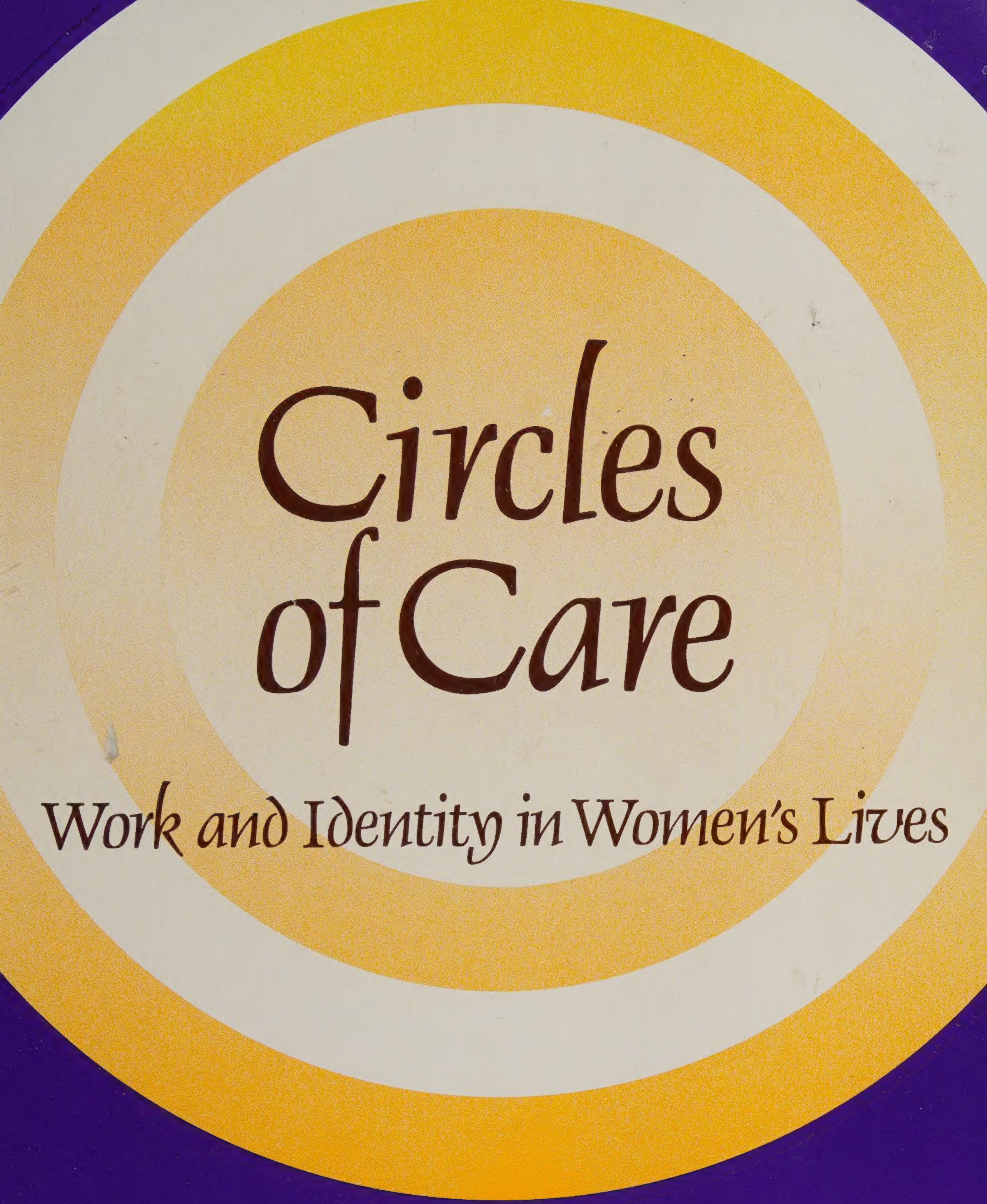

Circles of Care

Work and Identity in Women's Lives

Edited by
Emily K. Abel and Margaret K. Nelson

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CIRCLES OF CARE

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edited by
Emily K. Abel
and
Margaret K. Nelson

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Authors' prefaces are generally testaments to caring. We hope this book as a whole serves such a purpose.

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Part I

Theoretical Issues

Preface

Caregiving has been the subject of intense controversy among feminist scholars. Since the publication of "The Female World of Love and Ritual: Relations between Women in Nineteenth-Century America," by Carroll Smith-Rosenberg in 1975, some feminist writers have sought to describe a unique women's culture centered around caregiving. More recently, Carol Gilligan's book *In Another Voice: Psychological Theory and Women's Development* (1982) has sparked a line of writing concerned with elucidating women's special connection to an ethic of care. Although such scholars emphasize the positive aspects of caregiving in women's lives, another large group of feminists argues that caregiving is oppressive to women. Because most feminist writing about caregiving has ignored the social and historical contexts within which caregiving occurs, the two sides in this debate remain far apart.

The essays in this volume explore how specific settings shape both the nature of caregiving and the rewards that can be reaped from this activity. Many of the authors rely on qualitative methodologies, including participant observation and in-depth, open-ended interviews, which enable them to capture the experiential features of caregiving. But the essays are not limited to such types of data: they include as well theoretical overviews, historical investigations, and quantitative studies based on survey research. The authors represent a range of disciplines, including sociology, anthropology, history, political science, public health, education, nursing, and social work.

The first section in this volume contains two theoretical essays. The following three sections include essays grouped according to the location of care: the domestic domain, formal organizations, and the informal economy. The fifth section explores the intersections among these different settings.

The volume opens with an introductory essay by the editors which begins by defining caregiving, underlining the significance of this topic and reviewing some major feminist perspectives on this issue. The editors then delineate the characteristics of the specific contexts within which care is provided, demonstrating how each affects the experience of caregivers and the type of care that they render. Finally, the introductory essay addresses the relationships among caregivers in different settings and notes the dilemmas experienced by caregivers who operate in more than one setting.

Fisher and Tronto expand the discussion of some of the issues raised by the editors' introductory essay. These authors begin with a critical review of the major theoretical writings on caregiving. They then define caring as "a species activity that includes everything that we do to maintain, to continue, and to repair our 'world' so that we can live in it as well as possible." In the second section, the authors describe each of the four closely related phases of caring—caring about, taking care of, caregiving, and care-receiving. They argue that social arrangements fragment the caring process because individuals with divergent interests are responsible for different phases and because the resources necessary to care are unevenly distributed. The authors' detailed examination of three contemporary modes (or contexts) of caring—the household, the market, and the bureaucracy—illustrate these interrelated problems. In the final portion of their chapter, Fisher and Tronto analyze three relational models that feminists have invoked to develop an ideal of caring and consider the difficulties in using such models as the basis for our vision of the "good" society.

DOCUMENTATION

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1

Circles of Care: An Introductory Essay

Emily K. Abel and Margaret K. Nelson

Caregiving is an activity encompassing both instrumental tasks and affective relations. Despite the classic Parsonian distinction between these two modes of behavior, caregivers are expected to provide love as well as labor, "caring for," while "caring about" (Graham 1983; Ungerson 1983; Waerness 1984). Caregiving also is an essential activity. The social fabric relies on our ability to sustain life, nurture the weak, and respond to the needs of intimates.

This book examines the experience of providing care to children and to disabled and chronically ill adults, and thus differs from most writing about caregiving, which focuses on the care recipients, not the providers. As a society that enshrines the virtue of independence, defines instrumental work as superior to emotional work, seeks to distance itself from basic life events, and devalues the activities of women, we have tended to ignore the experience of caregivers.

It is particularly important to focus on this topic now because a constellation of events is transforming the nature of caregiving in our society. Increasing numbers of women are entering the expanding service sector as child care workers, nurses, home health aides, and social workers. As a result of cutbacks in public funding for human services, however, the burden of care for mentally ill and disabled persons is being reimposed on individual households. Simultaneously, the growth in women's labor force participation and the rise in single-parent households are compounding the problems of rendering care in the domestic domain. Finally, the aging of the population is altering the shape of informal caregiving responsibilities: many women can expect to spend a larger portion of their lives caring for elderly parents or ill spouses than for small children.

Despite these changes, caregiving continues to be a practice associated overwhelmingly with women. Because the sexual division of domestic labor remains firmly entrenched, women care not only for children but for disabled friends and relatives. More than 70 percent of caregivers to the elderly are wives and adult daughters (Stone, Cafferata, and Sangl 1987: 626). Women also dominate caregiving occupations in the public arena; for example, they represent 98.4 percent of nursery school and kindergarten teachers, 97.4 percent of child care providers, and 96.5 percent of registered nurses (Hacker 1983:127).

Feminist reformulation of basic issues can help to capture the meaning and nature of caregiving. A central accomplishment of feminist scholarship has been to demonstrate that concepts derived exclusively from the study of men's lives are inappropriate to women's experiences. It can be shown that the dichotomies between autonomy and nurturance, reason and emotion, and public and private are particularly irrelevant to the reality of caregiving.

Autonomy and nurturance are interconnected in three ways. First, as Carol Gilligan has argued, because women's identity in this society is inherently relational, caregiving can lead to maturity and self-development (Gilligan 1982; see also Miller 1976).[1] Second, caregiving requires self-integrity as well as a sense of connectedness. If caregivers must be attentive and responsive, they also must have the personal strength to make decisions about what they perceive others' interests to be and to take care of their own needs (Noddings 1984; Waerness 1984). Third, good caring fosters the independence and autonomy of people placed in dependent positions. Caregivers seek to preserve the dignity of care recipients and to encourage their growth and development.

Caregiving also challenges the division between reason and emotion. In the private arena, we provide care to those to whom we feel intimately bound. Moreover, there is a strong emotional component to the mode of thinking caregivers employ. Several feminist writers have sought to define a type of thought which incorporates emotion and intuition as well as reason. Kari Waerness writes:

> There exists something that should be called the "rationality of caring," of fundamental importance for the welfare of the dependents, and at the same time different from and to some degree contradictory to scientific rationality.... To accept a conceptualization like "the rationality of caring" is to go against the mainstream in western philosophy and sociology which are dealing with rationality and emotionality...as two mutually exclusive qualities of human action. (1983)

Similarly, Sara Ruddick remarks, "There is a unity of reflection, judgment, and emotion. This unity I call 'maternal thinking' " (1983a:214). Ideally, caregivers apply knowledge gained through intimate understanding of a particular individual rather than through abstract principles, and they learn through practice and example rather than through instruction. Nevertheless, they formulate and adhere to rules, hone skills, and seek to fulfill an ideal.

Finally, caregiving transcends the bifurcation between public and private. Women perform similar caregiving activities in the domestic domain and the public arena. Specific tasks shift back and forth between one realm and another. Events in each sector shape the nature of caregiving in the other. Informal caregivers spend a significant portion of their time mediating between the two spheres, linking household members to outside services.

If feminist scholars agree about the need to dissolve major dualisms long accepted as natural in Western thought, they disagree about the place of caregiving in women's lives. One group, emphasizing the instrumental component of caregiving, views this practice as oppressive to women. A basic tenet of socialist feminism, for example, is that women's work in the home is reproductive labor. This phrase helps to make visible women's hidden labor and calls attention to the benefits the capitalist economy derives from women's daily activities. By rearing children, women both replenish the labor force and imbue future workers with the characteristics capitalist employers demand. Like factory work, caregiving often involves a series of boring, repetitive, and alienating tasks. Socialist feminists also argue that, for most women, caregiving is not a freely chosen activity; a variety of material and ideological forces compel them to provide care. Women's caregiving responsibilities, in turn, help to explain their disadvantaged position in the labor market.

A second group of feminist scholars, emphasizing the emotional component of caregiving, views this activity in a far more positive light. They assert first that the intense emotional involvement of many women in caregiving activities suggests that they are not simply assuming assigned roles. As noted, writers such as Miller (1976) and Gilligan (1982) argue that caregiving is meaningful and fulfilling to many women. Second, they contend that the experience of providing care is humanizing. According to this argument, caregiving makes us better people—more attuned to the needs of others, more socially responsible, more capable of sustaining a variety of intimate connections.[2] Some members of this group have gone so far as to view caregiving as the model on which to reconstruct society. The characteristic thought and practice cultivated by caregivers, they argue, should be extended to the larger social arena (Ruddick 1983b). Third, they state that, when caregiving is distinguished from personal service, many of its most oppressive aspects vanish. Those who provide personal services are members of subordinate groups in society who operate from a desire to please others and win their approval; they cannot anticipate receiving equivalent aid in return. Caregiving, by contrast, is rooted in reciprocity. Caregivers of children have once been young; caregivers of the infirm expect others to care for them when they are in need. Unlike providers of personal services, caregivers are motivated primarily by a concern for the well-being of those they tend (Gilligan 1982; Waerness 1984).

The views of both groups are inadequate. While the first helps to strip caregiving of sentimentality and to illuminate the links between the public and private spheres, it ignores the most vital and distinctive aspects of caregiving. This activity involves the texture of human connectedness, not simply tasks and burdens. Although the second view helps to deepen our understanding, it also contains a number of pitfalls. The emphasis on the personal fulfillment women derive from caregiving shades easily into a celebration of differences that serve as the rationale for women's inferior position. The practices of caregivers cannot easily be writ large. Nor is caregiving an appropriate model for all social relationships. Caregiving fosters exclusivity and privatism rather than a sense of collective responsibility; intense preoccupation with one or two individuals often eclipses concern for the broader community.

Moreover, the views of the second group run the risk of enshrining activities that are entwined with women's subordinate status. As Eli Zaretsky has written, "It is a tragic paradox that the bases of love, dependence, and altruism in human life and the historical oppression of women have been found within the same matrix" (1982:193). In practice, caregiving often cannot be disentangled from personal service. In a society riven by divisions of class, race, and gender, relationships of mutuality are difficult to achieve. In both the domestic domain and the waged labor force, most caregivers are members of subordinate groups, who provide care from compulsion and obligation as well as warmth and concern. This leads to the final point: many writers who idealize caregiving ignore the social and historical contexts within which it occurs. Only by examining caregiving within specific settings can we understand what it actually entails and the meaning it has in women's lives. The following section of this chapter delineates the characteristics of specific contexts, demonstrating how each affects the experience of caregivers and the nature of their endeavor.

THE CONTEXTS OF CARE

The different contexts within which care is provided can be distinguished along three major dimensions: relationship of the caregiver to the recipient of care, payment, and location of work. We look first at caregivers who have a prior relationship to care recipients formed by bonds of kinship or friendship. These "informal" caregivers generally offer care within privatized settings without receiving payment. Such care often is viewed as the model to which all caregivers should adhere. We discuss caregivers to the elderly, the chronically ill, and the disabled, as well as parents of nonhandicapped children. Despite the persistent belief that families have abandoned the sick and the old, such care remains centered in the domestic domain. Studies repeatedly demonstrate that family members provide 70 to 80 percent of long-term care to the elderly (Comptroller General of the United States 1977; Stone et al. 1987); two-thirds of severely mentally handicapped children live with their parents (Gilbert 1983:121).

We turn next to two major groups of caregivers in the public arena. The first provides care in formal organizations. We explore the ways in which various features of social service agencies shape both the experience of rendering care and the capacity of caregivers to deliver good care.

Another major group of paid caregivers works within the informal economy, offering care in private settings—either their own homes or those of their clients. We refer to these caregivers as *unaffiliated providers*. After explaining why a significant portion of paid care in our society is located in the informal economy, we explore the extent to which unaffiliated providers can control their own employment situations.

In the final section, we consider the way caregiving tasks shift from one arena to another and the consequences of these shifts for caregivers.

DOMESTIC DOMAIN

Caregiving in the domestic domain is easily romanticized. Caregiving is embedded in intimate relationships that have histories and futures. Caregivers work according to the preindustrial clock and can deliver services at times dictated by human needs. Moreover, caregiving is divorced from the cash-nexus. Because informal caregivers reap no extrinsic rewards, their work more often can be construed as a labor of love.

Final Payments, by Mary Gordon, richly evokes the world of familial caregiving. Isabel's willingness to spend the years between nineteen and thirty caring for her impaired father strikes her contemporaries as "unusual, barbarous, cruel" (1978:2). The devotion she feels for her father, however, dignifies her decision. As she later remarks, "If those years were lost to me in ways that are impossible to calculate and impossible to regain, I knew why. I did this for the person I most loved, with the passion of mind and soul that he reserved for God" (p. 41).

But not all caregivers in the private realm feel a sense of special connection with the recipient of their care. As Hilary Graham writes, "Caring . . . is experienced as a labour of love in which the labour must continue even when the love falters" (Graham 1983:16). Some caregivers deliver services out of fear and obligation, not only out of affection and concern. Moreover, strong bonds between caregivers and care recipients can hinder the delivery of care. In a study of informal caregiving in Great Britain, Clare Ungerson found that adult daughters could render care only by ignoring the intense emotions this activity aroused: "They could care only if they cut themselves off from feeling altogether and simply got on with the tasks at hand. In other words, in order to care *for* their parents, they found it easier to forget about caring *about* them" (1987:116). In her autobiographical account of caring for her mother with Alzheimer's disease, Marion Roach (1986) admits that because her sister did not love her mother, she often could render far more appropriate care. The intensity of intimate relationships also can create a highly charged atmosphere, fostering tensions and conflicts as well as solicitude and warmth.

The domestic domain can have still other disadvantages for caregivers. Family members who are on-call all hours of the day easily can be engulfed by caregiving responsibilities. Moreover, caregiving in private households tends to be a solitary experience. The movement of productive labor out of the household emptied homes and left the women who remained bereft of companionship. As Jean Baker Miller comments, caregiving, as with many other activities in which women engage, is "removed from the life of one's time.... To nurse the old, the sick, and the disabled, is taking care of those who are temporarily or permanently retired; raising children is an involvement with those who are not yet in the main action" (1976:74).

Nevertheless, the outside society profoundly affects caregivers at home. A central target of feminist criticism is the intrusion of experts into the relationship between mothers and children. We have noted that caregiving involves a distinctive pattern of thought that can be learned and practiced, but which differs sharply from scientific rationality. As professionals have gained authority over mothering, however, childrearing has been subjected increasingly to scientific control. Alison Jaggar remarks, "In spite of their variety, the methods of scientific childrearing all share two assumptions. The first is that the child is a product which has to be produced according to exact specifications. The second is that mothers are ignorant of how to rear children and have to be instructed by experts" (1983:312).

The direction of professional advice has followed the changing contours of domestic caregiving responsibilities; the increasing dominance of parental care in women's lives, for example, has spurred the creation of a new enterprise devoted to counselling relatives of the disabled elderly.

Because most accounts of caregiving at home focus exclusively on mothering nondisabled children, it is important to highlight the activities of other informal caregivers. Most obviously, the demand for their services may be far more intensive and relentless. They also may be required to perform tasks commonly regarded as unpleasant, such as feeding and toileting adults. In addition, their work is becoming increasingly technological. A recent article in the *New England Journal of Medicine* reports: "Techniques previously used only in institutions have been adapted for use at home. Intraveneous lines, both central and peripheral, for the administration of parenteral nutrition, chemotherapy, antibiotics, narcotics, and occasionally, cardiac pressor agents have become commonplace in home care" (Koren 1986:917). The father of a severely impaired infant commented that "the price of bringing [him] home was to fill his parents' house with enough medical equipment to open a small clinic" (Adler 1987:59). Some relatives of the disabled elderly are responsible for care that is more complex than that which licensed vocational nurses are permitted to manage in hospitals (Estes and Arendell 1986:18).

Caregivers of sick and disabled persons also interact with an unusually large array of professionals. In her account of the experiences of parents of disabled children, Helen Featherstone notes that they often are barraged with advice:

> Physical therapists design programs for parents to carry out. Occupational therapists suggest better ways to feed, dress, and bathe the child. Doctors perform corrective surgery. Nurses describe a regimen of postoperative care which parents implement. Teachers try out educational strategies in the classroom and explain the importance of consistent home follow-up. (1980:113)

Even so, the isolation of caregivers who are not mothers of able-bodied children may be particularly intense. Ties of friendship often prove fragile. Almost none of the dozens of caregivers to the mentally ill interviewed by Phyllis Vine (1982) for her book *Families in Pain* received assistance from friends. In fact, the parents Vine interviewed often avoided former friends, fearing that they would be scorned or misunderstood. Linda Crossman, Cecilia London, and Clemmie Barry quote a women caring for an ill husband: "We were prisoners in our own home. Who can you talk to? Old friends and even family, they just don't understand" (1981:466).

Gaps in welfare services have a particularly severe effect on caregivers for the sick and the old. Although we have criticized the insensitivity of some experts, the primary problem of many caregivers is their inability to obtain any assistance at all. The proponents of deinstitutionalization of the mentally ill envisaged the creation of a vast network of community services, but family members often search in vain for adequate halfway houses, therapeutic residential centers, day hospitals, and outpatient services (Vine 1982). Noninstitutional services for the chronically ill also are fragmentary. Howard A. Palley and Julianne S. Oktay (1983) have concluded that more than 70 percent of disabled elderly persons in the United States live in states where the level of home health and homemaker services is inadequate. Data garnered by the 1982 National Long-Term Care Survey reveal that, despite the substantial burdens shouldered by family caregivers to the frail elderly, just 10 percent rely on any formal help (Stone, Cafferata, and Sangl 1987).

If the experience of caregiving differs dramatically according to the needs of the care recipient, it also varies according to factors of class and race. Several researchers have argued that economic necessity compels many working-class and racial minority households to pool resources and share tasks; as a result, caregiving may tend to be less isolating (see Rapp 1982). However, caregivers in these groups frequently have more intense demands placed on them. Because the incidence of chronic disease and disability is higher among poor people and members of racial and ethnic minorities, a larger proportion of these populations need care. And caregivers in low-income families are less likely to have access to services which ease their burdens.

Although the phrase *informal caregivers* refers to friends as well as relatives, we know little about the way care provided within the context of friendships differs from that delivered by kin. Because friendships are established voluntarily and are anchored in equality, are they more likely to provide the basis for reciprocal care? (see Acklesberg 1983). Friendships often lack the emotional intensity of kin relations, which increases the risk of conflicts and violence. But is the intensity of family life also a precondition for sustained caregiving? Lillian Rubin argues: "There's a limit to what we expect from friends. . . . Friends *choose* to do what kin are *obliged* to do. . . . Thus kin still seem to most of us to offer a safe retreat, an anchor in an uncertain and unsteady world—the people who can be counted on when need is most urgent" (1985:22). A study of caregivers to highly impaired elderly persons in 1986 found that 12 percent of the caregivers were not related to the care recipients (Stephens and Christianson 1986:25).

Other researchers note that friends render less care than family members and experience less stress. Moreover, friends typically provide help only when kin are not available (Horowitz 1985:201). Women have a more extensive web of relationships than men and their friendships are characterized by greater emotional intensity. Lesbians may be especially likely to be surrounded by a supportive network of friends. In order to enlarge our understanding of caregiving within the domestic realm, we should investigate situations in which friends do provide a strong base for support when things go seriously wrong.

FORMAL ORGANIZATIONS

The enormous expansion of the service sector has altered the nature of caregiving in our society. Many caregiving activities previously provided in the domestic domain have been transferred to the waged labor force. The great majority of service workers are women, who perform for pay jobs that are closely akin to those they leave at home.[3]

Arlie Russell Hochschild recently coined the phrase *emotional labor* to describe work that involves the processing of people and requires the display of feelings of warmth and concern. As she explains, "The emotional style of offering the service is part of the service itself...; seeming 'to love the job' becomes part of the job" (1983:6–7). But many social service jobs call for the expression of genuine feelings. Although the profound emotions evoked by mothering have been analyzed abundantly, we have yet to explore how caregivers employed by formal organizations experience their work. To what extent do they bring to their jobs the skills and patterns of behavior they developed in the domestic domain? How do they compare the relationships they create with clients to those they form at home? What meaning do they construct from the services they render on the job?

If research on such topics has lagged, some studies do suggest that many caregivers in the waged labor force are drawn to their jobs in part by the desire to provide a service (Fisher, this volume; Lipsky 1980; Lundgren and Browner, this volume; Sexton 1982; Withorn 1984), and that they derive job satisfaction primarily from their emotional attachment to their clients (Browner 1985; Waerness 1984). The context within which they work, however, may prevent them from fulfilling their ideal of good care.

As Ann Withorn writes, "The dominant reality for most service workers is bureaucracy, with its hierarchy, its specialization, its rules, and its constant quest for functional rationality" (1984:159). Caregiving fits uneasily into bureaucracies. Bureaucratic institutions operate on the basis of a set of general rules, but the essence of caregiving is attentiveness to the individual. The following quotation highlights the conflict between the universalism of bureaucracies and the particularism of caregiving:

> A nurse has been closely watching a post-operative patient whose psychological depression has been impeding his recovery. For days he has been silently brooding, unresponsive to all efforts to make contact with him. Finally, one evening he begins to respond to the nurse, talking about his worries and concerns for the first time. As she sits with him, listening sympathetically, using all of her interpersonal skills to support his emotional catharsis, she feels that this is one of those rare and precious moments when she is really "doing nursing" in the way she was trained.
>
> Unfortunately, just after the patient began talking, the dinner trays came up from the kitchens. It is dinner time, the food is getting cold, the other patients are hungry and restless. Organizational efficiency requires that patients be fed at a certain time. But if the nurse leaves her patient to serve dinner to the others, the patient may withdraw into his shell again. The optimal time for talking to an emotionally troubled surgery patient cannot be regimented, controlled, or even predicted. (Quoted in Cherniss 1980a:87)

In applying general rules, bureaucracies seek to expunge uncertainty, but caregiving is intrinsically unpredictable. Caregivers must be able to tolerate ambiguity and instability, adapt to changing needs, and foster growth and development. Although caregiving can occur only within the context of personal relationships, bureaucracies destroy links between workers and clients.

Moreover, bureaucracies compel workers to act on the basis of standardized techniques. This problem is exacerbated by the hierarchical structure of bureaucracies that separates conception from execution. Thus, staff are prevented from applying personal knowledge about the needs of their clients or drawing on their own experiences.

The performance measures on which bureaucracies rely illustrate these general problems. Such measures tend to bear little relationship to the quality of care provided. An elementary school teacher describes the work involved in administering tests and charting the results:

> A couple of years ago, they developed a reading checklist in this district. Each year you are supposed to check off what the child has accomplished during that year in your classroom. They developed a math checklist, and we have to give what is called a test of essential skills in reading, and that's supposed to measure their progress. Then we enter all the stuff on the checklist. And they have these little punch cards that during the year you're supposed to punch out each time they've learned something in math, and then you fill out the little checklist at the end of the year. . . . All of these things are absolute killers for teachers, and personally, I don't think they are valid. (Freedman, Jackson, and Boles, n.d.:5)

Moreover, recordkeeping typically fails to capture the reality of either the client's progress or the process of care. Reducing a client's complex situation into precise quantitative measures inevitably involves distortion. The relationship between caregivers and recipients of care also eludes calibration. Timothy Diamond (this volume), a sociologist who worked as a nursing assistant in a nursing home, comments:

> In the course of the work there is much that nursing assistants do that is not charted or chartable. Not the least of this is the constant social, emotional work of caring for residents who, in the midst of loneliness and confusion, are often in great need of human contact. Yet, in the charts . . . caring work remains invisible and unnamed. It is not officially recorded or rewarded; whether and how it is to be done is passed on only in an oral tradition.

Still other features of social service agencies retard the work of caregivers. It has become almost a truism to note that human services advance the goal of social control. The personal attachment many staff hope to form with their clients thus conflicts with the social engineering objectives of the agencies that employ them. Because they are expected to make delivery of care contingent on client performance, caregiving becomes part of the regulatory mechanism (Wrigley, this volume).

The medicalization of human services presents additional problems. For example, although nursing home administrators frequently claim to provide individualized care for the whole person, their institutions cater primarily to the physical needs of their residents; the definition of such residents as "mentally ill" and the heavy reliance on medications can impede the development of meaningful relationships between caregivers and care recipients (Diamond, this volume). Nurses aides—who deliver the overwhelming bulk of direct patient care—find that the emotional component of care can occur only in the crevices of "bed and body work" (Gubrium 1975).

Two recent and related developments have aggravated the difficulties of delivering care in all human service organizations. First, as a result of cutbacks in public funding, agencies are placing a premium on efficiency and cost-effectiveness. Many seek to reduce costs by imposing or raising productivity standards and increasing routinization in the processing of clients.

Second, proprietary enterprises are penetrating the human service field.[4] Although the consequences of the rise of for-profits on the actual delivery of care remain largely unexplored, some evidence suggests that organizations dedicated to profit maximization are especially likely to sacrifice the needs of their workers and undermine the possibility of providing care. For-profit hospitals may reduce staff-to-patient ratios and convert full-time nursing positions into part-time slots. Many rely on registry nurses, who lack any sense of community with either their patients or coworkers (Dallek and Lowe 1985). More seriously, the business model demands that caregiving be converted from a human service into a commodity. Timothy Diamond's (1988) ethnographic study of nursing homes explores this process. The operators of the facilities within which he worked sought to remove caregiving from human relationships and reduce it to a series of easily measured tasks.[5]

Because most caregivers occupy subordinate positions, they exert little control over institutional priorities. Occupations acquire status by shedding caregiving tasks. Upwardly mobile professions increase their ranking by laying claim to a distinct body of scientific knowledge and spurning the mode of thought employed by informal caregivers. Individual career advancement relies on a separation between the emotional and physical aspects of caring: for example, subordinate workers tend to the physical needs of hospital patients, thus freeing those with more training to respond to emotional needs. Advancement is ultimately contingent on relinquishing responsibility for the work of caring altogether. Nurses, social workers, and elementary school teachers advance their careers by becoming supervisors and administrators and relegating direct client care to others (Larson 1977). As a result of this process of individual and group mobility, most people engaged in the hands-on work of caregiving occupy low-level positions.

Nevertheless, the status of caregivers is far from uniform. Caregivers can be situated along a continuum that ranges from social workers and elementary school teachers at the top to nurses aides and attendants at the bottom. The various impediments to caregiving we have delineated affect workers in different statuses in different ways.

