lucrative practice in Washington, DC. He begins to gather investors for “his” hospital.

1952 – Werner’s good reputation pays off; and with the help of several investors in Washington and New York, he secures funding for Bishopsgate Hospital to be re-opened as a hospice and care home for those suffering from dementia

and retardation. He appoints a new board of trustees to manage the financial and employment side of the hospital.

1954 – Werner retires at the age of 55. Although he remains primary owner of the hospital, he leaves hospital management in the care of his assistant, Dr. Jeremiah. J. Moorcock. Although Werner dislikes Moorcock, Werner is overruled by the board of trustees he himself appointed in 1952. A follower of Walter Freeman, the so-called Father of the Lobotomy, Moorcock is an outspoken proponent of psychosurgery, even though it is beginning to fall out of favor among other medical professionals. Every new professional Moorcock will hire in the next two years is a psychiatrist.

1955 – Thomas Werner dies of a heart attack in April. By the end of May, Moorcock has convinced the trustees, who now own a controlling interest in the hospital, to allow him to return Bishopsgate Hospital to its former use as an institution for the insane. Care for most patients tends to the brutal under Moorcock’s directorate. Within about five years, the hospital will again become the sort of place where families send psychiatrically ill relatives in order to forget about them.

1956 – Moorcock re-opens three wards in the East Wing and renovates the Medical Center, adding a small expansion. With Werner’s permission, Moorcock retrieves the old asylum files from the Bishopston County Archive.

1957 – The last terminally ill patient moves to a hospice in the neighboring county, leaving Bishopsgate Hospital as a psychiatric hospital once more.

1959 – Moorcock adds a small extension to the Medical Center, which he calls the Thomas Werner Annexe. He dedicates it to psychosurgery and ECT. Over the next 14 years, Moorcock and his assistants will perform more than 500 prefrontal and transorbital lobotomies on Bishopsgate patients, 54 of whom die.

1968 – Alison Purchase, a 19-year-old woman from southern California, is admitted to Bishopsgate by the police. Although perfectly healthy in every way, the police who bring her in witness her behavior under the influence of nearly 50 milligrams of LSD. When the effects of the drug wear off, Purchase proves intractable, since she quite rightly protests that she has no business being here. Her fate is reminiscent of Randle McMurphy in Ken Kesey’s *One Flew Over the Cuckoo’s Nest*: after she causes several hundred dollars’ worth of damage to her ward, Moorcock lobotomizes her, rendering her docile but incontinent. Moorcock successfully defends himself against a lawsuit brought by her parents. Alison Purchase is still a resident at Bishopsgate today.

1973 – (August 1st) Jeremiah Moorcock receives a transorbital lobotomy from a person or person unknown. At approximately 9.15 a.m., Moorcock completes the procedure on a patient. His assistant, Dr. Francis Collier, along with two orderlies, returns the patient to his ward in the upper East Wing, leaving Moorcock alone in the Thomas Werner Annexe. At 9.40, Collier returns to the Annexe to find Moor-

cock, unconscious, strapped to a gurney. A bloody orbitoclast lies in the instrument tray nearby. The ECT generator is still switched on. Upon inspecting Dr. Moorcock, Collier finds slight bleeding from both of Moorcock's eyes. On regaining consciousness, Moorcock proves incoherent and listless. His once-forceful personality is wholly transformed. Once a life-long atheist, Moorcock soon develops an obsession with the Book of Revelation, which remains with him for the rest of his life. Moorcock is moved to an institution in Washington State, near the home of his grown son. Moorcock survives past the millennium and into the present day.

1974 – After protracted wrangling and an expensive campaign to keep Moorcock's bizarre fate out of the press, the board of trustees (who during Moorcock's tenure mostly kept out of daily administration) appoint an outsider, Dr. Jonathan Sendak, as director. Sendak shuts down and orders the demolition of the Thomas Werner Annexe. He immediately dismisses Collier and several staff members who assisted Moorcock, and will spend the next two years attempting to remake the hospital on more progressive lines. He meets with a great deal of resistance from the other staff members, many of whom had good pay and little work to do under Moorcock. Sendak discovers that Moorcock's surgical techniques have left the hospital in dire financial straits: there were been 17 out-of-court settlements between 1964 and 1972 for families of patients on whom he had performed psychosurgery.

1977 – Sendak convinces the trustees to sell half of the hospital's assets to the board of Barthes, a French pharmaceutical company. At the recommendation of his new masters, Sendak also appoints as his assistant Dr. Thomas Bateman, who manages the hospital in all but name.

1978 – Sendak encourages the trustees (against Bateman's wishes) to sell their remaining interests to pharmaceutical companies Peregrine LLC and Weide GmbH. This proves unwise, as the three companies proceed to engage in power plays (ordering the movement of staff to their own facilities, for example) that seriously damage the potential of the asylum to treat patients effectively.

1980 – Sendak retires. Bateman becomes director. Due to a pay dispute, Bateman's relationship with Barthes worsens. Bateman's first act is to engage in a vast program of building renewal, including the renovation and full re-opening of the East Wing. He also re-purposes several of the external buildings, particularly Brochardt House, which becomes a schoolhouse, and Whitehall House, which he operates as a dormitory for interns at the hospital. Over the next 10 years, profits plummet, and although the pharmaceutical companies retain control over the hospital, they lose interest in the hospital as a profit-making venture.

1991 – (April) Bateman murders his assistant, Dr. Alexander Valerio, with a scalpel and then absconds with the year's profits. Investigations reveal that the hospital's cash flow hemorrhage is partly to do with Bateman's decade-long embezzlement of funds.

1991 – (June) Police apprehend Bateman.

1992 – (January) Bateman pleads guilty to murder and embezzlement, but pleads diminished responsibility. Under questioning, Bateman cannot say why he killed Valerio, only that he felt a compulsion to do so. A federal court sentences Bateman to 26 years in prison.

1992 – (January) Dr. Bridget McClusky becomes director, the first woman to hold the post in the institution's 130-year history.

1993 – (March 4th) Adam Barker, a former patient at Bishopsgate, beats Bateman to death in prison.

Story Hooks: Apocalypses

- **Moorcock's Lobotomy:** Who scrambled Jeremiah Moorcock's frontal lobes? Why did they do it? More importantly, after 30 years, are they still around? Even if they aren't, it doesn't mean that it couldn't happen again. After all, the equipment is still there in old closets and walled-up rooms in the basement. A secret worth keeping is enough for someone to murder for, but there are other ways of making sure someone never tells. It takes minutes: render the subject unconscious with an electric shock to the temples, hammer an ice pick through the tear duct using a small surgical mallet and move the pick around inside the forebrain, effectively liquefying it. Walter Freeman apparently enjoyed the process immensely; it might have been the same for Moorcock. Then again, in lobotomizing all those people, Jerry Moorcock may have been keeping secrets for others as well as for himself. Perhaps an organization such as the CIA, or a terrorist group, or a religious group, or a cult or even whatever or whoever may or may not live under the sub-basement made Moorcock lobotomize certain individuals.

Characters who stumble upon evidence that Moorcock's victims weren't ill but were in fact people who knew too much could find themselves stumbling upon the same secrets — and the fact that there are still people who will silence those who know the truth in that same barbaric way. Why did Moorcock suffer the same fate? It could be that his masters discovered he was keeping records. It could be that he wanted out. Of course, the secret behind Moorcock's lobotomy might not be that much of a secret at all. Alison Purchase is still in the hospital. What if, locked deep inside her, there is still a little bit of the spark that caused her to become one of Moorcock's victims in the first place? What if somehow she managed to overpower the doctor with the electrical stunner and did to him what he did to her (and what if she was actually conscious when Moorcock lobotomized her?) And what if it happens again to some other apparently unjust doctor? What would make Alison Purchase rise out of her stupor and get her revenge: a eye for an eye, a tooth for a tooth, a forebrain for a forebrain?

- **Alternative Apocalypse:** The end of the world is a pretty common preoccupation for people suffering from psychiatric illness. Consider: Within the space of a month, staff and patients begin to experience disturbing dreams. Something comes from beneath the hospital and eats the world. Lots of people have the same dream, but not at the

same time, and only after having talked about it. How real are these dreams? They may be symbolic of something. Perhaps they represent nothing more than the fragmentation of the self, the madness that humans share that could kill us all. Perhaps the dreams represent some conspiracy in which the hospital plays a part. Matthew Gorlay may be long dead, but there are still people engaging in unethical experimentation on patients. Jeremiah Moorcock may only be able now to ramble about the apocalypse, but at some point, something happened that he was a part of — maybe this was the secret he knew that cost him his mind: the key to some sort of apocalypse. Could Moorcock's Biblical obsessions have the key to this symbolic apocalypse hidden inside? On the other hand, could Moorcock's ramblings be the key to a literal Armageddon? Could the dreams be portents of a real horror about to come about?

Tucker Jenkins' dream could mean something else. But it could be real. There really could be a primeval, malevolent horror poised to eat the world in the tunnels under the hospital. It could be the same horror that threads its nerves and eyes through the fabric of the building. It could be a Lovecraftian-style god, all tentacles and extra-terrene substance. It could be a machine of destruction, built by the Deros, those mythical underground beings whose whole purpose is to cause mayhem. It could be another one of those underground races, maybe a Lord Lytton-style Coming Race this time, preparing after decades, centuries

or millennia, to take the world for their own. Fundamentalist folklore (but not, incidentally, the Bible) tells of a time when the believers will be snatched up to Heaven and the non-believers will be left on earth to suffer. What if the fundamentalists are right? What if a fundamentalist-endorsed Jesus really does come back and snatch away the believers? And if the fundamentalists' God turns out to be both real, and the only God, could a decent, honorable doctor accept a God who could well be a cosmic sociopath? What if the dreams turn out to reveal that the Second Coming is one of the patients in the hospital? And if the Second Coming is an individual with delusions or developmental difficulties, what does that say about God?

What if it really is the Second Coming, but one that no one expected, a blind, capricious, childlike God who comes back and raptures nigh-on everyone? On the other hand, there are other players in the Ultimate End Game. The Antichrist could rise from the ranks of patients or staff. The Beast of Armageddon could slumber beneath the hospital. The Beast of Armageddon could be the hospital. Or it could all be a delusion. The terror of the world's end could sweep through the wards of Bishopsgate Hospital and all for nothing. A group of characters caught up in that kind of madness could have horrors to face, supernatural or not.

• **Programmed to Kill:** Was Adam Barker a rapist and murderer or an innocent dupe? Barker's delusions about the Deros are not unprecedented in the annals of psychiatry. Richard

SB: Sadie Brown, age 14. MH: Maggie Hyllel, clinical psychologist. BM: Dr. Bridget McClusky, Bishopsgate Administrator

BM: Sadie, do you know why we're here today?

MH: (quietly) She's not retarded, you know.

SB: About Gary.

BM: That's right. I need to know what happened between you two.

SB: What for? You already fired him.

MH: Sadie, please help us out, here. What was Gary doing in your room? Why did he have . . . that . . . with him?

SB: I can't tell you. You wouldn't understand.

MH: Sadie, I don't think that's fair. I've always been very straight with you.

SB: She (indicating BM) wouldn't.

BM: I just need to know if he touched you or anything . . . like that.

SB: No. He was doing me a favor. I asked him. I told him it was important, and he believed me.

MH: What favor? And why did he have one of your pads with him?

SB: (stands, angry) You don't have to say it like that!

MH: Sadie, I'm sorry, but you have to understand, they're talking about transferring you to —

SB: No! No! You can't make me leave! (screaming and crying) You can't make me leave! They'll kill me! They'll be waiting, and they'll kill me!

BM: (on phone) Get in here. Bring restraints.

MH: Sadie, tell me who'll kill you. Why did Gary have that pad? What was he doing?

SB: It's my blood. They can smell it, and Gary was just going to throw it away somewhere to lure them —

(orderlies enter, bustling, screaming, tape switches off)

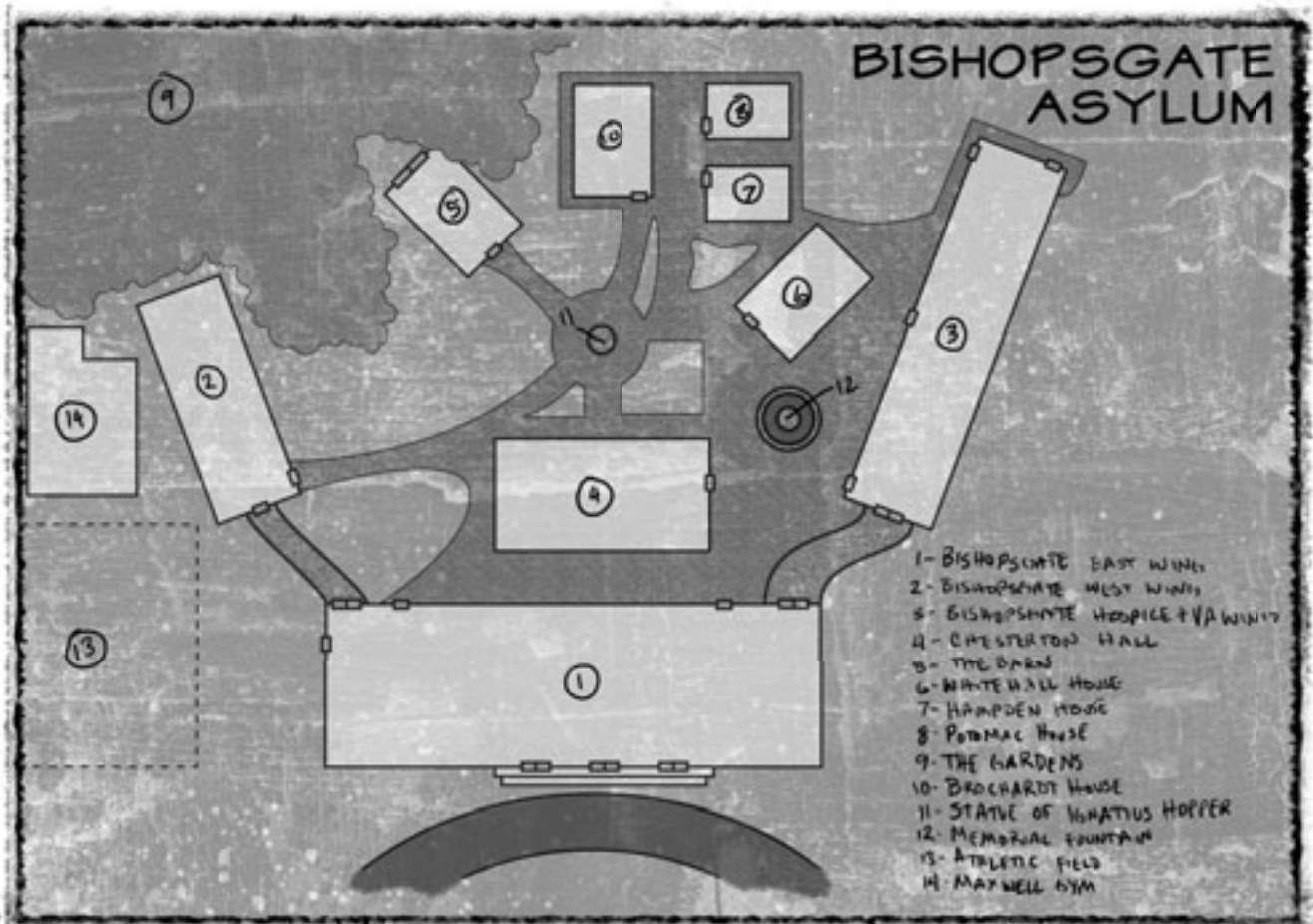
Sharpe Shaver, the savant who first wrote about the Deros, was a test case in paranoid delusion. He believed that there were two highly advanced underground races: the Teros, who worked for good, and the Deros, who worked for evil. They each had many powers. Both groups were telepathic. The Deros enjoyed both psychological and physical torture. Suppose they really exist: what would it mean for a patient? If Bishopsgate really were a conduit from their world to ours, the hospital could prove a prime recruiting ground. They could be behind every attempt to hide the tunnels, every coverup, every murder, every lobotomy, every twisted experiment, every act of medical torture. They sneak to the surface. They steal people and insert control chips in their heads, making them essential slaves to the Deros's every whim. More than that, they could use one agent to dispose of another who had outlived his usefulness, which is one interpretation of what happened to Andrew Bateman.

On the other hand, they could be purely delusional, a paranoid excuse to wear tin-foil hats and to live in a lead-lined trailer. A trail of evidence could lead right to the Deros, only for the characters who follow it to find that the trail was false and that the only Deros are the people who give into the delusions, whose tragedy is that control is forever out of their reach. The truth could lie somewhere in between. Through the use of drugs and post-hypnotic suggestion, a human member of staff could prime former patients to kill, steal or do any number of things. Why the "Deros" disguise? It could be a cruel, practi-

cal joke that only a truly jaded mind could enjoy. It could be a conspiracy. The members have recruited a sleeping army of former psychiatric patients, ready to be activated through shrewd use of radio, ventriloquism, lighting and torture, a properly drugged individual can be made to believe anything. And if the plan has been going for enough years, the army could well take on the world. Their agents could be anywhere, within and outside the hospital.

Bishopsgate Asylum

The Bishopsgate Asylum facility is a structure as complex and as twisted as its long, dark history. Through the efforts of the hospital's illustrious lineage of corrupt, selfish and derelict directors, the various buildings that compose Bishopsgate form a broken world where wrathful madness boils behind a face of medical sterility. Though the current director, Dr. Bridget McClusky, is making an effort to restore the hospital to its intended role as a place of healing, such a renovation of spirit is highly unlikely. Too much depravity and sheer malevolence have taken place — whether supernatural or disturbingly mundane in origin — to ever permit for such a drastic transformation of the asylum's essential nature.





Even without the supernatural elements, Bishopsgate serves as a disturbing backdrop for any campaign that requires a hospital setting. Whether an interview with a dangerous patient in the high-security ward, discovery of the extreme and disturbing levels beneath the East Wing, the clinically cold NEU ward of the West Wing or an unaccompanied walk through the long shadows of the hospital's gardens, Bishopsgate can serve any chronicle as a useful and flavorful backdrop.

What follows is a detailed description of Bishopsgate in its entirety. In the following text you will find all the pieces you'll need to place the hospital in your own chronicle — either as a disturbing place for characters to visit with the mad or Bishopsgate's unique specialists and staff, or even as a setting in which to base an entire chronicle.

Exterior

The Bishopsgate property is absolutely enormous. Visitors are met by its 12-foot high wrought iron gate above which is worked the name "Bishopsgate Asylum." To the right of the gate — which usually hangs open — modern signage gives directions to the main facility, as well as Maxwell Gymnasium and the athletic field. Vehicles enter the facility through this gate, from the south, along a wide cobblestone driveway with two lanes that loop around in front of the asylum's East Wing. Overgrown hedges of flowering quince speckled with bright red flowers in the spring border both sides of the driveway. The roundabout circles an old reflecting pond that is thick with algae and mud.

Throughout the day, the east, west and hospice wings of Bishopsgate Asylum cast a long shadow over

the property. Despite the renovated masonry, regular repainting and the addition of new wings, the buildings seem menacing. It is easy to see how Bishopsgate has acquired the reputation it has, hearkening back to when it was first constructed. Beyond the hedges are large, poorly kept lawns, terminating at the property's walls to the east and the facility's athletic field to the west.

Structurally, the facility is a jigsaw tangle of architectural elements — from the gabled windows and stone façade work crafted in the 19th century to the poured concrete and bland architecture of the late '60s. The main entrance, leading into the East Wing, sits directly ahead of any visitors, decorated with the images of the Six Saints of Bishopsgate.

Grounds

The Bishopsgate Asylum and Hospice facility sits on a 24-acre plot of overgrown farmland. Though the southern wall — with its road-side approach and general flow of visitors — is clearly intended to present a serene demeanor, the other three walls are topped with spindles of electric razor wire to hinder escape. However, in the northwest corner of the property, where the 10-foot high wall cuts through a section of the forest there, natural weathering has eroded the razor wire and its electrical defenses, leaving a large section of the wall unprotected and free of the razor wire.

The southern wall is patrolled by hired security driving a facility-owned and marked sedan. The single-car patrols are scheduled in four six-hour shifts. During the evening, the wall is extremely well lit by high-wattage sodium spotlights mounted on high steel poles set five feet outside of the perimeter wall with overhanging arms. With one of these lighting rigs installed every 20 feet,



the inside of the wall area approaches daylight level brightness on a moonless night. In addition to the wall and car patrols, patrols of eight security guards on foot walk the property on meticulous, winding beats. These guards, armed with pepper spray, Tasers and radios report to a security supervisor whose office is located in Chesterton Hall with the other administration offices.

East Wing

When most folk think of Bishopsgate proper, they are thinking of the East Wing. Whether it's the catastrophes that have occurred throughout the upper floors, the menagerie of violent psychopaths locked up in its basement, the extensively calculated bits of atrocity worked in its sub-basement or the dreaded Labyrinth, the East Wing is where everything you don't want to happen happens. Though the modern medical tortures conducted in the West Wing might be unthinkable to some, and the deformed bodies of the terminally ill and war-maimed might chill the blood of those who walk the halls of the medical wing, the East Wing is where the evil sleeps and does its work. Supernatural creatures able to detect great stores of spiritual or other sorts of "magical" evil will practically be knocked breathless by the extreme malevolence that has been imprinted on the physical and metaphysical fabric of Bishopsgate's main wing.

Exterior

The East Wing sits front and center in the hospital's approach; the wing's massive frontispiece gives an appearance of antiquated nobility. The walls are of gray stone and the roof of verdigris. Although the foundation is sound, something about the architecture lends the

Teesdale's Saints

Although surely not to the degree that he had hoped, Jonathan Teesdale's images do have some effect on malevolent supernatural beings. Ghosts, the restless dead and vampires must make a Resolve + Composure check at a -2 difficulty to cross the threshold unhindered. If the creatures succeed, they experience an uncomfortable warmth wash over them like a wave of nausea but are able to press on into the main wing. However, if the roll fails, they experience a much more intense sensation of heat, like the hot pulse of an open furnace, and are pushed back at least 10 feet from the door, unable to move in the direction of the door for the rest of the scene.

If the creature is absolutely insistent on using the main door, the supernatural creature may spend a point of Willpower to purchase a second roll. If the second roll succeeds, the creature still experiences two levels of bashing damage caused by the intense struggle pushing past the ward requires.

It is also important to note that only the main entrance is so protected and that all of the hospitals other entrances lack such wards. Because of this, the ward is mostly ineffectual for deterring creatures that know of its existence or have the option to take the other entrances. However, an unsuspecting vampire in the company of ignorant mortal contacts or allies could find himself in an awkward position if repelled by the Saints. The warded doors are also extremely helpful when fleeing creatures of the aforementioned types.

impression that the building is about to lurch forward.

The main entrance's most striking feature is the trio of authentic antique double doors, one set precisely in the center of the forward wall, and another set to its left and right, about halfway between the center doors and the ends of the building-front façade. Each of the six panels is carved with the likeness of one of six saints, one in each door. From left to right, the images are cut in relief from dark oak and gaze upward as if requesting peace for those troubled souls that would pass over the hospital's main threshold. Despite the creative wishes of the building's architects, the entire thing glares with a broken, tilted expression somehow menacing and pathetic, as though the sainted martyrs were praying for escape from the walls of Bishopsgate.

The saints pictured on the East Wing's main entrance are patrons of the mad commissioned by James



Teesdale's descendant, Jonathan Teesdale, the hopeful architect who attempted to warn Ignatius Hopper away from his hospital project. In order to protect and watch over the unfortunate souls who would come upon Bishopsgate, Jonathan carved the likenesses of six obscure patron saints of the mentally ill. However, stories and tales circulate among the patients and staff that the six saints of Bishopsgate are more concerned with making sure what dwells at Bishopsgate stays there.

The left-most pair of doors sport images of Saint Margaret of Cortona and Saint Romanus of Condat. This set of doors opens to the smaller of the two visitor waiting areas, which is where those who are newly struggling with the fact that their loved ones are here generally are asked to wait. This waiting room has seen decades of people, all struggling to understand what has happened to the people they love. The central pair of doors depicts Saint Eustochium of Padua and Saint Benedict Joseph Labre; these doors open into the large entry foyer, where an information and visitor's desk commands the view of the entry. The final set of doors depicts Saint Maria Fortunate Viti and Saint Osmund. These doors lead into the larger of the two visitor waiting areas, and sees quite a bit of traffic from families and other visitors who come here often.

Interior

The interior of the East Wing is quite a contrast with its exterior. The main lobby is a blend of high-tech medical sheen and antique architecture. Throughout the entire first floor of the building, the floors are hardwood that give way to brown marble tile in the lobby and at places where hallways intersect. To the right and left of the entrance are visitor waiting areas consisting of one green leather sofa, two green leather high back chairs, a walnut coffee table, a magazine rack and an end table upon which sits a blue and white porcelain lamp with a threadbare shade. Facing the entrance is a U-shaped, wooden information desk with racks of monitors, keyboards and file cabinets behind it. The desk itself also bristles with dumb terminals used to retrieve patient information from the hospital's database. Above the information desk hangs a massive chandelier installed by ex-Director Farnsworth W. Weaver to give the main entrance an expensive look to entice wealthy visitors into committing their mentally ill relatives at Bishopsgate.

The East Wing has two elevators located in the lobby and has five stairwells — one at each corner of the building and one located opposite the main entrance. The East Wing is also the only one of the three main wings that is fully operational (with the exception of two rooms located on the sixth floor). Each floor is broken into 44 rooms with a common area lounge, bathroom and group therapy room on each floor. Each floor also has a two-cell seclusion room for patients who become unmanageable. Each of these two-cell units houses a pair of 10-foot by 10-foot cells (each of which contains a pair of restraining beds fitted with eight-point

restraining rigs) and an observation alcove where seclusion teams and doctors can observe secluded patients.

Key Areas

The following are important areas within the East Wing.

Patient Rooms: Though many people come into an asylum expecting to find padded, windowless walls, the rooms where patients are housed differ little from other institutional quarters. Each room has a pair of metal-framed beds with foam mattresses, and a single window protected by simple white blinds. Patients are each assigned a single wardrobe in which to store their personal effects, and each room is set up with a desk and chair, generally situated between the two wardrobes.

The rooms on the third floor differ from other rooms. These rooms are reserved for more affluent patients. Though there are only 30 such rooms on this floor, each is a single-occupancy room, with its own bathroom. The administration goes out of its way to make sure that these rooms are provided maintenance and routine upkeep on a stricter schedule than those of the other floors.

All rooms are numbered, from one to 44, with a number designation in front of that indicating what floor the room is found on. Thus, Room 207 is the seventh room on the second floor, and Room 533 is the 33rd room on the fifth floor. In addition, each patient bed is given an "A" or "B" designation. Staff records keep track of who is sleeping where in such a fashion; on the nurse's log, James Delano is noted as inhabiting Room 422-A. Only the patient quarters

Ignatius Hopper's Office

Immediately after exiting the main elevator of the East Wing, a visitor is confronted by an unusual door made of mahogany and worked with a motif of doves and olive branches. This curious door, as interesting as it might seem at first, leads right into a large but unexceptional patient's room. This room was once the office of none other than Bishopsgate's founder, Ignatius Hopper. The man spent many of his final days here; indeed, he suffered the heart attack that killed him in this room, and his body wasn't found until the next morning by cleaning staff. For those with the ability to sense or feel the unseen, the room is a cold, frightening place, with an air of agitation. Occasionally, faint hints of a man's musk cologne (a pungent stench that used to follow Ignatius around during his breathing days) and the sound of a winding watch are heard here.

in the various areas of the facility are so noted — all other offices are left undesignated, or are given name designations, after important local historical figures, particularly founding members of the hospital.

The Basement: Protected by four sets of iron bar gates as well as a three-inch-thick stainless steel door, the basement of the East Wing houses Bishopsgate's high-security ward, a place of incarceration for the hospital's most dangerous residents. Incorporating some of the stonework of the original East Wing's foundation, the high-security ward is dark, dungeon-like and unnerving. The ward consists of two halls with the longer of the two halls running perpendicular to the shorter of the two halls. Once one passes through the security gauntlet at the ward's entrance, there is a dimly lit security desk behind which is an electronically locked steel vault that contains straight jackets, bed restraints, vials and ampoules of varying dosages of chlorpromazine (Thorazine), and a Taser. Two foldout chairs are collapsed against the wall behind the vault to be used by guests wishing to interview inmates on the ward. Two locks lock the gate into the actual ward — one standard keyed, one electronically keyed (using the ID badges carried only by security staff with clearance for this ward).

The main hall of the ward has eight square rooms each with a bed, toilet and sink lit from above by a neon light fixture. The rooms are secured by a four-inch security-strength Plexiglas barrier cut with a double-bolt locked door and a stainless steel rotating transaction door. The shorter hall has five cells, identical to those along the main hall — with a single exception. The bed in the back right cell conceals a set of stairs that are the only entrance to the East Wing's sub-basement (described in its own entry below). The patients housed on this ward are extremely dangerous — to others and often to themselves as well. Murderers, serial killers and a host of other tremendously dangerous criminal psychopaths from all over the United States have been interned here over the many years of the ward's existence.

Characters likely to gain access to this ward would be senior doctors, visiting psychologists or law officials dealing directly with a specific patient, or employed as security staff on the ward. Of those people, only security staff members are allowed to enter and exit the ward freely; everyone else needs to be keyed in by the security staff. There are, however, inactive keys located in the Bishopsgate director's office in Chesterton Hall that can be computer activated using a password and program accessible only by the hospital's director.

Sub-Basement: There is perhaps no place in all of Bishopsgate with a more dreadful past than the vaults beneath the East Wing. It's almost uncanny how such a place has managed such a legacy of atrocities and horror as the hidden torture chamber of Bishopsgate's most spectacular medical sociopaths. Accessible only by way of the stairway locked away in the security ward above, the Bishopsgate sub-basement is the hospital's best-kept secret. The layout of the sub-basement is altogether different from the layout





of the basement above: the stairs begin in the far eastern wall of the basements, and emerge in the central room of the sub-basement, a huge square room with three barred doors leading to rooms cut into the north, west and south walls. Multiple movable room dividers made of white cloth and aluminum divide the center room into eight working areas. Within each divided area is an adjustable surgical steel operating table that is bolted to the floor and fitted with restraints. The tables can be used either flat or in an upright position so that the patient strapped to it can be worked on in standing position, held in place by the restraints and the flip-up foot plate at the tables' bottom edge.

Next to each operating table is a steel instrument cabinet with five drawers on wheels. Each cabinet contains an assortment of standard medical instruments as well as the crueler, custom devices appropriate to whichever experiment is being conducted at the given station at that time. A high-wattage examination lamp lights each station, and six bare bulbs dangle from the ceiling light the room itself. The nine cells that surround the main operating area are identical. Each cell has rough-hewn, stone walls and a naked stone floor. They have no bed, sink or toilet — only a plastic bucket with the metal handle removed. In fact, the SPCA would probably consider the cells vaguely cruel quarters even for an animal. These cells are used to house the human guinea pigs that fuel the twisted experiments for which the sub-basements are infamous.

The sub-basement can serve as an excellent end point for an investigation into the evil of Bishopsgate without ever directly pointing at the supernatural. Similar to many such historical incidents in which human beings descend into a state of pure malice and sadism, the sub-basements convey a very human, if unbelievable, sort of evil — the sort of evil where the intellectual deconstruction of morality clears the path of compassion and sympathy and rolls out the red carpet for the very limits of human depravity, resulting in butchery and torture. The sub-basements don't even have to be in current use for their horror to become apparent — a mere reference to their history such as a hidden file or a hidden copy of Dr. Gorlay's personal journal could result in the sort of "what have they done?" realization as they sift through a collage of one gory, deluded experiment after the next.

If a Storyteller decides that she does not wish to have actively in-use sub-basements in her chronicle, the sub-basement can be sealed off completely, removing the secret entrance in the high-security ward. Removing the surgical equipment from the basement is also an option. Nonetheless, the atrocities that took place in the sub-basement created many angry ghosts, and the veil here has grown extremely thin. Due to the rips and tears caused by Gorlay's torture chamber and other fatal tortures that took place here, the sub-basements provide an exceptional +4 Manifestation modifier for ghosts wishing to take form here.

The Labyrinth: Beneath the East Wing, beneath the high-security ward, and beneath even the sub-basement,

lies the source of what gives Bishopsgate its very soul. Completely sealed off from the rest of the hospital by six feet of foundation and earth lurks the aptly named Labyrinth. The Labyrinth is the name given to the series of tunnels that lead in and out of the dreaded mounds about which the original settlers were warned. In fact, that these mounds not be disturbed or approached was the primary condition of the agreement made between Daniel Shepherd's colony of settlers and the Native Americans who had avoided the mounds since time without beginning. However, as the tendency of human expansion would have it, the negotiated ban upon the mysterious mounds was gradually diminished in its gravity, and eventually Teesdale built his mansion upon them. Since that time, that which the Native Americans avoided unconditionally throughout the memory of their people has stirred and spread its infectious malice using the Bishopsgate facility, its staff and patients as the means with which to express its nature.

The physical structure of the Labyrinth itself is organic and seemingly random. Although numerous universities have managed to get grants to fund in-depth excavations of Bishopsgate's foundation, they have all met with maximum resistance from the director either to hide the goings on in the sub-basement or for the purely practical reason that getting the funds to run the hospital has always been precarious and rebuilding the East Wing would devastate the hospital's operations and leave an enormous amount of reconstruction to be done, making applications for additional funding chancy at best. Nonetheless, if characters do somehow gain direct access to the Labyrinth, its physical structure is alien and disturbing. Shadows move to change the shape and seeming direction of the tunnels, irregularities in the walls' texture seem to form disturbing glyphs as a flashlight moves over them (becoming nothing more than protruding roots or stones if examined directly), and the whole place stinks with a sort of deep smell that triggers primitive fears and charnel revulsion. If a specific identity has been given to the evil, the Labyrinth provides marks of its passing, whether they be strange glyphs, evidence of human sacrifice, bizarre configurations of animal bones or some other signature of the Darkness That Lies Beneath.

It is important to remember that the Labyrinth is the egregore of an eons-old evil (of a nature up to the Storyteller's choosing) and that even supernatural creatures recoil in dread when exposed to its full yawning, abyssal magnitude. Teesdale and his ghostly band of villains are terrified of it and refuse to enter the Labyrinth even under pain of exorcism or some other form of final destruction. Any character, living, dead or otherwise entering the actual Labyrinth receive a three-dice penalty to all Composure-based rolls. This includes resisting supernatural abilities, using magic and resisting states of frenzy, etc. In addition, derangements are upgraded to their next step of severity; for example, an individual suffering from a mild Phobia of rats would react to the vermin as if in the throes of full-blown Hysterics.

Insofar as ghosts are concerned, the Labyrinth promises a special terror. Ghosts that reach zero Corpus or zero Essence while within this place — as far as anyone can tell — cease to exist. Such ghosts may exist as a thought in the Labyrinth itself and wander within the nightmare world that gave them birth, or they may be sealed within the moment of their souls being torn to shreds by the abyssal hunger of the old Indian mounds.

West Wing

Accessible from either one of the courtyard doors or the covered west-side exit of the East Wing, the West Wing of Bishopsgate has seen the least renovation of the three wings. In fact, only the first three floors of the West Wing are currently in use, the top two floors being sealed off from both patient and staff access, leaving only the director with access to the closed levels. As the West Wing is conveniently separated from the main hospital wing, the West Wing serves as a perfect location for the NEU (Neuropsychological Evaluation Unit) and Critical Long-Term Care Ward as well as the only access to the basement tunnel that leads to the high-security ward located in the basement of the East Wing. The NEU is broken into three wards, one per floor. All three floors are monitored from the first from the information desk, which is fitted with a double stack of observation monitors arranged in two rows — the top watching third floor rooms and the bottom observing those on the second floor.

The security doors behind the monitoring station are set up to allow passage through one door into a small passageway that leads to a second door. One of these doors can only be opened when the other is sealed. Similar doors can be found immediately beyond the elevator on the second and third floors. The second floor is for long-term high-maintenance patients suffering from debilitating conditions. The third floor, however, is the suicide watch wing that receives visits from any number of the other wards (including the hospice and VA Wing).

Key Areas

Experimental Therapy Room: Created by Dr. Thomas Bateman before he murdered his assistant, the Experimental Therapy Room was intended to serve as home for future “therapeutic projects” of the sort eventually practiced exclusively in the sub-basements. ETR currently acts as the home for a small number of highly controversial treatments — all of which were “perfected” in the sub-basement ward of the East Wing. A large portion of Bishopsgate funding is provided through its willingness to implement new technologies on behalf of enormous pharmaceutical and medical corporations, and some of these might very well be dangerous. Patients who take part in these experimental treatments are not always aware of the potential dangers or that the treatments haven’t been entirely approved — indeed, in some cases, the patents are still pending on the technologies being employed.

The following are some of the possible methods that could be under trial. Storytellers are encouraged to place their own projects — many of which might be considered psychological torture devices, all in the name of progress — in the ETR.

Electro-Convulsive Therapy: These days, ECT is a controversial therapy that has met with enormous success in treating severe depression and related disorders, and Bishopsgate, of course, uses the therapy method in a safe and careful fashion. But this hasn’t always been the case. During Thomas Bateman’s reign as Bishopsgate’s director (although his rule might be likened more closely to that of a despot), ECT was administered with no or little sedation. In addition, it was common for his staff to use ECT as something of a punishment for recalcitrant or difficult patients. To this day, some of the orderlies — who often learn their jobs from other orderlies — are quick to suggest that they’ll arrange an ECT session with the “doctor in charge” if a patient doesn’t behave. Several orderlies have been written up for using such approaches — the current director is an advocate of the therapeutic uses of ECT and dislikes those who treat it as something of a medieval torture device.

Sensory Deprivation Tank: Although not necessarily dangerous when used by healthy individuals, Bishopsgate’s choice to experiment with “float tanks” and sensory suppression is highly suspect. The float tank basically consists of an eight-foot-long, heated coffin of extremely salt-saturated water with a light-sealed lid. The water is heated in accordance with the subject’s body temperature as to create the sensation of not being able to tell where one’s skin ends and the water begin. So, in a lightless, silent, scentless, formless capsule, the subject floats deprived of any sensory input. As if this weren’t asking for enough trouble (in the case of psychotics and those suffering from hysteria-level phobias), Bishopsgate has also performed experiments that involve giving the patients strong tranquilizers, dissociative anesthetics and, in some cases, custom-formulated hallucinogens, in order to guinea pig pet theories about the effects of these often illegal or highly controlled drugs.

White Noise Therapy: White Noise Therapy dates back to the days of Dr. Gorlay. Though far less bloody and disturbing than some of his more visceral surgical tortures, the brutality of Doc Gorlay’s white noise helmet (a.k.a., “The Brain Toaster”) has gone unrestricted due to Thomas Bateman categorizing the treatment as “sound therapy” — the apparatus uses intense subsonic and hypersonic sound combined with rhythmic trance-inducing impulses. Many studies of the effects of sound on human psyches were performed here, and there are rumors that a few of the most heavily afflicted of Bishopsgate’s insane didn’t start out that way but were “toasted” into their current conditions.

Hydrotherapy: Though attributed with an innocuous name, this throwback to days when madness was treated as a form of demonic possession is among the most controversial of Bishopsgate’s experimental treatments. The patient is strapped, naked, to a flattened cushioned surface, and fitted



with a tight-fitting mask over nose and mouth. The patient is then lowered into the water beneath the bench and simply kept there for a period of time. Some patients react to this therapy with a sudden and intense calmness, while others undergo fits of panic while submerged. The intervals of submersion can vary. Several of the staff doctors have written complaints about the use of hydrotherapy, which they claim is more damaging than beneficial. However, the director is a strong believer in the benefits of hydrotherapy, though some claim that she has adopted its use in the same way Bateman used to use ECT: as punishment and threat for use against difficult patients.

Ghost in the Machine

If Storytellers want to make things really interesting, introducing a ghost with the Magnetic Disruption Numen could make things absolutely unpredictable in this room. A staff member could be checking the fit on the White Noise Helmet when it suddenly short circuits and blasts them with its ungrounded, amplified effect. Or, a sympathetic apparition witnessing a helpless patient being unnecessarily subjected to impromptu ECT could scramble the power source and save the subject from his painful fate.

The Lobotomy Room: Hidden away on the closed fourth floor of the West Wing is a locked room with a badly deteriorated door. Inside the room is a bulky wooden chair with screws on the arms where leather wrist restraints should be. There is a steel cabinet that swings open with several hooks where medical instruments used to hang. The wall panels are rotten on all the interior walls, and the outer wall is of bare brick. The single window is bricked up to the ceiling, and there is no working light. There is an unusual smell to the room that is a mix of sweetness and medicinal pungency. The floorboards at the foot of the chair appear to have been seriously damaged by repeated blunt force.

During the earlier period of the hospital's operation, this fairly nondescript room in the sealed portion was the room in which the patients were given so-called ice pick lobotomies. Though this procedure was considered humane during the 19th and early 20th centuries, Bishopsgate's facility was one of the last hospitals to discontinue the twisted practice. The

Procedure: Sedation and Seclusion

There are times, even among the lowest risk and least dangerous of patients, that measures must be taken to prevent patients from accidentally or deliberately doing harm to each other. When this occurs, certain measures must be taken.

The first step that is usually taken is that one or both of the patients is put on what is called “the 10-foot rule.” This means that the patients are required to stay at least 10 feet from other patients at all times. Obviously, patients passing each other in the hallway or sitting near each other in their therapy group are exceptions to such a rule, but when it comes to sitting in the lounge, walking to other areas of the ward, or sitting at mealtime, the rule holds. If patients refuse to abide by the 10-foot rule and insist on making physical contact (or sometimes even threatening physical contact), increasingly more severe measures are taken.

At this point, the patient is usually being emotional or hostile, insisting that the contact is necessary or unavoidable for some reason or another. This is when the psychiatric technicians call the seclusion team — a group of orderlies there to escort the trouble patient to a seclusion room.

When the seclusion team arrives, the patient is generally addressed in a calm, comforting tone as the seclusion team gradually circles him and gets into place. One of the members of the team hangs back a bit and prepares a restraining bed, some chlorpromazine tablets as well as a syringe filled with Thorazine. If the patient cooperates, he is escorted to the nearest seclusion room and kept there under the observation of a psychiatric technician. Generally, the patient is released after a review of his mood in an hour or two.

However, if the patient decides not to cooperate, the seclusion process continues. More than half of all the seclusion incidents that occur at Bishopsgate patients tend toward this more “time-out” style of seclusion. If the patient absolutely refuses to go to the seclusion room, he will be physically restrained by the seclusion team. Although the seclusion team is trained in methods of restraining the patient without using harmful force, accidents do happen, and injuries do occur for which the hospital then becomes answerable. Either way, the patient then needs to be attached to the restraining bed so that he can be safely wheeled into the seclusion room.

