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Motivation for taking family care  
patients: a study of six family care  
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BOSTON UNIVERSITY  
SCHOOL OF SOCIAL WORK

MOTIVATION FOR TAKING FAMILY CARE  
PATIENTS: A STUDY OF SIX FAMILY CARE MOTHERS  
OF THE BOSTON STATE HOSPITAL FAMILY CARE PROGRAM

A thesis

Submitted by

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(A.B. Equivalence, Boston University, 1956)

In Partial Fulfillment of Requirements for  
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CHAPTER I  
INTRODUCTION

A. Definition and Purpose of Family Care

A brief introduction to Family Care itself and how it operates was felt to be necessary before the subject of this study could be approached.

Dr. Malholm and Dr. Barton define Family Care as follows:

Family Care consists of placing and supervising in selected homes (other than the patient's home), mental patients who have reached a convalescent state and who no longer require full hospital care.<sup>1</sup>

As to the forms that Family Care can assume, they have been described under two headings: The Colony System and the District System. In the Colony System, in use in Europe, the patients are referred to a single hospital which is in charge of their care and supervision. The patients are placed in families living in or near the small town in which the hospital is located. In the District System, used in Europe, Canada and the United States, each institution is responsible for its own Family Care Program. In the past this system has also been termed "The Adnex System" described as the extension of the hospital into the community.

A third system was also recognized in earlier years, as

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1. Hans B. Malholm and Walter E. Barton, "Family Care: A Community Resource in the Rehabilitation of Mental Patients," American Journal of Psychiatry, 98:33, July, 1941.

the Scottish or Dispersion type of Family Care which scatters the patients in small groups over a wide area without any connection with the hospital. There seems to be no other known example of this system besides the Scottish one.

The District System is in use at the Boston State Hospital. From here on, this hospital will be referred to as B.S.H. In regard to the type of care given to patients in Family Care, there are two methods, referred to as Custodial Care (also called the Continuous Treatment Type) and Therapeutic Care. In this study the first method will be referred to as Custodial Care. Hester Crutcher describes them as follows:

A family care program may be developed for two general groups of patients. The larger group will be the continuous treatment type of patient whose chief needs are a moderate degree of physical comfort, a sympathetic caretaker, some freedom to wander about the house and grounds, and simple work or recreation of various kinds according to his interests. With the great majority of these patients selected for family care, marked improvement is not expected. Although the patients become more responsible as the result of the individual attention which they receive in homes, it is not thought that they will improve enough to be rehabilitated, that is, to become independent, social and self supporting people. The majority have regressed too far to be hopeful prospects for parole and subsequent living in the community unsupervised by the hospital.<sup>2</sup>

However, some custodial patients improve sufficiently in Family Care so that eventually plans can be made for their re-

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2. Hester Crutcher, Foster Home Care for Mental Patients, p. 35.

entering the community life. The support of social agencies may be enlisted to help and support them in their rehabilitation.

Miss Crutcher goes on to say that:

There is a second and smaller group for whom family care has been used by some hospitals and schools almost entirely as a therapeutic measure. This means that permanent and total rehabilitation of the patient is expected and that the family care is used as a treatment measure to bring about this result. A high level of adjustment may not be anticipated, but it is a level that is comfortable for the patient and one which he can maintain without continued assistance from the hospital aside from the usual service given during the parole period. . .<sup>3</sup>

When placement has this definite therapeutic aim, family care is thought of as a step toward normal life with the expectation that it will enable the patient to find a permanent place for himself in the community. Like the chronically ill in family care, the patients selected for therapeutic placement represent all diagnoses. Often those who have failed repeatedly when previous attempts have been made to help them adjust on parole respond well to family care. This may be because of a difficult family situation.<sup>4</sup>

When such a patient is placed with a family in a community where he finds the security and protection that he would in his own home, but without the emotional complication, often he is able to work out his own adjustment.<sup>5</sup>

The use of family care for therapeutic purposes required intensive casework not only with the patient and his foster family, but also with the patient's own family (if he has one). His own family must understand that this is part of the entire treatment plan of the institution. The relatives must know what

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3. Ibid., p. 35-36.

4. Ibid., p. 36.

5. Ibid., p. 36.

such a placement is expected to do for the patient and why one home is chosen in preference to others.<sup>6</sup>

B. Selection and Formulation of the Research Problem

1. Identification of general area of interest

With the increasing number of mental patient admissions, the shortage of hospital beds in hospitals, and, especially, the greater focus put upon the patient's rehabilitation in the community, the need for adequate Family Care Programs is steadily gaining in urgency and in importance.

At B.S.H. this program is the responsibility of the Social Service Department. As the system expands, more emphasis will be laid upon its therapeutic aspects and liabilities, the more so as a greater number of workers will become available to devote their time and attention to the problem.

2. Justification of the specific area chosen

Although the Family Care system has been in use both in the United States and in other countries for many years, there is little literature written from the standpoint of what motivates individuals to become caretakers or how glimpses into these factors could help the social worker in his selection of homes, matching home and patients, and in offering understanding and support to the caretakers

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6. Ibid., p. 38.

so that their work may best benefit the patients. Such knowledge could also be of help in foreseeing and in understanding the difficulties and areas of adjustment for the patients as well as for the caretakers; actually in using the homes to their fullest potentialities.

The term caretaker will be used when talking of the family care mother and her family. When referring to the former alone, the initials FCM will be used. FC will be used for Family Care.

In reviewing the field of FC work and foster placements in connection with this attempt to penetrate some of the motivating factors for undertaking such work, various problems and possibilities of the system will come to light. Since the therapeutic value of the program should be the keystone to future development, topics so raised will be grouped and discussed in the conclusion of this study.

### 3. Specific research questions

What are some of the detectable motivations of the six FCMs studied in their choice of work, other than those given by them at the time of their application? This is the main question around which this study revolves. A sub-question of interest in the inquiry will be: Does knowledge of the FCM's early history, background and personal experiences throw light on her motivations? That is, can a connection be established between those facts

and their desire to care for mental patients? Although not directly the subject of study, the following questions will also be kept in mind, and any information bearing on them will be noted.

- a. Does awareness on the social worker's part of the FCM's overdetermined choice help in understanding her handling of patients as well as of situations?
- b. Can a fuller and more constructive use be made of FC homes by such an understanding?

In such a limited study, the trends detected may be more fruitful in pointing to questions for further study than in arriving at firm conclusions.

#### 4. Limitations of the study

- a. The inadequacy of the sample: Out of eleven homes currently in use, only six were studied as it was felt that this was the number of homes that could be handled in view of the time limitation and the out-of-town trips these interviews called for. This is too small a number for statistical treatment.
- b. Limited interviewing possibilities: Because of the time limitation itself, only a single interview was held with each FCM to whom the writer was a complete stranger. Also, the reason given to the FCMs for doing this study, as it was introduced by the letter sent to them (Appendix A), was that of obtaining

their collaboration to learn how the program might best be interpreted to new FCMS. One could not digress to any large extent from what had been stated.

- c. The interviewees' suspicions and their need to give proof of their achievements: The situation gave rise to anxiety as they needed reassurance that they would maintain the patients in their care.
- d. The intangibility of some of the material gathered as well as the subjectivity of its interpretation: There was inevitably some subjectivity in how the facts related were understood and recorded and there was not opportunity for scientific evaluation as to the actual meaning of the facts that were collected.

##### 5. Research design

In selecting the sample, the six FCMS were chosen to give a range of the various types of homes in use, such as widowed FCMS, an elderly couple, two young couples whose relatives had done the same work, and a mother and daughter undertaking the work separately. Introductory letters were sent to the FCM interviewees to announce the study (Appendix A). Schedules were set up for the gathering of data and consisted of information collected during the application procedure (Appendix B), information gathered from the social worker supervising the homes as of the date of

the study (Appendix C), and a schedule to guide the interview with the FCM (Appendix D).

The data consisted of contacts and interviews with the social workers supervising the homes or having had any contacts with them, the FCMs and other people working in the same field. Literature bearing on three areas was reviewed: foster placement for children, FC in the United States and other countries, and motivation for choice of career or work. The material on foster placements and motivation will be discussed in Chapter V, Section A.

#### 6. Analysis and interpretation of the data

The data collected were divided and examined as indicated in the Table of Contents. To limit the discussion to the topic of the chapter under consideration as well as in an attempt to have it draw out possible trends and characteristics, only brief extracts of information concerning the FCMs are included within the chapters. The major part of such information has been summarized for each FCM and placed in Chapter III, Section C. In order to follow the development of the study, it is thus necessary to refer to these summaries.

The analysis of the data regarding motivations per se, is dealt with in Chapter V and subdivided into:

1. Theoretical factors concerning human behavior and choice of career.

2. Specific information given at the time of application and that gathered during the study.
3. Interpretation of the above, subdivided into material factors and emotional factors.

## CHAPTER II

## HISTORICAL SURVEY OF FAMILY CARE

As this study is primarily oriented towards seeking out the motivations of caretakers, the history and current situation of the state colony for mental patients in Gheel, Belgium, will be described at some length. This is the first known example of Family Care and is often referred to in connection with treatment of mental illness. The literature available in the United States does not appear to contain material regarding this subject beyond the year of 1948. For this reason the emphasis will be placed on the later years.

The existence of another state colony in the Wallon part of the country is less generally known. The Colony of Lierneux, in the province of Liege, was founded in 1884 for French speaking mental patients. The latter had been found to be at a disadvantage at Gheel, the community being mainly Flemish speaking. In 1908 the construction of several new buildings was started. This included such buildings as observation quarters, farms, auditoriums, libraries, and laboratories for psychiatric and neurological research. These buildings were more elaborate than those of Gheel. Lierneux was chosen as the site for the colony because it was the largest community in the province as it groups fourteen hamlets. Also its population is mainly agricultural. Family Care is not in operation to the same extent as in Gheel. From

unpublished notes on the colony, one can assume that acutely ill patients are not placed in Family Care.<sup>1</sup> In June of 1955, the population of the colony was six hundred and ten.<sup>2</sup> The number of hospitalized patients and those in Family Care are not known.

Similar colonies exist at Beilen in Holland and at Dun et Ainay in France. They were conceived from the same model (Gheel) and evolved with varying success.<sup>3</sup>

The chapter will be divided into two sections: (A) Gheel, Belgium, and (B) The Development in Massachusetts and at Boston State Hospital.

#### A. Gheel, Belgium

Gheel is known not only for being the first example of the colony system but also for establishing the first Family Care Program. Hester Crutcher in the following material describes the origin of the colony:

Towards the end of the sixth century, according to the legend, an Irish princess, Dymphna, fled to the European continent with her priest to avoid the incestuous advances of her mad father. He persued and overtook them at Gheel where he killed them. The people of the village rescued the body of the princess and eventually built a shrine to her memory, which soon became famous for its miraculous cure of mental illness.

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1. Notice sur la Colonie de Lierneux (typewritten).

2. Personal Communication from the Director of the Colony of Lierneux, June 18, 1955.

3. Personal Communication from Dr. A. Rademaekers, Director of the Colony of Gheel, June 29, 1955.

Since the Middle Ages a person who had a mental disease was thought to be possessed by evil spirits, it was believed that a shrine sacred to a saint who had resisted evil could free others from the powers of demons. Pilgrims began coming or were brought to the shrine in the hope of being cured of mental illness. Two small, strongly built rooms in the church housed these patients for the ten days duration of their devotions. Since those who did not recover could no longer remain in this psychiatric annex, they were often placed with families in the neighborhood in the hope that eventually they might benefit from a miracle at the shrine. Hence, the population of Gheel early in the Middle Ages became accustomed to having the mentally ill among them in their homes.<sup>4</sup>

In a pamphlet he wrote, Father Lovasik gives a fairly extensive version both of the legend and of the religious factors related to the existence of the colony. He mentions that:

Many details of the life of St. Dymphna are lacking, but the outstanding facts of her short life, as well as the many miracles worked through her intercession after her death, are well known. Her life was written by a certain Peter, a Canon Regular of St. Aubert's church in Cambrai, France, in 1680.<sup>5</sup>

The writer recalls the following popular belief heard while visiting the colony: St. Dymphna was beheaded by her mad father. A connection ensued between those two facts and her becoming the patron saint of those having "lost their head", which is the literal translation for the equivalent English saying "to be off one's top", meaning out of one's mind or mentally unbalanced.

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4. Hester Crutcher, op. cit., pp. 96-97.

5. Rev. Lawrence G. Lovasik, S.V.D., Saint for the Afflicted, p. 3.

The development of the colony is further described by Crutcher:

Originally the selection and acceptance of the mentally ill were functions of the families who gave them care. Because its sympathy was aroused by the manifestations of the illness of a certain patient, a family would take him into its home. In some instances relatives made arrangements directly with a family, but even then such placement was not particularly selective. The disorder and dissatisfaction which arose from this unplanned assumption of responsibility caused the church to take charge of finding places for the pilgrims to live.<sup>6</sup>

. . . The church also established a central hospital for the mental patients in Family Care. As the work grew, it became subject to governmental regulation, and in 1852 these semi-religious and semi-communal facilities became the nucleus of a State Colony for the care of patients suffering from mental illness.<sup>7</sup>

Speaking of the hospital's and caretakers' work with the patients, Crutcher goes on to say:

When the patients are sent to Gheel, they are first observed in the hospital, where both their mental and physical ills receive attention. After this period of observation they are placed in homes where it is thought they will make the best adjustment. The hospital requires that each patient have his own room and that not more than two be placed with one family.<sup>8</sup>

Originally the psychiatrist, assisted by a nurse or an attendant was in charge of placement and supervision. In recent years, however, the trained social worker has been given the responsibility of selecting the homes best suited to the needs of the various patients and much of the supervision has devolved upon him.

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6. Hester Crutcher, op. cit., p. 97.

