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Leanne Jeong April 12, 2022

Implications from Psychiatric Diagnoses in Milledgeville State Hospital

by

Leanne Jeong

Whitney Wharton, Ph.D.

Adviser

Neuroscience and Behavioral Biology

Whitney Wharton, Ph.D.

Adviser

Kristen Frenzel, Ph.D.

Committee Member

Kylie Smith, Ph.D.

Committee Member

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Abstract

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Recent studies on the psychiatric diagnoses of Black patients have shown evidence of racialized diagnoses of certain mental disorders. In Jonathan Metzl's *The Protest Psychosis: How Schizophrenia Became a Black Disease*, he states that one of the reasons for the racialization of schizophrenia may be due to the transitioning of the first *Diagnostic and Statistical Manual of Mental Disorder* (DSM-I) to the second edition (DSM II). However, there may be evidence of racialized diagnoses before the transitioning of the DSMs in 1968. To better understand how diagnoses may have become racialized before changes were made to the DSM-I, this thesis investigated Milledgeville State Hospital during the 1950s and 1960s. Previously known as the Georgia State Asylum for Lunatics, Epileptics, and Idiots, this psychiatric facility was at one time the largest mental hospital in the nation. While Milledgeville State Hospital was known for its inadequate care and horrific conditions, the occurrence of misdiagnosis at the facility is highly suspected considering the passage of the Jim Crow laws and other racial disparities during the 1950s and 1960s. Therefore, this study looked at psychiatric diagnoses at Milledgeville State Hospital from 1956 to 1967 to see whether one race-sex group was more likely to be diagnosed with a certain mental disorder compared to another. The diagnoses analyzed were "schizophrenic reactions", "chronic brain syndrome: cerebral arteriosclerosis", "chronic brain syndrome: senile brain disease," and "psychotic disorders: manic depressive reactions." After performing pairwise comparisons and a test for trend in proportions, the data showed that "Nonwhite" patients were more likely diagnosed with "schizophrenic reactions" and "manic depressive reactions" compared to the "White" patients from 1956 to 1967. In addition to this study highlighting the history of racialized diagnoses at Milledgeville State Hospital, it also exhibits how important it is for current psychiatric practices to continue taking steps in dismantling racial disparities and institutionalized discrimination when providing mental healthcare.

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Chapter 1: The Problem of Diagnostic Disparities

In 1961, psychiatrist Dr. Thomas Szasz became an influential figure in arguing against the validity of his own field after his publication titled *The Myth of Mental Illness*. [1] In his argument, he stated that "there is no such thing as 'mental illness'" and that the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder* (DSM) gave too much political and social power to psychiatrists.[2] This argument is still debated on in present day discussions regarding psychiatric diagnoses. Furthermore, reviews on empirical literature have exhibited how psychiatrists' stereotypical biases have racialized and affected the psychiatric diagnosis rate in minority groups.[3] For instance, recent studies have shown that African Americans are three to five times more likely to be diagnosed with schizophrenia compared to Euro-Americans.[4] While there are many speculations for the disproportionate rate of schizophrenia diagnosis in African Americans, Johnathan Metzl's *The Protest Psychosis: How Schizophrenia Became a Black Disease* examined how the mental disorder transitioned "from an illness of white feminine docility to one of black male hostility." He stated that the changes in the symptom criterion from DSM-I to DSM-II played a significant role in racializing the

[1] Carey, Benedict. "Dr. Thomas Szasz, Psychiatrist Who Led Movement against His Field, Dies at 92." The New York Times. The New York Times, September 12, 2012. https://www.nytimes.com/2012/09/12/health/dr-thomas-szasz-psychiatrist-who-led-movement-against-his-field-dies-at-92.html.

[2] Benning, Tony B. "No Such Thing as Mental Illness? Critical Reflections on the Major Ideas and Legacy of Thomas Szasz." BJPsych Bulletin 40, no. 6 (2016): 292–95. https://doi.org/10.1192/pb.bp.115.053249.; Szasz, Thomas Stephen. The Myth of Mental Illness: Foundations of a Theory of Personal Conduct. New York, NY: Harper Perennial, 2010.

[3] Bell, C C, and H Mehta. 1980. "The Misdiagnosis of Black Patients with Manic Depressive Illness." *Journal of the National Medical Association* 72 (2): 141–45. https://pubmed.ncbi.nlm.nih.gov/7365814.

[4] Schwartz, Robert C, and David M Blankenship. "Racial Disparities in Psychotic Disorder Diagnosis: A Review of Empirical Literature." World Journal of Psychiatry 4, no. 4 (2014): 133. https://doi.org/10.5498/wjp.v4.i4.133.; Payne, Jennifer Shepard. "Influence of Race and Symptom Expression on Clinicians' Depressive Disorder Identification in African American Men." *Journal of the Society for Social Work and Research* 3, no. 3 (October 8, 2012): 162–77. https://doi.org/10.5243/jsswr.2012.11.

diagnosis of schizophrenia to be more common in African Americans than White females in the 1960s,

> "the DSM-II criteria for schizophrenia, paranoid type, foregrounded masculinized hostility, violence, and aggression as key components of the illness. Earlier, the DSM-I had described schizophrenia… in a gender-neutral, passive-voice without sex-specific pronouns." [5]

Thus, to investigate the history of racializing psychiatric diagnoses in Georgia, this thesis analyzed the history of patient diagnosis in Milledgeville State Hospital, one of the largest and oldest mental asylums, between 1956 to 1967. Although the DSM-I distinguished mental disorders during this period, racialized diagnoses of schizophrenia and other mental disorders were present before the release of the DSM-II, as Metzl had stated. [6] Through the analysis of patient diagnoses at Milledgeville, this research considered how prejudiced and racist perspectives from 1956 to 1967 may have led to discriminatory diagnoses and treatment between "White" patients versus "Colored," or "Nonwhite" patients. Studies have been conducted regarding the history of psychiatry during the twentieth century, but little has been mentioned on the racism present in psychiatric diagnosis for African Americans. Even when interest in psychiatric diagnosis increased during and post-World War II, only a few sources mentioned the racial diagnoses of Black soldiers and veterans during this time. [7] Therefore, with limited research and investigations on psychiatric diagnosis and mental healthcare for Black patients during the tumultuous 1950s and 60s, this paper tested the hypothesis that racialized diagnoses were present in Milledgeville State Hospital between 1956 to 1967. Moreover, this thesis also

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[5] Metzl, Jonathan. *The Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston, MA: Beacon, 2011.

[6] Metzl, Jonathan. *The Protest Psychosis: How Schizophrenia Became a Black Disease*.

[7] Dwyer, Ellen. "Psychiatry and Race during World War II." *Journal of the History of Medicine and Allied Sciences* 61, no. 2 (2006): 117–43. https://doi.org/10.1093/jhmas/jrj035.

explored how the history of Milledgeville State Hospital may have affected psychiatric diagnosis and treatment then and today.

Methods

This research examined Milledgeville State Hospital patients using primary and secondary sources to investigate whether diagnoses were racialized at the institution. Milledgeville State Hospital's annual reports were collected from 1956 to 1967 to study the asylum's diagnosis of patients during this period. These reports were written by the hospital's administration and are located at the Georgia State Archives in Morrow, Georgia. Physical copies of the annual reports from the years 1960 to 1970 were retrieved from the collection *DOC 2636: Public Health – Central State Hospital – Annual Reports- 1960-1972*. Annuals reports from 1956 to 1960 were digitized and retrieved through the archives in the Digital Library of Georgia. The annual reports examined for this study included tables on first admissions diagnostic groups, readmissions, deaths, and fiscal reports. After 1961, however, these reports gradually decreased the number of data specifics on patients and included less information on the functioning of the hospital. From 1969, the reports only included a couple of tables on the number of patients in each diagnostic category and did not separate patients by race, gender, or age. [8] Thus, due to the lack of information on Milledgeville starting from the late 1960s, this research analyzed first admissions tables from 1956 to 1967. The data tables from the annual reports separated patients by age, gender, and race.

The conditions and environment of the hospital were investigated using newspaper collections of Jack Nelson's papers and other journalists from 1950 to 1967. These archives were

[8] Georgia. Central State Hospital. "One hundred and twenty-sixth annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1969 [1968-69]." 1969.

obtained through the ProQuest database provided by Emory University. The annual report from 1959 was excluded from our analysis since it did not contain any material or tables on first admissions diagnosis. The reasons for the missing data in 1959 will be discussed in the upcoming chapters. Additionally, the 1965 annual report was excluded from the analysis due to not being able to find the digitized or physical copy of the report.

From 1956 to 1960, patients were sorted into 16 different age categories ranging from "under 15" to "85 and over." Starting in 1961, the tables only included 9 age categories, which also ranged from "under 15" to "85 and over." Regarding race, annual reports from 1956 to 1960 distinguished race as two distinct categories: "White" and "Colored." However, beginning from the 1961 annual report, the race categories were modified to "White" and "Nonwhite."

This project analyzed the four diagnoses with the highest frequencies listed in Milledgeville State Hospital's annual reports from 1956 to 1967.[9] The following mental disorders with the highest occurrences were "schizophrenic reactions", "chronic brain syndrome: cerebral arteriosclerosis", "chronic brain syndrome: senile brain disease," and "psychotic disorders: manic depressive reactions."