When patients prove violently resistant to the point where the seclusion team simply can't restrain them without harming them, they are forcefully offered a tablet of chlorpromazine that they have a brief window to accept orally. However, if the patient is unflinching in his desire to cause as much of a problem as possible, the final step is the intramuscular injection of chlorpromazine. A decent dose of this stuff will render the patient entirely unconscious for a varying period of time based on body weight. At this juncture, the seclusion team affixes the patient to the restraining bed and is then quietly wheeled into the seclusion room.

A patient who has been chemically secluded must remain in the seclusion room for a mandatory period of time based on the hospital's policy; current Bishopsgate policy sets this at four hours. During that time, the patient is under the direct observation of the psychiatric technicians and usually the patient's primary psychiatrist.

From the patient's perspective, he can only lie there, racked with the thumping post-Thorazine headache, straining beneath his restraints in an attempt to appraise his unfamiliar surroundings, greeted by concerned faces looking at him through a tiny square window in the door. In some cases, when the sincerity of the patient's newfound calmness is in question, the patient will be denied bathroom requests, being told to relieve himself from his restrained position, with promises of the psych techs cleaning him up afterwards.

In incidents of repeated seclusion, the patient can be considered an extreme case and will be transferred to the NEU where he will be reviewed for more involved treatment. Though seclusion may not be a reliable or effective deterrent for some, it usually gives positive results in all but the most extreme cases.

Although the seclusion teams are supposed to view the seclusion as a necessary evil to protect the patient being secluded (as well as his fellow patients), an unfortunately high number of teams take pleasure in their jobs as disturbing power trips that can result in them taunting patients so that they can use as an increased level of force. Similar to most things at Bishopsgate, deaths have resulted from such abuses of power.

Procedure: Suicide Precaution Levels

Bishopsgate procedure recognizes multiple levels of potential suicide threat in its patients. As a long-term care facility, treating the possibility of suicide in its patients the same way is untenable. Therefore, the staff of Bishopsgate recognize three Suicide Precaution Levels, or SPLs. These are as follows:

SPL 1 – Low Threat: Low-threat procedures generally tend toward simple attentiveness to the patient and the deliberate exploration of suicidal tendencies by therapy and psychological staff. In essence, this is simply the status of a patient who has been treated at one of the higher SPLs previously, and the staff is on guard for potential future episodes. Patients under SPL 1 are not denied access to any possessions that other patients are allowed. Patients under SPL 1 are required to engage in at least one form of weekly therapy, preferably of the kind that the patient's therapists have judged to help reveal his state of mind. Indications of suicidal ideation are taken quite seriously by patients on SPL 1, and may result in the patient's immediate upgrade in SPL.

SPL 2 – Prolonged Threat: Patients under SPL 2 are long-term patients who experience frequent and strong suicidal ideations. Such patients are always involved in a course of therapy designed to help them confront and eventually overcome such ideations, although most of these patients simply don't *want* to overcome it, or feel that doing so is impossible. These patients have daily check-ins with a therapist, and are not permitted shoelaces, belts or anything else that may be judged potential suicide-enabling implements. Bishopsgate maintains a dizzying invoice of such items that can change from month to month.

SPL 3 – Immediate Threat: The highest-rated threat level is for those patients judged to be genuinely on the verge of committing suicide in the immediate future. Often in a state of extreme emotional distress, such patients are placed in almost entirely bare rooms in loose-fitting gowns and little else. These rooms, located on the first floor of the East Wing, are door-less, and located near areas of high traffic by hospital employees: a steady stream of doctors, nurses, orderlies and other staff pass by the rooms on a regular basis, and everyone knows it is his job to glance in and make sure anyone in these rooms is okay. This is intended for psychological effect more than anything else — the intent is to reassure the patient that someone is always watching. In addition, the nurse on staff makes a point of checking in on the patients once every half-hour, addressing them by name and asking how they are doing. This nurse is supposed to check responsiveness levels, and get the on-duty therapist should one of them exhibit a desire to speak with someone. Such patients are also kept on various calm-inducing pharmaceuticals. Most patients remain at SPL 3 for no more than a few days; after two or three days without suicide attempts, a patient is generally downgraded to SPL 2 and moved to one of the other rooms.

floorboards were actually damaged by the frenzied kicking and stomping of someone who was maniacally resistant to the lobotomy operation.

Patients still tell stories about this room, claiming that it wasn't bricked up until the early 1940s. After Bishopsgate stopped using the room, the stories claim that some patients found their way into this room, some on a dare, some on a lark. In at least three cases, patients seated themselves in the chair and were suddenly seized by the urge to snatch up a lobotomy skewer from the tools nearby and attempt to plunge it into their own heads. These same stories say that the first patient injured himself and the second was caught before she could. They also say that the third patient killed himself, an event that precipitated the sealing up of the room. They also say the tools for performing the lobotomies were removed after the first patient, but that somehow there was always one of the "ice picks" in the room when a patient came calling.

The Charred Ward: On the fourth story of the West Wing in a partially gutted area of a stripped and sealed hallway, there is a room that doesn't look a bit worse than the other neglected cells. When entering the room, those who come through the door are confronted with a completely unnatural stench of burned flesh and charred wood, though there are no signs of charring or other burning anywhere in the room. The clothing of those who spend even a few minutes in here smell like smoke, and the room's temperature is always a little hot, as though there were a nearby fire smoldering. This is Room 423, and this was once the room of the nameless patient who started the deadly fire in the lower wards.

Medical Center

The Bishopsgate Medical Center is the newest of the three main wings. Fully equipped with some of the newest

physical therapy and rehabilitation facilities and technology, this wing still provides the hospice and VA recovery services the hospital provided back in the 1800s. The waiting room of the recovery wing is located at the far west end of the Medical Center building. Insofar as services, the receptionist's desk located in the first floor lobby provides only the most general patient information and guest and patient check-in as most of the other services are provided at the main information desk in the East Wing or at the nurse's desk on each floor. Of the four floors of this wing, all but the top-floor rooms are in use. The second story of this wing is what is left of the Bishopsgate hospice program. Although the patients here are dying of terminal diseases or deteriorating chronic conditions, the second story is perhaps the least institutional-looking and feeling of any of the hospital's wards, as its decor and atmosphere are intended to make those who have come to die here feel a bit more at home in their last days. By comparison, the third-story VA ward is a poorly lit tunnel of rooms that terminates in a dismal patient lounge that smells of mildew and antiseptic.

The basement of the Medical Center wing holds stark white walls and a single long hallway bearing a variety of private offices and many locked rooms. The only public area in the basement is the pharmacy, which consists of a double-locked medicine vault and the computer for accessing the hospital's prescription database. Directly across the hall from the pharmacy window is a set of glass double doors with the word "Morgue" stickered to them in large black letters with gold edging.

Key Areas

The Veterans' Lounge: The VA Ward is one of the most depressing and bleak of the wards. The ward was once comfortable and underused, but recent conflicts in the Middle East have drastically increased the Veteran Hospital's population. With between 30 and 40 injured soldiers milling about on a single floor, the patients can grow restless and stir crazy. When this happens, they gather in the VA Lounge.

One would never suspect that the Bishopsgate VA Lounge was part of any sort of facility that could be considered medical — the air is usually thick with cigarette smoke, pipe smoke and occasionally the sweet smell of someone using medicinal marijuana. Despite hospital regulations, the veterans who convalesce here refuse to abide by code: they drink, play cards and pretty much do whatever they want and as they see fit. Screams of vets whose morphine has worn off may echo down the main hallway, but in the lounge, the patients are allowed to be human beings again.

However, the VA Lounge was not always such a social hub. During the Civil War, the room was used as the amputation chamber, with wounded soldiers guzzling spirits an attempt to anesthetize all sensation as their limbs were hacked from their gunshot bodies with comparatively dull bone saws gripped in the tightened fists of sweating,

overworked medics. A few hundred soldiers died or were irreversibly mutilated in this chamber for nearly three decades, and the trauma and dread have left their marks.

War Stories

Though certainly not the focus of the Bishopsgate setting, the presence of the VA Ward brings a whole new arena of horror into the mix — that of war. Though Bishopsgate certainly has its own, personal brand of atrocity, nothing can really compare to the incomprehensibly visceral dread of actual battleground violence. Characters with VA backgrounds may be more willing to investigate the disturbances at Bishopsgate as they have become hardened by military training and experience, or, the psychological scars they suffered in battle may make them twice as vulnerable.

However, it is best to remember that the entire topic of war may be too controversial a theme for some players to explore in a roleplaying game. Before you schedule a session that includes descriptions and characters that have been mentally and physically mutated by a very real human evil, please remember to make sure your players are interested in playing through such a story.

The Chapel: Found at the far east end of the Medical Center's first floor, the chapel is set up to serve as a sanctuary for the hopeful and the hopeless. Here visiting relatives pray for their loved ones who suffer from madness, war wounds or incurable illnesses, and those who have suffered hope for respite.

The Chapel is laid out to accommodate possibly a dozen people at any given time, as there are four pews that can each seat three adults. The walls are covered in wood veneer paneling with electrically illuminated plastic stained glass windows that shed their blue, yellow and red glow over the whole room. The main altar is made of oak and upon it sit an altar cloth, an offering bowl and an antique wooden cross. There are two plaques on the wall to either side of the entrance, one commemorating the names of the staff and patients who perished in the great West Wing fire, and the other bearing the names of the investors who paid to have the Chapel constructed.

The Morgue: Located in the basement of the Medical Center is the hospital's morgue. Unlike the white walls of the rest of the basement level, the walls of the morgue are a dingy shade of institutional green. The door directly opposite the entrance houses eight brushed-steel refrigerated drawers that are used for storing the bodies of the recently

deceased. The other three walls are covered in various procedural charts, including detailed explanations about worker's compensation and what to do in case someone accidentally ingests or inhales some of the more toxic chemical mixtures. The walls are also hung with anatomy posters, two utility shelves filled with various chemicals and an illuminated panel for viewing x-rays. The room has four examination tables, each with its own overhead light-source and as well as an adjustable examination lamp. The floor of the morgue is made of badly worn, brown ceramic tile with drains in the corners as well as the center of the floor. There is also a massive biohazard disposal bin against the right wall. Despite what one might assume about Bishopsgate's morgue, it is a relatively serene place despite being both underground and filled with the bodies of the dead.

The morgue is rarely busy, and its mortician and medical examiner are generally on call as there is no need to have either on duty. Because of the harmful chemicals and abundance of dangerous sharp objects (specifically designed to slice flesh, remove organs and cut bone), the morgue is kept locked and protected by a security alarm. If the alarm sounds, it can be heard throughout the medical wing as well as in Chesterton Hall. All of the toxic chemicals used for embalming and organ preservation are carefully logged and tracked on the morgue's computer as well as in written form in a large white binder kept on the medical examiner's desk.

Bishopsgate's morgue is unorthodox insofar as it not only examines the bodies of the dead but also prepares them for burial. Due to a lack of crematorium, anything other than burial would have to be handled by the deceased's family. Bodies that are not claimed by loved ones or that do not have specific burial arrangements are buried in the massive historic cemetery to the north of the hospital. In addition to providing postmortem service for many of the hospice's recently deceased, Bishopsgate's morgue also serves the VA Hospital and, when it is required, the asylum wards as well.

The Rest of the Facility

Beneath the looming edifice of the hospital's three main wings, a visitor may find a number of other buildings that serve more specialized functions. Chesterton Hall houses the hospital's administrative offices as well as its database and server room. The huge, two-story Whitehall House provides housing for the hospital's interns and some resident staff as well. Behind Whitehall House stand two identical buildings — Hampden House and Potomac House. Hampden House is the facility's Art Therapy classroom and studio, and Potomac House serves as a meeting place for substance recovery groups as well as housing the office of Bishopsgate's substance abuse program. In front of these two houses is Brochardt House, a recently renovated Edwardian monstrosity broken into well-sized classrooms for the hospital's school. To the northwest are the gardens



— a cluster of flowerbeds, trees and sloppy landscaping cared for by the patients of the hospital since the turn of the century. Standing at the edge of the gardens is a gabled barn that holds maintenance vehicles and tools as well as the groundskeeper's office. Finally, to the west of the West Wing is the Maxwell Gymnasium, which abuts the athletic field. A red brick patio (complete with plentiful patches of white concrete where the brick has become damaged to the point of being unsafe in some areas) connects most of the auxiliary houses with patchy flowerbeds in-between the walkways. Most if not all of the foliage is either overgrown or browning from poor care — the understaffed, underpaid maintenance crew has more important things to attend to than gardening.

Chesterton Hall

The first building purchased as a staff residence in 1866, Chesterton Hall is a saltbox colonial-style home that has had its many odd-shaped rooms converted into multiple offices as well as a staff lounge and the primary computer center for Bishopsgate. The exterior of the building is oyster gray, and the shutters have been painted black with flower boxes underneath. The building has three floors including the basement. The front door opens into a long hallway with a stairway leading to the second floor on the right, a door at the end opposite the front door and two doors on the left. The first door on the left leads into a waiting room, which is decorated with colonial antiques dating back to the period when Bishopsgate was built. The waiting room has a large bay window facing the back of the East Wing that is hung with heavy curtains, which are usually pulled shut during most of the day and always in the evenings. Converted antique vase lamps fill the room with a warm light that makes it seem smaller than it actually is. Two rose-and-vine pattern couches are pushed up against the right and back walls, and a basket of magazines sit underneath the end table between them. Two commercial prints with hunting scenes adorn the walls in imitation gold-gild frames.

The second door on the left leading out of the main hall leads to another corridor that has a door on each side. The corridor itself is hung with black-and-white photos in small black frames that feature some historical moments in Bishopsgate's history. The digging of the medical wing's foundation, the cutting of the ribbon of the rebuilt West Wing, as well as images of the various directors with various senators and congressmen, are but a few of the photos to be found here. The two rooms leading off this hall are the offices of the director and the assistant director. The assistant director's office has two windows on the same wall. The director's desk is antique mahogany monstrosity that seems a little big for the room. The room is only lit by a green-glass desk lamp, the glow of the computer monitor and a small imitation Tiffany lamp that sits on a small marble and iron end table in the corner. There's a print of one of Claude Monet's water lilies paintings hung

above the visitor's chair and a cluttered bulletin board behind the assistant director's desk. A coat rack stands next to the door.

Across the hall, the director's office is about three times the size of the assistant director's office. There is only one large window, which is located behind the director's original Edwardian oak desk that looks out into the main courtyard. There are two chesterfields and a pair of chairs for guests, all upholstered in the same orange-brown leather. The floor is hard wood and is covered in a huge oriental rug with a butterfly and lotus motif. There are two brass lion lamps on either side of the director's desk and one between the two sofas in the back of corner of the room, which never seem to provide quite enough light. Behind the original oil painting of Daniel Shepherd that hangs on the right wall, there is a hidden security safe that contains financial records, security key blanks, back-ups of the facility's various databases and files pertaining to incidents and individuals of a controversial nature.

The third door leading out of the foyer leads to the server room and IT consultant's office. This room is divided into two halves with the office situated against the back wall under the window. On the desk, there are two keyboards and three monitors. Against the right wall is a massive dry erase board covered in networking diagrams and partially erased notes. A water cooler is located next to the door. The other half of the room is dedicated to three racks filled with servers, monitors, modem banks, routers and a laser printer. In contrast to the technical function of the room, the walls are covered in antique raised-felt wallpaper bearing a stylized grapevine design. A ceiling fan and a window mounted air conditioner run at all times in this room.

The stairs leading to the second floor have a thick, black wooden banister that winds up and along the upstairs hallway. There are only four rooms on the second story of the building. Upon first climbing the stairs, one enters a large conference room cut down the middle by a long walnut table surrounded by eight Queen Anne chairs. The room has been designed with an open-rafter ceiling with two ceiling fan lamps suspended from the struts. There are five windows in total on the three outer walls of the conference room, the interior wall having three doors. The first door leads to the building's only restroom; the other two lead to empty offices currently being used for storage. Above the doors hang three portraits, one of Ignatius Hopper, one of Edward Blake and, between them, a portrait of Bridget McClusky, Bishopsgate's current director.

The entirety of Chesterton Hall is safeguarded by an electronic alarm system that patches in directly to the local police station. Only the staff members who work in Chesterton Hall and the facility's security teams have a means of disarming the alarm. If the alarm is set off, only the manual entry of a 12-digit code can disable the alarm at that point. If the alarm is not disarmed within two minutes, the local police will dispatch officers to investigate the disturbance.



The Gardens

Perhaps the most attractive of Bishopsgate's sites are the oddly laid out Victorian-style gardens that fill the entire northwest quadrant of the facility's property. Ever since the turn of the century, the Bishopsgate Gardens have been maintained and cared for, not by its staff, but by its patients. Several acres in size, the gardens have several areas that at one time had special significance for the ill and mad who cared for them. The distant northwest is thick with oaks and red maples encircled by cobblestone walking paths. Immediately north of the gymnasium is the once-loved hedge maze, which is now poorly manicured and impossible to successfully navigate due to the extremely overgrown privet that makes up its walls. Other areas include a reflecting pool filled with algae and goldfish, a cherub fountain that has not worked in more than 25 years and a neglected vegetable garden that stinks with rotting produce and buzzes with the sound of fat flies in warmer months. In the southeast corner of the garden stands the barn. This huge original farm structure dates back to the Ignatius Hopper period of Bishopsgate that is immediately apparent to anyone who inspects it.

The barn is divided into four purposes. The first is that it serves as an office area for the facility's maintenance crew. The office area consists of locker bay, a water cooler, a filthy coffee machine, a battered boom

box and a threadbare orange wool sofa. Above the main area of the barn, the loft is a makeshift workshop area with pegboard nailed to the walls and two sawhorses in the center of the room. Despite the crudeness of the shop, there are a number of decent quality power tools. The tractor-sized riding lawn mower parked in the barn uses up the bulk of the first level, with leaf blowers, chainsaws, rakes, shovels and hedge clippers hung on the wall beside it.

NOTE DISCOVERED IN
NATHAN SODACI'S LOCKER.

Thank you so much for doing this for me.
Just throw it somewhere as far away from Bishopsgate as you can. And don't keep it with you for too long. They can smell it.

Whitehall House

Whitehall House was acquired in 1867 during the period that Ignatius Hopper snatched up additional properties in order to house important members of Bishopsgate Asylum's staff. Since that time, most of the other houses have been put to other uses, including specialized therapies and administrative functions. However, Whitehall House has remained a residence since its original purchase and serves as a dormitory. Although directors and doctors tend to live in their own offsite homes in the modern day, Whitehall House still plays home to interns, some psychiatric technicians and occasionally security and maintenance staff. In addition, Whitehall House also houses Bishopsgate's staff dining hall, which fills the entirety of the first floor of the house.

Whitehall House is a giant, three-story Georgian Colonial made of red brick with black shutters with white trim. Ignored just as much of the facility's neglected landscaping, the house is completely encircled by a towering hedge of overgrown privet that has grown nearly 15 feet high in places. The dormitory also has a small front porch on which sit a pair of white wicker chairs with high backs and cluster of desperate-looking potted plants that occasionally get watered by the residents when it suits them. Above the front door is a walnut plaque with brass letters that say Whitehall Dormitory.

The interior of Whitehall House can be accessed by either the main entrance at the front or through the back door that leads directly into the cafeteria. Though the front door has a short flight of steps leading to its porch, the back door is fitted with a ramp as to be handicap accessible. Upon entering through the main entrance, characters will enter a large dining room with two large tables to both sides and one that runs perpendicularly down the center of the room. Each table seats 20, with the entire dining area capable of seating 100 people at maximum capacity. The walls of Whitehall House are covered in wooden award and recognition plaques of various sizes as well as a few portraits of local historical figures (generally those significant to a nearby town or the state in which the Storyteller has chosen to set his chronicle as opposed to characters particular to Bishopsgate itself). Whitehall House's kitchen lies through the double doors in the dining hall's back wall. There are brushed steel preparation tables, pots and pans suspended from hanging racks, as well as a commercial-sized oven, stove and dishwasher. The hospital's chef normally runs the kitchen with the assistance of patient volunteers from the VA, hospice and low-risk psychiatric wards. A restroom is located to the rear of the kitchen.

The actual residential area of Whitehall House begins at the top of the stairs on the second floor. With hardwood

floors covered in a hideous olive carpet and beige walls, the intern lounge is a gathering area for residents and other staff when they wish to relax or escape. The walls are covered with all manner of hangings including movie ads, novelty posters, tacked-up takeout menus, as well as multi-colored dittos that advertise Bishopsgate events as well as entertainment options that can be found in town. The room has two sitting areas consisting of three contemporary pine couches and a square, pine coffee table. Between the two sitting areas is a bumper pool table that has seen much abuse over the years. A 24-inch screen television looms in each of the room's corners suspended by a metal arm. A VCR and DVD player sit on top of a cabinet filled with board games, none of which have all their pieces.

Off the lounge are four doors — one leads to the second-story bathroom and the other three lead to dorm rooms. Each dorm room consists of a new yet uncomfortable single bed, a writing desk, a closet, a window-mounted air conditioning/heating unit and a reading chair. In the far corner of the recreation room is a spiral staircase leading up. The railing of the staircase has been wrapped in blinking white Christmas lights, and the stairs themselves are extremely narrow and steep. The third-floor hallway is very dark and cramped with too many doors leading into too small a space. The six rooms located on the third floor are nearly identical to the rooms found on the second floor save for the roof-sloped ceilings of the third-story rooms. The third-floor hallway gets light only from the second-floor lounge or from one of the rooms if the door is left open.

The basement of Whitehall House serves as both a laundry and utility room. Three washing machines, three dryers and the fuse box are all found in the basement. There is a card table with four folding chairs where some of the interns gather to play drinking games and other activities that they would rather engage in outside of the view of their supervisors.

Whitehall House has an electronic alarm system that monitors both doors and all of the first-story windows of the building. When the alarm is set, opening any of those will trigger a piercing series of beeps that will not stop until the alarm code is entered. However, because of the comings and goings of the various residents (as well as non-residents wanting to sneak a midnight snack), the alarm is almost never armed. Nonetheless, when any of the doors or windows is opened while the alarm is disarmed, a distinct series of three beeps is sounded from the alarm monitor consoles located next to both doors and at the top of the first flight of steps on the second floor.

Hampden House

Despite the dubious history of much of Bishopsgate grounds, Hampden House manages to remain a quiet place of hope within the center of madness. Whether it is the building's function as the hospital's creative arts



Gallery of Screams

Using disturbing art as a hook in horror is as much of a classic as unmanned stagecoaches and the rattle of chains in the attic. Sometimes it's deliberate, as a victim held captive by a monster who can communicate only through his artwork. Sometimes it's an omen, wherein an unwitting artist acting as a conduit for dark forces from beyond. Sometimes it is an account of a sanity-shattering glimpse into the shadow world in the tradition of Charles Pickman. And sometimes it's the very means by which a malevolent, knowing ritualist summons the evil to this world.

Whichever way you slice it, using the art projects and creative scrawling of lunatics to clue characters into the story is an opportunity not to pass up. Even if you choose not to make art a central part of your game, preparing a few disturbing vignettes for your players to uncover can add that subtle element of unease. The following are a few ideas that can be peppered throughout a Bishopsgate chronicle or just used to make comfy old Hampden House a little bit spookier.

- A staff member is tormented through her dreams by a ceramic mask crafted by one of the elderly psychotics who claimed to have eaten the souls of her stillborn children.
- A simple reddish brown finger-painting created by a loveable old veteran in the VA ward turns out to be rendered in human blood.
- A pre-teen patient constructs a diorama for extra credit for the history class he takes at the Brochardt House. The diorama is of a scene of Native Americans and Pilgrims sitting down for the first Thanksgiving dinner. When the boy brings the project to class, he places it on the windowsill until it's time to present. When he goes to present it, the figures have been re-arranged. The Native Americans stand with their backs to the Pilgrims, who are piled on top of one another with the head Pilgrim lying on the ground beside the mound holding a tiny effigy of a rifle to his little, construction paper mouth.
- A visiting therapist gathers the children's ward together and Potomac House for a guided visualization relaxation exercise. The therapist walks the children through a wonderland-like landscape based on those places and things they find most relaxing. While deep in the narrative, the therapist has a nightmare-like vision of herself being facially branded by a Civil War physician with glowing red eyes. The children, startled by a muffled scream from the therapist, are then handed markers and construction paper and asked to draw something from their journey. All 15 children draw the symbol that was branded on the therapist's face in her vision.

therapy center, the excellent condition of the building's interior and exterior or just the general mood of many of the patients when they are here, Hampden House is a wonderful exception to Bishopsgate's status quo.

Hampden House is an enormous Cape Cod with its door located at the west end. The house has white wooden siding and pine green shutters. Daffodil and crocus beds surround the house, and a vintage rooster-topped weather vane adorns the roof. The entire first floor has been divided into three rooms, including a restroom. The first-story classroom is used for general art classes and therapies. It is furnished with four huge wooden tables, each with 16 short metal benches. In the center of the room are a wooden table and desk for the supervisor, therapist or instructor. The walls are hung with collages, finger paintings, drawings and all varieties of paper and papier-mâché masks, which leer like the likenesses of protective grotesques. Along the windows at the front of the room are two motor-assisted and two

kick-propelled pottery wheels with a big, green plastic trashcan filled with slip and clay scraps.

The basement of Hampden Hall is used for storage and is unfinished. Items are stored on wooden stacking crates and aluminum utility shelving. The basement has a dirt floor and has a crude wooden closet area used for wet and dry storage.

In the back left corner of the room is the art therapy office, which is a general use office with two desks and two bookshelves stuffed with oversized art books, art history textbooks and piles of paper. A pair of bare neon bulbs lights the room. The middle room is a supply closet filled with all manner of art supplies stored in colored buckets labeled with big sloppy crayoned labels. The last door leads into the restroom, which has three restroom stalls, two sinks and a small square window fit with wrought iron bars.

The stairs heading up lead to the second-story classroom that is filled with 10 easels surrounding a

pair of wooden tables covered in brown tablecloths and stacked with plastic fruit in wooden bowls. The room has six windows set along the front and back walls sunk into the room's sloping ceiling. Against the far wall, there is a small chalkboard, and on the wall at the top of the steps, there is an extremely loud ceiling fan that is tolerated during the warmer months, as the second floor grows uncomfortably warm. The only separated room on the second floor is actually a walk-in closet where extra easels and a stack of folding chairs are stored.

Only standard locks on the windows and front door secure Hampden House, and so anyone wishing to enter the house during off hours would likely have a fairly easy time gaining entry with minimal criminal technique required.

Potomac House

Located right next to Hampden House, Potomac House is one of the few wards that is not named after one of Ignatius Hopper's investors and serves as a gathering place for all kinds of discussion therapy groups. Many patients staying in the east and medical wings meet here with their therapists and fellow patients to engage in everything from support groups and recovery groups (such as Narcotics Anonymous and Alcoholics Anonymous) to therapy groups arbitrarily organized by ward in the East Wing.

The outside of Potomac House is nearly identical to Hampden House in style. However, Potomac House is an oyster gray with black shutters and its original slate roof, which, despite the level of maintenance such a roof would normally require, looks pretty good despite its age. The windows are all fitted with flower boxes, and in the summer, they burst with marigolds that stay pretty healthy due to their parasite-repelling properties. Unlike the roof and flowers, the siding and paint on Potomac House are in terrible shape, and the wood siding has begun to warp due to the poor seal.

Potomac House is house has a main story, a restroom, a finished basement and an attic. The first story is a large open room with a floor covered in orange shag carpet likely installed during the late 1960s. The art on the wall is also dated as someone decided should be covered in all manner of hideous '70s string art depicting images of owls, sailboats, stylized faces and vaguely Christian images incorporating doves, suns and crosses. Low shelves run the entire wall, and those near the door are used to store shoes. The rest of the cubbies are filled with self-help and New Age books dealing with guided visualization methods and other group relaxation techniques. The corners of the room are filled with teetering stacks of exercise and camping mats as well as small round meditation pillows. Beanbag chairs are the only furniture aside from a stack of five folding chairs that are shoved behind the stack of exercise mats. The beanbag chairs are arranged in a wide circle, ready to be used by the groups that meet here.

The upstairs of Potomac House has hard wooden floors and baby blue walls that have been sponge painted

with blobs of patchy white paint that someone apparently thought resembled clouds. Six windows provide the majority of the rooms light and are hung with folding blinds. The only other light source is an imitation Japanese box lantern caked in dust that sits on the floor. A cassette player and a stack of cushions are stacked on a fake wooden cubby stack at the top of the stairs.


The basement room has a copper and orange linoleum tile floor that is curled and yellowed at all of its points of intersection. This room has a circle of folding chairs, a card table and a sofa. The room smells like coffee and cigarettes, and the walls are covered in banners for AA and NA and a glazed wooden plaque displaying the Serenity Prayer. Because of a lack of windows in the basement, and the near-total lack of security or locks on the windows upstairs, Potomac House is a common place for the younger interns and some of the patients to sneak off when they wish to be out of view.

Brochart House

Named after Gustav Brochart, owner of Brochart Savings and Loans, Bishopsgate's schoolhouse has seen half a dozen uses since it was first acquired. It wasn't until the half-hearted renovation initiative of Thomas Bateman that the building was permanently assigned as Bishopsgate's place of learning for its school-aged patients. Located right next to Potomac House and Hampden House, Brochart is huge by comparison, with more than double the square footage as the other two houses combined as it is has three levels (not including the basement). Brochart is a regular Bates Motel from the outside, roughly covered in scalloped wooden siding with an excess of gingerbread and other cosmetic novelties. Despite the trim and finishing touches, the whole of Brochart seems to slouch west, as if it's grown weary of all that goes on at Bishopsgate. A wrap-around screened-in porch surrounds Brochart House and serves as a comfortable place to relax when the poorly air-conditioned interior grows too hot in the summer and early fall. The front porch area has an assortment of wicker chairs, end tables and love seats, whereas on both sides, there are end-to-end picnic tables to accommodate an entire classroom's worth of students. Around back there is a pair of hanging swings that are often detached and bang against the building's walls given a strong southerly wind.

Brochart House can be entered through one of three doors. The front door is the main entrance and leads into a narrow hallway with doorways leading into the various first-story classrooms. The side door opens up into the reading area and Brochart's tiny student library — stuffed with dog-eared paperbacks, partially filled out workbooks and badly worn textbooks donated by various organizations that did not want them anymore. The back door enters into the office.

When entering through the front door, there are three doors leading out of the narrow stairway/foyer area. The right and left lead to classrooms, and the one at the



far end leads into the office area. The classroom on the left has a 24-student capacity insofar as desks and chairs. The windows to the right are left open except during the coldest part of the year, and the door opposite the entrance leads into the small library. The walls of this classroom are covered entirely in green chalkboards over which hangs a wrap-around banner of the alphabet and numbers, divided by dotted lines for use in handwriting lessons. Behind the wooden teachers desk is a pull-down screen to be used with the overhead projector that is kept in the corner of the room on a wheeled dolly shelf. The classroom across the hall is actually a bit bigger. Its walls are hung with posters of multiplication tables as well as posters with strange cartoon characters from the '70s and empty motivational slogans about "Finishing What You Start" and similar sentiments. This classroom can hold 32 students at maximum capacity.

Two more classrooms and another office can be found on the second story of the house. Although one of the rooms is nearly identical to the right classroom on the first floor, the other is often locked due to its special use. This room is where science-related classes are taught to the students, an idea proposed by current Bishopsgate Director Bridget McClusky. This room contains seven lab tables with beaker stands, test tube racks and gas spigots, which are fed a mixture of liquefied petroleum gas and butane from a self-mixing pair of tanks kept in a locked storage space beneath one of the tables. An oversized poster of the periodic table of elements covers the interior wall. The central window of the room is actually a set of atrium doors that are made safe by a wrought iron guardrail in front of which stands a telescope, which is usually used on the third floor given the better view of the sky. Microscopes, mostly harmless chemicals (there is, however, a small amount of pure sodium kept in a kerosene can in the bottom of the cabinet which will burn if exposed to air or explode if put in water), additional beakers, as well as a pile of rolled-up astronomical charts are also stored here. In the hall between the two classrooms is a narrow stairway that leads to the third floor.

The charming third floor of Brochart House is a sort of teacher/student lounge. Renovated at some point from unused attic space, the third floor has small gabled windows on three sides and a pair of atrium doors that open up onto a front-side balcony that looks out over the grounds. A few plastic green plastic chairs provide seating. As the balcony is three stories up, severe injury is the best someone could hope for if he were to fall (or be pushed) off over the ivy-entwined guardrail. It is also important to note that if someone were ever trapped on this level, it would be very easy to slowly climb over the balcony's railing, then down on to the roof of the first screened-in-porch area, leaving a mere 10-foot jump to the concrete walkway below.

The basement of Brochart House is an empty, dirt-

floored space with very poor lighting. The only thing of interest in the basement is the old wine cellar space that hasn't been used for decades. It consists of what amounts to a stone closet with a wooden door that locks with an old-fashioned tooth key from the outside. Though the wine cellar is certainly no elegant space in which to store choice vintage, its door, walls and lock are strong enough to keep someone securely locked inside.

Maxwell Gymnasium and Athletic Field

Bishopsgate's gymnasium is a rarely used facility. Aside from the occasional intramural volleyball games organized for the mental patients three times a week, the gym stands empty the rest of the time. Rather oversized for anything the hospital would use it for, the gymnasium houses enough seating for as many as 1,000 spectators and contains a regulation-sized basketball court. The locker room area is divided into men and women's areas and is basically a steel maze of locker banks with an area dedicated to toilet stalls in the back of the locker room's tiled area where the large open shower area can also be found. The gymnasium is usually locked and is lit by an array of sodium lamps and neon lights suspended from the building's rafters.

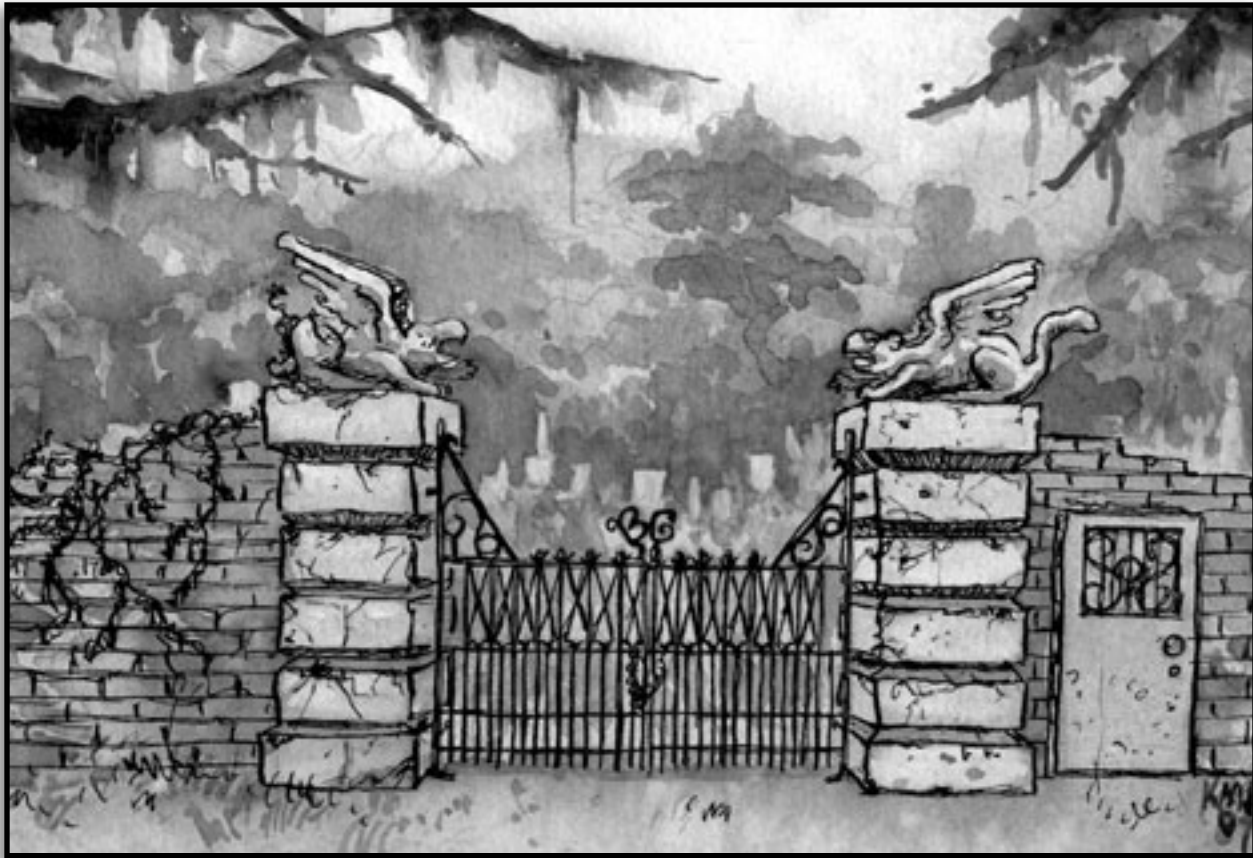
From the outside, the gymnasium is an eyesore. Sided with multi-purpose sheet steel and painted with pale green all-weather industrial coat, the gym looks like something you'd find in an industrial park, rather than a place attached to a building with so tremendous a history as Bishopsgate. An overgrown athletic field sprawls to the south of the gym.

The Graveyard

Beyond the security wall to the north and not officially part of the Bishopsgate facility is the massive Bishopsgate Cemetery, established by Daniel Shepherd in the year of the original settlement's founding. The graveyard covers nearly eight square miles and is filled with some of the most infamous names in Bishopsgate's history. A four-foot brick wall that rises at the east and west sides to form large gates atop which sit pairs of hunched stone griffons surrounds the graveyard itself. However, the wall has been torn down in sections along the north wall as to allow for expansion over the years, and each of all but the last of the six expansions has a similar break. The cemetery creeps through the hills north of Bishopsgate like ruin, sucking ivy that blights the places it touches.

Bishopsgate Cemetery has a parking lot outside, and only funerary processions are allowed to drive on to the property. A guard chain blocks both large gates except during the occasion of a funeral as well. Beside each gate is smaller wooden door that provides the standard entrances for visitors.

The Bishopsgate Cemetery can be divided into sections based on expansion. The first thing one sees upon entering



is the fascinating Bishopsgate Colony Cemetery with birth and death dates further back than nearly any other cemetery in the area. The stones are hand-carved and well worn, some completely illegible due to erosion and damage from the elements. Four crypts sit in the corners of the so-called colony garden, a rare extravagance in the days of their construction. Entering the next area, one is confronted with nearly 300 alabaster prongs, each marked with a chiseled cross and roman numeral. These graves mark the burial sites of those unfortunate souls who followed Reverend Jeremiah Bodycombe to spiritual salvation, consuming mug-draughts of arsenic at his request. A worn footpath circumvents this area over to the next expansion, as nobody seems to want to walk over the graves of Bodycombe's damned. The remaining expansions tell the story of Bishopsgate with patches of deceased veterans, smallpox casualties, dead madmen, as well as those who died in hospital riots, from neglect or in one of the terrible fires that immolated patients and staff. The newest expansion has very few graves so far, but given the nature of Bishopsgate, that could change at any time.

It is of interest that graveyard was re-expanded only last year, having been closed for 15 years due to permits and limits set by federal and state codes pertaining to the burial of the dead. Although the codes and standards have not changed, the old cemetery is open for business once again.

City of the Dead

Regardless of where the Storyteller places Bishopsgate geographically, the Bishopsgate Cemetery should be one of the oldest and largest graveyards of its type. Over the years, vast numbers of the land's victims have been buried here, and the veil between the world of the living and realm of the dead has been worn thin. The graveyard's age and size alone make it a likely place for supernatural activity, and the grizzly deaths that most of its "residents" met with absolutely guarantees such a designation.

Because Bishopsgate is such an abscess of death, madness and sadism, Bishopsgate Cemetery is exceptional insofar as its accessibility to the spirits of the tortured dead. Most of the cemetery has the normal +3 Manifestation modifier that most graveyards possess. The expansion that hosts the graves of Bodycombe's colony bears a +4 Manifestation modifier, as does the original graveyard. In addition, both of those areas grant a +1 bonus to ghosts using Numina while within the area, and a +2 bonus to the use of the Terrify Numina.



Story Seeds for Bishopsgate

There is nothing right about Bishopsgate. Though the intentions of the people who have run it throughout the years have started out altruistic and in a humanitarian fashion, the darkness always creeps in through the cracks of their broken weakness and twists their goodness into malevolence and evil. Below are a number of suggestions for the supernatural “truth” behind Bishopsgate. The Storyteller should feel free to choose among any of them, mixing and matching as his whim dictates, for the needs of his own game.

The Ghosts of Bishopsgate

Part of the horror that is Bishopsgate lies with its history, and there is no better way to bring that history to bear than by making horrors of the men who lived it. Though some details are understood about the founding of Bishopsgate and the role of its directors, the black legacy initiated by the sorcerer James Teesdale back in 1695 is a well-hidden secret concealed by the spirits of those who set it in motion. Though the characters will have little-to-no chance of ever discovering the truth of the matter through conventional research, committed investigation of the less accessible areas of the facility will gradually unveil what lies beneath.

In 1865, when the wealthy farmer James Teesdale built his family’s mansion on top of indigenous holy ground, he began a series of magical experiments dealing with the formulas of immortality and the dread operations of binding souls and raising the dead. Luckily, thanks to his need to keep up appearances as a farmer and the abusive head of his family, the ambitious magician managed to achieve not one success during the long series of workings. Although Teesdale did not achieve the power he was in search of, his work certainly had its results.

Disregarding the sacred and forbidden designation of the land previous to his arrival, Teesdale wanted to use the energies of whatever dwelt below the mounds as a battery for what he believed would be his Great Work. Aware of the warnings and stories forbidding the defilement of the site, Teesdale decided it was a perfect location to create a sort of spirit prison using a series of ancient wards and seals drawn from his grimoire. Instead of creating a cage of ethereal guinea pigs with which he could perfect his dark arts, Teesdale instead bound his own soul to the Bishopsgate site, forming the basis for a swirling crucible of madness and despair — an inescapable prison for the ghosts of those who would torment the helpless who dwell at Bishopsgate.

In addition, the ghosts who dwelt there before Teesdale’s coming were banished, chased away by the

new evil, and it is thought that it was that moment God turned his eye from Bishopsgate forever. After realizing the horrible situation he put himself in, Teesdale flew into a rage, terrifying his already estranged wife and two sons. Deciding to flee James, the family avoided a gruesome fate by narrowly escaping James’s decision to set fire to his own home with the intention of fleeing. Though his family escaped the fate he planned for them, James trapped himself in the conflagration, burning to death in the fire. At the moment of his death, Teesdale became the first prisoner of the mounds at Bishopsgate and, infuriated with his failure, became committed to inflicting the brunt of his suffering on every soul that ever sets foot on the ground where his mansion once stood.