7. Horatio M. Pollock, Family Care of Mental Patients, p. 119.

8. Hester Crutcher, op. cit., p. 98.

Since most of the caretakers have grown up with patients in their homes, they seem to have an unusual understanding of the mentally ill and are exceedingly tolerant of their vagaries. Even acute mental upsets are sometimes handled in the homes with the advice and help of hospital staff.<sup>9</sup>

Patients help as they can in the homes, wander around the village freely, and apparently derive real satisfaction from the freedom of the life which they lead. There is a spirit of service about the care of mental patients in Gheel. Perhaps because for centuries the program was tied up with religious duties, it now seems to be accepted as part of the religious and social heritage of the inhabitants. They feel perhaps that it is a vocation which, if well done, shows results in the betterment of human beings. Furthermore, to have patients for care in one's home is a mark of social approval.<sup>10</sup>

At Gheel it is evident that the strong religious component in the work gives the colony as it is established there certain advantages which would not be possible in colony systems without such a background. Furthermore, its long history has made family care a tradition maintained in most homes; children grow up accepting the care of mental patients as a part of family life which they in turn will carry on. This makes Gheel distinctive in the field. The tolerance of abnormal behaviour which the caretakers show and their willingness to keep patients in their homes even during periods of acute mental disturbance could not be expected of caretakers in the United States, nor would it be considered desirable to place so much responsibility upon them. Moreover, the freedom which may be given to a conspicuously sick patient in Gheel would probably not be feasible elsewhere.<sup>11</sup>

Regarding the religious component referred to above, Rev. Lovasik reported:

The relation between religion and a stable mentality

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9. Ibid., pp. 98-99.

10. Ibid., pp. 99-100.

11. Ibid., p. 101.

was expressed by Dr. Frederick Sano, internationally known psychiatrist, formerly director of the State Colony at Gheel, in these words: "The Belgian Hospital and Family Care System were originally founded upon Catholic religious principles, and while I am a non-believer, yet, as a scientist, I recognize that the faith, hope and charity of religion have important therapeutic values. Moreover, religion has a social value: it salvages the derelicts of society."<sup>12</sup>

In regard to the social values, Dr. Sano, at a conference given at the International Congress of Psychiatry in Washington in 1930, mentioned that patients of twenty nationalities and from all continents were to be found at Gheel. Belgium has international conventions with other countries for the repatriation of mental patients. For France, Luxembourg, and Holland, the indigents of these countries can be treated at Gheel when circumstances call for it.<sup>13</sup>

On August 20th, 1948, Dr. Rademaekers summarized the after war effects on Gheel in a paper read at a special meeting of the International Congress of Mental Hygiene in London. Among other points, he mentioned that the colony's highest patient population figure was 3750 in August, 1939. During the war years the population decreased by two hundred patients per year. The rate of admissions which had varied from four to five hundred in normal conditions was markedly reduced.

During military operations foster parents and patients were killed. Some two hundred foster homes were destroyed

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12. Rev. Lawrence G. Lovasik, S.V.D., op cit., p. 14.

13. F. Sano, Les Alienes Soignes en Dehors des Asiles, p. 2.

and several hundred damaged. The central hospital itself suffered considerable damage, especially the church of St. Synphna and its annex, the "sick room". At one time the central part of the hospital was taken by German troops. Unfavorable conditions brought on by the war were food rationing and "black market food" supplementation which had to be paid at ten or twenty times its normal price. Fees to foster families were not calculated to meet such enormous expenses. Therefore many families, unable to keep their patients any longer, had to bring them back to the central hospital. Hence they were forwarded to the closed institutions. Lack of fuel and food shortage produced a high rate of bodily disease and an increase in the death rate.

For the farmer who produced his own food, it was of course less difficult to keep their patients when other classes of society had to dismiss them. Another reason for this was their ability to make a better use of the patients' hand work. In this period of hardship, the farmers had been the backbone of the institution.

The other handicaps which interfered with the caretakers keeping these patients were the emotional stress of war events, the feeling of insecurity, the restriction of liberty, and the regulations of all sorts imposed by war. These factors not only influenced the foster families but also caused maladjustment of the patients. The end result produced the dismissal

of the patient.<sup>14</sup>

Insufficient allowances to foster families and the rise of the standard of living of the community as a whole figured among the after war problems. The allowance was less than half of what was officially stated as the cost of maintenance of a laborer or homeservant. In the last forty years the standard of living of the foster families has been rising steadily, not so much because they keep boarders, but more so on account of the increase of wages. In comparison to this, the advantage of keeping patients has been getting progressively smaller. In view of the above factors, and the fact that the patient will benefit by the increase, allowances to foster families should be reevaluated.<sup>15</sup>

Another difficulty is the lack of any regulation in regard to the distribution of mental patients. Most mental hospitals in Belgium are private. Patients are admitted directly without any previous observation or sorting out in a general hospital. Thus many peaceful and quiet patients remain confined instead of being sent to the colony. Sorting centers in most large towns, such as exist in two cities, have been suggested as a remedy.

As a final point, the moral aspect of Family Care was

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14. A. Rademaekers, The Present Position of Family Care at Gheel, p. 4.

15. Ibid., pp. 5-6.

discussed. Dr. Rademaekers stated the requirements for foster parents as follows:

. . . the desire to assist, the willingness to deal with other people's misfortunes, the acceptance of some inconveniences or some discomfort on behalf of the patients. . . Tolerance is needed, patience and understanding, in other words, the spirit of charity is essential. . . It has been argued that the tradition is weakening, that the patriarchal spirit is fading, that family ties are loosening, that modern man is less concerned with ethical or spiritual values than with his own material interest and that the idea of "serving" others has lost its prestige. If so, the time might come when people of Gheel would stop their humane work. . . As stated in one of the preparatory bulletins to this Congress "the breakdown of family ties and standards is a common observation in many nations".<sup>16</sup>

If this moral impairment is to be spread further and to affect still larger numbers, it may become serious and possibly the only menace to the future of this institution. But, in the meantime, the work is being carried out with the aid of those families which have remained healthy and are maintaining rigid standards of ethics. It is our good fortune to be able to declare that there are still living in Gheel many families of this type so that there does not seem to be a reason for despair.<sup>17</sup>

In 1953, Dr. Rademaekers called attention to the re-educational value of Family Care and its role as a stepping stone or "convalescence" for the patients reentering the community or before their return to his own family as well as the function of the "Placement Committee".<sup>18</sup> In discussing the

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16. Ibid., pp. 6-7.

17. Ibid., p. 7.

18. A. Rademaekers, "Allocution Presidentielle du Dr. Rademaekers a la societe Belge de Medecine Mentale," Session of January 31, 1953 (mimeographed).

various instances in which patients are returned to the central hospital, he states that at each of its weekly meetings, the Placement Committee examines twenty of these cases. That is to say over one thousand cases per year are examined excluding the four hundred new admissions who will be disposed of in the same way. After discussion, the patient is sent back to his foster family or is given another placement. It is noted in passing, that when patients are taken back to the hospital, they are kept only as long as is absolutely necessary. As soon as the patients become calm, they are returned to their caretakers, depending on the latter to do the rest. At this time the number of patients leaving the colony oscillated between one hundred and two hundred according to the number of new admissions.

One must bear in mind that many mental cases of average gravity have a long term prognosis. After an intense hospital treatment, many patients are not sufficiently recovered to return home or take up their usual occupations. For others, their relatives are still under the impact of the past annoyances and are fearful lest they reoccur. For both types of cases Dr. Rademaeker recommends Family Care. He urged that all mental institutions in the country adopt this type of help. Most of them are situated in rural areas, removed from any urban center. He suggested trying to get lay people in nearby communities and families of staff and employees inter-

ested in having the experience of caring for a mental patient while benefiting from supervision of the central psychiatric institution. It was felt that in Belgium, the mental institutions have placed all responsibility of caring for Family Care patients on the colonies rather than developing their own system. In other countries, many institutions have developed their own District System Family Care.

It was pointed out that for centuries, the mental patients have taught the people of Gheel respect, tolerance and kindness as well as not to irritate them with sterile discussions. Such qualities are often lacking in the patients' own families, but they should be possessed by all those who deal with mental patients. These assets, plus that of gaining knowledge of mental patients and how to guide them, were advantages gained by the caretakers of Gheel. One must also consider the moral satisfaction of helping others and contributing effectively to their recovery.

The colony has also had a share in educating the general public who are visitors, organized groups, and press members. The village lies wide open to all who come to it. Guided visits always include a discussion on current prejudices concerning mental illness. It is felt that this has helped to correct many erroneous views. Press members are considered best handled by confronting them rather than letting them roam around left to their own fantasies. They are then faced with

the evidence that Gheel is but a village similar to others and that mental patients resemble the so called "normal individuals".

To conclude, the following information is the most recent obtained from Dr. Radmaekers. In June of 1955, the colony consisted of some two thousand eight hundred patients, of which two thousand five hundred are in foster families. The hospital cares for two hundred and fifty of these patients. Each year there are approximately three hundred and fifty new admissions. Almost one hundred of these patients leave the colony after improvement or recovery. Gheel has a population of twenty six thousand inhabitants (patients included). There is thus one abnormal to nine normal persons. He also makes the following statement which seems to answer the point he made in his conference of 1948:

At Gheel, we have the advantage of benefiting from a very old tradition, which persists despite all changes, occurring at a rapid pace in our present world.<sup>19</sup>

B. Development in Massachusetts and at Boston State Hospital

In 1865 Dr. Samuel Gridley Howe, the Chairman of the First State Board of Charities, advocated the institution in Massachusetts of a Family Care System. His name, together with the names of Mr. Franklin B. Sanborn and Dr. Pliny Earle, appear among the first in this country as proponents of this

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<sup>19</sup>. Personal Communication from Dr. Rademaekers, June 29, 1955.

type of care. Dr. Howe enunciated the principles that it was better to separate the dependent classes than to congregate them and that we ought to avail ourselves as much as possible of those agencies which exist in society, i.e., the family, social influences, occupation, and the like. He referred especially to children, the defective and the blind.<sup>20</sup> He felt that there should be enlisted a greater popular sympathy and interest by families in the care and treatment of dependents and that no patient should be retained longer in the hospital than was for their own good.<sup>21</sup>

Following Dr. Howe's visit to Gheel, he favored a modification of the Gheel colony system but he did not live to see this plan put into action. He was followed by Franklin B. Sanborn, who in 1885 was successful in having laws passed by the legislature permitting the State Board of Charities to board patients with private families. Five were placed the first year.<sup>22</sup> In 1898, the State Board of Insanity was created, in 1916 the Commission of Mental Diseases, and in 1919 the Department of Mental Diseases. In 1938 the latter's name

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20. Elizabeth Davoli, "A Study of the Factors Contributing to the Changes in Placements of Fifteen Patients from Boston State Hospital in Family Care Homes from October, 1952 - March, 1953," p. 7.

21. Charles E. Thompson, "Family Care of the Insane," American Journal of Psychiatry, 91:339, September, 1934.

22. Ibid., p. 339.

was changed to the Department of Mental Health.<sup>23</sup>

From 1865 to 1905, all patients were placed by a Central Board. During the years 1901 to 1914, one board employed a medical director and two social workers to place and supervise patients in Family Care. In 1915 the State Board discontinued its own selection and placement, transferring many to the supervision of the various state hospitals.<sup>24</sup> In 1933 the Department of Mental Diseases transferred all remaining cases to the state hospital for supervision, as well as responsibility to select and investigate the Family Care homes.<sup>25</sup>

In 1922 the Boston State Hospital, under the supervision of the Massachusetts Department of Mental Diseases, established an occupational therapy center at Hopkinton, Massachusetts. The home was under the immediate direction of the housekeeper and her husband, both about sixty years of age.<sup>26</sup> This center was for female patients who were not well enough to go home but were well enough to leave the hospital under special care. Between seven and eleven patients were placed in these homes and the ages ranged from seven to seventy. This home was established to assist patients to make their first step in

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23. Ibid., p. 341.

24. Ibid., p. 341

25. Elizabeth Davoli, op. cit. p. 8.

26. Horatio M. Pollock, op. cit., p. 247.

adjusting to the community. Chronic or inferior patients were not placed here. A trained occupational therapist was hired to prescribe and supervise the patients in gainful work which would assist them in locating employment in the community. Patients were trained in household duties and restaurant work and also given sewing, knitting, or crocheting. The articles produced from the latter were sold by private sales, not for a profit, but to give the patient the feeling that what he produced had market value. The money received from the sales of this merchandise was used to purchase new materials and also a certain amount was given to the patients for spending money.

On August, 1930 the occupational center changed its residence from Hopkinton, Massachusetts, to City Mills and remained under the same caretaker. In 1937 the board was paid from the boarding out allowance of the hospital at a rate of twelve dollars a week and the occupational therapy worker was paid from the same financial source. Later that year the occupational therapy project was discontinued because the patients were slow in moving from the center into the community and also because some patients voluntarily returned from the community to the center. The costs of operation were considered too high for the results obtained. The home was supervised by the Head Social Worker who showed an intense interest in

the program.<sup>27</sup>

The program itself has been in operation here for many years. Up until 1955 all social workers were involved in Family Care work as a side-line, as their major work was elsewhere in the hospital. In the past the Family Care Program was never large enough to justify a full-time social worker handling it exclusively of other duties.

The fact that Family Care has been spread out among various social workers has probably handicapped its proper development, but interestingly enough has had little effect on its ability to grow. During the last four years for example, the Family Care Program has tripled in size and has grown from approximately fifteen patients in Family Care in 1951 to fifty-seven patients in 1955.

In 1955 one social worker was hired whose sole duty was to supervise the Family Care Program.

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27. Boston State Hospital Social Service Department, Report on the Occupational Therapy Center at Hopkinton, Massachusetts, 1929 (typewritten).

## CHAPTER III

### GENERAL INFORMATION ON THE FAMILY CARE HOMES

This chapter will describe the physical settings and financial situations of the FCMS, their social histories, employment and interests, their attitudes toward mental illness, and their relationships and attitudes with patients and others. Finally, it will attempt to identify characteristics which are common to the FCMS.

#### A. Physical Setting

Table I on page 27 presents a picture of the physical settings of the homes of the FCMS. This table uses symbols by which the specific FCMS will be identified throughout the remainder of the study.