The following race-sex groups were statistically compared for each diagnosis to see whether one sex-group was more likely to be diagnosed for a certain mental disorder compared

[9] Georgia. Milledgeville State Hospital. "One hundred and thirteenth to one hundred and seventeenth annual report of the Milledgeville State Hospital at Milledgeville, Georgia for the year ending June 30, 1956 through June 30, 1960 [1955-60]." 1960. http://dlg.galileo.usg.edu/do:dlg_ggpd_y-ga-be450-pm5-ba1-b1955-h60.; Georgia. Central State Hospital. "One hundred and eighteenth annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1961 [1960-61]." 1961.; Georgia. Central State Hospital. "One hundred and nineteenth annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1962 [1961-62]." 1962.; Georgia. Central State Hospital. "One hundred and twentieth annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1963 [1962-63]." 1963.; Georgia. Central State Hospital. "One hundred and twenty-first annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1964 [1963-64]." 1964.; Georgia. Central State Hospital. "One hundred and twenty-third annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1966 [1965-66]." 1966.; Georgia. Central State Hospital. "One hundred and twenty-fourth annual report of the Central State Hospital, Milledgeville, Georgia for the year ending June 30, 1967 [1966-67]." 1967.

to another: “White Male,” “Nonwhite Male,” “White Female,” and “Nonwhite Female.” First admissions tables from the 1956 to 1967 annual reports were inputted and organized into Microsoft Excel. Then, statistical differences in diagnosis between each race-sex group from 1956 to 1967, excluding 1959 and 1965, were analyzed using the chi-square test and a test for trend in proportions. The Bonferroni adjustment was used to interpret p-values. [10]

Outline of Chapters to Come

In the chapters to follow, this thesis will cover the history of Milledgeville State Hospital and elaborate on the importance of investigating the facility during the 1950s and 1960s. It will also include discussions on treatments, such as sterilizations, as well the history behind why the hospital began to change its conditions and policies starting in 1959. The paper will investigate the power of the *Diagnostic and Statistical Manual of Mental Disorder (DSM)* and how this manual serves as a gold standard in Western society. The information on the DSM serves as a helpful background for understanding the diagnostic categories used during the period investigated at Milledgeville State Hospital. Graphs and statistical tests of patient diagnoses from Milledgeville will also be examined in the next few chapters. After the results, the thesis will go into the discussions section on how the history of diagnoses explains the trends seen in recent diagnoses amongst minority groups. The last part of this project includes an interview with Dr. Jennifer Grant, a fourth-year psychiatry resident, from Grady Memorial Hospital. During the

[10] R Core Team (2021). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL https://www.R-project.org/; Hadley Wickham and Evan Miller (2021). haven: Import and Export 'SPSS', 'Stata' and 'SAS' Files. R package version 2.4.3. https://CRAN.R-project.org/package=haven; Hadley Wickham, Romain François, Lionel Henry and Kirill Müller (2021). dplyr: A Grammar of Data Manipulation. R package version 1.0.7. https://CRAN.R-project.org/package=dplyr; Hadley Wickham (2021). tidyr: Tidy Messy Data. R package version 1.1.3. https://CRAN.R-project.org/package=tidyr; H. Wickham. ggplot2: Elegant Graphics for Data Analysis. Springer-Verlag New York, 201

interview, she gives a glimpse into the current practice of psychiatry as well as her opinions on how to improve current-day racialized diagnoses and treatments.

Chapter 2: Issues in the History of Georgia: Milledgeville State Hospital

In the *One-Hundred and Thirteenth Annual Report of Milledgeville State Hospital* in 1956, the Superintendent of Milledgeville State Hospital stated that their facility "is a humane type of institution and we who operate it are more interested in relieving human suffering and doing our duty by the citizens of Georgia than we are in presenting 'good' statistical records." [11] First known as the Georgia State Asylum for Lunatics, Epileptics, and Idiots, Milledgeville State Hospital was once the largest mental hospital in the nation. This psychiatric facility is located in Milledgeville, Georgia and was established in 1842. Commonly referred to as Milledgeville, this hospital was infamous for its harsh environment; parents in the South would often use the popular phrase "If you don't straighten up, I'm going to send you to Milledgeville" as a threatening remark to their children when they were not behaving.[12] While repeated administrators of the hospital extolled the virtues of their institution, it was well known as a substandard and "horrific" hospital holding more than ten thousand patients.[13]

Spanning around 2000-acres of land, Milledgeville State Hospital held an overwhelming number of patients. Many patients were brought to Milledgeville for a variety of reasons, ranging from a woman's postpartum period to severe mental illnesses. Due to the increasingly high ratio of patients to staff members, however, the facility was downsized and renamed to Central State

[11] Georgia. Milledgeville State Hospital. "One hundred and thirteenth to one hundred and seventeenth annual report of the Milledgeville State Hospital at Milledgeville, Georgia for the year ending June 30, 1956 through June 30, 1960 [1955-60]." 1960.

[12] Segrest, Mab *Administrations of Lunacy: Racism and the Haunting of American Psychiatry at the Milledgeville Asylum*. New Press, 2020.; Monroe, Doug. "Asylum: Inside Central State Hospital, Once the World's Largest Mental Institution." *Atlanta*, February 15, 2015.

[13] Deutsch, Albert. *The Shame of the States*. Arno Press, 1973.; Georgia. Milledgeville State Hospital. One hundred and thirteenth to one hundred and seventeenth annual report of the Milledgeville State Hospital at Milledgeville, Georgia for the year ending June 30, 1956 through June 30, 1960 [1955-60]."

Hospital in 1967.[14] Today, Central State Hospital offers self-guided and trolley tours for visitors. In their trolley tour, they highlight some of Central State Hospital's historically significant buildings, such as the Powell Building and the Chapel of All Faiths, as well as the Cedar Lane Cemetery. Cedar Lane memorializes the 25,000 patients buried at the hospital with numbered iron stakes. Although the tour allows participants to explore the Cedar Lane Cemetery, which is the burial site for White patients, they do not even display the cemetery where African American patients were buried. The tour similarly does not exhibit any African American chapels, whereas the Chapel of All Faiths, which was for White patients, was greatly showcased for its beauty and even opened for visitation. Milledgeville attracts many visitors and college students for its touristic history and its haunted rumors, today, but it is crucial that we acknowledge the racist history of this hospital and how Black patients were treated, specifically during Jim Crow era. To have a better knowledge on the discriminatory care within Milledgeville, this paper will briefly investigate the history and origins behind segregation.

The Origins of Segregation

After the ratification of the 13th Amendment and the abolition of slavery in 1865, Southern state governments found alternative ways to establish the segregation of African Americans during the Reconstruction era. The passage of the Black Codes in 1865 marked one of the initial steps towards institutionalized discrimination in society. These laws limited Black individuals' freedoms and allowed White farmers to continue using them for cheap labor.[15]

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[14] Alan, Judd. "Asylum's Dark Past Relived as Cycle Ends." *The Atlanta Journal Constitution*, January 20, 2013. https://www.ajc.com/news/state--regional/asylum-dark-past-relived-cycle-ends/uq2OK0dgHCeynhFUGba36O/.

[15] History.com Editors. "Black Codes." History.com. A&E Television Networks, June 1, 2010. https://www.history.com/topics/black-history/black-codes.

Although African Americans were legally freed after the 13th Amendment, many faced hostility, marginalization, and discrimination as freed individuals. Even after the passage of the 15th Amendment, which allowed all people to vote regardless of race, White southerners were determined to maintain their power and supremacy over African Americans, resulting in the expansion of the Jim Crow laws. These laws were highly reinforced in the South, causing almost all public spaces, such as parks, restrooms, and elevators, to be segregated. The Jim Crow era, or the period when Jim Crow laws were popularized in the South, began around 1877. It was not until President Lyndon B. Johnson signed the Civil Rights Act in 1964 when segregation and the Jim Crow laws were legally done away with.[16]

Milledgeville did not take in any Black patients until 1867, when the Black Codes were still widely supported. Unsurprisingly, once Black patients were brought to the facility, numerous forms of segregation and discrimination within the institution continued for many years. Using archival research, Mab Segrest's *Administrations of Lunacy: Racism and the Haunting of American Psychiatry at the Milledgeville Asylum* highlights some of the discriminatory treatment and care in Milledgeville. For instance, one of the treatment plans prescribed at the hospital required White male patients to work as gardeners, White female patients to work as seamstresses, "Colored" male patients to work as laborers in the farm, and "Colored" female patients to work at laundromats. [17] In addition to Segrest's findings, some of Milledgeville State Hospital's annual financial reports showed that "Colored" patients received a

[16] History.com Editors. "Jim Crow Laws." History.com. A&E Television Networks, February 28, 2018. https://www.history.com/topics/early-20th-century-us/jim-crow-laws.

[17] Raz, Mical. "Psychiatry under the Shadow of White Supremacy" Review of Administrations of Lunacy: Racism and the Haunting of American Psychiatry at the Milledgeville Asylum. *Nature* 580, (April 21, 2020): 449–50.

smaller budget for personal and medical care compared to "White" patients.[18] While Milledgeville was infamous for its unlivable conditions, the history behind discriminatory diagnosis and treatment, such as sterilizations, is not well-established and must be further examined.

Eugenics and Sterilization

David Cooper, the first superintendent of the facility in 1843, set up the foundation for maltreatment of patients by exploiting them for labor and using harsh treatments. One such punishment that he instituted involved taking patients to the water closet and using restraining chairs and emetics.[19] Once Dr. Thomas Peacock became the superintendent in 1948, Milledgeville continued its abuse and significantly increased its execution of coerced sterilizations on patients. As the chair of the Georgia Eugenics Commission, Dr. Peacock was a firm advocate for sterilizations and eugenic doctrines.[20] Involuntary sterilizations became a common practice in Milledgeville and in the state of Georgia starting in the early twentieth century. The practice was widely supported for its "cost-saving" measures and effective removal of "defective genes from the gene pool." [21]

Georgia physicians began supporting eugenic sterilizations as early as 1913 at the Georgia Medical Association's Endorsement. The physicians at this conference advocated,

> "…criminals, moral degenerates, and imbeciles contain thousands of negroes – and in fact, in the south the negroes appear to constitute more than 50 percent of the criminal

[18] Georgia. Milledgeville State Hospital. "One hundred and thirteenth to one hundred and seventeenth annual report of the Milledgeville State Hospital at Milledgeville, Georgia for the year ending June 30, 1956 through June 30, 1960 [1955-60]." 1960

[19] Segrest, 32.