The claim of professional staff to unique expertise gives them a measure of prestige and independence. Although they remain subjugated to bureaucratic relations of authority, they often can carve out a sphere of autonomy and exercise some discretion. But, if professionalism can mitigate some aspects of bureaucracy, it intensifies others. All professionals learn codes of behavior that enable them to distance themselves from clients. Thus, bureaucratic norms of impersonality and emotional detachment are reinforced.

The working conditions of low-level employees retard caregiving in other ways. As Sacks notes in this volume, workers in these jobs are often in a prime position to render holistic care by coordinating the activities of a complex bureaucracy. However, they find themselves in a double bind. Because they are denied authority, acting on their knowledge can be the cause of reprimands from those higher up. So too, however, can failure to act. They are vulnerable to current cost-containment policies that entail workload increases and reliance on part-time staff. Not surprisingly, their work is marked by high turnover rates which, in turn, hinder the development of close, caring relationships.

The social status of clients also varies dramatically. Human service organizations constitute a highly stratified system. For example, while some nursery schools and day care centers serve a predominantly white, middle-class clientele, others cater overwhelmingly to working-class and minority children. Although the original intent of Medicaid was to allow the poor to enter the mainstream of health care, most office-based physicians shun Medicaid recipients, who thus are relegated to a separate stratum of practitioners. The sizable uninsured population receives care almost exclusively in hospital emergency rooms and outpatient clinics. Because for-profit institutions seek to capture wealthy patients, the privatization of health care is reinforcing the class structure of the health delivery system.

In short, both caregivers and recipients of care vary by gender, class, and race. When higher-status workers provide care to working-class and minority clients, caregiving shades easily into social control. When marginal workers deliver care to white, middle-class clients, caregiving tends to embody significant elements of personal service.

How do workers respond to the various constraints imposed by the organizations within which they work? Just as few researchers have examined the expectations service workers bring to their jobs, so we know little about their reactions to the obstacles they encounter. Nevertheless, various studies have correlated institutional rigidities with stress and burnout. As personal commitment wanes, some workers seek other types of employment. Some of those who remain gradually assimilate to the bureaucratic mold and become emotionally detached from their clients. Despite the idealism and altruism that originally may have motivated them, they deliver a mechanistic form of care (Cherniss 1980a, 1980b; Pines and Maslach 1978). To such workers, the demand by clients that they demonstrate the warmth and concern traditionally associated with caregiving may appear simply another oppressive feature of their jobs.

But organizational rationality and impersonality can advance as well as retard the interests of caregivers. Bureaucratic structures provide built-in limits to jobs. For example, if nurses who entered hospital employment surrendered control over their hours and caseload, they also gained protection from patients' problems and demands. Before 1940, the predominant form of employment for nurses was private duty. Because such workers lacked clear job structures and worked in privatized settings, their jobs easily were confused with those of mothers and domestic servants. Differences in social class made them particularly susceptible to the whims of their clients. Facing a patient population composed largely of their social superiors, they felt compelled to meet expectations of personal service. Many thus welcomed the routinization of the hospital setting, which helped to insulate them from their patients' requests (Melosh 1984; Reverby 1987).

According to Ann Swidler (1979), the loss of institutional constraints had severe disadvantages for the "free school" teachers she studied. Without set rules and prescribed roles, they had no way to prevent their students from encroaching on their free time. Moreover, they lacked mechanisms to limit their emotional involvement in their students' lives. Many veteran teachers who had withstood the bureaucratic rigidities of traditional schools for many years succumbed to burnout after a relatively short stint in alternative institutions.

We have seen that the values and structures of most institutions impede the work of caregivers. Although bureaucracies protect their employees by imposing limits, in all other respects they hinder the delivery of care. But delineating outside constraints should be only the first step in any analysis.

Scholars writing about women in a wide variety of settings have demonstrated that they participate actively in determining the conditions of their lives. Recently, some scholars have pointed to the *work cultures* created by women employed in different workplaces. As defined by Susan Porter Benson (1978), a work culture involves "the ideology and practice with which workers stake out a relatively autonomous sphere of action on the job, a realm of informal, customary values and rules which mediate the formal authority structure of the workplace and distance workers from its impact." In many instances such cultures have enabled women to resist oppressive conditions of employment (Lamphere 1985; Zavella 1985). In this volume, Lundgren and Browner demonstrate that a work culture can also support a commitment to empathetic care and provide a basis for mutual support among workers. However, as Lundgren and Browner suggest, this may be possible only under certain conditions. We should ask what happens to employees whose jobs provide few occasions for informal socializing, limited freedom from supervision, and minimal opportunities for worker solidarity. We should also ask whether a work culture can be linked to broader strategies for effecting changes that ensure protection for the needs of both workers and clients.

UNAFFILIATED PROVIDERS

Much of the paid work of caring takes place outside the boundaries of formal organizations. As unaffiliated providers, women offer care to a broad range of individuals: children, disabled and chronically ill persons, the frail elderly, and women giving birth at home. Two factors make calculating the size of this work force almost impossible. First, many unaffiliated providers offer their services off-the-books, and thus their activities are not documented by the economic measurement techniques of our society. We can count the number of regulated family day care homes for small children or the number of licensed board and care homes. However, we have no way of determining the number of women who offer unregulated family day care in their own homes or work as aides and attendants for disabled persons living at home. Second, many unaffiliated providers may offer more than a single service to an employer. A domestic worker, for example, may be engaged to tend small children, cook, and clean. This variety of tasks is concealed by a single census designation, thereby making it impossible to assess the extent to which such workers are employed to provide care. We do know, however, that the demand for such workers is enormous. For example, in the winter of 1984–85, only 25 percent of employed mothers used organized child care facilities for their youngest child under the age of five (U.S. Department of

Commerce 1987:4). Partly because organized home care services are inadequate, many frail elderly and disabled persons rely on home attendants whom they hire through informal arrangements.

Why does so much care work fall between the waged work of formal organizations and the unpaid work of family and friends? To some extent the location of care work in the informal economy[6] results from a supply of labor. Some individuals with the skills and credentials to obtain "good jobs" in agencies prefer to work in the informal economy where they can evade bureaucratic structures (Melosh 1982). A lay midwife attending a home birth can respond to the individual woman without worrying about the timetables that structure the hospital experience (Rothman 1983). A woman who runs a private preschool in her own home need not engage in extensive recordkeeping or limit her activities to those considered appropriate to her position in a hierarchical structure. Others view providing care within their own homes as a desirable means of making a living while meeting the needs of their own families. This choice clearly is conditioned both by an ideology of familial responsibility for the care of dependents and by the structural features of the formal economy that make it difficult to combine paid employment with adequate care of dependents. But most people who work in the informal economy have no real alternatives. For those tied to the home by the need to provide care for an aged or infirm relative, or for those who find that the costs of employment outside the home (including child care, transportation, appropriate clothing) outweigh the benefits, some form of home-based work may be necessary. Many workers lack the credentials that would enable them to move easily into institutional positions; many undocumented immigrants find themselves excluded from the formal economy entirely. Still others, such as lay midwives, offer services that fall outside the boundaries of what is legal.

The inadequacies of our welfare programs in the United States also help to push caregiving into the informal economy. Government funds for many caregiving activities are either extremely paltry or completely nonexistent. For example, the government offers limited direct financial assistance for dependent care through the Social Services Block Grant (formerly Title XX of the Social Security Act), but the number of clients supported through such funding always has been small, and the funding was cut substantially in recent years; in 1985, twenty-four states were serving fewer children than they had in 1981[7] (Blank and Wilkins 1985:9). People in need of such care are forced to fend for themselves, often making private arrangements with individuals who are not connected to agencies.

Although profit-making enterprises have penetrated the health care field, they eschew caregiving activities which are not heavily subsidized by the government. Most forms of caregiving cannot turn a profit. Because caregiving is a labor-intensive activity, it tends to be expensive. Moreover, it is purchased by people with limited financial resources. Elderly persons relying on Social Security or fixed pensions and disabled persons living on Supplementary Security Income cannot afford to offer generous salaries. Many women believe they can justify paying outsiders to care for family members only if their own salaries cover the cost; because most women's work is poorly paid, they must look for providers who charge extremely low rates.

The location of care is also determined by personal preferences. Although social ideology certainly plays a role in shaping these preferences, many people have legitimate concerns about whether institutions can render the personalized care that women in families traditionally have provided. Thus, even when cost is not an issue, parents often express a desire to find in-home care or care in home-like settings for small children (Davis and Solomon 1980).[8] Families of frail elderly persons continue to provide care at home long after they might reasonably have been expected to consider nursing home placements.

The following discusses various types of unaffiliated providers who offer care in the informal economy.[9] Like staff members in formal organizations, unaffiliated providers receive payment. However, they are paid directly by clients (or relatives of clients), and both their wages (or fees) and working conditions are subject to personalized negotiation. Like privatized care providers, unaffiliated providers typically offer care within a domestic arena—either their own homes or those of their clients—but they usually are not bound to the recipients of care by ties of family or friendship.

To be sure, enormous variations exist among unaffiliated providers. Social status is one major variable. At one end of the spectrum are trained educators running private preschools in their own homes; at the other end are private domestic workers who combine child care or care for the elderly with household labor. Those who work in offices or their own homes generally are self-employed and receive fees for providing services; those who work within their clients' homes are more likely to be engaged in a form of personalized wage labor. Finally, these workers differ in terms of legal status. Some care providers operate completely legal businesses; others, such as unregistered day care providers or lay midwives, work at the margins of legality; still others are undocumented workers who live in fear that they will be reported to authorities. These variables of social status, employment status, and legality all have consequences for the capacity of caregivers to control the shape of their work and the demands placed upon them.

Caring in the informal economy differs from caring in both institutional settings and the family. In theory, these differences enable unaffiliated providers to create optimal working conditions and offer high-quality care.[10]

Many unaffiliated caregivers—particularly those at the high end of the pay scale—can exercise individual control over the selection of clients served. Thus, lay midwives may exclude from their clientele women who refuse to abide by their standards of good health practices, particularly if they feel that accepting such clients will create the risk of exposure (Rothman 1982); family day care providers may limit their clients to children no longer in diapers or those who require full-time care. Unaffiliated providers may also drop clients with whom their relationship has soured. The setting is free from bureaucratic requirements controlling both the hours and pace of work. Moreover, unaffiliated providers are unlikely to have to negotiate around tasks, such as recordkeeping, which compete with care. No superior evaluates performance. They thus may be free to develop an individual style of care based upon personal experience and knowledge.

But the broader context within which unaffiliated providers work generally limits these freedoms. If the demand for their services is low, they cannot pick and choose a clientele. Although they stand outside of the formal economy, their hours may be determined by the needs of clients who work as wage laborers and their pace by the necessity of taking on large numbers of clients. Moreover, their work is not free of conflicting demands. Those who care simultaneously for their own and other people's children must decide who receives priority. (Such conflicts are particularly acute for women compelled to leave their own children with relatives or unattended while they care for other women's children.) Like many mothers, providers who either work in their own homes or are employed as domestic workers find that activities such as cooking and cleaning compete with the delivery of care. And the demands of clients for particular types of care may prevent them from relying on their own expertise or intuition.[11] To the extent that providers rely on individual employers for references and recommendations to other clients, they have an additional incentive for complying with these demands.

Possibilities do exist for unaffiliated providers to establish long-term and intimate relationships with the recipients of care. Family day care providers speak of their sense that individual children have become like one of the family and of painful loss when these children "graduate" into formal educational institutions or move away (Groves 1983; Nelson, this volume). Although this emotional openness is a prerequisite to good care and meaningful work, it can function to the detriment of the caregiver. As Shellee Colen suggests, some clients use the rhetoric of family love to manipulate workers:

> Often used to explain why members of the *same* family should sacrifice for one another, here [the ideology of family] is used to encourage people who are *not* family members to perform tasks or to tolerate treatment that may

> be exploitative. The image of family is called up to soften the edges of wage labor in personalized situations. (1986:60)

But the family ideology may not be introduced solely for the purposes of eliciting greater emotional involvement on the part of the caregiver. A woman who feels hesitant about passing care for a child or other family member onto someone else may need to justify her decision with the argument that the other person really "does care." When providers demand payment for extra services, their difference from family caregivers becomes clear.

Providers, in turn, have their own reasons for undervaluing their services. Some hope to retain their clientele by demonstrating that their care is a "labor of love." Others form strong attachments to their clients and share the widespread belief that care should be "freely" given. Barbara Katz Rothman, for instance, reports that most home-birth midwives "saw their work more as a series of favors" than a straight business proposition, and that they formed lasting friendships with the women they assisted (1982:232). We need to know more about the ultimate effects of giving care for which providers are so minimally reimbursed. Do providers eventually resent being underpaid? To what extent do they begin to restrict care to the tasks for which they receive direct payment?

Not only are the wages of unaffiliated providers subject to negotiation, they are also low and frequently unpredictable. Those who serve people with limited resources cannot command high fees. Moreover, the minimum wage provisions of the Fair Labor Standards Act omit much of this privatized care. Even when the work is covered, noncompliance is the norm (U.S. Department of Labor 1981:19). There are no paid vacations or other benefits. Because clients tie reimbursements to services rendered, a provider's income is immediately (and frequently without warning) cut off when clients go on vacation or fail to need the provider's services for several days. Many are compelled to accept large numbers of clients in order to piece together a living wage.

There are other areas of vulnerability. Unaffiliated providers are likely to be of lower social status than their clients; many are members of ethnic and racial minorities and serve a predominantly white clientele. Without the protection of an institution that sets rules for *both* clients and providers, the latter have little recourse when clients abuse the relationship by arriving late to relieve the provider or demanding special favors.

Unaffiliated providers may also be more directly vulnerable to the state. Those who operate at the margins of legality live under the threat of license revocation or prosecution; those with uncertain immigration status need to maintain a good relationship with an employer who may act as a sponsor for a green card (Colen 1986). Such situations increase the power of clients who might use the tacit threat of reporting them to give added weight to their demands. Even those who run legal businesses are subject to spot checks and selective application of rules.

Finally, unaffiliated providers share many of the disadvantages of caregivers in the domestic arena. They generally work in isolation from colleagues and, indeed, from any other adults.[12] Because no special training is required for the tasks of many unaffiliated providers, their work often is considered "natural."

OVERLAPPING RESPONSIBILITIES AND INTERSECTIONS

Although we have differentiated caregiving in three separate contexts, two groups of caregivers bisect our tidy divisions. Volunteers provide unpaid care in both formal institutions and the domestic domain. Despite their lack of remuneration, they are not bound to the recipient of care by prior ties of kinship or friendship.

A variety of different groups has exalted the virtues of volunteers as caregivers. Social reformers in the mid-nineteenth century asserted that middle-class volunteers should establish "friendships" with the poor, guiding them to acquire appropriate patterns of behavior (Abel 1978). The argument in support of volunteer work emerged in a different form in the 1960s and early 1970s. Founders of the alternative institutions which flourished during that period hoped to equalize relationships between service providers and their clients by substituting volunteers for paid professionals (Case and Taylor 1979). During the 1980s, the New Right touted the ideal of volunteerism as a means both of reducing government outlays for human services and reasserting traditional family values. But we know little about the extent to which payment alone changes either the relationship between caregivers and the recipients of their care or the meaning of this activity in the lives of caregivers themselves. Like friends, volunteers have the option of withdrawing when the tasks become overwhelming. We should explore just what binds volunteers to this work when family obligations and financial incentives are absent. The impact of social class differences on the experience of volunteering also needs greater investigation. Data from the U.S. Census Bureau confirm the traditional stereotype of the volunteer—married, college educated, upper middle-class women (Staff of House Subcommittee on Human Services 1980:74). To what extent are services provided by volunteers tinged with elements of social control? As increasing numbers of women enter the labor force, have many tasks previously accomplished by volunteers been left undone?

Some waged caregivers are employed by formal organizations but work in private settings on a daily basis; these include home health aides and attendants, visiting nurses, and both physical and occupational therapists.[13] Although nurses and physical and occupational therapists bring considerable skill and status to their jobs, the overwhelming majority of home care workers are untrained; they typically are paid at minimum wage rates, and many lack fringe benefits (*Black Box* 1987; Oriol 1985). A recent study found that 99 percent of home care workers in New York City are women; 98 percent are members of racial minority groups, and almost 50 percent are immigrants. A very high proportion are single mothers with three or four children. Eighty percent cannot afford adequate housing, and 35 percent often cannot buy enough food for their families (Donovan 1989).

Some of these agency personnel may be able to establish relationships which last for longer periods and entail greater responsibility than is possible for caregivers in formal organizations, which serve a constantly changing clientele and fragment staff into distinct shifts. But economic constraints have compelled many home care agencies to adopt such cost-cutting measures as increasing work loads and hiring per diem workers (*Black Box* 1987:75). The high turnover rates of many home care workers also prevent the development of continuous relationships with clients.[14] In addition, the influx of for-profit agencies may mean that business goals tend to dominate the delivery of care.[15] Finally, the work of home care workers often is constrained by reimbursement patterns, which tend to emphasize skilled nursing care, not personal care services.

Recently, national attention has focused on the quality of care delivered by home care workers (*Black Box* 1987; Rosenblatt 1987:13). As the Homecare Quality Assurance Act of 1986 declares, home care quality is a "black box—a virtual unknown" (*Black Box* 1987:7). Because the work of these caregivers is invisible and often unsupervised and because they tend to be some of the most vulnerable members of society, the opportunities for abuse are legion. Governmental monitoring systems for home health care are sorely inadequate (*Black Box* 1987). But little attention has been directed to the way in which the caregivers themselves experience their work. Rather than viewing themselves as being in control of dependent persons, do some feel powerless because they are "guests" in the homes of their clients? Are a significant number subject to abuse? Because they lack visible institutional backing, do they have difficulty ensuring client compliance with medical regimens? How do they respond to patient needs for services that are obvious to them but are uncovered by most third-party payers?

An analysis of volunteers and home health workers illustrates the difficulty of confining caregivers to predetermined categories. Neither group fits comfortably in any one context. Moreover, caregivers themselves often operate in more than one setting. Many women begin their days by fulfilling their domestic caregiving responsibilities, move into the formal or informal economy where they render care to nonfamily members, and then return home to resume domestic obligations. The chapter by Nancy L. Marshall et al. in this volume shows that providing double caregiving duty increases vulnerability to stress. Other critical issues, however, remain largely unexplored. As Chiara Saraceno comments, "Very little is known about the split many women experience in themselves, between being family members performing services for their families, and being professional workers performing analogous services for pay and for others" (1984:15). To what extent do women believe they are performing the same activities at home and at work? What distinctions do they draw between their activities in different realms? Do women who are responsible for caring at home and at work ever seek to limit their emotional involvement in both?

Caregiving activities also shift back and forth between different arenas. Despite the transfer of much caregiving to both formal organizations and the informal economy, public policies now are pushing some care back into the home.[16] The current emphasis on keeping the frail elderly out of both nursing homes and hospitals adds to the burdens of spouses and adult children (Sankar, Newcomer, and Wood 1986). As a result of cutbacks in social spending, informal caregivers can rely on fewer supportive services to alleviate the pressures.

Simultaneously, events in the private sphere increase the burdens of caregivers in the public domain. As the divorce rate rises and a growing number of women enter the labor force, elementary school teachers increasingly find they must offer both emotional and physical care to their students. Day care workers assume responsibility for after-school care for latchkey children. A number of questions arise. If the resources of both individual households and social service agencies are strained, is less total care being provided than before? How does the content of care change as it moves back and forth between different spheres? Does the provision of care in one sector affect the nature as well as the quantity of caregiving in another? For example, when family members are relieved of some of the most onerous caregiving tasks, do they provide more nurturant support?

Because the care of a single individual frequently is parcelled out among caregivers in different settings, caregivers must spend considerable time mediating between the realms. Informal caregivers solicit help from both agencies and unaffiliated providers for the family members they tend and seek to monitor the quality of the services obtained.

Staff members of agencies mobilize family members. Agencies with limited budgets seek to save money by relying on the services of family caregivers. Humanitarian considerations also prompt organizations to elicit greater informal care. Hospital policies now encourage family members to remain with patients throughout their stays.

In some instances, caregivers in different realms seek to forge close relationships among themselves. Teachers, day care providers, and social workers occasionally speak of becoming "partners" with parents. Informal caregivers often perform favors for service providers to ensure that they remain on the job or render their relatives special attention. Susan Sheehan (1982) has described the daily activities of Claire Quinton, who was responsible for her eighty-year-old mother with multiple health problems. Because her mother was eligible for a home-attendant program, some of Claire's burdens were alleviated. But she drove one home attendant to a food stamp center, transported another to her baby-sitter's and then home, and lent a third money for the subway.

If caregivers link different arenas, however, they also seek to maintain distinctions between them. Many family members want to safeguard their special connectedness with the care recipient, and they take pride in the services they believe that they alone are equipped to render. Formal providers want to differentiate their work from "mere" mothering. Moreover, a number of concrete issues divide caregivers in various realms. Competing notions of what constitutes appropriate care and what tasks fall within the domain of each sphere engender distrust among different groups of providers. When barriers of class, race, and ethnicity exist, communication may be further impeded. But similarities in status do not necessarily ensure that communication will be easy. According to Sara Lawrence Lightfoot, the mutual distrust of teachers and parents can be explained partly by the fact that both are women who believe they are doing the bidding of men:

> Mothers and teachers are involved in an alien task—required to raise children in the services of a dominant group whose values and goals they do not determine. In other words, mothers and teachers have to socialize their children to conform to a society that belongs to men. Within this alien context, it is almost inevitable that mothers and teachers would not feel an authentic and meaningful connection to their task and not completely value the contributions of one another. (1977:404)

The recent publicity surrounding abuse also aggravates tensions among different groups of caregivers.[17] For example, reports of sexual abuse have made parents increasingly wary of child care providers. The latter, in turn, are set against each other; day care center staff tend to be suspicious of family day care providers, whose lack of training and greater invisibility, they believe, heighten the potential for abuse. Parents also are subjected to greater scrutiny by teachers, doctors, and social workers, all of whom are charged with responsibility for ferreting out and reporting suspected cases of child abuse. The recent "discovery" of elder abuse has increased distrust among different groups caring for the frail elderly in similar ways.[18]

In short, the experience of caregivers is molded not simply by the settings within which they operate but also by the complex and constantly shifting relationships between these different arenas.

CONCLUSION

Because most policy analysts have focused on care recipients, they have ignored the needs of providers. Caregivers require flexibility, social support, a means of establishing limits, congruence between external expectations and the emotional work of caring, and the ability both to act on the basis of their own knowledge and to form attachments with the recipients of their care. As we have seen, each realm provides these conditions imperfectly.

The growing awareness of the problems of receiving high-quality care in any arena has sparked the creation of the self-help movement and the movement to humanize medical services. Neither, however, addresses the structural forces that retard the work of caregivers. This essay thus suggests that a broad transformation is necessary in order to create a society which fosters the preconditions for good care.

DOCUMENTATION

Authors' Note

We are grateful for the comments we received on earlier drafts of this essay from Carole H. Browner, Berenice Fisher, Christine Littleton, Carrie Menkel-Meadows, Helen McGough, Joan Smith, and Julia Wrigley.

Notes

1. It should be noted that Gilligan's theory has been criticized widely; see especially Auerbach et al. 1985 and Kerber et al. 1986.

2. "The Diary of a Good Neighbor," by Doris Lessing (1984), portrays the transformative effect of the experience of providing care. Having avoided childrearing and spurned the job of caring for either her mother or husband when they were dying, Jane Somers finds that her world has been narrowed to a concern with style and efficiency. When she befriends a poor and aged woman and provides increasingly intense levels of care to her, Jane grows disenchanted with the sterility of her former life and gains a richer understanding of the meaning of human connectedness.

3. Fisher (this volume) reminds us, however, that we should not regard such jobs as simply a continuation of domestic activities.

4. The influx of for-profit entities into health care in particular has been amply documented. Since the early 1970s, proprietary agencies have dominated the nursing home industry; during the early 1980s, major chains captured a significant share of the market. The growth of for-profit hospitals is particularly striking. Between 1975 and 1983, investor-owned institutions jumped from 6.3 percent to 13.1 percent of all U.S. hospitals (*The Nation's Health* 1986:1).

5. It is important to note that the line separating the profit and nonprofit sectors is dissolving. Many nonprofit entities operate for-profit subsidiaries. Because government agencies often contract for services with the cheapest providers, nonprofit organizations compete with proprietary entities in terms of price. Moreover, at a time of retrenchment, business methods are particularly appealing to managers of all human service organizations (Wood et al. 1986).

6. Some scholars reserve the phrase *informal economy* for those activities that take place off-the-books and thus are not registered by the economic measurement techniques of the society. Some subdivide the informal economy further by whether the income is generated through legal or illegal means (Gershuny and Pahl 1981; Henry 1981). Because this kind of approach isolates income reporting as a critical variable, it is not useful in an analysis that focuses on the range of care services that stand outside the formal economy—though structured by it—and share common characteristics with respect to the nature of the work entailed. We adopt the definition posited by Joan Smith, who speaks of informal economy activities as those "forms of nonwage labor...that actually produce goods and services *relatively* independent of the formal sector, and those that are associated with the circulation of these goods and services outside a formal market system" (1984:75).

7. Indirectly the government supports care through the Dependent Care Tax Credit, which allows families to deduct a portion of child care expenses from their federal income taxes. But the credit is of no advantage to the poorest families. Many cannot afford to make out-of-pocket payments for child care costs; many have tax liabilities so low that they get little or no relief (Kamerman 1984:6).

8. This conviction that care is a private responsibility is reflected in our hesitancy to have the government regulate such care (Alexander and Markowitz 1982). The purchase of home help for a disabled child or frail elderly parent is completely unregulated. While twenty-seven states require family day care providers to be licensed, another thirteen rely on voluntary registration, four states combine these two systems, and six states certify only those homes receiving public funding (Kahn and Kamerman 1987). Ironically, the absence of regulation for care in privatized settings may allow

such care to resemble the impersonal care associated with formal organizations.

9. Terminology is a problem in discussing care providers within the informal economy. To the extent that scholars have focused on distinctions between private and public and between waged and domestic work, they have obscured that which falls between these realms. Although we have spoken of the realm within which this work falls as the largely overlooked informal economy, the phrase *informal providers* has a special meaning within social service writing where it is reserved for those caregivers who are not part of formal organizational institutions, thereby referring to family members. There is also a large class of professional workers who offer care outside of bureaucracies—doctors, psychiatrists, psychologists, and social workers in private practices. These professionals differ from the workers under consideration here. Their credentials derive from mainstream training and their access to clients is shaped by networks within the formal economy.

10. A useful discussion of these issues, as they applied to nurses in the nineteenth century, can be found in Melosh (1982).

11. In the case of child care, state regulations concerning such issues as corporal punishment and nutrition can further erode the ability to act on the basis of personal experience.

12. Some networks are emerging to provide such support among family day care providers and domestic workers. They remain limited geographically, and they appear to attract the participation only of those with a clear professional identity. To many workers, they may seem to be just one more burden that lengthens a long work day and cuts into limited family time (Click 1981; U.S. Department of Labor 1981).

13. The U.S. Bureau of Labor Statistics estimates that approximately 150,000 home care aides worked for "organized employers" in 1984 and that their numbers are growing. The U.S. Department of Labor does not indicate separate categories for nurses and physical and occupational therapists by location of work.

14. Annual turnover rates for home health aides often exceed 60 percent (Holt 1986–87).

15. Proprietary home health agencies increased 300 percent between 1982 and 1984, and they now constitute 30 percent of all home health agencies (*Black Box* 1987:4); many are consolidating into major corporations (Wood and Estes 1983:243).

16. For example, the deinstitutionalization of mental hospitals has returned thousands of chronically mentally ill patients to the care of their families. Between 1955 and 1975, the total patient population of the nation's mental hospitals plunged from 559,000 to 193,000 (Vine 1982:117).

17. This publicity also shifts attention from the structural conditions

that impede caregivers' work to their individual failings.

18. By 1984, twenty states had passed mandatory reporting laws, modelled on child reporting laws, requiring that cases of neglect and physical abuse of the aged be reported (Salend et al. 1984).

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2

Toward a Feminist Theory of Caring

Berenice Fisher and Joan Tronto

Two different concerns gave birth to this chapter. The first grows out of our experiences as women and as feminists trying to make our way in a non-feminist world. In this world, where women are automatically designated as carers, we have had to struggle on a practical, everyday level with the tension between caring and other values. The second concern is more philosophical. Caring has virtually no place in the description of "the good life" that provides a focus for Western philosophy, despite the fact that caring permeates our experience.

Second-wave feminist thinkers have shown a growing interest in the topic of caring. Three main images of caring have emerged out of this exploration: the selfish carer, the androgynous carer, and the visible carer. The selfish carer grew out of the view that caring is a burden for women, and that in order to escape this burden women have had to put their own needs first (Blum et al. 1976). Although the selfish carer image appeals to women who feel overburdened by caring, it rings false on an intuitive level because it cannot account for the fact that human existence requires care from others and such caring is an important part of life. This image suffers from both conceptual and practical limitations because it does not tell us whether or how we should ever care for anyone except ourselves.

In reaction to the limitations of this view, feminists increasingly portray caring as a positive dimension of our lives that has been socially devalued by a capitalist and/or patriarchal order. The argument that caring is devalued because women do it leads to the image of the androgynous carer. Proponents of this image of caring claim that if we integrate men into women's caring work ("add men and stir," Charlotte Bunch might say), caring will become as valuable as other activities. On a theoretical level, this argument fails to come to grips with the way in which caring work is deeply implicated in our current sex/gender system: the sexual division of labor that defines caring as women's work cannot be abolished without a profound change in the construction of sexuality itself (Fisher this volume). On a practical level, experience suggests that the integration of men into women's work often results in new patterns of male dominance, as when men become the administrators in women's helping professions.

The third image, the visible carer, developed out of the argument that the devaluation of women's caring work is due to the dominance of a male value system. This argument suggests that although caring need not be changed and women need not stop caring, the worthiness of caring as an activity needs to be recognized (Gilligan 1982). The problem with this image is that recognition alone does not automatically improve the status of caring. It may, instead, invite us to ignore some of the oppressive and oppression-linked aspects of caring, reinforcing the status quo of caring as women's work (Tronto 1987).