This table shows that three of the six homes studied were rural, two were suburban and one was in an urban neighborhood. All the FC homes were privately owned, all but one being one family homes. One home contained two apartments. All but one had a garden. In three cases, FC parents did a little farming. (It is important to note here that this provided patients with something to do.) Two of the homes had backyards. The number of rooms ranged from eight to twelve. Members in the FC household ranged from one to five. All but one of the homes had six patients. In four homes, we see that there were three patients per bedroom. Two of the FCMS felt, however, that difficult patients had to be separated

TABLE I  
PHYSICAL SETTING OF THE HOMES

F C Home	Neighborhood	Type of Home	Land	No. of Rooms	Members in FCM's Household	No. of Pts. <sup>1</sup>	No. of Pts. per Bedroom	Other Rooms Used by Pts. <sup>2</sup>	Meals
A	rural	private single	garden & farming	10	2	6	3-3	family's L.R. & TV set (time limits)	apart from FCM
B	sub-urban	private single	garden	8	1	6	2-2-2	own L.R. & TV (some restriction)	varies
C	urban	private single	yard	12	1	6	2-3-1	family's L.R. & TV (no restrictions)	with the FCM
D	rural	private single	garden & farming	11	2	6	2-2-2	own L.R.; family's TV (some restrictions)	apart from FCM
E	rural	private single	garden & farming	8	4	4	3-1	family's L.R. & TV (some restrictions)	apart from FCM
F	sub-urban	private 2 apartments	yard	8	5	6	2-2-2	own L.R., TV & kitchen	apart from FCM

1. Pts. : patients

2. L.R. : living-room

and, consequently, they were given their own rooms. There were two such patients. All but one home had some restrictions on the use of their facilities. In half of the homes the patients were not always welcome to use the facilities. One home required the patients to retire early so the couple could be alone. One home had no restrictions at all. In one home restrictions did not apply since the patients had their own apartment.

In four of the six homes, the patients had their meals apart from the FCM. In one home, they had their meals with the FCM and in another home this procedure varied. It is interesting to note that the procedure of eating separately stemmed from a feeling by the FCM that in the interest of the children, it would be wiser to have the patients eat alone.

#### B. Financial Status

Very little information on financial status was available from the hospital records at the time of the study. This fact indicates the desirability on the part of the hospital to investigate the financial situation of prospective FCMs. It is recognized, however, that the hospital does stipulate that no FCM shall be totally dependent on hospital payments to FCMs.

All FCMs studied were using hospital payments to finance their home in some way. All FCMs except one (Mrs. D.) were dependent upon the regular salaries of the husbands at the time of application. Two of these FCMs (Mrs. B. and Mrs. C.)

had since become widowed and consequently, the financial situation had altered. The husband of one FCM (Mrs. A.) had since retired but, nevertheless, had sufficient financial means. Finally one FCM (Mrs. D.) was already widowed at the time of her FC application but owned some land and stocks left by her husband.

### C. Description of FCMS

Table II on page 30 presents the family status of the FCMS which will serve to orient the reader to the individual descriptions given below.

This table shows that in most of the cases (four), the FCMS came from large families. In half of the cases, there were significant changes in the parental family composition such as the introduction of step parents and step siblings. Most of the FCMS (four) were middle aged. Three had lost their husbands, one previous to becoming a FCM. Two were divorced and remarried. All but one had children. Four had relatives who were also FCMS.

In the following pages two FCMS will be described in detail with the use of subheadings to order the information on them. The remaining four FCMS will be summarized more briefly:

#### Home A

Social History: Mrs. A. was born and raised abroad, the only girl amongst six brothers. Mrs. A. referred to a "victorian period" upbringing. She hinted at strict attitudes as well as at the high moral standards of her parents, adding that they had "never done anything to hurt her". She connected this with the necessity,

TABLE II

## FAMILY STATUS OF FAMILY CARE MOTHERS

Family Care Mother	No. of Siblings	Ordinal Position of FCM	Changes in Parental Family Composition	Age of FCM	Marital History of FCM	No. of Children	Relatives also a FCM
A	7	unk.		64	married	4	daughter
B	8	6th		63	married twice; widowed after becoming FCM	6	none
C	unk.	unk.	mo. died; step mo. & step siblings	46	widowed after becoming FCM	0	none
D	10	8th		64	married twice; widowed prior to becoming FCM	4	daughter (see E)
E	4	3rd	child of 2nd marriage; step siblings; fa. died	23	married	2	mother (see D)
F	2	1st	fa. died; step fa. & step sibling	28	married	3	mother-in-law & husband's aunt

nowadays, to accept that one's own views and standards are not necessarily those desired or followed by younger people. She emphasized that one raises one's children according to one's beliefs and values but should keep their future happiness as the main focus. They, in turn, will act as they think best. This account of her views sounded half hearted and appeared to be linked with her feelings about two of her boys who had changed religion to adopt their wives' faiths at the time of their marriage, as well as to her daughter's divorce and remarriage, though she never mentioned the latter directly.

Mrs. A. also stressed that during her youth young girls were not to have any interest or conversations related in any way to sex. It was even considered "not proper" for them to visit a woman towards the end of her pregnancy. Mrs. A. talked about mothering her brothers and taking care of things for them as well as of an early desire to be a nurse. She made a reference to having to stand one's own ground with so many brothers and a remark about the "manly" jobs she had done. Mrs. A. has a fairly masculine appearance. She came to the United States with her husband, both being of the same nationality. Mrs. A. seems to be the dominant partner in their marriage. Mr. A. is a quiet and friendly sort of person whose personality very likely takes off the edge of Mrs. A.'s occasional bluntness.

In regard to their children, Mrs. A. expressed concern as to whether she had done right by her daughter in terms of her upbringing and education. She blamed herself that the latter had not completed her nurse's training. No such anxiety was detected about the upbringing of the boys who were several years younger and all adopted. All three are married happily in contrast to the daughter who was divorced and remarried. At one time Mrs. A. took care of the sister of one of her adopted sons, but this again seemed to have caused her worry and she returned the girl in care of her aunt.

Employment: Mrs. A.'s parents had been willing to give her a college education, though at the time it was not a common occurrence for girls. Her mother wanted her to be a teacher. Mrs. A. nevertheless pursued her childhood desire. After finishing high school, she entered a school of nursing.

Mrs. A.'s first job was nursing a private mental patient. After her marriage, she worked at a non-psychiatric hospital and later on spent a year in residence at a mental hospital. Her husband was in the construction business. In regard to the work itself, she implied that in those days working at a mental hospital was "a man's job practically", but she liked it and felt that much could be done for the patients. After this, Mrs. A. took care of private nursing cases. At this time, a friend, who had been boarding a mental patient for another hospital, became ill and asked her to take over his care. She then gave up her private practice to do this full time, discussing this with her husband. They took on a second patient too, but couldn't keep her as her behavior, out of doors, was too eccentric. Mrs. A. was bothered by what the neighbors would think. His work called for them to move to another state so they had to return the patient, much to Mrs. A.'s regret as the patient had been improving and happy with them.

When first established in their new home, Mrs. A. ran a small obstetrical clinic. She gave this up after some years, as the cost of running it was too high. Mrs. A. had always kept busy either nursing or raising children. When the latter were grown up, she wanted to remain active and felt it would be nice to board mental patients again. She originally applied at another hospital and was referred to B.S.H. for family care patients. Mrs. A. boarded patients for two and a half years. There was an interruption due to their moving again. When they finally settled in their present home, she reapplied and had had patients steadily since the fall of 1952.

Attitude towards mental illness: Mrs. A. felt that her nursing experience with mental patients was a natural outcome of her career. In view of her interest in both obstetrics and psychiatric nursing, she felt that a mental hospital experience would be valuable.

Relationship and attitude with patients and others: Mrs. A.'s general attitude was that this work calls for throwing your home and life open to your patients but she realistically added that such an attitude isn't always easy to keep as "there are some hard times in this work", for example putting up with patients' destructiveness, headbanging, and rocking. She felt that patients who persisted in their habits had to be returned to the hospital. The main way in which she

dealt with such behavior was to distract the patients, and try to get them interested in other activities. The patients were encouraged to participate in the housekeeping in a form of "teamwork". They worked in the garden too, but Mrs. A. saw to it that they did not feel pressed to do so. Mr. & Mrs. A. had had to re-educate these patients whose eating habits and manners were completely unknown or forgotten. In this respect, as well as in the organization of their lives, her patients were dealt with fairly much as one would deal with a group of children. In this way, she helped to give them control as well as support. Her handling of patients' psychotic symptoms may be illustrated in her blunt comment to them, "Stop hearing bells, it's all nonsense, there just aren't any bells ringing."

Mrs. A. was interested in helping her patients find jobs. She continued to show interest in patients no longer with her, offering them advice. She equally continued to exercise control over them, for example, when she instilled in one of her former patients the fear of losing her job should she not break up with her boyfriend who exercised an unhealthy influence over the patient. Such attitudes, while they may not appear to be helpful, were acceptable to the patients because they were assured of her genuine interest in them. Actually Mrs. A. was fearful of the patients' relationships with the other sex.

She showed initiative in obtaining whatever her patients needed beyond the regular supplies given by the hospital, such as clothing, etc. Mr. A. treated patients as a father would, teaching them how to read, write, and other activities. The couple watched television with the patients every evening. Mrs. A. supervised the choice of programs. They lived much as a family would having many activities together such as trips and picnics which all seemed to enjoy. When Mr. A. wished to be quiet or alone, Mrs. A. would reenforce his desire. Their children had shown interest in their parents' patients and were well liked by them. (Their daughter had recently become a FCM after one unsuccessful attempt.) Community opportunities offered very few activities to the patients. Some of the activities that were available were church meetings, grange meetings, and an occasional dance or theatre. Mrs. A. faced a problem in allowing the patients to mingle as much as possible with other people since she was the only chaperone available and this fact would stigmatize the patients.

The A.'s had gained the respect and cooperation of their community. The patients were well accepted by it with the exception of a few incidents in which Mrs. A. felt that her patients were being taken advantage of. At such times Mrs. A. reacted strongly and defended her boarders. As a result, community members came to discuss patients' social problems with Mrs. A. rather than upset the patients. Neither Mr. nor Mrs. A. had any outside interests. Mr. A. occasionally attended Mason Lodge meetings.

#### Home F

Social History: It is not clear whether Mrs. F.'s father died or whether her parents were divorced when she was quite young. Her mother remarried when Mrs. F. was eight years old and her stepfather had a daughter four years her junior. Mrs. F. felt that it had been hard for her to adjust to this new situation as by then, she was already settled in her ways. Mrs. F. wondered why her stepfather had adopted her when she was an adolescent. She felt adolescents had sufficient problems without adding new ones. She was in high school at the time and remembered that the change of name stimulated much talk. Mrs. F. thought that her mother was not too interested in being tied down with children. She then spoke of her patients saying that she knew what it was to come from a broken home: "It was none too good". Both her stepsister and she had been very active as children. They used to go to summer camps and became either camp counsellors or youth leaders.

Employment: It appears that Mrs. F. completed high school. While in summer camp, she learned many handcrafts which she found helpful in her present work. Mrs. F. liked crafts and hobbies. She had taken various evening classes, such as sewing and painting, and planned to take another class. Mrs. F. was also active in two of her church groups, one connected with the adolescent group and the other with a mothers' club. Mrs. F. had always thought she'd like to run a day nursery but considered that this interest had dwindled since she had three children of her own.

The F.'s live in a barn which belonged to Mr. F.'s father. This they have remodeled into a regular home doing the actual work themselves. They added a second floor which they intended to exploit financially either by renting it as an apartment or by taking in boarders. As her mother-in-law had been a FCM herself for several

years, Mrs. F. was familiar with both the program and the work itself. Mrs. F. suggested they do the same. Her husband was hesitant at first, fearing it might prove to be too much for her because of the three children. Yet, he was willing to give it a try at her insistence.

Attitude towards mental illness: Mrs. F.'s mother-in-law had for many years been boarding Old Age Assistance patients with whom Mrs. F. had been in contact. When her mother-in-law started taking FC patients, she did not tell Mrs. F. about it until quite a while later. Although Mrs. F. had noticed no difference between the two types of patients, she did remember feeling uneasy for a while after hearing that some of them were mental patients. She could not say what made her feel so anxious. Mrs. F. said she was a little apprehensive when she herself started taking FC patients wondering if she did the "right thing" and if "she would have the right attitude toward them".

Relationships and attitudes with patients and others: Mrs. F. seemed to be genuinely interested in her work and enthusiastic about it. She seemed to have high standards without being rigid. The writer got the feeling that there was a mixture of warmth and understanding of the patients, however, that she tended to reach them in an intellectual way. This was possibly part of Mrs. F.'s doubts about doing the right thing for them and this approach may disappear when she becomes more familiar with handling the patients.

Mrs. F. appreciated having her mother-in-law's support at the outset. She found her to be very helpful to her in certain situations as when a patient had an epileptic seizure. Mrs. F. also had some fear as to dealing with younger patients who might be "boy crazy". She felt it would be too much responsibility for her, but did not elaborate what this meant. She recalled that her mother-in-law had a patient whose only interest was to meet men.

Mrs. F. found it hard to help the patients work through the initial grief that they suffered when they were separated from the hospital and their usual surroundings. The writer thinks this was something of a shock to her. She was already a little anxious about having mental patients and was disappointed by their reactions which she felt should have been happy. She felt that it was easier for the patients to adjust

to their new way of life when there were several of them, as she felt that only two patients would reinforce each other's depression. She also told them that she needed their company otherwise she would be very lonely. She had one patient returned to the hospital because she was "bossing" the other patients and making them unhappy. Mrs. F. left another patient alone who refused to help out with the dishes. In addition, she soothed this patient and explained her own action to the other patients so that they would not feel jealous. Mrs. F. also provided this same patient with material for making rugs. She would like to help her patients find remunerative jobs. She wondered how to handle the feelings of those patients who could not work. Some of the patients accompanied the young couple to church, the movies or other community activities. The young couple found it convenient to live near Mr. F.'s parents as the latter supervised their patients when they were occasionally absent. Mr. F.'s father was retired and helped with various chores. Meals were cooked in Mrs. F.'s apartment and then brought up to the second floor. They could prepare snacks in their own kitchen. The second floor apartment, used by the patients, had a separate entrance to it, as well as one connected directly with the first floor which Mrs. F. used constantly. This allowed easy contact on either side. At a later date, the F.'s intend to arrange a living room for the patients on the first floor. In good weather, the patients spend much time out of doors and visit with Mrs. F.'s mother-in-law's patients. The neighborhood being suburban, there are more social contacts and activities open to the patients who do much shopping and attend the local theatres. FC homes have been known to the community over a period of years and Mrs. F. says that FC was practically synonymous with their names. Mr. & Mrs. F. encouraged patients to attend their own churches but a few chose to attend church with the caretakers.