[20] Segrest, 302.; Peacock, Thomas G. "Georgia Program for Sterilization." *Journal of the Medical Association of Georgia* 42 (1953): 276–78.

[21] Smith, Stephen Michael, "Eugenic Sterilization in 20Th Century Georgia: From Progressive Utilitarianism to Individual Rights" (2010). *Electronic Theses and Dissertations*. 594. https://digitalcommons.georgiasouthern.edu/etd/59

> population. If you, therefore, enact sterilization laws applying the criminals of certain characteristics, it will work out practically like the grandfather clause, applying largely to the negroes, and will result in preventing thousands of criminals or insane negroes from propagating their dangerous seed." [22]

The popularity of eugenics and sterilizations continued in Georgia, even after being informed on the atrocities committed by the Nazis during World War II. [23] The number of involuntary sterilizations at Milledgeville reached its peak during Superintendent Peacock's control.[24] Considering the dominant social ideas during the twentieth century, oppressed patients, such as "Colored" and female patients, experienced misdiagnosis and incorrect treatment plans at Milledgeville due to their race and gender. According to superintendent Peacock, patients diagnosed with schizophrenia and manic depression were most in need of sterilization to protect children from inheriting "unstable minds." [25] Historians have noted that Milledgeville performed more sterilizations for women and "Colored" patients.[26] While there are no specific data tables regarding treatment plans based on sex or racial groups, it can be inferred that "Colored" and female patients experienced frequent misdiagnosis and inappropriate treatments at Milledgeville State Hospital.

The Jack Nelson Exposes - 1959

Though the treatment and conditions of the hospital were well-known amongst Southerners, there was never a thorough investigation of the facility until 1959, when journalist

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[22] "DECLARES STERILIZATION IS SOLUTION OF NEGRO PROBLEM." *The Atlanta Constitution (1881-1945),* Apr 20, 1913. https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/historical-newspapers/declares-sterilization-is-solution-negro-problem/docview/496622343/se-2?accountid=10747.

[23] Smith, 6.

[24] Smith, 78.

[25] Peacock, Thomas G. "Georgia Program for Sterilization."

[26] Segrest, 267; Smith, "Eugenic Sterilization in 20Th Century Georgia: From Progressive Utilitarianism to Individual Rights." 594.

Jack Nelson exposed numerous "irregularities" within the hospital in *The Atlanta Constitution*. Because of his "distinguished example of local reporting" on Milledgeville State Hospital, Jack Nelson won the Pulitzer Prize in 1960. [27] Subsequently, multiple investigators began investigating the malpractices, unlivable conditions, use of unapproved drugs, and abusive treatments for Milledgeville patients.[28] Articles from *The Atlanta Constitution* in the 1950s and 1960s displayed some of the neglectful conditions of the hospital, including their hiring of physicians with drug and alcohol addictions, the use of involuntary sterilizations, and finding "human excrement" on the walls of the children's wards. [29]

Despite the AJC/Jack Nelson exposes about the miserable living conditions, very few investigations were completed on the segregation of African American patients at Milledgeville during this time. One of the few mentions of African American patients was during Georgia Governor Vandiver and his wife's visit to the hospital in 1959. They witnessed Black patients working as laborers on the hospital's farm as well as being housed in congested buildings. [30] Although the superintendent asked the State to build "more dormitory type buildings" for the White female patients "to relieve overcrowding", no recommendations were made for alleviating the overcapacity of the "Colored" buildings. [31] After Governor Vandiver's visit of the institution,

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[27] "Jack Nelson Gets Pulitzer News Honor." *The Atlanta Constitution (1946-1984),* May 03, 1960. https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/historical-newspapers/jack-nelson-gets-pulitzer-news-honor/docview/1537298536/se-2?accountid=10747.

[28] Nelson, Jack. 1959. "Doctors' Report Hits Irregularities in Operations of State Hospital: Surgery by Nurse Criticized." *The Atlanta Constitution (1946-1984)*, Apr 25, 1.

[29]JACK NELSON Constitution, Staff Writer. 1959. "Doctor Quits Milledgeville on 'Demand'." *The Atlanta Constitution (1946-1984)*, Mar 17, 1.; JACK NELSON Constitution, Staff Writer. 1959. "Unapproved Drugs Given Mental Cases." The Atlanta Constitution (1946-1984), Mar 05, 1. Nelson, Jack. 1960. "Health Unit Scored as Too Complacent: Insists Children Getting Proper Care at Milledgeville." *The Atlanta Constitution (1946-1984)*, Aug 13, 3.; Sibley, Celestine. 1960. "Old Georgia is Given a Year of Royal Raw-Hiding: Neglect at Milledgeville, High-Level Payola Bared." The Atlanta Constitution (1946-1984), 18.

[30] Constitution State, News Service. 1953. "Asks Boost for State Hospital." The Atlanta Constitution (1946-1984), Jun 09, 5.

[31] Georgia. Milledgeville State Hospital. "One hundred and thirteenth to one hundred and seventeenth annual report of the Milledgeville State Hospital at Milledgeville, Georgia for the year ending June 30, 1956 through June 30, 1960 [1955-60]." 1960.

he stated that the state government should begin remedying the harsh conditions of the hospital as soon as possible. [32] In addition to the legislative changes endorsed by Governor Vandiver, Jack Nelson's coverages on the institution prompted for an efficiency commission to investigate Milledgeville. After inspecting the facility, the Schaefer Report was released to implement changes within the facility. Though the report confirmed many of the "irregularities" mentioned in Jack Nelson's articles, it did not indicate any improvements on segregation or racist care in the hospital. [33] One of the few recommendations that was implemented immediately after the inspection was the retirement of Superintendent T.G. Peacock.[34] However, right after the report was released to encourage reform in the facility, improvements and reorganization of the hospital were hardly implemented. In fact, the job was described as "far from finished" when the facility was re-investigated in 1964. [35]

Changes Within the Hospital – Community Mental Health Act and the Civil Rights Act

Although the Schaefer investigation did not cause much reform at the facility, Milledgeville State Hospital underwent noteworthy changes due to the passage of critical laws, such as the Community Mental Health Act and the Civil Rights Act. The Community Mental Health Act was passed in 1963 when attention towards mental health care and treatment started increasing. This law ensured that local mental health centers would be opened to decrease the

[32] JACK NELSON Constitution, Staff Writer. 1959. "Vandiver Finds Hospital 'Worse than I Thought'." The Atlanta Constitution (1946-1984), Jul 10, 1.

[33] Schaefer, W. Bruce, et al. "Report of MAG Milledgeville Study Committee." J. Med. Assoc. Ga. 48 (1959): 275-286.

[34] Nelson, Jack. "Columbia Psychiatrist to Direct Milledgeville." *The Atlanta Constitution (1946-1984),* Jul 09, 1959. https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/historical-newspapers/columbia-psychiatrist-direct-milledgeville/docview/1636815025/se-2?accountid=10747.

[35] "Committee Complains Services at Milledgeville Hospital Bad." 1960. Atlanta Daily World (1932-), May 29, 7.; Nelson, Jack. 1964. "Hospital has Schizophrenic Look." *The Atlanta Journal and the Atlanta Constitution (1950-1968)*, Apr 05, 1.

number of institutionalized patients.[36] As a result, thousands of patients were moved out of Milledgeville State Hospital as Georgia began opening more regional mental health facilities across the state.[37] After the downsizing of Milledgeville and establishment of Georgia regional hospitals, Milledgeville State Hospital was renamed as Central State Hospital in 1967.[38]

Another significant law that caused momentous improvements to be made at Milledgeville was the Civil Rights Act in 1964. This act outlawed the discrimination and segregation of Black individuals. Before this law, however, Black patients were housed in different buildings, worshipped in different chapels, and had separate burial sites from White patients. However, after the Civil Rights Act, Milledgeville State Hospital had to address this segregated care. In 1965, superintendent Dr. Mackinnon released a statement on how the facility would implement reorganizations of the institution in response to the Civil Rights Act:

> "The desegregation will include dayrooms, rest rooms, bathing facilities, dining rooms, bedrooms, dormitories, as well as recreational, occupational, industrial, and musical therapies. Also included will be remotivational activities, all chapel exercises and all other treatments." [39]

While this act initiated a significant step towards desegregation, it is likely that high occurrences of racialized diagnoses continued due to prejudiced biases by psychiatrists. To better understand the significance and discussion of patient diagnoses in this project, we must also understand the

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[36] "Reflecting on JFK's Legacy of Community-Based Care." SAMHSA, March 18, 2021. https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/jfks-legacy-community-based-care.

[37] "Shattering Stigma." The Carter Center, November 7, 2010. https://www.cartercenter.org/news/publications/health/mental_health_publications/shattering-stigma-rosalynn-carter.html.

[38] Payne, David. "Central State Hospital." New Georgia Encyclopedia, last modified Mar 2, 2022. https://www.georgiaencyclopedia.org/articles/science-medicine/central-state-hospital/

[39] "Racial Barriers Will Drop at Milledgeville Hospital." *The Atlanta Journal and the Atlanta Constitution (1950-1968),* Mar 07, 1965, Sunday ed. https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/historical-newspapers/racial-barriers-will-drop-at-milledgeville/docview/1636140953/se-2?accountid=10747.

context of psychiatric practices in the United States and the background information on the DSMs. These issues will be explored in the next few chapters.