As we looked more closely, we noticed that none of these images of carers fully examined caring itself; they were focused much more on the actors than on the activity. There are two reasons for this lack of attention to caring itself: one is the tremendous fund of everyday experience that women especially have concerning caring. This experience encourages us to think that we already "know" what caring is. The second is the absence of a strong secular tradition in which to conceptualize caring (cf. Farley 1986; White 1981). The liberal tradition in Western philosophy centers on a world view in which the rational, autonomous man accomplishes his life plan in the public realm. This tradition assumes a theory of self in which people are isolated, in which the self is prior to its activities and to its connections with others (Sandel 1982).[1] From such a perspective, people need to be activated in order to be purposeful and goal-directed; hence, the question of motivation to act becomes a central philosophical issue. It also assumes that the caring needed to sustain these activities somehow will get done, if not by oneself, then by slaves, women, or lower-class or lower-caste people (Colen 1986; Foucault 1986; Katzman 1981).[2]

The best-known version of this tradition in modern industrial societies divides the world into two parts: that of the rational, autonomous man and that of the dependent, caring woman. In this bifurcation, men's motivations lead them to behave purposively in the male sphere, which encompasses public matters, legal rights, paid labor, and formal relations. Women's motivations lead them to care in the female sphere, which encompasses private matters, familial duties, unpaid labor, and personal relationships. Because this bifurcation both stresses women's caring motivations and makes women's caring work relatively invisible, caring remains a mystified and oppressive concept.

Although some feminists and nonfeminists have attempted to liberate the concept of caring from the assumptions in which it is embedded, we think their perspectives remain too rooted in the world of the rational, autonomous man and thus too concerned with motivation. For example, Milton Mayerhoff's (1971) well-known essay on caring has the advantage of making caring a central experience in human existence. But he approaches caring from the standpoint of "man," who is fundamentally alienated from his existence and needs to engage in caring in order to overcome that alienation (Mayerhoff 1971). The problem, as he construes it, is primarily a man's problem; he fails to see that caring is so taken for granted in women's lives that women do not need to be advised to care. Given this starting point, it is not surprising that Mayerhoff pays no attention to the material conditions of, and impediments to, caring activities.

Nel Noddings (1984) offers a quasi-feminist analysis that implicitly acknowledges the potentially oppressive nature of caring for women by arguing against an ethic of duty as the basis for caring. But her own solution seems very similar to Mayerhoff's. For Noddings, caring consists of an ethically natural "engrossment" of the carer for the one cared for. In order to sidestep the possibility that such engrossment could also perpetuate women's oppression, she argues that genuine caring always involves reciprocity, that is, a recognition of the efforts of the caregiver by the one who receives the care. This approach is necessarily individualistic, focusing exclusively on one-to-one caring relationships. It takes into account neither the many situations in which the one cared for cannot reciprocate (an infant, a comatose patient) nor the fact that caring is often difficult, unpleasant, collective work. As with Mayerhoff, Noddings completely ignores both power relations and the material conditions necessary for caring.

From our perspective, a major weakness of both Mayerhoff and Noddings is their excessive focus on the motivation for caring. They assume that with the right motivation caring becomes unproblematic. One of the major contributions of Clare Ungerson's (1983) and Hilary Graham's (1983) feminist essays on caring is to correct this overemphasis on motivation. Their account of caring as involving both love and labor argues that the psychological nature of our thinking often obscures the labor involved in caring. Feminist analyses of caring, they note, have been excessively psychological, rarely viewing caring as work or understanding the meaning of that work in women's lives. Ungerson and Graham try to redress this imbalance by making the labor side of the dichotomy more visible, but they do not fundamentally challenge the dichotomy itself. Thus, rather than caring being seen as an integrated core of human activity, it remains a battleground for conflict between two different sets of human values.

This chapter seeks to reconceptualize caring in a broad fashion, one that is comprehensive (including both the public and private), integrated (not based on the separation of spheres), and feminist (speaking to the ways in which caring often entails and perpetuates the oppression of women). The chapter consists of four sections. In the first, we offer a general argument about the nature of caring. In the second, we propose an analysis of the caring process that pinpoints its major phases and components. In the third section, we discuss the primary social modes of caring in our society: the household, the market, and the bureaucracy. Finally, we explore three prevalent feminist ideals of caring, based on motherhood, friendship, and sisterhood.[3]

Although this discussion focuses on a series of conceptual distinctions, we see them as closely intertwined with the actual experience of caring. We invite readers to bring their own caring experiences to our analysis to see whether it is helpful. Our hope is to provide a theoretical orientation that does not merely reproduce but helps to change how we think about caring. We further hope that with such an orientation we can work toward a feminist political practice that will transform both the place and character of caring in our lives.

WHAT IS CARING?

We begin our reconceptualization of caring with a scene from real life: a women's studies class on the topic of motherhood. Again and again, the students in this all-women class express an idea of caring that centers on spending long periods of time talking with one's child. These talks, it is said, serve to explore and to support the child's emotional realities.

The notion of caring expressed by these students is one that has grown to a great extent out of education (often psychologically-based expertise, books, courses), and in many ways resembles the ideal for middle-class women that feminist historians have called the "cult of domesticity" (see, among others, Cott 1977). This ideal developed in the nineteenth century with the entrance of white, middle-class men into the capitalist marketplace and the exclusion of their wives from paid work. The cult of domesticity emphasized women's emotional and moral sensibilities (versus the physical work of caring that could be done by servants), the duty of caring (versus the right to compete and express individual interest that was exercised by men), and the intensely private nature of caring (versus the public business of politics and profit-making).

In reality, however, the women students in this class are not the leisured, middle-class wives assumed by the nineteenth-century ideal. They work full-time at paid jobs and do much of the physical work of caring for their children and husbands. Yet, when they try to identify the part of their caring worthy of value, they stress its emotional and moral aspects.

During this entire discussion, Diane, the one black woman in the women's studies class, has been holding back her anger. Finally she bursts forth. Her mother, a divorced woman who worked as a night nurse to support her children, had had little time for long discussions about their emotional realities. Her talks with them took place during the chores they performed together or even during her daytime rest period, when she allowed the children to wake her to tell her about things important to their lives. Much of her caretaking revolved around making sure her children were safe and well while she worked—finding friends and neighbors to look after them or taking them along to the hospital where she tucked them into extra beds. Each morning when she returned home, she would cook a pot of food for her children to eat when they got home from school. That flavorful pot, those nights tucked in the hospital beds, those calls to friends and neighbors—all these things mean "nurturance" in Diane's life.

As Diane's story reminds us, survival establishes the fundamental context of caring. As a species, we have no choice about engaging in caring activities. When choices are possible, they involve how much of our lives to devote to caring, whether caring will emphasize emotional versus physical welfare, how to work with others in caring activities, and so forth. For Diane's mother, caring involved both love and labor, which gave meaning to each other. Caring was a duty (stemming from a religious, kinship, and neighborhood ethos) and a right (in the sense that to take on caring responsibilities made one a member of the community who could expect consideration from others). Caring was also a profoundly social rather than an individual activity, involving kin and neighbors with similar caring requirements (Carothers 1987; Stack 1975).

One of the lessons that we draw from Diane's story is the way in which caring permeates our lives. The idea of caring as a separate sphere for women's moral and emotional work does not match our daily realities. Similarly, our experience of caring is not reflected in the related moral claim that "justice" and "caring" constitute different perspectives on human life (Gilligan 1987). All activities, including those that we think of as political, involve a caring dimension because in addition to acting we need to sustain ourselves as actors. Conversely, all caring activities entail the political dimensions of power and conflict, and necessarily raise practical and real questions about justice, equality, and trust (Smith and Valenze 1988).

This point is often difficult to grasp because caring seems to flow naturally from our individual motivations—whether they are based in a biological, spiritual, or psychological process. But, the naturalistic interpretation of caring obscures its profoundly social and frequently problematic character. Caring is social because caring efforts speak ultimately to our survival as a species rather than as isolated individuals. It is problematic because it involves social interactions that contain the potential for conflict and because it requires material resources that might be difficult or impossible to obtain. For these reasons, we need an understanding of caring that allows for contradictions and encompasses the whole range of human activities that serve to sustain us. (See, for example, MacCormack and Strathern 1980.)

On the most general level, we suggest that caring be viewed as *a species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible.* That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. This effort to keep life going does not assume that certain people (women rather than men) have a special ability to sustain our world or that some efforts (healing rather than house-building) make a more important contribution to sustaining life on earth.[4] Nor does this notion of caring assume universal standards concerning what is needed to maintain and repair our world. We know that human "needs" change with the historical, cultural, class, and other contexts. We also know that such contexts involve power relations that affect the content, definition, distribution, and boundaries of caring activities.[5] Thus, the caring process is not a gracefully unfolding one, but contains different components that often clash with each other. By identifying these components we should come to understand the rich and knotty texture of our caring experience, why caring can be both so rewarding and so exasperating.

THE COMPONENTS OF CARING

Caring can be seen as a process having four intertwining phases: *caring about, taking care of, caregiving, and care-receiving.*[6] We will discuss each of these phases in more detail shortly, but we would like to define them briefly in the following ways. Caring about involves paying attention to our world in such a way that we focus on continuity, maintenance, and repair. Taking care of involves responding to these aspects—taking responsibility for activities that keep our world going. Caregiving involves the concrete tasks, the hands-on work of maintenance and repair. Care-receiving involves the responses to the caring process of those toward whom caring is directed. The caring process, as these categories suggest, may be directed toward things and other living beings as well as toward people, although our discussion in the remainder of this essay will focus on caring in relation to people.

The four phases of caring we have identified have certain overall properties that help define the sense in which they constitute a process. First, each phase operates as the general precondition for the next; that is, in order for a person or persons to take care of, some person or persons must care about. These caring phases may be carried out by one person or may be divided among different individuals or groups. Many of the features and problems associated with modern caring activities arise from the fact that people engaged in these phases have very different histories and perspectives. Moreover, these phases are not orderly stages of caring which culminate in some completion of the caring activity. In practice, phases of the caring process may be intertwined in chaotic and contradictory styles: care giving may proceed where no one any longer cares about the original situation. Or, the person who gives care may find herself also having to take care because of a vacuum of responsibility. Care-receivers may fight with caregivers about the kind of care being given.

To make matters more complex, caring is also a practice involving certain *ability factors*, specific preconditions of caring activity. The most important of these ability factors are *time*, *material resources*, *knowledge*, and *skill*. Each phase of the caring process involves such ability factors, although the balance between them depends on the actors involved and the historical and cultural context in which they find themselves. Just as the phases of caring do not fit together neatly, so ability factors may contradict as well as complement each other. Caregivers may have many skills but no time in which to apply them. Those who care about may have much knowledge but none of the needed resources. Together with the fragmentation of the caring process, these imbalances lead to many of the ineffective and destructive patterns we encounter in caring activities. The fault, of course, does not lie in the patterns of fragmentation and imbalance but in social arrangements that create them. Before turning to this larger social and political context, however, we look more closely at the caring process and some of the conflicts that arise within it.

Caring About

Caring about is the phase of the caring process in which we select out and attend to the features of our environment that bear on our survival and well-being. There is no intrinsic time limit to caring about, although situationally imposed time limits may require us to care about some things more than others (someone bleeding to death in an emergency room rather than someone slowly dying on a chronic illness ward). What we care about intertwines with what we know about: we expect people to have knowledge when they claim to care about (if they really cared about their friend they would have known she was unhappy), and we expect that certain kinds of knowledge will lead to caring about (she began caring about her mother's state when she heard the serious diagnosis). Caring about does not necessarily bring with it skills (she grieved that she could do nothing to heal the children), although skills in perception and trained attention may shape what we care about (how could they care about something they did not even notice?). Similarly, material resources do not directly prevent or require us to care about, although the lack or abundance of such resources has an obvious impact on how we care about (after a while they stopped caring about the polluted water because they could not afford to purify it).

In ordinary usage, the expression *caring about* is often used to suggest love or affection. Love or affection may play an important role in caring about (when you love someone or feel fond of them you are likely, although not certain, to pay more attention to their needs), but caring about extends beyond these particular emotions. Love and affection connect us to others; caring about assumes a connection with others. Thus, caring about is an orientation rather than a motivation.[7] Within this orientation, caring about involves selection. Limitations in time, knowledge, skills, and resources impinge on our caring about, forcing us to make choices. There are often more things to care about than we can comprehend, and we often care about more than that to which we can respond. Perhaps this accounts for the Old Saxon root of the word *care*, which is *sorrow* (Skeat 1958).

These contradictions assume a particularly sharp form, of course, for those groups of people who assume and/or are pressed into the role of those who *should* care about the repair and maintenance of our world. By stressing women's emotional and moral superiority, the middle-class ideal of femininity made caring about an ideal by which to judge all women. Women who lack the time, knowledge, skills, or resources to meet the white, middle-class standard of feminine caring about are often seen as defective in their femininity. Moreover, women, in general, are often pressed to care about more than they can manage, and are criticized for not caring enough. Such failure becomes a failure in achieving a basic gender identity, a failure at being womanly, motherly, or nurturant.

Taking Care Of

Whereas caring about someone or something does not necessarily involve any overt action, *taking care of* implies the responsibility for initiating and maintaining caring activities. (People may care about the suffering of those they see on television and in the streets but do nothing about it.) Taking care of requires more continuous time spent and more explicit knowledge of the situation than does caring about. To take care of some one or some thing or some situation, we need to know enough to predict or try to guess at the outcome of our intervention. Assuming responsibility means that we are accountable for consequences.

The central skill involved in taking care of, then, is that of judgment: the skill involved in choosing one course of action rather than another. Judgment involves assessing available resources. When someone or some group engages in taking care of a person or thing or situation, we expect them to find the resources required to fulfill that responsibility. Thus, the notion of taking care of has built into it assumptions about power, that is, about the ability not only to predict and to judge but to command resources. These resources may vary greatly (the money to buy food, the strength to lift a heavy person, the patience to deal with irrational behavior), and they may allow for flexible responses (although her welfare check was late again, she managed to make soup out of leftovers). But without resources, one cannot take care of.

One of the most pervasive contradictions involved in taking care of concerns the asymmetry between responsibility and power. To the extent that women are assigned responsibility for maintaining and repairing our world, this contradiction between responsibility and power becomes especially severe: the "caring woman" makes things better, regardless of how little she has with which to work. Where responsibility is great but power is limited, women are expected to compensate for deficiencies in the caring process.

How much women are willing to absorb this cost often depends on a variety of factors, such as the availability of resources, the existence of others who are willing to share responsibility, and the degree to which women acquire self-esteem through caring. Where the contradictions involved in taking responsibility become too great, women suffer from burnout and disillusion. Too much taking care of often leads to less caring about.

Caregiving

The responsibility involved in taking care of is even heavier when the same person must engage in caregiving as well. *Caregiving* is the concrete (sometimes called hands-on) work of maintaining and repairing our world. Caregiving requires more continuous and dense time commitments than taking care of. (In order to take care of her elderly aunt, the woman hired an aide as caregiver. The woman stopped in every day to see that things were okay, but the aide had to help the old woman constantly, lest she forget to turn off the stove or fall and break a hip.) Similarly, the knowledge involved in caregiving requires a more detailed, everyday understanding. Those who take responsibility for care may have to change the caring plan periodically: the caregiver must be ready to revise her caregiving strategy according to moment-by-moment or day-by-day conditions. To make such revision requires experience, skill, and, ultimately, judgment. The caregiver also needs certain basic resources to exercise her skill. She may become particularly adept at improvising resources—because real skillfulness requires us to be inventive—but improvisation has its limits, which caregivers discover, much to their sorrow.

Caregivers often suffer from a shortage of time as well as other resources. Sometimes they also suffer from a shortage of knowledge or skill. These tensions are compounded by the ways in which the fragmentation of the caring process tends to alienate caregivers from both caring about and taking care of. Alienation is greatest for paid caregivers in the lower echelons of human service hierarchies. Because most caregiving of this sort is done by women, women are especially experienced in dealing with, as well as especially oppressed by, these contradictions.

From the standpoint of the caregiver, any shortage of time, knowledge, skill, or resources impedes the caregiving process. So does the fragmentation of that process itself. For women caregivers, the fragmentation between caregiving and taking care of is particularly problematic. Women are expected to care about and give care to others. But, because of their lack of control over the caring process in many contexts, women's responsibility for caring remains ambiguous. In the home, women often lack such control because they lack the resources for caring. In human service bureaucracies, women lack control because they occupy lower-level positions. The constraints of professionalization often limit caregivers' attention to a narrow sphere, so that it becomes difficult for them to approach a situation "holistically." If they attempt to widen the sphere of their attention and to take more responsibility, they are often told they have "gone too far." If they stay within institutional limitations, their caregiving often seems inadequate to themselves and others. Care-receivers frequently blame them for not taking enough responsibility.

The complexity of the interrelationships among caring about, taking care of, and caregiving is heightened by the reactions of those who receive care. When caregiving not only suffers from limited power and authority but also from the alienation of those who receive care, the tension between giver and receiver is likely to become the focus of all the caring contradictions.

Care-Receiving

Care-receiving can be defined as the response to caregiving by those toward whom care is directed. Because caregiving acts upon something or someone else, there will necessarily be some response to it, although the response may not be intentional, conscious, or even human. (For example, a person might wince in response to receiving an injection, a patient might smile unconsciously at hearing the voice of a friend, a cello might sound richer if repaired by an expert instrument maker.) The response of the care-receiver is also conditioned by the ability factors in the caring situation. Care-receivers have their own time frame. (Although the nurse checked her medication periodically, she was in constant pain.) Care-receivers may have more intimate knowledge of their needs simply because they experience them. (She knew which of her muscles had been affected by polio and pointed them out to the physical therapist.)

When people needing care become their own caregivers, they must also acquire or teach themselves caregiving skills. They may, indeed, invent new skills and strategies because they are so much closer to the situation, especially when they have long-term needs. (People with chronic illnesses or permanent disabilities have plenty of time in which to evolve such strategies; people facing emergencies must often rely on the knowledge and skill of others.[8]) Pairs or organized groups of care-receivers sometimes succeed in mobilizing the resources to take care of and give care to themselves collectively. But, the capacity of care-receivers to make use of such knowledge or skills is limited by the resources available to them, and even where resources abound there are some needs that care-receivers can meet only with the help of caregivers. Thus, self-help strategies do not totally avoid the conflict between caregivers and care-receivers.[9]

Indeed, to some extent, conflict between caregivers and care-receivers seems unavoidable. The latter often imagine an ideal situation in which caregivers automatically meet the care-receivers' needs. But, finding a definition of "needs" that satisfies both the care-receiver and the caregiver is no easy matter (cf. Ignatieff 1984). The difficulties of reaching such agreement increase with differences in power. As we well know, power relations often shape the definition of needs to suit dominant ideas and interests, and care-receivers may have little control over how their needs are defined in the caring process. (For example, government agencies may see a poor woman's needs in terms of the breakdown of "the family ethic" rather than as her lack of money and other resources [Abramovitz 1988].)

Conflicts between caregivers and care-receivers are exacerbated by the way in which women relate to the caring process. Despite the image of women as natural caregivers, they are often pictured as ignorant (because only men truly know their own interests?) and incapable of taking responsibility for their own caring process. (Toni Morrison's character Pauline Breedlove shows how racism intersects with this treatment when she describes her experience giving birth under the "care" of white men, who think that black women do not experience pain [Morrison 1970].) Thus, alienation in the caring process reaches its culmination for women, who are torn apart as both caregivers and care-receivers. This fragmentation does not mean that women's caring activities always fail. But, it implies that in order to be adequate participants in the caring process, women need to struggle with alienation. In the next section, we address the larger political and social context that leads to such fragmentation. In the last section of our discussion, we turn to the ways in which ideals of caring might inform our feminist theory and practice.

MODES OF CARING: HOUSEHOLD/COMMUNITY, MARKETPLACE, AND BUREAUCRACY

In modern capitalist societies, the caring process is conceptualized and organized in three main ways: through the household/community, the marketplace, and the bureaucracy. Each setting affects the caring process differently, promoting integration or conflict among the phases of caring. Each mode of caring affects the other two, because of the ways in which household/community, marketplace, and bureaucracy interpenetrate. In this section, we examine these three modes in terms of how caring is defined in each context. We also look at the ways in which each mode of caring is seen as equitable, just, and trustworthy; and we begin to explore the implications of these different caring modes for women.

Household/Community

Let us begin with the household mode of caring that is precapitalist in its origins and centers on families based in communities (Brown 1982; Rapp 1982). Such families, as Rayna Rapp has argued, use the kinship network to mobilize the resources required to meet household members' needs and draw on nonkin members of the community for help. Women constitute the center of such support networks, although their power is not automatic and unambiguous. Status differences between women, relations with individual men, and the need for certain resources outside the community often limit women's control over their situations. But, with respect to caring, the strong emphasis on shared resources, and the frequent sharing of the other ability factors of time, knowledge, and skill, lead to a relatively integrated caring process and put women in a relatively empowered position (McCourt 1978; Stack 1975).

Because caring about, taking care of, and caregiving are communally shared values and activities, household and community membership confers a sort of equality on participants. (In traditional small towns or communities, any adult may scold or help any child, as though the child were her own.) In this respect, caring also embodies a sort of justice and inspires a type of trust. Caring is seen as just when it refers to a shared standard by which each gives and receives her "due." Trust results because these standards are shared, and one can count on other community members to maintain them (Naples 1987).

Marketplace

In contrast to household-centered caring, capitalism creates a situation in which the emphasis on men's wage-earning capacities and a diminution of community resources make women carers increasingly dependent on goods and services purchased in the marketplace. The marketplace has a double effect on caring. It alters household- and community-based caring, and it creates new forms for giving care outside the household/community. Within the family, women usually continue to retain a strong orientation toward caring about, taking care of, and caregiving, but ultimate power over the caring process itself is now concentrated in the hands of the men who have greater earning capacity. Middle-class women in the nuclear family become especially isolated from community-based social networks. They become solo caregivers, alternating much of their caring work with that of hired caregivers and professionals. Working-class women who become disconnected from community networks and who do not have the resources to seek the assistance of other caregivers and professionals may become still more isolated (Rubin 1976; Sidel 1978). Poorer women are pushed into accepting caregiving from bureaucratic agencies regardless of how such women define their own caring needs.

Still ultimately responsible for making the caring process work, the isolated woman has no guarantee that any of those who take over her work will care about it in the same way she does. These various others are not necessarily her equals; they do not share sets of values that can determine whether any instance of caring is just. As the purchaser of caring service, she meets them as strangers; as strangers, they have no built-in reason to trust each other.

In the marketplace (or exchange) mode of caring, everyone is an equal, in the sense that everyone has a chance to articulate and to attempt to meet their interests. The "invisible hand" of the marketplace ensures a kind of justice: creating supply where there is demand and reducing supply where there is none. These same principles shape the caring process, when it is reduced to the idiom of exchange. Any caring demand that is expressed in the marketplace will be supplied by the appropriate labor: those who pay a competitive wage find the lower-echelon caregivers they need. Those who offer "fee for service" get the needed professionals. Those who care about a given need take care of that need by purchasing caregiving in the marketplace. Responsibility for caring means spending money. Caregiving means meeting a demand for labor. Caring services are divided in ways that make them purchasable and marketable (Moccia 1988a). In theory, there is no kind of caring that cannot be reduced to the exchange idiom.

Even in theory, however, the marketplace mode encounters several serious contradictions with respect to organizing the caring process. Some individuals cannot enter the marketplace to pursue interests on their own behalf. The marketplace mode of caring requires the family to represent such people—to buy goods and services for infants and small children, for the elderly, infirm, and seriously disabled. The family, in turn, needs someone to organize this process of buying and using goods and services for the family members as care-receivers. The "someone" turns out to be women: women who are still the organizers of the caring process, women who are less available for paid work, women who are less highly valued in the marketplace, women who are supposed to be more sensitive to others' needs. Women also sell their labor as caregivers in the marketplace, offering their caregiving skills to those who can purchase care.

Another contradiction results from the fact that, despite the determination to encompass all values with the framework of exchange, the marketplace alone cannot create and sustain workers and products capable of fully meeting caring demands. The marketplace requires quick adaptability, but the knowledge, skill and capacity to organize resources required by caring often involve long periods of time to reach the point of usefulness (Hartsock 1984). The marketplace also treats people as individuals engaged in one-to-one exchange relationships. But, most knowledge, skills, and capacity to organize resources involved in the caring process are developed and transmitted in collective contexts—whether these produce the household skills and values brought by domestic workers to their jobs of cleaning and caring for other women's children or the professionally inculcated skills and attitudes brought by a neurosurgeon to her operations. In either case, marketplace values cannot exclusively account for the creation or sustaining of such collectivities, nor do the consumers of caring services want the marketplace to be their sole guarantee. The consumer counts on such collectivities (for example, the family background of the domestic, the professional training of the doctor) to inculcate in caregivers an orientation to caring about that puts care-receivers' needs at the center of attention.

Bureaucracy

The bureaucratic mode of caring relies upon large-scale hierarchical organizations to accomplish caring in the marketplace and public sector. The major difference between public sector and marketplace bureaucracies stems from how they decide what to care about. Market principles govern how market bureaucracies determine what caring needs to be done. (A private hospital may begin a weight reduction program to make money.) The government allocates caring tasks to public sector bureaucracies when other major institutions fail to meet certain socially defined caring needs.

Because bureaucratic caring grows out of a political process that precludes control by care-receivers, much bureaucratic caring is fragmented and inadequate. Caring in bureaucracies is often directed at those who are less well-off in society: the poor, the old, the young, the infirm, and women (Ferguson 1984; Nelson 1984). Study after study has shown that even under the best of circumstances, this social solution of needs by bureaucracy contains a gender bias, as well as class, ethnic, and racial biases (Abramovitz 1988; Nelson 1984). Instead of directing attention to client needs, the political process that creates the bureaucracy defines what it will care about and shapes caring to the agency's changing purposes and need for self-perpetuation.

Bureaucracies also separate caregiving from taking care of. The levels of responsibility in bureaucratic organization increase as one goes higher in a bureaucracy; the levels of caregiving increase as one goes lower in a bureaucracy. Thus, at the bottom, individuals are expected to engage in caregiving according to routines whose procedures and logic were derived at some distance from the actual caregiving itself. Because bureaucracies function through routines, furthermore, all of the problems that present themselves to the bureaucracy must become routine; that is, they must be standardized. When a problem that is not routine presents itself to a caregiver, she must find ways to fit it into the routines or to improvise new routines.

Because women are disproportionately found in the lower levels of bureaucratic organizations, they are more often faced with the dilemma of having to break rules in order to do what care-receivers or they themselves perceive as caring. Furthermore, because women bear the cultural burden of caring, they are expected to be willing to break the rules to make the agency more caring. The diffusion of responsibility in bureaucracies is thus a problem for which women workers pay a particularly high price.

Sometimes women are able to fulfill these ideals of caring through achieving professional roles within bureaucratic structures. The professional helper has at her disposal a professional identity to reinforce her claims and effort to care. But while professionalization can help to crosscut bureaucratic lines of authority, it also separates human service workers and thus contributes to structuring work and individuals hierarchically.

Another problematic aspect of bureaucracy from the standpoint of the caring process is that, just as bureaucracies cannot deal with problems except through their routines, so needs must be standardized to fit individuals into bureaucracies. Women in the household often take responsibility for presenting care-receivers to the bureaucracy so that the bureaucracy can deal with that person's needs. (Women take their children to schools, clinics, and social service agencies to present their needs in such a way that the bureaucracies will respond.)

Bureaucracy, by its nature, distorts and fragments the caring process through its division of labor, through the hierarchy of authority and power, and through its need to reduce problems to a standard form. Caring is considered just and equal in the bureaucratic context when the bureaucracy fulfills its rational functions. Caring bureaucracies therefore preclude other ways of raising questions about justice and equality. Trust in a bureaucracy depends upon the belief that bureaucratic forms will produce needed care or on the hope that a particular caregiver will really care about the care-receiver. From the standpoint of women, who are disproportionately the caregivers and care-receivers of bureaucratic caring, then, trust is an ephemeral quality.

This review suggests that, although the central institutions of modern life claim to promote caring, both marketplace and bureaucracy seriously distort and fragment caring activities. Even the household, with its focus on caring, often fails to provide adequate care because of its dependence upon marketplace and bureaucratic structures. In all of these institutions, too, women still assume the burden of caring, a burden made oppressive by inequalities in responsibility for caregiving and by the distortions of the caring process that result from these institutions. The inadequacies of these institutions are in some way evident in our daily experience. As feminists, we need to discover directions for change that facilitate caring itself and embody equality, justice, and trust.

FEMINIST IDEALS OF CARING

For feminists committed to making justice, equality, and trust part of all our life activities, some versions of the household mode of organizing caring have strong appeal. Where women remain central to the caring process and are able to draw on their relationships with kin and neighbors to facilitate caring activities, household/community caring can be conducted in a way that rewards rather than penalizes women. Even where women become more dependent on marketplace and bureaucratic mechanisms, the household gives a woman a certain status—although perhaps not at much as she deserves—connected with the social value of her work.

Yet, the household mode also remains in certain ways and for certain women an unsatisfactory ideal. In the middle-class version (as feminists have often pointed out), it denies women power commensurate with their caring responsibilities. Even in extended family and community settings, in which women's relative power tends to be greater and responsibilities shared more widely, the household mode limits the ideas of just caring to what is traditional (if physical punishment of children is part of the tradition, then it will be seen as caring behavior). Caring concerns are further narrowed to people who are seen as members of the community. Moreover, although the household may function well and even beneficially for women as carers, it is not itself constituted to challenge many of the social, economic, and political conditions under which caring is done. Women may find it necessary to go beyond the boundaries of both household and community to improve the conditions of caring and to affect the structures that shape caring activities. (For example, women may mount a welfare rights campaign to give them the resources they need as carers [Naples 1987; Piven and Cloward 1977].)

Feminism has encouraged women to understand the character of household caring, to explore its traditional norms, and to reconsider the social structures that limit its functions. This exploration has emerged in feminist attempts to rethink central relationships in household life: motherhood, friendship, and sisterhood. The remainder of this chapter explores the implications of these three relationships for a feminist ideal of caring.

