FROM HOME TO HOSPITAL:
ST. ANN’S INFANT AND MATERNITY ASYLUM,
1873–1983

The majority come to us not only to be fed and cared for, but even to be clothed as well. Often, if the family of the unfortunate girl be in a position to provide for her, it, as frequently in a time of trouble and disgrace, abandons her, and thus, she becomes an outcast.

Cleveland Catholic Diocese Archives, 1904

Sister Superior M. Peter may have exaggerated the destitution of these “unfortunate girls” in hopes of an increased subsidy from the Cleveland bishop, but as she suggested, the first patients at St. Ann’s Infant and Maternity Asylum were not only pregnant out-of-wedlock but dependent on Catholic charity. By the 1910s this asylum for outcasts spawned two separate facilities: a maternity hospital for married women and a separate facility for unmarried mothers, where the primary goal was spiritual and then psychological rehabilitation. The hospital closed in 1973. Ten years later the small home for unwed mothers did the same.

Like other hospitals, St. Ann’s began as a social welfare institution for the poor and became a medical facility for the middle class. But as married motherhood became a medical event, unwed motherhood retained spiritual rather than medical significance. The physical and moral segregation of unmarried women at this Catholic facility reinforced the definition of their motherhood as illegitimate.

HOSPITALS AND CHILDBIRTH

Until the very end of the nineteenth century, voluntary hospitals were religious or charitable enterprises, less medical than social service insti-
tutions, intended for and used primarily by the indigent.¹ Most health
-care, including childbirth, took place at home.

In their pre-industrial origins, hospitals were largely controlled by
nonmedical entities—religious orders or boards of trustees and philan-
thropists. These men raised the funds, made policies, and admitted pa-
tients. Consequently, except for the presence of doctors on their staffs,
hospitals resembled poorhouses and maternity homes in significant ways.
Some public hospitals, like Cleveland City Hospital, began as the medical
department of the poorhouse. “Dependence as much as disease” was the
criterion for admission.² The destitution and probable homelessness of
its patients meant that a hospital’s primary function was often simply
providing long-term shelter.

Hospitals played a marginal role in the health care of most Ameri-
cans for much of the century. Before the Civil War a doctor could practice
his whole life without ever going into a hospital.³ Further, because doc-
tors knew little about aseptic techniques and nothing about germs, hos-
pitals were unhealthy places. Lacking the facilities and the expertise to
diagnose and treat most illnesses, hospital staffs could provide little more
care than most patients could receive at home.

In the last decades of the century, hospitals underwent significant
changes. As doctors realized that hospitals could provide them with de-
sirable clinical practice on poor patients, as was the custom in the great
European medical universities, larger hospitals became teaching facilities,
often affiliating with the proliferating medical schools. The employment
by the 1890s of aseptic techniques made hospitals safer and more con-
venient sites for major surgery, the employment of new diagnostic tools
like the X-ray, and the treatment of acute illnesses. These new medical
strategies enhanced the role of doctors even as the rising costs of equip-
ment and staff, especially during the hard times of the 1890s, diminished
the ability of churches or pious philanthropists to pay the bills and con-
trol policies. At private hospitals medical purposes supplanted historic
charitable functions, and hospitals sought to replace their indigent clien-
tele with patients who could pay escalating medical costs.⁴

Childbirth—considered a natural, although sometimes dangerous,
female function—was slower than general medicine to move into a hos-
pital setting. During the colonial period American women gave birth in
their own homes and were assisted by midwives, whose approach to
child-bearing was noninterventionist because they had few tools with
which to hasten or ease the process. Even as fertility rates fell throughout
the nineteenth century, middle-class women gradually replaced midwives
with male doctors. Because few women could attend the medical schools
in this country or abroad, only men could boast of university-acquired
obstetrical training and specialized skills, especially with forceps, which might make birthing quicker and safer. For their part, male doctors were anxious to claim obstetrics as their own because it was steady work. The home remained the childbirth setting preferred by both patients and doctors.\(^5\)

The only institutionalized childbirths took place in poorhouses like the Cleveland Infirmary, the few private lying-in hospitals, or the maternity homes. The women patients were always destitute and sometimes unmarried, and therefore subject to discipline and moral reformation.\(^6\) The Cleveland Maternity Home, for example, although originally intended for "worthy women," served unmarried women as well, and its matron was required "to exert a religious influence over the inmates and hold some religious service each day," like the matrons in the maternity homes.\(^7\) Hospital childbirth consequently bore the double stigma of destitution and immorality.