Chapter 3: The "Bible" of Psychiatry: The Diagnostic and Statistical Manual of Mental Disorders (DSM)

The first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-I) was created by the American Psychiatric Association in 1952. [40] Diagnosis is an incredibly vital step in determining treatment and care plans for patients, which makes the reliability and validity of diagnostic benchmarks essential in the field of medicine. [41] The DSM has become known as the "diagnostic bible" in psychiatry due to the lack of biological markers when classifying and pathologizing mental disorders. [42] Even today, the current DSM (DSM-5-TR) acts as the gold standard for American psychiatrists when diagnosing patients. While it serves as the conventional guide for classification and diagnosis, frequent revisions have been made to the DSMs after contestations and intense arguments on symptom and diagnostic criteria. Furthermore, many health professionals throughout the years have expressed concerns with the DSM by stating that mental health and disorders could not be classified into strict categories, as mentioned by Dr. Thomas Szasz. Nonetheless, the DSMs increasingly gained prominence since the 1980s and have defined mental disorders for all health professionals. Now, the DSM-5-TR is not only used by psychiatrists, but it has defined mental health and illnesses for the judicial system, hospital administrations, insurance companies, social workers, and the general population.[43]

[40] Horwitz, Allan V. *DSM: A History of Psychiatry's Bible*. Baltimore, MD: Johns Hopkins University Press, 2021.

[41] Surís, Alina, Ryan Holliday, and Carol North. "The Evolution of the Classification of Psychiatric Disorders." *Behavioral Sciences* 6, no. 1 (2016): 5. https://doi.org/10.3390/bs6010005.

[42] Horwitz, 3.

[43] Horwtiz, 4.

Over the years, psychiatry has received a lot of criticism as the practice mostly relies on subjective observations and is susceptible to biases by physicians.[44] Psychiatry was not even considered a medical specialty in the early nineteenth century as people believed that mental problems did not have biological pathologies. Moreover, they thought that the developmental causes for mental illnesses were inseparable from an individual's specific background, circumstance, and life events.[45] As a result, Americans during the early 1800s did not consider diagnostic categories in psychiatry to be of significance.[46] After World War II, however, the United States began taking an interest in classifying mental disorders once symptoms of syphilis were distinguishable from other mental illnesses. Syphilis was originally labeled as a "general paralysis of the insane" and was sorted into a broad category of mental disorders; however, once the bacterium *Treponema pallidum* was discovered to cause this disease, people began to consider the importance of psychiatric diagnosis.[47] German physicians Emil Kraepelin and Alois Alzheimer also aided in supporting the impact of psychiatric diagnosis by focusing on the biological causes and organizing mental illnesses as a process of a certain disease rather than relating it to an individual's unique experiences. While their work was not recognized immediately, the increased attention towards diagnoses of mental disorders resulted in the publication of the first DSM by the APA in 1952.[48]

Though the DSM is based on clinical observations, many external and social factors, including political and economic powers, have contributed to the creation of DSMs.[49] Not only

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[44] Hsin, Honor, Menachem Fromer, Bret Peterson, Collin Walter, Mathias Fleck, Andrew Campbell, Paul Varghese, and Robert Califf. "Transforming Psychiatry into Data-Driven Medicine with Digital Measurement Tools." *npj Digital Medicine* 1, no. 1 (2018). https://doi.org/10.1038/s41746-018-0046-0.

[45] Horwitz, 2

[46] Horwitz, 16.

[47] Horwitz, 17.

[48] Surís et al. "The Evolution of the Classification of Psychiatric Disorders."; Horwitz, 18

[49] Horwitz, 7.

have major social groups affected the development of the DSM, but psychiatric authors of the manuals have developed subjective cutoff points in defining what it means to be normal versus abnormal. In doing so, they have established normality based on their own cultural norms and individual observations.[50] Horwitz cites Paula Caplan's *They Say You're Crazy How the World's Most Powerful Psychiatrists Decide Who's Normal* to support a significant criticism of the manual – rather than using the DSM for scientific reasons, it is used to give social power and influence to psychiatrists in labeling oppressed groups and setting ideologies for mental health.[51] Considering the impact of outside influences and subjective perspectives on psychiatric diagnoses, it is important to consider the limitations of the DSMs over the years and how biases and societal factors may have influenced the guidebook to label oppressed groups such as women, people of color, and the LGBTQIA+ community.[52]

For the purposes of this project, which investigates 1956 to 1967, this thesis will focus on the first DSM. This manual served as a guide for psychiatrists starting from 1952 and was not revised until 1968. The DSM-I divided mental disorders into two main categories: mental disorders characterized by impairments in brain functioning and mental disorders characterized by individual struggles when adjusting to their environment.[53] Although this first edition included many diagnostic categories, it was not very useful since there was a lack of specificity in symptom criterion when determining the mental illness.[54] In the manual, many of the

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[50] Khoury, Bassam, Ellen J. Langer, and Francesco Pagnini. "The DSM: Mindful Science or Mindless Power? A Critical Review." *Frontiers in Psychology* 5 (2014). https://doi.org/10.3389/fpsyg.2014.00602.

[51] Caplan, Paula J. *They Say You're Crazy How the World's Most Powerful Psychiatrists Decide Who's Normal*. Reading, MA: Addison-Wesley Publ, 1996.; Horwitz, 7.

[52] Horwitz, 7.

[53] Horwitz, 27.

[54] Micale, Mark S., and Roy Porter. *Discovering the History of Psychiatry*. New York, NY: Oxford University Press, 1994.; Surís et al. The Evolution of the Classification of Psychiatric Disorders."; Blashfield, Roger K, Jared W Keeley, Elizabeth H Flanagan, and Shannon R Miles. 2014. "The Cycle of Classification: DSM-I Through DSM-5." *Annual Review of Clinical Psychology* 10 (1): 25–51. https://doi.org/10.1146/annurev-clinpsy-032813-153639.

diagnoses were referred to as “reactions.” This was because psychiatrist Adolf Meyer’s views had influence over the creation of the DSM, and he considered “mental disorders represented reactions of the personality to psychological, social, and biological factors.” [55] Using this background knowledge on DSMs, the results and discussions of this research will explore diagnoses at Milledgeville State Hospital and the limitations of the DSM-I.

[55] ““DSM History.” American Psychiatric Association. Accessed March 24, 2022. https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

Chapter 4: Analyzing Historical Diagnoses

Overall Numbers

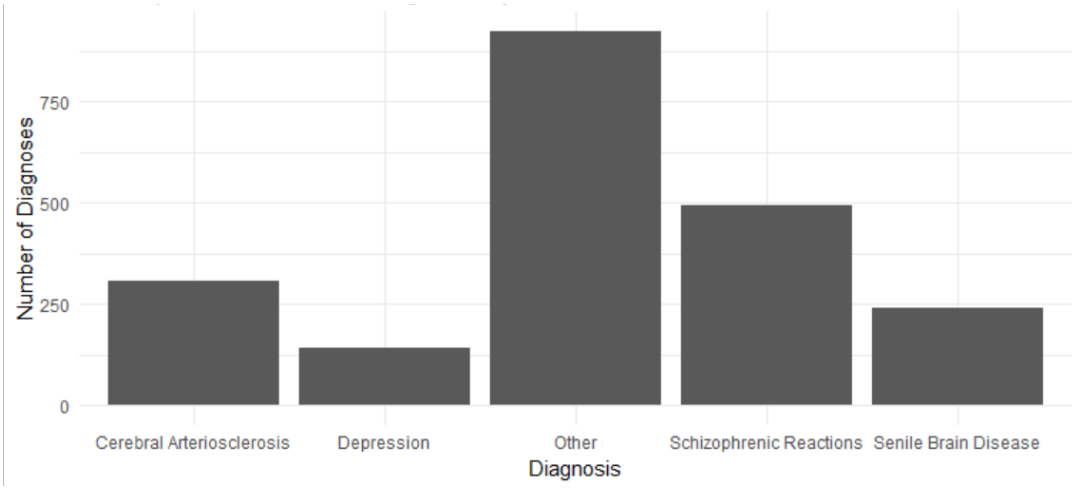

Figure 1a. Graph of Total Number of Diagnosis from 1956 to 1967

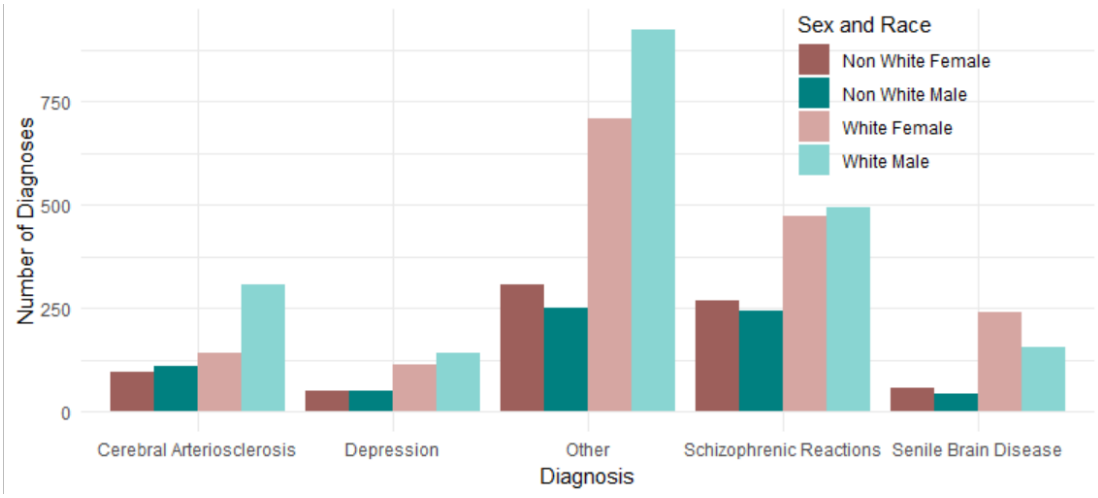

Figure 1b. Graph of Diagnosis Numbers by Race and Sex Group from 1956 to 1967

Diagnosis	Nonwhite Female	Nonwhite Male	White Female	White Male
Cerebral Arteriosclerosis	787	804	1142	2324
Depression	249	217	468	577
Other	3816	4429	13328	18946
Schizophrenic Reactions	1780	1566	3369	2912
Senile Brain Disease	309	264	1547	787

Table 1. Number of Diagnosis by Race and Sex Groups from 1956 to 1967

The top four common diagnoses out of more than 30 mental disorders were "schizophrenic reactions," "cerebral arteriosclerosis," "senile brain disease," and "psychotic disorders: manic depressive reactions." Figure 1a and Table 1 show that "schizophrenia reactions" was the most commonly diagnosed mental disorder during the period that was analyzed. Following "schizophrenic reactions," the mental disorders ordered from most to least diagnoses were graphed: "cerebral arteriosclerosis," "senile brain disease," and "psychotic disorders: manic depressive reactions." Figure 1b and Table 1 display the number of diagnoses for each mental disorder distinguished by the four different race-sex groups.