Motherhood

After years of disparagement by many second-wave feminists, motherhood has become the leading image of caring in current feminist discussions (see, e.g., Held 1987). In general, feminist mothers are defined by their autonomy, an autonomy often guaranteed by paid work and expressed in equality of caring responsibilities with any coparent who might be involved. Whether a single mother or coparent, the feminist mother cares about her child with intensity (the "attention" that characterizes Sara Ruddick's analysis of "maternal thinking"), and takes responsibility both by caregiving herself and by purchasing goods and caring services for her child (Ruddick 1983). She, or she and her coparent, struggle to control the caring process, despite their dependence on marketplace and bureaucratic resources. Skills, including education, enable her to exercise a certain amount of control over these resources. To the extent that she is able to control and integrate the phases of the caring process, her caring seems to give her an equal and just place in society.

As a guide for mothering, this ideal offers an attractive alternative to the image of the disempowered woman contained in the middle-class household mode of caring. As a guide for the social organization of the caring process, however, the motherhood ideal has serious dangers. This ideal is fundamentally hierarchical, even though hierarchy is justified by future equality: feminist mothering will help the child go beyond current dependency to a future autonomy. Yet, because new beings are always entering the system, the hierarchy itself is not temporary. It is permanently institutionalized, so that matriarchy replaces patriarchy.[10] At its best, the mothering image of caring leaves room for self-monitoring among those who are acting as mothers. For example, feminist mothers gather in support groups to talk about the contradictions of unpaid caring; feminist professionals such as teachers or psychotherapists gather to talk about the contradictions of paid caring (Culley at al. 1985; Eichenbaum and Orbach 1982).[11]

Put in the context of hierarchical organization, the maternal caring idea tends to replace the patriarchal bureaucrat with a "caring" manager. Although this ideal of caring may help individual human service workers to counter a harsher paternalistic approach to care receivers, the maternal ideal sidesteps the problems of exploitation and domination intrinsic to bureaucratic organization. Such misplaced maternalism helps disguise the fact that hierarchical organization profoundly fragments the caring process itself, and that people at the lower ends of this hierarchy—whether they are professional or nonprofessional caregivers, low-level supervisors, or care-receivers—rarely have the power and resources to take responsibility for caring (Ferguson 1984; Fisher 1983).

Friendship

Given the inherent dangers that the maternal image of caring implies, it is little wonder that some feminists have given equality in the caring process first priority. This priority characterizes the feminist ideal of caring based on friendship between women, which draws on the classic notion of friendship as a relation between equals. Such friendship poses an alternative to relationships based on kinship bonds. Kinship bonds involve duty and traditional norms of caring; friendship results from choice. We choose friends, in part to fulfill desires not met by kin. We choose as friends people who care about the same things as ourselves, whether it is a shared taste for sports, for talking over life problems, or for making feminist revolution (Rubin 1985). But caring about the same things does not necessarily entail taking care of or caregiving to each other.[12] Thus, Janice Raymond, who argues for friendship as the basis for feminist revolution, deplores the distorted maternalism she finds in women's communities, when women constantly attempt to take care of and give care to each other (Daly 1978; Raymond 1986). She lauds, instead, the truly liberated woman who first and foremost can care about and thus take care of herself. Such a woman can, by joining with women like herself, genuinely care about women's collective liberation and have the strength and clarity of thought to change the entire system.

Because such an ideal of friendship is based on autonomy and choice, it leaves little room for those elements of the caring process that do not involve choice or do not entail autonomy. In important ways, the friendship model mirrors the marketplace: individuals come together as equals and stay together as long as this serves their mutual advantage. As long as friends remain equal and friendship serves their needs equally, the relationship is a just one, and individuals may trust each other without reservation (Fisher and Galler 1988). But friendships may be bounded in time and place, or highly specialized; they may or may not involve attention to caring needs. The friendship ideal does not preclude nonfriends from meeting the caring needs of the friends. In a sense, the friendship ideal requires that other people be available when caring activities are not included in a given friendship. While all phases of caring are constitutive activities of the motherhood ideal, caretaking and caregiving are not necessary to friendship.

Sisterhood

The power of the sisterhood ideal of caring stems precisely from how it integrates taking care of and caregiving into our relations with others. Sisterhood is a powerful ideal for the caring process because it encompasses a double, and somewhat contradictory, meaning: sisterhood as equality with other women and in the human community and sisterhood as inequality based on birth order and the differing needs and obligations that flow from it. These two meanings for sisterhood do not stand in simple opposition to each other. The notion of sisterhood-as-equality leans, so to speak, in the direction of sisterhood-as-kinship, because women do not come together in political sisterhood as equals. We are not equals in power (access to resources, education, skills, and overall privilege in relation to the established order), and we are not equals in terms of our caring needs (as defined by our mental and physical health, degrees of disability, age, and so forth). The notion of sisterhood-as-kinship, on the other hand, leans in the direction of equality: no matter what the birth order, sisters (in our era) assume an equal birthright. As kinship sisters, we are entitled to become equals and hold each other accountable in realizing that potential.

These two images of sisterhood can, we believe, provide a beginning point for a feminist ideal of caring. Sisterhood-as-kinship points to the ways in which our struggle to repair and maintain our world has a deeply necessary and yet highly contingent quality. Contingencies such as birth order, illness, disability, and death, and all of the accidents of individual biography, affect sisters unequally as carers and care-receivers. Yet sisterhood assumes mutual obligation; being a sister means struggling with how to realize one's caring obligations in the face of these contingencies. Sisterhood-as-equality, on the other hand, prompts us to reassess these inherited mutual obligations. Because sisterhood-as-equality assumes equality as a desirable though transient value, it bids us to look at specific caring activities in terms of power relationships and the possibility of minimizing power inequalities between us.

If the sisterhood ideal implies a sort of equality, it also includes a notion of justice in that anyone may need care at any time. Although at one period some may find themselves doing a disproportional amount of caring about, taking care of, or caregiving, at other times they themselves may be in need of the same attention and help. Trust in sisterhood as the basis of caring means trust that this "to each according to her need, from each according to her ability" principle will not result in either exploitation or domination.[13] This does not mean that caring cannot be rationalized or specialized to some extent. But abstract principles of management cannot provide the core of caring. There needs to be the kind of caring about the welfare of others that flows from a sense of belonging together.

Given the current social and economic situation in the United States and many other industrialized countries, this ideal of sisterhood as the basis for caring seems especially visionary. It is easier at this period to imagine the motherhood or friendship ideals as the basis for caring because they are most easily assimilated into the privatized caring context, because in some essential ways they are more compatible than sisterhood with the hierarchical and marketplace structure within which we operate (Miner and Longino 1987). Sisterhood is a viable model for caring, but we need to find ways to realize it in a conservative era. In particular, we need to relate sisterhood as an ideal to certain key contexts for caring in contemporary life: the family, professsionalism, and bureaucracy.

The tension between sisterhood and the household mode of caring is well-known to most feminists. In the early years of this feminist wave, many young women pulled away from families to create collectives based on shared decision-making. The decision-making functioned to establish a shared set of values for caring (Koen 1984). As the early intensity of the women's movement waned and many women became involved in establishing quasi-traditional families of their own, the understandings that arose within these collectives became problematic. Tensions over what women really cared about and new priorities for taking care of and caregiving challenged the sisterhood ideal (Eichenbaum and Orbach 1988).

Although these tensions have made us uncomfortable and have resulted in a downplaying of the sisterhood ideal, they have a positive side. Formations outside the traditional household (support groups, collectives, alternative women's institutions) provide a resource for women living in the household context. Sisterhood groups, committed to equality as a principle, give women the experience of more equal relationships that they can then bring back into the household. For a number of reasons, including the dependence of children, households cannot be organized solely on the basis of equality. Sisterhood provides the alternative vision of equal relations that can challenge traditional household duties and power differentials. Conversely, family structures provide a kind of corrective to the more abstract versions of sisterhood as equality, reminding women about the limits on equality imposed by realities such as aging. For example, our aging parents, who are usually not a part of a women's collective, may nonetheless require us to learn and to evolve caring strategies that then become relevant to dealing with our own aging.

The tension between sisterhood and professionalism also has been an issue since the early years of this feminist wave. From a feminist viewpoint the male-defined professions have used professional education and specialization to dominate women caring professionals, caregivers, and care-receivers. In the place of expert knowledge, the sisterhood caring ideal argues for women's experience as the basis for the caring process, as for example, in feminist health collectives. Properly understood, however, the sisterhood ideal does not require a devaluation of professional knowledge and expertise, but only of the claimed inequality that has often accompanied such expertise. Some feminist collectives have managed to incorporate feminist professionals within them (Schechter 1982; Gottlieb 1980). Some feminists within the women's helping professions are developing interpretations of caring work that have a potential for embodying the sisterhood ideal in an effective way. Professions historically have claimed to embody a set of moral concerns that inform their practice. If feminist helping professionals can draw on the ideal of sisterhood to integrate the liberation of women into the moral concerns of their professions, then they can become a powerful force to change the organization of caring in our society (Moccia 1988b).

Finally, although the sisterhood ideal seems especially antithetical to bureaucracy, feminists working in bureaucratic contexts can employ such an ideal in trying to reshape the larger patterns of caring. Few bureaucracies are so tightly controlled as to preclude forming enclaves such as networks, caucuses, unions. Similarly, bureaucracies include the potential of organization among care-receivers. Perhaps the biggest problem posed for sisterhood by bureaucracy is how to crosscut the separation between different echelons of caregivers and between caregivers and care-receivers. Radical organizers of the 1960s and early 1970s developed such formations for bureaucracies such as schools and hospitals, but feminist experiments of this sort have been scattered and not very visible. Although these efforts constitute a relatively small subversion of bureaucratic organization, they provide a valuable source of theory and practice in challenging bureaucratic norms of caring (Withorn 1984).

These images of the sisterhood ideal as it relates to the family, professionalism, and bureaucracy do not in themselves comprise a feminist program for caring. They do imply, however, certain more general social and political values that might inform our attempts to change the caring system and to create a more caring social order.

CONCLUSION

This chapter argues for a feminist theory of caring that does not reproduce the distinctions we have inherited from the Western philosophical tradition. In reality, caring crosscuts the antitheses between public and private, rights and duties, love and labor. Thus, we need a vocabulary that reflects our actual caring experience and, at the same time, helps us to project a vision of caring that we want to realize. The vocabulary we propose emphasizes caring as a process and points to contradictions resulting from the lack of integration between phases of caring.

Our analysis also stresses the importance of understanding the political values involved in caring, both those implicit in the caring process as we experience it and those implied in the ideals of caring we might project. Even at its best, as our argument for the sisterhood ideal suggests, conflict will always be a part of caring. Even if our society devoted more resources to caring activities, this increase would not automatically resolve the dilemmas and conflicts involved in the caring process.

We also point to the importance of viewing caring contextually. Caring acquires its meaning in social contexts, such as the household, the marketplace, or bureaucracy. In order to reshape caring activities we ultimately need to reenvision social institutions. The women's movement of this generation has made very important contributions to this process. To build a feminist future we need to stretch our imaginations so that we can discover new visions of society in which caring is a central value and institutions truly facilitate caring.

DOCUMENTATION

Notes

1. Because the liberal tradition dominates most social and much feminist thought in the United States, we begin our critique with it. Nonetheless, both conservative and socialist traditions have important implications for feminist analyses of caring, which are implicit in our analysis.

2. We are convinced that the emerging feminist critique of this Western, liberal "model of man" constitutes a profound challenge to contemporary thinking. Bordo (1987) and Lloyd (1984) have addressed this issue at a more philosophical level. Sandra Harding has aptly summarized this point by thinkers such as Nancy Hartsock who work out of a Marxist materialist tradition: "Men in the ruling classes and races reserve for themselves the right to perform only certain kinds of human activity, assign-

ing the balance to women and men in other subjugated groups. What they assign to others they rationalize as merely natural activity—whether this be manual labor, emotional labor, or reproduction and child care—in contrast to what they regard as the distinctively cultural activity that they reserve for themselves. Of course, their 'ruling' activities (in our society, management and administration) could not occur unless others were assigned to perform the social labors they disdain" (Harding 1987:185).

3. Readers may wonder why we have not included daughterhood and relations among spouses and lovers as ideals for caring. We drew our list of motherhood, friendship, and sisterhood out of current feminist discussions of ideals: we do not suggest that this list of caring relationships is exhaustive. Daughters obviously do provide care (see, for example, Abel 1986). Perhaps as the second wave of feminists ages, there will be more careful writing about what daughterhood means. We are grateful to Rosalind Petchesky for pointing out this issue to us.

4. Our argument here has strong affinities to ecological, and especially feminist ecological, arguments that view caring globally (see, for example, Griscom 1981 and King 1981).

5. Much debate persists about the origin and meaning of the sexual division of labor, including its implications for caring activities. See the arguments offered by feminist economists (Hartmann 1987; Strober and Arnold 1987), anthropologists (MacCormack and Strathern 1980), and historians (Kessler-Harris 1982; Matthaei 1982).

6. Feminist analysts have used diverse terminologies to describe caring. Because of its special ambiguity we have decided not to use the phrase *caring for*. Our caring vocabulary should be compared to that of Abel and Nelson (this volume), Graham (1983), Mayerhoff (1971), Noddings (1984), and Ungerson (1983).

7. The notion of attention, as used by such writers as Sara Ruddick (1983) and Simone Weil (1951), resembles our account of caring about. For Weil and Ruddick, being attentive is selfless, but it is not a willful obliteration of the self or absorption of the self into the other. It is a suspension, for the moment, of the self's preoccupations (cf. Cheney 1987).

8. Individuals and families coping with chronic illness often devise well thought-out and tested strategies for coping with the daily needs of the care-receiver. Corbin and Strauss (1988) have argued that government policymakers should acknowledge and support these strategies rather than undermine them.

9. The self-help movement raises a number of serious questions for the description of the caring process, including where professionals do and do not facilitate caring and the extent to which self-help constitutes a progressive or a conservative force (Withorn 1980).

10. In making this point, we are not asserting that mothers have complete control. Ruddick (1983) has correctly stressed the limits to mothers' control over the forces that may enter their children's lives. Nevertheless, simply because mothers are not all powerful does not mean that they are powerless. We believe that it is important to recall that mothers do have power and can exert authority over their children.

11. Some feminist teachers and psychotherapists may deny that their professional relationships have any hierarchical components, but we have yet to see a description of such relationships that fully resolves the issue of power differences.

12. To say that friendship does not necessarily entail caretaking and caregiving does not preclude caring as a part of friendship. For an account of duties in friendship, see Stocker (1987). We find that Stocker's accounts of duties, however, reflect the philosophical tradition of rational autonomy. The duty to respect one's friend is very different from a duty to take care of or to give care.

13. Although we make no attempt to explore the commonalities and differences between sisterhood and the various ideals of socialism, we think it would be valuable to compare socialist notions of comradeship and fraternity with sisterhood as we describe it.

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Part II
The Domestic Domain

Preface

Although much writing about caregiving in the domestic domain focuses exclusively on mothers, demographic changes are transforming the nature of caregiving at home. As the population ages, care for elderly relatives occupies an increasingly dominant place in women's lives. The two chapters in this section explore various aspects of this type of care.

Abel demonstrates that most long-term care occurs in the private household. Her data also highlight the salience of this issue for women: not only do women predominate among informal caregivers to the elderly, but they also constitute the majority of the recipients of this kind of care. The bulk of Abel's chapter focuses on two issues. First, she delineates the burden caregiving places on many family members, paying particular attention to the ways in which factors of gender, class, and race shape the experience of caring for elderly relatives. Second, she discusses the knotty problems entailed in three proposals for alleviating the costs of caregiving: financial compensation, supportive services, and educational programs.

Many studies of caregivers of the frail elderly rely on quantitative data. Both authors question the exclusive use of this methodology. Abel finds, for example, that interviews with adult daughters caring for frail elderly mothers reveal interpersonal and intrapsychic factors obscured in more statistically-oriented studies.

Miller's chapter expands the discussion of both methodological issues and gender differences in caregiving. In the first part of her analysis of spousal caregiving, Miller relies on quantitative data from the Health Care Financing Administration 1982 Long-Term Care Study. She demonstrates that, contrary to findings in prior studies, husbands and wives caring for spouses with some form of dementia do not experience differences in perceived stress. In the second part of the chapter, Miller analyzes in-depth interviews with spousal caregivers. These latter data reveal more subtle differences between men and women. In general, Miller finds that, whereas husbands are able to distance themselves emotionally from their caregiving responsibilities, wives are more attentive to their husbands' needs.

3

Family Care of the Frail Elderly

Emily K. Abel

Although discussions of caregiving at home tend to focus exclusively on rearing small children, care for the frail elderly is assuming an increasingly prominent place in women's lives.

The great majority of people age sixty-five and older in the United States can carry out the activities of daily living without assistance, but almost one-fifth of those residing in the community do require some type of long-term care; a much higher proportion need help at some point in old age. There are an estimated 5.2 million functionally impaired noninstitutionalized elderly people (Macken 1986).

Researchers have exploded the myth that families abandon their elderly relatives. In a classic study conducted in 1975, Ethel Shanas (1979) concluded that elderly people do remain in close contact with surviving kin. Frequency of contact translates into assistance during times of crises. A consistent finding of studies is that families deliver 70 to 80 percent of long-term care (Community Council of Greater New York 1978; Comptroller General of the United States 1977; Stone, Cafferata, and Sangl 1987). The burdens typically fall disproportionately on a single individual. Spouses are the most common caregivers, followed by adult children, then other relatives, and finally friends and neighbors. Women constitute the great majority of caregivers in all categories. They are 77 percent of adult children caring for parents and 64 percent of spousal caregivers (Stone, Cafferata, and Sangl 1987).

The discovery of the extent of informal assistance to the elderly has inspired some observers to wax eloquent about the strength of the American family. But the elderly population is growing at a pace that threatens to outstrip the capacity of family and friends to care for them. The elderly represented just 4 percent of the population in 1900 (Feldblum 1985), but rose to 8 percent in 1950 and 12 percent in 1984. It is projected that those sixty-five and older will constitute approximately 17 percent of the total population by the year 2020 (Siegel and Taeuber 1986). The rate of increase of the very old, who are most at risk of illness and disability, is particularly striking. Those age eighty-five and older rose 165 percent between 1960 and 1980, and they are expected to increase a startling 500 percent by 2050 (Day 1985). The "old old" constitute the fastest-growing segment of the population (Siegel and Taeuber 1986). A very high proportion of the elderly are women. For every eighty-one men aged sixty-five to sixty-nine, there are one hundred women; for every forty-one men aged eighty-five and older, there are one hundred women—more than twice as many (Siegel and Taeuber 1986). Moreover, elderly women are far more likely than elderly men to be indigent, to be living alone, to be in poor health, and thus to require assistance from their children (Rix 1984).

The increasing need for family caregiving is not only the consequence of inexorable demographic trends. Because the reigning view is that the United States cannot afford the high cost of institutional care for the burgeoning frail elderly population, public policies seek to reimpose the burden of long-term care on family members. Several states have attempted to use Certificate of Need programs to limit the supply of nursing home beds and instituted preadmission screening programs to control utilization of those that exist. Federally-funded "channelling" demonstration projects have sought to divert the disabled elderly from nursing homes.

In 1983, the federal government introduced a prospective payment system under Medicare in order to stem the high cost of hospital care. As a result, the average length of stay in hospitals has dropped. Home health agencies are growing rapidly, but they cannot accommodate the growing demand for their services (Special Committee on Aging 1988). Family members thus must pick up the slack (Sankar, Newcomer, and Wood 1986).

THE COSTS OF CAREGIVING

A host of researchers recently have documented the costs of caregiving. According to data from the Health Care Financing Administration 1982 Long-Term Care Survey, three-fourths of unpaid caregivers to the noninstitutionalized disabled elderly live with the care recipient, and the majority render care every day of the week, devoting an average of four hours per day to caregiving activities (Stone, Cafferata, and Sangl 1987). Although the frequency and level of care vary dramatically (Horowitz 1985a), a study conducted in 1976 found that two-fifths of the people who care for elderly parents in their own homes do the equivalent of full-time jobs (Newman 1976). Patricia G. Archbold quotes a woman responsible for a severely-impaired mother:

> I get up at 8:00 a.m., shower and make coffee. By 8:30 I get her [mother] up, help her wash, then we have breakfast. The Day Center bus comes at

> 10:00. I clean the house, shop and do errands until she comes back at 2:00 or 2:30. We both take a nap. I get up at 5:00 to make dinner. We eat, then watch T.V. At 8:00 p.m., I get her ready for bed; that's when she moves her bowels and takes a bath. (1983:42)

Caregiving can last a long time. The 1982 Long-Term Care Survey indicates that approximately 44 percent of caregivers have been furnishing assistance between one and five years, one-fifth for five years or more (Stone, Cafferata, and Sangl 1987).

Just as economists have tried to assign a cash value to housework, so some have attempted to "price" the unpaid services informal caregivers render to the disabled elderly. Lynn Paringer (1983) has calculated both the "opportunity costs" and the "replacement costs" of the services caregivers provide to the noninstitutionalized dependent elderly population. If caregivers devoted the same amount of time to waged labor or home production, their time would be worth between $7.2 billion and $16.6 billion per year; the costs to society of replacing the services now provided "free" would be $9.6 billion. The magnitude of this unpaid labor becomes apparent when we realize that even the lowest figure is more than one-third the total amount spent for nursing home care in 1981.

But not all costs can be measured in dollars. Although many family members find caring for the elderly very gratifying, some also experience a range of physical, emotional, social, and financial problems. Researchers repeatedly report that the effects of caregiving on mental health status are especially profound (Montgomery, Gonyea, and Hooyman 1983; Robinson and Thurnher 1979; Stone, Cafferata, and Sangl 1987). Most studies focus on caregivers of elderly persons suffering from Alzheimer's disease and related disorders. In a study comparing caregivers of memory-impaired adults with age peers without caregiving obligations, Linda George and Lisa Gwyther (1986) found that the caregivers report three times as many symptoms of stress.

One source of stress is the conflict between caregiving responsibilities and labor force participation. A survey conducted by the Travelers Corporation found that 28 percent of their employees older than age twenty-nine provided care to elderly persons and 8 percent devoted at least thirty-five hours each week to this activity (The Travelers Companies 1985). Data from the Long-Term Care Survey reveal that 9 percent of caregivers quit their jobs, 21 percent reduce their hours of work, 29.4 percent rearrange their schedules, and 18.6 percent take time off without pay (Stone, Cafferata, and Sangl 1987).

Although financial considerations compel most caregivers to guard their work lives against intrusions by caregiving responsibilities, family members are less scrupulous about protecting their leisure. Researchers consistently find that caregivers sacrifice vacations, social activities, and time alone (Cantor 1983; Doty 1986; George and Gwyther 1986; Horowitz 1985a).

Caregivers also tend to lose any sense of control over their lives. A woman who cared for her mother complained: "We have no freedom. We had to give up the move to our house in the country because she's here in this city and needs our help. For years we have been planning to move as soon as our youngest left. Now we are panicked. We built that house for our retirement—she could live for another 10 years" (Archbold 1982).

Unlike childrearing, care for the elderly is intrinsically unpredictable. Reproductive technology has enabled many women to exercise greater control over the timing of childbirth, but they never will be able to control when a parent or spouse needs care. Recent writing has emphasized the need for predictability; we can cope better with events which arrive at scheduled times and for which we have prepared (Hagestad 1986). But caregiving obligations often occur precipitately, catching family members by surprise.

Many caregivers also feel powerless to control the conclusion of caregiving responsibilities. Contrary to the widespread myth that relatives "dump" the frail elderly in nursing homes, many family members assume that the quality of available homes is too low to make institutionalization a viable option. Caregivers thus often feel trapped because they realize that caregiving will only end when their relatives die.

Caregiving tends to be a lonely endeavor (Johnson and Catalano 1983). A pervasive theme in interviews with caregivers is their sense of intense isolation. According to Rhonda J. V. Montgomery (1984), 67 percent of the spousal caregivers participating in the Family Support Project at the University of Washington report having fewer than four contacts with other people each week. There are virtually no counterparts to the prenatal classes, playgrounds, day care centers, and schools that help to unite young parents. Moreover, although the devotion of a caregiver to an impaired person may testify to the strength of intimate ties, caregiving often fractures families. Loyalties to the elderly frequently vie with attachments to other family members. Because broader bonds of kinship and community have become progressively attenuated in our society, caregivers often lack social networks that might help to alleviate the burdens. The constant demands of caregiving make it difficult, if not impossible, to sustain ongoing friendships (Archbold 1982). As Hilary Graham remarks, caring in our society "is something women do as an expression of their connectedness with others, yet it is something invariably they do alone" (1983:26).

Although this chapter has stressed the social and economic disruptions wrought by caregiving, family members typically emphasize interpersonal and intraphysical factors. Because most studies of caregiving are based on closed-ended questions whose responses are analyzed statistically, these factors have not been adequately tapped. Quantitative research is more appropriate for examining the discrete tasks of caregiving than for exploring either the subjective experiences of caregivers or the human relationships within which this activity is embedded.

I therefore conducted in-depth interviews with fifty adult daughters caring for frail elderly mothers. The interviews lasted an average of nintey minutes and were tape-recorded and transcribed. I located respondents through support groups and service agencies. Three-fourths of the women were caring for mothers with some form of dementia.

Many women noted that caregiving brought them into intimate contact with their mothers, often for the first time since they had been adolescents. Issues they assumed had been fully resolved suddenly reemerged. Several women were shocked by the intensity of the feelings this experience provoked. Old resentments suddenly had renewed force. Many women also acknowledged that they found themselves once again looking to their mothers for approval and striving to please them. A few expected to receive the approbation and affection that previously had been withheld.

But, if caregiving reawakened childhood feelings, it also compelled these women to acknowledge how much had changed. Many women spoke of the difficulties of watching the deterioration of a person to whom they felt intimately bound. One woman, who had been caring for her mother, a victim of Alzheimer's disease, for two years, drew a sharp contrast with childrearing:

> When I brought my mother here I thought it wouldn't be difficult. I thought, I could manage. She acted very much like a three- or four-year-old. I had six children, I had ten grandchildren, so I thought, I can handle this. But it's not the same. Here there is no progress, only a slow deterioration, almost an invisible deterioration, but I know it's there. If you're doing a good job with kids, they move along, they progress, their world expands. But my mother's world is contracting.

Not surprisingly, fears of aging and death surfaced. Caregivers whose mothers suffered from Alzheimer's disease worried about inheriting a propensity for the illness:

> Aging never bothered me before. Now I wonder if I will inherit this, if I will do this to my own children. If I forget something, it's not just a funny matter any more. I wonder if this is how Mama started. It's made me more aware of growing older, and it's not such a wonderful thing anymore.

Alterations of affect and behavior were both painful and confusing to daughters of parents with dementia. As the disease progressed, women often felt that their parents' personalities had been ravaged. One woman's comment reveals her frightening sense of loss and abandonment:

> My mother was always a very dignified lady. It is sort of like seeing your mother stripped naked when she doesn't care for herself and her clothes are dirty and she has a look of total rejection on her face.

Caregiving itself accentuated the sense of loss. In providing care, daughters must relinquish the illusion that their mothers are omnipotent and still can offer protection. Also, caregiving demands that women redefine their roles vis-à-vis their mothers. Nel Noddings comments that "apprehending the other's reality, feeling what he [*sic*] feels as nearly as possible, is the essential part of caring.... Caring involves stepping out of one's own personal frame of reference" (Noddings 1984:16–24). Ideally, then, before a woman cares for her mother, she should be able to view her mother as separate from herself and understand the reality of her life. An article by Judith Kegan Gardiner about the school of self-psychology also helps to explain what is needed. Gardiner writes that members of this school "see empathy as an adult process in which one mature self takes the position of the other person.... From this perspective, empathy is not the same as but opposite to projective identification in which one person insists that the other is an extension of the first. This self-psychology view of empathy entails no merging, blurring, or loss of self for adults" (1987:771). Such empathetic understanding is a critical aspect of caregiving, but it requires that a woman cease viewing herself as a child in relation to her mother. The sense of fusion, which, Nancy Chodorow (1978) argues, many women experience in relation to their mothers, is antithetical to the stance women must adopt as caregivers.

Many women spoke about how difficult it was for them to assume responsibility for their mothers' lives. Several were acutely aware that their mothers resented their assertions of authority. These caregivers saw themselves as wounding their mothers further by taking control. Those who still were seeking to please their mothers and win their approval felt torn between the need to assume responsibility and the desire to accede to their mothers' wishes.

Although these women believed that their mothers resisted even essential help, they also portrayed their mothers as making impossible demands. Many women believed that their mothers had boundless expectations about what their daughters could accomplish. Some women interpreted their mothers' continuing requests as evidence that they had failed as caregivers. They themselves embraced a notion of caregiving that required them to improve the overall quality of their mothers' lives. Their mothers typically had experienced irremediable losses and suffered from physical and mental problems that could not be repaired. Nevertheless, the daughters held themselves accountable for making their mothers happy.

In short, caring for elderly mothers involves constant tensions between attachment and loss, pleasing and caring, seeking to preserve an older person's dignity and exerting unaccustomed authority, overcoming resistance to care and fulfilling extravagant demands, reviving a relationship and transforming it.

Obviously, it is important to be careful about generalizing from this study. The sample is small, and it contains a high proportion of women who sought assistance from support groups and social agencies. Also, the experience of caring for fathers, spouses, other relatives, and friends undoubtedly is very different from the experience of caring for mothers.

But this study does help to answer government officials who argue that, by returning care to individual households, we reinforce traditional values and strengthen intimate bonds. The women I interviewed often felt overwhelmed by the intensity of the feelings this experience provoked, and a few believed that this prevented them from rendering what they considered good care.

DIFFERENCES BY GENDER, CLASS, AND RACE

Gender

In a society riven by divisions of gender, class, and race, the experience of caregiving will differ dramatically among different groups. As noted, caring for elderly relatives, like other forms of domestic labor, continues to be allocated on the basis of gender. The gendered division of labor also extends to the particular tasks caregivers perform. Sons are more likely to assist parents with routine household maintenance and repairs while daughters are far more likely to help with indoor household chores and personal health care (Coward and Rathbone-McCuan 1985; Stephens and Christianson 1986). This gender difference may help to explain why caregiving has different consequences for men and women. Men take responsibility for tasks they typically can perform whenever they choose. Women, however, often assume tasks that keep them on-call twenty-four hours each day. Moreover, the tasks performed largely by women are the ones researchers have correlated with high levels of stress (Horowitz 1985a).