Hospital childbirth was dangerous due to frequent outbreaks of puerperal fever, caused by doctors' carelessness about antiseptic techniques combined with their tendency to use instruments. Doctors themselves sometimes attributed high maternal mortality rates to the low morals of their patients, as one doctor explained to an 1877 meeting of the American Gynecological Society: "The majority of patients who seek the lying-in asylums are unmarried, and it cannot be doubted that this circumstance has a bad influence on their chances of recovery" from the ravages of puerperal fever. Little wonder that the doctor did not recommend hospital childbirth except "if the women are very poor, if they have filthy homes, if there are many children, a drunkard for a husband, or other disturbing influences." And less wonder that in 1900 only 5 percent of American women bore their children in hospitals.\(^8\)

**Catholic Charities and Catholic Sisters**

Hospitals were among the scores of Catholic social welfare institutions founded in the nineteenth century. Within the Catholic church, most social welfare activities became the women's work of Catholic sisters.

Fleeing the economic and political woes of their homelands, Catholic immigrants to the United States became disproportionately dependent on public and private relief. Because relief was often accompanied by a strong dose of Protestant proselytizing, Catholic charity sought not only to rescue fellow human beings from destitution but fellow Catholics from Protestantism. Catholic dioceses sponsored scores of institutions for their dependent co-religionists, especially hospitals and orphan asylums.\(^9\)
FROM HOME TO HOSPITAL

The primary dispensers of Catholic charity were the religious communities of sisters. Although almost invisible in standard histories of the Catholic church in the United States, sisters "outnumbered male church workers in the last half of the century in almost every diocese. . . ." There were almost four times as many nuns as priests by the century's close"—more than forty thousand.10 Few male religious orders immigrated to the United States, but Catholic patterns of settlement spawned more than a dozen American communities of nuns, including the Sisters of Charity of Emmitsburg (known after 1850 as the Daughters of Charity of St. Vincent de Paul), the Sisters of Charity of Nazareth, and the Dominican Sisters. From 1830 to 1860 these women were joined by fifteen European orders.11

Nuns came at the urging of local bishops to serve as missionaries to the heathen or caretakers of the dependent. In 1851, for example, the Sisters of Charity of St. Augustine were invited to Cleveland by its first bishop, Amadeus Rappe, to administer the city's first Catholic hospital. Uprooted from European communities, emigrating nuns braved the trans-Atlantic passage, the hostility of American Protestants, and the necessity of supporting themselves. The cloistered life of European orders did not prepare them for earning a living in the United States. For a few the challenge was too great: two of the original Sisters of Charity returned to their native France, overwhelmed by the foreign customs and speech of Americans and the enormity of their task.

Most nuns taught in the growing number of Catholic schools, but they also staffed the Catholic orphanages, homes for the aged and working women, and mental institutions. Nuns became best known to Protestant Americans as nurses: four hundred served on both sides of the Civil War. The Daughters of Charity opened the first Catholic hospital in the United States in 1832 in St. Louis, and by mid-century, as nursing began to professionalize, the care of the sick became an increasingly popular ministry for nuns. In the course of the nineteenth century, nuns administered 2,645 hospitals in the United States.12 The hospitals appealed particularly to a Catholic clientele fearful of the alternatives—the poorhouse or a Protestant voluntary hospital—and some were designed for a specific Catholic ethnic group.13

American Protestants were suspicious of nuns (as well as priests) not only because of their Catholicism and their peculiar garb, but because they rejected marriage and motherhood, central to American definitions of gender.14 The nonconformity of nuns was more apparent than real. Catholics who had joined, or aspired to join, the American middle class shared its admiration for the cult of true womanhood and for its female virtues of piety, domesticity, and subordination. Life in the convent "in-
stitutionalized the true woman’s attributes.” Although celibate, nuns exemplified “maternity of the spirit” as “brides of Christ” and, like Protestant matrons, played their own spiritual roles as teachers and moral exemplars. Like housewives, nuns provided domestic services like cleaning, cooking, and sewing for priests. Many areas of nuns’ lives were controlled by priests, bishops, or the pope. When lines of authority were not clearly drawn—and sometimes when they were—nuns and male clergy struggled over property ownership, the management of institutions, or the choice of religious superiors within communities. Cleveland bishop Richard Gilmour interfered in the election of the mother superior of the Sisters of Charity of St. Augustine in 1883–84, placed disobedient nuns under ecclesiastical censure, and deprived them of some of the sacraments; the sisters appealed to Rome but ultimately capitulated. But cooperation, not conflict, between nuns and male clerics was the norm, and nuns, like Protestant women, seldom challenged—indeed, probably revered and sustained—the male religious hierarchy.