#### Home B

Mrs. B., the sixth of eight children, had a conflict with her parents when an adolescent and married against their wishes and felt rejected by her family. Later she divorced her husband. Prior to a second marriage with a much older man who had four children, Mrs. B. held domestic and factory positions. By the second husband, she had two sons and got along well with all six children. In later years Mrs. B. became reunited

with her parents and relatives whom she nursed through illness. For thirty years Mrs. B. boarded children among whom were those of a BSH female patient. It is through contact with the mother that Mrs. B. heard about the FC program which she looked upon as a continuation of her experience in bringing up children. She felt that this experience helped her in understanding and assisting hospital patients. She is therapeutically minded, having helped many of her patients to get jobs and reintegrate into the suburban community which offers activities such as shopping, theatre, etc. She seemed to believe that patients placed in FC should be quiet and retiring, and felt strongly about their cleanliness. She was very protective of them. She was fearful of dealing with younger patients about whose relationships with boyfriends she was anxious. She watched new patients carefully to get to know them and pacified them with food. She also tended to be embarrassed as to what her neighbors might think of patients who caused disturbance. Neither Mrs. nor Mr. B., who died a year ago, and who was referred to as a quiet, kind individual, had any outside interests beyond his being a Mason. After his retirement, he took an active interest in helping the patients. One of her stepdaughters came in daily to help her in the home.

#### Home C

Mrs. C., whose mother died when she was very young, lived with her father, an abusive stepmother, her own brothers and sisters as well as half siblings and step-cousins. Prior to and subsequent to her father's second marriage when she was nine years old, she lived in foster homes and a Catholic convent where she was the only colored child. After her father's death when she was fourteen, she went to an industrial school and was later hospitalized for three years for a leg infection. Subsequent to an operation for amputation which "made her feel different from others", she went to live on her own. She taught crafts, worked at factories and at a laundry but had to stop work at her doctor's recommendations. She felt that being a cripple she had to work harder than colleagues and thereby aroused their hostility. At thirty-seven Mrs. C. married a much older man and they bought a home. She gave up the idea of running a nursing home or boarding home for children and instead took care of an infirm adult male boarder. She finally learned of the FC program through a newspaper ad. Mrs. C. had a genuine interest in her patients, encouraging them to "try

their own wings" by experimenting with dress, money, etc. On the other hand, she reacted to them in a personal way, feeling hurt when they were hostile to her and disturbed when they ran away. She feared taking initiative in getting things for her patients without a doctor's authority lest she be criticized. She advised patients to achieve things through will power as she still had some confusion as to what could be expected from mental patients. She handled the patients' problems by telling them that "others are worse off than you". She had withheld from the patients that her husband died recently. Mr. C. was the family head who helped his wife by means of a calm, self controlled attitude and was well liked by the patients. Widowed, childless, and with no relatives, she spent all her time with the patients regarding them as a family group and helping them take advantage of the employment and entertainment that her urban community offers.

#### Home D

One of ten children, attached to a controlling mother and having lost her father when an adolescent, Mrs. D. was brought up to be self sufficient and proud of doing heavy chores, such as farming. She was always impressed by the respect shown to old members in her mother's family. At twenty-one, she married a "charming man who never worked" and lived with her mother. Divorced, remarried and widowed with four children (two by her second husband), Mrs. D. went to work in a store and ran her own business, with an unsuccessful attempt to board children. She regreted not having boarded her own children so she could have taken up more remunerative work. She demanded respect and achievement from them but feared their sexual maturing, hence her reluctance to board adolescents. Mrs. D. learned about FC through a newspaper ad. With the exception of a short period during which she tried earning more money by taking private rather than FC patients, she had been a FCM for the last fifteen years. Mrs. D. expressed discouragement about trying to rehabilitate her patients, most of whom were organically impaired, and treated them in a custodial way. Concerned with status, Mrs. D. felt she was not being recognized for her efforts and said that her advice was resented by the patients. Proud of being a patient person, she used a great deal of praise in getting patients to try new activities so they would feel better. Her use of praise, however, may conceal hostility. Mrs. D. likes to have patients

feel at home at the same time she finds it hard to deal with hostility, "boy craziness", profanity, untruthfulness, lack of manners, and uncleanliness of her patients. Mrs. D. felt, however, that mental illness could occur to anyone and took pride in having been brought up "not to be afraid". Her own children were at first not overly fond of the patients. Her neighbors, out of their fear of the patients, went so far as to isolate her home and remained cautious for a long while. Her patients are now accepted in her neighborhood, but seem to have little contact with members of this rural community.

#### Home E

The oldest daughter by her mother's second husband, Mrs. E. talked very little about her father. She said he died of cancer but denied his drinking. (His drinking was known, however, to social agencies.) She also expressed some feelings about their change of financial status from one which allowed for domestic help, to a lower economic status. Both Mrs. E. and her sisters learned a great deal from girl scouts and 4<sup>H</sup> club activities. Despite her financial limitations, Mrs. E. started to take English courses with the idea of becoming a teacher. Her plans to "work with her head rather than her hands" had temporarily been interrupted by the birth of her son. She considered boarding children but could not carry this out because of the fact she was of a different faith than that of her husband. She followed her mother's suggestion to take adults, working with whom entails less responsibility. Mrs. E., having had contact with her mother's patients, said she had taken them for granted since any early age and said she had no apprehension about becoming a FCM. Mrs. E., a cool headed, not easily perturbed person, accepted pranks both from her children and the patients. She has initiative in teaching them a sense of responsibility as well as skills in constructive occupations. Mrs. E. said she combines kindness, firmness, and interest in dealing with her patients and tries to distract depressed patients from their pre-occupations. Mrs. E., like her mother, felt that her patients could not be expected to obtain jobs outside of the home. She was critical of patients who are "boy crazy" and dirty. She also complained about one patient who was excited and wild, "since she is mainly afraid for her two young children's safety". These children had looked forward to having "ladies staying with us, just as grandma has". They had often visited Mrs. D.'s

home and been made the center of attention by her patients. Mr. E., while understanding of the patients, works late and leaves their care to his wife. Mrs. E. takes pride in the fact that her husband who handles difficult patients well, has studied some psychology. Like her mother, Mrs. E. lives in a rural community which offers the patients few outside contacts.

#### D. Analysis and Discussion of the Homes

This section will be devoted to an analysis and discussion of the FCMs in relation to their social history; employment and interests; attitudes towards mental illness; and their relationships with patients, FCMs' relatives, and the community.

The social history: The characteristics of the FCMs' social background were covered when discussing Table II. Only their marital relationships can be elaborated upon here. All six FCMs claimed to have satisfactory marriages with the exception of Mrs. D. and Mrs. E. in regard to their first husbands both of whom were irresponsible and immature individuals. However, information from social agencies indicate that Mrs. D.'s second marriage presented problems too. All six FCMs took the initiative in applying for patients. In general, their husbands seemed to have more passive personalities. In raising their own children, Mrs. B., Mrs. E, and Mrs. F. seemed to have had positive experiences. Mrs. A. felt successful in regard to her boys but had difficulties in dealing with girls. Mrs. D. seemed to have much anxiety in relation to the sexual maturation of her daughters. Some of these factors will be elabo-

rated upon in Chapter V.1.

Interests, previous employment and introduction to FC work:

The interests and previous work experiences of the FCMS cover quite a large range of subjects. The two younger FCMS (Mrs. E. and Mrs. F.) had belonged to youth clubs or organizations where they learned various skills and crafts. Mrs. F. had kept up several hobbies in which she took evening classes (crafts, painting, sewing). Mrs. C. had courses in crafts and Red Cross during her hospitalization. The activities of all three FCMS proved to be useful in their present work in helping them take care of and occupy their patients. Mrs. E. and Mrs. F. had had professional ambitions which their marriages did not allow them to fulfill: Mrs. E. wished to become a teacher and still intends following college extension courses. Mrs. F. wished to run a nursery school. Mrs. F. remained active in church groups. It can generally be said that the caretakers lacked outside interests. Mr. and Mrs. F. had church or professional activities. Mr. A. and Mr. B occasionally attended Mason Lodge meetings. In regard to their work experiences, jobs held by the FCMS were: factory work (Mrs. B. and Mrs. C.), laundry work (Mrs. C), waitress and domestic work (Mrs. B.), sales work (Mrs. D.), teaching crafts in schools (Mrs. C.), nursing (Mrs. A.), and taking boarders (Mrs. A., Mrs. B., Mrs. C., and Mrs. D.). All six FCMS had been interested in having boarders but the two younger couples

were discouraged by their relatives' and friends' experiences in taking private boarders whether children or adults. (This is elaborated in Chapter V, Section C, among Material Factors in the FCMs' motivations.) As they nevertheless desired to have an additional income, they applied for FC patients, being familiar with the FC program through their parents, also FCMs. Mrs. B. and Mrs. D. boarded children, the former through social agencies and the latter taking private cases heard of through newspaper ads or neighbors. Mrs. D. was dissatisfied with this experience. Mrs. C. had applied to and been accepted by a foster placement agency for children but no boarders were sent to her. She had an adult male boarder. Mrs. A. had previously boarded FC patients from another hospital. It is interesting to note that a trend is gradually becoming established: New FCMs are being recruited through relatives who are already members of the FC program. Mrs. A.'s and Mrs. D.'s daughters became FCMs. Mrs. F.'s mother-in-law is a FCM, her aunt became a FCM too and now Mrs. F.'s stepsister has been giving it some thought.

Mrs. C. and Mrs. D. heard of the program through newspaper ads. Mrs. B. became familiar with it through boarding the children of a BSH female patient.

Attitude towards mental illness: In general, the FCMs were very evasive in discussing their feelings and attitudes concerning mental illness. The defense used most often was the

denial of having given the matter any thought before undertaking this work. This was somewhat contradicted by their common statement that they all felt confident in the hospital's selection of FC patients as well as the reassurance they had gained from having the hospital's support should any patient have to be retruned to the hospital. Such remarks appear to indicate some concern as to what mental patients might possibly do. Mrs. D. protected herself by returning the question to the writer, wondering whether the latter had any fears in connection with her work with mental patients. She also remarked that "she had been brought up not to be afraid". Mrs. C. had mainly wondered what was meant by "ambulatory patients", saying she had given no attention to the fact that they were mental patients. Nevertheless, she was often puzzled by her patients' mental symptoms. She is the only FCM studied who had had no previous contact with mental illness. In this respect, Mrs. A., Mrs. E., and Mrs. F. had had sustained contacts with mental patients, Mrs. A. through nursing and FC experiences, Mrs. E. by having had FC patients in her home as she grew up and Mrs. F. through her mother-in-law's FC boarders. Mrs. B.'s only previous experiences seem to have been her acquaintance with the patient whose children she had boarded. Mrs. D., when a young adult herself, had witnessed a young woman's mental episode which called for the action of police. She had also heard that a former work colleague had

become mentally ill. As she had known this person prior to her illness, Mrs. D. felt such an event "might happen to anyone".

Relationships and attitudes towards patients and others: In their relationship with their patients, two FCMS (Mrs. A. and Mrs. B.) treated them much as one would act with children. The major difference between them is that Mrs. A. seemed to have the patients spend more time with her. Mrs. B. felt that her long standing experience with children was a great help in understanding her patients, considering this work to be a continuation of her work with children. The attempt of all six FCMS to pacify or divert the patient's attention with food seemed to be related to their adapting attitudes used with children to the handling of their patients. Mrs. C. in contrast to the other FCMS, spent all of her time with her patients relying on them for company and interest. She felt that they formed a family group, but also mentioned considering them as friends. It was the only home in which no time was set aside for the FCM's privacy. Mrs. A. made a point of having her meals alone with her husband, feeling this was the least she could do for him as well as ending the evenings alone, once the patients were sent to bed. Besides these two points, Mrs. A. felt that FC work called for laying one's home and life wide open to the patients, otherwise it would be best not to take FC patients. In all the other homes, the patients

were informally given to understand that they were welcome to spend some evening with the caretakers but that the latter wished to have privacy too. All FCMs encouraged the patients to do some household chores, but without putting pressure on them to do so. Mrs. A. helped her patients to work as a team. As most homes had gardens and three of them engaged in small farming (Mrs. A., Mrs. D., and Mrs. E.) the patients were provided with additional occupations which all seemed to enjoy. Mrs. E. and Mrs. F. showed most initiative in helping their patients find constructive occupations. Mrs. A., Mrs. B., and Mrs. C. had been active in obtaining employment for their patients. Mrs. A. and Mrs. C. had planned the greater number of family activities such as outings, trips, etc. All of the FCMs showed much initiative in obtaining things for their patients, such as clothing. Among the attitudes adopted by the FCMs, Mrs. A. and Mrs. D. tended to be somewhat controlling, Mrs. A. and Mrs. B. were quite protective of their patients as well as apt to brush aside their mental symptoms as being nonexistent. Mrs. C. was still often puzzled by her patients' symptoms, she also tended to expect her patients to exert will power such as she felt she had to do in her own experiences. Several FCMs tended to get hurt by their patients' manifestations of hostility (Mrs. B., C., F.), negative attitudes (Mrs. D. and F.), the former when patients did not heed her suggestions and by their lack of gratitude, the latter by their apparent grieving for the hospital when they

were first placed. Behavior and habits disturbing to the FCMS were: headbanging, rocking, uncleanliness, loudness, constant talking, hostility, and destructiveness. All six FCMS showed great concern less their patients act out sexually. Several preferred not to have young patients feeling they were more liable to get into trouble with boyfriends. It was the writer's feeling that the FCMS had influenced each other in this matter. Such a fear seems to have become practically "traditional".

As was previously mentioned, the FCMS' husbands were contented to go along with their partners' plans. They all showed interest in the work, proportioned to their free time. When Mr. A. and Mr. B. retired, they were especially helpful. Mr. C. was very well liked by the patients and seemed to have held a firmer position as "head of the family". As for the FCMS' children, when Mrs. D. first took FC patients, her children were not too fond of them but became accustomed to their presence in the home. The youngest became quite friendly with the patients. One of Mrs. B.'s stepdaughters helped her daily in running the home. All had helped in finding clothing, etc. and in general, were looked upon as "relatives" by the patients. Mrs. E.'s young children were enthusiastic over their mother's decision as they were fond of their grandmother's patients who had always shown them much attention. Mrs. F.'s children had always been accustomed to seeing their grandmother's patients. They had fewer contacts with the

patients in their own home since the patients used a separate apartment.