Nevertheless, women receive less assistance. Daughters-in-law (but not sons-in-law) remain an important source of informal care. Sons caring for elderly parents thus obtain more material help and emotional support from their wives than daughters can expect from their husbands (Horowitz 1985b). Some evidence suggests that formal services also are distributed inequitably. Men who are caring for elderly spouses or parents obtain more in-home services than their female counterparts (Fitting and Rabins 1985; Hooyman and Ryan 1985).

Women and men tend to resolve the conflict between waged work and caregiving in divergent ways. Daughters are more likely than sons to curtail labor force participation, while sons are more likely than daughters to reduce caregiving responsibilities. According to data from the 1982 Long-Term Care Survey, the proportion of caregiving daughters who relinquished paid employment was more than twice that of sons (11.6 and 5 percent). Of those who worked at some point during the caregiving experience, higher proportions of daughters than sons had reduced their working hours as a result of caregiving obligations (22.8 versus 15 percent), rearranged their schedules (34.9 versus 27.7 percent), and taken time off without pay (24.8 versus 14.1 percent) (Stone, Cafferata, and Sangl 1987). A study conducted by Eleanor Palo Stoller (1983) found that sons who held paid employment reduced the number of hours they helped their parents but that labor force participation had no significant impact on the level of assistance daughters provided.

But the most important gender differences may lie in those aspects of caregiving that are least adequately captured by the statistical methods dominating research in this area. It has become almost a truism to note that men and women experience relationships differently. As both parents and grandparents, men are more likely than women to take an instrumental, task-oriented approach, reducing caregiving to a series of specific activities while remaining somewhat distant and detached. Women are more apt to become submerged in caregiving, to experience emotional closeness and connectedness with the recipient of care, and to express empathy (Cherlin and Furstenberg 1986; Rossi 1985). If these generalizations apply to caring for elderly relatives, two consequences may ensue. First, women may be more likely to experience caregiving as a boundless, all-encompassing activity. Some studies have found that women are less likely to set limits and more likely to assume responsibility for improving the overall quality of the lives of the elderly (George and Gwyther 1986; Miller, this volume; Zarit, Todd, and Zarit 1986). As noted, the adult daughters I interviewed held themselves accountable for making their mothers happy. Second, women's greater capacity for intimacy may heighten their vulnerability to stress. According to Marjorie Cantor, the stress of caregivers is related directly to the closeness of their bond with the care recipient (Cantor 1983). Unfortunately, few have explored the extent to which a strong sense of attachment and affiliation simultaneously may imbue caregiving with meaning and purpose.

Class

A major flaw of most research on informal caregiving is its failure to bestow adequate attention on the impact of class and race. Adult children and spouses from poor and minority families have fewer responsibilities toward the elderly because life expectancy in those communities is lower than among middle- and upper-class whites. The need for caregiving occurs earlier in the life course. But low-income and minority people who do live past age sixty-five are especially likely to be in poor health and thus to require assistance from kin (Syme and Berkman 1976). This section describes class differences in caregiving; the next examines differences by race and ethnicity.

Low-income people face special problems in rendering care. Those who work tend to be governed by rigid schedules and unable to demand special consideration. They thus may suffer greater penalties if they telephone disabled relatives from work or take time off to help them during the working day. Data from the 1982 Long-Term Care Survey show that female caregivers employed as operatives and laborers are more likely than those employed in either professional/managerial positions or clerical/sales positions to take time off without pay, yet the latter are more likely to rearrange their schedules (*Exploding the Myths* 1987).

Many low-income people also have limited access to formal services. Although Medicaid pays for nursing home residents who have exhausted their savings, Medicaid reimbursement for noninstitutional long-term care services is negligible. Moreover, because the Medicaid reimbursement rate typically is lower than the rate nursing homes charge their private pay patients, these institutions look for residents who can pay their own way, at least initially. The heavy demand for nursing home places enables administrators to give priority to applicants who have sources of support besides Medicaid (Harrington 1984). In some communities, it is virtually impossible to find residential facilities willing to accept Medicaid recipients (Lewin and Associates 1987).

The problems of obtaining home- and community-based services are even more formidable for low-income people. The government subsidizes just one-fourth of noninstitutional care (Doty 1986). As a result, the utilization level of community- and home-based services varies directly with the income of the frail elderly (Liu, Manton, and Liu 1985). Beth J. Soldo and Kenneth G. Manton (1985) have concluded that 66 percent of the elderly people who utilize formal services pay at least part of the cost themselves, and almost one-half pay the entire cost. Recent developments may accentuate the class bias of community agencies. As public funding is curtailed, agencies are under increased pressure to direct their services to private pay patients (Wood et al. 1986). Moreover, a growing number of home health agencies are proprietary, and many are consolidating into major corporations (Estes et al. 1984). Organizations committed primarily to maximizing profiits may have little interest in serving a low-income clientele.

Poor people also are unlikely to be able to purchase assistance outside the boundaries of formal organizations. Although most researchers focus solely on services provided by community agencies, aides and attendants who are recruited and reimbursed privately constitute a major source of assistance. Finally, most low-income family members find it virtually impossible to purchase medical equipment and supplies and to undertake physical adaptations of their homes.[1]

Race and Ethnicity

The few studies that have investigated differences by race and ethnicity in providing care to the frail elderly are hampered by the difficulty of disentangling cultural values from socioeconomic necessity. It is unclear whether variations in caregiving behavior reflect ethnic difference or economic need (Lubben and Becerra 1987; Rosenthal 1986). Some researchers also may be cautious about pursuing this line of research because of the uses to which it can be put. The fear is that, if studies show that minority communities provide extensive assistance to the elderly, policymakers may conclude that they can take care of their own, without publicly supported services.

Because research has lagged, generalizations must be based on fragmentary evidence. Recent studies about the level of intergenerational help among different ethnic and racial groups are contradictory. Although some studies have concluded that elderly Blacks do not receive greater assistance from children than do elderly whites, others have found greater evidence of helping across generations in black families (Cantor 1977; Mindel, Wright, Jr., and Starrett 1986; Mutran 1985; Wolf and Soldo 1986).

If we have yet to understand adequately how cultural variations in household structure and in the meaning of family responsibility alter the caregiving experience, it nonetheless is clear that racial and ethnic minorities face particular problems in rendering care. Although elderly persons who are members of minority groups are most likely to suffer from functional disabilities, ethnic minorities are underrepresented among the nursing home population. This has been attributed variously to the concentration of minority populations in geographic areas that are underserved by nursing homes, to the greater reluctance of certain ethnic groups to institutionalize family members, and especially to discriminatory admissions policies (Eustis et al. 1984; Markson 1980; Vladeck 1980). Whatever the explanation, members of ethnic and racial minorities remain in the community with higher levels of functional impairments than whites (Crystal 1982). We can assume that a high proportion of noninstitutionalized minority elderly persons receive care from family members.

POLICIES

Policy analysts discuss informal caregiving from two competing perspectives. While one group seeks to encourage additional caregiving by family members, the other insists that the government acknowledge greater responsibility for caring for its elderly citizens.

Financial Compensation

One widely touted proposal to address the issues confronting caregivers is to provide financial compensation to them. Allowances for caregivers are common throughout western Europe, but financial support for family members in the United States is extremely scanty. Although a number of state programs reimburse family members for the long-term care services they render, stringent eligibility criteria exclude the great majority of caregivers, and reimbursement levels tend to be very low (Burwell 1986). The Dependent Care Tax Credit allows families to claim a credit against federal tax liabilities for expenses incurred in caregiving. Because this credit is not refundable, it is valueless to the very poor who owe no taxes. Moreover, families are eligible only if all taxpayers in the household are gainfully employed. The large proportion of caregivers who have dropped out of the labor force to look after relatives thus receive no benefits. Using data from the 1982 Long-Term Care Survey, one observer calculated that only a tiny fraction of caregivers are eligible for the tax credit (*Exploding the Myths* 1987).

Proposals to provide financial relief to caregivers win at least some adherents from both groups of policy analysts. But members of the two groups have very different notions of the purpose and shape of the programs they endorse. Many of those who belong to the first camp, stressing family responsibility, view cash grants and tax allowances as cost-effective alternatives to institutionalization. Monetary relief, they contend, can provide an incentive to family members either to assume caregiving responsibilities or to delay nursing home placement. This argument rests on the economists' model of the rational, calculating person and ignores the complexity of forces affecting decisions about caregiving. People's willingness to bestow care is shaped by a variety of determinants, including the nature of their attachment to the work force, the texture of their bonds to the care recipient, and the strength of their adherence to such values as family love and filial responsibility. It is highly unlikely that most family members will respond in mechanistic ways to the inducements this group of policy analysts would offer them. On the other hand, should financial incentives succeed in encouraging family members either to assume caregiving responsibilities or to continue providing care after they otherwise might have considered nursing home placement, caregiving patterns may be distorted in two ways. First, family members who are emotionally ill-equipped to provide care might begin to do so. Second, because the goal of such a program would be to save money, benefit levels would be too low to induce any but the poorest paid workers to quit their jobs to care for relatives. Thus, the class and gender biases of caregiving would be reinforced.

Members of the second group of policy analysts, who emphasize government responsibility, view financial compensation in a very different light. Instead of seeking to regulate the behavior of caregivers, they want to alleviate their financial burdens and accord recognition to the work they perform. But this argument encounters vehement opposition, even from members of the same camp. Some critics note that schemes to provide financial compensation leave untouched the most oppressive aspects of care of the elderly. The primary complaints of caregivers are the emotional and physical strains, not the financial costs (Stephens and Christianson 1986). Observers also fear that, when a financial reward is attached to the work of nurturance and caretaking, such work is transformed from a human service into a commodity. A study conducted by Amy Horowitz and Lois Shindelman (1983) suggests that a significant portion of caregivers share this concern. When family members providing care were asked if they wished to receive financial support, several responded negatively. The following comments were typical: "...it puts a price on your relative," and "I never thought in terms of getting paid because it's a relative."

But, if some caregivers spurn financial assistance, others desperately need it. When relatives with limited financial resources are severely impaired, the costs of special diets, equipment, and home modifications can mount up quickly (Stephens and Christianson 1986). Caregiving also can pose an economic hardship to family members who relinquish paid employment. And elderly wives who were economically dependent on their husbands often are at risk of impoverishment when their husbands either die or enter nursing homes.

Furthermore, by demanding that caretaking be divorced from the cash-nexus, we sentimentalize women's unpaid labor on behalf of their families. Women provide care not only out of love and concern but also out of a sense of obligation. At the same time, payment does not prevent some members of such "caring" professions as social workers and nurses from becoming emotionally attached to their clients and providing high-quality services. We know too little about the conditions that facilitate good caring to insist that remuneration would be detrimental (Waerness 1983).

Because the second group of policy analysts argues that the primary goal of financial compensation should be to aid caregivers rather than to control their behavior, they are willing to endorse programs that are far broader in scope than those currently in place. But it is not easy to design a model program. One difficulty is deciding whether the purpose should be to seek to offset the expenses incurred in caring for the elderly, enable family members to purchase outside help, or compensate caregivers for the services they render. If payment mechanisms seek to reimburse family members for their care, some method must be found to assign a value to their services. Another serious problem is deciding whether financial compensation should take the form of tax allowances or cash subsidies. Finally, if programs provide cash stipends to caregivers, a distributive principle is required. Implementing some form of means test would target payments to those with the most limited economic resources. But benefits allocated on the basis of financial need stigmatize recipients, and they tend to be cut first during periods of retrenchment. Using disability as a condition of eligibility involves the problem of determining functional need.

In short, framing an agenda for compensating caregivers raises a number of thorny issues. But to delineate the difficulties is not to argue that the project should be abandoned. Because a significant fraction of caregivers need economic relief, some method of rewarding their efforts must be found.

Supportive Services

Although most policy initiatives focus on financial compensation, caregivers express a preference for supportive services (Horowitz and Shindelman 1983). They indicate a desire for a broad array of community- and home-based services to augment their own assistance, including transportation, home maintenance and chore services, visiting nurses services, and day care. A critical demand of many caregivers is respite services which can provide temporary relief from the burdens of care.[2] Very few noninstitutional services of any kind are available. Although it has become fashionable to speak about providing a "continuum of care" for the chronically ill, home health care is simply nonexistent in many communities; in others, critical services are sorely inadequate (Palley and Oktay 1983).

The two groups of policy analysts hold sharply contrasting views about community- and home-based services. Those who stress family responsibility endorse supportive services only insofar as they can prevent or postpone nursing home admissions by reducing the strain on caregivers. Because they want to limit public expenditures, they are particularly concerned with delaying institutionalization of either Medicaid recipients or people who are likely to become Medicaid-eligible shortly after entering nursing homes. Their overriding fear is that community care will replace informal caregiving efforts.

Members of the second group of policy analysts take as their starting point the needs of caregivers. In order to promote the well-being of family members, they argue, a full panoply of services must be provided. It is important to acknowledge two problems with this strategy. First, although home health care originally was promoted as a means of saving money, a decade of research has cast doubt on this claim. As William Weissert (1985) has shown, the unit cost of most community programs is much steeper than originally anticipated. Moreover, home health care serves as an "add on" rather than as a substitute for existing services. Because the majority of clients of home and community programs are not vulnerable to institutionalization, the expansion of these programs cannot save money by reducing the need for nursing home care.

The studies reviewed by Weissert evaluated programs which were intended to delay or prevent institutionalization. Were community services shaped around the needs of caregivers, the costs might well soar. Because such needs are highly individualistic and change frequently over time, supportive services must be diverse and flexible. Family members who are caring for severely impaired elderly relatives may require intensive assistance. The few hours of relief offered by most respite programs may be grossly inadequate. Adult children who prefer not to share households with severely disabled parents may need around-the-clock care for them. Caregivers who do live with the elderly but work full-time often require at least forty hours of paid help.

The second problem with expanding publicly-funded noninstitutional services is that we lack an adequate way of distributing them. Although eligibility for acute health care can be based on medical diagnoses, eligibility for long-term care typically relies on assessments of functional limitation. But measuring functional abilities remains an inexact art, at best. Elizabeth Kutza explains: "The major shortcoming of functional assessment tools is that the level of functioning they measure is not readily translated into need for services. For example, a person may score poorly on mobility. A response to that problem can take various forms—a wheelchair, a walker, a cane, better shoes, podiatry service." (1981:126).

Allocating social as opposed to medical services poses particularly formidable problems. Social services lack natural gatekeepers. Although fee-for-service reimbursement schemes encourage some physicians to overutilize health services, these providers do help to guard the portals of the health care system. Moreover, home care services do not have built-in disincentives to consumption. As Stephen Crystal notes: "Just as people usually subject themselves to surgery only when convinced it is needed, hardly anyone goes into a nursing home if he feels there is an acceptable alternative. There is no such disincentive for home care. In fact, help with household maintenance is a key part, in some cases all, of home care, and almost anyone, disabled or not, would appreciate having this" (1982:92).

One Congressional staff member explained his opposition to expanded in-home care in the following way: "I'd like someone to come fix my roof or do my shopping for me too, but why should taxpayers have to provide me with that?" (cited in Vladeck 1980:217).

But one person's "latent demand" is another's "unmet need." Those who fear that the expansion of home- and community-based services will open the flood gates implicitly acknowledge that the elderly and disabled are drastically underserved. Data from the 1982 Long-Term Care Survey indicate that just 25 percent of frail elderly people in the community use any home-care services (Rivlin and Wiener 1988:90).

Although the potential pool of clients of home care programs is vast, however, an evaluation of a system of home care programs established in Massachusetts in 1973 found that the demand for services was "neither excessive nor uncontrollable" (Branch, Callahan, and Jette 1981). Some researchers report that family caregivers who contact service agencies make more modest requests than professionals deem appropriate (Horowitz 1985a; Moroney 1986). Moreover, at least some evidence suggests that the most critical issue for community agencies may be recruiting a sizeable clientele, not controlling intake. According to Weissert, "Many community care programs, especially geriatric day care programs, have opened their doors expecting a daily census of perhaps thirty patients, only to find that no more than half a dozen patients actually meet eligibility criteria and desire services" (1985:428). As Alan Sager comments, "The notion of a horde of greedy old people and lazy family members anxious to soak up new public benefits appears to be more a projection by a few wealthy legislators accustomed to domestic and hotel and restaurant service than it is a realistic image of our nation's elderly citizens" (1983:15).

The low take-up rate can be explained partly by the difficulties of locating potential clients. Many disabled elderly people live in isolation; in many cases, neither they nor their family and friends are connected to networks that can link them to formal services. According to a Harris poll conducted in 1986, just 40 percent of elderly persons can name an organization to which they would turn if they required assistance (Harris 1986). In addition, a significant proportion of both the disabled elderly population and informal caregivers may be unwilling to call upon whatever services are available. Elaine M. Brody argues that the resistance of adult daughters to formal services stems from emotional problems. Because they are overinvolved with their parents, she contends, they assume that they are uniquely equipped to minister to them (Brody 1985b). An equally compelling explanation may be that many elderly people and their friends and kin share with most other Americans the belief that dependence on any social services is a sign of personal failure. Having absorbed a value system which glorifies self-sufficiency, they may be unable to rely on others even when they are desperately needy. The same ideology that retards the expansion of home care programs thus inhibits the utilization of those that exist. Some elderly people also may cling to housekeeping chores as a way of separating themselves from their more severely impaired counterparts. An ability to manage routine tasks may serve as a source of self-esteem, especially for those who have suffered numerous other losses.

Although the difficulties of determining eligibility criteria for home- and community-based services should not be minimized, the intense concern with the issue of distribution and allocation may be misplaced. Our paramount concern should be to expand home care services dramatically and find ways to encourage disabled elderly people and family caregivers to take advantage of those available to them.

Educational Programs, Counselling Services, and Support Groups

If supportive services and financial compensation for caregivers are shrouded in controversy, educational programs, counselling services, and support groups enjoy enthusiastic support. Their attractions stem from a number of factors. First, they are relatively inexpensive. It is far cheaper to establish a ten-week course of lectures for caregivers than to provide them with the services of visiting nurses, home health aides, or homemakers over a period of months or even years. Second, these programs can help caregivers develop capacities to cope with the problems they encounter. Self-interest also dictates that certain groups of professionals promote these programs. Counsellors and public health educators, for example, see an expanded role for themselves in an aging society by advocating the delivery of counselling and educational services to caregivers. Robert Moroney adds: “If professionals spend years preparing themselves to function as therapists using the most sophisticated therapeutic methods, personal satisfaction and a feeling of work are associated with providing these services. The more concrete services are viewed as important, but their delivery is not necessarily a professional function” (1986:156–57).

Because educational and counselling programs receive virtually unanimous praise, it rarely is noted that they can incorporate different perspectives, assume a variety of forms, and serve divergent goals. Thus, despite their enormously positive aspects, a few programs also include potentially problematic features.

Educational programs typically cover a broad spectrum of issues, including the course of various diseases and their treatments, legal and financial affairs, community resources, and the psychosocial dimensions of caregiving. Such knowledge is essential and should be made widely available. Information about disease processes, for example, can empower caregivers, minimize their dependence on health care providers, and increase their competence and confidence. A recurrent complaint of family members is that physicians fail to answer their questions candidly and comprehensively. Moreover, a hallmark of most health care reform movements of the late 1960s and early 1970s was an insistence that providers share information broadly. Educational services clearly advance this mission.

But at least some types of training also serve as a means of shifting responsibility for the elderly from formal services to families. For example, as the average length of stay in hospitals drops, some home health agencies no longer can keep pace with the demand for their services. Instructing family members about the proper methods of administering medical care enables them to discharge elderly patients prematurely (Wood and Estes 1983).

Dispensing practical advice about the management of elderly patients also can increase the well-being and effectiveness of caregivers. Relatives caring for victims of dementia are especially prone to feel that they are negotiating new turf with few familiar signposts to guide them. Some can better tolerate troublesome and even frightening behaviors if they understand the genesis of these behaviors and learn techniques for dealing with them. Training also enables caregivers to gain distance from those they are tending; they can invoke the authority of professionals, at least in their own minds.

But the proliferation of programs providing advice about caring for the elderly also can have less desirable consequences. Rather than enhancing caregivers' sense of competence, such programs may undermine their faith in their capacities to solve problems on their own. The history of expert advice about mothering also may illustrate the limitations of this approach. Christopher Lasch (1977) has criticized the "invasion" of families in the late nineteenth century by professionals imparting advice about proper childrearing methods. As feminist writers have noted, this process devalued women's traditional skills and subjected them to male authority (Ehrenreich and English 1978). The creation of a new enterprise devoted to training relatives of the frail elderly similarly threatens women's autonomy.

Moreover, some professional advice may have limited usefulness. Noreen M. Clark and William Rakowski (1983), for example, advocate teaching caregivers skills in time management. It is unclear what benefits will ensue from bringing the values of the factory to the home. As Nancy Hooyman and Rosemary Ryan remark, "Economizing on the amount of time required to change an incontinent person's bedding does not substantially minimize the stress of performing this task several times a night. Nor do models of efficiency offer solutions to the constant vigilance required by a cognitively impaired person's wandering" (1985:27). Moreover, perfecting techniques based on standardized knowledge does not necessarily promote good caring. As noted in Chapter 1, several writers recently have argued that caregivers employ a type of thought that differs from scientific rationality. Kari Waerness argues that, in the context of caregiving, "one has to think and act on the level of the particular and individual. This means one has to understand from the position of an insider, and the kind of generalized scientific knowledge one may have at best seems very insufficient as a guidance for one's practices" (1983). Expertise, Waerness contends, depends both on "general practical experience in caregiving work" and on "personal knowledge" of the care recipient. The limited experience of many family members with the care of older people might suggest that Waerness' comments are irrelevant to them. But Elaine M. Brody (1985a) has called attention to what she terms the "caregiving career": many women begin providing services to parents and husbands after having devoted years to caring for other family members. If they lack specialized knowledge about the elderly, they bring to this situation considerable experience with caregiving in general. Thus, they have reason to trust their own ability to make good decisions and respond to their relatives in appropriate ways.

Counselling services also can have extremely important benefits. Therapy can enable adult children to disentangle unresolved emotional issues from the process of providing care and to impose appropriate limits. As noted, women are especially prone to becoming engulfed by their daily responsibilities. Counsellors can help them to draw necessary boundaries—to reclaim time for themselves, readjust their expectations about the care they can provide, and investigate nursing home placement when the burdens begin to seem intolerable.

But counselling programs have two potential problems. First, in seeking to engender a greater degree of emotional distance, these programs often use men's caregiving styles as a model. The disadvantages of men's greater emotional detachment rarely are mentioned. The intense involvement of many women in caregiving, which prevents them from establishing limits and places them at risk of stress, also may provide them with a measure of personal fulfillment. It also is possible that women's caregiving relationships are affectively richer than those of men. Second, because these programs stress changing individual attitudes and behaviors, they may serve to obscure underlying social structures.

Support groups meet regularly to exchange information, discuss personal experiences and coping strategies, and provide mutual support. They help to counter the intense isolation surrounding many caregivers by creating a sense of community. Members talk openly about stresses, share information, and gain solace and strength.

Nevertheless, there are a number of limitations inherent in the strategy of relying on support groups to alleviate the plight of caregivers. Some family members cannot afford the time to attend meetings on a regular basis. Some also are uncomfortable with the notion of disclosing intimate information to a group of strangers. In addition, most support groups serve caregivers who already are connected to networks of service providers; outreach to more isolated family members remains a serious problem.

Although most support groups promote personal adjustment rather than social reform, this emphasis is not inevitable. Sylvia Law (1986) proposes that support groups adopt the techniques of consciousness raising, encouraging members both to explore the common roots of their personal problems and to mobilize to demand change. A first step might be to help women understand the societal factors that compel them either to assume caregiving responsibilities or to become excessively absorbed in this activity. Many counsellors attribute women's overinvolvement in caregiving to their personality structures or family relationships. The consciousness-raising groups Law advocates could draw attention to cultural norms about women's responsibility for care, to the demands and expectations of other family members, and to the absence of alternative sources of esteem for many women in our society. These groups also could discuss how the failure of this society to recognize caregiving as socially necessary work and to provide appropriate services both threatens the well-being of caregivers and thwarts their ability to provide good care. Finally, consciousness-raising groups may encourage caregivers to seek common solutions to problems they previously viewed as private.

Women Who Care, a support group for women caring for disabled husbands, offers a model others could emulate. Organized by Clemmie Barry in Marin County, California, in 1977, the group originally restricted its focus to providing mutual support and encouragement. As the women exchanged stories about the dearth of supportive services, however, they recognized the need to take collective action on their own behalf. With the help of Marin Senior Day Services, a local agency, the group successfully established a program of respite care in their community. Joining forces with the Older Women's League, members launched a national campaign to increase public awareness of the concerns of caregivers and work for programs addressing their needs (Crossman 1985).

Caregivers of both the chronically mentally ill and handicapped children also have banded together to demand improved services for their relatives and expanded assistance for themselves. Many of the most effective national organizations arose from small-scale mutual aid groups whose members' awareness of their common predicament spurred them to work for change (Vine 1982). Broad-based advocacy clearly is imperative. In the long run, the allocation of societal resources for chronically ill and disabled persons will be determined not by the cogency of the arguments policy analysts can muster but rather by the strength of the organizations these groups and their caregivers can build.

BROADER CHANGES

Although financial compensation for caregivers, home health care services, training and counselling programs, and support groups are the favorite recommendations for alleviating the formidable burdens of many family members of the frail elderly, they remain inadequate solutions. Feminists repeatedly have demanded that we seek to restructure a working world that makes so little accommodation to the place of caretaking in the lives of its members. When we consider the entire lifecycle of caring, this goal assumes even greater urgency. Alternative work arrangements, such as job sharing and flexible work hours, are essential for many relatives who seek to combine paid employment and onerous caregiving responsibilities. Women who interrupt their work lives to care for the elderly need guarantees that their jobs will await them when they return and that they can continue to accrue pension credits. Although parental-leave policies currently cover only a minority of workers, support for them is growing (Mehren 1985). As Nadine Taub (1984–85) points out, leaves that focus solely on care for small children ignore the changing reality of women's caregiving obligations. Care for the frail elderly may come to equal child care as a central reason for relinquishing paid employment.

One danger of all leaves granted for caretaking is that they may reinforce women's subordinate position in the labor market. As long as more women than men take advantage of leave policies, employers have an added incentive to discriminate against women in hiring and advancement. As Taub argues, however, this problem may be alleviated by placing responsibility for funding with the government rather than with individual employers. In fact, widespread acceptance of caretaking leaves could help to eradicate the sexual division of domestic labor because men are more likely to participate in nurturing activities that do not jeopardize their places in the labor market. The movement for shared parenting has had a minimal effect on most U.S. households (Vanek 1983), and we therefore should be dubious about the possibility of equalizing the burden of care for the elderly. But it is at least conceivable that nurturing tasks not tied to women's reproductive capacities can be reallocated more easily than those that are.

Large-scale reform of the nursing home industry would enable caregivers to consider residential placement a reasonable option. Because we often accept as a given that institutional care must be dehumanizing and depersonalizing, we compel many family members to continue providing care long after they might reasonably have been expected to stop. A report prepared by the Institute of Medicine in 1986 confirms the worst fears of many family members, concluding that a high proportion of nursing home patients receive "shockingly deficient care" (p. 2). If we successfully take remedial action in response to this report, more family and friends might be willing to place the frail elderly in nursing homes before the burdens of caregiving become overwhelming.

Noninstitutional services have tended to receive less scrutiny than nursing homes. Nevertheless, scandals may simply be waiting to be uncovered. Governmental monitoring systems thus should accompany the expansion of the home-based services caregivers desperately need.

Finally, we should give greater consideration to the very high proportion of elderly people without relatives to provide care. Approximately 10 percent of the elderly receiving long-term care lack kin, and approximately 20 percent are childless (Soldo 1985:284). By emphasizing familial obligations, policymakers accord a privileged place to those older people who obtain services from kin. The needs of the elderly who have survived all their relatives, whose children are estranged, who remained childless, or who have lived their lives outside families are slighted. A high proportion of the elderly in decades ahead will have neither spouses nor children to care for them. The same housekeeping, personal care, and transportation services that reduce stresses on caregivers can permit some frail elderly people to manage the activities of daily life without assistance from friends or family. Alternative living arrangements such as congregate or shared housing enable older persons to create supportive communities among themselves.

Caring for the elderly in a just and humane manner clearly will not be cheap. Programs that are shaped to suit the needs of both the frail elderly and the caregivers who tend them may well involve staggering costs. An analysis of informal care thus throws into sharp relief the need to restructure social arrangements and reallocate economic resources.

DOCUMENTATION

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Notes

1. Of course, long-term care services and supplies are prohibitively expensive even to many middle-income people (Soldo 1985). Although some can purchase some assistance for limited periods of time, a protracted illness may exhaust their resources. Adequate help is a privilege only the very wealthy can afford.

2. Respite programs can take the form of either homemaker and home health care services in the home or adult day care and foster care homes in the community. Although respite services are widespread throughout western Europe, they are far less common in the United States.

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4

Gender Differences in Spouse Management of the Caregiver Role

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Family caregiving of the frail elderly involves complex relationships between caregiver and elder. Most studies of caregivers have focused on discrete chores, listing the total number of tasks performed and/or the number of hours spent on each. This emphasis on caregiving as "work" reflects one important component of the caregiving process. But it neglects the equally important socioemotional context of caregiving.

Spouses provide the most consistent and dependable care to the disabled elderly and resist institutional placements for longer periods of time than other caregivers, regardless of the level of disability (Cantor and Little 1985; Crossman, London and Barry 1981; Fengler and Goodrich 1979; Johnson 1983). The norms and values influencing families in the United States emphasize the obligation of husbands and wives to fulfill each other's instrumental needs while providing emotional satisfaction (Johnson 1985). Spousal care, thus, has been taken for granted as part of the marriage contract, and little attention has been directed to the meaning of caregiving in the context of long-standing marital relationships. This chapter draws on two different sources of data—a national survey and a small sample of white upper middle-class caregivers—to describe and analyze gender differences in spousal caregiving.

