A Note on the Paternity of "Family Care for the Mentally Ill"

The Uses of History in Mental Health

Humans are creatures who can achieve status on the basis of reported achievements of their ancestors. Families usually keep one or two internal historians hard at work pruning the family tree to display the current generation to the best advantage. And if ancestors (however distant) who enjoyed a moment of glory (however brief) receive more space and a bolder typeface than those whose exploits transgressed some important social boundary - or worse, were plain dull - is this not an expression of another higher human gift: the capacity to tell a story to one's own best advantage?

It's not surprising that the mental health business should work our history making and history bending abilities overtime. Here more than nearly any other area of endeavor (except perhaps the arena of late night TV commercials) language is a medium for keeping honor bright in the face of dismal performance and confounded motivations.

At least one publicly distributed version of the history of "Family Care for the Mentally Ill" (N.Y. Department of Mental Hygiene, 1974) - a practice which subsidizes some members of the community for giving a place in their homes to people who haven't the means to live on their own - provides a nice example of selective history bending at work. The technique is simple: present the program as deeply rooted in a highly valued and honorable past while simultaneously ignoring its less desirable antecedents and pointing out that it has been transfigured by modern science into a new and shining creation. This technique is the same used by the late night announcer who urges us to rush just $3.87 for seven all-time-great albums of Chubby Checkers' greatest hits newly re-recorded in stereo from the original monaural discs.

In the DMH version, family care is presented as flowing from the tradition of hospitality to the disordered practiced by the people of Geel, Belgium since the early middle ages. This unique setting grew from a religious tradition surrounding St. Dymphna, the Roman Catholic patroness of the insane who was martyred on that site by her mad father. The work of the town was somewhat secularized and formalized by the Belgian government in the 19th century.
Geel's particular strengths are enumerated by Samuel Gridley Howe, who visited out of his concern for reform of services to the dependent. As Chairman of the Massachusetts Board of State Charities he wrote in the annual report of 1867:

First, it furnishes employment to all patients in the company of sane persons. Secondly, the insane are provided with those social and family relationships with sane persons that nourish unperverted sentiments and affections thus restoring mental and moral balance. Finally, the insane enjoy the greatest degree of personal freedom which promotes cure by emphasizing self control and self respect.

At least three arguments can be raised with highlighting Geel as the programmatic ancestor of mental hygiene sponsored family care: first, family care was practiced in the U.S. as means of caring for the incurably mentally disordered from earliest colonial times, long before there was any knowledge of Geel; second, the influence of Geel on American psychiatric thought was predominately on institutional arrangements; and third, there are such significant differences between family care as currently practiced and the Geel tradition as to cast serious doubt on the purity of the bloodlines. Of these, only the first will be elaborated below. (For a consideration of the second point see, G. N. Grob; Mental Institutions in America (N.Y. 1973) pp. 320-340 and N. Dain, Disordered Minds: The First Century of Eastern State Hospital (Williamsburg: 1971); pp. 128-136. To test the third point compare the daily activities of a sample of today's family care residents with Howe's description of Geel above.)

"Boarding Out": An American Tradition

From colonial times some dependent people whose families lacked the resources to provide for their care were boarded out to households in the community. (Boorsten, 1957) Others, who were considered dangerous, found their way to jails and others ended up in almshouses when they were in fashion.

One group who has posed a significant problem until today are those our forefathers called the "incurable pauper insane." We know them today, by and large, as the "chronically schizophrenic." They have been creators and captives of a recurring cycle of jurisdictional disputes between welfare agencies and developing psychiatric facilities. In one phase of the cycle, pressure builds to get them out of jails, almshouses, and closets and into an asylum where they can be supervised appropriately. In the next, they are seen as blocking the operations of treatment-oriented settings and costing too much money; they should more appropriately reside in jails, almshouses, nursing homes, or closets.
In the beginning, it was created. And it was...
For most of the nineteenth century far more of these people were under the jurisdiction of welfare authorities than were living in the developing mental hospitals. Today, the extent to which they will be supported by welfare related funds (e.g., SSI) as opposed to living in state hospitals is an unsettled and unsettling issue. Any understanding of the family care system must draw as much on the welfare tradition as on "purely" psychiatric practices.