Cleveland’s St. Ann's Infant and Maternity Asylum, 1873–1909

In various versions of the story of the opening of St. Ann’s in 1873, the leading role is played by a worthy widow, turned away from the Catholic hospital in the last throes of labor, or a Catholic girl, sequestered in the Retreat and refused the ministrations of a priest. Although neither tale may be strictly accurate, both reveal the asylum’s sectarian beginnings.

Bishop Gilmour, head of Cleveland’s Catholic community from 1872 to 1891, was at first reluctant to provide shelter for unwed mothers, fearing that this would imply diocesan sanction for illegitimate pregnancy. Pressing moral and practical considerations overcame his reluctance. Like the founders of the Woman’s Christian Association homes, Catholic clergy feared for the bodies and souls of young women in the city. The poverty and sexual vulnerability of Catholic women immigrants—for example, the Irish in the Cleveland poorhouse—made these fears well founded. Consequently, by 1870 every major diocese had built institutions where “the virtue and innocence of destitute females of good character might be shielded from the snares and dangers to which their destitution exposes them.” For women who had already succumbed to vice, the Sisters of the Good Shepherd opened nine convents before 1870, including one in Cleveland, where erring and wayward women were encouraged to repent and join the order of Magdalenes.
Catholic proscriptions against birth control and abortion also strengthened arguments for an asylum for unwed mothers. The number of abortions in the United States peaked in the 1870s, and abortionists and abortifacients became so readily available that they were advertised in popular magazines, including Protestant journals. Abortion until the time of quickening was legal in most states until a wave of anti-abortion legislation began in the 1860s. The Catholic church (in 1867), the orthodox medical profession, and organized women’s groups also opposed legalized abortion.

Illegal or self-induced abortions, however, remained a dangerous possibility. Contraceptives such as pessaries or douches were used by the middle class, but when the 1873 Comstock Law made distributing contraceptives or information about contraception illegal, these became even less accessible to working-class women. Until the 1910s, there was in fact little public support for the greater availability of contraceptives, and the Catholic church also opposed their use. With neither abortion nor birth control readily available, a woman pregnant out-of-wedlock might abandon or kill her infant to hide her shame. Several Catholic dioceses therefore opened foundling homes and, after 1870, homes for both mothers and children.

The perennial anxiety about Protestant proselytizing also encouraged the opening of a diocesan home for unwed mothers. The many Irish women in the Cleveland Infirmary, sometimes pregnant out-of-wedlock, were easy prey for Protestant missionaries from the WCA. Some did end up in the Retreat, susceptible to its evangelicism.

Pressured by sectarian competition, by the welfare needs of the rapidly growing Catholic population, and by the church’s prohibitions against family limitation, the bishop gave permission to the Sisters of Charity to establish St. Ann’s Infant and Maternity Asylum. This nursing order already administered several hospitals around the country, including St. Vincent Charity Hospital in Cleveland, behind which the asylum was built.

The rationale for St. Ann’s resembled that of other Cleveland maternity homes. The official historian of the Cleveland diocese, George F. Houck, explained the home as Charles Crittenton had his: “A censorious world may say, this is fostering crime; but no, it is the Savior’s own method: ‘Woman, neither will I condemn thee. Go, and now sin no more.’” With spiritual reclamation its goal, the asylum’s means included regular masses, special services on Catholic holy days, and visits and confessions by priests. As at the other homes, reclamation was women’s work under male direction. The nuns were spiritual exemplars, as
were the volunteers and matrons at the Protestant homes. The Catholic Universe explained: “The patients are served by the Sisters, who not only bestow upon them temporal blessings, but also fervently and silently pray that the fallen one like Magdalene, may repent and return to grace.”