The chapter argues that spouses are not just family members sharing a unity of interests, but also individuals who have received different role socialization and have different interests. Caregiving has traditionally been viewed as women's activity, not only within the family but within the world of work as well (Finch and Groves 1983). Prior research has assumed that female spouses adopt the position of caregiver more easily because they can merely extend the nurturant component of their earlier role of homemaker. Male spouses, by contrast, must learn new behaviors to become successful caregivers. But we know little about what happens when husbands assume the caregiving role. To what extent do they behave in ways similar to those of female caregiver spouses? Do wives and husbands experience the stresses and strains of caregiving in the same way? Do they provide similar types and levels of support for the impaired spouse? Two theoretical perspectives suggest different answers to these questions.

The gender socialization framework assumes that gender roles become internalized in stable personality traits as a result of gender differences in socialization during childhood. This framework includes various approaches, such as social learning (Bardwick and Douvan 1971), psychoanalytic (Chodorow 1978), moral development (Gilligan 1982), and biosocial (Rossi 1984). Those who subscribe to this framework view the outcome of early socialization patterns as stronger affiliative orientations in women and more emphasis on autonomy, differentiation, and instrumental behaviors in men. Gender differences in sensitivity to relationships, role behaviors, the meaning and use of social supports, and illness behaviors are expected to occur throughout the life cycle (see reviews by Long-Laws 1979; Tavris and Offir 1977). Kessler argues that women experience greater stress than men, in part because of their greater sensitivity to a wider range of persons in their social networks (Kessler 1979; Kessler and McLeod 1984). Gilligan (1982) contends that women also are more likely to have a morality of responsibility that emphasizes the connection between individuals, while men express a morality of right that focuses on the separation of self from others.

The social role perspective assumes that adults engage in continuous construction of social realities and focuses more explicitly on current role demands as the primary explanation for gender differences in behavior (Blumer 1969; Maines 1977; Risman 1987). According to this framework, behavior and attitudes are adaptive to ongoing interactions, and they reflect individuals' interpretations of current situations. Proponents of this perspective argue that exposure to stressful situations in adult lives determines stress levels; women are more distressed because they have more stressful experiences. This theory would attribute any husband/wife differences in caregiving to gender variations in both the level of involvement in caregiving and access to current social resources, rather than early role socialization and personality factors. These latter factors, however, may continue to influence the way the situation is defined (Risman 1987).

Results from the few studies of husband/wife differences in caregiving are ambiguous. Fitting et al. (1986) found that husbands and wives caring for demented spouses experienced similar degrees of burden, but that wives reported more depressive symptoms. In a rare longitudinal study, Zarit, Todd, and Zarit (1986) reported that initial differences in subjective burden between husbands and wives were no longer present at the time of the two-year follow-up, findings that lend support to the social role perspective.

Many studies have found differences in levels of depression of older women and men, but researchers rarely assess reasons for the greater prevalence of depression among older women.

THE CONTEXT OF SPOUSE CAREGIVING

Marriage confers distinct advantages in terms of morbidity, mortality, and emotional and financial well-being (Hess and Soldo 1985). But marital rates vary systematically by gender and age. According to the 1980 U. S. Census, 79.4 percent of men between ages sixty-five and seventy-four are married, compared to just 48.1 percent of women. After age seventy-five, women's rates decline by more than one-half to 22.1 percent married, whereas men's rates drop only slightly to 67.7 percent. Approximately one-quarter (1.2 million) of all persons sixty-five and older are functionally disabled (Stone, Cafferata, and Sangl 1987) and almost one-half (43.8 percent) of these are married, including 72.5 percent of the men and 27.6 percent of the women (Macken 1986).

Demographics

The 1982 Long-Term Care Survey sponsored by the U.S. Department of Health and Human Services provides a broad perspective of gender differences in a nationally representative sample of spouse caregivers. Approximately 6,000 frail elders drawn from the Medicare enrollment files completed in-person interviews. The elders were asked to identify relatives and friends who helped them, and interviews then were conducted with a sample of 1,924 caregivers. (See Macken [1986] and Stone, Cafferata, and Sangl [1987] for description of sample and preliminary findings.) For an analysis of spouse caregivers, the two data sets were linked and a subsample of approximately 600 spouse caregiving dyads identified.

Women constituted the majority of all caregivers. They represented two-thirds (385) of the spousal caregivers. Eighty-nine percent of the caregivers were white. Seventy-nine percent of the couples lived in urban areas, and 78 percent lived in couple-only households. The general level of impairment was high. Fifty-two percent of the impaired spouses received assistance with three or more personal care activities such as bathing, dressing, or toileting. Almost one-half of the dependent spouses (44.5 percent) had been patients in the hospital at least once during the past year. Husbands providing care were older (mean age=73.9) than female caregivers (mean age=69.1), slightly less educated, and more likely to be white.

Caregiving Situation

Caregiving husbands and wives had relatively few average differences in their caregiving experiences. For example, the average number of caregiving tasks performed by spouses was 2.6 (out of a possible 6); care had been provided for an average of 7.2 years. The primary difference lay in the health status of their spouses: caregiving wives were likely to be caring for spouses who were more impaired and who exhibited more disturbing behaviors. There were, however, no significant differences in the number of recent hospitalizations of the impaired spouses. Husbands and wives reported similar levels of caregiver involvement with one exception: husbands were more likely to report spending additional time in caregiving tasks than wives. Because respondents were asked to estimate the amount of time they spent on domestic activities such as fixing meals and doing laundry that they may not have done previously, these results simply may suggest that the husbands in this sample had not undertaken such traditionally female household chores until their wives became impaired. Wives reported providing assistance with a higher number of general household tasks, such as shopping and cooking. Husbands and wives did not differ in their use of other household helpers. In fact, fewer than one-half of the sample had any additional help with their caregiving activities.

Caregiving Attitudes

Contrary to many prior studies, no gender differences in caregiving stress were found in this sample. But husband and wife caregivers did show statistically significant differences in the types of problems they experienced as a result of caregiving. Women were more likely to experience pressure to provide care when they did not feel well enough themselves, report that caregiving was hard for them emotionally, experience limitations on their social life, and feel greater stress when their impaired spouse became upset and yelled at them.

INTERPERSONAL EXPERIENCES OF CAREGIVING

Although the national survey found relatively few differences between husband and wife caregivers, it did not contain adequate measures of the sociopsychological dimensions of caregiving. This section of the chapter discusses an in-depth study of spousal caregivers, illustrating more subtle social and interpersonal processes. Fifteen caregivers of cognitively-impaired spouses were interviewed with a semistructured interview schedule as part of the evaluation of a small adult day care program for persons with memory loss in an upper middle-class, white suburban community. The center program emphasized socialization experiences and had a bimonthly support group for caregivers. In addition to interviewing caregivers, I observed the support group discussions. Two-thirds of the impaired spouses had diagnoses of Alzheimer's disease; the rest had related diagnoses of brain dysfunction such as Parkinson's disease, multi-infarct dementia, and severe depression. The general differences described by male and female spouses in caregiving experiences were not the result of any statistically significant differences in level of impairment. Such differences may, however, have influenced behavior in specific instances.

The interview sample consisted of nine women and six men. Most of the female spouses were in their mid-sixties and seventies with a median age of seventy-two. Although most rated their health as good and reported no disabling conditions, many of the wives did mention having periods of depression. The male spouses were older than the female spouses. Three husbands were between ages of eighty-eight and eighty-nine, two were between ages seventy and seventy-three, and one was sixty years old. With the exception of the sixty-year-old, all the men were retired businessmen or professionals with some physical deterioration, typically an arthritic condition. All but two of the caregivers had been aware of their spouses' cognitive impairments for at least three years. Most of the impaired spouses had diagnoses of Alzheimer's disease, although a few had nonspecific patterns of memory loss.

The data collection techniques were a semistructured in-person interview and a checklist of the occurrence and frequency of everyday problems associated with dementia (Zarit and Zarit 1983). Interviews lasted an average of two hours and were tape-recorded and transcribed. Among other areas, caregivers were asked about their daily routines, the changes that had occurred in patient care and in their own lives since they became aware of the cognitive impairments, and the barriers they encountered to providing care.

The dementias, such as Alzheimer's disease and related disorders, have complex symptomatology with variation in rate and pattern of decline in functioning. Because behavior can vary dramatically on a momentary basis, a caregiver rarely can anticipate exactly what response an interaction will take. Caregivers thus are faced with the task of trying to cope with their spouses' behavior and their own lives in such a way as to reduce their feelings of uncertainty and maintain as normal a life as possible. This study found that men and women taking care of cognitively-impaired spouses emphasize different dimensions of management in four areas: interpretation of the disease process, assumption of authority, managing care tasks and spouse behaviors, and use of social support.

Interpreting the Disease Process

With the exception of two men, all the caregivers indicated that it was important to treat their spouses as normally as possible by maintaining meal routines, holding informal conversations, and visiting family and friends. Both female and male caregivers needed to make sense out of the disruptive and irritating behaviors of their spouses. They did so, however, through different interpretations of the disease process.

Although many women said they read what they could and wanted to know more about brain dysfunctioning, none explained her husband's behavior in terms of a disease process. Instead, the women emphasized the meaning of the symptoms of brain dysfunction in terms of changes in their relationship with their husbands. Many used the analogy of child care to express the changing relationship. For Jane Thomas, the differences between child and adult were critical: "It's a difficult life—it's worse than a child because he's stronger and yet he has emotional senses. . . . He talks about being lonesome and knows when people are laughing at him." For others, the analogy with child care helped to convey the quality of the care needed: "When we go out socially, it's like having a child that you have to wait on." Still others employed the analogy to describe levels of docility. As Ann Perry commented: "When he was taking medication, he was easier to manage in the sense that an infant would be easier to manage than a child."

Most of the husbands referred to "mind problems" or "problems getting through to the brain" to explain the changes in their wives. They attributed their spouses' dependency and confusion specifically to the disease process. After describing how he asked his wife to get a glass from the dining room table, Mark Smith noted, "You have to take into consideration the failure of the mind all the time." The older men, especially, had little interest in learning more about Alzheimer's disease, because they were convinced nothing could be done. Instead, they tried to accept their wives' behavior as inevitable correlates of illness. It was not clear how they defined their own role in responding to these "mind problems," although some appeared to act like teachers offering precise instructions. John Martin (whose wife suffered from multi-infarct dementia) devised assignments for his wife, telling her what she should do in order to "get her mind working so she can think of these things herself."

Assuming Authority

Both husbands and wives expressed the need to manage and take control over most details of their impaired spouses' lives. But the assumption of authority over their spouses was much more problematic for the wives than for the husbands. The men interpreted their increased authority over their wives as a natural extension of their position in the family. In a typical comment, Bill Jones noted that if he is strong about what he wants done, his wife is too weak to cross him. Although a few husbands expressed discomfort about having to dress their wives and monitor their bathroom behavior, most mentioned their own ease in assuming household responsibilities.

For the wives, asserting control over another adult—especially a man who may have been the authority figure in the marriage—was one of the hardest aspects of caregiving. Many women remarked that it was difficult to tell their husbands what to do in financial areas and everyday decisions, such as use of the car. Two women feared violent reactions from their spouses. Others believed the shift in authority involved heavy personal costs for themselves. One woman remarked: "Since this is a second marriage for me, I feel uncomfortable making many of the decisions . . . like selling his car or taking him to an unusual medical treatment. It's not my nature to raise my voice, but I do it more now. That's the hardest thing."

For many women, the most devastating aspect of assuming authority seemed to be their feelings of anger at having to tell their husbands what to do. Their awareness of parts of their personality that they had never acknowledged affected not only their emotional balance, but also their self image. For example, Jane Thomas became frightened by how angry she could become because she had always viewed herself as a quiet woman.

Many of the wives displayed considerable sensitivity to their spouses' feelings when they assumed new authority positions. They tried to stage their involvement, maintaining the illusion of their husbands' previous activities in innovative ways. Thus, Susan Richmond rented a post office box to divert the bills from the house so her husband, a retired accountant who eagerly collected the daily mail, would not have to confront his inability to manage his finances. Martha Jackson wrote out checks, but then gave them to her husband to sign, thereby maintaining his sense of control over his money. In this way, the wives sought to define a balance between previous marital role relationships and the new realities, drawing on a previously acquired repertoire of supportive behaviors.

Managing Care Tasks and Spouse Behaviors

The home is the major environment of caregivers. Yet the home traditionally has different meanings for women and men. Traditionally, the home has been the location of women's work, the major arena of responsibility, status, and presentation of self (Bernard 1981). The subjective meaning of home among retired men has received little study, but we can speculate that the home, no longer just a place of refuge from work, may take on such workplace attributes as scheduling and hierarchy.

Although all the husbands and wives I interviewed described caregiving responsibilities as time-consuming and fatiguing, they managed caregiving tasks and problematic spouse behaviors very differently. All the female caregivers had been full-time homemakers, and they talked about their loss of control over their home environment because of their husbands' behaviors. These women complained that their husbands were constantly present and intruded into all their personal time. Mary Ellis stated: "For a while, I found it unbearable to live with him in the house. . . . He breaks things, changes things around. . . . He gets bored and loves the kitchen . . . puts things in different places, likes to work at the sink scrubbing silverware." Discussions in the support group sessions confirmed that planning activities was a constant struggle because any specific successful activity only worked for a short period of time. Despite their concerns with completing chores, the women gave priority to their husbands' needs and sought to be flexible in their routines. They emphasized their need to "live from day to day" in order to be more attentive to their husbands' needs.

Male caregivers were more likely to present a greater sense of control by focusing on caregiving tasks and projects rather than on their changed relationships with their wives. Unlike the women, many of the men described their routines on a weekly basis with events planned for each day of week. For example, Mark Smith recounted how he went marketing on Monday, took his wife to the day care center on Tuesday while he attended senior center activities, did shopping while his wife had her hair done on Wednesday, ran errands on Thursday, and again made use of the day care and senior center on Friday. Surprisingly, most of the men continued to carve out their own territory in the home. They described with enthusiasm their household projects, such as gardening or painting.

Unlike the female caregivers, the male caregivers viewed their wives as passive and undemanding. They thus assumed that their wives would not interfere too much in their projects. For example, Bob Unger said, "[My wife] spends a lot of time sleeping. . . . She's not interested in television. . . . If nobody is coming in to do something that I have to show around and take care of, I try to get in some gardening which is my favorite occupation. . . . [She] doesn't ask any questions . . . just watches me work." Moreover, the male spouses were more willing to leave their wives home alone despite potential dangers.

Using Social Support

Adult children provided emotional support but little practical assistance to both male and female spouses. There was not sufficient data to analyze caregivers' relationships with adult children, but comments of the respondents did imply that the quality of these relationships remained unaltered. A few, however, noted that they felt closer to the children who did not live in the community than to those who lived nearby, expressing disappointment at not receiving more practical help.

Relationships with friends did change dramatically as the impairments of the spouse increased. Some caregivers withdrew from social activities because of lack of time or the problematic public behavior of their spouses.

Some also reported a decrease in invitations from friends. Both men and women were upset that friends did not pay enough attention to their impaired spouses on visits. Although they continued to present themselves as a couple, others saw them now as individuals, one healthy and one impaired.

Women and men focused on different solutions to this problem. Many women sought social activities such as ballroom dancing, in which their husbands still could participate. They also participated more actively in the program's support group, thereby reinforcing their roles as caregivers and their ties to their husbands. The men, on the other hand, were more successful in locating activities for themselves as individuals. Most of the husbands did not attend the family support group, claiming it was upsetting to hear of other difficulties associated with Alzheimer's disease. Mark Smith thought "they overdo the medical talks at the center anyhow." Many husbands stated that it was more helpful to them to use free time for interests unrelated to their family situation.

Although some studies have reported that husband caregivers are more likely to receive greater support from both formal and informal sources (Johnson 1983), the husbands in this study used only occasional paid cleaning or help from neighbors and did not mention the need for additional help in the home. They stressed instead their ability to manage their daily routines by themselves, despite their fatigue. Most female caregivers were interested in finding companions or "baby-sitters," although few had regular plans for respite. Several expressed uncertainty about what kind of household help would be appropriate. Should they seek a housekeeper who would do cleaning, or a companion who would watch their spouse? Mary Ellis summed up many of the difficulties: "I had trouble finding the right person to stay with [my husband]. One person just sat and watched [him] too closely. Another served his meals insensitively, another was expensive and unreliable, another was sarcastic. They were sitters—they weren't helpers."

Concern about their husbands' acceptance of these persons complicated the problem. The wives took complaints about "why is so and so coming" seriously and struggled (usually unsuccessfully) with ways to explain the presence of this new person to their husbands. Most feared that their husbands felt demeaned by the connotation of baby-sitting. Male caregivers were less concerned about finding companions for their wives.

SUMMARY AND CONCLUSIONS

This chapter relied on both a national survey and a small-scale qualitative study to describe gender differences in spousal caregiving. In both studies, complex patterns of gender similarities and differences emerged, supporting elements of both the gender socialization and current social role theoretical perspectives. Husband and wife caregivers were equally committed to caring for their cognitively impaired spouses and performed the necessary caregiving tasks. But their attitudes toward caregiving and the strategies they adopted often differed greatly.

Data from the 1982 Long-Term Care Survey show that, contrary to findings in prior studies, husbands and wives did not experience differences in perceived stress. This supports the contention of the social role theorists that the similarity of caregiving commitment leads to similar appraisals of the situation. Because the wives were caring for husbands who displayed more behavioral disturbances, however, the fact that the wives did not report higher levels of stress suggests that women's tolerance for stress may be greater than that of men. Moreover, the wives were more likely to express concern about limitations in social activities, feel greater upset when their spouses yelled, and feel pressured to provide help even when not feeling well themselves. These findings suggest that the effects of gender socialization are ongoing.

The case study focused on sociopsychological processes; it therefore revealed more subtle gender differences. Because the sample is small and limited by class and race, the findings necessarily are suggestive. In general, the wives displayed greater sensitivity to interpersonal concerns; the husbands were more able to distance themselves emotionally from caregiving responsibilities. Husbands and wives agreed that they had to assume authority over their memory-impaired spouses and that the diseases limited their social activities. But they employed very different strategies as caregivers. The husbands took charge of their wives without questioning their ability to do so or the impact of their actions on their wives. The wives found assuming such authority very difficult for two reasons. First, this shift in power relations threatened their self-image. Second, they were sensitive to their husbands' helplessness and thus sought to sustain whatever functions remained.

The wives were more apt to adopt new behaviors and report personal growth. In the social arena, the wives tried to locate activities in which they and their husbands could continue to participate as couples. They also adopted a new identity as caregiver and sought sources of support for that role. The husbands were more apt to focus on ways to continue individual activities that were distinct from their impaired wives' situations and maintained their previous identities.

Both husbands and wives emphasized the need to maintain as normal a life as possible. Husbands defined their wives' behavioral difficulties in terms of a medical model, interpreting changes in behavior as symptoms to be managed. Wives, on the other hand, tended to view altered behaviors in terms of their consequences for the marital relationship.

In the remaining areas, managing at home and use of household help, gender differences emerged both in the ways the situations were defined and in the strategies used. The wives emphasized the loss of their home environments, yet created flexible caregiving routines, whereas husbands adopted a task orientation to home management and tended to routinize care procedures. Although the wives perceived a need for respite from caregiving tasks, they found suitable household help difficult to arrange, in part because of their concern about their impaired husbands' reactions. Because the men did not perceive their home activities as being threatened, they saw little need for additional help at home. By defining their wives as passive and needing less active supervision, the husbands may have left their wives in potentially dangerous situations.

The preponderance of gender differences in these subtle arenas of care lends support to the gender-role perspective. As noted, this framework postulates that women have been socialized to have a stronger commitment to caregiving than men, especially in terms of sensitivity to interpersonal elements (Finch and Groves 1983; Gilligan 1982). Abel (1987) notes that caregivers receive two competing types of management advice: caregivers should treat their impaired relatives with dignity and individualize caring regimens; and caregivers should develop emotional distance from the stresses of intensive caregiving. In some respects, these patterns of advice reflect female and male models of caregiving (Abel 1987). The wives in this study followed the female model in many ways. Their standards of care encompassed emotional support as well as task completion. They were creative in finding ways to carry out necessary tasks and constantly assessed the impact of their actions on their husbands. In turn, the husbands reflected the male models. They were more successful in distancing themselves emotionally from their wives' situations and carrying on with their own activities.

We may speculate that congruence with previous sex-role behaviors becomes especially highlighted when elderly individuals are faced with the ongoing ambiguous caretaking situations that occur in families with a cognitively impaired member (Lazarus and Folkman 1984). The variability of behavior was a dominant concern of the wives, leading to an emphasis on living for the moment and maximizing what remained of the relationships with their cognitively-impaired husbands. Men, on the other hand, stressed the continuity of those aspects of the environment under their control. In this way, they selectively ignored some of the uncertainty they experienced as caregivers.

Pearlin and Schooler (1978) suggest that the effectiveness of coping behaviors should be judged according to how well they prevent hardship from resulting in emotional stress. The male caregivers gave the impression of less emotional stress because they presented themselves as being in control of the caregiving situation. But the female spouses were engaged in a wider range of problem-solving activities, and, although they expressed more stress, they also displayed a greater willingness to respond to their husbands' changing needs. The results of this study suggest that evaluation of effective coping may vary systematically by gender definitions of the relative importance of self versus the other.

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Part III

Formal Organizations

Preface

As caregiving moves from the domestic domain to formal organizations, increasing numbers of women find employment in the service sector, where they do for pay and for nonkin what women previously provided as a "labor of love" in private households. The first chapter in this section explores the complex relationships between domestic work and paid employment and between autonomy and dependence in women's lives. According to Fisher, women who receive advanced education in order to enter professional positions in the human services assume that they will achieve economic independence, confirm their gender identity, and find valuable work. Fisher further argues that human service professionals can be grouped according to the political perspectives that inform their work. Some view caring as a way to meet human needs, others as a central component of the definition of a professional, and still others as a means of transforming society. Fisher concludes by noting that women who invest considerable effort in obtaining professional status often fail to understand the vantage point of either their clients or women who occupy lower-level jobs. She contends that professional human service workers must recognize their unity with these groups in order to satisfy the "impulse to liberation" implicit in their commitment to caring.

According to Reverby, the first women who entered the field of nursing had far fewer options than contemporary human service professionals. Because nursing was one of the few careers open to women during the late nineteenth and early twentieth centuries, women who needed to earn a living had limited alternatives. Nevertheless, altruism and a desire to conform to prevailing conceptions about female nature also conditioned their occupational choices. Reverby suggests that the central problem facing nurses has been to find a way to render care without self-sacrifice. Because nurses traditionally have been expected to accept a "duty to care," they have lacked the political standing necessary to assert the right to shape both their own working conditions and the structure of care delivery. Reverby urges nurses not to cling to a liberal political strategy that emphasizes individual rights but rather to adopt a broader political agenda addressing collective social needs.

The final three chapters in this section are based on participant observation, and they explore a common theme: although health care institutions rely on the altruism of female workers, these institutions fail to acknowledge the caring skills women bring to their jobs; moreover, they operate according to priorities that undermine the emotional component of care.

Lundgren and Browner trace the experiences of psychiatric technicians working with the severely and profoundly mentally retarded residents of a state mental hospital. The authors counter the widely held view that such workers are indifferent to the needs of their clients. Like the higher-level workers Fisher and Reverby describe, psychiatric technicians are drawn to their occupation partly because they want an opportunity to serve others. Moreover, by respecting the dignity of a group of people who traditionally have been treated with contempt, these workers enhance their own self-esteem. But the conditions of their employment hinder their efforts. By forging a work culture, psychiatric technicians are able to promote their interests as workers while resisting institutional structures that prevent them from rendering good care.

According to Diamond, nursing assistants employed in nursing homes encounter the same institutional barriers as psychiatric technicians. Although nursing assistants often provide the only personal contact residents receive, their jobs are defined solely in terms of medically-oriented tasks. In framing institutional policies, administrators disregard the personalized knowledge nursing assistants acquire. Because the recordkeeping process is geared toward corporate balance sheets and government licensing inspections, it distorts the central rituals of daily life. And nursing assistants who take time to respond empathetically to residents can be reprimanded for doing so. Diamond links these issues to the broader dynamics of capitalist medicine. Institutions that base decisions on profit keep wages low, quantify tasks, view care as a commodity, and ignore the emotional needs of the residents.

Sacks demonstrates that similar issues arise in acute-care settings. Although caring and coordination are not part of the formal job descriptions of clerical, technical, and service workers, women employed in these occupations find themselves compelled to provide such services in order to compensate for the rigidity and impersonality of hospital routines. These workers are caught in a catch-22—both successful and unsuccessful care delivery may call forth negative sanctions. Like Diamond, Sacks moves between two levels of analysis. In the second half of her chapter she notes that, although the reform movements of the 1960s and early 1970s responded successfully to many of the demands of both workers and consumers, these movements failed to insist that the caregiving skills of low-level workers be recognized and rewarded, and they left intact the hierarchical structure of health care institutions. As a result, Sacks suggests, hospital workers have been powerless to resist harsh employment policies imposed in the wake of prospective pricing and other cost-cutting measures.

5

Alice in the Human Services: A Feminist Analysis of Women in the Caring Professions

Berenice Fisher

Alice, a long-time feminist and human service professional, wonders what is happening. For years, a conservative, white, male-run government has underfunded and underrated the human services.[1] Curiously enough, many people blame women for the increasing human service problems. A prestigious newspaper implies that the women's movement has helped to bring about the nursing shortage. The dean of a school of human services blames his declining enrollment on women who have abandoned their "traditional" occupations. The head of a major union claims that women's wider range of occupational choice has depleted the ranks of teaching. Some of Alice's older colleagues themselves blame feminism for the devaluation of human service fields.

Alice questions this looking-glass version of reality. Like many contemporary feminists, she has fought for the rights of clients and against the exploitation she herself has experienced as a human service professional. She has gained insight from feminist analyses by social workers, teachers, nurses, and other human service professionals (e.g., Moccia 1987; Muff 1982; Norman and Mancuso 1980; Weiler 1988). She has long identified with the women's movement and its goals.

At moments, however, she wonders if she truly belongs to this feminist wave. She was disturbed in the early 1970s when activists called for women to "Be a doctor, not a nurse!" or charged that human service professionals merely colluded with capitalist patriarchy. She feels that many feminist researchers have looked down on the women's human service professions. As she hears women being blamed for the current "crisis" in the human services and watches many younger women turn away from such work, she longs for a broader perspective. "How puzzling these changes are," says Alice, as she begins to search for a feminist theory.

The task of developing a politically progressive and intellectually coherent perspective on women's human service work is not an easy one. Such work is obscured by devaluation (low prestige and low status make it an inferior segment of the job market), invisibility (stereotypical images mask the real nature of human service work), and fragmentation (bureaucratization and professionalization separate human service workers from each other). The search for an adequate theory is also hindered by the tension between feminist analyses that stress the oppressive function of women's caring work and those that laud such work because of its value to humanity and the special role it gives to women. Clearly, however, human service work has both oppressive *and* valuable aspects. For feminists, the problem is to find an interpretation that neither glorifies nor dismisses such work, that takes into account its complexities and its contradictions.

One of the most promising beginning points for this search seems to be the feminist understanding of the public/private dichotomy. This dichotomy, many feminists have argued, has contributed greatly to the oppression of women in industrialized societies by supporting equality and freedom for men in public life while fostering dependency and servitude for women at home (Jaggar 1983). From the perspective of this split, work in the public realm offers an escape for women—a way to become a citizen, a person, a worker who controls her own labor power.

As everyone knows, however, this escape proves illusory in many ways. Women continue to perform unpaid work in the private sphere, regardless of their status in the marketplace. Women who undertake paid work find themselves constrained by class, race, age, and a variety of other social characteristics that limit the kind of work available to them and the conditions under which they work. Furthermore, all women are affected by the broad gender segregation of work. Women are often encouraged to pursue "service" jobs that in certain respects parallel women's work at home. Ideologies of career "choice," as Patricia Sherman (1988) has shown, help to mask the realities of gender segregation in the marketplace. Pay for work done mostly by women continues to fall far behind pay for male-dominated work. Thus, when looked at in terms of choice, control, and compensation, women's work in the marketplace has far fewer advantages than first appears (Berch 1982; Bergmann 1986). The public/private distinction is, in a sense, overwhelmed by the gendered division of labor. The promised escape from servitude turns into a vicious circle.

For female human service professionals, the contradictions of gender-segregated work are especially severe. Limited control and relatively low pay call into question the meaning of *professional*. The continued association between human service and domestic work leads to criticism from feminists and nonfeminists alike. Feminist solutions to problems of women's oppression and exploitation have ambiguous consequences for women in the human service professions. While women's struggle for access to male-dominated fields challenges gender privilege, gender integration in the human service professions often results in men taking over the higher positions. While women's alternative institutions (such as health clinics and schools) offer some women the opportunity to define their own needs, the place of professional expertise in such projects is open to question. While the drive to organize women through unions and professional associations empowers many women professionals, these organizing efforts often reinforce the very hierarchical structures that oppress women workers and clients in human service institutions.

This chapter explores the contradictions pervading human service work by focusing on one particular group of human service professionals: women who pursue their career commitments through advanced education in their respective fields. Although some of these women might be seen as professional "leaders" (see Scott 1985), many do not hold high professional positions. They do, however, represent a relatively elite segment of the women's work world. Thus, they should not be seen as representing human service workers or women workers in general, and any analysis based on their experiences alone suffers from significant limitations.

My wish to understand this group of women human service professionals has grown out of my experience. For many years, I have taught in a school for human service professionals and have thought about the meaning of feminism for such fields. My position enabled me to arrange easily the open-ended interviews from which I quote.[2] In these interviews, I tried to understand what draws women to and keeps them in the human service professions, despite the many drawbacks of these fields. I wanted to grasp more fully what such work means for the women who claim it as their own. In a way, I see women who become passionately committed to the human service professions as spiritual descendents of the early leaders of these fields: women who saw human service as a way of changing the world, as well as a way of changing the lives of the women who made this work their vocation.