The second individual thus trapped was Benjamin Bodycombe, a religious leader who brought his benevolent community of Christian devotees to live on the land formerly owned by Teesdale. During their stay, Teesdale assaulted Bodycombe with nightmares and visions that eventually lead to his doomsday decision. After being broken of his devoted spirit and any desire to truly help his spiritual flock, Benjamin Bodycombe transformed his cult’s religious canon into an elaborate ritual with which he could feed Teesdale’s malevolence in one fell act. After six years of carefully orchestrated indoctrination that he chronicled in a detailed written revelation, Benjamin Bodycombe and four dozen of his followers (half of whom were children) consumed a concoction of wine and arsenic in mass suicide. Upon his death, Bodycombe joined Teesdale in his imprisonment, and the two conspired to make Bishopsgate a place of uncompromising evil.

However, Ignatius Hopper’s building of the first Bishopsgate Hospital brought things truly into full swing. Much to Teesdale’s pleasure, Hopper ignored all warnings from the natives insofar as the mounds and their curse were concerned. Hopper was also warned by his architect (a mortal descendant of James Teesdale), who believed very strongly that the Bishopsgate property was cursed and haunted. Ignatius Hopper stood resolute in his vision, and the hospital was completed. Despite Hopper’s best intentions of public service and despite such seemingly benevolent projects such as the construction of the spa or the annexing of the main facility for wounded military, Teesdale and Bodycombe worked to recruit Hopper. Even after years of wearing away at his resolve, Hopper held on to his senses until Bodycombe grew desperate and appeared to Hopper in his office. At that point, Ignatius Hopper became the first of a long line of directors who joined Teesdale’s circle of trapped spirits, and suffered a massive heart attack from overwhelming shock and fear.

Since that time, five more directors have joined their ranks, and more are sure to follow if something is not done to appease the restless and wicked ghosts of Bishopsgate. Of the five, four died on the grounds, and a prison inmate (who had formerly been chosen as a “servant” of Bishopsgate’s ghosts) murdered Dr. Thomas Bateman in his prison cell.



Though the “board of directors” has no unified agenda aside from increasing their numbers, it is highly likely that their numbers will slowly swell as each director falls sway to the evil and fails to make the hospital a place of peace and respite. It is important to note that even this circle of powerful ghosts is unsure insofar as the true nature of what lies beneath Bishopsgate. It is also important to note that the “board of directors” is not the cause of Bishopsgate’s malevolent legacy but rather a result of it.

The Board of Directors

Inaugurated on the evening that the Teesdale mansion burned to the ground, Bishopsgate’s so-called board of directors is effectively the history of Bishopsgate told in ghosts. Working together to increase their numbers (with the exception of one dissenter), the actual methods of the board are subtler than one might think. Despite their best efforts, the majority of the board met their demise through means other than the direct machinations of those who died before them. Although the board certainly sets up the pins, it always seems that Bishopsgate Hospital itself (or, in some chronicles, whatever lurks beneath it) has the last say. If confronted with their crimes, the majority of the board of directors will plainly claim that their victims

simply did what they would have done anyway. However, because chaos, fear and mistrust feed the directors’ souls, they intend to create an environment in which they can dine well. Because of this, all manner of disturbances, weirdness and violence can potentially be attributed to their dark meddling.

What follow are the statistics for the average Bishopsgate ghosts followed by notes on Teesdale, Bodycombe and Ignatius Hopper. Statistics for the other members of the board (Edward Brake, Donald Roe, Farnsworth Weaver, Jeremiah Moorcock and Thomas Bateman) are up to the Storyteller to create as she sees fit.

Attributes: Power 3, Finesse 2, Resistance 3

Willpower: 6

Morality: Varies, by individual

Virtue: Varies, by individual

Vice: Varies, by individual

Initiative: 6


Defense: 3

Speed: 16

Size: 5

Corpus: 8

Numina: Varies, by individual



James Teesdale

Although the other ghosts of Bishopsgate may possibly be viewed as victims of the hospital's curse, James Teesdale is quite possibly the father of said curse. An accomplished sorcerer, Teesdale blatantly refused to abide by the warnings of the Native Americans who once lived on the land and built himself a sanctuary where he could work with his coven and tend to his child bride. Within the walls of his home, Teesdale performed rituals attempting to bind the spirits of the dead, drawing power from the darkness beneath the mounds. Rash and ambitious, and consumed by heaving tides of megalomania, Teesdale's experiments went horribly wrong, resulting in his death and binding himself to the land he defiled. For nearly three centuries, Teesdale has continued his work in a fashion he never intended. As one of the dead he previously wished to have power over, he has reshaped the objectives of his magical practice to include reconstructing a coven of the dead to further enhance his own powers. With seven followers sympathetic to his ends, Teesdale's new "coven" promises to make Bishopsgate a hellish place for a long time to come.

Attributes: Power 7, Finesse 5, Resistance 7

Willpower: 14

Morality: 1 (Megalomania)

Virtue: Justice

Vice: Greed

Initiative: 12

Defense: 7

Speed: 22 (species factor 10)

Size: 5

Corpus: 12

Numina: Clairvoyance (dice pool 12), Compulsion (dice pool 12), Ghost Sign (dice pool 12), Ghost Speech (dice pool 12), Magnetic Disruption, Phantasm (dice pool 12), Possession (dice pool 12), Telekinesis (dice pool 12), Terrify (dice pool 12)

Other Notes: James is an extremely powerful ghost with exceptional attributes and abilities. He is not the sort of entity that a Storyteller should casually throw up against his players. In addition to a comprehensive arsenal of Numina, James knows the hospital inside and out and has been here longer than it has.

Reverend Benjamin Bodycombe

The Reverend Benjamin Bodycombe established his religious compound on the old Teesdale property in 1851 with the best of intentions. He'd been touched by God, filled with the Holy Spirit and ordained as a prophet of special brand of spirituality unique to his experience and understanding. Through transmissions received from the "Holy Ones," Benjamin unknowingly achieved a sort of genuine communication with unseen powers — unseen powers that gradually convinced Bodycombe of his own spiritual failure. However, it was Bodycombe himself who willfully and independently decided that, rather than

rebuild the rock of his faith, he should order and bring about the suicide of his numerous followers and then put a bullet through his own skull. So, it was much to Teesdale's delight when Bodycombe's ghost arrived. United by the realization of nearly identical motives, the two conspired over the next several years. It wasn't until the construction of the first Bishopsgate Asylum that their course became apparent and laid plain. Since that time, Bodycombe has been instrumental in dealings with the other ghosts insofar as getting them on board with Teesdale's master plan.

Attributes: Power 4, Finesse 5, Resistance 5

Willpower: 9

Morality: 2 (Zealotry)

Virtue: Faith

Vice: Pride

Initiative: 10

Defense: 5

Speed: 19 (species factor 10)

Size: 5

Corpus: 10

Numina: Animal Control (dice pool 9), Clairvoyance (dice pool 9), Compulsion (dice pool 9), Ghost Sign (dice pool 9), Ghost Speech (dice pool 9), Phantasm (dice pool 9), Terrify (dice pool 9)

Other Notes: Bodycombe, though firmly under the yoke of Teesdale, is a formidable adversary in his own right. Bodycombe's Attributes are beyond those of a normal ghost, and he is an master manipulator capable of coaxing the virtue out of a saint. He's not much for direct confrontation, but he knows how to use certain parts of the hospital to deadly effect.

The Rustic Cross in the Chapel (Anchor): In the Medical Center's Chapel sits a rustic wooden cross. The cross predates all of the buildings on the property and was donated by Albert Teesdale when the chapel was dedicated. Despite its simple design, the cross is tied to a great evil in that it serves as the anchor of Reverend Benjamin Bodycombe. Although the Reverend Bodycombe has more than what it takes to wander freely through a large area of Bishopsgate, he is least strained when lingering in the Chapel. Consequently, he reacts most violently and directly to those who threaten the integrity of this room insofar as it serves as his tie to the world. If anyone were to blatantly attempt the theft of the cross, or try to damage or destroy it, Bodycombe would unleash the full range of his destructive abilities in an attempt to prevent it.

Doctor Ignatius Hopper

After the horror brought about by Bodycombe's religious ambitions, nobody in his right mind would set foot on, let alone purchase, the Bishopsgate property. That is, until a freethinking doctor with a vision decided to step outside local stigma and superstition and lay the foundation of a place of healing that would pioneer new advances in medical treatment for years to come. Though the Bishops-

gate legacy began with the best of intentions, it is in many ways that of Ignatius Hopper himself — an exploration into hope twisted in on itself only to be cast into a world of dread and madness.

Dead from a heart attack after Bodycombe's desperate attempt to seize control of him, Dr. Ignatius Hopper was crushed beneath an avalanche of realization as his faith in an explainable world was shattered right in front of his eyes. Lucky for Hopper, he had a committed guide in the Reverend Bodycombe, who helped Hopper adjust to his ghostly existence. That has left Hopper utterly terrified and paranoid about a world that seeks to destroy him. He is the most apt to lash out at mortals around him, fearing they can somehow see him and wish him harm.

Morality: 4 (Paranoia)

Virtue: Fortitude

Vice: Pride

Numina: Ghost Sign (dice pool 5), Ghost Speech (dice pool 5), Magnetic Disruption, Telekinesis (dice pool 5), Terrify (dice pool 5)

Other Notes: Relatively speaking, Ignatius Hopper is not dramatically younger than Bodycombe or Teesdale. However, the scope of Hopper's spirit was not quite as passionate, and his personal agendas didn't translate quite as

well into his ghostly form. But what Hopper lacks in ancient evil, he makes up for in bloody-minded tenacity. Hopper has a wide variety of Numina but is otherwise an average ghost of Bishopsgate.

The Doctor's Office (Anchor): Dr. Hopper's old office — now a patient room — in the East Wing serves as a source of power for him. It was here that Reverend Benjamin Bodycombe appeared to Ignatius in a desperate attempt to begin Hopper's decent into madness, succeeding to such a degree that he collapsed from a heart attack upon seeing Bodycombe's manifestation. Though Bodycombe did the dirty work here, the room is a place of power for Ignatius Hopper's ghost. As the Hopper's death, this room serves as an anchor for Hopper, allowing him to move freely between this location and the director's office in Chesterton Hall (where the mahogany desk upon which Dr. Hopper's heart stopped is located).


Though Hopper is certainly protective of this chamber as one of his power spots, there isn't much to threaten here. However, if a character proposed an initiative to remodel or tear down and rebuild the East Wing in its entirety (which has been attempted many times in the past), Hopper take a much more destructive interest in things. Nonetheless, Dr. Hopper's ghost still experiences a great amount of pride and self-satisfaction when pacing the space that used to be his

We are Legion

You might be thinking at this point, "Come on. A million fucked-up things have gone down here. Death doctor experiments, fires, murders, medical torture and monstrous levels of neglect. Why the hell are there only eight freakin' ghosts?"

The thing is, there aren't. The board of directors just happens to serve a very specific role in the way the supernatural underbelly of Bishopsgate operates. It is safe to assume, that if the Storyteller chooses, the hospital is, literally, dripping in paranormal activity. From the sub-basements to the gardens to the Bishopsgate Graveyard, the entire facility is rife with excellent sites to which you can bind a ghost's tormented form. The following are some ideas for ghost characters drawn from Bishopsgate's past.

- A 17th-century Native American who was buried too close to the mounds.
- One of Teesdale's insubordinate slaves who was beaten to death when he walked in on one of Teesdale's magical rituals.
- A vacant, sycophantic apparition whose weak will resulted in her consuming Bodycombe's arsenic cocktail as a part of his cult.
- One of the patients who starved in the basement when the hospital was under Donald Roe's control.
- Any number of Dr. Gorlay's torture victims.
- One of the 17 patients or five staff members who perished during the riot caused by one of Gorlay's victims.
- A veteran who suffered on the table during an inhumane and brutal amputation at the turn of the last century.
- An irrational and horribly deformed victim of the fire.



seat of power and receives a bonus die to all Numina rolls he makes in this chamber.

Breaking McClusky

Considering the trend established by Teesdale and company, it is safe to assume that current Bishopsgate Asylum Director Bridget McClusky is in for a pretty rough ride. As Storyteller, you may decide that McClusky is the one to break the curse, and that she'll rally the players' characters together into an elite investigation team and get to the bottom of the curse and banish it once and for all.

But what fun is that?

Although she has arrived with good intentions and has broken new ground by being the first female director in the history of Bishopsgate, by virtue of being a human being with final say on what goes on at the asylum, there has to be something that the board of directors (or the more or less defined evil lurking beneath the hospital) can exploit in order to lead her down the well-traveled road of directorial corruption and failure. As none of those before her were able to resist the temptation, it is safe to assume she won't either. But how will she break? What exploitable vice or naiveté does Director McClusky possess that will finally break her and add her to the roster of villains under Teesdale's control?

Whatever it is, the gradual corruption of the Bishopsgate director should be mirrored by changes occurring in the hospital itself. If her vice is an uncontrollable temper, perhaps a patient riot occurs. If her vice is greed and McClusky decides to succumb to the temptation of embezzlement, perhaps part of the hospital will be consumed in a fire. If her virtue is pride, perhaps an embarrassing scandal concerning doctor-patient relations will come to life as a result of her misplaced trust in the hospital's integrity. Whatever her vice is, the director of Bishopsgate shares a sacral-king-like tie to the condition of the hospital and should be given some time and thought when preparing a Bishopsgate chronicle.

Of Spirit Doorways and Lines of Power

Though it may seem that Bishopsgate is a place of repose for the ailing and mad, yet wrought with misfortune and the greed and cruelty of men, these are merely the outer signs. In reality, the true players of the Bishopsgate chess match are well hidden and playing out a game with consequences that are anybody's guess. What is important to remember is that, good or evil, the Bishopsgate grounds are loaded with some of the most potent, albeit freakishly malevolent, energies and the supernatural creatures that feed off and/or protect those energies and want total control.

The players are three. Or rather, the players consist of three factions lead by three very powerful individuals. The oldest hold over Bishopsgate is that of the Ordo Dracul, a devout order of vampiric evolutionists who aspire to greater mastery over their undead powers while tending to the flow of metaphysical energies that pulse beneath the earth and

through places of power (such as the hospital). Even before Hopper's construction of the hospital, these blood-parasites have taken a deep interest in "the Mounds" and the fell and powerful energies that writhe within its tunnels.

The next to come was a small dedicated cabal of Mastigos-initiated sworn to the service of the Mysterium who believe that the egregore of magical power beneath the hospital is rightly theirs to master and understand. Because the vampires spend so much time hiding themselves and their aims, the living, breathing mages are able to seize more control over the hospital's operations as they have little to hide but the blatant use of their magics and the initiatory secrets of their order. Descended from the original tribes who gave their warning to the original colonists who created the Bishopsgate settlement, a pack of Bone Shadows was the last to come. Drawn by the alternating congestion and uncontrolled flow of spirits between the worlds, these warrior shamans now observe the hospital from outside its walls, and occasionally venture onto the grounds.

Though the leadership of these three factions has shifted as time has gone on, the agendas have varied very little. If a Storyteller decides to use this explanation for what is afoot at Bishopsgate, she could easily insert the player characters' coterie, cabal or pack into the setting as the current incarnation of whichever of these characters would like to belong to (be they mages, vampires or werewolves).

Though **Vampire: The Requiem**, **Mage: The Awakening** and **Werewolf: The Forsaken** are self-contained and independent games that don't necessarily emphasize strong rivalries between these types of supernaturals, this situation at Bishopsgate does. However, because Bishopsgate is such a disaster when it comes to administration and the effectiveness of the hospital's security, these powers at play are not always aware of the master's hand. Though something may appear to facilitate the agenda of the Ordo Dracul's manipulation of the ley lines, it could really be the unseen hand of the Mastigos-initiated Mysterium that is cultivating the catastrophes at Bishopsgate to gain greater insight into the mysteries of madness and death, or the effects of the powerful Bone Shadow werewolf pack positioning itself for another strike against the corrupting elements at work within their loci. Although each of the World of Darkness expansion games is playable on its own without the need for crossover rules, this option for Bishopsgate does allow for a level of crossover that some players and Storytellers may find enjoyable.

Heaven's Casualties

The settlement established by the Reverend Benjamin Bodycombe didn't happen upon the Bishopsgate settlement by random chance. Though the reverend may have caked his inspiration in the manipulative ploys of an arrogant man aspiring to some sort of twisted messianic status, what he saw and felt was exactly what he claimed it was. Having visited the land previous to the establishment of his religious village, Bodycombe was, in fact, contacted by an angelic servant of God. Well, almost.

Spoken of in the earliest parts of the Old Testament, before the ascendancy of man, there was an angelic war in Heaven. Though the forces of good were triumphant and order was restored to the celestial realm, there were those angels who sided with the Dark One who were cast down from spirit and thrust into the hold of vulgar matter. Encased in a chthonic prison, these angels writhed and twisted against their natures that until their banishment were fed only by the light of their creator. Now sealed in tombs of isolation, these creatures went mad, and where benevolence was once the only motivation, a whole array of twisted, meaningless motivations now blossomed — a state of suffering only yearning to find more of itself in the souls its limited reach could touch.

One angel, a dark and bitter being calling itself Inothiel the Herald, was sent to the Dark Ones' court to discuss terms before that war ended. However, this angel was easily swayed and never returned to the Creator's side. A betrayer of God, Inothiel was flung from Heaven as thousands like him and plummeted into the world of men, where his twitching body grew rancid and dark as the ages passed, beneath the ground — beneath the mounds.

It is Inothiel who spoke to Bodycombe. It is Inothiel's perverse agenda that played out in that community. In fact, in some ways, the Reverend Bodycombe's entire legacy is the story of Inothiel's fall written in microcosm for the world of men. However, the tale of Bishopsgate is nothing less than the result of the black wishes this angel holds for all of creation as Inothiel starves and rots, unfed by the distant light of Heaven. Each madman, each of the suffering war-wounded and each mother who has to watch her terminally ill child fade from her is like methadone for the raging seraph sealed beneath the asylum.

Storytellers using the story of Inothiel as Bishopsgate's should subtly present the asylum and medical facility as what it is — a prison for an angel who betrayed the light of Heaven. Though the superficial appearance and feel of Bishopsgate is obviously that of an isolated sanitarium and hospice, the presentation and the language used in that presentation should convey a sort of "First Circle of Hell" feel that players can delve into more deeply as the plot progresses. The underground areas of Bishopsgate should be treated as the deeper layers, where reality's hold fades a bit more as the characters get closer to this creature of festering wrath that cannot escape from its confinement. Painting the patients and staff as misled and tortured souls facilitating the operations of Hell on Earth should certainly instill a sense of foreboding and sense of inevitable disaster.





The Slumbering Puppet Master

Ambrose Gant was perhaps the greatest psychic the world has ever known. Though his parlor tricks were popularized during the mid-'70s on kitschy commercials on late-night television and his Las Vegas stage show was lauded by critics as “dazzling,” “unbelievable” and “must see with your own mind!,” the true breadth of power possessed by “The Mystical Ambrose” was not something he hid, even in his days of doing low-budget performances on Coney Island. During this time, Ambrose Gant met the love of his life, Wilhelmina Teesdale, whose fair skin and fine breeding among American aristocracy spelled the beginning of the end for the great mentalist.

Constantly demanding of the great performer's time and affections, Wilhelmina created enormous amounts of unneeded stress and drama for Gant as he toured the United States. Although her motivations seemed purely selfish, Gant's 19-year-old bride seemed to possess a sincere concern for Ambrose and ultimately just wanted him to stop using his powers of ESP as liberally as he did because both his use of the powers and the outcome caused her great anxiety and fright. However, Gant was strong-willed and resistant to his bride's requests and eventually distanced her so that the show could go on. Estranged and defeated, Wilhelmina filed for divorce in May 1984, but being financially dependent upon the performer, continued to live with him for the next five years. Then, while in retreat upon his yacht in Cape Cod, Massachusetts, Ambrose Gant, in a drunken stupor, tripped on the deck of his boat, struck his neck against a protruding cleat and fell into the water. It is not confirmed whether Wilhelmina was on board at that time, but help arrived before Gant drowned, and he was pulled from the water and taken into intensive medical care. Despite the best efforts of local medical staff, “The Mystical Ambrose” spent the next several years in a deep coma. Although close friends claimed he would have preferred release from his comatose prison of flesh, Wilhelmina checked her ex-husband into long-term care at Bishopsgate Asylum and Medical Center, where he lies unmoving to this day.

In a world where his body no longer provided any outlet, Gant's mind grew more powerful. His already noteworthy ESP ability has now unfolded into a massive arsenal of extremely powerful psychic abilities, including telekinesis and full-on mind control. Extending his awareness beyond his five senses, Gant's consciousness can observe and move about the Bishopsgate grounds with total freedom either through a potent form of astral projection or by psychically possessing the mind of a staff member or patient.

However, Gant wants to die. Doctors claim that Gant can't feel a thing, but they are dead wrong — he suffers intensely. Locked in his flesh prison, Ambrose is going mad from loneliness and an inability to truly interact with the world. Although he's tried to force patients and staff to pull the plug, it seems to be the one limitation to his powers. Something in his subconscious desire to remain alive overpowers his conscious desire to die. So, in a state of perpetual

yearning and inability to end his imprisonment, Ambrose takes out his frustrations on those who hold him captive, which spells bad news for Bishopsgate and its residents.

Ambrose Gant has become a powerful psychic monster with powers that are barely approached by the highest levels of ability described in *World of Darkness: Second Sight* and are potent even by the standards of those magical powers described in *Mage: The Awakening*. Storytellers may find it best to use those rules to model some aspects of what Gant can do.

At this point, Gant understands what he must do — others must suffer, and he must find someone with the ability to understand that he is the source of that suffering. He must find someone who can believe that he is responsible for the horrors he inflicts, and that someone must be willing to snuff out his existence. So, for the moment, he turns his capabilities to expressions of horrors, speaking terrible threats through the mouths of an entire hospital ward of catatonics at the same time, driving madmen to carve symbols in their own flesh and torturing all who come to Bishopsgate with nightmares.

The Evil That Men Do

To call Bishopsgate a place that was founded on old money is an understatement. Ignatius Hopper's private funds gave birth to the hospital, and the private investments of bluebloods up until the modern day have kept Bishopsgate from disintegrating over the years. Although some of the directors have aspired to help the hospital out of its never-ending string of ruts, most have only fed the madness. However, most did it out of selfishness, greed or blind ambition. It wasn't until the early part of the 20th century that they started doing it for other reasons.

This trend truly began with Farnsworth W. Weaver. In no way a doctor, Farnsworth was sympathetic to nationalist movements and philosophies of elitism and social Darwinism. With friends throughout the Aryosophic Movement of the late Weimer period in Germany, Farnsworth gave family money to fund new methods of surgery and experimentation that resonated with his warped social ideals and sense of false nobility. First among these controversial ideas was the practice of eugenics — the philosophy and “science” that believed that through breeding programs and the exclusion of “undesirable genetic traits” one could create a smarter, healthier and better human being. However, the ghastliest vein of this eccentric belief system was what Farnsworth took the deepest interest in — the branch of belief that endorsed questionable medical techniques designed to isolate, modify and remove those undesirable traits in postnatal subjects. However, Weaver did not have the stomach to personally bring about the ends his thinking embraced. For that dark task, he retained the services of one Dr. Gorlay.

Gorlay's experiments and atrocities were truly another level of human degradation, even more self-indulgent and pointless than even those performed by Josef Mengele

during his time at Auschwitz. This was because Gorlay's interest did not lie in the deranged thinking of eugenics but in his own strange worldview that amounted to little more than pure, unadulterated homicidal mania and pathological sadism. In the blood-soaked basements of Bishopsgate, Gorlay and his disciples raped, brutalized, mutilated and tortured dozens of captive human beings, all supposedly as part of some kind of long-term scientific research (or so his followers reassured themselves).

However, it wasn't until the breadth of Gorlay's mania became known to Farnsworth that the true inhumanity to man really took off. Under threat of being turned over to the authorities to cover Weaver's own ass, Gorlay proposed the unthinkable: a profitable extermination program that allowed the ultra-wealthy to perform procedures not unlike Gorlay's in exchange for hospital funding (which could later be embezzled by Farnsworth). Repulsed by the initial idea, Farnsworth flung Gorlay from his office, only to bring him back moments later so that the grim enterprise could be sealed with a handshake and vow of silence on the matter. So, during Farnsworth W. Weaver's reign as asylum director, the darkest period of Bishopsgate's history began. And it continues to the modern day.

After the arrests and scandal created by Gorlay's death and Weaver's arrest, patrons of their horrid service demanded more. Although such activities could no longer take place in the basements of Bishopsgate, Gorlay's associates worked toward consolidating the truly dedicated into a society that could work toward recreating their devil's Heaven. Since Gorlay's time, the society has had no way to reclaim their former playground, until now. The daughter of a powerful member of the society has recently taken a position at Bishopsgate. Her name is Bridget McClusky — Bishopsgate's current director.

Shortly after the installment of Bridget McClusky as director of the old asylum, the sub-basements are once again unlocked, and funding has suddenly become reinvigorated. And though the wealthy no longer believe there is any scientific basis for what they do, the few researchers — many of whom are descendants of the original disciples, and no longer even actually work at Bishopsgate — believe the research goes on. For Gorlay's interest in eugenics had nothing to do with breeding undesirable traits out of humanity. Rather, he was intent on proving his theory of "moral obfuscation denial," that all the world really saw their relationship with fellow men the same way he did, and that by providing the means to allow men to act out the worst horrors in a safe fashion, through multiple generations, human beings would reliably do so, every time.

Thus far, his theory has borne itself out.

"The Evil That Men Do" is the non-supernatural horror option for Bishopsgate's current state. As this scenario relies entirely on the most predatory, sick and repugnant sort of human evil, it can serve as an excellent red herring for supernatural games. However, despite its lack of occult influence and monsters, turning the hospital into a hu-

man butcher shop playground for the filthy rich may not be something your players will be comfortable with. If the full span of deviance that goes on at Bishopsgate includes ideas that may offend your players, it may be best to scale this option back or reduce it to a vague alternative. Perhaps, instead of butchering these people, they are sold off to the incredibly rich as slaves (or to powerful vampires as food, for a supernatural twist). Either way, a lack of supernatural foundation may add a more visceral sort of terror that some players may not be okay with.

Children of Madness (The Brood)

Dr. Thomas Bateman was not a coward. Challenged with bringing new and innovative research projects and technology to Bishopsgate, Bateman was responsible for many of the hospital's most effective treatments as well as its most cruel. Nonetheless, of all of Bateman's sponsored investigations into the psyche and its workings, nothing surpasses Bateman's DTT research initiative — also known as Project: Homonculus.

DTT, or Displacement/Transference Therapy, coined by 19th-century fringe psychotherapist Reinholde Wilhelm, functions under the notion that the shadow self, or rather, those negative qualities that one normally considers "other" or "not of the self" are to some degree sentient, in and of themselves. He postulated that, given room for development free from the suppressive tendencies of the conscious mind, the shadow self can be nurtured and made healthy through a form of hypnotic therapy that is catalyzed by a series of low pitch tones that stimulate the pineal gland. Over time, this fragment of other is reabsorbed and accepted as part of one's self, also under the effects of the tone used in this procedure. Though some progress had been made within the field, the American Psychiatric Association, which even went as far to institutionalize Reinholde Wilhelm when his methods began yielding results, stifled any truly significant advances.

Lucky for the psychiatric visionary, Dr. Thomas Bateman was a fan. After navigating oceans of red tape and bureaucratic obstacles set in place by Wilhelm's critics, Bateman tracked down the aging Dr. Wilhelm and arranged to have him transferred into Bateman's care. Once removed from the sub-par conditions of a state facility, Dr. Wilhelm was made a guest of honor at Bishopsgate, where Bateman provided the psychotherapist with every freedom and privilege that one could imagine: an office, a private room in a low-occupancy wing of the hospital, as well as higher quality meals and reading material. Bateman used Reinholde as a resource of information for bringing DTT back into regular research. Bateman even embezzled funds so that he could step up the resources available to the researchers who had been assigned to the project. Though Reinholde Wilhelm died before the culmination of his work's revival, the effects of Bateman's efforts were more than he had ever bargained for.



Why did a man who had spent time at Bishopsgate hunt down Thomas Bateman after his imprisonment? Some say it has to do with his interest in DTT; others say it was God striking him down for giving birth to an otherworldly evil born of human madness. While experimenting with the DTT methods, Thomas Brakeman received funding from powerful pharmaceutical megacorporation Branston Medical. Unable to procure test subjects for its new dissociative anesthetic, Branston and Bateman made a backroom deal to assist Bateman in his research and to move Bateman into the next phase for the pharma's new drug. Although Branston was never satisfied with the outcome of the tests and canceled the run, Bateman got the better end of the bargain. Under the influence of the anesthetic, Bateman's DTT subjects experienced a terrifying effect.

By chemically suppressing the patient's physical body beyond anything that could be managed with electronic tones and relaxation exercises alone, Bateman put patients into a deep physiohypnotic state. As Bateman guided the patients through their issues, the combined effects of the therapy caused a black ichor to form in the mouths of the subjects that would bubble and coagulate as the therapy proceeded. The "displacement byproduct," as Bateman called it, was then stored for testing. As the experiments continued, more and more of the ichor was produced and, each time, took on a more and more definite form, eventually displaying fragments of bone and hair. It wasn't until the project had moved into its ninth month that the first of

the creatures was birthed from the ooze, taking the form of a distended, mucus-covered effigy of the subject, and filled with the subject's darkest most aggressive tendencies.

Easily incarcerated at first, the little monsters eventually became too many. Held captive in the basement out of view from the dangerous criminals imprisoned there, the homonculi, as Bateman called them, stirred restlessly. Though others on the project pressured Bateman to destroy the homonculi, he refused, as he saw them as proof positive that his take on DTT was not only effective but miraculous. That is, until the creatures escaped. Knowing that they would certainly come for him, Bateman abandoned the hospital and prepared to take his embezzled monies and leave the country. If not for the intervention of Branston Medical turncoats on Bateman's staff, he would have gotten away with it.

Though Bateman's projects have been brought to a rather final close, the manifestations of insanity given flesh in his work still exist and records of the method for their creation are still out there. Creatures of pure, Freudian id, these little monstrosities hide in the cracks and crevices of human society, searching for madmen with which to increase their numbers.

What Bateman's "children" actually are is really a matter of speculation. Though certainly not as advanced as the characters presented in **Promethean: The Created**, there are certainly ideas presented in the sourcebooks for that game that could enhance and give a deeper mythic color to Bateman's little monsters.

"I LOVE IT!"

LOCAL MAN SETS WORLD RECORD
IN CHOCOLATE PUDDING EATING
CONTEST OVER THE WEEKEND



LOCAL MAN DISCOVERED MAULED TO DEATH



Nathan Sodagi, 18, was found dead yesterday morning near his home in Pine Hill. Preliminary investigation seems to indicate that Sodagi was mauled by one or more wild animals, possible dogs or coyotes. Witnesses report hearing a muffled cry and barking sounds around midnight, but thought a raccoon

had run afoul of some local pets.

Sodagi was recently discharged from Bishopsgate Asylum, where he had been undergoing treatment for severe clinical depression. His mother, Ella Sodagi, 43, tearfully recalled their last conversation. "He didn't want me to pick him up.

He said that he didn't want me to see him there, but that he'd come over for dinner the next day and we'd all see how well he was doing. He said he was feeling happy for the first time and that he was thinking about going to college to be a psychologist or a therapist. This is unreal. I keep praying to God to take it back."



Chapter Four: Case Studies

The archives of Bishopsgate hold hundreds of case studies, patients who passed through briefly, patients who stayed for their entire lives, some who came back again and again. Some were cured. Some weren't. The doctors managed to explain some conditions. Some conditions they didn't. The records make for fascinating reading. Some people who were locked up a century ago who would have been thought perfectly sane now. Others who have been consigned to the secure wards in recent years who in previous decades would have been ignored as simply eccentric. And some could never be explained.

In the last few years, the staff at Bishopsgate Hospital have made a token effort to get their archives copied onto a database, but when there aren't even enough staff to run the whole building, spending hundreds of man-hours on data entry isn't high priority. The cases that fill these dusty filing cabinets are all too often forgotten. A long-serving member of staff might recall a case from years ago that might shed light on a current story, but without a name, the chances of finding it in the Bishopsgate archives are small.

New cases appear weekly with their own challenges, their own mysteries. They make it onto the system, but even so, it doesn't mean that they're necessarily any less of a mystery.

The Case Files

In the World of Darkness, psychological illness sometimes has supernatural causes. There really are ghosts. Possession happens. Lycanthropy and vampirism are more than just the names of delusional psychoses. Sometimes, people go mad because a hidden world has revealed itself to them, and they've cracked under the strain. Sometimes, they're not mad at all, consigned to a psychiatric hospital because, through perfectly reasonable efforts to face the supernatural evil that surrounds them, they pose a danger both to themselves and others. But mostly, they're just ill.

Each of the case files presented in this chapter has two explanations: one supernatural, one mundane. One version of each account is founded in the bizarre and the unnatural. In the other, the patient at the center of the mystery is simply mad. Each account is the springboard for a story, as players, taking on the roles of mental health professionals or those associated with the victim, investigate the root causes of their patient's madness. But which story? The supernatural version can be the foundation of an episodic chronicle, as the characters deal with one patient at a time, investigating one after the other and uncovering terrible truths.

The danger with this kind of chronicle is that madness becomes something cheap. If every insane person the characters meet turns out to be mad because of the "Monster of the Week," the net result is that madness becomes less of an illness and more the first clue leading to some supernatural monster. Mental illness becomes just another plot point leading to the supernatural source at the heart of every story.

That isn't to say that this can't be the foundation of a thrilling, horrifying, terrific chronicle, and certainly, this book gives a Storyteller all he needs to create that kind of game. Having every single patient of note in a psychiatric hospital turn out to be affected in some way by supernatural horrors can stretch

I have nothing to say on this point except that no madness of mine could account for all the evidence.

— H.P. Lovecraft, "The Thing on the Doorstep"



BISHOPSGATE MENTAL ASYLUM
(555) 555-7935
[HTTP://WWW.BISHOPSGATEHOSP.ORG](http://www.bishopsgatehosp.org)
ADMIN@BISHOPSGATEHOSP.ORG

Session Report — S.B.

Subjective: S.B. reports no change from last week, but the changes are obvious. Since the incident with Gary, and then learning of Nathan Sodagi's death, S.B. has grown quiet and withdrawn. Still, her manner is much different from when she first arrived. She obviously blames herself for Gary's termination and Nathan's death, but she won't talk further about why she asked them to do what they did. Patient seems more resigned and guilty than fearful. Medication seems to be having a lessened effect — check with night staff to make sure she's really taking it.

Objective: No exams given.

Assessment: S.B. doesn't seem to be responding to treatment. She doesn't seem to want to recover and go home, because she is still afraid that the animals that chased her and killed the Ulrich boy are waiting for her. She is, however, smart enough to change her behavior to make sure she remains in minimum security. It may be necessary to move her to maximum security to motivate her to improve, but her parents might not agree. Dr. Travis still wants to try ECT, but I'm not convinced this will be helpful, especially since she's cognizant enough to alter her behavior to manipulate the staff.

Plan: I'll tell her that I'm on to her and let her know that she might be discharged if she refuses to actually address what's happening. Let her know that she can help herself by telling me the whole story.

the limits of belief just a little too far. If insanity is always the result of malign supernatural interventions, what's to stop players reacting to the introduction of a new patient by immediately looking for the spooks (or werewolves, or vampires, or magicians or Frankenstein monsters)?

The hospital doesn't exist in a vacuum. Psychiatric institutions are linked to health authorities. Hospitals receive government subsidies. Doctors at a loss to treat patients share notes with other professionals in other institutions. If every important patient in a chronicle is mad because of monsters and magic, the authorities are going to take note. If someone in a reputable medical establishment *repeatedly* finds incontrovertible proof that supernatural phenomena of whatever kind exist, the effects could be seismic. One occurrence, even two, can be covered up or denied. The more objective Fortean phenomena the characters find, the harder things are to cover up. Suddenly, the whole axis of the world turns, and the next thing anyone knows, everyone knows all about it. (Mind you, this is a perfectly viable ap-

proach to what will invariably be an interesting game; such a chronicle simply lies outside the scope of this work.)

When the supernatural appears, it should have at least some kind of shock value. It shouldn't be certain whether or not a bizarre case is the result of something supernatural or just something weird.

When Uncanny Things Do Happen

It is a truism in the World of Darkness that when the supernatural events that *do* get noticed *will* get covered up. Bishopsgate, similar to many institutions, is built on fear as well as secrets. The psychiatric professionals who work here are scared of losing their jobs and their reputations. Scientific establishments — particularly in the World of Darkness — are reluctant to accept way-out theories that challenge their preconceptions of what should happen in an ordered, scientific world. Of course, while it might be tempting to



search for some grand conspiracy behind this fact, there is a simple explanation. Fear is behind it: fear of looking like a crazy person, fear of making a fool of oneself, fear of losing all credibility, fear of losing out on the next pay review while the guy in the next office succeeds, fear that every thing one has based one's existence and reality upon is now false. In the face of these fears, even good, honest people are likely to engage in tremendous levels of self-deception.

Doctors in Bishopgate *do* see the supernatural come to their doorstep, and they see it more than many others do. But they don't *acknowledge* it. Part of it is they don't recognize it. They don't understand how such a thing could exist, and so they don't accept the supernatural as even a possible explanation for what's in front of them. It just doesn't occur to them. There must be a reasonable explanation, and that explanation has no room for vampires, demons or ghosts.

Others don't want to see it. They desperately cling to their certainties about the world, about the laws of science and the way that the world *should* work. H. P. Lovecraft's oft-quoted assertion that "the most merciful thing in the world . . . is the inability of the human mind to correlate all its contents" holds true. Because if one of these doctors, even for a second, contemplated the idea that there really were these malevolent forces manipulating the lives and existence of the human race, the doctors might end up being the asylum's inmates rather than their keepers. So, the doctors deny the existence of this supernatural weirdness, even to themselves. The core of this fear isn't even fear of the supernatural — it is fear of the possibility that the supernatural may even exist.

Buying into Delusions

Psychiatric illness is a tragic thing. It removes dignity. It destroys relationships. Sometimes, a psychiatric illness is just an illness. People lose their reason because they are sick, or suffer a trauma of some sort. It might just be a chemical imbalance of some kind or a degenerative condition caused by genetics or environmental sources. Even so, an ordinary sickness can be a mystery. Something with a perfectly sensible reason can be inexplicable if that reason is missing.

A story can end with the discovery that a patient's condition has an explanation that, although it might be in its own way bizarre, has nothing to do with ghosts and spirits and monsters. Even a more mundane, human tragedy can be the foundation of a story as the characters, intent on finding something supernatural, face conflict from hospital authorities and patients' families.

No respectable code of medical practice has anything in it that says that buying into a patient's delusions and maybe even helping him to destroy the monsters he believes in under the terms of the delusion is an acceptable way to find a cure. Medical staff certainly can intervene, and it's perfectly reasonable to do background research, but taking stories of monsters and voices so seriously and maybe even beginning to believe them blurs the line between patient and doctor, in more ways than one. An imprudent and credulous doctor can easily end up suspended at best, or at worst locked up in another institution, far away.

Behind the Walls



BISHOPSGATE MENTAL ASYLUM
(555)555-7935
HTTP://WWW.BISHOPSGATEHOSP.ORG
ADMIN@BISHOPSGATEHOSP.ORG

Patient: Various

Attending Physician: Various – Report compiled by A. Moore, R.N.

Case Number: Various

Incident Report and Investigation

This is a strange issue, but following last week's unfortunate incident, it requires immediate attention. I have compiled all of the information I could find, but as I am going on maternity leave tomorrow I am leaving this matter in the hands of the administration, with the strong recommendation that they follow up.

Last week, as we all know, Martin Holly committed suicide while locked in Room 202, East Wing. He was discovered at bed check after a period of screaming. He had torn open his own wrists and mangled his own face so badly that he was completely unrecognizable.

For the benefit of others who might investigate this matter, some background is in order on both Holly and on Room 202. Martin Holly self-admitted to Bishopsgate six months ago following a nervous breakdown at work. He had been making progress with his anxiety, but in the last few months had become belligerent, abrasive and hostile toward the staff. At the beginning of last week, he struck a nurse and was warned that he would be put in Room 202 if it happened again. Later that week, it did. He was placed in Room 202 and was found as described a few hours later.

Room 202 was once used as a patient room, but for the last few years, it has served a different function. It has no furniture and padded walls, and is situated far enough away and in such a position that sound from the room doesn't carry out into the rest of the wing. As such, it makes a perfect "solitary confinement" room for unruly patients.

In doing some research, however, I found something extremely disturbing. The last six patients who lived in Room 202 before its conversion to a padded room all underwent a change in symptoms shortly after beginning their time there. Those symptoms, in all six cases, included the following:

- Auditory "hallucinations" of scratching, chewing and other rat-like sounds in the walls
- Feelings of being watched
- Painful sensations, often described as "bites"
- Nightmares about being eaten by small, carnivorous creatures (the specifics varied, but the dreams were remarkably similar)

The similarity was not noted previously because the patients had markedly different pathologies and so were seen by different doctors and psychologists. Notes were never compared. It wasn't until the last patient to inhabit that room (the son of a wealthy family) complained to the administration that the room's function was changed.

This obviously has some disturbing implications. If the administration knew that the room was infested, why did they not arrange for an exterminator? If they discovered that other patients had similar complaints, why did they not investigate the matter further? In fairness, I must admit that I haven't been able to find any records of such investigation or of an attempt to rid the area of pests, but such records might be kept someplace to which I don't have access.

In any event, I was able to find records of the construction work done on the room (removing the bed, placing the padding on the walls, etc.). Following that, the threat of "Room 202" became a great motivator for keeping patients in line, and very few patients ever actually visited the room. I interviewed two patients who were incarcerated there for a few hours (there are two other patients who were, but one is catatonic and the other would not talk to me). Without priming them, I asked them about their time in Room 202. They responded that they heard strange sounds, "like rats in the walls," and felt odd, painful sensations "like little teeth."

Of course, it is possible (even probable) that these patients heard stories about Room 202 from other patients or even staff and told me what I was expecting to hear. The obvious test would be for a "control," a person with no psychological illness, to spend some time shut in Room 202, but I freely admit that I am not brave enough to undergo such an experiment (certainly not at 34 weeks pregnant!). I have, however, entered Room 202 with the door open and the lights on. I pressed my ear to each of the walls and to the floor, and I did not hear any of the sounds that the patients described. I opened the padding on the wall and found no evidence of nesting, and no droppings. Room 202 is on the other side of the building from the common room and other food areas, there is no visible access to the outside and there is no evidence of mold or other exposure to the elements. If the room is infested, it is infested by the most careful and intelligent rodents I have ever seen.