The medical staff was all male and was appointed by the bishop, although the mother superior occasionally challenged an appointment. Doctors and medical students from Western Reserve University School of Medicine served at St. Ann’s without pay to gain valuable clinical experience, professional status, and possibly paying patients. Students needed the permission of both the house physician and the mother superior to examine patients. Unlike other Cleveland maternity homes, St. Ann’s did not allow women doctors to deliver patients there, at least through the mid-1920s.

Despite the free services of student nurses and doctors, nuns, and volunteers, the expenses of maintaining a growing physical plant and acquiring new medical technology continued to rise, and in the first decade of the twentieth century, St. Ann’s, like other private hospitals, began to seek paying patients. From 1888 to 1900, only 39 of the 249 women admitted to St. Ann’s were able to pay even part of their fees. By 1906, fully a third of the 365 patients were full-pay patients. Bishop Ignatius Richard Horstmann then approved the expansion of St. Ann’s facilities to accommodate those “who would be glad to pay a good sum” so that the institution might become more self-supporting.

Persuading respectable women to give birth in a hospital was not easy, and like maternity hospitals elsewhere, St. Ann’s began a campaign to recreate its public image. In 1910 the St. Ann’s house physician announced in the Cleveland Medical Journal that the hospital now welcomed private patients and their doctors. For many years, he conceded, St. Ann’s purpose had been “to care for unfortunate girls only . . . but in time the advantages of hospital care in confinement began to be recognized,” and married women sought admission as well. Anxious to dissociate the hospital from the stigma of unwed motherhood, he claimed that in the previous year, half the patients had paid full rates and that most of these were married. The article cited several advantages of hospital birth to doctors and patients. Doctors could conduct “labor cases of whatever nature, with . . . strict regard for cleanliness,” and could better control both patient and environment without the interference of midwives, family members, or domestic routines. “To the woman about to pass through the perils of childbirth,” St. Ann’s offered “not only all the safeguards of a completely equipped hospital but also all those home comforts which seem to be essential to this class of patients.” What class
the doctor referred to is implicit in the comforts he described: twenty private rooms, each of which had furnishings valued at five thousand dollars.  

HOSPITAL VERSUS HOME, 1910–1973

After 1910 married and unmarried women were housed in separate buildings at St. Ann’s. In 1918 St. Ann’s Infant and Maternity Asylum was renamed St. Ann’s Maternity Hospital, the “hospital” indicating its new medical mission, and the building for unmarried women became Loretta Hall. The physical separation of the two groups of women emphasized the growing differences in their treatment.

St. Ann’s Maternity Hospital flourished as middle-class women increasingly became persuaded that hospital childbirth was safe and less painful than birth at home without anesthesia. Only 26 percent of all registered births in Cleveland took place in hospitals or maternity homes in 1919; in 1930 that number increased to 60 percent. (See Table 4.1.)

St. Ann’s Maternity Hospital’s 141 beds made it the second largest maternity facility in the city (Maternity Hospital was the largest), and the vast majority of St. Ann’s patients were married women—90 percent in 1930. After the lean years of the Depression, the hospital enjoyed rising occupancies, and in 1951, filled to capacity by baby-boom births, St. Ann’s moved to a handsome building on a new site near Cleveland’s eastern suburbs, closer to the hospital’s potential clientele. This facility changed its name to St. Ann’s Hospital and in 1952 incorporated separately from the facility for unwed mothers and infants. The hospital had also become an important medical teaching institution with a large staff of interns, residents, and student nurses. In 1965, with the help of a large federal grant, the hospital added a 135-bed wing.

Loretta Hall, meanwhile, remained a social service agency directed by nuns, and one of forty-four Catholic homes for unwed mothers administered according to guidelines established by the National Conference of Catholic Charities. Founded in 1910, the conference was intended to bring Catholic social welfare agencies and institutions into line with professional social work standards. For example, it endorsed the policy of keeping mother and child together, using the rationale of Dr. Kate Waller Barrett and the Cleveland Conference on Illegitimacy. The National Conference, however, continued to stress the spiritual causes and cures for illegitimate pregnancy: “Many of these girls have become careless in their religious obligations, neglecting confession and Holy
Communion, but after they have made their peace with God . . . then they are ready to begin the uplift in their lives,” the director of a maternity home in Pittsburgh told her conference audience in 1931.36