WOMEN'S SOCIAL VALUE AND THE HUMAN SERVICE PROFESSIONS

In order to understand the meaning of the women's human service professions, we need to call into question the two images that dominate so much discussion of women's paid work: the image of women's paid work as an escape from domesticity and the image of women's paid work as a continuation of domestic work. Both images correspond to important realities in women's experience. However, taken as the basis for feminist analysis, each image suffers from distortions.

The image of "escape" exaggerates the extent to which any of us can escape from domestic, that is, caring, work. If (as Joan Tronto and I argue elsewhere in this volume) caring work is the work of maintaining and repairing ourselves and our world, someone always has to do it. Although individual women may escape caring work to varying degrees, they do so by passing it on to others—usually other women and often women with fewer resources than themselves. The escape image also implies that women's work choices grow out of rationally derived "interests." Such an assumption downplays the serious structural limitations that women encounter in the marketplace. This emphasis on rationality minimizes the ways in which the gender segregation of labor permeates our lives and shapes our values. It implies that if individual women would only make the "right" personal and/or political choices, women would not remain trapped in oppressive and exploitative work.

The image of women's paid work as a continuation of domestic work is equally distorted. This image obscures the ways in which access to paid work often strengthens women's position in both the private and public spheres. It exaggerates the extent to which women's paid work simply mirrors work in the home (for example, it makes no sense of the fact that women have a difficult time getting work as commercial cooks [Cohen 1985]). The image of paid work as a continuation of women's domestic work tends to assume an unchanging and monolithic marketplace. It tends to ignore the historical changes in the definition of women's and men's work and to neglect the internal differentiation of work within large job categories. Finally, this image often attributes far too much explanatory power to women's socialization. Women who seek out "women's work" are portrayed as dupes, passively accepting or happily cooperating in their oppression. Such "socialized women" are not credited with sensing the contradictions we all experience between how to live in the world we inherit and how to make our lives better.

In place of this limited and moralistic dichotomy between escape and continuation, I propose that we emphasize women's attempt to gain control over their lives in the face of many external and internal constraints. This effort revolves around the problem of woman's social value: her value as a human being to herself and others (Glaser and Strauss 1965:38). The need for women to establish their social value does not arise in a vacuum. It results from the emergence of particular social forces that render women's value problematic. As feminist historians have shown, women in preindustrial and precapitalist societies could, to a great extent, take their social value for granted (Cott 1977; Harris 1982; Matthaei 1982; Rothman 1978). That is, although women might be objects of fear or derision, their fundamental economic and reproductive value to the household could be assumed.

The advent of industrialization in countries like the United States challenged this assumption profoundly, especially as it related to middle-class, white women. For these women, the movement of most economically productive activities into the public sphere meant reduced power in the household. To compensate for their loss, women often supported the emerging "cult of domesticity" that made them the moral and emotional center of the home and, therefore, still valuable to it. This same redefinition, however, did not serve unmarried women (or widows or women whose husbands could not afford to buy them the goods and services needed to sustain the family) (Gissing 1977; Meyerowitz 1988). As the birthrate fell and immigrants enlarged the pool of inexpensive domestic labor, never-married aunts and daughters faced an especially serious loss of social value. Their "redundancy" meant economic and social marginality. Yet, it also meant opportunity—the chance to build a life in which the household was no longer the center. This opportunity may have been a mixed blessing for many women, but it played a key role in the development of the women's human service professions.[3]

Whether they raged against the family (see Nightingale 1959) or idealized family life (e.g., Beecher and Stowe 1870), never-married women played leading roles in the creation of the modern human service professions. Fields such as nursing and teaching originally recruited or even limited themselves to unmarried women workers. These women's professions, as feminist historian Martha Vicinus (1985) has suggested, created both a refuge and a frontier for women who did not marry: a way to earn a livelihood, a home away from home, a way to contribute to society. Such professional careers, as Susan Reverby's (1987) history of nursing has shown, were far from ideal. In many respects, they perpetuated the exploitation of women professionals as well as the exploitation of women who worked under them in human service institutions. Nevertheless, the human service professions represented an important path for women whose value was no longer defined primarily by their relation to the household.

Since the mid- and late-nineteenth century heyday of the founding of the modern women's human service professions, two major changes have taken place that affect this social reconstruction. One is the rise of homophobia, which called into question close bonding between women who were not kin (Faderman 1981; Vicinus 1985). Although homophobia did not stop the growth of the women's human service professions, it helped individualize women's human service careers. That is, it shifted their meaning away from that of a collective solution to the problem of women's social value (as represented by the residences in which so many early human service professionals lived) toward that of a particular solution for the individual woman who did not want or could not take the household as the basis of her life.

The second major change was the movement of more married women, especially middle-class white women, into the work force and into the women's human service professions (Matthaei 1982). One might expect this influx of married women to have transformed the meaning of women's human service careers. But because women's value outside of their relationship to the household remained problematic, so did the link between women's social value and the women's human service professions.

The next three sections of this chapter explore three major aspects of women's attempt to establish their social value through the women's human service professions. These aspects speak to three serious questions that arise once women begin to define themselves outside the traditional household system: How will I survive economically? Will I be a woman? Will I be of any value to others? The ways in which women have answered these questions may not be fully consistent with each other. Nor does a career in the human service professions offer the only possible answer: women strive to establish their value in many ways. Still, the human service professions represent an important alternative, one that has far-reaching and important implications for understanding women's lives.

THE STRUGGLE FOR INDEPENDENCE AND THE GENDERED DIVISION OF LABOR

The women human service professionals with whom I spoke in the course of developing this chapter stressed "independence" above every other value for their work. By independence, they meant the capacity to support themselves (and dependents if they had or expected to have them) at a standard of living that was "comfortable." Their interpretations of "comfort" varied, but all the women sought to establish a way of living that did not seem deprived. Independence meant not only literal financial independence but the chance to determine how one would live.

In her recent study of older, never-married women, Barbara Simon (1987) found a strong connection between the desire for independence and a determination not to marry. The women I interviewed connected independence to the possibility of marriage in a variety of ways. For some, independence did mean a total rejection of marriage. For others, financial self-sufficiency gave the time to discover whether they wanted to marry. It protected them from being pushed into a marriage they did not want, or from being dependent and dominated if they decided to marry.

The value of such independence often emerged in childhood, when helping others came to be seen as a route to independence. If the women I interviewed had a typical growing-up story, it resembled this: Alice was the oldest child in the family (or the middle child who took care of younger children) and was given or felt a great deal of responsibility to help her mother. As an adolescent, she rebelled against the role of the helpful daughter, but she never rejected it completely. She saw her mother as caught in a domestic trap or unfulfilled in important aspects of her life. As a result, Alice herself took a cautious if not negative attitude toward family: one had to be careful to guard against domination by men or being trapped by child-rearing. This desire to direct her own life could be reconciled with helping others, if her helping activities also gave her independence. By becoming a professional helper, she could retain her social value and continue her connections with others without losing control of her life (cf. Miller 1976:94ff.).

Particular growing-up stories revealed variations on these themes. Isidra, who watched and helped her mother raise five children, developed a strong determination to achieve independence. Rather early in life, she had discovered that many people were unhappy, and she saw a role for herself in responding to that unhappiness. Eventually, she carved out a career as a psychological counsellor—a career that enabled her to postpone marriage until she felt ready. Lucy, who had been a "junior mother" to four younger siblings, chose a vocation in the church in part to avoid childbearing. Through joining a religious order, she could carry out her desire to be a teacher—a role she had played enthusiastically with a much younger sister. This teaching experience, said Lucy, made her realize that she "wanted to help develop people's minds." Maria, an oldest child whose mother devoted much of her time to caring for Maria's emotionally troubled grandmother, began by wanting to be a psychiatrist. As an adult, Maria finally made her way to the field of counselling psychology. Basically, she said, "It meant that I would be able to help my grandma."

Seen in the light of conventional wisdom, these stories illustrate the degree to which women are "socialized" into helping roles, which they then compliantly pursue in the world of paid work. Such stories, however, can be read in a different light. They can be interpreted as the attempt of a certain group of growing girls and, then, women, to *appropriate* an arena of human activity that they see as guaranteeing their own independence. They learn about caring work when they are young, and they have a chance to practice it. They gradually see that it has value in the world outside the family. Consciously or not, they pay attention to its potential for empowering them in relation to gender expectations. If they dislike doing it, they will search out another direction for their lives (look for paid work which is not helping work, try to enter a male-dominated field, seek out the sort of husband who supports his wife's independence and makes enough money to relieve her of domestic caring activities). But, even if they cannot escape from the world of women's work (because of exclusion from male-dominated fields or because the pressure to fulfill one's mother's dream of becoming a teacher or a nurse is too great to resist), they often will find some central value in human service work that redeems it. Among the women with whom I spoke, there was a strong feeling that caring work was *needed* work and as such would help to assure their independence. If the work is needed, their remarks implied, the worker will be needed as well. "People," as one interviewee put it, "will always need nurses."

By stressing this process of appropriation, I do not mean to downplay the fact that social structure systemically encourages women to accommodate to the gendered division of labor and discourages, if it does not outright prohibit, women undertaking certain kinds of work. From the standpoint of the girl/woman trying to increase her independence from mandatory marriage and motherhood, however, gender segregation in work may seem less salient than the possibility of obtaining what she sees as needed work.

For Kathleen, for example, the discovery that her chosen field of rehabilitation counselling was becoming a women-dominated field was initially disappointing. But, her independence was far more important. A young, disabled woman from a blue-collar background, Kathleen always assumed that she would work: "I didn't know if I would ever get married, so I didn't expect a husband to support me." She also wanted to live near her family (whose support she found crucial when "something happened" to undermine her health), and to do work that didn't require her to drive. Rehabilitation counselling was ideal: she knew this was needed work that she could do. Because many of the counsellors she first encountered were men (often veterans of the Korean War), she had assumed that this was a mixed field. She was surprised, on entering graduate school, to find herself in a virtually all-woman program. Although she had not envisioned doing women's work ("I tend to get along better with men"), she rapidly developed a new image of her field. She admired the women heads of her program for their strong professional commitment. And, she noted, her recent engagement to be married and her wide circle of friends gave her ample opportunity to socialize with men outside of work.

As Kathleen's story suggests, the desire to do needed work goes well beyond whatever psychological need-to-be-needed may develop during childhood. Women seeking work face a job market in which a place for women is not ensured. No matter how much gender seems to determine who does what, no matter what imagery justifies the division of labor, the definition of *women's work* depends to a great extent on whether the economy makes room for women. As the history of women's recruitment into heavy industry during World War II demonstrates, where economic room is yielded to women (or to the disabled or Blacks or men belonging to these and other disempowered groups), it can also disappear. As feminist economists such as Heidi Hartmann (1987) and Myra Strober and Carolyn Arnold (1987) have argued, gender segregation in work reflects the struggles between men and women about what work "belongs" to each group. The outcomes of such struggles are influenced by the ways in which capitalist and patriarchal structures favor male earners: women are likely to gain access to an arena of work only when it has become less economically desirable to men. Thus, women's desire to associate themselves with needed work implies an economic rationality above and beyond the wish for individual, financial independence. It reflects an implicit understanding that women's claims to paid work have remained fundamentally weaker than those of men.[4]

THE MEANING OF GENDER IN THE HELPING PROFESSIONS

Financial independence does not, of course, solve all the problems women have in relation to the household system. Nor does the ability to earn one's living confer autonomy within work situations. Women entering human service professions find themselves fighting at work many of the same gender battles they found in the household (and, if they are black or belong to other stigmatized groups, fighting additional battles as well). I will not explore the many ways in which women human service professionals deal (or fail to deal) with oppression and exploitation in the workplace. But, I think it important to note that the orientation toward independence I have described does not imply the passivity and acquiescence so often associated with "women's work." Rather, feminist research suggests that women human service professionals sometimes engage in spirited resistance to workplace oppression (Statham, Miller, and Mauksch 1988). As with other professionals and workers in general, they also yield to the pressures on them.

One of the crucial factors affecting women's responses in the workplace is gender. Feminist discussion about the meaning of gender for the women's human service professions has been minimal, in part because this meaning seems self-evident. Feminists generally reject the idea that women are "naturally" suited for certain kinds of work in the home and (should they venture there) in the marketplace. We insist that "women's work" is socially defined and that, in the best of all possible worlds, no gender stereotypes or discrimination would stand in the way of women's work preferences. We do not generally acknowledge, however, that without a "natural" basis for women's activities and without stereotypes and discriminatory structures, there might be *no* basis at all for gender distinction: that, as feminist anthropologist Gayle Rubin (1975) and others have argued, without a gendered division of labor, there might be no sex/gender system (see also Bolin 1988; Cucchiari 1981). Although the abolition of such gender categories might be an ideal for which feminists should strive, the failure to achieve a gender identity constitutes, at present, a fundamental threat to an individual's social value.

Because most women continue to establish and maintain their gender credentials within the context of a gender-differentiated household system, such an identity can, by and large, be taken for granted. When household members feel some threat to their internal division of labor, they may encourage women members to confine their paid work to "women's work." When, as Mary Lindenstein Walshok's (1981) study of female blue-collar workers' experiences suggests, the family feels no threat, it may fully support a woman pursuing high-paid "men's work." Or, when the family experiences little threat to its own division of labor and needs a woman's income, family members may encourage her to earn money regardless of the kind of work that generates it.

However, if a woman's relation to the household system itself becomes problematic, she cannot rely on her household roles to validate her gender identity. If she seems to have a "natural" impediment to fulfilling those roles (e.g., the disabled woman or the infertile woman), if she rejects marriage outright (e.g., the lesbian who "comes out of the closet"), if she does not wish to have children, or if she merely wants to delay her integration into a traditional household system because she is not "sure," she is not "ready"—a woman's very gender identity is open to question.

Pursuing "women's work" is not the only way to validate her gender identity, of course. She may seek a husband, adopt a child, take fertility treatments, engage in heterosexual relations, use certain gestures, dress in a certain way, speak in a certain style. She also may change the venue, so to speak, of gender validation, by trying to find another regional or class or sexual or ethnic setting in which she can be recognized as the kind of woman she wants to be. But, because work offers one of the most important arenas of human activity, and because for the "independent woman" entrance into this arena is obligatory, doing "woman's work" becomes an important route for establishing the gender aspect of a woman's social value.

For example, Jane, an unmarried white woman in her late twenties, finds herself trying to maintain a delicate balance between her firm desire for independence and her wish to be valued as a prospective wife and mother. The greatest source of contention with her long-time "boyfriend" revolves around her unwillingness to stay within a rigid gendered division of labor. Whenever she crosses the boundary (as she did when she learned how to fix her own car), he becomes "threatened": he feels unmanned and, by implication, she is unwomanned. Her decision to study occupational therapy enables both of them to maintain more traditional gender identities for the present: she sees her work as building on womanly sensitivity, while he shows no interest in her work unless it pulls her away from their relationship. But, Jane's commitment to her profession has deepened, and she is determined to give it priority in her life. She has put off dealing with the conflict between this commitment and her boyfriend's insistence that she stop work when she has children—put off dealing with it until she can figure out where marriage and the family "fit in."

Natalie is a counsellor who works with adolescents. An "out" lesbian, she has experienced the threat of gender loss through her struggle with homophobia. As the child of an emotionally ill mother to whose needs Natalie early learned to attend, she herself longed to be taken care of. The most conventional route to this end, she believed, would have been marriage. "The only catch was that I was a lesbian, and I just wasn't interested in men." As Natalie moved from taking care of family members to being a home health care assistant, the idea of career and independence became more attractive. Finally, she decided to become a nurse. "I thought I was gay, and I didn't want to stick out in society. And being a nurse fit so well for a woman. I felt a lot of social approval; people gave me lots of pats on the back.... Also, it was my way of saying I am definitely a woman."

Far from simply accommodating to the sex/gender system, the women who enter the women's human service professions may, to varying degrees, make this step a part of their resistance to that system. Unfortunately, such a strategy also may be turned against the women who use it. As social worker Margaret Adams (1971) argues in her classic feminist critique of the human services, women's acquired orientation toward caring for others may be easily exploited in our professional roles. But, the women I interviewed for this essay and the many human service professionals I have talked with over the years show quite a keen awareness of this problem. In general, they try to free themselves from the "compassion trap" (to use Adams's phrase) by turning the structures in which they have worked against patriarchal definitions of "femininity." Some of these strategies—such as the old doctor-nurse game in which nurses manipulate doctors to adopt their point of view—build on established gender expectations to get things done behind the scenes. Other routes, such as pursuing education or choosing certain specializations, help to empower women human service professionals in more straightforward (and to feminists, more satisfactory) ways.

Education for the human service professions has a reputation in many quarters for dullness and inferiority. This reputation itself often perpetuates sexist and class-biased views of professional education. Nursing school may prove no duller than law school, and differences in professional education may reflect more about the incomes of different professional groups than about abstract educational quality. This same reputation also keeps us from looking more closely at the part played by gender in such education. For, despite the claims to scientific universality that characterize professional human service education, such education cannot be neutral in its gender implications.

Because women are surrounded by widespread expectations that they will care for others, education in the human services represents a critique of women's "natural" ability to do such work. Even those early human service leaders who argued that women were naturally fitted to nurse or teach rejected the notion that women have innate knowledge of how to provide such services. Quite the contrary, Beecher and Stowe (1870), Nightingale (1959), and others fought for practical and/or theoretical training on the grounds that both homemakers and paid nurturers needed to learn how to do their work (Sklar 1973; Smith 1982). Proper education transformed emotional impulse into wise practice.

Most of the women I interviewed expressed a passionate interest in professional education. This intensity in part reflects the select nature of the group—their strong desire to earn higher degrees that would give them more autonomy within their chosen fields. Their keen interest in study also suggests a great desire to fulfill their intellectual potentials, to negate the image of women defined by innate responses. Natalie, for instance, talked about seeing herself as a "stupid" girl who finally discovered her intellectual ability when she began to study nursing. "It was the first time I was really into school, and I was really doing well. And, I thought, maybe I'm not so stupid." Nursing education was especially appealing to her because it gave her analytic tools with which to approach human need: "It was so challenging to me. It was marvelous to be able to pick apart, to analyze, to put together all the different parts of that person. To figure out what would be the best way to help them grow." Anna, who had an early desire to cure mental illness, talked about her attraction to the study of psychology: "I was fascinated by the idea of making sick people well . . . of finding a way to stop the revolving door cycle. . . . " Phyllis also counted on her education as a counselling psychologist to give her the tools for understanding people's minds. As a black woman, Phyllis was particularly determined to understand the psychological aspect of "why my people were so oppressed." She did not expect to find much anti-racist consciousness in the literature of her field, but she saw knowledge as a powerful tool, one she could refine in the light of her own experience and use to help others.

Like education, specialization enabled these women to gain some control over the meaning of human service professions as "feminine" occupations. Many women I spoke with searched long and hard for the "right" specialization—the right balance of emotional, technical, and intellectual demands. Many had shifted from one women's human service profession to another (from nursing to counselling, from teaching to occupational therapy). Still more had sought some speciality within their field that allowed them to gain control over their emotional and other resources. Gloria, who "never wanted to be a nurse" but did so to please her mother and have a dependable way of earning a living, eventually chose to work in the abortion unit of a large hospital. She liked dealing with short-term patients who did not require endless care. Her goal was to help them "have a safe abortion" and leave.

This theme of women human service professionals being able to *place limits* on their work is a common one. The definition of adequate limits varies, of course. And our understanding of why it is so difficult to place such limits still needs to be developed—how much of the problem is due to women's emotional socialization to caring work, how much is due to professional definitions of responsibility, how much is due to the structural features of the work (job expectations, power, resources, etc.). In their study of nurses, for instance, Mary Corley and Hans Mauksch (1988) suggest that professional education builds on women's socialization to create an unlimited sense of "commitment." Yet, Betty Ross's study of nurses (1982) shows how women in different nursing specialties exercise varying degrees of control over their own resources, depending on the conditions under which they work. Dalia Sachs's (1989) study of occupational therapists suggests that the ability to place limits may be especially influenced by the staffing of human service institutions. Occupational therapists find themselves assuming a wider range of responsibilities as other hospital staff, especially social workers, are taken away from direct service to patients.

Sachs's study also implies that women human service professionals may have particular problems placing limits on the use of their emotional resources where the prospects for client improvement are themselves especially limited. Occupational therapists who work with chronically ill or permanently disabled patients seem to view themselves as especially "caring"—a caring that testifies to the social value of their work, even when dramatic improvements do not. Thus, this example suggests, merely doing "women's work" may not be sufficient to establish the social value of one's efforts or oneself. To be a fully valued person outside the context of the household, a woman must not only support herself and maintain a gender identity. She must show to herself and others that her work is of value to the society.

POLITICS AND PROGRESS THROUGH THE HUMAN SERVICES

For women human service professionals to establish their work as valuable to society, they must connect that work to some definition of the social good or social progress. The nineteenth century cult of domesticity portrayed women's caring work in the family as contributing to the progress of (Western, white, Christian) civilization because the family was seen as the bulwark of that civilization. Early women human service professionals built on this notion of women's social value but, by planting their work squarely in the public sphere, cut through the public/private dichotomy on which the cult of domesticity was based. Their work was a public matter so that any claim to social value based on caring would have to take into account the political dimensions of their activity.

Because politics involves highly diverse notions of what constitutes the good society or progressive social change, these differences have been reflected in the ways in which human service professionals talk about their work. Among the women I interviewed, three political perspectives on human service emerged: caring work as an effort to fulfill an unmet social need, caring work as part of a professional mission, and caring work as an attempt to change the structure of society. For a given human service professional, one rather than another political perspective might inform her sense of social value; or she might draw on more than one viewpoint, depending on the particular human service context.

The sense of value in fulfilling a social need can arise, as it did for Miriam, out of childhood experience (cf. Coles 1986; Lagemann 1979). The oldest child of divorced parents, Miriam spent a lot of time with her younger full and half siblings: "I was always interested in working with children, even from the age of twelve." After moving from psychology to special education, she began working with mentally retarded children, where the need for caring work was evident. People would ask her, she said, how she had the patience for such work: "But I don't even think of it that way. . . . It's just that the slightest changes, the slightest improvements in their behavior are so noticeable to me. . . . That always kept me going, wanting to see more, wanting to do more. . . . When people say to me, 'Wow, I couldn't do that,' I say to myself, 'Maybe that's why I'm doing it . . . because there aren't that many people who feel the way I do.'"

For some women human service professionals, this desire to meet unmet social needs may stem from a belief in women's distinct talent for caring. Although, in my interviews, no one used the nineteenth-century notion of women's "natural" duty to care, some drew on feminist language to suggest a similar idea. For example, Luisa, whose encounter with feminism strengthened her image of herself as a counsellor, sees growing girls as having a particular need for guidance. "I have a special place in my heart for women. I feel that the survival of the planet depends on women."

Sometimes, the meaning of fulfilling unmet social needs was linked to religious values taught at home. Esther spoke about "that element in my family that to be happy you have to do good for others. Everyone was active in something, and the values of Judaism just came through." Other women, like Lorraine, saw the impulse to meet the needs of others as growing out of a certain type of personality. Even as a child, she had always defended those who needed help. Her work as a rehabilitation counsellor and especially her interest in advocating for the disabled seemed an extension of this early response. Now she envisioned doing rehabilitation counselling in the corporate world. "I want to meet people that are capitalist," she said. She was "challenged" by a certain tension between herself and those friends who had chosen business careers. They joked with her about ending up "in heaven by herself." Yet, she felt they basically appreciated her work: "I think people feel good that there is someone out there doing this, while they're on Wall Street. . . ." Lorraine, who grew up in a feminist era, did not see this division of functions as gender-related: she had encountered "men in this field that are wonderful" and hoped that more would enter her field "because little children respond so well to men."

For Miriam, Luisa, Esther, and Lorraine, the politics of fulfilling unmet needs assumes, as did the nineteenth-century cult of domesticity, a type of social harmony: people who have the ability and motive to do caring work will complement, balance, or compensate for those who lack such ability or motive. The motive may be seen as stemming from various sources, including socialization. Feminist consciousness may contribute to this image of social harmony by reinforcing the caring impulse, or, as with Lorraine, by pointing to men's capacity for caring work. Whether women and men are seen as similar or different in their caring potentials, however, this outlook treats caring and noncaring as separate spheres. They may coexist in more or less harmony, but they do not entail fundamental conflict.

In contrast, the politics of caring work as professional mission takes a higher degree of conflict for granted. From this perspective, the interests of the profession are identified with its caring work. Because such work does not automatically receive social validation, the profession must establish its value through political struggle for legitimacy. That struggle usually takes place through activities of professional associations—establishing educational standards, lobbying for licensure requirements, and the like (Larson 1977). Although these efforts parallel the territorial struggles of male-dominated professions, their meaning for women human service professionals often differs.

Emma's commitment to her chosen profession, occupational therapy, began with careful weighing of her vocational options. As a "caring type of person," she first imagined herself as a medical doctor. After pursuing a medical internship at college, however, she decided that medicine smacked too much of a "power game." Doctors, and especially male doctors, stayed at an "impersonal distance" from patients. Physical therapy did not appeal to her because it followed too closely the medical model. Occupational therapy, with its interest in the whole person, best fulfilled Emma's image of caring work. Moreover, this profession needed her efforts to gain the "respect" it deserved: "I feel I can really do something and make a difference in the profession," she said. As a student, she had already joined a licensure campaign in her state (which still did not license occupational therapists). She saw herself in the future taking an active role in her professional association. She envisioned lobbying, studying for a higher degree, conducting research, and writing. Emma did not object to men's entering the field (indeed, she saw entrance into the women's human service professions as a way for men willing to do so to overcome their "socialization"). Yet, she wanted to see her profession earn respect *as* a women's field. "I would like to see us do it on our own."

The political perspective on the women's human service professions that stresses professional interest assumes a pluralistic image of society—a society composed of interest groups that compete and sometimes cooperate to establish certain values in the larger social context. As the result of this interaction, the society may incorporate more and higher-quality human service work. But the basic social structures themselves are not necessarily changed. Competing interest groups often settle for gaining recognition and reward rather than challenging the broader organization of society—and its human services.

The third political view that emerged from my interviews pictures the women's human service professions as intertwining with a social movement that tries to effect broader social change. For instance, Eve, who was raised in a Christian evangelical family, wanted to become a missionary. She chose nursing as an acceptable way for unmarried women to do religious work overseas. Phyllis, who was deeply affected by the black liberation movement, found a vision that shaped her work as a school psychologist. Inspired by activist Angela Davis, Phyllis saw the need "to understand the system" as crucial to black liberation. To her, psychology represented one important way to gain such understanding. Through psychological work with black children, she could help them grasp the character of the system that now oppressed them. Merle, whose long involvement with the Zionist movement meant a strong desire to work cooperatively with others, finally chose to be an occupational therapist in the United States. She loved her job in a community center where she became part of a professional team: "It seemed that I had learned more in my socialist upbringing about how to be in a therapeutic community than I had learned in the occupational therapy school. . . . Here I was in the middle of New York, going to work on a Kibbutz."

Others saw their work as human service professionals in the light of the contemporary women's movement (cf. Weiler 1988). Luisa discovered feminism through her feminist-oriented program on counselling women.

Natalie saw her choice of nursing as a part of the feminist impulse to build bonds between women: "I imagined that nursing could ideally be wonderful, because they were all working together." Pauline's work in a shelter for battered women made feminist politics real to her. She loved counselling in the shelter because it emphasized feminist "process." She felt comfortable there because many of the women shared her working-class background. The shelter was different from her family of origin, where she also had been a caregiver: this feminist environment enabled her to feel that she was "doing something for other people."

These various intertwinings between women's human service professions and social movements are not, on one level, surprising. Professions, as Rue Bucher and Anselm Strauss (1961) have pointed out, resemble social movements in many ways. And social movements, as Ann Withorn (1984) shows, often have developed a human service dimension or component. Nevertheless, the relation between the professional human service professions and movements for social change is fraught with tension. Women human service professionals may minimize these tensions by finding or creating an enclave that expresses the values that support their work—Pauline's feminist shelter, Merle's community-oriented clinic—but most work settings do not reinforce their political visions.

Pauline's next job took her to a state-funded agency for battered women. Here, instead of bonding through their common struggle against violence, the staff expressed angry differences. Women who saw their work as a "job" remained suspicious of politically inspired women. Like Pauline, many of the latter group identified themselves as lesbians. She and other lesbians found themselves fighting homophobia as much as serving battered women. Meanwhile, said Pauline, none of the staff members exercised real power because that grew out of the old-boy network. Natalie's ideals for nursing and community-building among women were gravely tested in her first hospital position. The overworked and underpaid nurses did not help each other. They often treated patients with contempt. Many of the patients, like Natalie, were Jewish, and she often overheard anti-Semitic remarks. Disillusioned and hurt, she began wearing a Jewish star. Phyllis, the only black professional in her agency, found herself pressured to wear a smile. Despite her outstanding record of work with clients, her supervisor harassed Phyllis with racist criticisms: her confident style was called "arrogant"; her unwillingness to "chit-chat about what you fixed your husband last night" was seen as "condescending." The supervisor wanted to meet constantly with Phyllis to "improve communication."

Regardless of their particular political perspectives, most of the women human service professionals with whom I spoke complained bitterly about the problems of working in bureaucracies (see also Ferguson 1984). Unless women were able to find some protected enclave within the institution, bureaucratic authority dominated their caring practice. Miriam spoke for many women human service professionals when she described her experience in a school for emotionally disturbed boys. Sponsored by a religious organization but receiving public funds, the school shaped its policy around financial considerations. The children were kept in line by a male "psychologist" who intimidated them with his huge size. The teachers were frightened and apathetic. The administration finally fired Miriam as a "troublemaker" because she asked for more supplies and permission to take the children on outings.

Miriam eventually went back to graduate school. Other women I interviewed sought higher positions in the hope that they could change such institutions from the top. Still others thought that private practice offered the best alternative to bureaucratic work sites. Some switched human service fields in the hope of finding a better way to achieve their social values. In general, these women expressed little desire or hope that they could change human service bureaucracies. When they were frustrated or angered by the problems of achieving their human service ideals, they turned to changing themselves and their own lives—to seeking alternative ways of pursuing human service, to learning more so that they could fulfill their ideals in another form.