Most of the homes were rural or suburban (five) which doesn't allow for many community activities. It is possible that the FCMS' own lack of outside interests was a contributing factor in the lack of community contacts for their patients. Mrs. B. was very sensitive about critical remarks her neighbors might pass about her patients. Mrs. A., Mrs. C., and Mrs. D. had in common this need to "stand up for the underdog" and fight their patients' quarrels at the least provocation.

## CHAPTER IV

THE FAMILY CARE MOTHERS' RELATIONSHIPS WITH  
BOSTON STATE HOSPITAL AND THEIR  
REMARKS AND SUGGESTIONS ABOUT THE FAMILY CARE PROGRAM

As the FCMS' reactions to this study may bear upon their attitudes towards the hospital, these attitudes will be considered together. This chapter will discuss FCMS' reactions to the study, their relationships with B.S.H. and their criticisms, remarks and suggestions about the FC program.

A. FCMS' Relationships with B.S.H. and Their Reactions to the Study

It is of interest to note that in spite of the letter sent out to them and the explanation given for wishing to contact them, Mrs. A., Mrs. B. and Mrs. D. had to talk of their current experiences and successes first before it was at all possible to discuss any other subject. There seemed to be a need for approbation from the writer before they would proceed. Once this initial step was taken, all six FCMS were helpful in one way or another.

It took a very long interview to break through Mrs. D.'s defenses. She was very much on the alert and watching for possible traps, but in the end, she was able to voice quite vehemently her criticisms. Mrs. B. was never able to achieve this. Mrs. A. was anxious to draw comparisons with other caretakers she knew of regardless of the lack of encouragement offered. Mrs. C. manifested great lack of confidence in

herself or the worth of her own ideas and initiative fearing retaliation should she be doing things contrary to the rules of the B.S.H.

Mrs. E. and Mrs. F. showed the greatest degree of self possession. Mrs. E. was certainly the most reserved of the FCMs. Underneath her congenial attitude there seemed to be a more cool and calculating element. This might have been mainly connected with her wariness about the whole situation and an indirectly expressed reluctance for any "half baked" psychological delving into her decision of taking on FC patients. She showed the keenest awareness of what was at hand. Mrs. F. was well at ease throughout the interview and seemed to welcome discussing her job. There was a minimum need to give proof of the quality of her work. Both with the writer and in her dealings with her children, there was an apparent affectation in her manner which led one to wonder whether it was part of her personality or her need to be efficient and poised in everything she undertakes. In all FCMs there was a common fear of criticism of their work and desire to remain on the right side of the fence.

The following impressions on attitudes toward and use of supervision are based on the writer's interviews as well as the supervisor's records. Supervision is apparently regarded as a doubled edged blade: It offers help and support on the one hand and this is greatly looked forward to - but on the other, there is the danger of not living up to its expec-

tations which takes the form of a threat to holding the job. In this connection, the United States Children's Bureau points out that the social worker has the responsibility to deal with the anxieties of the foster parents in caring for the child. Though not offering therapy, he must help the foster parent make any necessary changes in his attitude which might be detrimental to the child. He recognizes that the foster parent is neither a colleague nor a client, yet realizes that the foster parent's service, while not professional, is important. The social worker thus uses his relationship and applies case-work skills and the principles of learning to help the foster parent grow motivated by free choice, rather than by the responsibility of developing a professional self.<sup>1</sup> It is also said, in the above mentioned article, that the social worker must recognize the foster parents' own needs for taking foster children. The same applies to the FC Supervisor himself. The writer feels it is necessary to stress this point as it has many implications in connection with this study. For one, there is the need for the social worker to be willing to know more about himself, his experiences and their effect upon himself in order better to understand and help the persons he is dealing with. It is also important in regard to his interpretation of facts revealed to him. In home finding, his own

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1. Subcommittee of the Citizens' Committee on Adoption of Children in California, The Training of Child Welfare Workers for Placement Responsibilities, pp. 10-12.

needs may affect his evaluation of the homes. He must also be aware of the fact that in this role the weight of the anxiety is on his side, not on the applicant's. The latter is offering a service of which the hospital is badly in need: that is homes for the patients. In brief, he must first be aware of his own needs and motivations before looking for them in others if effective work is to be achieved. This will be discussed further in Chapter V, Section A.

In general, there was a trend towards delaying the discussion of problems with the supervisor until a good working relationship was established. This came from the FCMs' fear of their ability being questioned. At the time of this study, they were all quite at ease to discuss problems as they arose and welcomed the supervision, help, and counsel.

Two exceptions noted were Mrs. C., who tended to lean somewhat on her supervisor on general matters but always reacted well in emergencies, and Mrs. F., who tended to avoid asking for help of any sort at the start, looking upon it as a sign of weakness. Time has altered both of these attitudes.

In order to clarify, it should be noted that each home has a social worker supervising it but that different social workers have placed patients in the home and keep in contact with the patient and the FCM. FCMs felt this was confusing and the hospital is trying to avoid it in the future.

Mrs. A. was considered by her supervisor to be warm,

direct and realistic in her contacts. She stated herself that she liked to deal directly with her supervisor in all instances and would write or call her if anything needed to be discussed between her visits or required an extra visit. Mrs. A. had been threatened a little on learning that a suicidal patient she had to return to the hospital was later replaced in another home. She had to bring this up and point out how this attempt had been unsuccessful.

Although Mrs. B. could discuss problems, she showed obvious signs of looking upon her supervisor as the one holding the whip. No negative feelings were expressed. Only those of praise and gratitude for her job. Such feelings as "I'd better be good or else" were indirectly expressed. She needed much approbation and was still always anxious to do the right thing. Mrs. B. would follow through on suggestions. There was also, at times, a feeling of being "checked upon" as in earlier days when the social workers would inspect the ice box.

Mrs. C. related well and positively. She talked freely as far as her work was concerned. There was fear of authority if it was not on her side. She feared such organizations as the Health Board or Public Welfare. On one occasion, when requesting support on some initiative, she made it plain that her social worker would not carry the necessary weight but that a doctor's approbation would be welcomed.

Mrs. D. was an old hand at this work and had had several social workers over the years. She was the only caretaker to speak straight forwardly in regard to negatives and criticism. She considered her very first supervisors to have been "the best". On exploration this meant that they fulfilled their promises most promptly and diligently, e.g., in furnishing clothing required, etc. She also felt they were more careful of the condition in which they brought the patients. It became clear that Mrs. D. was generalizing from two unfortunate instances which had occurred. Her ability to talk about this was considered an asset by the writer, even to the point of hostility, saying how she'd like to show society in general the clothing patients have after "all the propaganda on radio and television asking for help for the mental patient." Her complaints dealt with the cleanliness and the belongings of the patients when brought to her and the following through of her requests. These experiences occurred during the several changes of the workers as both the social service department and the FC Program were being revised. Mrs. D. seemed to look upon her supervisor mainly as a "provider", not a counsellor.

Two of her daughters had worked at B.S.H. several years ago. One was an attendant and the other, a nurse. She also had friends who worked there. From hearsay, during these experiences, Mrs. D. had picked up the idea that patients who are able to work are kept at the hospital to help out. Others would be placed with doctors (not on the staff) who would be

paid a higher rate than the FCMS and in addition the patients would receive medical supervision. These ideas were deeply ingrained and shared by her daughters. All in all, there was a hostile feeling of being taken advantage of.

Mrs. E.'s only indication of her relationship with the hospital was in terms of her disapproval of the choice of a couple of patients and the handling of one case. She felt that her observations had not been acted upon adequately. She indicated that there was a limit to what one should have to put up with in one's home even though peculiar behavior was to be expected.

Mrs. F., according to the supervisor, related well to her social workers and made good use of her supervision. She did tend to be overly friendly, putting things on a personal basis. Mrs. F. reacted well under stress. She would take action rather than let herself get flustered by things. She could ask for help when needed though this was something she acquired later as in the beginning she considered such action to be a sign of weakness.

Mrs. F. seemed to want to be efficient in her work. She was hurt when on one occasion, she considered that she had done the right thing by calling up the social service department, in an emergency, to get precise instructions. She later received a letter contraindicating such action and felt she was being blamed unjustly. Though it was actually a

question of crossed communications, she took this to heart. When this was pointed out to her, she was appeased.

Mrs. F. felt it rather confusing to be dealing with several social workers at the same time, finally not knowing whom to contact for what. She preferred to be in constant contact with the same supervisor. She realized this was to be so in the future. Mrs. F. stated that she looked forward to contacting the social worker and found this helpful. She felt it would be nice if, every now and then, the supervisor would sit down with her and discuss things in general, rather than just current situations.

#### B. FCMs' Suggestions and Remarks about the FC Program

The FCMs' remarks and suggestions were mainly geared towards the training of new FCMs. This is the one consistent point throughout the study on which most FCMs adhered to the focus explained in the introductory letter. It is possible that it was easier for them to make remarks or criticisms in terms of being helpful to newcomers.

All of the FCMs felt that it would be helpful to have greater knowledge of the patient's background as it would help them to better understand them and in the handling of some situations. The four oldest FCMs were more definite or clear about their opinions on this matter (A,B,C, & D.).

Mrs. F. showed foresight and initiative in making suggestions as to how the hospital could help her in her attempts

at rehabilitation.

Mrs. A. thought that the patients' social standing should be fairly similar to enable them to get along together. One patient, whom she had quite a few years ago, had a better background than the others and considered herself "above them". This made many difficulties in relation to the other patients and she had to let her go. The whole question of social standing seemed important to Mrs. A. Some knowledge and details of their habits and problems would be helpful and could be given at the time or before the social worker brought them.

Mrs. A. thought things should be talked over with the social worker and consideration be given to what might disturb one's husband. In regard to this, Mrs. A. had made a habit of eating with her husband apart from the patients, feeling he was entitled to it, and she felt that the patients did not resent this in the slightest. Mrs. A. put foremost the need of a "good table" and the ability to open up your house completely to the patients without reservations. She thought that the caretaker must realize this was a job that called for her constant presence and be willing to have it that way. Just as one cannot be a good nurse unless one likes people and is giving to them, the same qualities are necessary to make a good caretaker. She felt that the new FCMs would get the hang of how to handle them by observing them and so get to know them better. She had no special recommendations

as to how the hospital could be of better help to new caretakers.

Mrs. B. suggested not to mix young and old patients together. The younger ones should be placed out in the countryside to avoid boyfriend trouble and only progressively moved nearer to town as they were "better adjusted". She also suggested the following advice to new FCMs: to know something of the patients' backgrounds and habits, to spend a couple of weeks observing them as this would give the FCMs many clues as to the patients' characters and how to handle them, to be careful not to hustle and bustle them, and neither to bully them nor to speak harshly to them as this never helps. She felt that patients must be respected and well treated.

Mrs. C. felt she had little to say in particular beyond what had been covered during the interview as a whole. She suggested that FCMs be warned about the constant talking of the patient, not to let themselves be pinned down by their questions (i.e., "You believe what I say?"), and to make sure to keep promises made to them. Like many other FCMs, she felt it would be helpful to have some idea of the patients' backgrounds, their habits and mannerisms. Though she didn't really say so, she intimated that possibly the hospital should be careful not to place patients likely to get very excited. This statement referred to her fear of the physically strong patient she had had and instances of broken windows.

Mrs. D. suggested that one should observe patients to know them, to learn about their likes and dislikes such as food, and the best method to handle each one of them. One should be considerate in how one treats and addresses them and make them feel at home in the house, never belittle them, avoid making remarks or observations to them in front of anyone else, and realize that it's a twenty-four hour job. She also remarked that the money was highly inadequate. There should be consistency and follow up by social workers providing clothing and other requests made by FCMs. The patients should be prepared for placement and be ready to take care of themselves. The patients' manners, bodily cleanliness and clothing, should be given more attention at time of placement.

Mrs. E. felt that she had few suggestions to make. One was to expect odd behavior on the part of the patients. Also, greater care should be taken in the selection of patients placed in FC. She also complained about the low rates which she considered ridiculous, and she felt that they hampered many prospective FCMs from undertaking the work.

Mrs. F. felt that the big problem was to keep the patients busy and help them find employment. She had bought them much material for handcrafts but couldn't keep it up financially. (This point she was asked to take up with her supervisor to see what could be worked out with the hospital or the Occupational Therapy Department.) She also felt that they ought

to have a market for their work, though agreed that that would call for well finished work. Mrs. F. thought it would be of great help to know something of the patients' backgrounds and habits as they are placed. She also felt it was important to select patients who would fit into a group and not disrupt things. She also recommended having only one social worker contact a home.

## CHAPTER V

ANALYSIS AND INTERPRETATION OF  
THE FAMILY CARE MOTHERS' MOTIVATIONS

The preceding chapters have presented the information obtained in interviews. They form a background for this chapter which is an attempt to identify and analyze the motivations of the FCMs for undertaking this work. This analysis is necessarily to some extent speculative and makes no pretence to finality. It does not approach what could be revealed by a deeper knowledge of the caretakers, which would call for a strong personal relationship.

First, some reference will be made to literature on motivations as a background for the analysis. Most of these references can easily be adapted to FC work. Next, the reasons given by the FCMs themselves for undertaking this work will be presented. Last, a tentative analysis and interpretation will be made from the information at hand. The subdivisions will be as follows: (A) Literature on motivation and its application to the FC program; (B) Reasons given by FCMs; and (C) Analysis and interpretation of the FCMs' motivations, which will be divided into the material factors and the emotional factors.