Schizophrenic Reactions

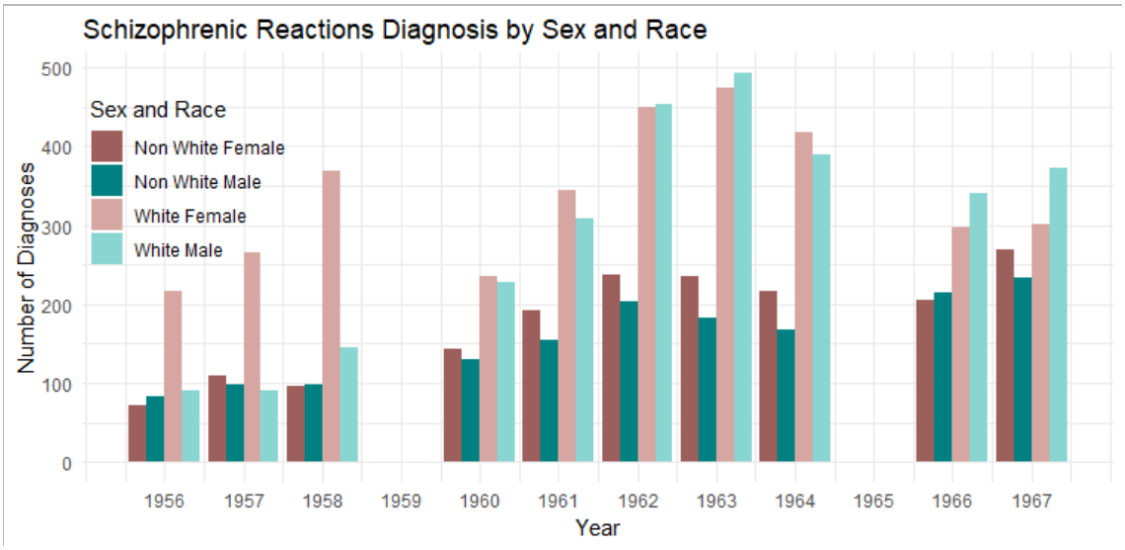

Figure 2a. Graph of Total Schizophrenic Reactions Diagnosis by Race and Sex Groups from 1956 to 1967

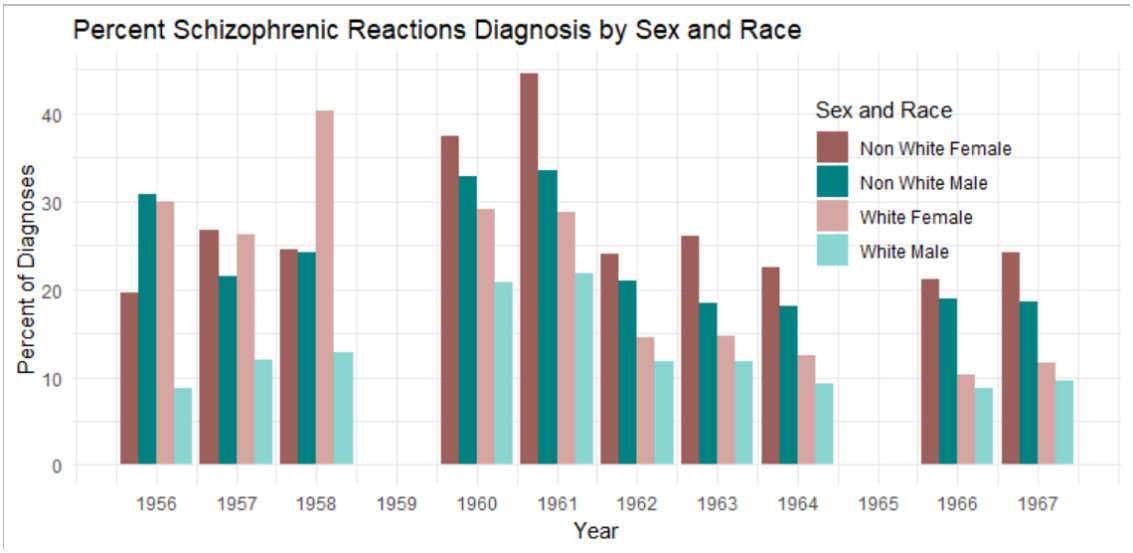

Figure 2b. Percent Schizophrenic Reactions Diagnosis by Race and Sex Groups from 1956 to 1967

Group	Proportion Schizophrenic Reactions
Nonwhite F	0.256
Nonwhite M	0.215
White F	0.170
White M	0.114

Table 2. Overall Proportion of Schizophrenic Reactions Diagnosis by Race and Sex from 1956 to 1967

Analysis of the “schizophrenic reactions” category showed that the percent of patients diagnosed with schizophrenia (Figure 2b) was not equal among race-sex groups (chi square = 1052.4, p-value < 2.2e-16). Pairwise comparisons were executed to determine which race-sex groups were different from the others, and it was determined that all race-sex groups were statistically different from one another: Nonwhite Male vs. Nonwhite Female (p-value = 7.1e-09), White Female vs. Nonwhite Female (p- value < 2.2e-16), White Female vs. Nonwhite Male (p- value < 2.2e-16), White Male vs. Nonwhite Female (p- value < 2.2e-16), White Male vs. Nonwhite Male (p- value < 2.2e-16), and White Male vs. White Female (p- value < 2.2e-16). Overall proportions from Table 2 showed that Nonwhite Females were more commonly diagnosed with “schizophrenia reactions” compared to the other race-sex groups.

A trend in proportions for all race-sex groups was detected from 1956 to 1967. For all race-sex groups, there was an increasing trend for “schizophrenic reactions” diagnosis: Nonwhite Females (p-value = 0.001341), Nonwhite males (p-value = 7.791e-12), White Females (p-value < 2.2e-16), and White Males (p-value < 2.2e-16).

Cerebral Arteriosclerosis

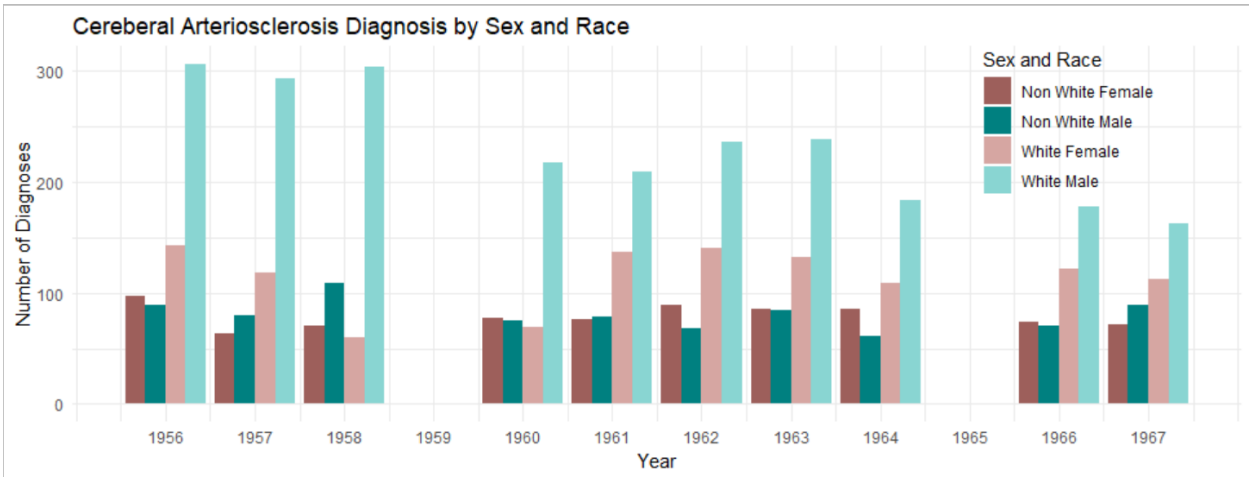

Figure 3a. Graph of Total Cerebral Arteriosclerosis Diagnosis by Race and Sex Groups from 1956 to 1967