In Loretta Hall the religious mission remained paramount. An unwed mother received spiritual instruction, attended evening chapel, and was encouraged to join the Sisters of the Good Shepherd as a Magdalene. Even if she was not a charity patient, she was required to work in the home and the infant nursery. As at the Retreat and the Florence Crittenton Home, these domestic chores were justified as essential to moral rehabilitation, but the work also helped pay for a woman’s six- to eight-month confinement. Visitors were limited to family and “young men if marriage [was] imminent.” 37 In 1939 Sister Annette, director of Loretta Hall, told the annual Conference of Catholic Charities that although patients at the home received the same medical care as did the patients at St. Ann’s Hospital (“some of our finest married women in Cleveland”), at Loretta Hall “the real work is in that invisible world of human souls where only God Himself can estimate its value.” 38

However, like the hospital three decades earlier, the home began to change its clientele in the wake of the Depression. In 1935, the great majority of the inmates at Loretta Hall were domestic servants, with a few factory workers and waitresses. This working-class profile corresponds with data in the Federation’s 1936 Bolt Report and with information collected in 1914 and 1923 by the Federation. (See Table I.2.) 39

This clientele could not pay for or even work off its lengthy confinements in the maternity homes. Because Ohio did not fund maternity home care

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FROM HOME TO HOSPITAL

TABLE 4.1
PLACES OF BIRTH, CLEVELAND, 1930

<table>
<thead>
<tr>
<th>Living Births</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total for the City</td>
<td>17,895</td>
</tr>
<tr>
<td>Total Home Cases</td>
<td>7,416</td>
</tr>
<tr>
<td>Total Hospital Cases</td>
<td>10,479</td>
</tr>
<tr>
<td>Maternity Hospitals</td>
<td></td>
</tr>
<tr>
<td>Booth Memorial</td>
<td>64</td>
</tr>
<tr>
<td>Florence Crittenton</td>
<td>15</td>
</tr>
<tr>
<td>Mary B. Talbert</td>
<td>55</td>
</tr>
<tr>
<td>Maternity</td>
<td>2,293</td>
</tr>
<tr>
<td>Retreat</td>
<td>20</td>
</tr>
<tr>
<td>St. Ann’s Maternity</td>
<td>1,285</td>
</tr>
<tr>
<td>Cleveland City Hospital</td>
<td>836</td>
</tr>
</tbody>
</table>

Source: City of Cleveland, Department of Public Health, Annual Report, 1930 (Cleveland, 1930), 36.
for dependent or medically indigent women, all homes remained entirely privately funded.

By the early 1940s, the Federation, as a primary source of funds, began to pressure the homes to raise rates—which were then fifty dollars for women from within the county, seventy-five dollars for out of county, and $100 for out of state (Mary B. Talbert Home charged less)—and to collect more money from clients. The homes, accustomed to behaving like charitable institutions, protested but eventually acquiesced.40 The homes did not exclude women who could not pay because the Federation required them to take dependent clients. However, the rising fees obviously limited the number of women who would be likely to apply.

This trend toward a middle-class clientele, noted already at the Florence Crittenton Home, was encouraged by two other factors. First, private health insurance, which helped to cover rising medical costs, was available primarily to middle-class clients. In addition, the new insistence by social workers that maternity homes encourage adoption made them attractive to middle-class women, who were often more reluctant than working-class mothers to keep their illegitimate children. Consequently, by the late 1950s, the inmates of the Catholic home, like those at the Florence Crittenton Home, were no longer working-class dependents but middle-class paying clients: “middle-middle”-class women, “90 percent white Catholic,” from families who preferred placing an illegitimate child for adoption to an early and unsuitable marriage.41 The two Salvation Army homes in Cleveland had a similar clientele.42

Despite their middle-class backgrounds, unmarried women remained physically and morally segregated from married patients. When St. Ann’s Hospital moved to the suburbs, the facility for unwed mothers, now DePaul Infant and Maternity Home, stayed in the old central city location. At DePaul, women were still treated as though they were charity patients, required to work in the home and nursery. There were sound economic reasons for this because maternity home confinements were still long: in 1960 the average length of stay at DePaul was three months, and many clients stayed longer.43