A. Literature on Motivation and its Application to the FC Program

In discussing the choice of a career, Lewis B. Hill has pointed out:

The decisions behind the choice of career may be assumed to be highly overdetermined in their motivations. Such a series of choices is derived from meanings and values arrived at by way of many experiences occurring at various ages and at various levels of conscious and pre-conscious activity.<sup>1</sup>

Likewise in all fields of work in which helping people is the main issue, many common reasons are given as to why people desire to undertake such work. Some of these reasons are liking people, being interested in the, and wanting to help them. Lewis B. Hill explores them as follows, in talking of the choice of career of residents in psychiatry:

Each of these attitudes may be genuine and mature but unfortunately each can also be a manifestation of underlying intentions that can be disastrous to the patient in therapy. The phrase "to help human beings" can both conceal and indicate motives to set one's self up as superior to and control and force patients into preconceived patterns of behavior, and even motives to achieve distinction by way of morbid self sacrifice and self-punishment. Thus the urge to help requires careful evaluation in the light of much knowledge of a therapist's overall character to distinguish a useful genuine sublimation from a neurotic reaction formation. It may well be that the urge to help is not so productive as the willingness to be of use to the patient. The latter attitude is active but not domineering.

. . . Being interested in people also requires a second look. Such a professed interest may be, and often is, a valid motive based in warm human sympathy. Or it may be a legitimate scientific thirst for knowledge - less formatively, it may be a kind of infantile curiosity - if this latter is not understood for what it is and freed to develop, it can repeatedly distort the therapeutic relationship with the patient and increase the patient's already difficult problems with the therapist.<sup>2</sup>

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1. Lewis B. Hill, Therapeutic Intervention in Schizophrenia, p. 2-4.

2. Ibid., p. 2-4.

Such remarks pertain very directly to FCMS especially since they refer to dealing with mental patients. As to the specific choice of working with mental patients, Lewis B. Hill points out that among other reasons, there may be a profound concern by the resident about his own mental integrity or he may have had an appalling experience of mental illness in someone very close to him.

The needs of the mental patients are similar to those of the foster child in regard to placement in a foster or FC home. Since it is recognized that such a great part of their emotional problems stem from traumatic childhood experiences, the rehabilitation of patients in FC includes giving them a corrective emotional experience in a healthy family setting. The patients are at various levels of emotional development, often at quite an infantile one in one or more areas. Thus all references to "child" can be seen as valid for the mental "patient", those to "foster parent", valid for FCMS, and those to "own parents", valid for patients' relatives.

In speaking of the foster parent Mary Buell Sayles says that one may find foster parents to be:

. . . in search primarily of self fulfillment in an object of devotion, or of a response that they failed to obtain elsewhere, or of an opportunity to shape to their own design some young, malleable personality. . . Like own parents, they are sometimes seeking compensations in children for frustrated affections and disappointed ambitions, or are endeavoring to find through them release of feelings of guilt which may

long have been warping their own personalities.<sup>3</sup>

Concerning the same subject, Dorothy Hutchinson raises several questions concerning the applications for boarders:

The worker is interested in what the request for a child signifies to the foster parent. What is it to accomplish? How does she wish to use the child? How to incorporate him into her life? What need must he fulfill?<sup>4</sup>

Such questions would certainly provide good leads to possible motivations if borne in mind during home investigations.

She also points out the universal desire to love and be loved, how foster parents are often looking for more of a different kind of love. After drawing attention to neurotic love specifications, she concludes that "the crux of the matter is in the normality and reasonableness of their love specifications".<sup>5</sup>

In view of the suggestion for so much caution in selecting foster parents, Miss Sayles reassures us that many people can be considered "normal" and acceptable foster parents. She states: "Normality is something that is hard to define yet easy to feel and see. In it is assumed a wide range of behavior and attitude, not narrowly fixed concept."

It does mean that these people have made reasonably satisfactory adjustments to the every day demands of

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3. Mary Buell Sayles, Substitute Parents, p. 17.

4. Dorothy Hutchinson, In Quest of Foster Parents, pp. 24-25.

5. Ibid., p. 9-10.

life. They can hold a job, make and keep friends, marry and enjoy love, and meet the common strains and stresses of life.<sup>6</sup>

What should the social worker's attitude be towards understanding the motivations of FCMS? Exploring motivations can be positive and constructive. Too often, only the negative aspects are stressed. As far back as 1936, Mary Buell Sayles made the following statement in a discussion of the advantages of education in mental hygiene in viewing unacknowledged or unrealized motives:

It tends to free one from the impulse to classify motives as base or noble, selfish or unselfish, and accustoms one to recognize behind any given action or habitual attitude, a mingling of many different motives and a fairly constant drive for satisfaction of one sort or another.<sup>7</sup>

It is the social worker's responsibility to gauge when the individual's personal needs are exaggerated or unreasonable and could be detrimental to boarders under his care.

In considering motivations, financial reasons can not be taken on face value. Charlotte Towle points out that money forms a convenient rationalization. Few if any organizations pay enough to compensate foster parents for their efforts. As for "pin money", the latter can be earned in less time consuming ways. She reports a study which suggests that applicants who have purely financial motives withdraw their appli-

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6. Mary Buell Sayles, op. cit., pp. 53-53.

7. Ibid., p. 17.

cations.<sup>8</sup>

B. The Reasons Given by the FCMs

Mrs. A. decided to spend a year in a mental hospital as she had "some hunch" that that was the work she might like to do later on in her life. She questioned how one got such hunches and guessed we all have some idea as to what we want to do. Her first interest in nursing had nevertheless been in the field of obstetrics.

Mrs. A. considered that to be a good nurse and especially to work with mental patients, one had to like people and have no hatred towards them. Also, one must be very giving. She considered that when one has all one needs, there is no reason not to share it with others and she was rather scornful of nurses who do not wish to do so. She also objected to people turning to "plain boarding home work" which gave them more freedom as constant supervision was not required. To her such an attitude was plain selfishness. Discussing her experience at the hospital, she remarked that such work in those years was much tougher and not considered or thought of as it is today. Though she thought it hard work, she liked it and felt much could be accomplished for the patients.

When her friend asked her to take over her mental patient, Mrs. A. talked it over with her husband who considered that

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8. Charlotte Towle, "The Psychiatric Approach in Home Finding," The Social Worker, 7:11-12, June 1931.

if she wished to do so, he had no objections. She had never interfered with his work and he felt the same way about hers. She implied that he thought it would be nice to open their home to the patient.

When her children had left home, she felt it would be nice to take on this work again. She'd always kept busy whether with nursing or children and wanted to go on being active. Her philosophy was that one cannot have everything in life; being comfortable and having a nice home was as much as she wanted. Both she and her husband liked being at home and had little or no outside interests. Mrs. A. felt that one could not shut away part of one's life. This work called for throwing your house and life entirely open to the patients. She stated that one should let others partake of one's good fortune. She liked the work and was interested in seeing the patients' progress. It implied satisfaction and gratification through the results achieved though she realized the patients were limited and that most of those she had would never be able to be out on their own.

On her application form, Mrs. A. mentioned as motives for boarding patients that she had a suitable home for this type of work as well as having done this work before. On her second application, she stated wanting to help the mentally sick.

Mrs. B.'s reason for undertaking the work was because of the restrictions in boarding children and the complications

involved in other connected fields as well as the fact that she chanced to get acquainted with the program. It took some prompting for her to acknowledge the financial aspect. As the writer implied that this was a realistic and natural attitude, she spoke of it in terms of helping to cover the costs of paying and running the house. As she wasn't too comfortable about it, she pointed out how other family care parents saw it and did it for similar purposes. With further encouragement she mentioned she had it all worked out in her mind: She is very intent on having always a full quota of patients (from the financial view point). At present she has six patients and one former patient she is keeping with her who does some day work to earn an income.

Mrs. B. said too that she was doing this work for a purpose as she wished to help them. Someday she might need a home and some kindness herself as anyone can get sick. She prayed to God for her patients and to help her with her work. Mrs. B. had boarded children for thirty-five years. On her application form she stated she had taken children to board in order to help them. Now she would like to take ladies and help them.

Mrs. C., although she stated that her husband's salary was adequate for their needs, considered this work would help to pay for their home. She implied that their realtor had talked them into buying such a large house. They had origi-

nally planned to run a nursing home but that involved many costs, equipment, sprinklers, personnel, etc., so she had thought of doing something else first and started to inquire about foster children. At present she wonders if she'll ever bother with the latter. She was satisfied with her present work and felt she and the patients formed a happy family. Plus the financial aspect, she felt she couldn't remain home all day doing nothing and this would give her company as well as help in the house.

Mrs. D., when applying for FC patients, gave the following reasons:

To help finance my home and keep my family together. . . I buried my husband in. . . I'm living on stocks fast dwindling away. Must take children or adult boarders. I am a plain, sensible woman and would give anyone left in my care best I have in my power that would be good for their benefit both physically and mentally.

Mrs. D. felt sorry for the patients and maintained that should their relatives have a better attitude towards them, many more could be in their own homes. She just couldn't conceive of not keeping one's own relatives and taking care of them. She would certainly do so, if any of her own family was taken ill. Mrs. D. was very vehement as she expressed these views. She made further reference to how one treated members of one's family in her mother's surroundings (old country).

During the interview Mrs. D. said that she would not do this kind of work if she had to choose her type of job again. With this kind of job, one was unable to take a holiday. She

stated that she would continue to do it because she has done it for such a long period of time. She likes the work and it also helps her to keep her home going which she feels she is entitled to, for she has worked so hard all her life. Even so, she has often had to draw upon her reserves.

As Mrs. D. moved a couple of times, during which periods she interrupted her work, she was asked whether she had contemplated taking other boarders rather than mental patients. She said she hadn't thought about it but was used to mental patients and "had made a study of them". A friend of hers has O.A.A. patients and Mrs. D. thinks, "They're worse in so far as they act even more in a childish way and need a lot of care".

Mrs. D. mentioned that a friend of hers was boarding ten to fifteen year old boys and was getting much gratification from doing this. The boys apparently shower her with tokens or gestures of appreciation. Mrs. D. felt the lack of this in her own work. She inquired whether she should consider following her friend's example, musing over whether she would be too old to do it. Mrs. D. was also interested in infants but felt she was too old for that now. She liked the fact that one can have them all neat and tidy and in their cribs, fed and kept clean. She doesn't think much of the "three dollar patients" as she calls those patients for whom the state pays twenty-one dollars a week. The seven dollar differ-

ence doesn't justify the extra work and bother they create in her opinion. Mrs. D.'s doctor and friends often told her she could do more remunerative work and disapproved of her for it. She repeated that she liked her work but wished she could get away from it for two or three weeks vacation which is impossible as there is no one to replace her.

Mrs. E. was familiar with the work through her mother's experiences. She made plans to take boarders as her house was too big for her own family and she had a great deal of grounds. As she said, "Since I'm stuck anyway with my own children, I might as well do this kind of work". Mrs. E. felt that it helped her financially at the same time as providing a home for the patients. She viewed it as a temporary job, as she might terminate it when her children were of school age. Mrs. E. had wanted to take children but her mother suggested trying FC as there was less responsibility and work involved than with children.

Mrs. E. added that she would have had difficulties in obtaining foster children according to what she read in reviews, etc., because she and her husband were of different religions. Private cases didn't pay well enough and weren't steady in regard to payments whereas this work was stable (this seemed to be influenced by her mother's experiences). She insisted, without questioning, that she was doing it for financial purposes as they were buying the house. Mrs. E.

seemed to want to make it clear that there was no nonsense underneath it. She knew she wouldn't get rich on it but it covered the current expenses and her husband's income was adequate for their family.

In her application Mrs. E. stated she had two extra bedrooms and several acres of land and that she "may as well use it to the advantage of patients and myself". The home had been used continuously for this purpose for the last several years. (Her mother used to live there.)

Mrs. F. made the decision to take patients herself. At first her husband wondered if it wouldn't be too much for her. They had often been asked how they managed to take on so many things at the same time. Mrs. F. thought they had active minds and liked to keep busy. Their new home had been a challenge which they enjoyed and they now wanted "to keep going". In her application for FC patients and during the initial home investigation, the F.s declared that they had these rooms which they weren't using and which they'd like to have benefitting someone. They were interested in boarding mental patients because they wanted to help people less fortunate than themselves.

Mrs. F.'s children had befriended their grandmother's patients. Mr. and Mrs. F felt it would be a continuation of a kind of life they and their children had had with patients. The children wouldn't be in too close a contact with them.

It would naturally be a source of income, but Mrs. F. had wanted to undertake some kind of occupation and as she had given up the idea of a nursery school, this work interested her.

They had considered renting the apartment to a family or taking in regular boarders but decided against it as they heard from friends how much trouble one can have with tenants. Mrs. F. thought that regular boarders are known to be mainly transient which makes for a very unstable income and constant worries, and felt that, though poorly paid, had the great advantage of being steady and quiet. By this Mrs. F. meant that if anything disturbing happened, the hospital would back you up and take back the patient with no more fuss about it. At the same time their extra rooms were being used and they were doing a worth-while job.

### C. Analysis and Interpretation of the FCMS' Motivations

General trends concerning motivations will be drawn out from the data collected. The discussion will be divided into material and emotional factors. This analysis will attempt to clarify how emotional factors, whether recognized or suspected, can be interpreted in linking the past to the present.

#### 1. Material factors

The material factors related are: administrative requirements, stability of work and remuneration, financial factors and FCMS' limitations in regard to choice of work.

a. Administrative requirements

Several of the FCMS (B,C,D, & E) brought up the fact that there are fewer administrative prerequisites for FC patients than there are for any other type of boarders one would apply for through social or public agencies. Prerequisites of other agencies they found difficult or expensive to comply with were as follows:

1) For a Nursing or Boarding Home: Obtaining a license to operate the home; sprinklers and other fire department requirements (the latter are less exacting for boarding mental patients); the physical set up required (i.e., spacing of beds, number of rooms); personnel and professional staff required; and in general, the rules and regulations of various sorts required.

2) For child placement agencies: Regulations concerning the age of the foster mother in relation to the age and number of children she would be allowed to board (this becomes a problem as the foster mother ages, if she does not wish to board adolescents); importance attached to the religious affiliation of the foster parents in relation to the faith of the children to be boarded; regulation that both foster parents have to have the same religious affiliation; in the past, more detailed investigation of personal inter-relationships (marital discord, parent and own child, etc.), as well as attention to various areas and details not gone into for FC work; and in

general, more rules and regulations of various sorts.

b. Stability of work and remuneration

FoCMs found that their present work insured a greater stability in comparison to taking private patients, answering private newspaper ads, running a rooming house, and having tenants. The advantages of FoC were seen as follows:

1) The security offered by the hospital's support and intervention when the patient's condition calls for their being rehospitalized. This is in opposition to the risk one takes with any of the cases mentioned above. Problems with difficult tenants and the rent control were especially feared in addition to the general problem of selecting one's boarders.