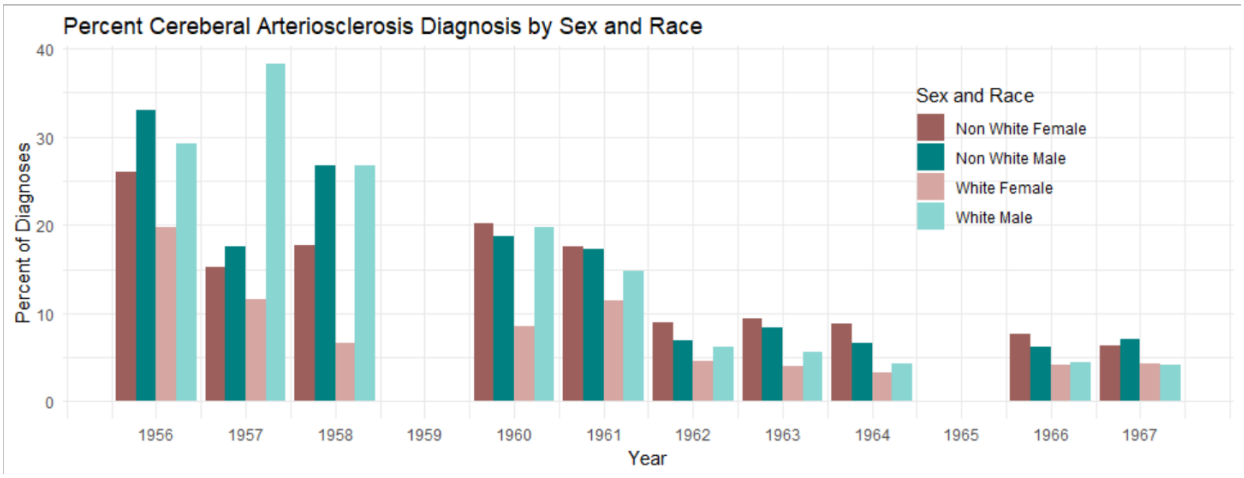

Figure 3b. Percent Cerebral Arteriosclerosis Diagnosis by Race and Sex Groups from 1956 to 1967

Group	Proportion Cerebral Arteriosclerosis
Nonwhite F	0.113
Nonwhite M	0.110
White F	0.058
White M	0.091

Table 3. Overall Proportion of Cerebral Arteriosclerosis Diagnosis by Race and Sex from 1956 to 1967

Analysis of the “cerebral arteriosclerosis” category showed that percent of patients diagnosed with cerebral arteriosclerosis is not equal among race-sex groups (chi square = 337.6, $p < 2.2e-16$). Pairwise comparisons were executed to determine which race-sex groups were different from the others and it was determined that Nonwhite Males and Females were not different from each another, however all other race-sex groups were different from one another. Nonwhite Male vs. Nonwhite Female (p-value = 0.6), White Female vs. Nonwhite Female (p-value < 2.2e-16), White Female vs. Nonwhite Male (p- value < 2.2e-16), White Male vs. Nonwhite Female (p- value = 6.3e-08), White Male vs. Nonwhite Male (p- value < 1.4e-06), and White Male vs. White Female (p- value < 2.2e-16). Overall proportions from Table 3 and pairwise comparisons showed that Nonwhite Females and Nonwhite Males were more commonly diagnosed with cerebral arteriosclerosis compared to the other race-sex groups.

A trend in proportions for all race-sex groups was detected from 1956 to 1967. For all race-sex groups, there was a decreasing trend for cerebral arteriosclerosis diagnosis: Nonwhite Females (p-value < 2.2e-16), Nonwhite Males (p -value < 2.2e-16), White Females (p-value < 2.2e-16), and White Males (p-value < 2.2e-16).

Senile Brain Disease

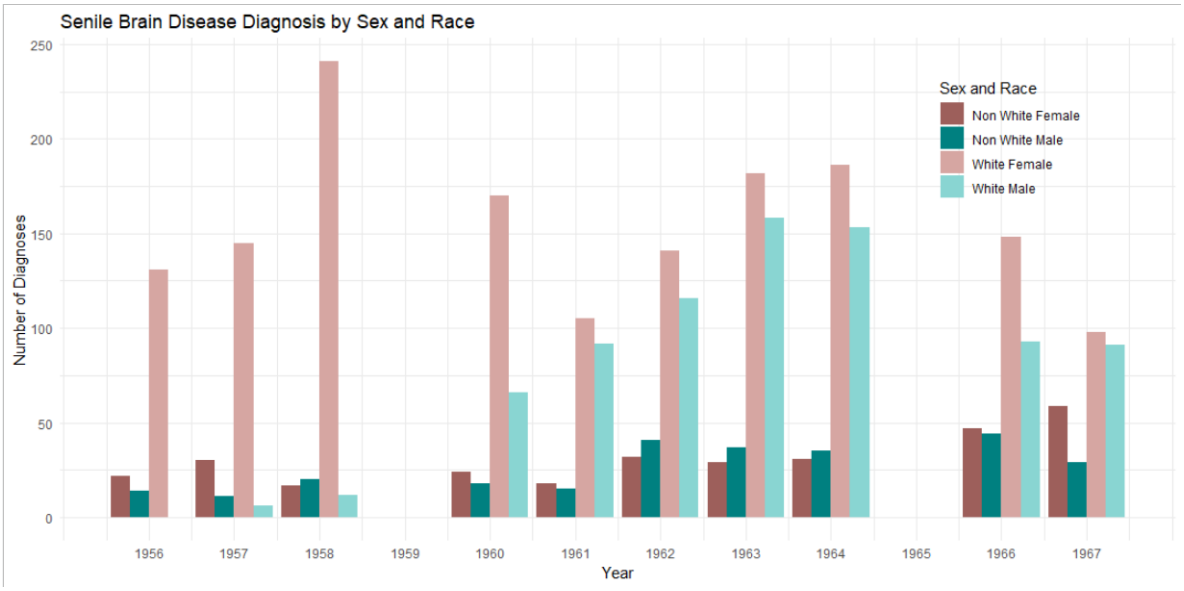

Figure 4a. Graph of Total Senile Brain Disease Diagnosis by Race and Sex Groups from 1956 to 1967

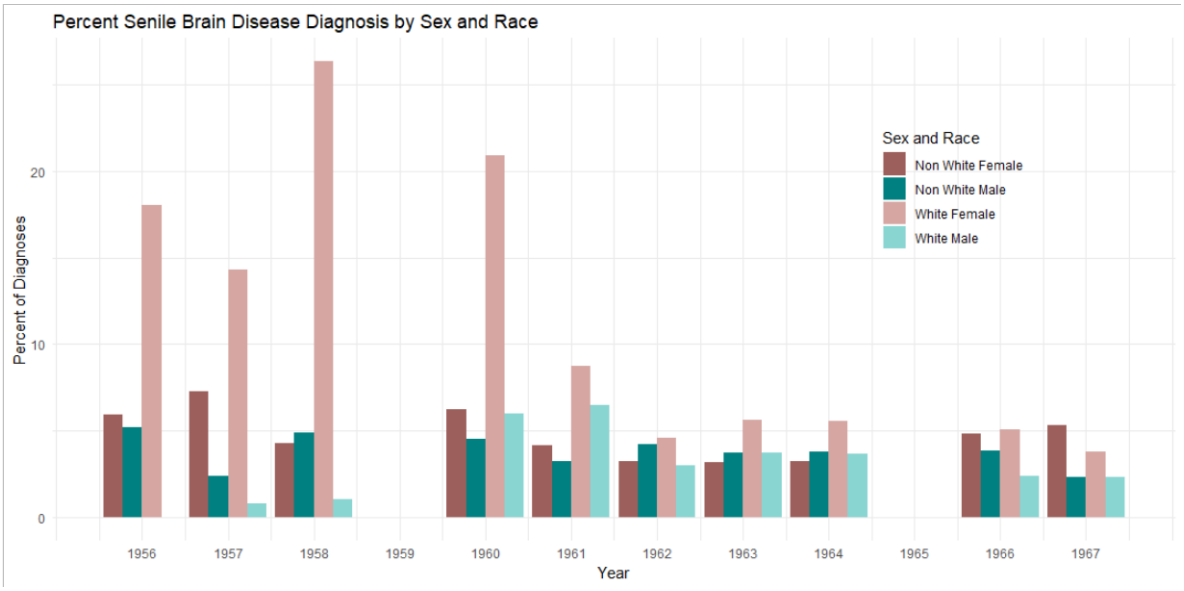

Figure 4b. Percent Senile Brain Disease Diagnosis by Race and Sex Groups from 1956 to 1967

Group	Proportion Senile Brain Disease
Nonwhite F	0.045
Nonwhite M	0.036
White F	0.078
White M	0.031

Table 4. Overall Proportion of Senile Brain Disease Diagnosis by Sex and Race from 1956 to 1967

Analysis of the "senile brain disease" category showed that percent of patients diagnosed with senile brain disease is not equal among race-sex groups (chi square = 568.68, $p < 2.2e-16$). Pairwise comparisons were executed to determine which race-sex groups were different from the others. It was determined that there was no difference between Nonwhite males and Nonwhite females, as well as Nonwhite males and White males: Nonwhite Male vs. Nonwhite Female (p-value = 0.028), White Female vs. Nonwhite Female (p- value < 2.2e-16), White Female vs. Nonwhite Male (p- value < 2.2e-16), White Male vs. Nonwhite Female (p- value = 7.5e-08), White Male vs. Nonwhite Male (p- value = 0.028), and White Male vs. White Female (p- value < 2.2e-16). Overall proportions from Table 4 and pairwise comparisons showed that White Females were more commonly diagnosed with senile brain disease compared to the other race-sex groups.

A trend in proportions was detected for White Female patients but not for any other race-sex groups from 1956 to 1967. For White Females, there was a decreasing trend for senile brain disease diagnosis: White Females (p-value < 2.2e-16). On the other hand, there was no trend in proportions for the other race-sex groups: Nonwhite Females (p-value = 0.1321), Nonwhite Males (p-value= 0.07845), and White Males (p-value = 0.3616).