All jokes aside, clearly *something* is wrong with Room 202. Martin Holly had never harmed himself before, and yet he tore chunks of his own flesh out with his teeth, ripped out his own eyes, chewed back the skin on his wrists and tore them open. He died of blood loss and traumatic shock. Room 202 has since been cleaned and the padding on the floor and walls replaced (although a patient walking by the room yesterday started screaming that she could "still see Martin's blood").

Recommendations

I recommend three courses of action be taken immediately: 1) Stop using Room 202 for patients for any reason. 2) Appoint a committee of people, preferably from outside Bishopsgate and preferably with some experience with psychiatric medicine to investigate the room. 3) Interview all past patients who spent time in Room 202 and determine when the problems started.

Game Systems

Room 202 can be used in a chronicle in a number of ways. It can highlight the conditions in Bishopsgate and the general problems with the health care system. That is, it's easier to gloss over a problematic situation by making sure that consequences get avoided rather than problems get solved. The people who made Room 202 what it is and enabled it to keep harming patients didn't do so out of malice, but because of apathy, laziness and pressure from the administration (or, perhaps it is a matter of malice; see below).

Room 202 can also be used to bridge the gap between the supernatural and the asylum. What if the "rats" in the walls of Room 202 have been chewing for quite some time, and have opened up gateways out of the asylum and out of the physical world? The next time someone peels back the padding, where might they wind up? Or what might try to poke its way through into our world?

Finally, a chronicle in which the characters are all "trapped" in the asylum, either as patients or staff, might benefit from Room 202 as a constant threat. The creatures that live there can escape when they want to and terrorize people, but they can disappear in seconds, so there's



no point complaining. All the hapless inhabitants of the asylum can do is try to endure and maybe find a way to trap the monsters.

Below are several possibilities for what's happening in Room 202, as well as facts that investigators might uncover as they research it.

Option One: Rats in the Walls

The creatures in the walls are rats . . . after a fashion. They are spirit-beings called Rat Hosts, known in some circles as *Beshilu*. These little monsters occasionally possess people, burrowing into their stomachs and eating their hearts, then “driving” the corpse around until it falls apart or until the rat gets bored. They can also consume eat other, resulting in huge rat-like creatures. But the ultimate goal of the *Beshilu* is to chew holes in reality, allowing the spirit world and the world of flesh to merge or spill into one another. They are crazed, chaotic beings . . . and they have been chewing at the “walls” between spirit and flesh in Room 202 for a long, long time.

Why haven't these possessed any of the previous patients? Who says they haven't? Maybe Martin Holly killed himself rather than become one. Maybe they possessed him anyway, and the *Beshilu*-thing he's become will be found searching the local hazardous waste dump looking for the bits of flesh that Martin bit off in his mad frenzy.

Though there is enough information here for inventive Storytellers to expand upon, more information on *Beshilu* can be found in **Werewolf: The Forsaken**.

Option Two: The Nest

Room 202 is a *locus*, a place where spirits can enter the physical world (though they can't stray far from the locus and must return before they run out of energy). The locus was born out of the fevered imagination of the first patient to inhabit the place, and has been fed by the delusions of everyone there since. The “bites” that patients feel and sounds they hear are the spirits, some of which do look like rats, but others are humanoid or insectoid, trying to drive the patients to even greater depths of madness. Martin Holly was their greatest success, and now the locus is more powerful than ever. It's only a matter of time before a powerful (and probably malevolent) spirit notices the locus and uses it as a watering hole. Other potential visitors to the locus include werewolves (who can use such places to step back and forth from the spirit world), mages (who might be interested in studying the spirits there) and even vampires (some of whom might be fascinated by the predator aspects of the place). Game traits for these spirits appear below.

Option Three: Vicious Creatures

The things in the walls aren't rats, but they're very much alive and hungry. They feed on blood, like bedbugs, and they

don't require much . . . at least, not when they're still young. The bites that patients felt were exactly that, but the creatures were so small at that point that there were no untoward marks (none that got reported, at least). Martin Holly, though, completely lost his nerve in Room 202 and tore himself apart. The massive amount of blood spilled fed the creatures, and they are now big enough to start eating flesh. They are territorial, though, and are happy to wait until someone is alone in Room 202 before attacking. Game traits for these creatures appear below.

Option Four: Madness

There are no creatures in Room 202. Some time ago, a pair of orderlies discovered that a heating vent ran from their locker room straight up past Room 202. They amused themselves by banging on the vent and running fans and other loud machinery next to it to produce odd sounds. This "prank" escalated — the orderlies even laced the bedsheets for the room (and later the padding) with stinging nettles, which provided the "biting" sensation. After Martin Holly died, though, they have taken care to remove all evidence of their activities. Because their actions could lead to jail time, they might even seek to make Ms. Moore's report — even Ms. Moore herself — disappear before anyone goes digging too deeply.

Investigation

Characters looking into the mystery of Room 202 might learn the following:

- **Blood on the Sheets:** Conversations with the laundry staff reveal that sheets and clothing from that room had tiny flecks of blood. The staff never reported it because most of them don't speak much English. They were sure no one would care, anyway.
- **Possessions:** Past residents of Room 202, after being released from Bishopsgate, sometimes report "lost time." This is largely assumed to be a side effect of their medication, but it seems to coincide with incidents in Room 202. The spirits that once bedeviled them, it seems, have made a lasting impression.
- **Haunting:** Martin Holly didn't leave Room 202. His quiet ghost lingers on, trying to warn others against entering the room. Just as many ghosts, though, he is confused about his condition (being mentally ill before he died didn't help), and tries to "warn" people by causing cryptic messages to appear on walls and mirrors, odd sounds to emanate from corners (leading away from Room 202) and other classic haunting signs. See the information on ghosts on pp. 208–216 of the *World of Darkness Rulebook*.

Room 202 Creatures: Spirits (Rank 1)

These creatures' traits function much as ghosts'. The creatures are considered to be in Twilight, but cannot leave Room 202 at their current level of power.

Quote: <skittering, squealing rat-like noises>

Description: These spirits are no bigger than cats, but they vary in form. Some resemble rats, some are tiny humanoids with vicious fangs and tiny, wriggling tails and

some are spider- or insect-like horrors, with wings and glistening chelicerae.

Storytelling Hints: These spirits feed on fear and madness. Bishopsgate is perfect for them, but they are restricted to the spirit world until they can make the locus in Room 202 more powerful. If it grows in power, the spirits can remain in Twilight and spread throughout the floor . . . and one day the whole facility.

Attributes: Power 2, Finesse 4, Resistance 2

Willpower: 4

Essence: 10 (max 10)

Initiative: 6

Defense: 4

Speed: 16 (species factor 10)

Size: 1

Corpus: 3

Influences: Madness 1

Numina: Animal Control (rats only), Possession, Terrify (see pp. 211–212 of the *World of Darkness Rulebook* for systems for these Numina)

Room 202 Creatures: Monsters of Flesh

Description: These creatures are no bigger than large rats, or perhaps small woodchucks. They move on all fours, but are capable of sitting up on their haunches. They have gray flesh, wicked black teeth and four eyes situated high on their heads (they can see in 360 degrees).

Storytelling Hints: Where did these monsters come from? Are they spirits who learned how to remain materialized? Are they mutations, escaped from a laboratory somewhere? Are they cryptids, monsters that science never discovered? Refugees from a mad wizard's summoning circle? The characters might never learn the truth. All that matters in the short term is that these creatures are hungry, and they are growing.



Attributes: Intelligence 1, Wits 3, Resolve 2, Strength 1, Dexterity 4, Stamina 3, Presence 0, Manipulation 0, Composure 2

Skills: Animal Ken (Rats) 2, Athletics (Climbing) 3, Brawl (Bite) 2, Stealth 4, Survival 2

Merits: Fast Reflexes 2

Willpower: 4

Health: 4

Initiative: 8

Defense: 4

Speed: 15 (species factor 10)

Size: 1

Weapons/Attacks:

Type	Damage	Dice Pool	Special
Bite	0 (L)	4	Usually attack in groups of at least 5

The Doppelgänger



BISHOPSGATE MENTAL ASYLUM

(555) 555-7935

HTTP://WWW.BISHOPSGATEHOSP.ORG

ADMIN@BISHOPSGATEHOSP.ORG

Patient: Various

Attending Physician: Various - Report Compiled by M. Case, B.A. (Student Intern)

Case Number: None

Incident Report

As part of my internship at Bishopsgate, I have been interviewing as many of the patients as I can, in part for my own research for my master's thesis and in part to test out some of the new psychological tests made available to the facility. Over the course of my work, I have gotten to know many of the patients quite well (especially in minimum security), and recently one of those patients shared a strange story with me. I was recording the conversation; the transcription of the relevant section follows:

Charlene Brezniak: There's a monster here in East Wing.

Matt Case: A monster? What do you mean?

CB: It's a monster. It can look like anyone it wants to.

MC: But you can recognize it?

CB: No, not always. I don't think it comes around during the day. I see it most often at night.

MC: How do you know when it's here, if it can look like anyone?

CB: I don't know. Sometimes if you look at it right, you can see it kinda ripple. Like water or smoke. Sometimes somebody walks into the room, and Mike'll say, "Hi, Bill!" [Bill refers to the orderly, Bill Carlyle] But then Josh'll say, "That's not Bill, that's Steve." [Not sure who "Steve" is.] And that's how I know to look, when two people see somebody different.

MC: But if it can be whoever it wants, why -

CB: No, no, not whoever it wants. I think maybe it becomes who you expect to see. And then it drinks your breath.

Consent Form

MC: What?

CB: I saw it in the corner. It was kissing Amy [Amy Moore, a nurse currently on maternity leave]. At least I thought it was kissing her, but then she stumbled and it disappeared.

MC: Disappeared?

CB: Like smoke.

Charlene, the woman who told me this story, self-admitted to Bishopsgate after her teenage son committed suicide. She is lucid and intelligent, and only takes medication as needed for depression. She has no history of hallucinations or any other kind of psychosis or thought disorder, so when she told me this story, it gave me pause. I asked her if anyone else had seen the "monster," and she told me that no one wanted to talk about it.

I interviewed a few other people in minimum security, including Mrs. Moore (via telephone). She told me that she had, some months ago, passed out while on the clock, but it was in the early weeks of her pregnancy and she hadn't eaten that day. She said that Charlene was probably getting a little stir crazy (she has since been discharged, and is apparently doing quite well), and might have been poking fun at me. I decided to ask around some of the patients; Mrs. Moore advised me to avoid "priming" them so as to avoid bias.

What I found was interesting, if not remarkable.

Good

Of the 28 patients in minimum security at the time, 10 were unable or unwilling to speak with me. Of the remaining 18, six of them told stories similar to Charlene's when I asked them if they'd seen anything strange in Bishopsgate (all of them had stories to tell, but 12 out of the 18 told stories consistent with their disorders). These six patients were all self-admits, three for depression, two for anxiety and one for agoraphobia. Similar to Charlene, none of them were predisposed to seeing things.

It's possible, of course, that Charlene told them what to say, but the details varied enough while remaining internally consistent to make me think that something strange is happening in minimum security. All of these patients told specific stories about people seeing someone walk into the room but "recognizing" the new arrival differently. In all cases, the "people" whom witnesses saw made sense in context; no one ever saw the Pope, for instance, but employees of Bishopsgate and family members were common. It was as though whoever walked through the door appeared to these people as whomever they expected or wished to see.

This by itself was strange, but then I looked into the hospital records and looked at the codes for the nights (always nights!) that these incidents occurred. In all six cases, someone passed out, vomited, tripped, fell asleep in a strange place or reported dizziness or weakness. It was never the same person twice, and never the person who reported seeing someone. Other such reports (dizziness, fainting, etc.) happen on other nights, too, of course. There doesn't seem to be a pattern, but rarely does a week go by without something like this happening.

Of course ... you're in a hospital jackass

Charlene said that the monster drinks people's breath. Many cultures have legends about creatures that do exactly that. We're all familiar with Western legends of vampires. *I thought they drank blood*

Ghosts, though, in some stories do so as well. ~~They are supposed to steal the breath of sleeping people.~~ A German legend talks about the *doppelgänger* or "co-walker," a ghost that takes the form of a living person. And here were have witnesses talking about something that takes the form of whoever the people around it are expecting to see. Meanwhile, other people collapse or grow weak when it is near.

To say the least
Obviously, all of this sounds rather far-fetched. But the fact that people who have neither seen the "doppelgänger" nor the people who witnessed the doppelgänger have collapsed, vomited or otherwise been afflicted is significant because it implies that the doppelgänger is attacking the people who don't see it at all. It strikes only at night, when staff is minimal and those on staff are tired, and most of the patients are in bed. How many more patients might have had their breath stolen while they slept? *This is ridiculous*

That's Confusing
One of the lingering questions is: Why the East Wing? Why does the doppelgänger not haunt the higher-security wards, where many more people have died over the years? Note that I'm not suggesting there ~~is~~ *yes you are* a ghost present in Bishopsgate, I'm simply stating that *something* is going on, and it requires us to keep open minds about possible causes.

Let's not open our minds so much that our brains fallout, OK?

I would like to stay on at Bishopsgate and write my thesis on the doppelgänger, try to figure out where these stories come from, whether Charlene Brezniak spread the story around before she left and, in short, whether there is a rational explanation for these occurrences.

MATT: YOUR INTERVIEWS ARE GOOD, AND YOU'VE GOTTEN GOOD REFERENCES FROM BISHOPSGATE, SO I'LL LET YOU STAY. BUT YOU CANNOT GO INTO THIS WITH THE ASSUMPTION THAT THERE'S A GHOST. YOU NEED TO PROCEED LIKE A SCIENTIST, FIGURE OUT WHAT'S REALLY GOING ON AND THEN WRITE YOUR THESIS ACCORDINGLY.

Game Systems

The doppelgänger is meant as a target for characters to investigate. Going into the story with the assumption that the doppelgänger is a ghost can make for a nice twist later on when it turns out to be false, or it can prove correct, depend-

ing upon your desires for the story. A ghost story requires that someone died at Bishopsgate, which, as these other case files indicate, isn't at all hard to arrange, but there are other possibilities, too. Several options for the true nature of the doppelgänger are listed below, along with evidence that characters might discover if they go searching.

Option One: The Vampire

The “doppelgänger” isn’t a ghost at all, but a vampire who has mastered a Discipline called *Obfuscate*. This power cloaks the vampire from the sight of those around him, but an advanced application of the power allows him to appear as the person a given witness expects to see (as described in Mr. Case’s report). The vampire uses this power to move through minimum security and feed on patients and staff, but doesn’t chance going into the maximum security wing, both because he isn’t sure how his power would work on people with such advanced pathologies and because he isn’t sure he could get out again. He has no desire to kill his victims, but if scrutiny starts to heat up at Bishopsgate, he will figure out who’s searching for him and eliminate them — the asylum is too good a hunting ground to lose. Characters might discover Matt Case’s paper after reading about his untimely death at the asylum, or they might be tracking the vampire from another location and follow him to Bishopsgate.

Option Two: The Ghost

Matt Case is right. The being stalking the minimum security wing of Bishopsgate is a ghost. The ghost has the unique ability to change its form, but can only do so by pulling images out of people’s minds. It is barely self-aware and searching for a purpose to its existence, but just as many ghosts, it causes harm to others by doing so. It consumes the breath of living people when it tries to talk with them, and though it hasn’t killed anyone yet, it is probably a matter of time.

Who is the ghost? How did this person die, and why is it haunting Bishopsgate? These are questions for the Storyteller to answer, perhaps in conjunction with one of the other case files presented in this chapter. Game traits for the ghost are provided below.

Option Three: Madness

Matt Case got a little overexcited. Charlene, feeling a bit annoyed at Case’s condescending attitude, told him a story, noted his reaction and then told several of other patients. They took the story and ran with it. Matt, however, stands to lose his assistantship and set his schooling back considerably unless he can produce something interesting out of this “ghost story” (even if he can’t find an actual ghost), so he isn’t through with Bishopsgate yet. If he discovers that Charlene deceived him, he might decide to get back at her somehow.

Investigation

Obviously, if you as Storyteller decide that the doppelgänger is a ghost, you’ll need to decide on who this person was, how he died, what his anchors are (see p. 209 of the **World of Darkness Rulebook**) and how he might best be laid to rest. Other avenues of investigation might lead characters to the following discoveries:

- **Matt Case’s Agenda:** If the characters research Matt Case a little more, they find that he isn’t an intern, and he’s not

even a college student. He is researching Bishopsgate for his own reasons, and his discovery of the doppelgänger was entirely accidental (he might even have fabricated the whole thing, paying off or threatening patients to go along with the story). What is Case really after? He might be a reporter seeking to expose corruption at Bishopsgate. He might be a paranormal investigator looking into reports of strangeness at the asylum (which, again, could tie into other stories). He might have lost someone close to him in Bishopsgate and be seeking to free her.

- **Patterns of Breathlessness:** The characters might come at this story from another direction. They find that nursing homes, maternity wards, asylums and other such facilities experience a “doppelgänger” phenomenon, complete with people getting sick and collapsing. But at these other facilities, the cycle ending in death — sometimes as many as a dozen people died in their sleep.

- **Administration:** If the characters talk to members of the Bishopsgate staff, the characters find similar stories of the doppelgänger (someone walks into a room and is recognized differently by different people). When the staff is involved, though, the being’s appearance seems to stabilize quickly, leaving someone in the room thinking “Why on Earth did I think that was Bill instead of John?” or the like. The staff does not report the same ailments, though; apparently the doppelgänger walks among the staff but does not feed on them.

Doppelgänger: A Ghost

Attributes: Power 3, Finesse 5, Resistance 3

Willpower: 6

Essence: 9

Morality: 5

Virtue: Hope

Vice: Gluttony

Initiative: 8

Defense: 5



Speed: 18 (species factor 10)

Size: 5

Corpus: 8

Numina: Breath Stealing (dice pool 8), Ghost Sign (dice pool 8), Compulsion (dice pool 8), Mimic (dice pool 8) and Telekinesis (dice pool 8)

• **Breath Stealing:** The ghost can replenish its Essence by stealing the breath of living people. This requires that the ghost "touch" the person, though the victim doesn't have to be able to see the ghost. Roll Power + Finesse - victim's Stamina. Every success inflicts one level of bashing damage to the victim and bestows one point of Essence on the ghost.

• **Mimic:** Similar to Phantasm (see p. 212 of the *World of Darkness Rulebook*), but much more specific, this Numen allows the ghost to take the form of specific people. Thus far, the ghost can only take the form of people who appear in the surface thoughts of the living, but if the ghost grows more powerful it might gain the ability to choose who it mimics. The ghost must first manifest to use this power, but it can activate Mimic in the same turn that the ghost manifests (see p. 210 of the *World of Darkness Rulebook* for rules on Manifestation). Spend one Essence and roll Power + Finesse. If the roll succeeds, the ghost takes on the physical appearance of whomever the people who witness it are expecting to see. This doesn't give the ghost any insight as to who it appears to be, but the ghost usually doesn't care.

The Girl from the Snow



BISHOPSGATE MENTAL ASYLUM

(555)555-7935

[HTTP://WWW.BISHOPSGATEHOSP.ORG](http://www.bishopsgatehosp.org)

ADMIN@BISHOPSGATEHOSP.ORG

Patient: Jane Doe

Attending Physician: Dr. Tucker R. Jenkins

Case Number: BG-1012

Description and History

Jane Doe. Apparently some age between 18 and 23. Caucasian, five feet five inches tall, 107 pounds. Red hair, brown eyes. Hospital examination prior to admission to Bishopsgate shows that she's had a child at some time in the past.

She's been in Bishopsgate a month and a half now, and no one seems to have any idea where she's from. Missing persons records have drawn a blank statewide; we're currently in the process of looking farther afield.

Her initial appearance was pretty odd. The local papers, unsurprisingly, told the story in a rather sensational manner, but as far as I can make out, the facts are something like this: she walked into a diner in Normanstown, Grange County, on the morning of January 17th this year, from the direction of Windy Ridge. She said she was hungry and asked for food. She was filthy and completely naked. Although the temperature outside at the time was something like 15 degrees, she apparently - and this is according to her attending physician at the local emergency room (see attached), where she inevitably ended up - showed none of the symptoms of exposure.

At the hospital, she showed some confusion when nurses tried to dress her. When they asked her what her name was, she was similarly disoriented, apparently asking one of the nurses if she needed one. Other questions were met with equally strange answers. When asked where her home was, she pointed towards the mountain. She had forgotten if she had parents, she said. She answered questions about a boyfriend or husband - after the nurses explained the words to her - in a slightly more positive fashion. She said there was someone, but when asked what his name was, she said that he didn't have one either and apparently asked if that was a problem. Finally, when asked about her children, she said nothing at all. That was all the hospital staff could get out of her.

Since she was in perfect physical health, the hospital wasn't able to hold her any longer. Her attending physician referred her case to me. I drove out to Ratcliffe and after meeting the patient and consulting with Dr. McClusky, we decided to admit her to Bishopsgate as a *pro bono* case, at least until some family turn up.

Treatment

Dr. Tucker Jenkins, tapes, Case BG-1012, Jane Doe; January 23rd, transcription (Extract):

TUCKER JENKINS: Can I call you Jane?

JANE DOE: Why?

TRJ: Because I want to be able to call you something until we find out what you're really called.

JD: Why?

TRJ: Because - uh, it helps us to know who you are.

JD: I know who I am. I'm one of Us.

TRJ: "Us"?

JD: Yeah.

TRJ: So, does that make me one of Us?

JD: No. You're one of Them.

Dr. Tucker Jenkins, tapes, Case 10121, Jane Doe; January 26th, transcription (Extract):

JD: I don't like it here.

TRJ: Why not?

JD: It's too square and . . . and like it wasn't made.

TRJ: Wasn't made?

JD: With hands.

TRJ: Did you build things with your bare hands?

JD: We did. Yeah.

TRJ: Who are "We"?

JD: We. Us.

TRJ: Where are the others?

JD: Up the mountain.

TRJ: Where?

JD: Under the snow. Under the earth.

TRJ: Underground?

JD: In the tunnels.

TRJ: What tunnels?

JD: The tunnels we made. My home.

TRJ: And you . . . and your friends . . . you lived in the tunnels?

JD: Yes.

TRJ: Tell me about your friends.

JD: Why?

TRJ: Because if I know about your friends, I might be able to help you.

JD: You'll help me get out of here?

TRJ: Yes. I'll help you to get out of here. I'll help you to find out - what happened.

JD: I know what happened.

TRJ: What happened?

JD: I got old. I got sent down the mountain.

TRJ: Because you got old?

JD: Yeah.

TRJ: Is that what happens when you get old? You get sent down the mountain?

JD: No. Not usually.

TRJ: So what usually happens?

JD: Someone gets old, we eat them.

[pause]

TRJ: What do you think is "too old"?

JD: As old as I am.

TRJ: Do you know how old you are?

JD: Yeah.

[pause]

TRJ: So how old are you?

JD: Too old.

[pause]

TRJ: So why didn't they eat you?

JD: My boy didn't want to eat me. And he talked the rest of Us round. He said I was special.

TRJ: Why were you special?

JD: Because we made a baby. Because I had a baby.

TRJ: And your - boy - he was the father?

JD: Yeah.

TRJ: And hadn't any of the others made a baby?

JD: There was one who had a baby coming when I left. But it hadn't come yet.

JD: And there were a couple before me who nearly made babies. But something went wrong. One got sick and the baby came out too early and it was all covered in blood and half-made and dead. And one made it all the way, but the baby came out wrong and she died. And the baby died. And we all cried. Because she was one of Us.

JD: Then we had to eat them.

TRJ: You had to eat them? Why did you have to eat them?

JD: Because we did. Because we had to carry on living.

TRJ: But they didn't eat you?

JD: No.

JD: Most of the other girls wanted to. Some of the boys, too. But my boy wouldn't let them. My sister wouldn't have, either.

TRJ: You have a sister?

JD: I had a sister who was older than me.

TRJ: Older than you?

JD: We ate her.

JD: She got too old.

[pause]

TRJ: But you have a boyfriend. And he's still up there?

JD: Yes.

TRJ: With your baby?

JD: I think the other girls might be looking after the baby.

TRJ: Do you miss your baby?

JD: Yes. I -

JD: [sobs]

TRJ: It's OK. You can cry. It's OK.

Dr. Tucker Jenkins, tapes, Case BG-1012, Jane Doe; January 26th, transcription (Extract):

JD: We lived in the tunnels. In the snow. And when the snow melted, we went under the earth.

TRJ: How long had you been there?

JD: We don't know.

TRJ: Had you always been there?

JD: No. We knew we had been somewhere before. But we forgot.

JD: We forgot what our names were. I guess we didn't need them.

JD: We forgot everything we used to know. We let our hair grow. Our skin got thick. From living in the snow. We started over.

TRJ: How did that happen? Why did you forget?

JD: It just happened. The mountain wanted it that way.
The mountain kept us safe. The mountain loves us.

TRJ: But if the mountain loves you, why does the mountain make you and your friends eat anyone who gets too old?

JD: Because that's the way things have to be. It isn't personal. The mountain doesn't mean to hurt us. It's good to us.

TRJ: How do you know that?

JD: We just know. It's just how things are.

TRJ: How do you feel about the mountain?

JD: I love the mountain. We sing the hymns every day.

TRJ: Hymns?

JD: Golden hymns of praise. Hymns of love.

TRJ: To God?

JD: To the mountain.

TRJ: So the mountain is like God – is that right?

JD: No. It's a mountain.

TRJ: OK.

[pause]

TRJ: Could you sing me one of your hymns now?

JD: Don't be silly. I'm not there.

TRJ: Right. So . . . do you want to go back?

JD: More than anything else. More than breathing. You can't know what it's like. Having the mountain loving you . . . feeling the mountain in *here*, inside me, in the back of my head. And now it's gone. And I'm just alone. In my head.

JD: And I can't go back. I want it, I want it so much, but I can't.

TRJ: Why?

JD: I'm too old.

Plan

So. It seems that the mystery of our Jane Doe has been cleared up. Or at least, one mystery has. In the end, it was Trisha who thought of it. She got hold of the yearbooks from about six to eight years ago, which is about when she would have been there. Grange County Junior-Senior High School, of course, held the main catchment for Barnstaple. It was a long shot, really.

It turns out that Trisha was right. I've got the book in front of me as I say this. She's on page thirty-nine. Her name is Regine, Regine Butler. Born January 17, 1988. Girl most likely to be a millionaire by 30, it says. Class president. Looking only slightly younger. Her hair's a little longer, but I've got no doubt. I don't think I ever did. We got hold of the records from Grange Memorial. Regine had had her appendix out when she was 16, and there was enough in their records to make a positive ID. It only took a few tests. It's her.

Which is, I suppose, a step forward. But only in some ways. I called her by name this morning. She didn't register the least bit of familiarity. Knowing who she is might help us, but it's not even the first step to her recovery.

And then there's the issue of her reappearance. The problem is – I mean, the issue we have, the difficulty with all this – is, well, the Barnstaple disaster happened more than two years ago. And Regine, she was on the list of the missing, she along with her whole family. Since then, the whole Grange County area's had three of the hardest winters in living memory. Which begs the question, where has Regine been? It's feasible enough that she should somehow survive the disaster. That happens. It happened. Like those kids who had to go to the school for vacation lessons, so they were out of town when the mountain came down. And sure, you hear about people managing to live out in the wilds for years on end, but the way they found her – how do you explain that?

And then there's her condition. The amnesia is one thing. What makes it so unique is the way that it's married with a delusion. Like the other children of Barnstaple survived under the snow. It makes a kind of sense that she should imagine the other

children surviving. If, assuming that she somehow *could* survive for two years or more up that mountain, the trauma could bring about a textbook dissociative psychogenic fugue. Global amnesia is then supplemented by a rich fantasy life. The invention of a tribal society of children with its own rules and its own religion makes a kind of sense. She lost her friends, her parents and her contemporaries. The religion, based around veneration of a beneficent mountain, also makes sense in the way that Stockholm syndrome makes sense. The mountain takes everything away, the mountain kills; Regine, a prisoner of the mountain, sympathizes with the mountain.

The fact that at some time in the past Regine has had a baby almost certainly has some bearing on her condition. I can't imagine that as a teenage mother, it would have been easy for her in that little town, and the distress caused by whatever she had to go through could have been a contributory factor to the loss of her psychological balance.

All this is conjecture. Few cases of this have come up. Past evidence, such as the David Fitzpatrick case, for example, suggest that there isn't an enormous amount we can do. We can attempt to help her deal with her delusions — mild application of antipsychotics would help, I expect — but I think that her memory isn't going to come back any time soon. Once we've got to the heart of those delusions, and I think we have, the only thing is to chalk it up to mystery and let her out, so she can try to piece some sort of life together.

Still. I wonder where the child is now. It strikes me that the truth of her condition — and its possible resolution — lies somewhere on that mountainside.

THE MAN WITHOUT A PAST

A real world case study: In December 2005, Briton David Fitzpatrick passed out while walking in London. When he came round, he knew how to walk, speak English and read and so on, but apart from the basics, he didn't know anything. It was all gone, wiped from his brain. He had to start completely from scratch.

It was a well-publicized case, and it stands to reason that Dr. Jenkins would connect the dots when faced with something that seems, on many levels, very similar.



Game Systems

In the aftermath of any disaster, modern-day myths proliferate. Some have a ring of truth. But in the wake of the Barnstaple tragedy, with an entire community vanishing under snow and earth, there were no stories, except the one that Regine, in her strange, broken way, tells. But how true is it?

Option One: The Carnibal Children

Jenkins is almost completely wrong in his assessment of what caused Regine's condition.

In 2004, Windy Ridge awakened. The mountain became conscious. A strip-mining site some 15 miles from the peak of the mountain, a source of employment for a large proportion of the men in Barnstaple, caused the mountain so much pain that it reached out and the mind of the land — not a spirit, not a being inhabiting the land, more a kind of gestalt entity composed of the living land itself — appeared as new in the heads of the children.

The sentience of an ecosystem is not the same as human sentience. Its needs, its thoughts are different. It blossomed in the minds of the nearest community — Barnstaple — and changed them. The mountain's power was limited to the children and teenagers of the community. Maybe they were weaker. Maybe their psyches were more open, more fresh. Maybe it was another reason entirely. Whatever the reason, one night, every single sleeping human being under 17, and a fair proportion of 17, 18 and 19 year olds, heard the call of the mountain in their dreams. It told them that it loved them, and that the world would change, and that they would be spared. And the following morning, every one of those children behaved strangely. Some hid in the cellar. Some pretended to oversleep. Some found manholes in the street and hid in the sewers. And at 10:35 that morning, the mountain came down on Barnstaple.

And the children were spared. They were untouched by the avalanche.

They began to burrow in the snow, making a vast complex of tunnels, and then they burrowed into the sludge

that had come down with the snow. Under the rocks and mud and snow, the town of Barnstaple lives again. Over time, the mountain wiped away the children's memories, taking away names and memories of parents and homes, wiping away inhibitions.

They became part of the mountain. They are still there, naked and feral. Still human, they interpret the mountain's presence in their minds as the marks of a divine being (although they don't or can't allow themselves to use words like that) and they worship the mountain. On quiet days, the wind carries their crooning songs of praise across the mountain range. The mountain wants its children to persist.

The mountain's sentience depends upon the children. But as they grow older, the mountain's consciousness loses its hold on them, one by one. Mostly, the others fall upon their former friends and eat them. Realizing that they've lost something, the older teenagers allow themselves to be eaten. The children allowing Regine to go is a new thing. It's a sign that the mountain's power is diminishing as the population of children (there were only 33 to begin with) falls. Some got old and got eaten. Some died in accidents: characters who investigate news archives will find reports of the unsolved death of a lone naked boy, aged about 13, found at the base of an escarpment with his neck broken. Some have fallen foul of animals (there are bears on the mountain) or disease. Although the mountain is pushing the children to make babies — such as Regine's child, born a year ago — the population is falling faster than it rising. Within a few years, there will be fewer than 40 children. Then the mind of the mountain will fade, and although the children's minds and memories can never be restored, the mountain's hold on them, its power over the fabric of the land fades and the mountain slumbers again.

The mountain doesn't really think in these terms (if "thinking" is even remotely close to describing the way the mountain's sentience works), but it wants more children. It's losing the battle.

Option Two: Child of Tragedy

Jenkins is mostly right in his diagnosis. He's just missing a few facts. There isn't a tribe of feral, cannibal children up there. Regine spent the last two years on her own. Regine's father, Clayton Butler, was scared of the government. Clayton was fired up by reports of the recent siege at Ruby Ridge, Idaho, and so in early 1993 he began to build a bunker halfway up the mountain. Most of the family finances went into planning, digging, building, arming and supplying a bunker that, he hoped, would keep his family safe for a year or more should the government choose to enforce the will of the New World Order with violence. His wife Vicki agreed with him. Clayton and Vicki's daughters Regine and Kimberley, although home-schooled, weren't quite as dedicated to their father's ideals.

When Regine got pregnant, she kept it secret from her mother and father as long as she could. Kimberley knew, and

Investigation: Crippled Boys of Hamelin

The Storyteller might wish to add this piece of information to the investigation should he decide that the "Cannibal Children" scenario is true. The parents of Reed Davies, 13, and Bryan Hughes, 14, were concerned that both boys were set to flunk the semester. They enrolled both of them for vacation school in Grange County Junior-Senior High School. That's where the boys were when the disaster happened. Their parents and all their friends were lost.


The two boys, who are both now in foster homes on the other side of the state, know the truth about what happened, and live with the knowledge that they were deprived of a promise land, of sorts. The grief and shock Bryan and Reed expressed at the time was naturally interpreted as being due to the loss of everything they knew; actually, they were more pained at the loss of their chance to join the children of the mountain in the tunnels.

Neither boy is well adjusted. No one thinks that's unusual. Any medical professional with reasonable contacts with state health authorities should be able to find the boys in a short time.

By the time anyone finds them, they may already have run away. The boys have been are planning to run away to the mountain for some time. Bryan, now 16, has just got the keys to his foster-father's car, and both boys have girlfriends whom they've managed to talk into joining them. The girls don't really know why going to the mountain is so important. When they feel the touch of the mountain in their minds, of course, the girls will understand perfectly.

kept it secret too, but there's only so long a pregnancy can be hidden, and eventually Clayton found out. On December 19, 2004, Clayton, enraged, locked Regine and Kimberley in the bunker, meaning to let them out and do something about his daughters in a few days, when he'd cooled down a bit. Which is why, when the mountain came down two days later, Regine and Kimberley were in the bunker.

Further down the mountain, the town was gone. The bunker, with its own generator, air vents and supplies was mostly undamaged. The storeroom had partly caved in, but the girls were safe. Regine and Kimberley could have walked



out at any time — if they'd had the key. As it happened, they were there for nearly two years. They had felt the ground shake outside, and realized that something had happened when the ceiling cracked and half of the storeroom vanished under a fall of rubble. But what, they didn't know. Neither had ever seen Clayton so angry before. They had no idea when he was going to come back. Still, Kimberley and Regine held on to the hope that he would, eventually. He was their dad, after all.

After a month, they decided that he wasn't coming back. That he'd flipped completely; that he'd left them here in the bunker to die. The following March, Regine's baby, Stephen, was born. The girls hadn't had any training in what to do with a baby. Regine didn't even know how to breastfeed. They tried to use torn up sheets from the beds as diapers, but they couldn't get it right. The baby lived five days.

They had to put him in the waste chute. The smell stayed with them, long after the baby was gone. Regine began to have nightmares about her dead child, crawling from the waste chute, coming back to her in the dark, crying piteously. At times like these, she'd wake up and hold Kimberley tightly.

They began to wonder if Clayton was right, if the government had descended upon Barnstaple and the rest of America, if everything they knew was dead or overtaken by a tyrannical government. They began to wonder other things: maybe Jesus had come back and swept Clayton and Vicki away in the Rapture and left them behind, unrepentant sinners that they were.

Most of the tins of food were gone. Sure, there was enough food to keep them both going for a year or more, but no more than that. And they didn't manage their stocks all that well. The food began to run out. Kimberley prepared the meals. She began to forgo her own meals, just to make sure that Regine was fed. And Kimberley made Regine promise that if one died first, the other would eat her. It'd make the food last longer. And the one who survived would survive longer. It was obvious to Kimberley who was going to starve.

It takes a lot for someone to reach that point, but to be trapped there together for two years took its toll in all sorts of ways. For Kimberley, keeping Regine alive was all she had, the driving force behind her own sanity. By making Regine her project, Kimberley had a reason for living. Regine, on the other hand, with little to do herself, withdrew.

She began to live in a fantasy world. In her mind, she lived under the earth. She hid who she was in the back of her mind. Kimberley, who never really talked much, did little to counter Regine's delusions. In some ways, Kimberley entered a state of denial: she was keeping her little sister OK, and if her sister wasn't OK, then what good would she be, and if she wasn't keeping her sister OK . . . she'd fall apart. It's all in the diary she kept religiously, right up to a couple of days before she died, which sits on a cluttered desk in the bunker, covered with dust.

Kimberley starved herself to death after just over a year. And Regine ate her, just as Kimberley had asked, working the guilt into her fantasy, driving her knowledge of what was happening into the back of her mind, talking to the imaginary tribe who lived their lives under the mountain as she paced back and forth through the bunker for days on end — she'd lost all sense of time, of day or night, going three or four days at a time without really sleeping, just pacing back and forth and talking to herself and eating sometimes and collapsing on the floor and losing herself in sleep for just as long as she'd been awake. She stopped wearing clothes; her fingernails grew long and thick. Her hair got long and matted. The bunker became filthy. She never cleaned the toilet. Eventually, she stopped using it altogether, allowing her waste to fall where she stood. She ate with her hand straight from the tins on most days. Sometimes she'd stand in the shower for an hour or two, but these occasions became more and more rare.

All the while, the stresses of a slightly unstable mountainside on Clayton's not-altogether-competent construction gradually began to crack the place open. Another minor rockslide in January this year damaged the above-ground entry to the bunker, meaning that the lock on the door was crushed and the door, closed for some two years, swung open. Kimberley heard the noise, saw the sunlight and walked down the mountain, following the road for some 10 miles before she came to a small-town diner, and there she asked for some food.

Investigation

Everyone knows about the Barnstaple Tragedy: news media across the world covered it back when it happened. The small town of Barnstaple (population 276) was situated on the side of Windy Ridge. In late 2004, freak falls of snow led some residents to voice concerns about the stability of the mountainside to the county authorities. Assured that everything was fine by an official who hadn't even bothered to consult the local rangers, let alone hire an engineer to survey the mountainside, the residents stayed exactly where they were.

At about 10:35 A.M. on Tuesday, December 21, 2004, the mountain came down on Barnstaple. The movement of the snow and ice brought down with it the side of the mountain, burying the town in ice and rock. It's presumed that 192 of the inhabitants of Barnstaple died that morning, including all but two of the town's children under 18. Fifty more were dead by the end of the week. Most of the bodies were never recovered.

Charles Inman, the county official who failed to evacuate the mountain, lost his job. He received a sizable severance check and moved to Tallahassee, Florida, a year later. Characters who want to solve the mystery of what happened to Regine may want to go up the mountain. The further up they go, the more inhospitable and unstable the mountain is.

Whatever the real reason behind Regine's psychological condition, characters ascending the mountain should feel as if the mountain is against them. The swarms of

midges (if it's summer), the falls of rocks, the bears and maybe the mountain lions, the way that trees and earth seem to stand in their way should lead characters to the unsettling conclusion that they are being stopped from finding the truth. There should be a feeling of being watched, even if the watcher is just an irritable black bear.

If Regine spent the last two years in a bunker, the first indication that the place exists is likely to be the smell of human waste, which is so extreme that regardless of weather conditions, it wafts across the path of the characters. The bunker itself has a rusty metal door that's wedged open. Rainwater or melted ice has already begun to pool on the prefabricated metal staircase leading down into the bunker. Inside, the smell is nearly unbearable. The concrete floor is awash with decayed feces and stagnant urine. Damp has already begun to seep in from outside. A desk, cluttered with unwashed plates and open cans of rotten food holds Kimberley's diary. The skeleton of a teenage girl lies all jumbled up in the store room.

If Regine really did live with a tribe of feral kids under the influence of the mountain, the characters will eventually come across a tunnel entrance, left open by the children who have been watching them. Going in may well be irresistible to a curious investigator. Getting out again — there's the trick.

Regine Butler

Quote: *I can't. I can't go back. You don't understand.*

Background: Regine's childhood wasn't happy. Although close to her sister, Regine's slightly paranoid father terrorized her. She cut loose quite early on, growing to be a fairly ordinary teenager and getting up to ordinary teenage stuff (which would have horrified her father). She had a boyfriend, Cody Bartlett, son of the local Baptist minister. She was sleeping with him, a fact that would have incensed both sets of parents. She cared for Cody a lot, and he's the boy she mentions when talking with Dr. Jenkins. Cody was also the father of her child.

Description: Regine is skinny, and has red wavy hair that falls halfway down her back. Her skin is pale; a dusting of freckles crosses her nose. The gauntness of her face accentuates the size of her huge, round blue eyes. She talks very quietly.

Storytelling Hints: Regine is quietly spoken, polite and shy. In her current state, Regine doesn't want to go back up the mountain. She fears that the feral children of Barnstaple will try to eat her. If that isn't true, and all there is is the bunker, no one will be able to talk her to go inside willingly. If she's forced to go inside, if her sister's diary is read to her (she's forgotten how to read) or if evidence is shown to her in the right way, it's not going to cure her, not remotely, but it might be the first step towards her recovery. On the other hand, it might cause her to retreat further into her delusion.

Characters who present the facts to her sensitively have a better chance of curing Regine than those who force them upon her. If there really *are* feral children, her fear of the mountain is perfectly justified. Whatever happens, she can



never be cured. The consciousness of the mountain wiped her mind clean, just as it did with all the others, the better for her to live in the tunnels.

Regine may begin to get tired of Bishopsgate, and plot an escape. Where she goes to after that is uncertain. She may attempt to return to the mountain and try her chances with the cannibal kids (or she may want to be eaten); if she gets there and finds nothing, it may be the truth she needs to begin the process of healing.

Attributes: Intelligence 2, Wits 3, Resolve 2, Strength 2, Dexterity 3, Stamina 3, Presence 1, Manipulation 3, Composure 2

Skills: Academics 1, Animal Ken 1, Athletics 2, Brawl 2, Crafts 2, Empathy 2, Intimidation 2, Medicine 1, Occult 2, Stealth (Mountains) 3, Subterfuge (Sticking to Her Story) 2, Survival (Hiding Things) 3

Merits: Danger Sense, Direction Sense, Iron Stomach, Quick Healer

Willpower: 4

Morality: 5 (Avoidance, Irrationality)

Virtue: Fortitude

Vice: Wrath

Initiative: 5

Defense: 3

Speed: 10

Health: 3

The Cannibal Children of Barnstaple

Quote: *You're too old to be here. That makes you food.*

Background: Whatever the truth is about Regine's condition, the children of Barnstaple are under the earth of the mountain. Whether that earth is their grave or their home is yet to be discovered. Once upon a time, they might have been perfectly normal small-town kids. Now they're talking animals.