2) Assurance of always having boarders as there is such a need for FoC homes. In the other cases one would often have to seek or wait for new boarders as the former ones left. This involves a financial loss, extra work in finding boarders, and anxiety as one had difficulty in securing them.

3) As a natural sequel to the last point, comes the assurance of a stable income from a stable job.

c. Financial factors

All six FoCMs mentioned finances as being one of the reasons for applying for FoC patients. Mrs. A. was the only one who did not state this directly, but it was implied in her statement of wishing to do this type of work, since work presupposes remuneration.

The financial needs stated were fairly similar, i.e., paying installments or mortgage on the house (B, C, D, & E), meeting the cost of transforming the home (F), and as a livelihood to supplement what the FCM had inherited from her husband (D). All of the FCMs, with the exception of Mrs. A, mentioned also that this remuneration helped them to meet the current expenses of the household. With the same exception, they all commented on the insufficiency of the allowance paid, but in spite of the low rate, the security of a steady income appealed to them. Mrs. B. and Mrs. D. had boarded children either through newspaper ads or through acquaintances and in some instances they never got paid for their service. In this regard, Mrs. D. remarked that the extra dollar a day paid for patients needing more care, was not worth the extra work it entailed. In analyzing each home separately, it becomes apparent that none of them had the financial remuneration as sole motivation. The reference to Miss Towle's article referred to above is most relevant to the FCMs studied.

d. FCMs' limitations in regard to their choice of work

Various limitations were mentioned by the FCMs, which may be summarized as follows:

1) The FCM's presence being required in her home. This was true for Mrs. B. and Mrs. D. at the time of their application as they were still raising their own families. It was the current situation for Mrs. E. and Mrs. F. These FCMs

wished to engage in some remunerative occupation while having to remain home with their children.

2) Lack of professional training or of previous experience, which limited their choice of work

3) FCMs having to change their occupations because of health or age (Mrs. C. & Mrs. A.). Also, as in the case of Mrs. A., the FCM did not wish to take care of mental patients while raising her own family. Once the latter had grown up, she desired to take up this kind of work, with which she was already familiar.

## 2. Emotional Factors

As has been pointed out previously, this discussion of the emotional components in the FCMs' choice of work can only be tentative. It will deal with the psychological elements and emotional motivations which from the data available seem to play a part in the FCMs' choices.

The factors listed below are related to the six FCMs studied, and the points made will be illustrated with case material. Many of these factors could be included under several headings. No specific sequence is followed in the enumeration of the personality factors revealed beyond ordering them so as to lead up to the more mature and genuine motivations.

Some general personality factors will be described before discussing the FCMs' motivations. These were the FCMs' re-

actions to the standards and mores of their own upbringing, their guilt feelings and their feelings of rejection.

Reactions to the standards and mores of the FCM's own upbringing seemed to play a part in the career activities of some of the FCMs. As illustrated in the cases of Mrs. A. and Mrs. D., these reactions were both negative and positive. Mrs. A.'s need was mainly to shatter the barriers of taboos through her choice of this unusual career which was at the same time acceptable. Mrs. C. had identified with individuals "feeling different" from others, as indicated in her attitudes toward her convent education, racial difference at school, and her lameness. She felt that the confinement of her education separated her from others and also inferred that teen age activity was "cheap behavior" that she herself could not follow. Mrs. D., though she expressed pride in her achievements, apparently felt that she had had a harder life than most people as well as having contributed to the family's well being from a tender age. For years, she performed fairly heavy chores. She seemed to be disillusioned by the difference in attitudes towards relatives and elders amongst her peers as compared to her mother's description of the old country. There was a hankering after such standards.

Guilt feelings seemed to be present in some cases. Mrs. B. left no doubt about the presence of guilt both in her general behavior and in her conversations. There was quite a

residue of guilt feelings attached to her first marriage as she related this event to the writer as well as in mentioning the long break she had with her family. Many factors focused on her feeling of being a "bad girl", calling for punishment or disapproval from others as well as herself. She finally voiced, with great relief, how she eventually renewed contact with her relatives and took care of several of them. This had a definite quality of atonement, and her interest in FC patients probably had the same quality. Mrs. D. expressed, less directly, guilt feelings in regard to her divorce and remarriage as such actions were in conflict with her faith. She rationalized that she had relieved her husband from his obligations to her to enable him to take care of a natural child. Mrs. D. was later to spend years caring for others.

Feelings of having been rejected seemed to be present in most of the FCMS. Mrs. B. felt rejected by her family after her marriage (possibly earlier but no information is at hand) and also by her first husband. Mrs. C. felt rejected by her stepmother and her relatives, her peers and her colleagues at work. Mrs. D. felt rejected by her marriage, church, friends, and society insofar as it did not meet her expectations. Mrs. E., possibly as a child, felt rejected by the inclusion of the patients in her family group and by her father's death. Mrs. F. felt rejected by both parents and steprelatives (lack of interest or concern in her).

Unresolved or unacknowledged personal problems and needs such as have been described can take on a great variety of forms as the individual attempts to handle them whether unconsciously or with some self awareness. They play a part in several of the following motivating factors:

a. Identification with the "under dog". This motivation could, if pushed too far, have a Don Quixote quality. This trend was most apparent in Mrs. A., Mrs. C., and Mrs. D. as described in their relationship with the community and with patients' relatives. There can be positives and negatives to such a trend according to the extent to which it goes. The experience of having someone stand up for them can be helpful to the patients because of their own feelings and past experiences which interfere with or warp their relationships with other people.

b. The desire to take care of individuals less fortunate than oneself, weaker or in need of assistance. This often pairs off with the need to feel superior to or to control others because of one's own feelings of inadequacy. Mrs. D.'s description of why she would like to look after infants (have them all lined up, neat and tidy in their cribs, fed and clean) would illustrate the need to control. Her desire to have the patients follow her instructions faithfully as she trained them in housework could be indicative of the same or of the need to feel superior to them.

c. Lessening of the threat of failure through dealing with individuals suffering from some impairment. Should one not achieve one's goal, the patients handicap can always be used as a good reason for this failure. Mrs. D.'s and Mrs. E.'s attitudes in regard to custodial FC patients is an example of this. It can also be connected with their concern about sexual behavior. Though all FCMs expressed fear of their patients getting involved with boy friends, they very likely would have different attitudes to a similar event concerning a "normal" person under their care, especially an own child or relative. There is also the possibility of blaming the hospital for placing patients likely to get into trouble. Insecurity and fear of competition make FCMs seek a field of work devoid from any strong competitive spirit, where there is no obligation or necessity to keep up with others. Even so, Mrs. A. had to tell the writer about another FCM's failure with a suicidal patient placed with her after having been returned to the hospital from Mrs. A.'s home. Mrs. B., when talking of financial reasons for boarding patients, had to protect herself by citing other FCMs whom she knew to have the same reasons. A similar reaction occurred when mentioning her fear of possible acting out behavior on the part of younger patients; she enumerated FCMs who had had the same problems.

d. Desire for status and recognition. These factors

stem mainly from the FCM's feelings about themselves, such as feelings of inadequacy, worthlessness, non-acceptance of themselves, etc. Mrs. D. and Mrs. E. illustrate these points. Earlier in this study, attention was drawn to their desire for status. Mrs. D. called attention to how her present work called for recognition in that few people are willing to devote their time and energy for so little reward. Her daughter, Mrs. E., clearly indicated her aspiration to an intellectual occupation rather than having a manual job, and in general, her desire for self improvement. Mrs. D. apparently derived more satisfaction from her friends' and the community's recognition of the difficult and, as outsiders viewed it, unrewarding work she was doing. Even her friends' rebukes about her not taking a more remunerative employment seemed to provide her with some vicarious gratification. Mrs. C.'s desire for recognition pertained more to her inferiority feelings connected with her infirmity and having lived mainly on the fringe of her family, practically as though she were not one of them. This cannot be dissociated from her feelings of being rejected. The feelings surrounding an unsuccessful marriage can also be linked with the person's feelings of failure, inadequacy, and worthlessness.

e. Feelings of loneliness and concern about the future.

The problem of loneliness was primarily the concern of the widowed FCMs. Associated with it was some anxiety as to who

would take care of them as they got older. Mrs. B. expressed such concern by saying that one never knows when one might need a home, kindness and someone else to look after you as she was doing for her patients. Mrs. D. made many references to her ancestors in regard to the esteem shown to them and the place they held in the family circle. Her hostility towards the patients' relatives for not keeping them in their homes was indicative of the same concern. Such feelings had led them to identify with the patients as the latter were faced with similar problems. This attitude can be summarized as, "Do to your brother what you would like done to yourself".

f. Wish for companionship. As the FCMs' own families had grown up, or when they retired from their usual occupations, they found themselves at a loss. Being alone in a house that had previously been full of life or in which they had been accustomed to spend far less time, they enjoyed sharing their home with others whose company was welcomed. Mrs. A. and Mrs. C. illustrate both of these aspects.

g. Desire to remain active. This was seen in both the older and the younger FCMs. Mrs. A. and Mrs. C. clearly indicated such a desire. Whether health reasons or retirement caused them to change occupation, they seemed to enjoy opening their homes to the patients and accepting the challenge of caring for them. Mrs. E. felt she wanted to engage in such an activity while having to stay home though her family did

not require all her time and energy. Mrs. F.'s desire to keep active could not be considered as similar to that of the other FCMs. She had far more outside activities available to her and had engaged in several. It is the writer's feeling that in her case, this activity served to meet some of her neurotic needs.

h. Interest in perpetuating the family's participation in the FC program. It is of interest to this study to relate such a motivation to family or community traditions as described in connection with the colony of Gheel. Should more FCMs share such feelings, one might see the nucleus of a tradition developing in the FC program of B.S.H. It was Mrs. F. who brought out this factor.

i. Genuine warmth and desire to help. As was pointed out by Dr. Hill, it is difficult to differentiate between a healthy sublimation and a neurotic reaction formation, the latter being potentially destructive to the patients. Mrs. F.'s interest in running a nursery school as well as her present ambition to do an efficient job with her FC patients could be illustrative of either. On the one hand, it might be a desire to and the ability to give her patients the love, affection, and interest which she felt she was so deprived of herself. On the other hand, it might stem from an unconscious desire to hit back at her relatives for what she went through herself, channelled and controlled by her interest for the

welfare of her boarders. At the same time it could provide her with the gratification of giving her relatives a living example of what one can and should do for those we are responsible for. Regardless of how they are interwoven with other motivations or traits, one must acknowledge mature and genuine attitudes. FCMs, like foster mothers and other caretakers, have altruistic motivations and natural gifts of warmth, capacity to love and to give, interest in and liking of others. Such qualities are not uncommon amongst persons who have found satisfaction in their work, marriage, interrelationships with others or in activities and interest in their community. The writer recalls a psychiatrist's comments on how a satisfied adult can have a surplus capacity to love from which he does not have to draw for his personal emotional needs or growth. This is in contrast to the child's need of love and self-love for his emotional development and growth. Such an adult would be apt to seek and find many healthy outlets. Among the six FCMs studied, Mrs. A. was the best illustration of this healthy motivation. Besides the factors already noted in her case, the following points are pertinent here: Her satisfactory marital relationship in which the partners' personalities seemed to complete each other to their mutual satisfaction; the gratification she found in her nursing career; the acceptance of and respect for this couple in their community. With these factors in mind, there is

little reason to doubt the presence of mature and genuine attitudes as components in her decision to share her home and life with others. She did mention feeling she had more than she needed, in many respects, and wished others could benefit by it too.

There is no hard and fast line between "normal" and "abnormal". Neurotic personality traits do not necessarily preclude qualification for FC work. On the contrary, one way of dealing with one's neurosis is making good use of it. It has already been noted that it is the supervisor's responsibility to detect any traits in the FCs which may be harmful to the patients.

CHAPTER VI  
CONCLUSIONS AND SUGGESTIONS

The first part of this chapter will show how and to what extent the specific questions asked in this study were answered. The second part, the suggestions, will group some of the observations which arose during the process of the study.

A. Conclusions

The analysis in Chapter V, brought out several motivations that were unknown at the time of application. There seemed to be a connection between factors and experiences as revealed by the FCM's background and history and some of the reasons for choosing to care for mental patients. The clearest examples were those related to the FCMs' feelings and experiences of rejection, guilt, and insecurity as revealed by their fear of competition and of failure. The first two factors were related to their feelings about themselves, and in some cases the source of these feelings in their early history seemed evident. Such feelings may well be the basis for identification with the patients. They may also lead the FCM to seek atonement in caring for the patients. The FCMs' fears of competition and failure may lead them to select work in which they are dealing with handicapped individuals.

Being aware of the overdetermination of the FCMs' choice of work should help the supervisor to understand the mechanism of their behavior and reactions towards the patients and

specific situations. Examples of this were supplied by Mrs. C. as she emphatically pushed her patients to strike back at anyone being aggressive with them. The exaggeration and obvious fear connected with her attitude can be comprehended as one knows of hostile experiences she met with at work. The same thing seemed to hold for Mrs. B.'s fear of sexual acting out by young patients. Again, knowing the events of her adolescence, makes it possible to understand such a strong reaction on her part.

The use of such factors in making a fuller and more constructive use of FC may be noted here. If it is not the supervisor's role to help the FCM in a psychotherapeutic situation, it does enter his function to assist FCMs to understand their own needs and attitudes as they reflect on their approach to patients. This can only be done by having a better knowledge of the dynamics of the FCMs' personalities. Also, the selection of FC homes and the matching of FCMs and patients could be more adequate. The possession of such information would make it possible to foresee areas of conflict or difficulty both for FCMs and the patients. It would thus put the supervisor in a better position to help clarify and remedy many situations.

Another general trend noted in the data was the FCMs' search for security in material factors, such as security of uninterrupted work and payment. Also, there was emotional

security in the backing up from the hospital should patients need to be returned. Such assurance makes for greater emotional security as much anxiety is thus alleviated.