Psychotic disorders: manic depressive reactions

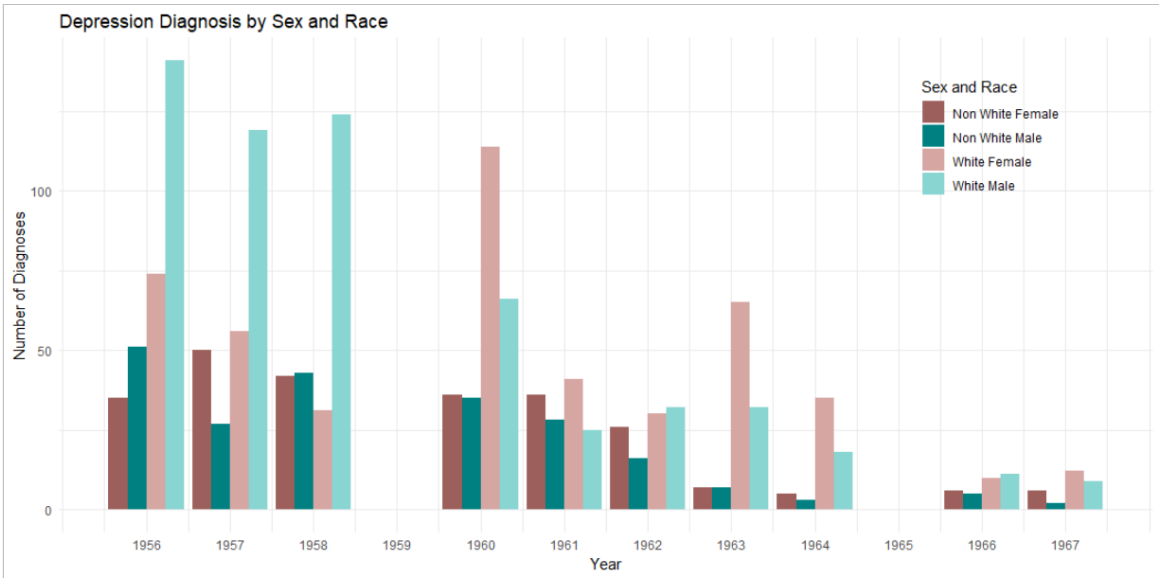

Figure 5a. Graph of Psychotic Depressive Reactions Diagnosis by Race and Sex Groups from 1956 to 1967

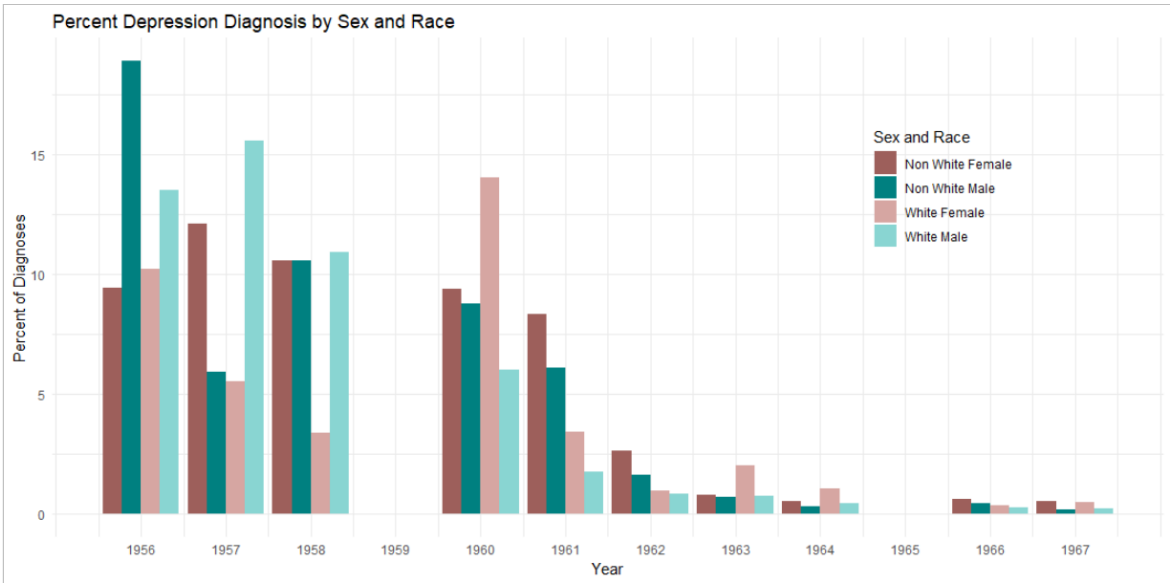

Figure 5a. Percent Psychotic Depressive Reactions Diagnosis by Race and Sex Groups from 1956 to 1967

Group	Proportion Psychotic Depressive Reactions
Nonwhite F	0.036
Nonwhite M	0.030
White F	0.024
White M	0.023

Table 5. Overall Proportion of Psychotic Depressive Reactions Diagnosis by Sex and Race from 1956 to 1967

Analysis of the “psychotic depressive reactions” category showed that percent of patients diagnosed with psychotic depressive reactions is not equal among race-sex groups (chi square = 47.42, p =2.837e-10). Pairwise comparisons were executed to determine if race-sex groups were different from one another. It was determined that there was no difference between Nonwhite males and Nonwhite females, as well as White Males and White Females; however all other race-sex groups were different from one another: Nonwhite Male vs. Nonwhite Female (p-value = 0.0945), White Female vs. Nonwhite Female (p-value = 2.9e-07), White Female vs. Nonwhite Male (p- value = 0.0128), White Male vs. Nonwhite Female (p- value = 3.5e-09), White Male vs. Nonwhite Male (p- value = 0.0019), and White Male vs. White Female (p- value = 0.5073). Overall proportions from Table 5 and the pairwise comparisons showed that Nonwhite Females and Nonwhite Males were commonly diagnosed with psychotic depressive reactions compared to the other race-sex groups.

A trend in proportions for all race-sex groups was detected from 1956 to 1967. For all race-sex groups, there was a decreasing trend for psychotic depressive reactions diagnosis: Nonwhite Females (p-value < 2.2e-16), Nonwhite males (p-value < 2.2e-16), White Females (p-value < 2.2e-16), and White Males (p-value < 2.2e-16).

Chapter 5: Discussing the Results

The results showing the total number of diagnosed patients suggest that psychiatrists at Milledgeville labeled the majority of their patients in the "schizophrenic reactions" category. Since the DSM-I only contained a short and broad description for each mental disorder, psychiatrists may have commonly categorized their patients under "schizophrenic reactions" using subjectivity rather than the diagnostic criterions from the DSM-I. The current DSM, however, has become increasingly useful for psychiatrists since they have transitioned from the broad categorizations of the DSM-I to more medically descriptive symptoms and criterion.[56] Before these modifications, the history and data implies that Milledgeville psychiatrists diagnosed most of their patients with "schizophrenic reactions" without really using the DSM-I as a source.

The analysis of the statistical report shows evidence to support racialized diagnoses in Milledgeville State Hospital between 1956 to 1967. For the "schizophrenia reactions" category, the statistics show that there is a higher diagnosis rate in the "Nonwhite" patients compared to the "White" patients. While the increased schizophrenia diagnosis in African Americans has been observed recently, this analysis also supports Jonathan Metzl's statements on how the diagnosis of schizophrenia transitioned from a disease prevalent to White housewives to African Americans once the word "dangerous" became associated with the mental disorder in the late 1950s.[57] Even though the transition from DSM-I to DSM-II did not occur until 1968, there is evidence from this data showing that psychiatrists began characterizing symptoms of

[56] Blashfield, et al. 2014. "The Cycle of Classification: DSM-I Through DSM-5."

[57] Johnson, Frank M. 2012. "Jonathan M. Metzl, The Protest Psychosis: How Schizophrenia Became a Black Disease." *The Journal of African American History* 97 (4): 499–501. https://doi.org/10.5323/jafriamerhist.97.4.0499.

schizophrenia as aggressive and being more prevalent amongst the "Nonwhite" patients before changes to the DSM-I were made. Moreover, this further strengthens the idea that psychiatrists at Milledgeville used more of their personal opinions rather than consulting the DSM-I when diagnosing patients.

In addition to discriminatory diagnosis by race, there is also evidence of gender discrimination for "schizophrenic reactions." The higher rate of diagnoses for female patients compared to male patients in both racial groups can be explained by Superintendent Peacock's views on sterilizations. In Segrest's argument, she cites physicians encouraging more sterilizations in the female population: "the feeble-minded girl is vastly more dangerous to the community than the feeble-minded boy." [58] Thus, psychiatrists may have diagnosed "schizophrenic reactions" in female patients more frequently to implement increased sterilization treatments for women as well as for "Nonwhite" patients.

"Cerebral arteriosclerosis" was under the "Chronic Brain Disorders" category in the DSM-I and is described as a permanent "impairment of the cerebral tissue function." [59] This mental disorder was considered to be the cause of Alzheimer's Disease, or senile dementia, before the 1960s. [60] Though there is no known information on racialization of this condition, results showed that there was a higher proportion of "Nonwhite" patients diagnosed with "cerebral arteriosclerosis" compared to the "White" patients.

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[58] Segrest, 267.

[59] *Diagnostic and Statistical Manual of Mental Disorders*. Washington, D.C.: American Psychiatric Association, 1952.