Description: Boys and girls alike are naked and long-haired, smeared with earth. Their nails and teeth are wickedly sharp, and their eyes are bright and blank. They move quickly and suddenly. They breathe shallowly. Each morning, they sing strange, crooning songs in praise of the mountain. If the wind's right, their voices waft down the mountain, eerie snatches of wordless song that cause chills to shoot down the spine.

Storytelling Hints: The children understand English perfectly. They have a kind of limited group telepathy (it's when they lose that telepathy that they know that they're "too old"), meaning that they'll know if one of their own is hurt or in danger, and that they'll all know about any characters who set foot on the mountain, the moment even one child spots them. Their reaction to adult interlopers is simple: the children'll try to trap the adults and eat them, one or two at a time. There isn't really much reasoning with them: if you're too old, you'll get eaten and that is all.

None of the children can ever be "cured"; the Gaia-consciousness of the mountain has erased everything they were before the mountain buried their home town. A child taken away from the mountain feels the influence fade and can be made to become part of society again, but none of them will ever develop more than a vague intellectual assent to the idea that they once had these names, these parents, these homes.

Abilities

Sneak Through the Bushes (6 dice): The cannibal kids are like shadows. They flit from tree to tree, never really visible until they wish to be.

Throw Stuff (5 dice): The kids throw rocks for bashing damage.

Ask for the Mountain's Help (7 dice): Any of the cannibal children can gain the aid of the mountain once a scene. The mountain offers its aid, and for the characters, suddenly, things don't work out as they should. Just as the characters are about to capture one of the children, a black bear stumbles into the clearing. Or a character running from the cannibal kids steps on an unstable part of the mountain that gives way under him, and he falls, breaking his leg. The kids run away, and sun gets in the eyes of their pursuers. The paths up the mountain twist and bend when no one is looking. The children don't have any say over what happens. It just happens (it's up to the Storyteller to decide exactly *what* happens). If what happens has the potential to cause injury to a character, the victim's player should resist with a roll of Stamina + Resolve; if the mountain wins, the character should take no more than one point of bashing damage for each success rolled — the Storyteller can cap it if she wishes. The mountain's power should be ambiguous and indirect — the players should always be wondering if it's coincidence. The mountain shouldn't kill characters, either — just scare them.

A Little Girl Lost



BISHOPSGATE MENTAL ASYLUM

(555)555-7935

HTTP://WWW.BISHOPSGATEHOSP.ORG

ADMIN@BISHOPSGATEHOSP.ORG

Patient: Amy Paige Haim

Attending Physician: Dr. Preston Cates

Case Number: BG-811

Description and History

Amy Paige Haim is a Caucasian adolescent of 13 years of age. Despite her irrationality and the stress of her mental ailments, she appears in excellent health, free of poor hygiene and other glaring marks of neglect so often seen of an individual incapable of self-care. Nonetheless, Amy is not wholly free of self-mutilations. Etched on the top of her right and left thighs are the names of the six saints found on the doors of the main hospital entrance. Unfortunately, these marks were not detected until well after they'd been slightly infected and then healed, leaving scars that can't be removed short of dermabrasion or laser surgery.

It's difficult to decipher the short bit of life that has been lead by Amy Paige Haim. From conversations with the patient, her earliest memories are that

of a standard, well-developed family life. Both parents were present and participated heavily in Amy's development. Extreme religious or conservative views were conspicuously absent, and from what we can tell, Amy was a happy, well-adjusted child until very recently.

According to police evidence, Amy was found on the second story of her family's raised ranch suburban home on the evening of July 14th, three years ago. Amy was curled up in the master bedroom closet with a 16-inch shard of mirror wrapped in a bloody washcloth. The bodies of her parents were located in the first-floor kitchen and the second-floor office space. Joan Anne Haim's corpse, found in the office, had been hoisted over the back of the leather armchair in the center of the room. Rough incisions were made down either side of the spine, and the ribs were separated from the spine using during the process of the incision. From the two slits, upper chest cavity organs were pulled through, left hanging from the wounds. The broken mirror matching the fragment found in Amy's hand was also located in this room. Barry Andrew Haim's remains, located in the kitchen, were less recognizable. Blood splatter specialists determined that the body had been dismembered near the center of the room and that an assailant of exceptional skill inflicted repeated downward, ripping strikes with a sharp tool and then randomly flung the viscera about the room, leaving arcs of blood across the cabinets, ceiling and floor. Blood from both victims was found on the mirror fragment possessed by Amy although none was found on Amy's clothing, skin or under her fingernails. Due to the inconclusiveness of the evidence found at the scene, Amy was not charged with her parents' murders and was instead institutionalized for the past four years here at Bishopsgate.

Despite the grisly events that placed her under hospital care, Amy is, for the most part, a normal girl of her age and background. However, Amy still recoils at any mention of that evening and does demonstrate symptoms of several disorders. Least among these is her somnambulism. The condition manifests at irregular intervals and depths, though the depth and nature of her trance are entirely consistent. When observed during her sleepwalking spells, Amy does not demonstrate the standard movements seen in routine somnambulist behavior. Instead, Amy appears fully awake albeit in a state of deep fear. She holds her arms extended in front of her, as if they are pulling her along - unwillingly. Her facial expressions support this as well as her face and head pull back, her face resistant and terrified. During one observation, the subject seemed to almost be attempting to backpedal with her feet as she pulled away. Despite her hesitance, she continued forward. Attempts to rouse Amy to awakened consciousness during these spells have met with dramatically undesirable results. In every instance, the subject convulses slightly, and the eyes widen, her head turning forward her mouth in rictus. At that point, Amy explodes into a howling, screaming tantrum, whipping her body against the floor with the amount of force that one would not think possible in a 13-year-old girl of Amy's height and weight. After her body stills (often after injuries have been sustained from the seizures), Amy can be stirred but will become very dramatic and emotional, usually gripping herself tightly against the nearest adult female.

Perhaps Amy's most disturbing episode occurred two months after her admission. After being taken off regular observation, Amy, having demonstrated no sign of violent behavior or desire to flee the grounds, was allowed to wander the grounds during daylight hours. Somehow, psych techs on duty lost track of Amy's whereabouts, and Amy apparently fled the complex. Local authorities were enlisted in the search for the missing girl, but all efforts made by the police and the hospital proved fruitless. It wasn't until nearly three weeks later that Amy was found. At approximately 12:00 P.M. on January 18, 2004, Amy was found fully conscious standing in front of the three doorways of the main Bishopsgate entrance. Amy was entirely calm and lucid and complained only of the cold when found by orderlies. Amy had no recollection of the three weeks she had been

missing and did not respond with any agitation if pressed on the matter – she simply had no idea. However, after a medical examination, Amy’s self-mutilation became apparent when the names of the six saints of Bishopsgate had been carved into the tops of her thighs. Tiny fragments of broken mirror were recovered from the wounds.

Treatments and Results

Amy is currently enrolled in standard treatment, therapy group for victims of abuse, and art therapy. She is also a student at the hospital’s school program held at the Brochardt House. Amy has responded well to all of her therapies but is still triggered easily by actions, words and images that evoke the evening of her parents’ murders. Amy is not on any medication though she is occasionally sedated in instances when she cannot be reasoned with or loses control or is disturbed in the midst of her sleepwalking.

Plan

All of the hospital staff who have interacted with Amy feel that there is an excellent and likely chance that she will recover fully from her traumatic experiences. She is social and compassionate, and able to form normal relationships, even with others who cannot.

Game Systems

Aside from Amy Paige Haim’s sleepwalking and refusal to discuss the events of her parents’ deaths, she seems to be a normal girl. She’s sociable when approached by non-threatening people, and likes television, pop music and whatever other bits of the outside world she can experience despite her institutionalized state. Nonetheless, there is something locked inside of Amy that may very well be the key to understanding what darkness lies beneath Bishopsgate’s remodeled veneer. Amy’s not stupid. She knows that to share these sorts of things with the psychiatric technicians, doctors and counselors is the best way to never leave Bishopsgate again. However, if Amy’s trust is ever truly earned, and if someone is capable of communicating to Amy that he wants to help her on *her* terms based on *her* ideas about what is going on, then a number of truly disturbing facts will be brought to bear.

Option One: Victim

Amy is a genuine victim. A still-at-large murderer (who may or may have not killed others in a similarly grisly fashion) entered her home, rendered her parents unconscious and literally forced her — through a combination of physical coercion and psychological torture — to kill her parents. Amy was forced to mutilate the corpses of both parents, only getting assistance from the murderer when her lack of physical strength prevented her from doing what he demanded. As one might expect of a child subjected to such extreme psychological torture, Amy’s mind snapped, and several disorders developed including severe post-traumatic stress-disorder, which hinders her recovery while at Bishopsgate. Aside from the one fugue incident when Amy lost her memory and cut on herself with a piece of mirror (re-

enacting some element of her parents’ murder), Amy’s just a messed-up kid who’s been through unimaginable hell.

Option Two: Sacrifice

Amy’s family was not murdered. They were selected and sacrificed by a cult of vampires who needed to appease the demands of their most sacred rites. After offering her parents’ pain to whatever darkness they served, the vampires baptized Amy in her parents’ blood and bestowed on her the instrument of her parents’ deaths. Paralyzed by the simultaneous events of her parents’ deaths and the realization that monsters are real, Amy was helpless to save herself. Now, burdened with a story that nobody will ever believe, Amy creates desperate ruses in order to pull a possible adult “helper” into her world so that she can once again be safe and free from the bogeymen that effectively ate her parents in front of her. Occasionally, one of the vampires still comes around, to whisper to her outside her window; she saw that the saints at the door repelled him, however, and so carved the names of the saints in her legs in hopes of gaining their protection.

Option Three: Savior

Amy is the savior of Bishopsgate. Although she’s been through a lot and is certainly not the sanest little girl in the world, Amy, for some reason or another, has been marked by what little benevolence makes its home at the Bishopsgate Asylum. Amy has made a connection, initiated during the time she went missing, with whatever power infuses the Saints of Bishopsgate. Though she has certainly witnessed her share of horrors, the mounds, the ghosts and the other malevolent denizens that make their home in the hospital have no power over Amy and cannot approach her directly. Although Amy



will likely be able to leave Bishopsgate at some point, she is content to stay and help those who cannot help themselves or are subject to the torments of evil men.

Investigation

Very little outside of directly getting Amy's trust will provide any real answers. The murders of her parents yet remain unsolved. Her only remaining family are Craig and Sarah Thompson, her maternal grandparents, though anyone interviewing them for even a few moments about Amy realize that they both blame her for the death of their daughter, Joan. Craig wants nothing to do with the child, and Sarah has entertained the desire to acquire custody of Amy, clearly for the purpose of exacting revenge, on some level.

Whether Amy is a victim of the mundane or supernatural, or an avatar of the Six Saints, she's still a little girl and is subject to the same worldview and needs as any other girl of her age (despite her mental scars). These simple needs and childish wants are what characters will need to appeal to if they want to get the skinny on Bishopsgate. It's also important to remember that Amy has had her whole world flipped over on her and is not likely to trust easily. In fact, earning Amy's trust to the degree that she'll share Bishopsgate secrets could be the focus of an entire game session.

Amy Päige Häim

Quote: *You don't know. You just don't know. <pause> I wish I didn't.*

Background: Amy grew up in a loving, nurturing environment. In fact, it might be suggested that she lived a very sheltered, protected life before the events of that night. Since coming to Bishopsgate, however, she has seen lots of things others probably wish she hadn't. Nothing seems to surprise her, however. It just is.

Description: Amy is a beautiful teenager, with waist-length black hair that she combs out every night the way her mother taught her. She won't allow anyone else to brush it for her, despite the pleas



of some of the nurses. Her skin is pale, as she tends to prefer remaining indoors, and she has pale blue eyes. She makes a point of dressing herself in normal clothing every morning and going about her life as though she weren't confined in an asylum.

Storytelling Hints: In addition to the derangements listed below, Amy also suffers from a variety of anxiety disorders and somnambulism. She is shy and retiring, preferring to let others show their interest in befriending her than to approach people herself. When in the company of too many people, Amy becomes fatigued and anxious and seems near the verge of tears sometimes. She's very embarrassed about those instances, though, and makes a point of apologizing for running off or "freaking out" when they happen.

Attributes: Intelligence 2, Wits 3, Resolve 3, Strength 1, Dexterity 2, Stamina 2, Presence 2, Manipulation 3, Composure 2

Skills: Academics 1, Crafts 1, Investigation (Eavesdropping) 2, Occult 1, Athletics 1, Larceny 1, Stealth (Sneaking Out) 2, Survival 2, Animal Ken 1, Empathy 3, Expression (Drawing) 2, Subterfuge 2

Merits: Unseen Sense

Willpower: 5

Morality: 7 (Insomnia, Repression, Schizophrenia)

Virtue: Faith

Vice: Wrath

Initiative: 4

Defense: 2

Speed: 8

Health: 7

God's Monster



BISHOPSGATE MENTAL ASYLUM

(555)555-7935

HTTP://WWW.BISHOPSGATEHOSP.ORG

ADMIN@BISHOPSGATEHOSP.ORG

Patient: Cameron Mueller

Attending Physician: Dr. Payton Oliver

Case Number: BG-365

Description and History

Cameron Mueller is a giant of a man, standing slightly over seven feet in height and weighing more than 300 pounds. Cameron's face always looks somewhat serene, his brow rarely knitted and his big blue eyes always wide with understanding and forgiveness. Cameron's head is shaved bald at his request, and he keeps his face closely shaved. Nonetheless, Cameron enraged is a terrifying sight that can strike terror into all but the most experienced (or well-armed) of seclusion teams.

Cameron Mueller is a very rare specimen indeed. Considering his methodical nature and exceptional intelligence, it was highly unlikely that Mueller would be captured alive. That is, unless he wanted to be, which is what he himself claims.

Alienated from an early age by cruel children mocking his enormous size, Cameron viewed himself as an outsider, preventing him from developing normal social tools. Cameron possesses a genius level IQ but became sensitive around other children his age due to feelings of deep inadequacy apparently cultivated by his parents. During a one-year period when Cameron was seven years of age, Cameron's father, Daniel Mueller, forced the boy to sleep in a crawlspace beneath his mother and father's bed, where he could overhear the couple discussing how problematic he was. Cameron's mother Andrea, a deeply religious woman, often made accusations of Cameron being "not okay with the Lord." All of these factors contributed to Cameron Mueller becoming detached and separate from the world he lives in.

At the age of 12, Cameron's father caught the boy while he was in the midst of burying the remains of the family cat. Cameron had stretched the animal on a piece of plywood, sliced open its abdomen and, as the organs were spilling out,

set the animal aflame. After being savagely beaten by his father, Cameron was ordered by his mother to explain his actions. His only response was that he had "been moved by the Holy Spirit to give the precious creature to God."

Exhausted by Cameron's repugnant behavior, Daniel and Andrea sent the pre-teen to live with his mother's parents, Charles and Agnes Holpepper. On a cool evening in early March of 1968, Cameron killed his grandfather, stabbing him 43 times with a paring knife from the kitchen. When Cameron's grandmother returned that evening, Cameron ambushed her on the porch with a baseball bat, killing her with multiple blows to the skull and neck. Cameron Mueller then went into the kitchen, and while his dinner was cooking, decided to call the authorities, who arrived and arrested Cameron, who was found calmly eating his supper, the bodies of his dead grandparents left where they had died. When asked why he killed his grandparents, Cameron only stared at them and gave no explanation as to why he'd committed murder.

After being processed and tried, Cameron Mueller was declared criminally insane and was interned at Utah's Brentwood State Hospital. During his time at Brentwood, Cameron demonstrated none of the volatile behaviors that had been attributed to him and participated heavily in the hospital's interfaith fellowship. In 1973, after demonstrating calm manner and drastically improved social adaptation, Cameron Mueller spent three months in a group home and then returned to live with his mother and father.

Fully grown at nearly seven feet two inches and slightly over 300 pounds, Cameron found a job working on the loading docks in his hometown. During his free time, the now-adult Cameron Mueller spent most of his money and time on medical texts, religious texts and alcohol. Still subject to the scrutiny and ridicule of his parents, Cameron himself says that he enjoyed playing out their murders in his head. Cameron said he'd even stand outside his parent's first-story bedroom window with one of his knives, playing out the blade's work in his head.

It was three years later that Cameron began spending time at the local community college campus during the evenings. He had taken a second job as a custodian to increase his personal spending money as well as keeping himself out of his parents' home as much as possible. The first victim he snared in this way was 19-year-old Annabelle Tate who had allegedly locked her keys in her car. Mistaking Cameron's maintenance uniform for campus security, she agreed to ride with him to the information office on the other side of campus. Instead, Cameron choked Annabelle into unconsciousness and then took her to an industrial park three miles from campus. After restraining her to a table, Cameron performed the first of his first "surgery"-style murders by dissecting Annabelle's body while she was still alive. After thoroughly mutilating the corpse, Cameron proceeded to cut pieces from the victim and ingest them. According to Cameron, he blessed each piece as if it were some sort of ritual sacrament before eating it. Unlike in the case of his grandparents, Mueller managed to cover his tracks adequately, and the first of a string of 14 similar cannibalistic murders began.

It wasn't until the end of his eight-year killing spree that Cameron Mueller claimed he was "abandoned by Heaven." Cameron was uninterested in the prospect of suicide as he felt the mortal sin of taking one's own life could endanger the well being of his soul, and Cameron Mueller turned himself in to local authorities, confessing in gratuitous and enthusiastic detail every detail of every murder as well as the locations of murder weapons and the location of the potter's field where he had buried all of his victims. In accordance with these confessions and a history of insanity, the State remanded Mueller to a lifetime stay in one of Bishopsgate's high-security cells, where he remains to this day.

Treatments and Results

Since Cameron has been at Bishopsgate, he has only gotten worse. Now caught in the throes of a penitent depression, Mueller believes he may have "misin-

terpreted the omens" and that it is an imperative of the soul that demands he continue his murder spree. As some sort of strange means to maintain his feelings of control, Mueller has taken to decorating small religious images that he's made from paper. Cameron's odd attempts at hybridizing Roman Catholic iconography and the likenesses of his victims are always lined up neatly along the walls of his room. Mueller prays to the images, talks to the images and reacts horribly if the images are taken away from him. The prayers that Cameron offers to his paper pantheon are often a chaotic jumble of bastardized Latin (verified by qualified persons) and uncontrollable crying. Nonetheless, despite the glosso-lalia jumble of his prayer language, he conducts his prayer ceremony four times a day at regular intervals.

Insofar as Cameron Mueller's desire to cannibalize his victims, no progress has been made. After more than half a dozen years spent at Bishopsgate, Cameron has been entirely uncooperative in this area and refers to these practices as "personal religious beliefs about which he refuses to be interrogated."

Plan

Whether Cameron recovers from his psychosis or not, he will not be leaving Bishopsgate alive unless he's transferred to a similar facility. He is highly intelligent and fully capable of sabotaging his own therapy as well as convincing inexperienced hospital staff that he is safe and trustworthy, which is very much not the truth.

Cameron Mueller is to be monitored 24 hours a day in his secure cell. He is not permitted metal or sharp objects and is only given crayons and paper with which to play out his fantasies. Even when secured, either by restraint and face guard, or in his actual cell, it is recommended that an armed guard or seclusion team be within earshot.

Game Systems

Cameron Mueller is a dyed-in-the-wool, cold-blooded, natural-born psycho killer of the highest order. Despite his need for divine affirmation, Cameron is fueled by his desire to kill and devour pieces of his victims. Why does Cameron mutilate his victims in a medical and ritual fashion? What is so sacred about his sick desire to cannibalize? What would happen if Cameron were to escape Bishopsgate or merely get a hold of an unaccounted for sharp object?

Option One: Psychopath

Cameron Mueller, due to developmental issues and chemical imbalances, is psychologically predisposed to violent, homicidal behavior and necrophagia. He is a genuinely malevolent person who has deliberately cultivated and fed his disorders through murder-based rituals of self-empowerment intuited from his personal egomaniacal mythology in an attempt to create a feeling of control and power. He is not in touch with anything supernatural or anywhere near as knowledgeable as he implies. However, Cameron's guile and skill as a predator should not be underestimated based on his lack of inhuman powers and abilities. It is in fact his very inhumanity itself that gives him the edge in violent confrontations as he's not limited by the moral constructs or innate hesitation to mutilate a member of one's own species that make him as deadly and unpredictable as anything else that goes bump in the night.

Option Two: Occultist

Cameron, through primitive hedge ritual involving the visceral rites of cannibalism and fetish construction, has developed his own system of necromancy. Empowered by the soul-snaring energies of Bishopsgate itself, Cameron Mueller has become a captive king, capable of communicating with and even commanding the spirits of the dead who dwell there. His paper fetishes are, in fact, tiny conduits to the spirits of his past victims from which he draws strength. Through his experimentation and the development of his personal system, it is not entirely impossible for Cameron to come into contact with Awakened mages. Such an event could elevate Cameron to a level of power that could usher in a new, even more terrible age for old Bishopsgate. The Storyteller may wish to use the rules from **World of Darkness: Second Sight** to reflect some of Cameron's abilities; Storytellers with access to **Mage: The Awakening** may also find in Cameron an excellent Awakened villain.

Option Three: Husk

Weak-willed and empty from years of neglect and a lack of genuine intimacy, the person who was Cameron Mueller slowly deteriorated, becoming more and more absent as the years went on. It was the morning of the day on which he would murder his first human that Cameron Mueller died.



As the last of his humanity was consumed, tiny spider spirits devoured Cameron insides and he became a husk ripe for the *Azlu* — the Spider Host. Cameron is no longer human and Bishopsgate is the most hideously well-designed web he could possibly ask for. He has created others since his transformation and sits at the center of the web. The congested spiritual/material exchange on the Bishopsgate grounds is a product of his machinations, and he's perfectly content to remain in his cell until all transmigration between the world of spirit and the world of flesh come to a halt. Cameron's only hassle is maintaining the appearance of humanity that he sidesteps to the best of his ability by creating neurotic red herrings for his therapists to hunt. Though the concept of a hollow husk of a man serving as the home of an intelligent swarm of spiders is more than enough spark for a Storyteller's imagination, those interested may find more about the *Azlu* in **Werewolf: The Forsaken**.

Investigation

Depending on which interpretation of Cameron Mueller the Storyteller decides to use, a connection with Cameron could result in anything from a merely disturbing interview to a fatal glance into the very truth of Bishopsgate's evil. If Cameron is merely a serial killer, he could have vital information and insights into the violent ritual crimes of others or have even come into contact with someone the Characters are trying to find. If Cameron is a Necromancer, he could help the characters

contact the dead or, more likely, work against the characters by attacking them with his spectral pawns. If Cameron is, in fact, one of the *Azlu* and at the very center of what the mounds are about, directly confronting him could result in total catastrophe as he expends every grotesque resource in his attempts to destroy them or cast them away permanently.

Cameron Mueller

Quote: *I'll thank you not to cast aspersions on my methods of spiritual expressions. They are as meaningful to me as your own expressions — mine just have the misfortune of also being unacceptable in society today.*

Description: Cameron is tall, and quite heavy, though not in a manner that suggests he is fat or muscled. He is simply large, with a thick frame. He seems to be built in strange proportions, as though his arms were a little too long, or his legs a little too short. He has very wide hands and no chin to speak of. He also keeps his head and face closely shaved, almost obsessively.

Storytelling Hints: Mueller can be incredibly engaging to converse with — he is intelligent and cognizant of others around him. He seems curious about how others view the world. He isn't the kind of madman who assumes that everyone sees the world the same way he does; he knows that each person has a unique perspective on the world, and can be very



persuasive that his worldview is just as legitimate as any other. Of course, his world view happens to encompass ritual murder and cannibalism.

Attributes: Intelligence 4, Wits 2, Resolve 4, Strength 4, Dexterity 2, Stamina 3, Presence 3, Manipulation 1, Composure 1

Skills: Academics 1, Brawl 1, Expression 1, Intimidation 3, Larceny 2, Medicine (Crude Vivisection) 2, Occult (Ritual) 4, Persuasion 1, Subterfuge 1, Weaponry (Knives) 2

Merits: Giant, Strong Back, Iron Stamina (3)

Willpower: 5

Morality: 3 (Megalomania, Obsessive Compulsive, Schizophrenia)

Virtue: Prudence

Vice: Pride

Initiative: 3

Defense: 2

Speed: 11

Health: 9

Weapon/Attacks:

Type	Damage	Size	Dice Pool
Fist	0 (B)	1	5
Scalpel	1(L)	1	7

The Lost Nurse



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Patient: Lara Woronov

Attending Physician: Yee Lin, M.D.

Case Number: BG-0002

Description and History

Lara Woronov is a white female, age 45, admitted to Bishopsgate approximately 10 years ago (date on file illegible). Diagnosis is paranoid schizophrenia characterized by delusions of grandeur and persecution. Specifically, Woronov believes that she was once an employee of Bishopsgate. The fact that other patients occasionally agree with her doesn't help any treatment that we have tried to provide, but even when she is kept separate from other patients she remains obstinate. In fact, she has been here longer than any other patient currently in maximum security; she predates my own time here by at least three years.

Woronov occasionally tries to act in the capacity of a psychiatric nurse. She is, in fact, no longer allowed to dress in anything other than a patient's gown, because families of patients, in addition to the patients themselves, believed her to be a nurse once too often. She even helped subdue a particularly violent patient once, and removed an orderly's keys before he realized what had happened.

Woronov's medical files are a disgrace. It isn't uncommon for a form or two to go missing, but so much of her medical history is missing that we have to be

very careful what medications to administer since we don't know if she has any allergies (she refuses to tell us or claims she doesn't know). Woronov claims to be a registered nurse, but there are no records of anyone by that name in the state's registry files. Note, though, that she also sometimes claims that "Woronov" isn't her real name, but she refuses to give any other name, so no verification could be made. She claims that she was employed by Bishopsgate "for almost eight years," but given that she became a patient here more than 10 years ago, that would mean that she was hired nearly 20 years ago. Unfortunately, Bishopsgate suffered a fire that destroyed most of the employee records not long after that, so even in the extremely unlikely event that Woronov's story is anything more than delusion, it is impossible to verify.

Her medical records *do* indicate, however, that she has a history of drug abuse (mostly hallucinogens and narcotics) and might have come from an abusive home environment. She has no living family, according to her medical file, and her medical care is provided by the state. Her coverage is minimal, and she is listed as a "potential threat to herself or others." It is unlikely that Woronov will ever be released.

Treatments and Results

During her long time at Bishopsgate, Woronov has been under the care of no fewer than seven different doctors and five different clinical psychologists. She has been given many different prescriptions as new drugs become available, but she is notoriously uncooperative about taking her meds and often has to be given them IM or IV rather than orally. She responds badly to antipsychotics, but we have hope that atypical or second-gen antipsychotics will work better for her. Antidepressants help with her mood, but do nothing to lessen her delusions, and, given the difficulty she gives us with taking them, she receives this medication only infrequently. She is, however, on a strict regimen of tranquilizers in order to keep her compliant. See attached drug schedule and history (but again, the history is incomplete).

Psychotherapy has mixed results at best. Woronov demonstrates considerable knowledge of psychiatric medicine; whether or not she ever truly was a nurse, she has certainly received schooling from somewhere. She understands different behavioral and therapeutic techniques and has a habit of playing along for months, fooling her providers into thinking she is making great strides, only to fall back into her old patterns of believing she is an employee and trying to act in that capacity. She has no interest in expressive therapy, cognitive therapy, behavioral therapy or any other modality that requires her to examine her own thoughts or consider the possibility that she might not be what she thinks she is.

Plan

Woronov receives very few scheduled sessions with psychiatric professionals, and much of the allotted time is spent working on her cocktail. Scheduled sessions with clinical psychologists take place twice a month. Presently, the plan is to continue with group therapy and place her with patients who are lucid and almost ready to be released. Hopefully, this will entice her to recognize her own situation and become serious about her own therapy.

Game Systems

Lara is a good example of a patient whose story might unlock some unpleasant, far-reaching secrets of the World of Darkness. If she truly was a nurse at Bishopsgate, consider the amount of work that would be required, even by

a powerful supernatural being, to place her in her current situation. Characters might encounter Lara as a warning if they get too close to something — look what happened to the *last* person who came snooping. Below are three possibilities for the truth behind Lara, as well as some suggestions for what characters might discover if they investigate.

Option One: The Body Jumper

An otherworldly creature that leaps from body to body became incarcerated at Bishopsgate. Maybe the creature decided to see what life was like for a patient, or maybe it can only jump bodies under specific circumstances and wound up here by accident. In any case, the creature possessed a young nurse, absorbed part of her mind and personality, and then jumped into a patient named Lara Woronov. Unfortunately, the medication that Lara was (and remains) on prevents the creature from collecting its thoughts, and from jumping out of the body. The creature has mixed the information it absorbed from the nurse (who is probably dead or comatose) with Lara's mind. The medical files are a shambles, but there's nothing sinister there — just bad recordkeeping. If the creature can convince the characters to let it off its meds for a while, it might be able to escape. Would that be a good thing or a very, very bad idea?

Option Two: The Agent

Lara Woronov once worked for a society of mages called the Seers of the Throne. These mages believe that they serve the will of powerful, otherworldly beings called the Exarchs. The conspiracies of the Seers run deep and complex, and one sect doesn't always (or even often) know what the other is doing. Lara, not a mage herself, wound up in the middle of a complicated conspiracy with enough information to piece together some highly damaging truths about the Seers. She was a nurse at Bishopsgate, and at the time, the Seers used Bishopsgate as a base of operations. After Lara discovered whatever it was that she discovered, they abandoned the place.

Why didn't they just kill her, rather than going to the extremes that they did to cover everything up and suppress Lara's mind and identity? Because they found in Lara a perfect living information repository. Every few years, a member of the Seers visits Lara, extracts some information and replaces it with new secrets. This is why she seems to improve but then slides right back into delusion.

Option Three: Madness

Lara Woronov *was* a nurse at one point, but not at Bishopsgate. She was a psychiatric nurse at a large, inner-city hospital. A drug user with schizophrenia, she overdosed one night and wound up at Bishopsgate, confused and addled. The damage to her brain is much greater than anyone suspects, and combined with the medication she's on, she probably only has a few more months before she suffers a catastrophic stroke and dies or sinks into a persistent vegetative state.

In this scenario, Lara might make for a good object lesson in just how convoluted and appalling things are at Bishopsgate. The characters might wind up saving her life if they do something as simple as perform a CAT scan or an EEG and discovered her deteriorating condition.

Investigation

Characters assigned to Woronov — or who investigate her from the outside — might discover the following:

- **The Fire:** The local fire department has no record of a fire at Bishopsgate within 10 years of the one that supposedly destroyed any record of Woronov's employment. No one at Bishopsgate has ever checked, because no one really believes she was ever an employee anyway.

- **The Online Search:** Several years back, there was a small but persistent drive on the Internet to "find Lara Woronov." The email stated that she disappeared while going to work "at the hospital" one day. She is not listed as a missing person, and the email has since been declared a hoax by an online encyclopedia of urban legends.

- **The Curse:** One therapeutic technique that characters might consider for Lara is hypnotic regression, the act of retrieving repressed memories in a hypnotic state. If they do a little digging, however, they find that this has been tried before — and every single doctor or psychologist who has tried has died within a week. The deaths are never mysterious, though: heart attacks, strokes, car accidents, household accidents and other completely understandable occurrences claim their lives.

Lara Woronov

Quote: *Am I on shift tonight?*

Description: Lara is in her mid-40s and is perpetually drugged. Her brown eyes are unfocused, and her dishwater blonde hair hangs tangled down to her shoulders. She carries herself like a nurse, though, behaving kindly toward the other patients and watching them for signs of trouble.

Storytelling Hints: Lara is pleasant, but professional, most of the time. If reminded that she is a patient, she becomes agitated and belligerent, though usually not hostile. As her meds start to wear off, she usually demands to speak to her doctor or a lawyer, but these demands are never met,



and she winds up taking her tranquilizers and sinking back into her haze.

Attributes: Intelligence 4, Wits 2, Resolve 2, Strength 2, Dexterity 2, Stamina 3, Presence 2, Manipulation 4, Composure 3

Skills: Academics (Bishopsgate) 3, Computer 2, Drive 1, Empathy 2, Expression 2, Investigation 1, Medicine (Psychiatric Medicine) 2, Persuasion 3, Science 2, Socialize 2, Subterfuge (Posing as a Nurse) 3

Merits: Eidetic Memory, Language (Latin), Strong Back

Willpower: 5

Morality: 6

Virtue: Hope

Vice: Envy

Initiative: 5

Defense: 2

Speed: 9

Health: 8

The Man with the Damaged Face



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Patient: Teesdale, Bryan

Attending Physician: Dr. Tucker R. Jenkins

Case Number: BG-1026

Description and History

Bryan Teesdale. Age 29. Admitted April 22nd this year. The patient has one of the most interesting conditions I have ever seen. The patient began exhibiting odd behavior about a year ago. He'd been through a messy divorce, apparently; moving in with his parents, he took to investigating family history. His family regarded this as a harmless pursuit. After a few weeks of this, though, he began exhibiting obsessive behaviors. He'd apparently sit in his room, without eating, for days. Sometimes he slept in the library. He barely talked to anyone. His parents and sister (six years younger, also living at home) thought that maybe he'd taken the divorce worse than they'd thought, and that he'd be best left alone until he worked it through.

After a while, he put all the books away and started going for long walks. His parents' relief turned once again to worry when he began to go out for days on end. On more than one of these occasions, he came back covered in black earth, but refused to reply to his parents' good-natured inquiries as to where he had been. One time, he came back with splatters of blood on him. He said he'd cut himself falling, but wouldn't show his sister where the wound was.

Incidentally, it was about the end of this period, which lasted something like three months, that he was caught trespassing in the area around the East Wing of this very hospital. No one pressed charges. I was on duty that night. It was clear he'd been looking for something. God knows what. It was raining harder than I'd seen it for ages.

After that, Bryan stayed in a whole lot more. His parents told me that they could hear him talking loudly to himself in his room. He got his appetite back. They'd leave plates of food outside his room, and it would be gone next time they looked. After a couple of particularly loud nights, when he could be heard ranting to himself, he went silent on April 11th. He had apparently left the house

before dawn. That morning, he was found on the land of Shaun Stewart, having collapsed on the bounds of Stewart's farm, suffering from severe sunstroke.

Bryan is 29; he now looks like a man 10 years older. Part of this is to do with the acute chloracne he appears to have developed on his face, shoulders and chest. Chloracne is normally a symptom of poisoning by dioxins or other hydrocarbons, and manifests itself in a particularly virulent and persistent outbreak of pustules and lesions on the skin. This is often accompanied, as it is here, with porphyria cutanea tarda, where the skin becomes abnormally sensitive to sunlight. It's particularly severe here; the patient's skin burns within minutes of exposure to direct sunlight, and we have to keep the curtains drawn in his private room. He appears to have some damage to his respiratory system: his breathing is heavy, and his voice is rather hoarse. On the other hand, we had the General Hospital do some tests, and he tested negative for toxins. Certainly, unless he came across some toxic chemical or something on his travels, I can't see why he should have these symptoms. They could be psychosomatic. Alternatively, whatever caused the chloracne could well be the cause of his psychological imbalance.

Treatment and Results

May 2nd

He's too smart. Still, there's some things you just can't hide. Consultation this morning pretty much confirmed it. He has many of the characteristics of an individual with antisocial personality disorder. Not all of them. Before this year, he exhibited no signs of any disorders at all, not in childhood, not now. Not even a mild depression. The divorce turns out to have been due to infidelity on her part, although you'd be hard-pressed to find any evidence of him caring.

He's aggressive, verbally if not physically, and apparently incapable of human empathy. He tries to hide that fact, but it's not something he really understands how to fake. In fact, faking seems to be central to him. He is trying as hard as he can to fake being normal. He's trying to appear empathic. He's trying to appear as if he recognizes societal obligations. And this is the really interesting thing: he's trying to fake the fact that he's evidently suffering from some sort of fugue state.

The simple fact is that he doesn't actually know who he is. And he's trying to hide it. It's fascinating. He has this peculiar, stilted, formal way of talking, as if he's trying to concentrate on using English. And he knows his name, the names of his parents, the name of his sister, the name of his ex-wife and he knows the grounds of the hospital and the countryside outside the gates pretty well. But, on the other hand, he didn't seem to know what a stethoscope was when he was examined in the Medical Center. He apparently doesn't understand how the records of everyone in the hospital could be held in a computer. He has a real need to know about the minutiae of daily life, from power showers down to telephones, while at the same time trying to look like he knows already. He has this way of pumping you for information, while trying to hide the fact that he's doing it.

It's fascinating. I'm going to try something.

May 4th

So, I fed him a few random lines of false information in passing on Tuesday. We were talking about politics. We do that a lot. Some nonsense about Clint Eastwood's presidency. He acted like he knew all about it.

Today, however, he clammed up. Stopped asking me about things altogether. Barely talked. I think someone has let him know. It was irresponsible of me. I abused the patient's trust. Except, I don't think he trusted me at all.

Dioxin Poisoning

Dioxins, found in cigarettes and many other chemicals, can have catastrophic effects on the human body. Dioxin poisoning can result in, among other things, thyroid disorders, problems with the nervous systems, severe skin complaints (such as chloracne), damage to the immune system, heart disease and cancer. Dioxins are soluble, and once absorbed into human tissues, don't leave. They just accumulate.

The most famous case of dioxin poisoning in recent years was the alleged poisoning of Ukrainian presidential candidate Viktor Yushchenko, in 2004, whose condition was in some ways similar to Bryan Teesdale's. The culprit of the poisoning, which nearly killed Yushchenko, was never found, if, indeed, Yushchenko's death was a result of deliberate poisoning.

Game Systems

It was curiosity that really ended the life of Bryan Teesdale. His research into family history, which perhaps should have been best left buried, annihilated him, and whoever Bryan Teesdale was, he doesn't exist any more.

Option One: The Patient Is More Than 300 Years Old

This isn't Bryan Teesdale. This is James Teesdale, the alleged witch and previous owner of the site of Bishopsgate, who disappeared in 1714. Bryan Teesdale's research into family history, which really were a pastime to help him think about something other than his messy, painful divorce, led him to find out some disturbing things about his ancestor. Apparently, he really did have supernatural powers. More than that, he'd discovered the secret of immortality — of a kind.

Bryan found, in the town archives, a deed going back to 1699, which delineated James Teesdale's holdings, and discovered that not all of James Teesdale's land was under the asylum. More than that, through piecing together clues in his ancestor's journals, old maps and letters to and from various individuals held in the family collection and in the city archive, Bryan discovered two things: the clay jar, buried in woods just east of Bishopsgate, which was lined with lead and contained James Teesdale's shriveled heart, and a piece of parchment on which was written, in the old sinner's spidery hand, the incantation that would enable Bryan to bring his ancestor back to life.

In his room, Bryan sacrificed a raccoon, said the words and watched as the dessicated lump of flesh grew more flesh, a ribcage around it and bones to make the flesh stand up, eyes to see, a tongue to speak, and skin to cover it all. They talked for a long time, both remarking on the close resemblance they bore to each other. It wasn't long, however, before Bryan Teesdale realized the mistake he'd made. He spoke with his ancestor all night, but he never made it out of the room.

James buried the body that night while the family was asleep. The following morning, he discovered two things.

First, that the sun damaged his skin. The moment the sun rose, lesions appeared over his face and upper body, literally in seconds. He attempted to return to the entrance of his old catacombs, now on land owned by farmer Shaun Stewart. He didn't make it. The pain from the sunlight caused him to pass out, and Stewart took James to hospital.


Second, that while masquerading as a descendant was relatively easy, masquerading as sane in a world that had changed more than he could have dreamed was more dif-

The Case of Iris Farczady

In 1933, a 15-year-old girl from Budapest named Iris Farczady collapsed. When she awoke, she could only speak Spanish, and claimed she was Lucia Alvarez de Salvio, a washerwoman from Madrid, whom she said had died some years earlier, aged 41.

For all intents and purposes, Iris was gone. The change in her personality was total. Lucia never went away, and when Iris died 65 years later, she was still Lucia. The case has never been explained. There are no records of a Lucia Alvarez de Salvio ever having lived. Was Iris possessed by a dead woman's spirit? Or did she experience a kind of fugue unknown to medical science? If she did, how on earth did she learn how to speak Spanish?

This, one of the strangest cases in the history of psychology, offers all kinds of possibilities for the Storyteller. Instead of having been murdered, Bryan could have experienced something like this, an inexplicable displacement of his personality and the conviction that he was his evil ancestor James. Whether he's actually possessed or suffering from his breakdown is up to the Storyteller to decide and the players to find out.



difficult than he could have imagined. It was a matter of days before a psychiatrist signed the order to have an uncomprehending “Bryan Teesdale” committed to Bishopsgate.

Option Two: The Patient Is Suffering from Poisoning

Up until the fateful day of Bryan’s collapse, Teesdale’s story is the same. Bryan did indeed become obsessive about learning his family history, and he found James Teesdale’s shriveled heart in a jar. Bryan even tried the ritual in Teesdale’s writings to bring the man back. But actually, none of it worked.

On the morning of April 11th, Bryan, having failed in his attempt to raise his ancestor from the dead, suffered a nervous breakdown. In turmoil, he stole out of his parents’ house and made his way to the place where he was sure that he could find the missing elements he needed to successfully raise James Teesdale from the dead. Unfortunately, Bryan arrived at the bounds of Shaun Stewart’s land just as Stewart was beginning to spray his crop with pesticides, effective but highly illegal pesticides, heavily loaded with dioxins. As Stewart was coming in to land, he noticed the figure collapsed on the edge of the fields.

He landed and took Teesdale to the hospital as quickly as he could, making sure that he was attended by his cousin, one Mark Hardwide. Stewart explained to his cousin what had happened. Hardwide changed the test results. Bryan Teesdale is suffering from a severe case of dioxin poisoning, and more than that, he’s suffering from brain damage as well — the fumes very nearly suffocated him, and the loss of oxygen had a catastrophic effect on his brain. Similar to some dementia patients, Bryan knows that there are holes in his memory, but the holes aren’t ever going to come back. His genealogical obsessions and his final breakdown left him in the peculiar state of knowing more about life two centuries ago than he does about the modern age. He wants desperately to be normal, but doesn’t know how to be. He’s just a victim.

Investigation

Bryan’s room is full of his personal effects, overwhelmed by the paraphernalia of his genealogical researches. As his journals progress, his research became increasingly dark, culminating with his recording the incantation to raise his ancestor, in an entry dated April 10th. Depending on the true reasons behind the case and the inclinations of the characters, it could offer an insight into the deteriorating psyche of Bryan Teesdale, or into the dark history of Bishopsgate.