Other material factors which influenced their choice of work were as follows: Fewer administrative requirements such as licenses, fire department regulations; no need for professional staff; and in general, less rules and regulations. Among the emotional reasons influencing the FCMS the most apparent ones found in the study were: The FCMS' identification with the "under dog"; their desire to take care of individuals less fortunate than themselves; the lessening of the threat of failure through dealing with individuals suffering from some impairment; and their desire for status and recognition. Also their feelings of loneliness and concern about the future which leads to the attitude of "do to your brother what you would like done to yourself", as well as their wish for companionship; a desire to perpetuate the family's participation in the FC program; and the FCMS' genuine warmth and desire to help.

Several indications for future studies became apparent.

1. Repeating the same type of study with a larger group of FCMS either from B.S.H. or elsewhere. It might offer additional interest to use another family care program. The main purpose would be to compare the findings of the various studies, and see whether they run parallel, contradict or add to each other.

2. A study of the FCMS' husbands might be of interest. Though no great attention was given to them in the present study, all six appeared to be passive personalities, the FCMS having the leading role in their marriage. Several aspects could be studied: their emotional needs, choice of job and what it offers them emotionally. Their total personalities, and how having FC patients in their homes affects them.

#### B. Suggestions

Before listing the suggestions, the writer wishes to clarify that it is fully realized that the present conditions and limitations make it impossible to fulfill various plans or ideas formulated by the B.S.H. Social Service Department. The same applies to suggestions that are about to be made. But lack of funds or facilities should not be equated with lack of foresight and initiative. The social workers have endeavored to keep ahead and be ready for any possible changes.

After completing this study the writer came across the information given by Roger Cumming and Irene Grant of the Veterans Administration.<sup>1</sup> Their findings are quite extensive and some of them corroborate those of the writer. The suggestions will be subdivided under several headings for clarification and easier reference. The headings are: 1. Administrative factors and factors pertaining to supervision of FC

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1. Roger Cummings and Irene Grant, Foster Home Care for Psychotic Patients in the Veterans Administration: Developments in 1953.

by the Social Service Department, 2. Factors pertaining to the FCMs, and 3. Factors pertaining to the FC patients.

1. Administrative factors and supervision of the FC program

Records and application forms: The FC home record should contain a full report of the application procedure: interview, home visit, interviews with the FCM's relatives living in the home, and application form. It should be currently kept up to date as relevant information is gathered on the caretakers or patients. A summary of the supervisor's contact with the home, written every three months or so, would be valuable in evaluating the homes periodically as well as in providing continuity to the work in case of change of staff. A summary on each patient placed in the home should be filed in the FC homes records. It should contain any relevant data in connection with their placement, their doctor's recommendations and observations, and those of all other staff members having worked with the patient. Information on reasons for patients being returned to the hospital should also be filed.

Reduction of the number of patients placed per home: The present maximum in a home is six patients, but for a real therapeutic use of FC, two patients per home should be the limit. This would allow for a better integration of the patients in the family group. The present number of homes compared to the number of patients in need of FC makes it impossible to make such reduced placements on a general basis.

Nevertheless, this new trend has been introduced in the last year.

Teamwork approach to FC placement and public relations:

In past years, the teamwork concept had been used, but apparently, never to its full potentiality nor with sufficient conviction on the part of the whole staff to carry it through. At a staff meeting, each member of the team should give his observations and recommendations as suggested in talking of the FC records. The team could include many disciplines: the ward doctor, psychologist, social worker, nurses, attendants, occupational therapist, vocational rehabilitation counsellor, workshop supervisors, etc. In a therapeutically oriented program, the full services of these disciplines should be called for. The occupational therapist should know the patients' abilities and interests as well as the homes, FCMs and facilities at hand which would allow to plan or suggest activities for the patients. The vocational counsellors should also know the homes, their neighborhood, and the work history or abilities of the patients to be placed. The counsellor could play a very active role in the patients' occupational rehabilitation. It should be his and the supervisors' shared responsibility to become fully acquainted with the communities' potentialities. Both employment opportunities and contacts with community groups and leaders should be actively sought (such as churches, associations, clubs, settlement houses,

nationality groups). The interpretation of the FC program, the need for homes and jobs as well as knowing the recreational opportunities are all important. The choice of the first FC home in a new neighborhood and the rejection of applicants call for tactful handling for the future success of the program. Nurses and attendants know best the patients' routine, idiosyncracies, reactions, and behavior. These are helpful in preparing the FCMS for the patients.

Orientation of the staff and employees to the FC program:

Too often, the staff does not have sufficient information on the program and its functioning or they remain skeptical towards it because of negative experiences related by patients returned from FC. The staff's acceptance and cooperation with the program should be sought.

Temporary FC homes: They would avoid patients' discouragements at losing their trial visit status when, for reasons other than their mental conditions, they have to change homes. This is detrimental to the patient as well as uneconomical in the hospital's disposition of patients. It might well be found, as in the field of child placement, that some women excel at caring for patients on a temporary basis, whereas they would not desire or need to have them constantly in their home. Such homes could be used even at a later stage, when patients have no place to go to between periods of employment or in other anxiety provoking situations.

Location of FC homes: Efforts should be made to avoid homes too far removed from community centers as they cannot fulfill the needs of the program. Only custodial patients could use such placements, though for them too, it is undesirable to isolate them.

FC volunteer workers: Lay persons with an interest in FC could help to interpret the program to the community, serving as a link between it and the hospital. They could also, with supervision, serve as the equivalent of Big Brothers and Big Sisters, taking an active part in the patients' re-integration in the community.

Other factors which would enable FC to run smoothly are: The furnishing of adequate funds for the needs of the program and cars available to the FC supervisors.

## 2. Factors pertaining to the FCMS

Supervisor's relationship with the FCMS: The supervisor has to be able to accept, within the limits of admissible actions, the different ways in which individual FCMS will handle similar situations, and be able to accept their limitations and be able to work within them. He also needs to be aware of the flexibility of the family unit and inter-relationships. These factors may differ or be affected by the placement of FC patients in comparison with the situation at the time of application, so that the supervisor has to be alert to all signs of such changes and what they may entail for the

patients. He should also prepare the FCMS as to the type of behavior to expect and the patient's possible lapses, as they will be less defensive and more amenable to supervision once this is clarified.

Acknowledgment of their place and importance in the hospital's program: There is already under consideration the idea of giving the FCMS a certificate recognizing their position. It would give them both status and a sense of belonging. It may possibly provide them with incentive and initiative for their work.

A FC quarterly bulletin: It would serve as a link between the homes. FCMS would be asked to contribute stories, exchange of experiences, photos of activities done with their patients, etc. Staff members of the various disciplines could also be asked to bring their contributions. With their consent, news of former FC patients could be given, their achievements and progress serving as an encouragement to others. A section might be reserved for the patients, on a fly leaf or within the bulletin. Letters from past or present patients would interest them. As copies of the bulletin could be circulated in the hospital, it might stimulate both personnel and patients in regards to FC placements.

FCMS' meetings: This was discussed when this study was first started. Since then, steps have been taken towards its realization. As the homes are spread out over a wide area,

only a few meetings could be held, unless the future development of FC warrants setting up district meetings. Movies, talks, discussions on mental illness, handling of situations, exchange of experiences and many other subjects would be fitting for the meetings. The FCs could be asked for suggestions, opinions on the meetings held, and their collaboration in organizing them.

FCs' role in the patient's rehabilitation: The supervisor should help the FCs to understand how all events within the home have a therapeutic value to the patients and the demands this may put upon them. Also, the weight carried by the FCs' recommendation of their patients, to prospective employers, should be stressed as the latter may attach more importance to their relations with the patients than to anything the hospital might tell them.

The FCs' need for a vacation: Many FCs get discouraged, and some women never enter the program because the constant supervision of the patients does not allow them to get away. Arrangements could be made for outsiders, nurses or attendants to replace them for the duration of their vacation. FCs could maintain a greater interest in their work if given such relief. It might be worth considering some arrangement to have a person, screened and interviewed by the supervisor, come to "sit" half a day per week for FCs who have no relatives so that they could have a break throughout the year.

### 3. Factors pertaining to FC patients

Preparation of the patients for FC: This has many aspects. The ward doctor should make early referrals for FC placement before the patients become institutionalized. The plan should be discussed thoroughly with the patient by the ward doctor and social worker. His cooperation in the planning should be sought and some choice be given to him. An important step for the success of the placement is the social worker's contacts with the patients' relatives. After individual interviews, a joint session with the relatives and the patient, could be helpful in providing an all round explanation and clarification. Next, the patient should visit the prospective FC home, after which both he and the FCM would have a chance to discuss their mutual reactions. Before the placement, the patient should have all physical needs met, such as dentist, going to the beautician for female patients, receiving adequate clothing, and the patient's personal cleanliness should be rigorously checked by the ward attendants. Such items are important for the patient's self esteem, the FCMs' acceptance of them, and the hospital's reputation.

Relationships with the patient's relatives: These should be maintained throughout the duration of the placement to assure its continued success, as well as to prepare them for the patient's eventual return home or his need to get out on his own.

Shorter placements: These should be aimed for if the program is to be therapeutic.

Patient's communication with supervisor: The patients should have the assurance of being able to reach their supervisor.

Pocket money and financial incentive for employment: Pocket money should be supplied for patients not yet able to make efforts towards self employment. It would enhance their self-esteem. Once the patients are ready to prepare themselves for employment by whatever form of training or reeducation, they should be given some financial reimbursement throughout the period when their production does not yet warrant payment by an employer.

Sharing of their positive experiences: They could be encouraged to visit their friends at the hospital. This would be an additional help in counterbalancing the impressions made by the bitter and discouraged patients returned from FC.

Forming a "BSH - FC Alumni": This could be operated on the basis of the Chicago Recovery, Inc., program organized by Dr. A. Low, or on A.A. principles. That is, former FC patients would help present patients in their rehabilitation. Supervision would be necessary. This kind of service would be beneficial to both parties, as it would give additional assurance and self confidence to the recovered patients.

Accepted 8-2-56  
Katherine J. Jansen

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APPENDICES

## APPENDIX A

## LETTER OF INTRODUCTION

May 20, 1955

Dear Family Care Mother,

The good work achieved through your participation in our Family Care program and the great need for more such opportunities for our patients have urged us to give much thought and consideration to expanding and developing this service.

In view of this, and in collaboration with Mrs. Walsh and Wolf who are in charge of our Family Care service, we would like to make a study to find out how best to introduce new Family Care Mothers to this work and be of greatest assistance to them in undertaking it and the questions which may arise in so doing.

Your help in accomplishing this would be extremely valuable. The purpose of this letter is to solicit your cooperation by looking back upon the time when you started boarding our patients: What questions did you have about this work? What would you have liked us to tell you? How could we have been of better help and assistance to you? What are some of the difficulties and puzzling situations you were faced with at the time, was there anything we could have done to ease the situation? Were we sufficiently available to you should you have wished to call upon us for help or advice? These are some of the questions about which we would like your opinion and suggestions.

Should you be willing to help us in this effort to better understand and meet the difficulties new members may encounter by recalling the days when you became acquainted with this work, I would appreciate having the opportunity to come out and talk it over with you in the near future. Please let me know as soon as you conveniently can.

Thanking you for your cooperation,

Very sincerely yours,

(Miss) Genevieve TORCHIN  
Social Service

## APPENDIX B

## INFORMATION COLLECTED AT THE TIME OF APPLICATION

## IDENTIFICATION DATA:

	Date of application			
Name:	Birth Date:	Religious affiliation:		
Address:	Phone:			
Family constellation:	Name:	Sex:	Relation-ship:	Age: Occupation:

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

FCM's marital status:

## SOCIO-ECONOMIC FACTORS:

Physical set up of home:

Type of neighborhood:

Sources of income other than patients' board:

Social Index information:

Interests - recreation - community resources:

Previous occupation of FCM:

## INFORMATION CONCERNING FC:

Date applied:	Date started:	Number of patients at date of study:
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Preferences:	Sex:	Number of patients:	Age:	Nationality:
				Religion:

References:

Motives for boarding patients as stated on form:

Motives otherwise known (references - interviews):

How did they hear of program:



## APPENDIX D

## GUIDE FOR INTERVIEWS WITH THE CARETAKERS

- I. First mention the letter sent to FCMs with a brief explanation of the study and the writer's interest in their reactions to the program:
  - A. Their recollections of their early experiences with FC patients:
  - B. FCMs reactions to the various types of behavior of patients (fighting, soiling, etc.), their moods, actions. Which were more difficult to put up with and to handle?
  - C. Their opinion and suggestions in regard to new FCMs:
- II. How did they become interested in this work?
  - A. Material factors, i.e., financial:
  - B. Reasons for choosing FC patients:
    1. Factual Reasons: rules and regulations, number of patients allowed, all seemingly more flexible than in other settings.
    2. Personal reasons: Why mental patients? Had they had any previous contacts with them? What was their understanding of mental illness: If altruistic intentions given, why our patients rather than old people, children, blind, etc.?
- III. Specific questions asked the older caretakers and the younger caretakers:
  - A. Older caretakers:
    1. If they boarded children before, why did they change to mental patients?
    2. Why did they take boarders in the first place?
    3. If private nurses, how did they come to choose that profession?
    4. All other previous work done.

## APPENDIX D

(Continued)

5. How was their original understanding of mental illness brought out by working with the patient?
  6. Family constellation prior to their application.
- B. Young caretakers:
1. Recollections of parents' work in FC.
  2. Did they grow up with patients in the home? How did they feel about it at the time?
  3. Why and how did their parents start?
  4. How did they understand it at the time?
  5. How was it accepted by their friends and did it make them feel different from them?
  6. What was the attitude of other members of the family?
  7. At that time, what was their understanding of mental illness? Was it confirmed or changed by their FC experience?
  8. Their own children's feelings regarding the patients.
- IV. Common interests of family members in this work: Did they share the decision and participate in the work or did they just agree to FCM doing it?
- V. Common recreations, activities, daily experiences shared with the patients, i.e., meals, TV, living arrangements, activities in the home and outside of it.
- VI. Outside of this work, what are the interests and recreation of the FCMs and other members of the family? Did they share their outside interests together as a family or on an individual basis?
- VII. Relationship with their supervisor:
- VIII. Were they agreeable to a second visit, if possible?
- IX. In summing up have their FC experiences lived up to their expectations? What experiences have they had

## APPENDIX D

(Continued)

which might be helpful to others? Last ten minutes may be kept for direct questioning according to material covered and cooperation given.