Dorothea Dix's Liberation Movement and Why It Matters Today

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The attics and cellars of early America held a dark secret. People with serious mental illness languished in these hidden spaces, confined by families and communities with no recourse. The predicament of those confined in these spaces, which were practically dungeons, went largely unrecognized until the early 1800s, when a courageous advocate brought attention to their plight. Dorothea Dix exposed this dark secret of early American society and educated the public about a new approach to the treatment of mental illness that she discovered and gained experience with during her extensive travels. Although many noteworthy figures influenced the founding of asylums in the 19th century, Dorothea Dix was the one who convinced many state legislatures to pay for them (1). By doing so, she liberated many people with serious mental illness from neglect and inhumane conditions. The story of her quest is especially relevant today, faced as we are with a dilemma similar to the one Dix addressed in her time.

In the early days of the United States, mental health care was practically nonexistent. Families were expected to keep relatives with serious mental illness from disrupting the lives of others, which typically meant confinement of the individual in an attic, cellar, or shack. It was much the same as it was in Ancient Greece: "If someone should be mad," wrote Plato in *The Laws*, "he is not to appear openly in the city. The relatives in each case are to guard the persons in their homes" (2). If no relatives or neighbors assumed responsibility, the person with mental illness was confined in a hut built on the town common at public expense. In cities, authorities confined people with serious mental illness in jails or almshouses (3). At these places, one could expect a life in manacles, since restraints were the only way to manage harmful behaviors. There was little or no attempt at treatment, except perhaps for exorcism by a priest. People with mental illness could consider themselves lucky if the available therapies were merely ineffective—they were often brutal and harmful, guided as they were by superstition (1). Unless a member was afflicted with serious mental illness, most early American families were unaware of this hidden human suffering.

Dorothea Dix discovered this dark secret because of her interest in improving the lives of people living on the margins of society. As a nurse and teacher to prisoners, she encountered people with serious mental illness who were confined in jail. She described the abysmal conditions she witnessed: "In cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience" (4). Through her work in jails and prisons, Dix had an insider's view of the suffering of these people, which was hidden from others. She became an advocate for people with serious mental illness. Traveling from state to state, Dix inspected the various places in which they were kept, gathering evidence and statistics to portray the extent of the crisis to legislatures.

As Dix won the hearts and minds of her audience, she had an immense impact on national mental health policy. Her feat was especially impressive as this was a time when women could not vote. Her pleas to lawmakers evoked the plight of people with serious mental illness: "I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane, idiotic men and women; of beings sunk to condition from which the most unconcerned would start with real horror; of beings wretched in our prisons" (3). Dix did not rely on emotional impact alone; her petitions employed persuasive statistics and detailed evidence (5). The most remarkable thing about Dix's vision, however, was that it addressed not only providing humane conditions but also treatment for people with serious mental illness.

Reformers in Europe had recently created a promising new paradigm for the treatment of mental illnesses. It was originally known in France as *a traitement moral*. The best translation of the French word *moral* in English is "morale," and it connotes the psychological nature of the treatment rather than a sense of right and wrong (3). Regardless, this form of treatment became known as moral treatment in England, where Dix came across it while touring an asylum called the York Retreat (5). The facility impressed Dix with its humane alternatives to the brutality she witnessed in the United States. In brief, moral treatment entailed a highly structured environment in which patients were persuaded to internalize behaviors and social values as a method of recovery. In addition to occupational therapy, it included activities recognizable in the therapeutic milieu today, such as handicrafts and a form of art therapy. Harsh physical discipline, confinement, and restraints were avoided at all costs (3). When Dix launched her campaign, the concept of moral treatment was just becoming popular in the United States (1). Through this, Dix provided asylum superintendents with a beneficent alternative to the neglect and complacency she sought to replace.

The first asylums funded through Dix's campaign began accepting patients

in the 1830s, freeing scores of people from restraints (6). With an approach that incorporated elements of moral treatment, superintendents strove for more than humane custody; they sought to cure their patients. There is evidence that many patients improved and some even recovered (1). Despite this initial success, state hospitals were mostly shut down in the second half of the 20th century. The long journey for the establishment of these hospitals is another story (6).

Whatever flaws these American asylums possessed, it is worth noting that the Los Angeles County jail system is now the largest mental health care provider in the country (7). In North Carolina, a brand-new, five-story prison hospital for inmates with severe mental illness lies across the street from the shuttered Dorothea Dix Hospital (6). As many as 700 inmates with serious mental illness are currently incarcerated at Rikers Island in New York City (4). Our society may have a new dark secret: a large population of people with serious mental illness who are interned not in attics, cellars, and pens but in modern jails and prisons. They share the overall demographics of those caught up in the War on Drugs, three-strikes laws, mandatory minimum sentencing, and "broken windows" policing, not those of people transferred or released from state hospitals half a century ago (4). This difference suggests that it was not just deinstitutionalization but also mass incarceration that led to this predicament.

Hospitalizing these people in facilities designed to treat their condition offers several advantages over treatment in jails and prisons. Some law enforcement officials have done an admirable job of shouldering a task for which their personnel are not trained (4, 6), showing that a minimum standard of care can be achieved in a penal setting. However, although conclusive comparisons of health outcome are not available, it is difficult to see how institutions designed to control and punish can produce optimal psychiatric outcomes. Especially under such conditions, psychiatrists' duties to their patients and employers may diverge, resulting in ethical dilemmas. The cost of incarcerating a person with mental illness is already significantly higher than that for the average inmate, and this cost is likely to skyrocket due to a relatively recent ruling by the U.S. Supreme Court calling for upgrades. Furthermore, people with mental illness released from prison usually change their source of treatment, leading to gaps in care that almost certainly contribute to the higher than average rate of reincarceration of these individuals (8). Bringing back American asylums would probably be less expensive, as well as being less ethically fraught.

Most of the overwhelmed state hospitals were shut down in the second half of the 20th century. However, there are some enticing alternatives to them, some of which are reminiscent of moral treatment. For example, at the Gould Farm in Massachusetts, approximately 40 residents with serious mental illness tend to the fields and animals, prepare communal meals, and run a café and bakery as part of their treatment. Although this setting may not be feasible for patients with very severe illness, only 1% of people with serious mental illness pose a significant threat to themselves or others (6). Addressing flaws in how we pay for treatment would remove a long-standing disincentive for states to hospitalize such patients when needed. Such a reform could provide funding to chronically ill patients and allow them to access less restrictive (and less expensive) levels of care when possible, which will aid the transition from hospitalization to involuntary outpatient treatment and supportive housing without interruptions in treatment (9).

The decline of state hospitals coincided with the rise of mass incarceration. Together, they led to the imprisonment of many people with serious mental illness who would otherwise be in facilities designed to treat their conditions. Deinstitutionalization was really transinstitutionalization, and we have thus come full circle to the problem Dix faced in the 1800s. Once again, humane and effective solutions for the long-term care of people with serious mental illness are needed. There are mistakes to learn from, but with many people lacking access to treatment despite advances in it, perhaps it is time to get it right.

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