Shaun Stewart’s land holds other pieces to the puzzle. Either way, Stewart isn’t friendly to people blundering in answering questions. If the supernatural explanation is real, he’s lived with the knowledge that something awful is under his land — and neighboring Bishopsgate — for much longer than he’s been there. He’s not willing to talk about it, or accept that it’s real. He’s scared and would rather it all just stopped.

Regardless of which possibility is true, Stewart has something to hide. His wife Elise and his two strapping sons, Cody and Forrest, know the truth as well, and they’re all better-than-average shots with a twelve-gauge. Stewart’s cousin, Mark Hardwide, the doctor who filed Teesdale’s report, is twitchy. If the patient is really a resurrected warlock, Hardwide is uncomfortable and defensive around doctors asking questions because he’s scared that he might be thought incompetent, having come up with such a peculiar set of results. On the other hand, if Bryan was poisoned, Hardwide’s simply terrified for the loss of his job.

A Storyteller could easily run Bryan’s story without deciding himself what the truth is until the last moment, tailoring the results to the players’ expectations — or completely flouting those expectations.

James Teesdale

Quote: *I’ll not talk to ye more. This is all indignity and I will not countenance it further.*

Background: If the patient really is James Teesdale, it’s the same man who led a witch-coven in the catacombs under Bishopsgate three centuries ago (see p. 57 in Chapter Three). In this version, he’s an out-and-out Satanist, a devil-worshiping blackguard whose desire for power overrides any concern he might have for any other human beings.

In psychological terms, he’s a classic psychopath, unable to even understand others’ emotions or feelings. More than that, he’s spent nearly 300 years in (what he believes to be) Hell, centuries of agony that he cannot explain in words. He doesn’t want to go back, and will do anything to get out of returning there.

Description: He’s the spitting image of Bryan Teesdale, only with the porphyria and chloracne that’s a side effect of his resurrection. His voice is hoarse, and the painful lesions on his skin make his movements slow and awkward.

Storytelling Hints: Teesdale has decided to stay inside the asylum, since he has only recently realized that it was built on the site of his old mansion. He’ll try to get down to the basement and into the catacombs as soon as he can. He won’t hesitate to achieve his aims. He’s charming, but archaic. He tries to understand the modern era, but he’s a foreigner here, and he keeps making mistakes that tip off the doctors and frustrate his efforts to be thought of as sane.

Teesdale takes one point of bashing damage for each minute he’s in direct daylight.

Attributes: Intelligence 4, Wits 3, Resolve 5, Strength 2, Dexterity 1, Stamina 3, Presence 2, Manipulation 2, Composure 4

Skills: Academics (Enlightenment Demonology) 3, Animal Ken 1, Brawl 1, Crafts 1, Expression 1, Intimidation 4, Investigation 1, Larceny 3, Medicine 1, Occult (Satanism, Demons) 4, Persuasion 2, Stealth 2, Subterfuge 2, Survival 2, Weaponry (Sacrificial Knife) 3

Merits: Languages (Latin, Greek), Iron Stamina 3, Iron Stomach, Quick Healer



Willpower: 9
Morality: 2 (Megalomania, Paranoia)
Virtue: Fortitude
Vice: Wrath
Initiative: 5
Defense: 1
Speed: 8
Health: 8

Teesdale's Powers: James Teesdale doesn't have to have any defined powers; the spells he knows are complex ritual incantations, few of which actually do anything. Without the materials in his lab, he's powerless. Storytellers who own **World of Darkness: Second Sight** might want to consider allowing Teesdale some of the magical Merits allowed in that book. Alternatively, Storytellers running **Mage: The Awakening** could easily make Teesdale an Awakened mage, with powers that pose an adequate challenge to the players' characters.

The Quiet Man



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ADMIN@BISHOPSGATEHOSP.ORG

Patient: Heron, John W
Attending Physician: Dr. Tucker R. Jenkins
Case Number: BG-1354

Description and History

John Heron. 31 years old. Six foot even, 164 pounds. Mild asthma, wears glasses to correct short-sightedness. No other health problems. Mr. Heron was admitted to the hospital on March 11th this year, after having been released by the court on charges of Vehicular Manslaughter. The accident claimed the life of his wife and two-year-old son. The patient suffered concussion and several broken ribs; the airbag saved his life, it seems. Mrs. Heron and the little boy weren't so lucky.

The patient claims that he had recognized an individual who had been pursuing him for over a year, and attempted to run the man down. The only thing Heron hit was a concrete wall, head-on. According to the patient, the individual, who may or may not be called James Carver, has been a constant presence in Heron's life since their first meeting, when the patient believes that he killed Carver. The patient is manifestly not a violent man, although he is, I think, an angry one.

The patient is suffering from clinical depression (and I suspect, has done for some years, judging by statements made in interviews). He has himself wondered himself whether or not the figure, this "James Carver," who has been causing him so much trouble is actually delusional. I don't know yet if this is an encouraging sign or not.

Treatment and Results

Mr. Heron's first few interviews have been rambling, and hugely detailed. He's still grieving for his wife and child, and the guilt he feels seems to affect most everything he does. It seems that on February 14th two years ago, the patient had agreed to meet his wife, Madeline, at the home of Simon May, a friend. He'd had a bad day. In his own words:

"I could have died at my desk and no one would have noticed."

He decided to walk, since his office was less than a dozen blocks from the office, and the weather was clement. He said that he needed to think. When asked if he could remember what he was thinking about, the patient said that he had no idea.

The patient was passing the Holy Trinity Episcopalian Church, which he attends, or at any rate used to attend, when, he heard somebody say something. Apparently, without even thinking, the patient acknowledged the person. A man had passed Mr. Heron on his right, which was the edge of the sidewalk nearest to the road. The man stopped and turned around. The patient describes him as being at some age between 22 and 25, about the same height as himself, fairly slim and dressed in a fashion the patient describes as "preppy."

The patient suddenly conceived the idea that this individual was dangerous, and tried to apologize and walk on. The man barred his way and tried to start a fight. The patient describes himself as a physical coward.

Dr. Tucker Jenkins, tapes, Case 1354, Heron, John W; March 19th, transcription (Extract):

JWH: The man asked me what I'd said, a second time. So I said, nothing.

JWH: I'd just put myself in a weak spot. He knew that. He came up close and whipped out his left hand. And I grabbed his wrist, with both hands. Like this. Which was a bad thing to do.

JWH: Then he said. "I'm drunk." Which was unnecessary. I could smell his breath. He said, he wanted cash for a cab. He asked how much money I had. Still holding tight on to my neck.

TRJ: Then what?

JWH: I said I didn't have anything, and my voice was all high-pitched and I was obviously lying, so he slapped me hard and knocked my glasses off. He let me go, and I fell over.

JWH: And he's standing over me, and saying get up, get up, and I can't get up and then something in me snaps and I get on my knees and then I don't get up, I barge into his shins with my shoulders and he stumbles, and I grab his ankle and pull and over he goes and then I don't know how, but I'm on top of him, beating his face in. Over and over again. Just punching and punching and punching and screaming, bastard, you bastard at the top of my lungs. And then I noticed he wasn't moving, so I got up and I kicked him again and again, five or six times until he just went kind of crack and coughed up blood, once, and then just went limp.

TRJ: Wasn't there anyone around?

JWH: Not a soul.

TRJ: Didn't that strike you as odd?

JWH: I was beating someone to death.

TRJ: Have you ever done anything like that before?

JWH: No.

TRJ: So why him?

JWH: He took away my dignity. He made me cower. On my knees. I wasn't going to let that happen again.

TRJ: Again?

JWH: It happened to me all the time as a teenager. I wasn't a popular kid. When I went to college - I wanted to forget being a teenager ever happened to me.

TRJ: But you couldn't?

JWH: It never went away. Sure, for the first couple of years after I left, I thought I'd escaped. But I hadn't. I used to have nightmares, and it would be like everything was exactly the same as it was at school and I wasn't ever going to get away and I'd wake up screaming and with the sweats and stuff.

TRJ: What was so bad? What happened?

JWH: Hardly anything you'd think important. Name-calling. A shove in the hall. My stuff getting stolen. Having no social circle apart from the other outcasts, who you'd only hang out with because there was no one else, and you'd loathe them for it.

JWH: You were in a team at high school, weren't you, Doctor?

TRJ: Yes, I was, actually. Swim team.

JWH: And a frat at college?

TRJ: I never got round to it.

JWH: It doesn't matter. You can't know what it's like. Every single day, year upon year. And knowing that it's never going to go away. You can't understand.

TRJ: This makes you angry, doesn't it?

JWH: It doesn't go away. I was at the mercy of so many other people then, and I'm still at their mercy. Sometimes I fantasize about what I would do to some of the boys I knew in high school if I met them again. I close my eyes and imagine meeting one of them, grabbing him by his hair and punching him over and over in his face until it caved in, until his nose was no more than a flattened concave smear. I'd imagine the blood going all slippery and sticky on my knuckles.

JWH: It stays with me every day of my life. Every little failure. Every acceptance that I'm at the mercy of the rest of the world. It just builds up, and it never comes out.

TRJ: Except it did -

JWH: And I beat a man to death.

TRJ: So what did you do?

JWH: I ran. I had his blood on my jeans. I can still see it. It was bright red. Like stage blood.

JWH: By the time I'd run a couple of streets, my legs were shaking so much that I had to stop. I sat on the sidewalk. On the curb. I had this knot in my chest, and it was so tight that I could no longer think or see straight or breathe. I nearly cried.

JWH: I sat there for a while, I don't know how long, few minutes maybe. Got my breath back. And then I realized I couldn't see. So I ran back to go looking for my glasses.

TRJ: To the scene of - the altercation?

JWH: I was panicking. I wasn't thinking.

JWH: So I got back to the church, and I realized that I was actually wearing my glasses. I put my hand up, and I was still wearing them.

JWH: And outside the door of the church - there was no one there. No body. Not even a pool of blood. No blood on my jeans. No dirt. Nothing. He was gone. It was like it never happened.

JWH: Except I could still feel his fingers around my throat.

Dr. Jenkins' report:

Although, unsurprisingly, shaken by this experience, the patient continued to the party, where he met with his wife. Here, it seems that he developed the conviction that the assailant had followed him. Talking with his wife, he explained what he had experienced. He remembers his wife's reaction as being negative, which is likely to be significant.

However, the patient and his wife continued to put on a face for the sake of the gathering. The host, Simon May, approached them, introducing them to one James Carver, who, apparently, was new to the area. The patient became convinced that this Carver, although not showing a mark and not showing any signs of rec-

ognition up to this point, was the man he had believed he had killed.

The patient and his wife made conversation with the man for a few minutes, who continued to behave as if he had never met the patient before and to make friendly conversation. The patient, concealing his reaction, became increasingly uncomfortable and eventually made an excuse for he and his wife to leave.

On parting – Heron's wife had gone to retrieve their coats – Carver, so the patient says, gripped him by the hand and whispered to him the words, "Just you wait." The patient, unable fully to explain his discomfort to his wife, went home with her. They argued. The persecution appears to have begun the following day.

Apparently, the patient woke up, thanks to some intuition, and ran to his son's room. He saw Carver standing by the baby's crib, holding the boy in his arms. Mr. Heron snatched the boy back; Carver offered no resistance. The man smiled, and walked out past the patient. The baby began to cry, waking up Mrs. Heron. The patient, checking all available exits, found every door and window in the house locked. This precipitated another argument.

Dr. Tucker Jenkins, tapes, Case 1354, Heron, John W; March 19th, transcription (Extract):

JWH: It was constant after that. It never stopped.

TRJ: How do you mean?

JWH: He was everywhere. He was everywhere. Like I'd walk down a street, and he'd be standing around the corner. He'd smile, and vanish into the crowd, or be standing behind me and he'd say something about my wife. I'd get into the elevator going into the office and he'd be coming out of it, and he'd smirk at me and the doors would close, and I'd get up to the office and my desk would be re-arranged.

TRJ: Was anything missing?

JWH: No. But it was all moved around. And no one could see anything. Whatever it was he was doing, he was invisible. One time – I was at church, and it was the Eucharist. I was at the communion rail and glanced to one side, and he was there kneeling beside me. He just glanced at me, and raised one eyebrow, and then he spat in the chalice as the celebrant handed it to him. And then the priest wiped the rim and handed it to me like there was nothing wrong. And I drank out of it, even though his spit was in it. He got to his feet and went through the curtain that goes to the corridor that leads you out to the back of the sanctuary. I got up just a little too quickly but –

TRJ: – he was gone?

JWH: Yes.

JWH: When I got home that evening, he was there. Danny was asleep in bed and Madeline was there, sitting there with him, drinking coffee. She'd been out with Danny and she'd run into the guy in the street and they got talking and she asked him back. Somehow she thought I'd enjoy seeing him.

TRJ: What did you do?

JWH: I sat down and I had a cup of coffee and I talked with him.

TRJ: What about?

JWH: Work. He was in marketing or something. And we talked about the weather. And politics. He was a Democrat, too.

TRJ: That's all?

JWH: Yes. No. There was a moment where Madeline heard Danny stirring. So she went upstairs to see if he was all right. And he looked at me. The man looked at me – It's like he was laughing at me. And I stared and stared like I was paralyzed. And then he said thanks, he'd better be going and we saw him to the door when he got his coat and then he went home. And I went nuts at Madeline. And she never figured out what for. And the following day, I saw him coming out of the elevator at work. And then I saw him every day after that. Every. Single. Day.

Dr. Jenkins' report:

It seems that after two years of this figure's constant presence, the patient snapped. While driving his family on the freeway on January 3rd this year, apparently at the beginning of a trip to see Mrs. Heron's parents, the patient saw Carver standing in the middle of the road. He swerved. He admitted that he was trying to hit him. He lost control of the car. The results you know. This was the last time John Heron saw this James Carver.

Treatment

Heron's depression and his repressed memories of childhood persecution appear to have formed this imaginary figure, as I've been prescribing antidepressants, obviously. The patient's issues with his childhood are going to need a long course of therapy.

I had thought that after his wife and son's deaths, the delusional figure had gone away, although I asked him to tell me if the persecutor came back. Last night, it appears he did. I'm prescribing antipsychotics. Therapy continues. I'm not holding up a lot of hope.

Dr. Tucker Jenkins, tapes, Case 1354, Heron, John W; March 24th, transcription (Extract):

JWH: I saw him again last night. He came to see me.

TRJ: When was this?

JWH: About three in the morning. I woke up about three in the morning. The clock said it was three in the morning, and there was something on my bed, so I leaned over and turned the light on and it was him. He was sitting on my bed.

TRJ: What did he do? Did he say anything?

JWH: Yeah.

TRJ: What did he say?

JWH: He said, "Maybe you should go see your wife and son."

Game Systems

Saint Paul wrote that nothing can separate us from hope and love and the divine: height, depth, devils and angels, nothing in the present or the future. He said nothing about the past. Maybe he understood that things past can't be gotten round. It's the past that really can destroy us. Whether his visions of James Carver are real or delusional, John Heron is a man whose past has all but destroyed him. It's just waiting to finish the job.

Option One: Psychic Projection

James Carver was the name of a kid who John knew when he was in his early teens. The boy died in a car accident, aged 14. John has forgotten the names of many of his schoolyard tormentors. Part of it is deliberate. He tried to forget. He'd had so many other persecutors when he was a kid, and this one, just as many others, he forgot, just a name in the back of his mind that didn't even have a face to it.


The driver of the car that ran over the boy said at the time that he lost control of the car, that he'd felt that there was someone standing next to him, that someone yanked the wheel out of his hand and forced him to run the boy over as he crossed the street. It was John who caused the original James Carver's death — specifically, it was John's

misery that killed James Carver.

John has no idea of the psychic power with which he was born. It lay dormant in him until he was about 13. The power was awakened by John's depression, by his powerless anger at being a victim, at being at the mercy of the world. John unwittingly created a *tulpa*, a sentient thought form given material existence. The *tulpa* manifested in the presence of the boy whom John most identified as his tormentor, scaring him, stealing things from him, shadowing him after school. It was the *tulpa* that caused a spooked James Carver to run across a busy street. And it was the *tulpa* that sat alongside the driver of the car and drove it into the boy.

When the news hit the junior high school, most people made a huge show of organizing a memorial. Some donated to a fund set up by his parents to set up a stop sign on the street where James died. John didn't tell anyone, but he felt nothing but relief.

He was glad that Carver was dead. Inside, he was cheering. And as John's misery abated, just for a while, the *tulpa* vanished. The bullying soon started again. When John found himself a college in Tennessee, as far away from his hometown as he could afford to go, John thought he'd moved on. Not really. He gained some social skills, developed a circle of friends he actually liked and even got himself a girlfriend whom he later married. By the time he returned to Bishopgate, every single one of the kids who'd



made him suffer had moved away. He never had to see any of them again. It took him too long to get his act together. He began to regret that he'd never really had a childhood. As time went on, the memories came back. And so did the anger. About the time he hit 30, the *tulpa* reappeared, now with many more years of anger and frustration to draw upon. Originally, the *tulpa*, taking the form of what John himself would like to be, younger and better looking, appeared as an outlet for John's anger. But the act of allowing John to beat it to death revived it, gave it a separate consciousness, a mind of its own outside of John's impossible desire to revenge himself on his past.

John's own misery empowered it; the *tulpa* began to make John's life miserable, to the extent that it engineered the car accident that caused the deaths of John's wife and two-year-old son. But the *tulpa* depends upon John to exist. It resents him for that. And this is why the *tulpa* is trying to drive John to his death; the *tulpa* believes that the release of one final outburst of sorrow and pain — John's suicide — will give the *tulpa* the energy to begin an independent existence.

The *tulpa* doesn't know if it's right or not. Its hatred for John is an artifact of the emotions that created it. It doesn't have any real reason to hate him; it just *does*. As long as John's depression continues, the *tulpa* continues to exist and grow. It slips in and out of John's psyche. The *tulpa*'s growing more powerful daily, especially since John's wife and child died.

When manifest, it appears as an ordinary human being. It can vanish any time it likes, and appear, instantly, anywhere else, as long as it's a place where John himself has been, and as long as no one is looking. It can't vanish while even one person is watching it, although a split-second is all it needs to vanish (it slips behind a corner or just out of sight behind a tree, for example, and it's gone). It knows everything that John knows and wears similar — but not identical — clothes. It's possible to injure the *tulpa*, and maybe even kill it, but as soon as it's out of sight and re-appeared somewhere else, even if it was previously "dead", the *tulpa* returns to perfect health. The only way to destroy the *tulpa* is for John to come to terms with the emotions that created it.

This is much easier said than done. John's depression is all-consuming, and he lacks the willpower to face his demons. The first step to facing the *tulpa* is, however, to understand what it is. A bit of research into the schooldays that so trouble John might lead a perceptive investigator to find reports of James Carver's death. John's old junior high school in Pennsylvania has a bench under a tree, on which is fixed a plaque in memory of James, and local news reports of the day mention it a few times. An account of James Carver's death will bring it all back to John.

In the hospital, the *tulpa* is limited to places that John knows: the grounds, the wards, the consultation room. Closer to John's home, the *tulpa* can become manifest in many more places: the streets of his old home town, the

streets of his new home town, his home, his place of work. If the *tulpa* feels that the truth might come out, particularly when it comes to the secret of James Carver's death, the *tulpa* will resort to any means it can to stop John finding out and remembering — including murder.

The *tulpa* represents everything John hates. The *tulpa* is charming, smug, anti-intellectual (although just as smart as John), plays on weaknesses and is utterly selfish. This can be its downfall: John spent his teens being ignored, mocked, brutalized and marginalized by people like this. Since leaving school, he's always felt terribly inferior when faced with this kind of person. If he understands that this person actually depends on him to survive, it could be the beginning of the *tulpa*'s destruction.

The biggest problem after finding out the truth about James Carver's death is in figuring out what the being with his name actually is and where it comes from. The most obvious conclusion characters might draw is that John is being haunted by James' vengeful ghost. It should be plain quite early on that the *tulpa* is not a ghost. When manifest, the *tulpa* is as material as any other human. It can — and, when it begins to get frustrated — will interact with people outside of John's knowledge. The *tulpa* might not be able to go places where John hasn't gone, but it can cause mayhem. For one: John worked at a local newspaper. He had access to the archives, and so does the *tulpa*, which has already misplaced the files dealing with the death of James Carver and caused damage to the computer database.

Option Two: Real Person

There is no *tulpa*. The part about James Carver's death is true, but the driver's story, although told honestly, is more to do with the fact that he was high at the time than because of a malevolent force that forced him to run over the boy.

The name was buried in John's consciousness. His rising depression caused him to experience delusions. When he met a real person who — entirely coincidentally — was also called James Carver, John's delusions warped to accommodate the completely innocent man. Whenever John sees this real James Carver (who, it turns out, lived only a couple of blocks away from him), John unwittingly imposes his own delusions upon the man's actions.

James Carver heard about John's accident, and feels sorry about the family. James Carver wasn't there. That was in John's tortured imagination. The fight on the street that began John's tortured two years was entirely delusional. But James *did* visit John's home, and he *did* meet John at the party. He *did* pass John on the street and nod in acknowledgment several times. John's delusions changed the way John interpreted James' smile, over and over again. Once, James even had cause to visit the newspaper where John worked on one occasion, popping in on one of John's colleagues who was a friend of his and passing John as he left the building.

The combination of the coincidence behind the man's name, John's paranoia and the death of the boy so

many years ago can, with John's help, take on a sinister turn. Files and pharmaceuticals get mislaid, but not because John's persecutor is doing this; it's because an orderly pressed the wrong button on the system. Characters see the man on the street the next time they take a trip to the nearby city; maybe they hear him say his name in a shop or something. Suddenly, he seems to be everywhere. It's all a coincidence, but there's a great deal of opportunity for investigating doctors to buy into his delusions — and make them that much worse.

Meanwhile, John's illness, made all the more tragic because it has led to the death of his wife and child, grows and makes him more and more irrational. The real tragedy of John's sickness is that even if he recovers from his illness, it's too late for him. His wife and child are dead, and he was driving the car. He might not have been responsible for his actions, but no matter how he recovers, he won't ever forgive himself.

Investigation

The newspaper archives aren't really that professionally organized, and, depending on which version of the story is true, the *tulpa* found it easy to misplace the story about James Carver's death. Either way, the story's going to take an exceptional success on an Investigation roll, and this after deciding to visit the newspaper's archives.

If the *tulpa* is real, it might begin to make itself known, stealing stuff, invading the homes of the doctors who threaten its existence and maybe even trying to set up accidents.

Whether John's troubles are delusional or not, there really is a man called James Carver walking around Bishopsgate. He's pretty difficult to pin down. The fact is, James Carver isn't really his name. He's actually called Philip Leonard, and he's in town thanks to a witness protection program. Although the Baltimore mobster Philip turned State's evidence against is in prison, "Carver," who was given the name of that dead teenager (and hence, the dead boy's birth certificate and so on), had to start a new life. He's got a handler who checks up on him every so often. Doctors who investigate this Carver may find themselves warned off by a sinister man in a black suit and sunglasses, and may find evidence of the man actually being nearly 18 years dead. It's all a misunderstanding, but misunderstandings take a while to clear up, and while all this is going on, John Heron grows increasingly suicidal.

John Heron

Quote: *No. You don't understand. He's not going to stop until I'm dead.*

Background: John admitted himself to the Bishopsgate Hospital, but it's not helping him at all. His conviction that James Carver is persecuting him is becoming





more and more grounded with each passing day.

Description: John has broad shoulders, but isn't very physically fit. He's got sandy hair, and he wears glasses. Without them, he has a great deal of difficulty seeing. He talks quickly and earnestly, as if everything he has to say is of great importance.

Storytelling Hints: Although an experienced professional, he's lost his job, his wife and his child in short order. He has little or nothing left, and the chances are that he'll find it hard to get work again. He's not stupid. He knows that. John can be smart and funny, and sometimes his sense of humor shines through, but mostly, he's in a bleak pit. He's terrified of dying. Only that fear of death has kept him from committing suicide. When his depression overcomes that fear, it'll be the end of him.

The *tulpa*, meanwhile, is working to make sure that even though he's scared, he's going to go through with it sooner or later. The *tulpa* and John have almost identical stats (which is why these stats are fully detailed, since it's likely that characters may come to blows with John's imaginary evil twin). If the *tulpa* dies due to violence or an accident, which can happen fairly easily, since it has no powers other than the ability to appear around John and steal his Willpower (see below), it can't reappear until the next scene. Whatever happens, the *tulpa* always heals any injuries it has the next time it appears.

The *tulpa* doesn't know whether or not killing John will give it the freedom. John's suicide might indeed make the *tulpa* whole and free, turning it into a real flesh-and-blood human with no other powers. Alternatively, the *tulpa* might be wrong, and John's death might simply destroy the *tulpa* forever — it's up to the Storyteller.

Attributes: Intelligence 4, Wits 2, Resolve 2, Strength 2, Dexterity 2, Stamina 2, Presence 3,

Manipulation 2, Composure 2

Skills: Academics (Local History) 4, Brawl 1, Computer 2, Drive 1, Empathy 3, Expression (Journalism, Editing) 3, Intimidation (*tulpa* only) 2, Investigation 1, Politics (Local Politics) 4, Persuasion 2, Socialize 1, Streetwise 1, Subterfuge 1, Survival 2

Merits: Contacts (Local Politics, Journalists), Eidetic Memory, Languages (French, German), Resources 2

Willpower: 4

Morality: *John*—7 (Melancholia, Inferiority Complex, Paranoia); *tulpa*—3 (Narcissism)

Virtue: *John*—Charity; *tulpa*—Fortitude

Vice: Envy

Initiative: 4

Defense: 2

Speed: 9

Health: 7

Defeating the *Tulpa*

The *tulpa* has the same statistics as John. It survives by leeching Willpower from him on its visits. Each time the *tulpa* visits him, John loses one Willpower point, which goes towards feeding the *tulpa*. This allows the *tulpa* to survive independently for 24 hours.

For every 10 successes John gains toward overcoming his derangements through the use of therapy (see Chapter Two for details on this), the *tulpa* loses a *dot* of Health. Even once he has defeated his psychoses (he requires a total of 50 successes to stop suffering from his derangements), he still has another 20 successes to go to completely defeat the *tulpa*.

Each time the *tulpa* visits him, however, it can reverse some of this progress. The *tulpa* makes a contest Manipulation + Intimidation check against John's Resolve + Composure. For every success beyond John's successes the *tulpa* scores, it subtracts one from the total therapy successes accrued. The *tulpa* doesn't do this every time it visits, however; as long as John continues to suffer from his normal derangements, the *tulpa* is content. As he begins making progress, however, the *tulpa* strikes back with greater ferocity.

The Repentant



BISHOPSGATE MENTAL ASYLUM

(555)555-7935

[HTTP://WWW.BISHOPSGATEHOSP.ORG](http://www.bishopsgatehosp.org)

ADMIN@BISHOPSGATEHOSP.ORG

Patient: John Bennings

Attending Physician: T. Harris, M.D.

Case Number: BG-0323

Description and History

John Bennings is a white male, age 32, admitted to Bishopsgate following being found incompetent to stand trial in the murder of Jane Doe (see attached police file). Bennings maintained his innocence throughout the trial and has several corroborating witnesses offering an alibi, but as the trial progressed, they all recanted. All other witnesses reported being afraid of Jane Doe (the victim remains unidentified to this day, but since she was burned to death her body didn't allow for easy recognition) and that this fear led them to protect Bennings because he had done what none of them had the courage to do. Bennings, for his part, broke down in court when his last alibi witness recanted, saying that he knew that Bennings had left to find the victim and had taken along a can of kerosene.

In statements to myself and other psychological care specialists, Bennings stated that he was unsure what drove him to such homicidal lengths against Jane Doe (whom he refers to as "the beautiful lady"). He claims that his will was not his own, that he is not a violent man by nature and that he wishes forgiveness for his crime. His first suicide attempt came the night after his breakdown in court, but was foiled, and he has been placed on suicide watch ever since. Despite popular opinion at the time, his behavioral profile indicates a true, strong suicidal impulse, and he remains on SPL 2 even now.

Bennings claims that he wants to let go of his guilt, but still cannot offer a satisfactory reason for his behavior. He has no history of violence, and there is no evidence of abuse in his family, drug or alcohol abuse prior to or on the day in question. He has never struck any of our staff or acted out in any way, and if not for the danger of suicide, I would have no hesitation in recommending a transfer to minimum security.

According to the interviews conducted by police, Bennings became obsessed with "the beautiful lady" for several weeks leading up to the attack. His girlfriend reports that she left him because she believed he was having an affair with "the beautiful lady." His former manager reports that his job was in jeopardy because he spent his time writing letters to her (see attached) rather than working. Bennings reported that he had recurring dreams about her every time he slept (see "Treatment and Results"; his dreams have not improved much). Sometimes these dreams were erotic in nature, sometimes he would dream about her as a monster, "something like out of a zombie flick," to quote his own testimony. Following such dreams, he reports awakening and hating himself for dreaming such things about her.

Since being admitted to Bishopsgate, Bennings has improved by small stages, but at this time he is not ready for reintroduction to society. Fortunately, Bennings understands this - he is truly a rare case, because he realizes that he needs treatment. He takes full responsibility for the death of Jane Doe (even

though he doesn't know her name or anything about her beyond her appearance) and wishes forgiveness.

This desire for forgiveness, however, has become an obsession of its own and has warped into some truly strange hallucinations. He believes that Jane Doe's "creator," a being as terrifying and hideous as Jane Doe was beautiful, to paraphrase Bennings, visits him monthly. This being - whom Bennings refers to as Higgins, though he isn't sure where he heard the name - is, according to Bennings, able to appear and disappear at will, to walk through our security without being seen and to wake Bennings no matter how much medication he is given. While some of the things that Bennings reports make sense, given his condition and the medications that he takes, there are other facets of the "Higgins" story that simply don't follow. For instance, although Bennings reports that Higgins shows up "monthly," an examination of the reports that Bennings has made to myself and other providers indicates that Higgins actually visits him roughly every six weeks. This rules out a lunar cycle. An examination of Bennings's medication regimen indicates that Higgins has continued to visit despite several changes in prescription and dosage.

Bennings's description of Higgins has not remained entirely consistent. Higgins is always male, and appears to be in his late 40s, strongly built and stern-faced. But when he first arrived, Higgins was African American. Starting on his third visit, Higgins was white and has remained white ever since. Bennings has always described Higgins as "strange," but had trouble quantifying that. At times, Bennings described him as "fake, like a statue" or "made of plaster and paint." Higgins' clothes change, but Bennings has never made a point of mentioning them, so we must assume that he does not attach significance to this facet of the hallucination.

Of extreme interest, though, is the fact that Higgins seems to be growing more monstrous as the visits progress. Bennings reported following Higgins's seventh visit that he now had a "hole in his stomach, and there's something living in there." After the 11th visit, Bennings said that Higgins had a third eye on the back of his neck. Only last month (which would mark Higgins' 19th visit), Bennings told me, with growing panic, that Higgins had grown two tentacles, "like a squid's," that emerged from his navel and the small of his back.

Throughout the time that "Higgins" has visited Bennings, Bennings reports that he begs Higgins for forgiveness for killing the beautiful lady. Higgins' relationship to Jane Doe in Bennings's mind is not clear; at first, Higgins seemed to be a father, but further conversation makes it seem that Higgins actually created Jane Doe. This fits with Bennings's idolization of the woman; she was so perfect that she couldn't have been born under normal circumstances. In any event, Higgins consistently refuses to forgive Bennings, but also refuses to kill him, wishing him to be kept alive and in torment here. It could be that Higgins is Bennings's way of sublimating both his guilt at his crime and his angst over his loss of freedom from being incarcerated at Bishopsgate.

Treatments and Results

Treatment thus far has been largely psychopharmacological: mixture of antidepressants and mood stabilizers combined with sleep aids. Sleep aids removed when dreams became too vivid; currently looking for a better prescription. Prescription schedule attached - still open to suggestions for changing the cocktail, since we haven't found the right mixture yet.

Psychotherapy thus far has included cognitive therapy, expressive therapy (Bennings enjoys painting and charcoal sketching) and journaling. In particular, Bennings has been encouraged to keep a dream journal, and it has been helpful to point out to him that his dreams grew more vivid on certain sleep aids.

Plan

Helping Bennings to understand that it is his brain chemistry, not an outside influence from the "beautiful lady" or "Higgins" that causes his dreams might be

key to helping him to understand that "Higgins" doesn't exist at all and that the "beautiful lady" was just a normal woman. Once this is accomplished, we can help Bennings to understand that it is not Higgins who needs to forgive him, rather that Bennings needs to forgive himself.

Bennings is cooperative and willing to try any therapy we recommend. He is an excellent candidate for experimental pharmaceuticals, both because he is a prisoner of the state and because of his extreme desire to be "normal" again.

A secondary avenue of approach, but one that has consistently failed, is to identify Jane Doe. We know so little about this unfortunate woman that it is difficult to piece together why five men would initially protect someone who burned her alive, to say nothing of why Bennings burned her in the first place. The police made every effort to identify her before the trial, but were unable to find a single witness who knew her name or any photographs. We have only Bennings's drawings to go by. The crime scene, an abandoned building where Bennings claimed that Jane Doe lived, still stands, despite fire damage, but it is unlikely that any clues remain after all this time.

Game Systems

Obviously, the main issue in this case isn't Bennings himself, but the story behind his actions. What drove Bennings to murder Jane Doe? Who is Higgins and what is happening to him? Below are three explanations for Bennings's sad story, as well as some information that characters might uncover if they go digging.

Option One: Disquiet

Jane Doe was a Promethean, a living being created out of dead flesh and the power of the Divine Fire. "Higgins," another Promethean, created her as part of his quest to become human, and was training her to follow in his footsteps. Jane, however, discovered Bennings, and Disquiet (see p. 175 in the Appendix) took its toll. Bennings became obsessed with possessing Jane, as did several of his friends, but to a much lesser degree. John could not bear the strength of his feelings and murdered Jane one day while Higgins was absent. Although John's friends initially backed him, the effects of Disquiet wore off on them, one by one, until John was left with no alibi and a story full of holes. Higgins plans to murder John, but wants to torment him as long as possible. Using his powers of deception, he sneaks past the Bishopsgate security and visits John every few weeks (see below for the secret behind this pattern). Higgins also uses special powers to avoid letting John fall under his own Disquiet, because he doesn't want to give John that "refuge."

Option Two: The Demon

Jane Doe was evil. She was a creature spawned in a place that human beings are ill-equipped to recognize, and so they call it "Hell." Trying to wriggle her way into our world, she took on the body of a young woman, one whom John Bennings knew in passing. Only John was able to recognize the

change, and tried to convince his friends of the possession. Initially, they agreed to back him. John burned the body that the demon inhabited, but the demon was not destroyed. It was simply rendered incorporeal. It possessed another body and made Faustian pacts with each of John's friends, stripping him of his alibi. Invading his dreams, it drove him mad, locking away the truth of what had happened. And now, in its new body (Higgins), the demon visits Bennings. As the demon calls in the "markers" and consumes the souls and flesh of John's onetime friends, the demon grows more inhuman. It is saving John's flesh and soul for last.

Option Three: Madness

John is a paranoid schizophrenic. He had suffered, quietly, from auditory and visual hallucinations all his life, and when he met "Jane Doe," a homeless woman trying desperately to escape her unfortunate circumstances, he snapped. He became obsessed with her and eventually wound up killing her. His friends initially tried to protect him, but when they realized just how ill he was, they stopped. He is, unfortunately, resistant to many of the drugs prescribed for him at Bishopsgate, and this has impeded his progress to recovery.

Investigation

Characters looking into the Bennings case might discover some of the following, depending on what the Storyteller has decided:

- **The Higgins Cycle:** Characters who investigate Higgins' visits discover that a freight train passes through the area every six weeks, corresponding to his visits. The train makes a circuit of nearby cities. Higgins, apparently, uses it for transportation, or might even live in an empty car.
- **The Crime Scene:** Jane Doe buried a box near the abandoned building where she died. In it are *her* dreams, artwork and the notes about her obsession with John.

• **The Security Breach:** Some of the guards and orderlies at Bishopsgate know about Higgins. They might be under his control, they might be deceived into thinking he's a doctor or they might simply be on the take. Either way, they could help characters catch him — or they might warn him that someone's on his tail.

John Bennings

Quote: *Why can't he just kill me? If he won't forgive me, why can't he just kill me?*

Description: Worn, haggard and wasted, John Bennings looks much older than his 32 years. He was in good physical condition before his incarceration, but years of poor nutrition and lack of exercise have left him weak and flabby. His hair is unkempt, he only shaves every third day and the medications made him dizzy and unfocused.

Storytelling Hints: Bennings's one goal in life is to be rid of the guilt he feels, one way or another. He has no idea how much he really knows about Jane Doe or "Higgins," and it's probably that many other details about them (and any companions they might have had) are locked away in his tortured mind.

Attributes: Intelligence 2, Wits 3, Resolve 2, Strength 3, Dexterity 2, Stamina 2, Presence 2, Manipulation 2, Composure 3

Skills: Academics 2, Brawl (Aikido) 2, Computer 2, Empathy 2, Expression (Art) 3, Persuasion 1, Politics 1, Science 1, Socialize 1, Survival (Camping) 1, Weaponry (Baton) 1



Merits: Barfly, Resources 2

Willpower: 5

Morality: 6 (Schizophrenia)

Virtue: Temperance

Vice: Lust

Initiative: 5

Defense: 2

Speed: 9

Health: 7

A Vacant Stare



BISHOPSGATE MENTAL ASYLUM
(555)555-7935

HTTP://WWW.BISHOPSGATEHOSP.ORG
ADMIN@BISHOPSGATEHOSP.ORG

Patient: Jesus Emilio Alvarado

Attending Physician: Dr. Preston Cates

Case Number: BG-0414

Description and History

Fifteen years ago, Jesus Emilio Alvarado was once a small business owner in Brownsville, Texas. He had a wife, Esperanza, two children, Antonio and Amelia and a prosperous hardware business consisting of two stores, and he was about to open a third. However, in that same year Jesus went missing and wasn't to be seen again until 10 years ago. During those five years, the man who was Jesus Emilio Alvarado was subjected to unimaginable terrors, leaving a severely disturbed and damaged person in his place.

One of the primary causes for confusion with this case is our inability to account for Jesus during the five-year span. Though the details are

a bit spotty, the previously mentioned hypnosis therapy has met with some success and this story, according to Alvarado, is what happened.

Jesus Emilio Alvarado left his family to travel across the border to arrange a new wholesaler for his business in Tampico, Mexico. After displaying his passport to border patrol at Matamoros, Alvarado stopped at a slightly out-of-the-way café for refreshment before continuing south. It was at this café that Alvarado encountered his abuser-to-be, a woman Jesus knows only by the name "La Santísima Muerte" – the name of a patron saint revered by the cultic practitioners of Brujería, or Mexican shamanic witchcraft. After serving him a cup of coffee, the woman returned with three large men who subdued Jesus when he attempted to go to his car. It was at this point, that Alvarado's story turns into a nightmare.

After being transported, blindfolded, in the flatbed of an old truck, the woman from the café and her three assistants unloaded Alvarado into a decrepit ranch-style house. Inside, Jesus was stripped, shaved, handcuffed and then locked in a closet without food or water for several days. Once this period of isolation was over, Alvarado, believed to be mostly delirious at this point, witnessed the ritual murder of a teenage boy – a fate that Alvarado assumed would be his own. The killing involved skinning the boy alive at the foot of a crude altar atop of which sat a cauldron filled with all manner of bones and odd protrusions of wood. During the moment of the boy's final bloodcurdling scream, the woman called "La Santísima Muerte" cut off his head with a machete and offered it to the cauldron, requesting protection and power. Over the next several months, Alvarado witnessed six more of these murders, which varied in their torture methods but always ended with a prayer and offering to the cauldron.

After what Alvarado experienced as years, he was taken to the altar and restrained there. While being beaten with palm fronds as some kind of symbolic act, he claims he was invaded by a tortured spirit – most likely Alvarado's rationale for a schizophrenic breakdown brought on by the sustained terror and anxiety of his experience. He claims that when the so-called spirit filled him, the man named Jesus Emilio Alvarado ceased to be "as if held underwater by a dark hand, unable to speak, or breath. Only fear. Only fear." Alvarado claims that this ritual was conducted every night for a span of time he has no concept of.

Ten years ago, the farmhouse was located and raided by Mexican Police and American Border Patrol as part of an initiative to locate safehouses for those seeking to immigrate illegally. It was only by lucky coincidence that the Matamoros farmhouse was uncovered. In addition to the remains of more than 22 ritual sacrifices, authorities rescued Jesus Alvarado, whom they found wandering in circles in a nearby field when the raid occurred. After two days of researching Alvarado's identity, authorities notified his family of his rescue, and, after a silent, frightened reunion with a family he could no longer recognize, Jesus was taken to a Matamoros institution.

Within a few months, however, the Mexican facility – which was already suffering significant overcrowding – received a request from researchers at Bishopsgate to transfer Mr. Alvarado to Bishopsgate. Because the researchers were studying the ritual child abuse phenomenon, they wished to make comparisons between his experiences and those of individuals who claimed to have been ritually abused. The necessary bureaucratic arrangements were made, and Alvarado was transferred to Bishopsgate, where he has remained since.

Treatments and Results

Jesus Emilio Alvarado is a sporadic catatonic, occasionally breaking from his malaise to become barely functional. His language skills are generally nonexistent, and his awareness of his surroundings is likewise severely limited. Only under the effects of deep hypnosis is the man who was once Alvarado

able to communicate with those outside of his prison. During these times, his eyes widen as if distracted by something in the room that is gradually growing in prominence, and his face gradually but steadily transforms into a mask of horror. At the climax of this transformation, Jesus will let out a chilling scream that he will sustain until his throat is so stripped he can make no more sound. During the scream, however, his hands slash at his own chest, ripping at the skin, as if trying to release something that he feels is trapped inside his flesh (Jesus has experienced severe injury and infection due to this seizure-like behavior). Nonetheless, outside of hypnosis, he shows no anxiety related to what appears to be a post-traumatic condition and is generally quite docile.

Plan

Alvarado is perhaps one of the most tragic cases of our current patients, having had his mental disorders inflicted on him through traumatic, systematic torture both psychological and physical rather than naturally occurring deterioration due to a pre-existing condition. Mercifully, he has little-to-no recollection of what he's lost. Nonetheless, his recovery seems unlikely. However, there are certainly things we can learn from Alvarado insofar as dissociative disorders. Though his case may be hopeless, we're sure that further testing and experimentation with Jesus's therapy could result in progress with less severe cases.

It should be noted that after three years of institutionalization, his wife filed for divorce and remarried. He is occasionally visited by his now-adult children, however.

Game Systems

Though characters will make any number of assumptions as to what caused Alvarado's state, any and all of them will be very difficult to verify. However, because of his near-vegetative state, a moment of lucidity from Jesus Alvarado could provide a terrifying instance of portents and omen to your chronicle. What follows are some possibilities as to what actually happened to the man who once was Jesus Emilio Alvarado.