This involves an appreciation of another cyclic controversy, that between "indoor" and "outdoor" relief. Outdoor relief involves providing support to individuals and families. Indoor relief strategies include a variety of institutional arrangements: almshouses, county farms, workhouses, and nursing homes.

The chronically disordered are at risk under either arrangement. Conditions in welfare institutions are notorious (and were justified as such as a deterrent to malingerers). Under outdoor relief conditions those who can't manage on their own often wander in confusion and neglect. "Boarding out" represents an attempt at a middle ground between these two strategies. It hasn't always been successful.

In 1824, John Yates submitted a report to the New York State Assembly describing two boarding out strategies in common usage: The contract system paid a farmer or townsman who agreed to care for groups of dependent people for an annual lump sum, fixed as low as possible. The second system involved auctioning off individuals in need of care to the householder who agreed to take them for the smallest amount. (cf: Coll, 1969) Yates' report details the abuses of these means of provision of care and recommends the expansion of almshouses to protect the best interests of both the community and those in need.

In 1843, Dorothea Dix described a success in the boarding out process in her memorial to the state legislature of Massachusetts.

Some may say these things cannot be remedied, these furious maniacs are not to be raised from these base conditions. I know they are. Could give many examples. Let one suffice. A young woman, a pauper, in a distant town, Sandisfield, was for years a raging maniac. A cage, chains, and the whip were the agents for controlling her, united with harsh tones and profane language. Annually, with others (the town's poor), she was put up at auction, and bid off at the lowest price which was declared for her. One year, not long past, an old man came forward in the number of applicants for the poor wretch. He was taunted and ridiculed. "What would he and his old wife do with such a mere beast?" "My wife says yes," replied he, "and I shall take her." She was given to his charge. He conveyed her home. She was washed, neatly dressed, and placed in a decent bedroom, furnished for comfort.
and opening into the kitchen. How altered her condition! As yet the chains were not off. The first week she was somewhat restless, at times violent, but the quiet, kind ways of the old people wrought a change. She received her food decently, forsook acts of violence, and no longer uttered blasphemies or indecent language. After a week the chain was lengthened, and she was received as a companion into the kitchen. Soon she engaged in trivial employments. "After a fortnight," said the old man, "I knocked off the chains and made her a free woman." She is at times excited, but not violently. They are careful of her diet. They keep her very clean. She calls them "father" and "mother". Go there now, and you will find her "clothed," and, though not perfectly in her "right mind," so far restored as to be a safe and comfortable inmate.

In his 1859 annual report, John Galt, Superintendent of Eastern Virginia State Hospital mentioned the exploitation of patients boarded out to local farmers in a preamble to a proposal to adopt what he called the "Geel System." This to him, as to other 19th century American psychiatrists, was seen as a means of organizing an asylum around decentralized cottages, not as a means of moving people away from hospital.

If an heritage is to be found for contemporary mental health agency sponsored family care, it would most logically be in the practice of boarding out. This may be less glamorous and more tainted with confusion and potential for abuse, but I think it's ultimately far more accurate than assigning parentage to the people of Geel.

So What?

To rescue this note from charges of pettifogging some moral needs to be derived,

A clear sense of the history of family care points to three issues unresolved in the past 300 years:

1. How are we to provide adequate safeguards for people placed in such arrangements to insure that they are not exploited or abused? The history of "boarding out" is replete with examples of abuses; usually occurring in the best intended and most glamorously described arrangements.

2. How are we to arrange services to those who live in family care settings so as to maximize the advantages Howe noted in the Geel System: personal freedom, gainful work roles, and a range of personal relationships with the non-handicapped which offer concern and respect. This is made more difficult by the fact
that Geel is a unique setting which cannot be replicated no matter how hard we bend the language.

3. How do we keep services focused with sufficient intensity on the needs of the chronically disordered who lack social contacts and prevent a drift of intensive services toward more attractive or less demanding people?