More significant was the cruel difference in the definitions of married and unmarried motherhood, especially in the context of the postwar baby boom. Making up for time lost during the Depression and World War II, Americans rushed to marry and have families. Birth rates reversed a century-and-a-half-long decline as married women had third and fourth children. Although women continued to enter the paid work force in record numbers, the nineteenth-century cult of domesticity enjoyed a revival as the “feminine mystique,” the belief that marriage and motherhood defined woman’s identity.
Affirming its historic conservative position, the Catholic church had opposed both woman suffrage and then the Equal Rights Amendment when it was first introduced to Congress in 1923 on the grounds that they would endanger home life and women's traditional roles. In the postwar period, Catholics, like other Americans, sought to reassert the importance of family and female domesticity, founding, for example, the Christian Family Movement. In 1948 and 1949 pastoral letters from the American bishops described the family as "a divine institution that human will cannot alter or nullify."\(^{44}\)

In this context, motherhood without marriage represented shocking deviance. Accordingly, the Catholic maternity homes found particularly congenial the new medical definition of pregnancy out-of-wedlock as symptomatic of psychiatric disorder. As the psychiatric consultant to DePaul explained in the early 1960s, many of the middle-class "girls" came from families that had a "history of internal conflict. . . . Some girls verge on the psychopathic and others, at least on the surface, appear to be . . . well controlled with their essential problem appearing in the area of the management of their sexual impulse." An unwed pregnancy, he concluded, "might be equated with suicide."\(^{45}\)

The psychiatrization of unwed motherhood had its origins in the 1910s, when illegitimacy was occasionally blamed on the feeblemindedness of immigrant or working-class women who did not score well on the IQ tests administered sporadically by maternity homes and other social agencies. In 1917 a psychologist reported to the annual gathering of the National Conference on Social Work that unwed mothers were far more likely than a "law-abiding group of working women" to score badly on a "card sorting test" or an "easy opposites test."\(^{46}\)

During the 1920s, influenced by the work of Mary E. Richmond and Mary C. Jarrett and the popular vogue for Freudian psychiatry, social casework moved in the direction of psychological diagnosis and treatment and placed renewed emphasis on psychological services to unwed mothers. In 1928 the Cleveland Conference on Illegitimacy heard a psychiatrist recommend both psychological testing and psychiatric counseling for unwed mothers.\(^{47}\) However, none of the maternity homes employed a psychologist during the 1920s.\(^{48}\) In the post-Depression period, as psychiatric social work became a prestigious specialty, psychodynamic casework was especially recommended for child-placing and child-guidance agencies, and psychiatric or emotional problems became almost the only professional justification for institutionalizing children, as the Cleveland orphanages had realized some decades earlier.\(^{49}\)

By the mid-1950s, psychodynamic interpretations had finally come to dominate social workers' thinking on unwed motherhood, for two
reasons.\textsuperscript{50} First, such interpretations explained the otherwise inexplicable behavior of the illegitimately pregnant white, middle-class women who had become the clients of maternity homes and social agencies. Secularly trained professionals could hardly rely on the nineteenth-century interpretation of illegitimate pregnancy as a fall from God’s grace. Environmental explanations relying on cultural deviance or economic deprivation, such as those advanced by the U.S. Children’s Bureau in the 1920s, did not seem to work either.

From the new psychoanalytical perspective, sex without marriage could be attributed to a woman’s personality disorders. The caseworker at the Florence Crittenton Home explained some of her clients’ pregnancies this way: “——— has been an unhappy person who feels that neither of her parents really care what happens to her. . . . ———— is a typical product of county child welfare homes, a very passive, conforming youngster, who has had little in life and is uncertain as to how she can get anywhere,” or “——— had a very unfortunate marriage that ended in divorce soon after the birth of her daughter. She has never since then been able to get hold of herself or put any real direction in her life. She is very sorry for herself and bursts into tears at the least provocation.”\textsuperscript{51}

Second, although phrased in scientific terminology, the psychiatric approach was by no means antithetical to the traditional religious approach to illegitimate pregnancy and in fact provided added justification for traditional treatment: the lengthy confinements, now described as necessary for therapy; the separation of mother and child and subsequent adoption; and the use of professional social workers.