Option One: The Refugee

Jesus Alvarado's family was put deeply in debt when they moved to the United States. After paying off corrupt officials and other shady characters to put themselves in position for the immigration to America, they owed many favors, and many of those were forgotten. Although the police could certainly reap richer bounties from the countless other families in a similar predicament as the Alvarados, certain criminal facilitators were not so easily appeased. Deeply indebted to a consortium of black-marketers, Alvarado thought he could escape payback by quickly achieving legitimate citizenship in the United States. However, he was carefully observed by these operatives and apprehended when re-crossing the border in order to sustain the needs of his business. It was during one of these business trips that he was apprehended and subjected to extreme torture while

his captors demanded an enormous ransom from his family in the States. Unable to pay the costs without endangering the citizenship of both herself and her children, Alvarado's wife left her husband in the hands of his captors, where his sanity was whittled away to nearly nothing.

Option Two: Possessed

In addition to the horrors that he's witnessed and the isolation and torture he's sustained, Jesus Emilio Alvarado is the product of multiple, forced possessions at the hands of a malevolent and brutal ghost of significant power. At the hands of the Palo/Brujeria cult, Jesus was skin-ridden to the point of uselessness, his own mind constantly pushed under as these strange, cruel spirits ran about in his form. As a result, there is very little left except an exhausted shred of a human who would likely welcome death rather than continue his walk through the darkness as the ghosts of Bishopsgate still use him as a transport whenever it strikes their cruel fancy. However, if one is able to penetrate Alvarado's trance, he may be able to give more specific and useful information pertaining to the ghostly residents of Bishopsgate. Although fully capable of recovery upon arrival, Jesus has since become the joyride vessel of nearly every ghost at Bishopsgate. The longer he's been at the hospital, the worse his condition has gotten, and now, he really is just a shell with just enough sense and body left to remain

among the living. Because of this, you never quite know who's listening in a room with Jesus Alvarado in it. It could be the shy ghost of a child who died in her sleep from illness, the wrathful spirit of a patient who died in the fire or one of Teesdale's company collecting information from unsuspecting staff.

Option Three: Puppet

It would be sad but comfortable to view Alvarado as merely a victim of inhuman tortures and madness. In a way, even his fate as a vessel of spirits would somehow be within the acceptable parameters of what Bishopsgate is. However, Alvarado is neither madman nor a zombie, but a perfectly functioning sensory organ of That Which Lies Beneath Bishopsgate. Although he was certainly a man when he arrived at the hospital, he is now a pseudopod of sorts, wandering slowly across the Bishopsgate landscape, absorbing data and observing the personalities who dwell there. Like some sort of Hell-spawned periscope, Alvarado has the appearance of random wandering when in fact he is always on a mission for the mounds. Due to the completely alien nature of what he is now, the use of mind-probing abilities (such as vampiric Telepathy or the mind-invading abilities of mages) could have catastrophic results, as one would, for all intents and purposes, be starting directly into the core of Bishopsgate's darkest shadow.

Investigation

There are two main aspects of investigation that could lead to interesting chronicle twists when investigating Case BG-0414 — the condition of Jesus Emilio Alvarado himself and the investigation of the cult/organized crime group that kidnapped and tortured him. Prodding into Alvarado's psychological conditions could prove rather uneventful and monotonous, as he's really not capable of providing much help. For all intents and purposes, a psychic or medium would need to be present in order to gauge the slight differences in Alvarado's behavior, which are contingent upon the ghost to whom he is playing host at the time. However, it is possible that an arrogant spirit will leave some sort of recognizable ego-signature in order to let its presence be known. Automatic writing, an obsession with a particular object or room located somewhere in the hospital could all clue in investigators. Insofar as the cult that kidnapped Alvarado, they would likely be extremely difficult to locate based on any information that could be provided by Jesus. However, if the characters can locate and interview Alvarado's wife, it is likely she could provide them with some sort of direction to lead them to the cult, though she'd likely be reluctant to assist as it would be very difficult to convince her of her safety after providing the characters with this sort of information.



Jesus Emilio Alvarado

Quote: <silence, as he rocks back and forth, staring off into the distance>

Background: Jesus grew up watching his mother and sisters go to work in the *maquiladoras*, the factories along the border of Mexico owned by American companies in order to take advantage of the low-income population thereof. He learned the value of hard work from them, and learned to avoid drink and despair from his drunken father. Jesus worked hard to get where he was, only to have it all snatched away by a twist of fate.

Description: A man of Latino origins, Jesus has become rather overweight since his institutionalization. His black hair is thinning, and though he seems to prefer to wear his facial hair in a goatee, he is often scruffy from going days between shaving. He always dresses in somber colors, refusing to wear anything red.

Storytelling Hints: Jesus is a broken man — he has seen the worst that humanity has to offer, and his mind snapped under the experience. He spends most of his time in a fugue state, emerging every couple of days into a depressed funk. He begins experiencing hallucinations within a day or so, and from that point his anxiety builds to the point of hysteria, where upon he lapses back into a fugue. His drugs haven't really prevented this cycle — they seem to only lengthen out the individual parts of it.

Attributes: Intelligence 2, Wits 1, Resolve 1, Strength 2, Dexterity 2, Stamina 3, Presence 3, Manipulation 1, Composure 1



Skills: Academics 1, Brawl 1, Computer 1, Crafts (Carpentry) 3, Drive 1, Empathy 1, Survival 1

Merits: Unseen Sense

Willpower: 2

Morality: 6 (Fugue, Hysteria, Melancholia, Schizophrenia)

Virtue: Faith

Vice: Pride

Initiative: 3

Defense: 1

Speed: 9

Health: 7

To: d.travis@bishopsgate.com
From: m.hyllel@bishopsgate.com
RE: Sadie Brown

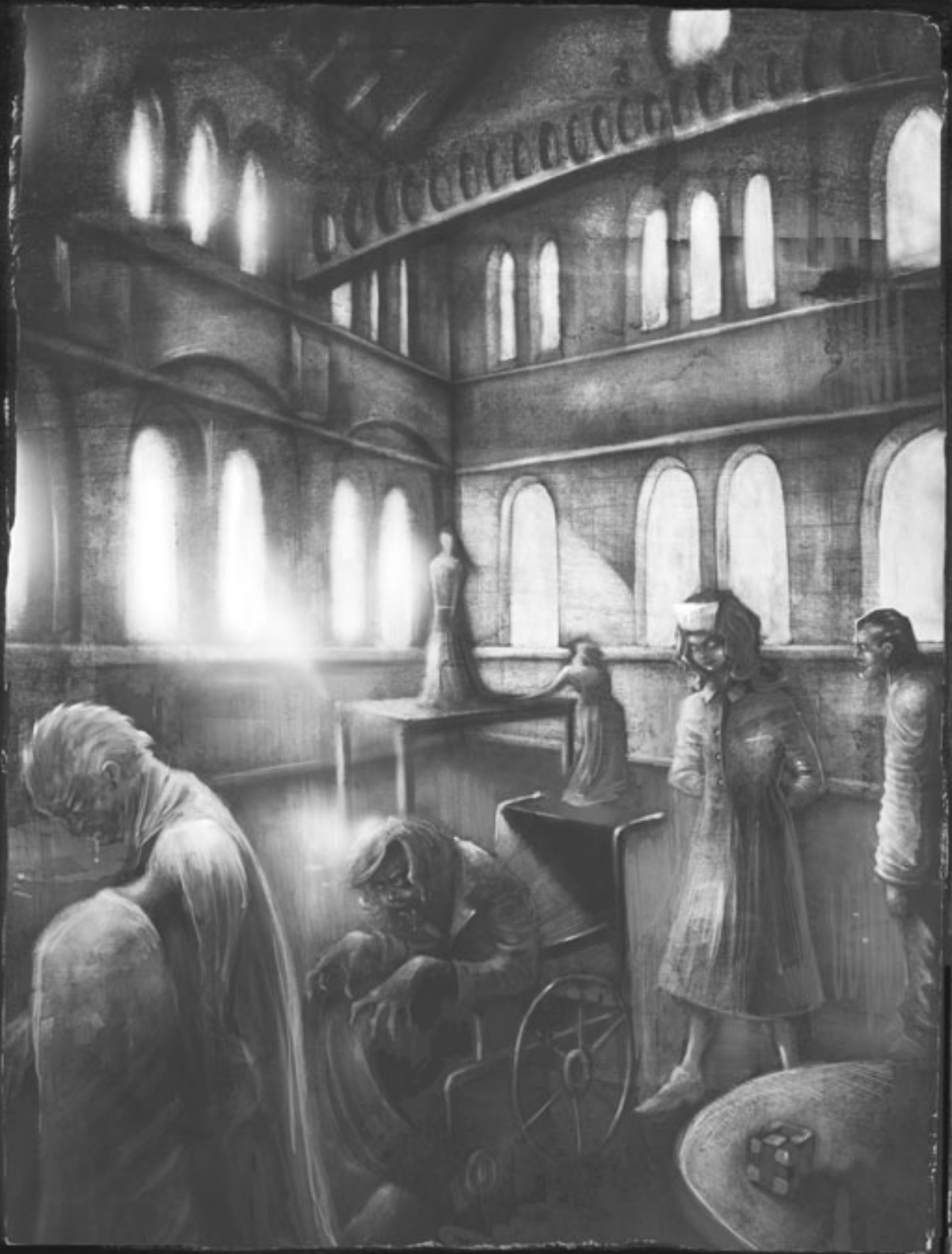
Dick,

After a long conversation with Sadie last night, I've determined that her pathology is much more severe than either of us initially guessed. She is convinced that a boy and four other girls at her high school (she refuses to name names) included her in some kind of "blood circle," in which the boy helped them in casting spells through bloodletting and sex. It seems fairly clear that boy was charismatic enough to make at least Sadie believe this, but it's not clear whether the other girls fell for this boy's manipulation or were just playing along. In any case, Sadie believes that the boy summoned up creatures called "The Hounds" to chase down and kill Sadie, and that if she is released from Bishopsgate they will find and kill her.

She was adamant that I not tell you or anyone else about this, and I must admit that the way she told the story sent chills up my spine. Even so, I think we need to consider a more aggressive treatment plan for Sadie, especially since she has incorporated Bishopsgate into her delusions. She sees the facility as a safe haven, a place that "The Hounds" can't reach her (they can apparently enter most structures; as is to be expected from someone as creative as Sadie, her delusional architecture is intricate, highly personalized and completely airtight).

I'm still not convinced that ECT is the way to go, but the meds obviously aren't having the effect we want. I'd much rather up her dosage or even switch to a different prescription before going with ECT, but I'm willing to consider it.





Chapter Five: Staff Records

People make places, not only by designing and building them but in the way they use them. An empty building carries only possibilities for good and evil; it's the people who use it that turn those into realities. Good doctors and staff can make an ugly asylum seem vibrant and wholesome, while callous doctors and brutal staff can make the most beautiful, thoughtfully designed complex seem nightmarishly awful. Here is a collection of people both good and bad ready to use to breathe life into your chronicle's version of Bishopsgate or any other asylum. Some are good people, some mean well, some are horribly misguided, a few are human monsters. They are all types of personality rather than specific individuals with full history, so that you can adjust for the needs of your chronicle.

Staff

These are the people who make the asylum run, from its top office down to the grunts at the bottom of the chain of command. All of them come in contact with inmates on a fairly regular basis, so that whether your chronicle focuses on patients or those trying to treat them, any of these could be regular companions, allies or antagonists.

The Jaded Department Head (Seasoned)

Quote: *Oh, God, not this again.*

Background: The Jaded Department Head has worked in psychiatric medicine his whole career, sometimes shifting particular emphases but always working in some place much like this one. He's genuinely good at his medical practice, but for years now he's been an administrator to the almost complete exclusion of actual clinical time. He's honest and principled, willing to do his part to keep the place running smoothly, but it's been a long time since he had any real surprises or discoveries, either in his job or in his personal life, and he's feel just plain tired of it all sometimes.

Description: The Department Head is a middle-aged man, either white or one of the minorities common to the asylum's part of the country. He is scrupulously clean and neat at any hour of the day or night, except that his hair keeps getting frazzled and needing some combing, and he never quite gets the dandruff as under control as he'd like. In a suit, he's indistinguishable from most businessmen in their mid-40s to mid-50s; in surgical or clinical garb, he looks like someone right out of central casting for precisely the role he plays at the asylum.

Storytelling Hints: He's almost never deliberately rude, but he is somewhat brusque with most people, particularly when he feels that they should be dealing with one of his subordinates instead. He expects that anything unusual that comes up will quickly settle down again, thanks to the good work of his staff, and would never voluntarily admit to hoping for something that's too much for all of them.

Attributes: Intelligence 3, Wits 2, Resolve 3, Strength 2, Dexterity 3, Stamina 1, Presence 2, Manipulation 2, Composure 3

In the name of
Hippocrates, doctors
have invented the most
exquisite form of torture
ever known to man:
survival.

– Luis Buñuel,
My Last Sigh



Skills: Academics 2, Athletics 2, Computer 2, Drive 2, Empathy 2, Expression 2, Intimidation 1, Investigation 2, Medicine 3, Persuasion 2, Politics 3, Science 2, Socialize 2

Merits: Contacts 3, Fame 2, Iron Stamina 2

Willpower: 6

Morality: 7

Virtue: Hope

Vice: Pride

Initiative: 6

Defense: 2

Speed: 10

Health: 6

Yesterday's Innovator

Quote: *I'm telling you, we had this one nailed back in . . . you're not paying attention.*

Background: Twenty years ago, Yesterday's Innovator was part of one of the promising trends of her day. Just as most trends in mental health, it did some good but not as much as its founders and champions would have liked. And just as most such trends, it proved to make some problems actually get worse, in the absence of corrections and adjustments that weren't at all appealing to the trend's members. The experience of feeling a great crusade slow and stagnate and of having to admit that once again the Hippocratic ideal of "first, do no harm" had proved easier to appreciate than to achieve demoralized Yesterday's Innovator deeply. She still hopes for vindication of the good work she and her allies did, and is sometimes rather obnoxious about it. Her own rude enthusiasm embarrasses her, and in discouraged times she retreats to the standard dogmas of her medical school days, fearing others' attempts at innovation will end in the same sloppy mess as hers.

Description: Yesterday's Innovator is the local representative of a style of feminist professionalism that her younger colleagues find quaint at best, with meticulously tailored suits and a manner that she intends to be calm and controlled but that younger doctors (and patients) find cold. Her taste for severe haircuts, minimal makeup and the like used to get her frequently accused of being some sort of lesbian. After she won two sexual harassment suits, that's no longer said much in public, but it's still the common currency of comments about her when she's far away.

Storytelling Hints: If some new diagnosis or treatment were to catch on at her current institution, she might become one of its greatest champions or fiercest advocates, and there's no way to predict which side of the gap she'd end up on. In the meantime, she aims for a scrupulously even-handed and generally conservative approach to all the patients in her jurisdiction.

Attributes: Intelligence 4, Wits 2, Resolve 3, Strength 1, Dexterity 3, Stamina 2, Presence 3, Manipulation 2, Composure 2

Skills: Academics 2, Athletics 1, Computer 1, Drive 1, Empathy 1, Expression 2, Firearms 1, Intimidation 2, Investigation 3, Medicine 4, Persuasion 1, Politics 1, Socialize 1, Survival 1

Merits: Encyclopedic Knowledge, Language: German 3

Willpower: 5

Morality: 5 (Derangements: Suspicion, Vocalization)

Virtue: Justice

Vice: Envy

Initiative: 5

Defense: 2

Speed: 9

Health: 7



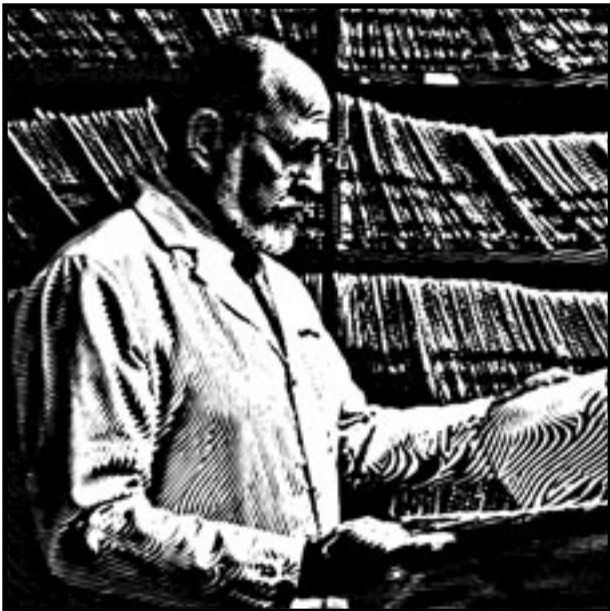
The Fraud

Quote: *That's absurd. The error must be elsewhere. You can see for yourself that it's all in order here.*

Background: In the normal course of events, the Fraud would have been a reasonably competent and moderately successful member of some asylum's staff. That wasn't enough for him. Ten years ago, he started falsifying some of his own research reports, then stealing data from others to claim as his own. He's now regarded as something of a regional celebrity among clinical psychologists, and his colleagues eagerly await his new results. If he ever has trouble finding new people to steal from, it'll all come down around his ears. To protect himself, he's one of the most reliable voices on staff in favor of firing long-term staff members and hiring new ones, who will take longer to realize what he's up to. If and when the moment of exposure finally comes, he sometimes wonders, will he kill himself or arrange for "death by cop" through some sort of violent rampage? He can't imagine actually surviving the scandal.

Description: In his professional capacity, the Fraud is relentlessly and persistently dull as a speaker. He writes with a lively style, even in clinical reporting, and would like to be that way in personal interactions, but it's just too risky. The tedium repels many threats to his secrets. Once a fairly fashionable dresser, he now cultivates a style right in the middle of his colleagues' preferences. (This has the advantage of making it easier to pretend to be one of them for after-hours sneaking around.) He's more open around patients, because he sees them as far less threatening to his interests; if he hadn't tried his shortcut, he might have developed into a genuinely good therapist.

Storytelling Hints: The Fraud is constantly, painfully aware that he's stuck and it's his own damn fault. If he could, he'd undo it all. Instead, he's forced to keep raising the stakes, because if he tries coasting, his reputation will slide. Similar to many con men, he compensates with aggressive



moralizing about almost everything else. He's desperate for a friend he could trust, and may at any point unwisely settle on a colleague or patient more or less at random.

Attributes: Intelligence 2, Wits 3, Resolve 3, Strength 2, Dexterity 2, Stamina 2, Presence 2, Manipulation 4, Composure 2

Skills: Computer 2, Empathy 1, Expression 1, Intimidation 1, Larceny 2, Medicine 2, Persuasion 2, Politics 3, Socialize 2, Stealth 2, Subterfuge 4

Merits: Ambidextrous, Language: French 2, Language: Spanish 2

Willpower: 5

Morality: 4 (Derangements: Anxiety, Paranoia)

Virtue: Faith

Vice: Greed

Initiative: 4

Defense: 2

Speed: 9

Health: 7

Tomorrow's Innovator

Quote: *Something's missing, but I don't think these blocker compounds are exactly it.*

Background: Scientific genius often flowers early, but not always: some crucial discoveries occur to people only in their later years. Tomorrow's Innovator is still young, and hasn't yet realized that she has the capacity for genius in the treatment of one of the major mental health problems facing her and her colleagues today. She knows only that she greatly enjoys research and has been able to contribute small but meaningful advances, and hopes for more of the same in years to come. She's noticed that she's more persistently curious than many of her colleagues, and she's alert enough to realize that some of them regard her as a dedicated ass-kisser and sometimes annoying rival for bosses' endorsement.

(Tomorrow's Innovator is a constructive crisis waiting to happen. When she happens upon some major discovery about treatments used in the asylum, it could affect player character patients as well as Storyteller characters, and may well change the balance of power among the staff. This could be a way to change the direction of a chronicle, driving other concerns into the background, or it can be an additional force at work while old imperatives continue to drive some of the asylum's inhabitants. She is a license for players and Storytellers to suggest changes both small and great, at whatever time they'd be welcome.)

Description: Many doctors neglect their own well-being, but not Tomorrow's Innovator. She's fit and a fan of exercise, and in addition to her own research, helps supervise calisthenics for the patients. She's not a beauty queen by surrounding standards, but she's one of the best-looking people in the institution and the object of many unrequited crushes.



Storytelling Hints: The Innovator likes helping people who need it, but her real passion is simply to know and understand how the brain works and how that affects thought and feeling. She welcomes opportunities to study the patients in detail and tries to build friendly relationships with them so that they'll trust her with experimental protocols and apparatus. She also works very hard to keep on the good side of the asylum's management so that she won't get drowned in paperwork. Above all, she keeps hoping for a key to unlock some large mystery in front of her.

Attributes: Intelligence 3, Wits 2, Resolve 3, Strength 2, Dexterity 3, Stamina 2, Presence 2, Manipulation 2, Composure 2

Skills: Academics 2, Athletics 3, Brawl 1, Computer 2, Empathy 1, Expression 2, Medicine 4, Persuasion 1, Politics 1, Science 2

Merits: Eidetic Memory, Direction Sense, Striking Looks 4

Willpower: 5

Morality: 7

Virtue: Hope

Vice: Lust

Initiative: 5

Defense: 2

Speed: 10

Health: 7

The Businessman (Expert)

Quote: That's simply not possible. Look at our data from the last round of clinical trials. The problem is not with our drug.

Background: The Businessman is part of the asylum staff, whether as a doctor, a laboratory technician, an office manager or in some other position, but his primary loyalty is to a pharmaceutical company, and everyone around him

knows it. For him, "us" is always the company, never the asylum, unless he's making a conscious effort at it. As a young man, he developed his split loyalty in the sincere belief that he could help advance the overall state of the art in treating mental illness. As middle age approaches, he's mostly concerned at securing his own future well-being and not contributing in any very big way to any very nasty new scandals. He no longer believes that either the asylum or the pharmaceutical company does much good, or *can* do much good, but at least the company's rich enough to let him look forward to a luxurious retirement. Healing, well, that's a dream for another generation.

In day-to-day matters, the Businessman is a voice of reason, calm and conventional wisdom. He doesn't panic easily, and he's very good at calming others down. He's devoted to keeping things running smoothly . . . whatever the cost may be to individuals who have needs getting paved over. When it comes to the interests of his suppliers, on the other hand, he can be ruthless, pushy, temperamental and just plain a nuisance. Experienced staff and patients try to get out of his way when there are tests to perform, leaving unsuspecting newcomers to deal with his imposing demands.

Description: The Businessman looks ready for a press conference at almost any time of day, almost every day. He dresses in conservative, immaculate suits, and keeps himself impeccably groomed. In clinical settings, he looks ready to expound on some key plot point in the manner of a movie scientist. He very deliberately aims to take control of whatever scene he's in, not pushing his agenda aggressively so much as being ready to pounce if it's necessary to protect his interests.

Storytelling Hints: The authoritative manner isn't just a matter of looks. The Businessman is an authority on his specialty and well-informed on much of what the asylum does, and he genuinely likes to be the teacher. When others



haven't irritated him or jeopardized his interests recently, he's quite happy to answer questions and solve mysteries for them, even to the extent of gathering information from others that he needs to have a complete picture of the answer. When trouble does approach, all the charm turns off, and he comes brutally direct.

Attributes: Intelligence 3, Wits 3, Resolve 3, Strength 2, Dexterity 3, Stamina 2, Presence 3, Manipulation 3, Composure 2

Skills: Athletics 1, Computer 2, Drive Empathy 2, Expression 2, Intimidation 2, Investigation 2, Larceny 1, Medicine 3, Politics 2, Science 3, Socialize 1

Merits: Contacts 3, Encyclopedic Knowledge

Willpower: 5

Morality: 6 (Derangement: Fixation)

Virtue: Prudence

Vice: Greed

Initiative: 5

Defense: 3

Speed: 10

Health: 7

The Devout One (Seasoned)

Quote: Jesus wept tears of blood and died calling out to God. Our suffering isn't removed, only redeemed, friend.

Background: The Devout One went into medical work because she sought to literally fulfill the biblical injunction to heal the sick. She lacked the opportunities to become a doctor, so she works in the asylum in a supporting role, perhaps a specialized nurse or orderly of some kind, or a specialist in some of the diagnostic gear. Whatever her specific role, she's one of the people who turns doctors' instructions into specific actions taken for and to the inmates. Along the way, she tries to share her hope for a future in which suffering comes to an end,



and there's something beautiful gained through all the suffering the inmates now suffer.

The simple cliché approach would be to make her a narrow-minded obsessive, bent on forcing all facts through the tiny keyhole of her perception. The more dramatic approach would be to make her faith genuine and sincere and fully compatible with the competent performance of her duties . . . but to include a threshold at which she breaks just like everyone else. Then comes the crisis of belief, and *that's* the stuff of potentially horrific complication. Whether she succumbs to despair, retreats from belief into dogma or lashes out in an effort to destroy the threat, staff and inmates alike will have to deal with a sudden, catastrophic and quite likely irreversible change in someone who holds a key position in the asylum.

Devout What?

As written here, the Devout One is some flavor of Christian. Her temperament isn't just a matter of creed, whoever. If your chronicle would benefit from a similarly dedicated Jew, Muslim, Sikh, Ba'hai, pagan or adherent to some other belief, go ahead and adapt freely. The spirit of loving compassion and hope can manifest in many communities of faith.

Description: Short, a little stocky and homely, the Devout One is seldom compared to any movie star more glamorous than Linda Hunt or the latter-day Angela Lansbury. She favors simple uniforms decorated with jewelry of religious design or featuring wildlife.

Storytelling Hints: She carries herself with a pleasing combination of dignity and charm, taking the worth of other people very seriously while simultaneously recognizing the foibles and delights of life with eager enthusiasm. She makes finding the bright side of a bad situation seem worthwhile, and the comfort she offers is never founded on denial of tragedy, only on refusing to take it as the final word of a situation. At least, that's how she is until the crisis comes.

Attributes: Intelligence 2, Wits 3, Resolve 3, Strength 2, Dexterity 3, Stamina 2, Presence 3, Manipulation 2, Composure 3

Skills: Athletics 2, Drive 1, Empathy 3, Expression 2, Medicine 3, Occult 1, Persuasion 3, Politics 1, Science 2, Socialize 2, Stealth 1, Streetwise 1

Merits: Common Sense, Holistic Awareness

Willpower: 6

Morality: 8

Virtue: Faith

Vice: Pride

Initiative: 6

Defense: 3

Speed: 10

Health: 7



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Discharge Notice

I, [Signature] (clinician's name), hereby discharge Sadie Brown (patient's name) from psychiatric treatment for the following reason: Persistent Veget State (reason for discharge; add notes below if necessary).

Patient fell into persistent vegetative state following ECT. Investigation revealed that protocols were all properly followed. Cause of vegetative state is unknown - believed to be psychosomatic. More testing to follow.



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INTAKE FORM

The contents of this form are confidential, as per our confidentiality regulations. Complete all areas.

Name: Sadie Brown **Parent or Spouse:** —
Address: 6061 Elm Dr. **Home Phone:** —
City/State/Zip: King of Prussia, PA **Work Phone:** —
Date of Birth: unknown **SSN:** 676-83-9999
Marital Status: Single Married Widowed Divorced Domestic Partnered
Employer: _____

Intake Date: 7/3/05 **Gender:** Male Female Identifies as Other
Intake Technician: _____
Reason for Intake: _____

Patients

These are all people in the asylum in hopes of a cure, or in need (in some authority's judgment) of time away from the outside world, or both. Some stand balanced on the edge of a crisis that can drag in the characters, whether patients or staff. Others march on through situations unlikely to change, and can form part of the long-term environment for their asylum mates. Some of them are very typical sorts of patients, ones you could expect to encounter again and again if you were to go touring asylums. Others are much rarer, and some are unlikely to exist in the real world at all, but draw on fictional traditions about asylums and their residents. None of them depend on supernatural phenomena; all operate within the bounds of normal human potential for good, evil and ignorance.

The Difficult Case

Quote: *I'm sorry, Doctor, but it really doesn't seem to be helping.*

Background: The Difficult Case has been in and out of mental institutions and regular hospitals since she was 15. Something deep down in the life of her cells is really wrong, and keeps making this tissue or that gland break down. Unfortunately, so far nobody's been able to identify the root cause; all they can do is try to treat each new problem as it comes up. Her mood varies, sometimes day by day or even hour by hour, though there's a general theme for each of her bouts in custody and treatment: sometimes she despairs and just wants the suffering to end, sometimes she developed a zeal for the next religious creed to catch her fancy, sometimes she's stoic, sometimes violent and cruel. Many of the staff and long-term patients know her, and are divided in their reactions to her, some feeling very sorry for her and wanting to help, others envying her ability to sometimes get out of here.



The great irony of her existence is that apart from the endless stream of secondary illnesses and disabilities, she's remarkably healthy. If doctors could ever find and treat the underlying cause of them all, she'd flourish.

Description: Unless she's in one of her manic moods, the Difficult Case makes no particularly strenuous effort to present a good appearance. She meets the institution's standards for hygiene and decorum, with basic cleanliness and simple sweat suits as her standard outfits. Strangers usually expect her to be heavily medicated and therefore hard to interact with, and that doesn't bother her. She saves her surprisingly intelligent and kind conversation for a handful of trusted associates among the staff and patients.

Storytelling Hints: Raised by parents who are both successful professionals, accustomed to safety, comfort and the expectation of reliable progress, she fell apart badly when she realized she'd face collapses in her health and sanity at irregular intervals for the indefinite future. She's pulled herself together some since then and gained some toughness from surviving so far. She'd like to just be healthy, but long ago gave up hoping for it. Instead, she now tries only to hang on for the next bout of relief, however long it may last. In the meantime, she sees much more than she ever comments on, and would go to great lengths to help one of the few people she trusts in the place.

Attributes: Intelligence 2, Wits 2, Resolve 4, Strength 2, Dexterity 2, Stamina 3, Presence 1, Manipulation 1, Composure 4

Skills: Academics 1, Animal Ken 2, Athletics 2, Crafts 1, Empathy 3, Larceny 2, Medicine 2, Stealth 3, Streetwise 3, Subterfuge 3

Merits: Natural Immunity 1, Quick Healer 4; Allies 2

Willpower: 8

Morality: 6 (Derangement: Depression)

Virtue: Fortitude

Vice: Sloth

Initiative: 6

Defense: 2

Speed: 9

Health: 8

The Schemer

Quote: *Yeah, but it's going to work this time.*

Background: The Schemer was a successful entrepreneur before a drug overdose set off the first of several psychotic episodes. He's been in institutional care for three years now, and hasn't for one moment stopped working out elaborate plans either to get out, make a pile of money by exploiting conditions within the asylum somehow or both. They never work out, because he's not as clear a thinker as he believes, but the fact of what he regards as unexpectedly brilliant opposition hasn't stopped him yet. For the sadists and bullies of the asylum, the Schemer is a perpetual source of amusement; for most of the others in the place, he's a constant nuisance.



Description: Those who've seen *Twelve Monkeys* tend to remember the Schemer as looking like Brad Pitt in that movie, simply because he shares that frenzied drift from laser-like focus to chaotic confusion and back again. In truth, the Schemer actually looks much milder; when he's calm, he could disappear into the lunchtime crowd at any gathering spot for 30-something businesspeople. He manages to make whatever he's wearing at the moment—and it's seldom a coordinated ensemble—seem natty and dashing, in part because he retains excellent posture and control over his movements. He grooms himself well whenever not in the depths of mania, too, with short brown hair that bleaches easily into blond-white streaks whenever he gets much sunlight and a close-cut beard maintained meticulously. It's only when mania strikes that he resembles the cinematic clichés so much.

Storytelling Hints: The Schemer is not calculatedly cruel, ever. But he is constantly oblivious to the feelings of others; he simply doesn't care much about the inner life of anyone who isn't actively aiding him at the moment. He dreams of the day he can return to the outside world, and refuses to acknowledge how seriously impairing his condition actually is.

Attributes: Intelligence 3, Wits 2, Resolve 2, Strength 1, Dexterity 2, Stamina 3, Presence 3, Manipulation 3, Composure 2

Skills: Computer 2, Empathy 1, Expression 2, Intimidation 1, Investigation 2, Larceny 2, Persuasion 2, Politics 3, Socialize 2, Stealth 2, Subterfuge 3

Merits: Barfly, Inspiring, Striking Looks 2

Willpower: 4

Morality: 4 (Derangements: Hysteria, Megalomania, Phobia: cats)

Virtue: Faith

Vice: Pride

Initiative: 4

Defense: 2

Speed: 8

Health: 8

The Inconvenient Heiress

Quote: Deciding to believe me could be the most profitable decision you ever made.

Background: In the normal course of events, the Inconvenient Heiress would have taken over one of the richest family fortunes in the state. One of her younger brothers didn't want that to happen. As part of the pre-Beatles jet set, the Heiress did her share of drinking and drug use while a teen, and it wasn't hard for her brother to arrange for a series of bad trips that a compliant doctor would and did diagnose as the onset of schizophrenia. She's been in institutions ever since. The brother and his few knowledgeable aides are all dead, and with them all chance of full understanding passed away. The Heiress is now experiencing the early symptoms of Parkinson's disease, finally gaining the diseased mind all doctors after the first thought she had. What she has in her head now is a generation's worth of clear-eyed, compassionate observation of the little world around her, and an equal volume of practical wisdom about how to survive in it. Those willing to listen to her know that she isn't insane at all, and even those convinced that all those doctors can't have been that wrong respect her surviving judgment.

(This pattern of perpetual favor to recognize the truth was more common than it is now. Professional courtesy can still hide a multitude of sins, but it's no longer so common for a life-changing diagnosis to go unverified. What allows people to continue in the Heiress' situation is modern doctors' fear that if they simply override their predecessors' ac-



tions, they might be letting loose someone who'd promptly have another breakdown for which they'd be held liable.)

Description: Now in her late 50s, the Heiress is small and stooped, having never eaten or exercised as well as she should have. She was never very glamorous—it was wealth that made her a socialite, more than her individual charms—and now she's thoroughly homely, suggesting a maid more than a (would-have-been) millionaire. What she does have is a thoroughly kind expression, and that gift of focusing her attention that makes those who speak with her feel blessed with respect and interest, whatever it is they may wish to talk about.

Storytelling Hints: The Heiress gave up expecting justice for herself decades ago . . . and never did know just who it was that set her up, only that someone did. She's transmuted that lost desire into the intent to do what good she can for others, from helping them adjust to the vagaries and rigidities of asylum life to making effective use of *pro bono* legal counsel to settle specific complaints. Nothing shocks her and very little surprises her, and she's willing to listen to others' complaints, from staff as well as patients. There's a note of pure goodness somewhere in the depths of many places of suffering, and the Heiress is the one for this place.

Attributes: Intelligence 2, Wits 2, Resolve 3, Strength 1, Dexterity 2, Stamina 3, Presence 3, Manipulation 3, Composure 2

Skills: Academics 2, Animal Ken 2, Athletics 1, Brawl 1, Crafts 1, Empathy 4, Expression 2, Investigation 1, Medicine 3, Streetwise 3, Survival 2

Merits: Common Sense, Meditative Mind; Contacts 2

Willpower: 5

Morality: 8

Virtue: Charity

Vice: Sloth

Initiative: 4

Defense: 2

Speed: 8

Health: 8

The Tool

Quote: *Sure!*

Background: The Tool is not a fool or a moron, but he is clinically unable to properly evaluate many claims made to him. Because he's eager to please and happy when with people he can think of as friends, he's lured into one bad scheme after another. He finds release from the unhappiness over the last failure by jumping into the next proposal, guaranteeing the cycle will continue.

(At the most basic level, the Tool can be a fine comic supporting character, available for slapstick and other jokes. He can become a richer, deeper supporting character without losing that, or become a figure of great tragedy, innocence abused and ultimately destroyed. Rather than



acting as a catalyst for new action, he can serve to intensify the consequences of the choices the player characters and others have already made.)

Description: The Tool isn't a particularly handsome or impressive figure. What he has, along with the desire to help, is a nearly constant good cheer. When he's not tangled in someone else's bad idea, he's one of those people who can be counted upon to tell genuinely funny jokes and have interesting news to share. His age can be anything fairly close to one or more of the player characters.

Storytelling Hints: The Tool desires above all to help out those around him who have some goal they can't achieve on their own. Nearly everyone who's been in the asylum more than a year or so has put this willingness to work at some point, whether it was cleaning up a particular spill or trying to smuggle something valuable into or out of the asylum. The Tool doesn't volunteer information about his past exploits, or suggest new ones; he's entirely a follower when it comes to unauthorized action.

Attributes: Intelligence 2, Wits 2, Resolve 2, Strength 3, Dexterity 3, Stamina 2, Presence 2, Manipulation 2, Composure 3

Skills: Animal Ken 3, Athletics 3, Brawl 2, Crafts 2, Empathy 2, Expression 1, Medicine 1, Politics 1, Socialize 3, Streetwise 2, Weaponry 2

Merits: Unseen Sense; Disarm, Iron Stamina 2

Willpower: 5

Morality: 6 (Derangement: Inferiority Complex)

Virtue: Charity

Vice: Pride

Initiative: 6

Defense: 2

Speed: 10

Health: 7

The Violent Case

Quote: *He had it coming, you must see that.*

Background: She was a problem child, and then a troubled adolescent and finally an uncontrollably violent young adult. She was committed to the asylum not long after her 28th birthday, when a minor disagreement with guests at her birthday party led her into a violent frenzy in which she stabbed three of them with steak knives. Her case file is filled with contradictory diagnoses about what it is that just what it is that drives her into these frenzied episodes a few times a year, and that makes it difficult for her to feel or act on any emotion at all in between them. Each diagnosis comes with a roster of treatments tried, all unsuccessfully. Clearly something is wrong with her, but nobody yet knows what.

The Violent Case is trouble waiting to happen. There may be some specific trigger for her rages: a word or phrase reminiscent of a bad moment of her youth, or a color associated with an unhappy memory or a particular kind of frustration that she can't handle. It may also be a more or less random occurrence, set off by a chemical tipping point that doesn't connect to anything at the human scale. The mystery is part of the danger, and also a challenge for characters inclined to try to solve it.

Description: Years of mixed medications and the effects of her underlying illness have given the Violent Case an eerie beauty. In moments of rest, she can resemble a marble statue, her pale skin almost as motionless as stone, her blue eyes glittering with bright reflections of any light available. She keeps herself fastidiously clean and happens to fit the standard inmate's garb fairly well. It's only in her violent moments that she shows any passion, and then only destructively: whatever's got her attention is at serious risk for injury and destruction.

Storytelling Hints: The Violent Case is watching her life and the world go by. She finds it hard to care about



very much, and is afraid that anything she cares about will become her next target when the rage returns.

Attributes: Intelligence 2, Wits 2, Resolve 3, Strength 2, Dexterity 2, Stamina 4, Presence 3, Manipulation 2, Composure 1

Skills: Academics 1, Athletics 3, Brawl 3, Computer 2, Crafts 2, Drive 1, Intimidation 2, Medicine 2, Stealth 2, Streetwise 2, Survival 2

Merits: Direction Sense, Iron Stamina 3, Strong Lungs

Willpower: 4

Morality: 6 (Derangement: Suspicion)

Virtue: Fortitude

Vice: Wrath

Initiative: 3

Defense: 2

Speed: 9

Health: 9

The Perpetual Mourner

Quote: *Not just yet. If I let go now, the last of them will be gone, don't you see?*

Background: Sometime, years ago, the Perpetual Mourner suffered a tragic loss, such as a child (or children), a lover or spouse or someone else very, very dear to him. Most people who go through that grieve hard for a while and continue to feel some grief ever after, but it was worse than that for him. Something inside him stopped and simply will not start. In all the years since his loss, nothing has ever felt quite real or important in the way things used to, and he cannot muster enough interest to deal responsibly with the day-to-day duties of life. Eventually his self-neglect became severe enough to warrant his institutionalization, and now he's in the asylum while doctors try to find some way to un-stick him from the moment of greatest grief.

In most circumstances, the Perpetual Mourner is a nuisance. If given the chance, his endless recitations of how precious his loved one was and how great his loss is will take over any conversation. This can be more serious than many of the people around him realize, given how reluctant inmates can be to open up about important but difficult problems; one dedicated boor can lead to a lot of missed opportunities for timely help. Furthermore, if he feels threatened or that the object of his grief is being abused and disrespected, he can be a very dedicated, very dangerous enemy.

Description: One of the clichés of stories about asylums is the patient of indeterminate age and bland looks who spends all day, every day, shuffling around in a bathrobe and old slippers, talking quietly to himself about something irrelevant. That's the Perpetual Mourner. Beneath it all he might be stunningly handsome, hideously ugly or anything in between, but he doesn't care and so nobody else will get the chance to know.

Storytelling Hints: His loss is the biggest thing in the



world. He shares it with others. If anyone else has suffered something similar, that person is his true companion, to console and aid as best he can. Most people are irrelevant, but those who'd try to take away his grief or change its meaning are the foes of the only thing that really matters, his lost loved one.

Attributes: Intelligence 2, Wits 2, Resolve 2, Strength 2, Dexterity 2, Stamina 3, Presence 3, Manipulation 3, Composure 2

Skills: Academics 1, Brawl 2, Crafts 2, Empathy 2, Expression 2, Firearms 2, Intimidation 2, Medicine 2, Politics 1, Science 1, Socialize 1, Subterfuge 3

Merits: Allies 1, Contacts 3, Resources 3

Willpower: 4

Morality: 5 (Derangements: Avoidance, Vocalization)

Virtue: Faith

Vice: Envy

Initiative: 4

Defense: 2

Speed: 9

Health: 8

The Fugitive

Quote: No, I mean it literally. The asylum is my sanctuary, from . . . what the hell, you're not listening to me anyway.

Background: A decade ago she was the ex-wife of a Mafia underboss. At least, she thought of herself as his ex-wife. He wasn't about to accept the divorce or her efforts at escaping him: he wasn't going to face the shame of having a wife so out of control. He used his connections with the FBI to find her even in the witness protection program, twice, and she knew that he'd keep doing it unless something changed. So with her third false identity, she also adopted the persona of a woman with some severe mental problem,

as she'd seen her ex-husband's bosses do when they were trying to avoid racketeering charges. It didn't work for them, but it worked all too well for her. She was committed . . . and now she can't convince anyone that she belongs in the outside world again. A woman with a documented history of obsessive behavior who suddenly claims to be the ex-wife of a notorious mobster clearly belongs right where she is. Nobody outside the asylum who could confirm her story knows her current identity and all have better things to do than answer random pleas from strange mental patients who probably saw them on cable TV documentaries and built her delusions around them.