[60] Anderson, Neill H, and Kirstie Woodburn. 2010. "22 - Old-Age Psychiatry." In *Companion to Psychiatric Studies (Eighth Edition)*, edited by Eve C Johnstone, David Cunningham Owens, Stephen M Lawrie, Andrew M McIntosh, and Michael Sharpe, Eighth Edi, 635–92. St. Louis: Churchill Livingstone. https://doi.org/https://doi.org/10.1016/B978-0-7020-3137-3.00022-X.; Engelhardt, Eliasz, and Lea T Grinberg. 2015. "Alzheimer and Vascular Brain Disease: Senile Dementia." *Dementia & Neuropsychologia* 9 (2): 184–88. https://doi.org/10.1590/1980-57642015DN92000013.

"Senile brain disease" was another mental illness categorized under "Chronic Brain Disorders" and included symptoms of memory loss, "self-centering of interest, difficulty in assimilating new experiences, and 'childish' emotionality." [61] Today, this illness would be considered Alzheimer's Disease, or senile dementia. This mental disorder was more commonly diagnosed in White female patients at Milledgeville compared to the other race-sex groups. Considering the "childish emotionality" and progression of memory loss in "senile brain disease," psychiatrists at the time may have commonly diagnosed this mental disorder in White females experiencing menopause or postpartum. While women are more at risk for senile dementia, studies have also shown that both menopause and the postpartum period are linked to memory loss and emotional fluctuations in women; [62] thus, psychiatrists at Milledgeville may have more frequently diagnosed women with "senile brain disease," even though they might have been experiencing similar symptoms from menopause or postpartum.

Current research shows that African Americans with depression are often misdiagnosed with schizophrenia. [63] However, the data showed that "Nonwhite" male and female patients were more often diagnosed with "psychotic disorders: manic depressive reactions" compared to the "White" patients. These results suggest that "Nonwhite" patients were diagnosed with depressive reactions so that eugenic sterilizations could be done through the influence of Superintendent Peacock. Dr. Peacock's encouragement for sterilization in patients diagnosed with schizophrenia

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[61] *Diagnostic and Statistical Manual of Mental Disorders*. 1952; Pedersen, Ward. 2007. "Senile Dementia." In *XPharm: The Comprehensive Pharmacology Reference*, edited by S J Enna and David B Bylund, 1–18. New York: Elsevier. https://doi.org/https://doi.org/10.1016/B978-008055232-3.60662-2.

[62] Zheng, Jin-Xia, Yu-Chen Chen, Huiyou Chen, Liang Jiang, Fan Bo, Yuan Feng, Wen-Wei Tang, Xindao Yin, and Jian-Ping Gu. 2018. "Disrupted Spontaneous Neural Activity Related to Cognitive Impairment in Postpartum Women." *Frontiers in Psychology* 9. https://doi.org/10.3389/fpsyg.2018.00624.

[63] Rutgers University. "African-Americans more likely to be misdiagnosed with schizophrenia, study finds: The study suggests a bias in misdiagnosing blacks with major depression and schizophrenia." ScienceDaily. www.sciencedaily.com/releases/2019/03/190321130300.htm

and depression correlate with the higher proportion of diagnoses for these mental disorders in "Nonwhite" patients.

The decreasing trend in proportions for race-sex groups in "cerebral arteriosclerosis," "senile brain disease," and "psychotic disorders: manic depressive reactions" may have been a result of the passage of the Community Mental Health Act of 1963. As more regional mental health institutions were opening in the state of Georgia, the declining number of patients may be linked to the decreasing trend in proportions for the three diagnoses listed.

One of the limitations to this research was the missing data from the 1959 and 1965 annual reports. Due to the release of the Jack Nelson exposes in 1959, it is likely that Milledgeville State Hospital was in the process of undergoing investigations and implementing administrative changes. As a result, the annual report for 1959 had minimal information on patient diagnoses and lacked data tables for this project to analyze. Another limitation to this research was the lack of data on treatments for the different race-sex groups. If this information were provided, statistical tests could be run to see if there were correlations between certain treatments, such as sterilizations, and different race-sex groups. For example, if the annual reports included tables on the proportion of sterilizations in "White" patients compared to "Nonwhite" patients, this would provide support for the racialized diagnoses and treatment of patients at Milledgeville State Hospital.

Chapter 6: Today's Psychiatric Diagnoses – Grady Memorial Hospital with Dr. Jennifer Grant

On March 23, 2022, I had the opportunity to interview Dr. Jennifer Grant, a fourth-year resident in the Emory Psychiatry and Behavioral Sciences Residency Program. She is from Los Angeles, California, and serves as the co-Chief Resident at Grady Memorial Hospital. In addition to doing an interview on current practices of psychiatry, Dr. Grant provided me with the opportunity to join virtual case discussions and observe in-person diagnostic interviews with patients at Grady Memorial Hospital.

Dr. Grant is currently starting a research project which investigates how biases and racism can impact the diagnosis and treatment of patients with psychotic disorders. She will be collecting and analyzing data from Grady Memorial Hospital's EPIC system to determine disparities in diagnosis and treatment. When asked about the research project, Dr. Grant described that she is looking at "potential areas of disparity and discrimination that could be systematically embedded within our services, specifically in our out-patient clinics and care."

After discussing her research project, I asked her the following: "Knowing some of Milledgeville State Hospital's background, how do you think their history influenced today's psychiatry, specifically regarding diagnosis?" In her response, she stated that although it is only her personal opinions, she thinks that

> "from the patient perspective, there is still a lot of mistrust about mental health, particularly amongst minority populations. I think there is this belief that one can get 'trapped' if they say the wrong thing. Even though I am a minority provider, we must all be very careful about implicit bias in our diagnostic approaches and be conscience about our countertransference, especially when looking at how quickly or easily we might be willing to diagnose a person of color."

When I asked her some ways in which we could improve racialized diagnosis in today's practice of psychiatry, she gave a couple of propositions.

> "One proposal is to standardize diagnostic approaches by using standardized interviews, written forms, etc. Once we get into formulaic processes, however, I worry that we might miss some of the individualistic nature of patient presentations and have a more difficult time understanding the complexity of what might be going on with the patient. One thing that is beautiful about the art of psychiatry is that it is very subjective, and it is very nuanced. Another approach that I have tried to teach with the incoming residents and medical students is to be aware of what we don't know. I really focus on teaching social medicine and having people realize that patients come from incredibly different lived experiences and environments. Helping people become aware of their biases, fears, and assumptions can be done through conversation and formal lectures. In case discussions, I go through their documentation and sit in interviews with residents and really challenge them by asking questions, such as 'Why is it you're labeling them with this certain diagnosis?' or 'Why is it that you're asking them this question in this way?' or 'Would you have explored this if it were another patient?' When I am diagnosing patients, I also consider things like, 'Am I looking at everyone in depth as they observe?' and 'Am I using the same information to come up with same formulations?'" [64]

Following this, I asked about Dr. Grant's medical education, and she did not recall having a formal course focusing on racialized diagnoses or treatments; thus, one of the ways in which I believe would improve the field of medicine is implementing a required course regarding systemic biases in medicine. By having open discussions and lectures on the subject, future medical professionals can be better trained and prepared on how to prevent discriminatory care towards patients. As Dr. Grant had mentioned, it is crucial for healthcare professionals to be self-aware of their own biases for the patient to be best supported and cared for.

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[64] Grant, Jennifer. Today's Psychiatric Diagnosis. Personal, March 23, 2022.

Chapter 7: Conclusion

Considering the time period that this thesis investigated, it is important to be aware of the limitations of the DSM-I as well as the racist views towards Black individuals. While the DSM has become a gold standard for psychiatrists, we must question whether psychiatrists at Milledgeville State Hospital used this manual to diagnose their patients in the 1950s and 1960s. With no treatment plans or specific criterions for the mental disorders, it is likely that these physicians categorized patients based more on their prejudiced biases than the DSM-I.

Not only did this thesis highlight the history of Milledgeville State Hospital, but it also displayed misdiagnoses and discriminatory mental health care for oppressed individuals at the facility. The racialized diagnoses observed in this data supports Metzl's findings as well as studies showing common misdiagnoses of certain mental disorders in African American patients. Misdiagnosis of patients come with severe implications and consequences, including incorrect treatment plans, an inescapable social label, and more.[65] Therefore, it is imperative that contemporary societies constantly strive to get rid of stereotypical biases in psychiatric diagnoses, care, and treatment for the betterment of citizens' health.

Hence, to combat historical offenses, Georgia legislators have increased their attention towards mental health care for all people by passing bills like House Bill 1013. This bill was passed in January of 2022 and aims to provide better access to mental health care services for all Georgia residents.[66] In addition to recent developments made by legislators, the field of psychiatry is in the process of dismantling previous biases and assumptions of minority groups in diagnosis. The American Psychiatric Association's most recent release of the DSM (DSM-5-TR)

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[65] Bjorklund, R. W. "First Person Account: Psychosocial Implications of Stigma Caused by Misdiagnosis." *Schizophrenia Bulletin* 24, no. 4 (1998): 653–55. https://doi.org/10.1093/oxfordjournals.schbul.a033357.

[66] Prabhu, Maya T. "Wide-Ranging Mental Health Bill Aims to Increase Access to Services in Georgia." *The Atlanta Journal Constitution*, January 26, 2022.

in March 2022 “includes a comprehensive review of the impact of racism and discrimination on the diagnosis and manifestations of mental disorders” and ensures “appropriate attention to risk factors such as racism and discrimination and the use of non-stigmatizing language.” [67] Doing away with prejudiced and systemic biases in psychiatry will take more time; however, it is essential that our legislative and medical leaders continue to take further steps on improving access and care for mental health resources for oppressed groups so that the history of Milledgeville is not repeated.

[67] “Diagnostic and Statistical Manual of Mental Disorders (DSM–5-TR).” Diagnostic and Statistical Manual of Mental Disorders (DSM–5-TR). American Psychiatric Association, March 2022. https://www.psychiatry.org/psychiatrists/practice/dsm.

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