The psychological diagnosis of unwed motherhood received the enthusiastic endorsement of Catholic and lay professionals in the Catholic Charities Review as well as secular social work journals. Writing in the Review, DePaul director Sr. M. deMontfort explained “pregnancy out-of-wedlock as a result of symptomatic behavior” and the DePaul program as “a constructive treatment for the illness of which sexual behavior is the symptom.”\textsuperscript{52} In 1965 Sr. Joseph Marie, the director of social services at DePaul, stressed the “changed philosophy” of maternity home care. In 1920, she said, the home’s purpose was “to care for unmarried mothers and their more unfortunate offspring”; today, however, “since science is beginning to understand more clearly the psychological patterns which often lead to pregnancy out-of-wedlock, the entire living experience at DePaul is focused on treatment.”\textsuperscript{53}

Exactly as in professional casework, there was probably more lip service than application of modern policies. An account of daily activities at DePaul suggests that little had really changed. On Easter Sunday in

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1960, the "girls all wore becoming Easter hats and corsages. . . . Sister and girls sang hymns all through Mass." DePaul and the other maternity homes added psychiatrists to their consulting staffs and psychiatric consultation to their list of available services, but the psychiatrists actually spent little time at the homes and gave primary assistance and direction to the staff rather than to the mothers. The DePaul psychiatrist was usually on site only an hour and a half a week. A 1965 survey of maternity homes across the country revealed that in only 5.7 percent of the institutions did all inmates receive psychological testing and in only 2.1 percent did all inmates receive psychiatric evaluation at admission. In 59.5 percent of the homes, no inmates received evaluation.

The psychiatric approach also had the allure of being potentially publicly funded because of federal legislation in 1966 that provided monies for the building or maintenance of state mental health programs. In 1969 DePaul joined with the Florence Crittenton Home and Booth Hospital in the Maternity Home Mental Health Consortium. The consortium was supposed to provide new psychiatric, psychological, and group therapy to unwed mothers, putative fathers, and families. The project received one year's funding from the Cuyahoga County Board of Mental Health and Retardation and operated for a second year with funds from the Cleveland Foundation. Even with this financial support, the consortium could employ only two part-time and one full-time psychologists to conduct personality inventory testing and group therapy. There was never enough money to hire even a part-time psychiatrist for the consortium's clients, most of whom were white, middle-class, Catholic, and probably from DePaul.

The ineffectiveness of this approach, or at least of its implementation at DePaul, is illustrated in an article in a DePaul newsletter probably written in 1972. The writer, a young mother, described "group counseling every week to help us help each other so that we may be able to make the decisions that are best for us." This meant the decision to put their infants up for adoption. The writer, however, had not internalized—or at least could not verbalize—the psychiatric explanation of her pregnancy: "Expecting and bringing a child into the world is the most wonderful experience in life. Because it is happening at an unfortunate time, I am thankful I found DePaul."

In 1969 annual admissions to DePaul dropped to 138 after holding steady at about 170 from 1961 to 1968. Home administrators blamed the decline on higher fees mandated by the Federation. Pressured itself by social welfare activists to provide more services for the poor but caught in budget shortfalls of its own, the Federation in 1971 turned over responsibility for the allocation of monies to the United Torch. United
Torch was not any more interested than the Federation had been in supporting services for middle-class white women, and in 1972 it cut its allocation to DePaul because "it is not appropriate to continue allocation of scarce community resources to low and declining community needs."  

CONCLUSION

In 1973, a century after the founding of St. Ann's Maternity and Infant Asylum, St. Ann's Hospital closed its eight-year-old building. Its sister facility for unwed mothers survived for another decade, but ultimately neither could outlast changing sexual behavior and birth control technology.

In 1973 the DePaul Home became DePaul Family Services. It retained twenty beds for unwed mothers but offered primarily outpatient services such as day care, health care, and counseling. In 1976 the residential unit admitted only forty-two women. In 1983 this small facility at DePaul, once part of the city's second largest maternity hospital, also closed. The Catholic diocese continued to offer unmarried mothers outpatient medical care and counseling in Cleveland or maternity home care elsewhere in one of the few remaining Catholic homes for unwed mothers.