There are three dramatic paths open to the Fugitive now. She might succumb to genuine mental distress from the cumulative weight of her confinement, and become a truly deserving patient. Someone might take an interest in her case and put in the time necessary to actually test her claims, and find them true. The ensuing news event might very well touch off further investigations, which could expose the truths around the Inconvenient Heiress, the Fraud and others in the asylum with secrets they might not all want exposed. Finally, her ex-husband might get wind of her situation and come after her, bringing the Mafia's tradition of brutal reprisals with him. That might also lead to exposure of other secrets, or if his own attack can be covered up to more intense concealment all around.

Description: As she puts it herself, she was born trailer trash, and her idea of glamour is part Grand Old Opry, part Mafia glitz. Out of her slowly dwindling funds, she does what she can to preserve some notes of that mix, including her beloved bouffant hairdos and the rhinestones decorating collar and hemlines on clothes she's allowed to sew modifications onto. She speaks with a harsh nasal accent and broad gestures, the sort that could command the attention of drunk killers when she needed them to pay attention to her. She's getting quieter with time, though, as her hopes of escape fade and a nagging worry of her ex-husband's return grows. Another few years here will likely smooth away her remaining distinctiveness.

Storytelling Hints: Above all, the Fugitive wants to convince the doctors in charge of her case to let her go. But she's not stupid, and knows that a direct assault on their conviction of her insanity won't work. Instead, she focuses now on helping her fellow inmates earn their release, in hopes that once outside, they'll do the research she can't and help her in return. She's kind and attentive to anyone she thinks might help her, gruff and dismissive with those who seem to have no prospect for impending release or change of venue.

Attributes: Intelligence 2, Wits 3, Resolve 2, Strength 2, Dexterity 2, Stamina 2, Presence 3, Manipulation 3, Composure 2

Skills: Athletics 2, Brawl 2, Drive 1, Empathy 1, Expression 2, Firearms 1, Intimidation 2, Larceny 1, Persuasion 1, Socialize 3, Streetwise 1, Subterfuge 1



Merits: Barfly, Danger Sense, Resources 2, Striking Looks 2

Willpower: 4

Morality: 6

Virtue: Fortitude

Vice: Wrath

Initiative: 4

Defense: 2

Speed: 9

Health: 7

The Perpetual Child

Quote: I want to play now.

Background: He is 11 years old, coming up on 12. He's experiencing the onset of puberty, which is sometimes exciting, sometimes scary. He can tell you all about the most exciting and interesting moments of his life so far, from his earliest memories on up to the neat things that have happened to him today. He knows that he's unusually big for a kid, but there are few enough children in the asylum that he doesn't get many opportunities for comparison. At least that's how he sees it.

In truth, the Perpetual Child is closer to 40 than 11. His true memories stop the day before his family's home burned down, killing all of his close relatives while he escaped untouched. His mind absolutely refused to lay down the memories of seeing them burn after a gas explosion pushed him out onto the lawn. Everything that's happened to him since then gets blended together and stored or discarded from long-term memory at subconscious whim. For many years, the asylum's doctors tried to find some way of helping him work past the blockage, but now they settle for keeping him safe and reasonably supervised, in hopes that some future remedy might do the trick.

That's Experience?

When she was among the Mafia, the Fugitive had more Skill dots than she does now. Among others, her Firearms, Intimidation, Persuasion and Streetwise ratings were all at least one dot higher. From being a seasoned character, she's atrophied thanks to lack of practice in such matters while in the asylum, and is now down to levels similar to those of starting characters. If she ever gets out, she'll regain the lost Skills faster than usual, if the Storyteller wishes to simulate the process of re-acquisition by doubling her experience awards for a few months of game time.

A breakthrough in the Perpetual Child's condition could unleash all sorts of surprise. The fire his family died in might have a connection to something else that's going on in the chronicle, or it could be the beginning of a new complication, from an unwanted haunting to encounters with a killer bent on completing the job. In addition, the surprising recovery in one patient could shock others who've forgotten things or lost parts of themselves into revivals of their own, and the secrets they hold might not be ones that delight those who have to deal with them.

Description: The Perpetual Child is shorter than average for adult men in the asylum's area, and naturally clean-shaven. His whole complexion is smooth, unmarked by worry lines or most signs of aging. Life has left its marks on his hands and arms in the little scars and marks that almost everyone accumulates; he finds these very unsettling to look at and tries to avoid concentrating on his hands more than is absolutely necessary for whatever he's doing at the moment. He's happy with his hair cut short, and wears any clothes given to him that allow him good freedom of movement and don't make him too cold in the asylum's chilly depths.

Storytelling Hints: He's a pretty good kid, with very few cruel impulses. He's often kind and generous, and keen to share his pleasure with anyone nearby who seems in need of encouragement. This doesn't make him an angel, however. He's also at the mental stage where he's just discovering the range of scatological slang, and because he forgets most of the details of his current life, he keeps rediscovering it, and wanting to share his new acquisitions. He will, until treatment comes, *never* get tired of some poop and pee-pee jokes, any more than he'll get over his fascination with knock-knock jokes, and he won't remember patients or staff telling him that they've had enough. He is, in short,



sooner or later a trial of everyone's patience and self-restraint. When it comes to paranormal and other strange

events, he'll interpret them in the same spirit as whichever authority figures he's trusting most at the moment. Over time, therefore, his convictions about such things have changed a great deal, and will continue to do so.

Attributes: Intelligence 2, Wits 2, Resolve 2, Strength 2, Dexterity 4, Stamina 2, Presence 2, Manipulation 2, Composure 3

Skills: Athletics 3, Brawl 2, Computer 3, Crafts 3, Empathy 1, Expression 1, Larceny 2, Socialize 1, Stealth 2, Subterfuge 1

Merits: Fast Reflexes 2, Iron Stomach, Natural Immunity, Unseen Sense

Willpower: 6

Morality: 7

Virtue: Hope

Vice: Gluttony

Initiative: 9

Defense: 2

Speed: 11

Health: 7



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Incident Report

Time of Incident: 1:30AM

Reporting Staff: Luisa Marigold, RN

Description: Night nurse A. Jones left side door open while she went to smoke. Dog entered hospital and entered room of patient (S. Brown). Brown in PVS. Dog jumped up on bed. Brown appeared to wake up and screamed. Dog barked and snarled. I called security and then yelled at dog. Dog jumped down off bed and ran out side door. Brown coded, pronounced dead one hour later from heart failure.

Signature

Luisa Marigold

Appendix: Reaping Madness

The supernatural inhabitants of the World of Darkness are familiar with the effects of fear on the mortal mind. They know that the mind can only take so much pressure before it snaps, forcing the unfortunate person to find some way to cope. The human mind is, by nature, ill equipped to handle too much supernatural knowledge, and as much as a werewolf might lament the Lunacy that makes her unable to true share her nature with a human being or a mage rails against Disbelief and its effect on Paradox, these phenomena are defense mechanisms for humanity as much as for the supernatural.

But even these defense mechanisms are merely bulwarks. If a human being is exposed to the supernatural for a long period of time or repeatedly, one of two things happens. The person might become part of the supernatural, generally developing the Unseen Sense Merit or, in rarer instances, by Awakening (the only supernatural “transformation” that happens spontaneously and without any prerequisite). More often, though, the person goes mad, developing derangements that allow him to accept the world as he now knows it, even if this acceptance comes at the cost of his sanity and his ability to function in that world.

There is a third possibility, but it is arguably a merger of the first two. The human might decide that the supernatural needs to be destroyed, and devotes his life (short though it usually is), to the hunt. This most often happens to human beings who have repeated contact with vampires, for reasons explained anon. Note, though, that becoming a monster-hunter in no way precludes madness, nor, as the Banishers prove, does it preclude joining the supernatural.

The remainder of this appendix discusses the different kinds of supernatural characters presented in the **World of Darkness** games published to this point, and their possible effects on human sanity. Although **World of Darkness: Asylum** focuses mainly on mortal characters, it is important both from the perspective of the chronicle and from the perspective of maintaining a character’s Morality to examine the toll that a supernatural being can take on the human mind.

Vampires

“I’ve had a relapse.” Sheila sat on the couch, staring at her hands. Dr. Slane noticed they were raw and red. She’d obviously been scrubbing them vigorously. He made a note; that wasn’t a good sign.

“Can you tell me about it?”

“I went over there to get some stuff out of his place.” She glanced up at the doctor, and then back down. “I know I’m not supposed to go there alone, but I didn’t think he’d be there. He’s never there at night. But he was there, and as soon as I saw him, it was just like it was before. And he told me he needed me to . . .” She broke down crying. Dr. Slane waited, tapping his pen against his leg. “He needed me to do something awful.”

Dr. Slane sat up. Sheila’s boyfriend had never asked her to break the law before, so this “task” he’d given her was probably something of a degrading, sexual nature. Still, there was something in her tone. . . . “Did you?”

“My homicidal maniac is of a peculiar kind. I shall have to invent a new classification for him, and call him a zoophagous (life-eating) maniac. What he desires is to absorb as many lives as he can, and he has laid himself out to achieve it in a cumulative way. He gave many flies to one spider and many spiders to one bird, and then wanted a cat to eat the many birds. What would have been his later steps?”

— Bram Stoker, *Dracula*

Bram Stoker,

Mind Control and Morality Loss

This is a sticky subject, and it requires a bit of meta-examination of the rules of the Storytelling system and what they represent. The question is this: If a person is under mental command from a supernatural being and commits an act that would normally require a roll to avoid degeneration, does the player still make that roll even though the character isn't willfully taking the action?

There are two ways to approach this question. The first way is from the perspective of "game balance." In this light, the character is not responsible for his actions and so the player does not risk degeneration. The character might well feel remorse or confusion over what happened, and the player is encouraged to roleplay these feelings. The character might face consequences from his actions, and this is entirely appropriate and in-genre for the World of Darkness. But mechanically, the character's Morality is not at risk.

The other option is to consider what Morality really represents. Despite the name, it doesn't measure whether someone is a "good" person. It measures, among other things, empathy for one's fellow human beings and the ability to function around them (which one might call "sanity"). Morality can fall when a person's actions conflict with his ethical and behavioral precepts (and yes, the game system presupposes a certain set of these precepts for purposes of ease of use; it's not necessarily made to represent the way things "really are"). So if a character takes an action under the control of another being, but *has no way to know* that his actions were not his own, it's appropriate for the Storyteller to ask for a degeneration roll.

Considering what kind of power is at work is also appropriate, though. Certain mind- or emotion-controlling powers leave a character with no memory of his actions, and degeneration is inappropriate for such powers, even if the action is later brought to the character's attention, because the character can justifiably say, "I would never do that!" Some powers or effects, such as the sanity-bending fear that werewolves create, lead humans to rationalize away what happened, and for such powers, too, degeneration is probably not warranted. Powers such as a vampire's Dominate Discipline, however, that leave a target with full knowledge of what he did but not *why*, might, at the Storyteller's discretion, require a check to avoid Morality loss.

If the Storyteller chooses to have the player make such rolls, the Storyteller is advised to give the player a bonus of one or two dice on the roll, to reflect that some part of the character's mind *knows* that this action was not her own. Success on this roll might indicate that the character is aware, on some instinctive level, that his actions were not his own. Alternately, the Storyteller can have the player roll to avoid gaining a derangement (this roll should be Resolve + Composure, rather than Morality, since the impetus isn't Morality loss but psychological shock) instead of checking for degeneration.

The Morality system is simply meant as a way to gauge a character's mental and psychological functioning. It is appropriate, in a horror roleplaying game, for characters to make difficult choices and to lose their minds along the way. The system can get in the way of the story (as can any game mechanic), and the Storyteller needs to be aware of when this is happening. The players, too, need to come to a consensus on when to apply degeneration rolls and how stringent this system should be. Some troupes might not need the system at all, while others might prefer one of the approaches discussed here. Do whatever your troupe would find most entertaining, and don't take the Morality system as commentary on the real world. It's just an abstraction.

Sheila stood up, still crying, and pulled a pistol from her jacket. "I have to," she said.

The popular image of the vampire is of a seductive predator, a manipulator of minds and emotions. While this portrayal of the vampire is comparatively new in folklore, it is a face that the Kindred have worn for time immemo-

rial. The fact that it took humanity so long to recognize the predators among them and portray them in popular literature is testament to the subtlety and skill of the undead (and, perhaps, to the dangers that mass communication and media pose to these beings, but that's another subject).

Vampires can affect the human psyche in many diverse ways. They are discussed below individually.

Disciplines

The supernatural powers of the Kindred are called *Disciplines*. Each *clan* of vampires shares an affinity for several of these powers, but for the most part, any vampire can learn any Discipline. Two Disciplines in particular are important for our purposes: Majesty and Dominate.

Dominate

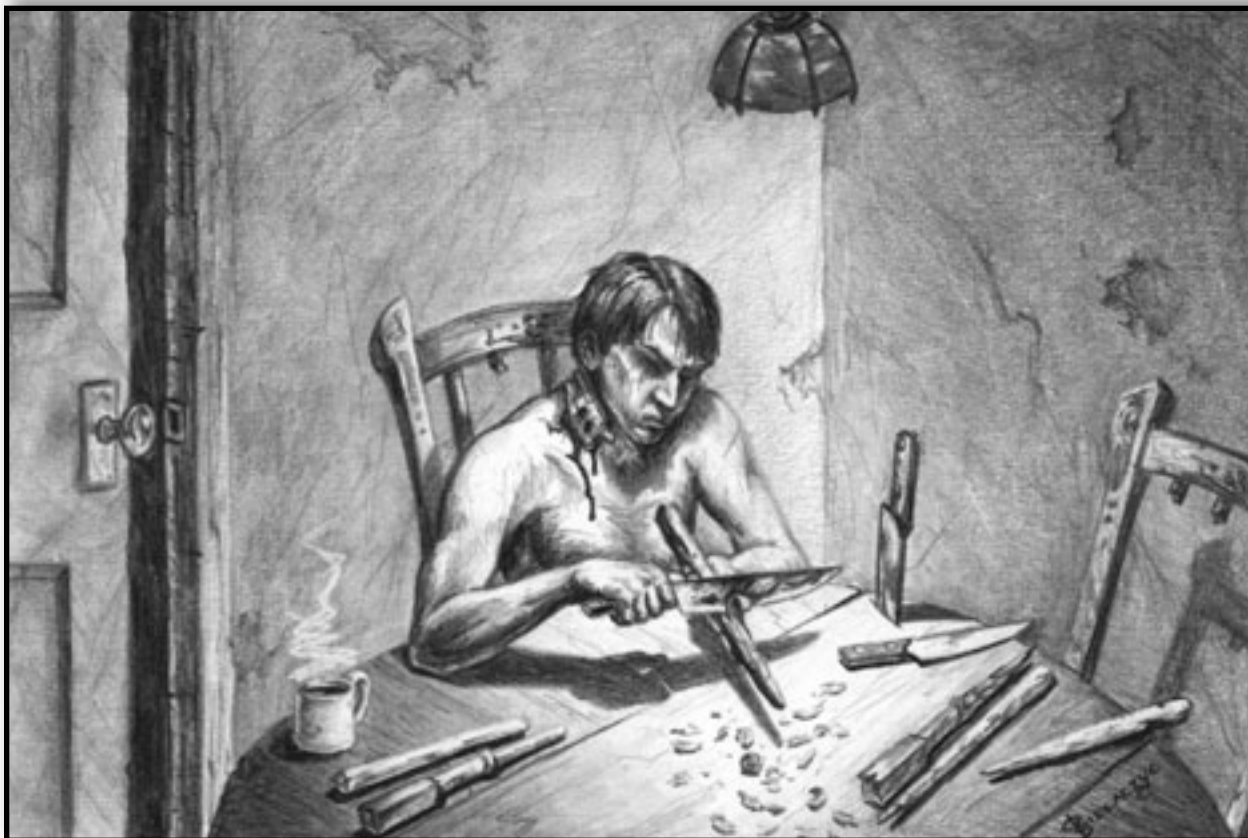
Some vampires simply control the thoughts and behaviors of their victims, using the Dominate Discipline. This series of powers is even more frightening and, perhaps, damaging than Majesty. If a human is forced to fall in love (see “Majesty,” below), at least he can latch onto the concept of “love” as a basis for his action. Dominate simply compels behavior, offers no reason or rationale and leaves the victim to pick up the pieces. Humans subject to Dominate repeatedly often develop elaborate explanations for their behavior. Sometimes vampires skilled in this Discipline provide new memories for their victims, which is a humane thing to do, under the circumstances. The problem is that vampires often don’t have a good enough grasp of their victims’ lives to fabricate realistic memories, and so a married man with no thoughts of straying might have memories of going to a strip club, or a young woman who has never yet listened to anything other than punk might remember spending an evening at a concert hall. One such occurrence can be dismissed with a laugh and a resolution to lay off drinking for a while, but vampires are creatures of routine, and if one finds a capable pawn, he is likely to use her again and again. Over

time, memories conflict with one another, and the victim might develop symptoms that resemble schizophrenia or even multiple personalities.

Even a single incidence of compelled behavior, though, can be enough to destroy a person. Consider: A vampire fleeing from an enemy bangs on the door to an apartment and commands the sleepy-eyed man who (unwisely) opens it to “Go back to bed.” The man does so, and the vampire hides out in his coat closet. The man might wake up in the morning and go about his routine (hopefully avoiding his closet), but he might wake up and find himself unable to get out of bed, even to go to the bathroom or call in to work. He might feel a sense of lethargy every time he glances at his bed for weeks afterwards, and find himself sleeping for 12 hours at a time, no matter when he lies down. His mind is unable to expel that one simple command that the vampire placed there, and continues responding to it on a daily basis. What would have happened if the vampire had commanded him to do something more sinister? “Yell at that woman” isn’t at all out of the realm of possibility for a vampire with some skill at Dominate, but such a command could easily get someone arrested if it lingers.

Majesty

A vampire with the proper talents can cause a human being to fall in love. The effect is temporary, true, but as anyone who has ever been in love knows, a moment of suspended judgment, a simple assumption taken on faith in one’s beloved, is enough to have lasting effect.



One of the most dangerous powers of the Majesty Discipline, called Entrancement, allows a vampire to cause a person to fall in love for a period of a *month*. The power doesn't compel any particular behavior and it won't turn a person into a mindless foot soldier, but people in love are more open to manipulation, deception and to doing things they normally wouldn't in the interest of keeping their beloved happy and safe. Once the month ends, the victim is usually unaware that anything supernatural happened, just that her feelings are not as strong as they once were. Should the vampire try to use the power on the same victim at this point, he finds the attempt difficult (though not impossible) — a kind of psychological “pendulum effect” occurs that makes the person more resistant to the vampire's attentions, if briefly. Soon, though, the pendulum returns to equilibrium, and the person is just as susceptible to Entrancement as she ever was.

Majesty, by itself, doesn't usually drive a person mad. If the victim is diametrically opposed to being in love with the vampire, whether because of past events or simple instinct, the effect of the Discipline is more damaging because it causes more friction. The person develops feelings of self-loathing, hating herself for loving the vampire, but unable to stop the cycle. She behaves in some ways like an abuse victim and in other ways like a rape victim, feeling by turns angry, unclean and trapped. Suicide is not uncommon (which is usually fine with the vampire, since it removes any need to get his own hands dirty). Other victims, though, seek out psychological help. Most vampires are wise enough to let their victims alone at this point; the Discipline will fade and, with time and therapy, the victim recovers. Some victims, though, know enough to implicate the vampire, and those victims are in mortal danger.

Blood — Feeding and Slavery

All vampires, regardless of which Disciplines they practice, have the power to enslave mortals with only a few drops of blood. This effect is called the Vinculum — a person who consumes vampire blood on successive nights feels a growing loyalty and even love for that vampire. The Vinculum is less immediately potent than applications of the Majesty Discipline, but it doesn't wear off as quickly, either. The Vinculum forms a lasting emotional bond between the mortal and the vampire, and while it doesn't engender suicidal, unwavering love, the Vinculum does create a willing servant out of an otherwise reasonable human being. (The Vinculum and its effects on the human psyche are discussed extensively in the **Vampire: The Requiem** sourcebook called **Ghouls**, and so receive only minimal coverage here.)

The Vinculum is an emotional dependence, which is troublesome enough by itself, but vampire blood is also physically addictive. Therefore, a person who has been under the Vinculum for any length of time is also a junkie, and junkies, generally, don't *want* to let go of their addiction. They want to make their lives work and still keep using, and so any attempt at “freeing” them from the spell of the Kindred (assuming the mortals understand the na-

ture of the addiction, and many of them don't) is probably going to fall upon deaf ears unless it's couched in a such a way as to allow the human an alternate means of feeding. A blood-bound human can “detox” if denied her fix for a long period of time. The blood addiction fades in a matter of months, but the Vinculum can take years to subside completely. At the end of that time, the person may regain her sanity . . . but then again, she might forever pine for her undead master.

One other vampire-related topic needs discussion. Human beings who serve as victims to vampires experience a few moments of exquisite pleasure. This effect is called the Kiss, and the Kindred use it to their advantage when feeding. In the right venue, a young man might not think twice about feeling lips on his neck until the fangs slide home, and at that point, the Kiss takes over. The Kiss is a euphoric rush, coupled with the effects of sudden blood loss, and most humans who experience remember it as an intense make-out session or simply as a dizzy spell.


But predators fall into habits, and some Kindred feed on the same subset of people night after night. If a vampire visits the same nightclub, odds are he's going to feed on some of the same people. Likewise, if a former victim remembers only sneaking off to a dark corner with that handsome stranger and then later feeling spent and euphoric, she might well seek out that stranger again.

The Kiss isn't addictive in a physiological sense; it doesn't cause withdrawal or tolerance. But a person with a thrill-seeking or addictive personality might well go chasing this high, trying to replicate the events that led up to it, night after night, and this can lead to some disastrous consequences. Also, if the victim is emotionally unstable or needy, she might seek out the vampire and try to reconnect, searching for that special, perfect feeling she got when they were together. What a vampire does in such situations depends very much on how far from his human days the bloodsucker has strayed. Young or humane vampires might try to explain to the person what happened (in appropriate terms), or sternly rebuff her so as to let wounded feelings do the rest. Older or truly monstrous vampires might simply kill the victim or, worse, place her under the Vinculum.

The Hunter Response

Some human beings seemed geared to protect others. Maybe this is a genetic response, maybe it's based on experience or personal choice, but even in the World of Darkness, some people are protectors. Without any supernatural exposure, these people might become policemen, soldiers or simply people devoted to protecting those around them, regardless of the situation. They learn self-defense, some carry weapons and the vast majority are never called upon to do more than look menacing or raise their voices (cops and soldiers, of course, are often called upon to do more).

But people with this mindset who *do* discover the supernatural, vampires in particular, are often unable to put the incident out of their minds. They look at the world around



them and realize that human beings are being hunted on a nightly basis, and this notion haunts them, driving them mad with the knowledge that *everyone* needs protection. These people become obsessed with wiping out the undead scourge, leaving their lives behind, liquidating their assets and becoming full-time hunters.

Why do vampires in particular trigger this response? Mostly it's because vampires prey on human beings directly, and they have no intrinsic methods of covering their tracks. As discussed in the following section, werewolves, though they occasionally consume human flesh, don't do so often or to survive, and they have the Lunacy to help them evade detection. Also, vampires are very much part of the popular consciousness, and although many of the myths surrounding them in the media are false, enough are true to give hunters a handhold. All of this means that hunters who target vampires tend to live long enough to become dangerous. But these hunters are far from stable, psychologically. Most of them are obsessive and extremely paranoid, and are willing to fight and die to protect other human beings. While vampires often find it expedient (or necessary) simply to kill these people, if the mundane authorities catch one of them first, he might well wind up in a place similar to Bishopsgate.

Werewolves

"God damn it! You need to tell me if the patients have those kinds of aversions!" Heather was furious. She crouched next to Leo, stroking the dog's fur and trying to calm him. "You didn't say a god-damned thing to me when I —"

"I didn't know!" Renee was almost in tears. "I swear to God, he's never said a word to any of us about dogs before today! He came in here a month ago after some kind of bar fight, and he's behaving like he's got PTSD. I thought the therapy dog would be good for him, I swear!"

Leo crouched down on the floor, whimpering. He was bleeding from the wound that the patient had given him, his yellow fur still stained with ink from the pen he'd used as a weapon. Heather lowered her voice and soothed him. "It's OK, baby. It's OK. You're a good boy. The vet's on his way. It's OK." She looked back up at Renee. "I've never seen anybody go that nuts before. Where is that guy now?"

"Sedated." Dr. Wolochowski walked into the room and started washing his hands. "Took four orderlies to hold him down. He kept screaming about wolves."

Werewolves — *Uratha* in their own language — are among the deadliest beings in the world. They attack in packs, slaughter their enemies and disappear into the moonlight. Their very presence triggers animal instincts in humanity, instincts of fear and danger. Werewolves are predators of a sort that simply do not exist in any other form, and the human subconscious knows them even if the conscious does not.

Quite apart from the psychological trauma that might be inflicted from watching a man change into a wolf, or seeing a wolf-like creature tear another person limb from limb, werewolves engender an effect in human beings called *Lunacy*. Lunacy strikes humans when they see werewolves in one of three forms: a "near-man" form called Dalu (hairy, muscular and brutish, but humanoid), the "near-wolf" form called Urshul (a gigantic wolf) and the horrific "man-wolf" form called Gauru (a humanoid monster with wolf features, truly the stuff of nightmares). The Lunacy reaction is strongest when the onlooker sees a werewolf in Gauru form, but in no case is it possible to resist the reaction. Deep in the lizard brain of humanity lurks the fear of being eaten, and the werewolf is that fear incarnate. While under the Lunacy, humans flee the area. Strong-willed people have the presence of mind to lock doors or perhaps even to fight if necessary, but for the most part, they flee, trying to put as much distance between themselves and the monster.

Mercifully, most humans' minds also rationalize away what they saw. The same coping mechanics that compel them to run away also prevent the incident from solidifying in their memories. If a person remembers anything at all, it might have to do with wild dogs, bears, or even other people rather than shapeshifters. Even if a person tries to remember, he must struggle against his own mind to do so, and the images are usually relegated to nightmares within a week of the sighting.

But not everyone is so blessed. Sometimes, people have strange reactions to the Lunacy. Repeated exposure, especially, can cause damage to a person's psychological makeup. If a human being is exposed to Lunacy too often (what this means in game terms is up to the Storyteller, but a number of times in a month equal to the person's Willpower rating is a good rule of thumb), he might develop derangements such as Phobias (dogs and other canines, the moon, howling sounds, blood and even raw meat), Obsessions (being indoors on nights when the moon is showing, carrying silver or wolfsbane) or, in more vicious cases, Catatonic or Fugue states. Repeated exposure to the Lunacy can sometimes compel a person to believe he *is* a werewolf. Such people are sometimes said to suffer from "lycanthropy" or "complex lycanthropic disorder," and they believe that they change into wolves under certain conditions. Similar to those with paranoid delusions, these people construct elaborate fantasies for why they cannot *prove* their shapeshifting abilities. Often these rationales involve necessary and highly exotic tools (wolf-skin belt, blood freshly drawn from an infant, etc.) or special "rules" for shapeshifting (the sufferer might believe that he cannot change shape during the day, or in front of "the unworthy" or might fear the bloodlust and loss of control that comes with the transformation). This disorder is more typical of people who have actually been bitten by werewolves than of those who have only seen them.

Sometimes repeated exposure isn't necessary, though. For some witnesses, what they have seen lingers in their subconscious minds, festering there like an unintended

wound, until it develops into a full-blown derangement. The sufferer usually presents with nightmares, mild aversions or phobias and odd fixations that might resemble obsessive-compulsive behavior. If the person can get good psychiatric help, he might be able to confront his memories, at which point he actually falls under Lunacy again, briefly, and then forgets the incident. This reaction is best triggered with talk therapy rather than pharmaceuticals. In fact, the drugs typically prescribed for these symptoms — sleep aids, relaxants and so on — actually worsen the situation because they prevent the sufferer’s mind from coming to grips with what he has seen. If such treatments continue, the sufferer eventually slips into permanent catatonia or the above-mentioned lycanthropy.

More information on Lunacy can be found in **Werewolf: The Forsaken**.

Mages

“Look who’s here!” Randy glanced up from the puzzle he was putting together. He felt a little clearer this morning. He recognized more of the faces around him, and, for some reason, he knew he’d met a woman named “Janice” who had blonde hair. He didn’t know why that was important, but it was.

The nurse was walking toward him, followed by a man in a gray suit. The man leaned down and looked at Randy’s eyes, and then glanced up at the nurse. The nurse blinked a few times, and then showed them to a therapy room and shut the door.

That’s weird, Randy thought. I’m not supposed to be alone with anyone but my doctor.

The man took Randy’s hand and drew on it with a white marker. It didn’t leave a mark on his skin, not one that he could see, at least. He mumbled something under his breath, staring at Randy, and Randy felt the clarity going away. The lights in the room were too bright. The colors were dimming. And Janice . . .

“Janice?” He whispered.

The man shook his head. “Sorry, Randy. See you next month.”

They call themselves “Awakened,” and the term fits as well as any other. They are mages, possessed of the power to impose the natural laws of other, higher realms of the existence upon this one. Unfortunately, the minds of the unAwakened (whom they dismissively call “Sleepers”), are very much part of this “Fallen World,” and that means that some mages have the power rewrite human thought by casting a spell.

Arcana

Mages can affect a person’s mind in a number of ways, depending on what kind of magic they use. Magic, for pur-

poses of **Mage: The Awakening**, is divided into 10 subsets called “Arcana.” While some overlap among them exists, they each enable power over a certain facet of reality. The three Arcana that most directly affect the human mind are Death, Life and Mind.

Death


A mage with sufficient skill in the Death Arcanum can remove a person’s soul from his body. The soul flies free unless placed in a container (also possible with Death magic). Without a soul, a person loses a dot of Morality per week, and must check for gaining a derangement as usual when this loss occurs. Normal sins against Morality can also cause degeneration during this time. If the mortal’s soul is restored before Morality reaches zero, any Morality lost due to soul loss returns as well over the course of the next week (and Morality lost to degeneration might return more quickly than usual as well, depending on how the person behaves; see p. 94 of the **World of Darkness Rulebook**). If not, the victim becomes hopelessly insane, nearly catatonic, wandering the world like a zombie. Some victims commit suicide, but others are unable to muster the will and often wind up incarcerated in asylums. Some such victims wind up as hosts for spirits and other entities that possess human bodies; an entity attempting to possess such a person receives a +2 modifier to the attempt to do.

Note, by the way, that Awakened magic is not the only force in the World of Darkness that can remove a person’s soul. Very powerful spirits are sometimes capable of doing so, and some monsters that do not neatly fit into the classification systems of vampires, werewolves and mages evince this dreadful power.

Life

We are our brains. Every action and thought we have has a neurochemical antecedent. And yet, in the World of Darkness there is clearly some non-physical portion to people (as proven by the ability to remove a person’s soul, for instance). Be that as it may, control over Life enables the mage to force the release of neurotransmitters in the human brain. The simplest application of such a spell is to trigger a fight-or-flight response (normally a mage chooses to make an opponent flee rather than fight, of course), but a mage with more skill can cause a person to feel love, hatred, anger or even more complex emotions such as jealousy. These spells don’t affect a person’s “mind,” but work on the person’s *brain*. Therefore, presuming the spell succeeds, the victim has no way of knowing that the emotions he felt or the actions he took were not his. Life magic is therefore extremely damaging to a person’s self-concept, because although the spell might wear off, the victim doesn’t have the bulwark of rationalization that Mind magic (see below) or Lunacy (see the section on werewolves, above) provide. If the mage forced the victim to brutally attack a stranger





by triggering a biological impulse to homicidal anger, that victim is left wondering why he snapped like that. Morality loss might be appropriate (see the sidebar on p. 169).

Mind

The Arcanum of Mind is an entirely different beast, though. It controls behavior on a direct level, not unlike the Dominate Discipline that some vampires use. Mind can also, incidentally, raise or lower a person's Mental Attributes, which means that if a mage has the time, he can make a person less resistant to mental attacks by first lowering the victim's Resolve.

A mage with sufficient control over the Mind Arcanum can alter thoughts, behavior and memory, but no mage can make such a change permanent. Living creatures' minds are dynamic entities (and, some mages note, the "mind" as separate from the body is a scientifically false concept, not that this matters for magical purposes), so they return to their original states. One month is about the longest a Mind spell will last, but nothing stops a mage from re-casting the spell at that time. This is particularly useful for spells involving the alteration of memory, and if the spell is repeated often enough, the victim's mind might assimilate the false memory, making further casting unnecessary (whether this happens and how long it takes is up to the Storyteller, as it goes against the **Mage** rules somewhat).

People who are subject to Mind magic over a long period of time might develop Avoidance derangements. Their minds become used to being shut down, and so these people become more suggestible and pliable, even to mundane methods of persuasion. They sleep often and for long periods of time, but seldom dream. Creativity wanes and language suffers as the person's affect becomes flat and prosody disappears. Movements often become choppy, and fine motor control suffers. Emotionally, these people become deadened. They don't become sociopathic, normally, but they can't muster much emotion of any kind for other people. They need magic to tell them what to do and feel.

Disbelief

When people see obvious magic at work, something in their soul reacts. Explaining the hows and whys of Disbelief would require a digression into the metaphysics of magic (you can read all about it in **Mage: The Awakening**), but for purposes of this book, it's enough to know that the unAwakened, human soul rejects magic.

This rejection doesn't work on the same primal, animalistic level of the Lunacy. Disbelief is slightly more integral to the human experience than that, as Disbelief works *partially* on the expectations of how reality works. Disbelief is the soul desperately trying to remain Asleep. It acts on the mind to come up with excuses or lapses in memory, but it's the soul that is at fault for Disbelief. When this expectation is challenged, the soul is compelled to rebel by the Abyss — the metaphysical gulf separating the magical realm from our mundane — leaving the

mundane human searching for a handle on the situation. The soul then finds some way to explain what the sensory system has processed, and if the soul can't, the person forgets the whole experience. Disbelief is usually harmless, resulting in a few stories of weird occurrences or some recurring dreams at most.

But again, repeated exposure is a problem. More is at work with Disbelief than a single human being's mind — Disbelief is a function of greater magical truths and conflicts. If a person is repeatedly exposed to magic, the mind must work harder to rationalize or forget the information and come to terms with the impulses of the sleeping soul. If a critical mass is reached (and again, how much magic exposure this requires is for the Storyteller to decide), one of three things might happen.

First, the character might Awaken. Her mind breaks free of Disbelief and comes to a fundamental understanding of the nature of the world. Her soul flies free on the way to the aforementioned realms of power, and there forges a connection that makes her a mage.

Second, the character loses her mind entirely. She has no way of explaining what she has seen, but the truth — *magic* — continues to elude her, and so her mind simply shuts down or shatters. Such unfortunate people often present with symptoms similar to schizophrenia, or else they fall catatonic and do not recover.

Third, the mind might reach some middle ground. The character realizes that what is happening is magic, but lacks the strength to Awaken. These people are called "Sleepwalkers" — they don't cause or suffer from Disbelief, but they cannot perform magic, either. Note that becoming a Sleepwalker provides no context for magic; such a person doesn't gain the ability to recognize mages or identify spells by sight. All that happens is that the protective effects of Disbelief are no longer present, which means that the person might go insane from the sheer trauma of witnessing magic with no bulwark (should it continue to happen around her), if no one educates her. Fortunately, Sleepwalkers are valuable assistants to mages, and once Sleepwalkers are identified, they usually wind up under someone's aegis, for better or worse.

Prometheans

"Look, Mr. Allan, it'd help if you could tell us why you shot him." Good cop/bad cop had long since been abandoned. Sergeant Nichols had never seen a case like this before. Mike Allan was a normal guy, happily married, two kids, good job and the rest of it, and now he was facing charges for shooting a guy in broad daylight. Only thing weirder than the fact that the victim wasn't pressing charges — hell, hadn't even stuck around to give a statement — was that Allan wouldn't shut about it. He kept repeating —

"I shot him. It didn't kill him, but I tried. I'm not a good shot, but I tried. I aimed for the head and I shot him —"

"Mr. Allan, I'm going to advise you don't say anything else without a lawyer —"

"You don't understand!" Allan stood up, and Sergeant Nichols tensed. He heard movement behind the mirror. "I shot him, but he got away! He's still out there!"

Behind the glass, another officer looked to the man standing next to him. "Wow. I think he's one for you, Doctor . . . Brin?"

"Brine," said the man, staring at Allan. "It's Doctor Brine. And I think you're right."

The Prometheans, sometimes called "the Created," are rare, perhaps one per one million people. This is well, as they have a strange and damaging effect on the minds of those they meet. They engender feelings of anger, lust, jealousy, resentment and spite in people, and if they remain near the same group of people too long, the result is a mob howling for blood. This effect is called *Disquiet*, and it is something that every Promethean has to contend with.

But for purposes of this section, we consider the aftereffects of *Disquiet*. *Disquiet* progresses in four stages. In the first, the person is vaguely fixated on the Promethean and might treat her differently (though not, at this stage, necessarily worse) than he would normal people. As the condition worsens, though, the obsession deepens, and the person eventually wishes to destroy or possess the Promethean. *Disquiet* is also contagious, which has the effect of forming the mobs mentioned above. Once the Promethean is gone, though, either destroyed by the mob or fled the area, *Disquiet* fades in a few weeks. But what do the lingering effects of *Disquiet* do to a person?

It depends very much on the person, of course. A man who encounters a beautiful female Promethean and begins to lust after her, eventually deciding that he must have her and is willing to leave his wife and family for her, might question his notions of "love" and "family" once the Promethean is no longer around. He might decide that he was right — the Promethean really is his destiny, and he needs to follow her. He might live the rest of his life feeling ashamed of what he almost did and rededicate himself to his family, which fine . . . unless the Promethean reenters his life at some point. At that time, will he seek to destroy her or drive her away so that she can't ruin his life again? Or will all the old feelings come crashing back?

Likewise, some Created spawn feelings of spite and blame. The fault for any local problem or difficulty in the person's life lies with the Promethean. These are the Prometheans who most often spur people to violence and mob rule. But what happens when the Promethean is dead, torn limb from limb and set ablaze? The members of the mob look at each other in horror, realizing what they have become, and struggle to find rationales for their actions. If the Promethean fought back, perhaps killed one of them (not at all unthinkable, for Prometheans are terrifying combatants), this process is easier. If the Promethean just tried to run, or worse, allowed himself to be destroyed, the perpetrators now have blood on their hands and must come to grips with the fact that they have committed murder.

Time actually makes these feelings worse, as *Disquiet* fades and leaves the people in command of their faculties again, and they realize that they killed for spurious or downright false reasons.

It might bear noting here that unlike the mental command powers of vampires or mages, *Disquiet* is *not* an external force. It is a *reaction* to the Promethean's inner fire, the blazing power that animates their flesh and gives them life (this fire is called *Azoth*). Strong-willed people instinctively look past this fire and are able to judge a Promethean by behavior rather than succumbing to *Disquiet*, at least for a while. People who resist *Disquiet* for a long period of time and then succumb often have a very difficult time recovering from the *Disquiet* and from their own actions, because they have had time to get to know the Promethean on his own merits before the *Disquiet* sets in.

A former sufferer of *Disquiet* might be wracked with nightmares, cold sweats or bouts of uncontrollable grief and guilt. He might also be unable to let go of the notion that the Promethean was evil or monstrous, because if he *does* let go of that notion, that makes him the monster. Note, though, that some Prometheans really are monsters, and such beasts might trigger not only *Disquiet*, but the hunter response (see p. 173) in the right kind of person.

Changelings

Jason collapsed into the break room's one comfortable chair. "I'd give my left nut for a beer."

Clark was rooting around in the fridge for the sandwich he'd brought. He had a feeling Christie had taken it. Again. Bitch. "What's up?"

"Oh, that new girl they just brought in last night. The teenager."

"The one who tried to saw her wrists open?" Clark gave up on the sandwich and turned around. "Who uses a fucking saw?"

Jason shook his head. "She said she couldn't find an ax. She's a barrel of laughs." He rubbed his temple gingerly.

Clark noticed the bruise. "What happened to your face, man?"

"That new girl. She's a barrel of laughs, until lights out. She doesn't want to sleep. She keeps screaming that 'they're going to come for me again.'"

"Crazy."

Jason thought back to the look in the girl's eyes, and what she'd said to him — they rape me, all night, they rape me. "Yeah, I guess."

Changelings have some control over the human psyche, influencing emotions and thoughts to a minor degree, and the effects of such powers have already been discussed. But where the fae are truly dangerous to human minds is in the realm of dreams.



Any changeling of sufficient skill can enter the dreams of a sleeping mortal and reshape them. Some changelings can even harm a sleeping person by poisoning her dreams, granting her nightmares or attacking her “dream-self.” This damage doesn’t normally come in the form of lost Health, but lost Willpower. Therefore, constant dream-attacks won’t kill a person, but they can certainly drive her insane.

Derangements gained through dream-attacks are most likely to take the form of recurring nightmares, avoidance behaviors and phobia (focused on sleep or objects and situations commonly encountered in the dreams), insomnia and drug addiction (stimulants to stay awake or heavy barbiturates to induce dreamless sleep). Going without sleep for too long induces hallucinations, paranoid psychosis and, of course, impaired judgment and functionality due to fatigue. Eventually, though, a person *will* collapse from exhaustion, no matter how strong-willed she may be, and any problems

caused by sleep deprivation resolve themselves within a few nights of normal sleep. That assumes, of course, that the victim isn’t subjected to more dream-attacks.

Changelings are also capable of crafting illusions and changing perceptions of reality, which can in themselves bend sanity. Worse, they can steal mortals away to the Hedge. A trip into the Hedge, the strange barrier between our world and the realm of Faerie, can strip away part of a person’s soul (and therefore her Morality; see the section on soul loss on p. XX) and grant derangements that way. A person might remember vividly her time in the Hedge, the Thorns tearing away tiny pieces of her and ravenous beasts dogging her every step, but even if she tells someone, the whole experience is likely to be taken as evidence of a mental disorder. And yet, humans taken into the Hedge and thus abused might well be more fortunate than the changelings themselves, pressed into service by the cruel and capricious True Fae.

You people!

You people!

Listen to me!

I know all about this – I know what is going on here.

You aren't healers – you're jailors!

They're all terrified of us, so they let you treat us any way you like!

But I know what goes on in here, what goes on behind those doors, when the secretaries and the orderlies go home!

You think we're the monsters, because we don't think like you do?

You haven't seen monsters, until you've been in **HERE.**

WITH US!

**– Red Samuel,
Bishopsgate inmate**

This book includes:

- A look at insanity and its use as a Storytelling tool for horror games — including comprehensive rules for gaining and curing derangements, as well as systems for the treatment of madness.
- A history of institutions and asylums, as well as useful advice for players and Storytellers in using these locations either as backgrounds or as the setting for an entire chronicle.
- Bishopsgate, a fully detailed insane asylum ready to be placed anywhere in your World of Darkness chronicle.

*For use with the
World of Darkness Rulebook*



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