Loretta Hall/DePaul had flourished partly because of the large Catholic population of northeastern Ohio and partly because of close identification with the medical services of St. Ann's Hospital. Although the treatment of married and unmarried mothers became different, both facilities initially benefitted from the medicalization of childbirth that began at the turn of the century. In the 1960s, both became victims of the medicalization of family planning as birth control devices became widely available and widely used. During the 1920s and 1930s the laws prohibiting the distribution and sale of contraceptives were modified in many states in response to legal challenges from feminists like Margaret Sanger, the acceptance of birth control by the medical community, and Americans' Depression-born desire to limit family size. After the baby boom, however, the middle class opted again for smaller families, an option made easier by the availability of the contraceptive pill. Birthrates dropped as rapidly in the 1960s as they had risen through the 1950s. The emerging women's movement made reproductive rights a key demand, and a sexual revolution, evidenced in rising rates of premarital intercourse, made legal means of family limitation a necessity. There was also growing public concern about a rapidly increasing world population and about poverty in the United States.

Family planning, in short, became viable social policy. In 1965 fed-
eral legislation provided funds for family planning programs, and the 1973 Supreme Court decision *Roe v. Wade*, permitting abortion under certain conditions, was followed by the establishment of abortion counseling facilities and clinics. The Cleveland Federation first supported family planning in 1966 and in 1971 endorsed “programs of effective contraception for unmarried women” and “abortion on request for those who wish it and have no religious or other moral objections” as means to “reduce illegitimacy.”

The Catholic church did not alter its opposition to birth control or abortion. The Florence Crittenton Association waived its original objections to family planning and abortion in the late 1960s, and the Salvation Army okayed birth control in 1972 but has remained opposed to abortion. Opposition to family planning had historically provided one of the significant intellectual and moral justifications for maintaining Catholic maternity homes and outpatient services such as those at DePaul. By the early 1970s, the prohibitions against family planning that had sustained the maternity homes made them irrelevant to their secular funding sources such as the Federation or state and federal governments.

More important, maternity homes became irrelevant to the middle-class clientele they had cultivated. These women—even Catholic women—had easy, legal access to birth control and abortion, and married or unmarried, could effectively control pregnancy. According to John d’Emilio and Estelle B. Freedman, although 70 percent of American Catholics conformed to church teachings on birth control in 1955, by 1970, encouraged both by the theological ferment of the period and the growing availability of birth control, “nonconformity among Catholics had jumped to 68 percent.”

Historians have documented the movement of childbirth from the home to the hospital and its results: the “masculinization” of childbirth as female midwives were driven out of business by male obstetricians; the increased use of intrusive medical techniques in delivery; the necessary rationalization of the hospital setting to prevent infection; and the patient’s loss of control over the birthing process to the doctor and the institution.

These mixed reviews most accurately describe childbirth for middle-class married women, for unlike the nuns at St. Ann’s Infant and Maternity Asylum or the pious matrons of the Retreat and the Florence Crittenton homes, historians have assumed that all child-bearing women had husbands. For unwed mothers the hospitalization of childbirth had different implications. Maternity homes, like hospitals, may have changed from charitable to for-profit institutions, but homes never became medical institutions, and childbirth out-of-wedlock never became a wholly
medical event but remained charged with spiritual significance. The moral and physical segregation of these mothers, like their early removal from the poorhouse, the lack of public funds for their institutional care, and the lack of professional staff, was further punishment for their sexual misconduct. Sexual deviance even outweighed class differences, as illustrated by middle-class women’s treatment as charity patients.

In the longer run, the demarcation between married and unmarried received dramatic definition in the changed meaning of motherhood. Although considered a lapse from grace, unwed motherhood had been credited with having redemptive powers by rescue workers like Kate Walker Barrett and social workers at the Cleveland Conference on Illegitimacy in the 1910s and 1920s. In 1933, at the sixtieth anniversary of St. Ann’s, Cleveland bishop Joseph Schrembs eulogized the unwed mother, “who has enough of the truth in God in her, enough of the spirit of faith in her, she [would] sooner bear the scar on her breast than to stain her hands with the blood of her unborn child.”66 In the psychiatric vocabulary of the postwar years, however, an unwed mother was no longer a lapsed saint but a disordered personality, and moreover, one that there was not time or money enough to heal.

Finally, the expenses of medicalization, far greater than the expenses of professional social work, meant that after the Depression maternity home services would be available to fewer of the charity patients for whom St. Ann’s and the other homes were founded. By the late 1960s, women who became pregnant out-of-wedlock were most often those who had less access to birth control or abortion, the poor and black women whom the private sector had served least.