WHITHER THE WOMEN'S HUMAN SERVICE PROFESSIONS? OR, SHOULD ALICE GO TO MEDICAL SCHOOL?

In the late 1980s, women human service professionals are caught in a bind between conservative criticism that blames women for the society's failure to support "caring values" and feminist criticism that urges us to question the exploitative and often self-oppressive function of women's caring work. In response to this tension, Alice thinks about exercising her "equal opportunity"—by going to medical school to "beat the boys at their own game," or by going to Wall Street to make some "real money" for a change. Yet, Alice and many of the rest of us also recognize the limited character of such solutions: they may provide answers for individual women, but they do not attack the underlying causes of women's oppression.

The limitations of individual choice-making should not, of course, discourage women from taking advantage of the wider job opportunities for which feminists have fought during the last two decades. Several women I interviewed clearly had wanted to be doctors or lawyers rather than nurses or occupational therapists. In all likelihood, they would have pursued such careers if they had been born a few years later or a few miles closer to this feminist wave or into families with more financial resources. But, although wider vocational choice may mean more satisfying lives for individual women, it does not seem to change the underlying patterns. Where substantial numbers of women are able to enter male-dominated fields or specialties, these areas often turn into women's fields or specialties.[5] Valuable as they are, short-term victories of "equal opportunity" yield to the long-term pattern of gender segregation (Hartmann 1987; Strober and Arnold 1987).

As my argument in this chapter suggests, the process of changing this pattern cannot be simple. A feminist politics for the human services has to challenge not only the gendered division of labor but the relation between gender, work, and the construction of women's (and men's) social value. Although such a challenge would be radical at its core (radical in the sense of going to the root of the problem of gender oppression), it could be expressed through very specific and practical reforms: a labor union that fights for "comparable worth," a professional association that pays serious attention to the impact of the household system on women's paid work, a counselling center that takes into account the profound impact of women's paid and unpaid work on women's "problems."

The sort of women human service professionals I have described in this chapter have an important contribution to make to this process of change. As women who have a strong stake in women's independence through caring work, such women transcend the established dichotomies between dependence and independence, between private caring and public business. Through their very lives, they raise fundamental questions about how we can realize caring values at the same time that we support liberation from gender oppression. But, ironically, the very strengths such women human service professionals acquire in their struggle to transcend these dichotomies lead to certain weaknesses that make it difficult to develop a human service politics with others. The woman who has invested so much of her own social value in becoming a human service professional often has a difficult time seeing and understanding the perspective of "nonprofessionals" or professionals with less formal education. The hierarchical distinctions fostered by human service bureaucracies play into this lack of awareness. With few exceptions (mainly minority and working-class-identified women), those I interviewed for this essay did not seem to have a clear picture of people who worked below them in human service bureaucracies. The individualistic ways in which we often learn caregiving at home and in formal education seem to reinforce the alienation between caregivers in many human service settings.

The socially-structured conflict between women's professional lives and household responsibilities increases these tensions. The overworked nurse without children deeply resents the (equally overworked) colleague who takes time from her paid work to attend to her sick child. Because of understaffing, the first nurse is left with twice the responsibility and work. Because of inadequate child care arrangements, the second nurse must cope with both paid and unpaid caring obligations. As a result, women are pitted against each other: caring becomes fragmented both within and between the public and private worlds.

Because human service settings also reflect racial and class hierarchies, racism, class bias, and a host of other socially-created conflicts add to these tensions. (Imagine the above example of the two nurses, with one black and the other white or vice versa, or with one having more and the other less formal education or vice versa.) Homophobia also adds to these tensions in ways we have yet to fully understand. Because human service work involves intimate engagement with the bodies, minds, and psyches of others, social sanctions against same-sex attraction and lesbian relationships are likely to generate fear and caution in women's human service work. Currently, formal and informal education in the human services pays relatively little attention to these various sources of tension. Efforts to change and improve human service work require increased consciousness of how individual difference and structured conflict affect human service institutions.

Given the difficulty of developing and sustaining an alternative vision of human service; given, as well, the current devaluation of human service itself in many industrialized countries; and given, finally, the support for "entrepreneurship" in such conservatively-governed countries, it is little wonder that many of Alice's colleagues look favorably on private practice.[6] Social workers, nurses, and occupational therapists dream of their own offices; teachers apply for jobs in private schools. If conditions change in the United States and elsewhere, human service institutions may become more attractive settings for women human service professionals. But, even under current conditions, many such women (from choice and/or limited resources) continue working in large human service bureaucracies. Many, too, continue to oppose oppressive conditions by doing their best to serve clients, patients, and students. They continue—as one such professional put it—"to wage my own tiny guerilla war" in the hope of fully realizing their human service goals (Pike 1988).

This struggle to make a valuable life for oneself through realizing caring values contains within it a broader impulse for liberation. To take form, such impulse needs to be collective; it needs to deal with the differences that divide women human service professionals from each other and from coworkers and clients in human service settings. It also needs to reject the notion that caring limits women's concerns to their separate sphere. For, to the extent that women (and the men who wish to join them) become genuine advocates of the human services, they inevitably will find themselves confronting capitalistic and patriarchal structures. Physical and mental health, educational and psychological growth cannot coexist with militarism and exploitation. Integrating this truth with our work means taking a serious look at what we as professionals want to profess and what ends we want our human service to serve.

DOCUMENTATION

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Notes

1. This characterization is based on the situation in the United States in the 1980s, although similar attacks on the human services have been launched during this period in other capitalist countries.

2. My thinking grows as much out of my classes and discussions with women human service professionals over the last two decades as from the interviews I conducted with twenty students. The twenty ranged in age from twenty-three to fifty-one. About one-half came from working-class backgrounds, and the other one-half from middle-class backgrounds. Most were raised in white "ethnic" (Italian, Irish, Jewish) families. Two of the women were black, two Puerto Rican in family origin. About one-fourth of the women were currently married; only a few had children. Three identified themselves as lesbians.

3. Because of the involvement of many wealthy and philanthropically-minded women in human service projects, critical interpretations of women in the human services often mistakenly identify human service professionals with the stereotyped "Lady Bountiful." Daniels (1988) offers a recent feminist analysis of women volunteers.

4. If one views caring as an intrinsically nongendered activity (as Joan Tronto and I have attempted to do in our chapter "Toward a Feminist Theory of Caring" in this volume), women's interest in "needed" work can be seen as a valuable survival strategy—comparable to the desire of many working-class people for "steady work"—rather than a special, morally or psychologically motivated female career decision.

5. This pattern was evident among the women I interviewed. The few who were considering leaving the women-dominated human services indi-

cated an interest in law and saw themselves as fulfilling human service goals through certain legal specialties (e.g., educational law, advocacy for the disabled or "minority" clients.) One can easily envision certain law specialties becoming "women's work," complete with an ideology of caring.

6. The movement of women human service professionals toward establishing their own private practices has its own political values and problems. Supported by the liberal feminist ideal of women's autonomy, private practice may offer such women freedom from bureaucratic control and may possibly pressure some human service institutions to improve their conditions. (As one nurse argued to me, the nursing shortage was a way of nurses "voting with their feet.") But, as Joan Tronto and I suggest in "Toward a Feminist Theory of Caring," (Chapter 2 in this volume), the entrepreneurial model does not take into account the fact that many people cannot enter the marketplace—clients who cannot buy care or human service professionals who do not have the resources to set up a business. Patricia Moccia (1987, 1988) has pointed out the limits of this entrepreneurial model for health care.

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6

The Duty or Right to Care? Nursing and Womanhood in Historical Perspective

Susan M. Reverby

The vivid television images of closed emergency rooms in local hospitals and abandoned elders in overcrowded nursing homes viscerally sear in our mind's eye what appears to be a growing societal crisis in caring. As such images remind us almost daily, the problems of caring have left the supposed quiet of domestic life or the hospital bedside and intruded into public consciousness and political discourse. Nowhere is this public "talk" about caring louder than in the widespread media coverage of what is labelled the "nursing shortage" and women's seeming abandonment of this most traditional of the so-called women's occupations (Aiken and Mullinix 1987). In many of the commentaries on this "problem" the underlying assumption is that caring was always central and unproblematic in both women's and nurses' lives, surfacing only recently as a dilemma as feminism and changing structures in our capitalist economy have transformed women's work.

In the last decade, however, scholars from many different disciplines within Women's Studies and nursing have analyzed the many meanings of the term *caring* and suggested its problematic status is not a new one (Blum et al. 1976; Chodorow 1978; Dalley 1988; Finch and Groves 1983; Gilligan 1982; Leininger 1981; Noddings 1984; Watson 1979). Much of this literature, however, runs the danger of universalizing caring as an element in female identity, or as a human quality, separate from the cultural and structural circumstances that create it (Benner and Wrubel 1989). But as the editors of this volume and policy analyst Hilary Graham have argued, caring is not merely an identity; it is also work. As Graham notes, "caring touches simultaneously on who you are and what you do" (Graham 1983:13). Because of this duality, caring can be an unbounded act, difficult to define, even harder to control.

Graham's analysis moves beyond seeing caring as a psychological trait, but her focus is primarily on women's unpaid labor in the home. She does not fully discuss how the forms of caring are shaped by the contexts under which they are practiced. Caring is not just a subjective and material experience, it is also an historically created one. Particular circumstances, ideologies, and power relations thus create the conditions under which caring can occur, the forms it will take, and the consequences it will have for those who do it.

The basis for caring also shapes its effect. Nursing, since the Nightingale-inspired reforms, has been organized under the expectation that its practitioners would accept a duty to care, rather than demand a right to determine how they would satisfy this duty. Nurses were expected to act out of obligation to care, taking on caring more as an identity than as work, and expressing altruism without any thought for autonomy either at the bedside or over control of their profession. Thus nurses, as with others who perform what is defined as "women's work" in our society, have contended with what appears as a dichotomy between the duty to care for others and the right to control their own activities in the name of caring. Nursing is still searching for what philosopher Joel Feinberg argued comes prior to rights, that is, being "recognized as having a claim on rights" (1980:41). The duty to care, organized within the particular, political, and economic context of nursing's development, has made it difficult, although not impossible, for nurses to obtain this moral, and ultimately, political, standing.

Because nurses have been given the duty to care, they are caught in a secondary dilemma: forced to act as if altruism (assumed to be the basis for caring) and autonomy (assumed to be the basis for rights) are separate ways of being, even human characteristics distributed along gender lines. Nurses are still searching for a way to forge a link between altruism and autonomy that will allow them to have what philosopher Larry Blum (1976:223) and others have called "caring-with-autonomy," or what psychiatrist Jean Baker Miller (1976:71) labelled "a way of life that includes serving others without being subservient." Viewed from the nursing perspective, our contemporary crisis in caring can thus be seen as a consequence of the efforts by nurses and other women to create the conditions for such a life.

In this chapter, I argue that while caring has always been essential to nursing work and often to women's sense of self, it has been far from unproblematic and not merely psychological. Indeed, the crucial dilemma of American nursing has been the order to care in a society that refuses to value caring. This article is an analysis of the historical creation of that dilemma and its consequences for nursing (Reverby 1987). To explore the meaning of caring for nursing, it is necessary to unravel the terms of the relationship between nursing and womanhood as these bonds have been formed over more than a century.

Most of the writing about American nursing's history begins in the 1870s when formal training for nursing was introduced in the United States.

But nursing did not appear *de novo* at the end of the nineteenth century. As with most medical and health care, nursing throughout the colonial era and most of the nineteenth century took place within the family and the home. In the domestic pantheon that surrounded "middling" and upper-class American womanhood in the nineteenth century, a woman's caring for friends and relatives was an important pillar. As a form of caring, nursing was often taught by mother to daughter as part of female apprenticeship, or learned by a domestic servant as an additional task on her job. Embedded in the seemingly natural or ordained character of women, it became an important manifestation of women's expression of love of others, and thus integral to the female sense of self (Reverby 1987; Young 1983). In a society where deeply-felt religious tenets were translated into gendered virtues, domesticity advocate Catherine Beecher declared that the sick were to be "commended" to a "woman's benevolent ministries" (1846:214).

The responsibility for nursing went beyond a mother's duty for her children, a wife's for her husband, or a daughter's for her aging parents. It attached to all the available female family members. At any time the family's "long arm" might reach out to a woman working in a distant city or mill, pulling her home to care for the sick, infirm, or newborn. No form of women's labor, paid or unpaid, protected her from this demand. "You may be called upon at any moment," Eliza W. Farrar warned in *The Young Lady's Friend*, "to attend upon your parents, your brothers, your sisters, or your companions" (1837:35). Nursing was to be, therefore, a woman's duty, not her job. Obligation and love, not the need of work, were to bind the nurse to her patient. Caring was to be an unpaid labor of love.

Even as Farrar was proffering her advice, pressures both inward and outward were beginning to reshape the domestic sphere for women of what was then called the middling classes. Women's obligations and work were transformed by the expanding industrial economy and changing cultural assumptions. Parenting took on increasing importance as notions of "moral mothering" filled the domestic arena as other productive labor entered the cash-nexus. Female benevolence similarly moved outward as women's charitable efforts took increasingly institutional forms. Duty began to take on new meaning as such women were advised they could fulfill their nursing responsibilities by managing competently those they hired to assist them. Bourgeois female virtue could still be demonstrated as the balance of labor, love, and supervision shifted (Beecher 1876; Hale 1844; Strasser 1982).

An expanding economy thus had differing effects on women of the various classes. For those in the growing urban middling classes, excess cash made it possible to consider hiring a nurse when circumstances, desire, or exhaustion meant a female relative was no longer available for the task. Caring as labor, for these women, could be separated from love.

For older widows or spinsters from the working classes, nursing became a trade they could "profess to" relatively easily in the marketplace. A widow who had nursed her husband till his demise, or a domestic servant who had cared for an employer in time of illness, entered casually into the nursing trade, hired by families or individuals unwilling, or unable, to care for their sick alone. The permeable boundaries for women between unpaid and paid labor allowed nursing to pass back and forth when necessary. For many women, nursing thus beckoned as respectable community work.

These professed or "natural-born" nurses, as they were known, usually came to their work, as one Boston nurse put it, "laterly" when other forms of employment were closed to them, or when the lack of any kind of work experience left nursing as an obvious choice. Mehitable Pond Garside, for example, was in her fifties and had outlived two husbands—and her children could not, or would not, support her—when she came to Boston in the 1840s to nurse. Similarly, Alma Frost Merrill, the daughter of a Maine wheelwright, came to Boston in 1818 at age nineteen to become a domestic servant. After years as a domestic and seamstress, she declared herself a nurse (Home for Aged Women 1850).

Women such as Garside and Merrill differed markedly from the Sairy Gamp character of the Dickens' fiction *Martin Chuzzlewit*. Gamp was portrayed as a merely besotted representative of lumpen-proletarian womanhood, who asserted her autonomy by daring to question medical diagnoses, to venture her own opinions (usually outrageous and wrong) at every turn, and to spread disease and superstition in the name of self-knowledge. If not Gamps, nurses such as Garside and Merrill were also not the healers of some more recent feminist mythology that confounds nursing with midwifery, praising the caring and autonomy these women exerted, but refusing to consider their ignorance (Ehrenreich and English 1972). Some professed nurses learned their skills from years of experience, demonstrating the truth of the dictum that "to make a kind and sympathizing nurse, one must have waited, in sickness, upon those she loved dearly" (Penny 1863:420). Others, however, blundered badly beyond their capabilities or knowledge. They brought to the bedside only the authority their personalities and community stature could command: neither credentials nor a professional identity gave weight to their efforts. Their womanhood, and the experience it gave them, defined their authority and taught them to nurse.

Nursing was not limited, however, to the bedside in a home. Although the United States had only 178 hospitals at the first national census in 1873, it was workers labelled "nurses" who provided the caring. As in home-based nursing, the route to hospital nursing was paved more with necessity than intentionality. In 1875, Eliza Higgins, the matron of Boston's Lying-In Hospital, could not find an extra nurse to cover all the deliveries. In desperation, she moved the hospital laundress up to the nursing position, while a recovering patient took over the wash. Higgins's diaries of her trying years at the Lying-In suggest that such entry into nursing was not uncommon (Higgins 1889).

As her reports and the memoirs of other nurses attest, hospital nursing could be the work of devoted women who learned what historian Charles Rosenberg has labelled "ad-hoc professionalism," or the temporary and dangerous labor of an ambulatory patient or hospital domestic (Rosenberg 1977, 1987). As in home-based nursing, both caring and concern were frequently evinced. But the nursing work and nurses were mainly characterized by the diversity of their efforts and the unevenness of their skills.

Higgins's memoirs attest to the hospital as a battleground as nurses, physicians, and hospital managers contested the realm of their authority. Nurses continually argued their right to control the pace and content of their work, to set their own hours, and to structure their relationships to physicians. Aware that the hospital's paternalistic attitudes and practices toward its "inmates" were attached to the nursing personnel as well, they fought to be treated as workers, "not children," as the Lying-In nurses told Higgins (July 11, 1876; July 1, 1876), and to maintain their autonomous adult status.

As with home-based nursing, hospital nurses had neither the formal training nor class status upon which to base their arguments. But their sense of the rights of working-class womanhood gave them the authority to press their demands. The necessity to care, and their perception of its importance to patient outcome, also structured their belief that demanding the right to be relatively autonomous was possible. However, their efforts were undermined by the nature of their onerous work, the paternalism of the institutions, class differences between trustees and workers, and ultimately, the lack of a defined ideology of caring. Mere resistance to those above them, or contending assertions of rights, could not become the basis for nursing authority.

Much of this was to change with the introduction of training for nursing into the hospital world. In the aftermath of Nightingale's apparent triumph over the British army's medical care system in the Crimea, similar attempts by U.S. women during our Civil War, and the need to find respectable work for the daughters of the middling classes, a model and support for nursing reform began to grow. By 1873, three nursing schools in hospitals in New York, Boston, and New Haven were opened on the model of the Nightingale School at St. Thomas's Hospital in London.

Nightingale had envisioned nursing as an art, rather than a science, for which women needed to be trained. Her ideas linked her medical and public health notions to her class and religious beliefs. Accepting the Victorian idea of divided spheres of activity for men and women, she thought women had to be trained to nurse through a disciplined process of honing their womanly virtue. She stressed character development, the laws of health, and strict adherence to orders passed through a female hierarchy structured like an upper-class household with a mistress and retinue of servants of various statuses (Summers 1988). Nursing was built upon a model that relied upon the concept of duty to provide its basis for authority. Unlike other feminists at the time, Nightingale spoke in the language of duty, not rights.

Furthermore, as a nineteenth-century sanitarian, Nightingale never believed in germ theory, in part because she refused to accept a theory of disease etiology that appeared to be morally neutral. Given her sanitarian beliefs, Nightingale thought medical therapeutics and "curing" of lesser importance to patient outcome, and she willingly left this realm to the physician. Caring, the arena she did think of great importance, she assigned to the nurse. In order to care, a nurse's character, tempered by the fires of training, was to be her greatest skill. Thus to "feminize" nursing, Nightingale sought a change in the class-defined behavior, not the gender, of the work force (Reverby 1987; Rosenberg 1979).

To forge a good nurse out of the virtues of a good woman and to provide a political base for nursing, Nightingale sought to organize a female hierarchy in which orders passed downward from the nursing superintendent to the lowly probationer. This separate female sphere was to share power in the provision of health care with the male-dominated arenas of medicine. For many women in the Victorian era, sisterhood and what historian Carroll Smith-Rosenberg (1975) has called "homosocial networks" served to overcome many of the limits of this separate but supposedly equal system of cultural division. Sisterhood after all, at least in its fictive forms, underlay much of the female power that grew out of women's culture in the nineteenth century. But in nursing, commonalities of the gendered experience could not become the basis of unity because hierarchical filial relations, not equal sisterhood, lay at the basis of nursing's theoretical formulation (Roberts-Gersh 1987).

Thus unwittingly, Nightingale's sanitarian ideas and her beliefs about womanhood provided some of the ideological justification for many of the dilemmas that faced American nursing by 1900. Having fought physician and trustee prejudice against the training of nurses in hospitals in the last quarter of the nineteenth century, American nursing reformers succeeded only too well as the new century began. Between 1890 and 1920, the number of nursing schools jumped from 35 to 1,775, and the number of trained nurses from 16 per 100,000 in the population to 141 (Burgess 1926:36–37). Administrators quickly realized that the opening of a "nursing school" provided their hospitals, in exchange for training, with a young, disciplined, and cheap labor force. Thus, often no difference could be found between the hospital's nursing school and its nursing service. The service needs of the hospital continually overrode the educational requirements of the schools. A student might, therefore, spend weeks on a medical ward if her labor was so needed, but never see the inside of an operating room before her graduation.

Once the nurse finished her training, however, she was unlikely to be hired by a hospital because it relied upon either untrained aides or nursing student labor. The majority of graduate nurses, until the end of the 1930s, had to find work in private duty in a patient's home, as the patient's employee in the hospital, in the branches of public health, or in a few hospital staff positions. Beyond their hospital school, trained nurses still had to compete with the thousands of professed or "practical" nurses who continued to ply their trade in an overcrowded and unregulated marketplace. The title *nurse* began to take on very ambiguous meanings (Reverby 1982, 1984). Nor was the phrase *trained nurse* a uniform designation. As nursing leader Isabel Hampton Robb lamented in 1893, the title "'trained nurse' may mean then anything, everything, or next to nothing" (quoted in James 1979:229).

In the hospital-based schools, the exigencies of nursing increasingly acutely ill or surgical patients required the sacrifice of coherent educational programs. Didactic, repetitive, watered-down medical lectures by physicians or older nurses were often provided the students, usually after they finished ten to twelve hours of ward work. Training emphasized the "one right way" of doing ritualized procedures in hopes that the students' adherence to specified rules would be least dangerous to patients (Ashley 1976; Reverby 1987). Under these circumstances, the duty to care could be followed with a vengeance and become the martinet adherence to orders.

Furthermore, because nursing emphasized training in discipline, order, and practical skills, it made possible the rationalization of the abuse of student labor. And because the work force was almost entirely women, altruism, sacrifice, and submission were expected, encouraged, indeed demanded. Exploitation was inevitable in a field where, until the early 1900s, there were no accepted standards for how much work an average student should do, how many patients she could successfully care for, or any mechanisms through which to enforce such standards. After completing her exhaustive and depressing survey of nursing training in 1912, nursing educator M. Adelaide Nutting bluntly pointed out: "Under the present system the school has no life of its own" (1912:49). In this kind of environment, nurses were trained. But they were not educated.

It would be a mistake, however, to see the nursing experience as only one of exploitation and the nursing school as a faintly concealed reformatory for the wayward girl in need of discipline. Many nursing superintendents lived the Nightingale ideals as best they could and infused them into their schools. The authoritarian model could and did retemper many women. It instilled nurses with idealism and pride in their skills, somewhat differentiated the trained nurse from the untrained, and protected and aided the sick and dying. It provided a mechanism for virtuous women to contribute to the improvement of humanity by empowering them to care.

For many of the young women entering training in the late nineteenth and early twentieth centuries, nursing thus offered something quite special: both a livelihood and a virtuous state. As one nursing educator noted in 1890: "Young strong country girls are drawn into the work by the glamorer [*sic*] thrown about hospital work and the halo that sanctifies a Nightingale" (Wells 1890:98). Thus, in their letters of application, aspiring nursing students expressed their desire for work, independence, and womanly virtue. As with earlier, nontrained nurses, they did not seem to separate autonomy and altruism, but rather sought its linkage through training. Flora Jones spoke for many such women when she wrote the superintendent of Boston City Hospital in 1880, declaring: "I consider myself fitted for the work by inclination and consider it a womanly occupation. It is also necessary for me to become self-supporting and provide for my future" (Boston City Hospital Training School Records 1880). Thus one nursing superintendent reminded a graduating class in 1904: "You have become self-controlled, unselfish, gentle, compassionate, brave, capable—in fact, you have risen from the period of irresponsible girlhood to that of womanhood" (Snively 1904:838). For women such as Jones, and many of nursing's early leaders, nursing was the singular way to grow to maturity in a womanly profession that offered meaningful work, independence, and altruism (Armeny 1984a).

For many, however, as nursing historian Dorothy Sheahan has noted, the training school "was a place where . . . women learned to be girls" (1981:2). The range of permissible behaviors for respectable women was often narrowed further through training. Independence was to be sacrificed on the altar of altruism. Thus, despite the hopes of aspiring students and promises of the training school superintendents, nursing rarely united altruism and autonomy. Duty remained the basis for caring.

Some nurses were able to create what they called "a little world of our own." But nursing had neither the financial nor the cultural power to create the separate women's institutions which provided so much of the basis for women's reform and rights efforts (Freedman 1979; Tomes 1978). Under these conditions, nurses found it very difficult to make the collective transition out of a woman's culture of obligation into an activist assault upon the structure and beliefs that oppressed them. Nursing remained bounded by its ideology and its material circumstances.

In this context, one begins to understand the difficulties faced by the leaders of nursing reform. Believing that educational reform was central to nursing's professionalizing efforts and clinical improvements, a small group of elite nursing reformers attempted to broaden its scientific content and social outlook. In arguing for an increase in the scientific knowledge necessary in nursing, such leaders were fighting against deep-seated cultural assumptions about male and female "natural" characteristics as embodied in the doctor and nurse. Such sentiments were articulated in the routine platitudes that graced what one nursing leader described as the "doctor homilies" that were a regular feature at nursing graduating exercises (Dock 1912:136).

Not surprisingly, such beliefs were professed by physicians and hospital officials whenever nursing shortages appeared, or nursing groups pushed for higher educational standards and defined nursing as more than assisting the physician. As one nursing educator wrote, with some degree of resignation, after the flu pandemic in 1920: "It is perhaps inevitable that the difficulty of securing nurses during the last year or two should have revived again the old agitation about the 'over-training' of nurses and the clamor for a cheap worker of the old servant-nurse type" (Stewart 1920:183).

The nursing leadership, made up primarily of educators and supervisors with their base within what is now the American Nurses Association and the National League for Nursing, thus faced a series of dilemmas as they fought to raise educational standards in the schools and criteria for entry into training, to register nurses once they finished their training, and to gain acceptance for the knowledge base and skills of the nurse. They had to exalt the womanly character, self-abnegation, and service ethic of nursing while insisting on the right of nurses to act in their own self-interest. They had to demand higher wages commensurate with their skills, yet not appear "commercial." They had to simultaneously find a way to denounce the exploitation of nursing students and make political alliances with hospital physicians and administrators whose support they needed. While lauding character and sacrifice, they had to find a way to measure it with educational criteria in order to formulate registration laws and set admission standards. They had to make demands and organize, without appearing to be "unlady-like." In sum, they were forced by the social conditions and ideology surrounding nursing to attempt to professionalize altruism without demanding autonomy.

The seemingly higher claim of duty also continually undermined a direct assertion of the right to determine that duty. Whether at the bedside or at a legislative hearing on practice laws, the duty to care became translated into the demand that nurses merely follow doctors orders. The tradition of obligation made it almost impossible for nurses to speak about rights at all. By the turn of the century, as necessity and desire were pulling more young women into the labor force and the woman's movement activists were placing rights at the center of cultural discussion, nursing's call to duty was perceived by many as a somewhat antiquated language to shore up a changing economic and cultural reality. Nursing became a type of collective female grasping for an older form of security and power in the face of rapid change. Women who might have been attracted to nursing in the 1880s as a womanly occupation that provided some form of autonomy were, by the turn of the century, increasingly looking elsewhere for work and careers.

In the face of these difficulties, the nursing leadership became increasingly defensive and turned on its own rank-and-file. From their vantage point as educators and supervisors, many in the leadership lost touch with the pressing concerns for their constituencies in the daily work world of nursing and the belief systems such nurses continued to hold. Yet many nurses, well into the twentieth century, shared the nineteenth-century vision of nursing as the embodiment of womanly virtue. A nurse named Annette Fiske, for example, although she authored two science books for nurses and had an M.A. in classics from Radcliffe College before she entered training, spent her professional career in the 1920s arguing against increasing the educational standards. Rather, she called for a reinfusion into nursing of spirituality and service, assuming that this would result in nursing receiving greater "love and respect and admiration" (1920:8).

Other nurses, especially those who trained in the smaller schools or were raised in families that held to working-class ideals about respectable behavior in women, shared Fiske's views. They saw the leadership's efforts at professionalization as an attempt to push them out of nursing. Their adherence to nursing skill measured in womanly virtue was not merely a conservative and reactionary stance. Rather, it was a belief that seemed to transcend class and educational backgrounds to place itself in the individual character and workplace skills of the nurse. It grounded altruism in supposedly natural and spiritual, rather than educational and middle-class, soil. For a nurse such as Fiske and many others, nursing was thus still a womanly art requiring inherent character in its practitioners and training in practical skills and spiritual values in its schools. Their beliefs about nursing did not require the professionalization of altruism, nor the demand for autonomy either at the bedside or in control over the professionalization process.

Still other nurses took a more pragmatic viewpont that built upon their pride in their workplace skills and character. These nurses also saw the necessity for concerted action, not unlike that taken by other American workers. Such nurses fought against what one 1888 nurse, who called herself Candor, characterized as the "missionary spirit...[of] self-immolation" that denied that nurses worked because they had to make a living (pp. 167–68). These worker/nurses saw no contradiction between demanding decent wages and conditions for their labors and being of service for those in need. Indeed, they were also unconsciously trying to redefine societal understandings of a woman's work of caring. But the efforts of various groups of these nurses to turn to hours' legislation, trade union activity, or mutual aid associations were criticized and condemned by the nursing leadership. Their letters were often edited out of the nursing journals, and their voices silenced in public meetings as they were denounced as being "commercial," or lacking in proper womanly devotion (Ashley 1976; Melosh 1982).

In the face of continual criticism from nursing's professional leadership, the worker/nurses took on an increasingly angry and defensive tone. Aware that their sense of the nurse's skills came from the experiences of the workplace, not book learning or degrees, they had to assert this position in the face of continued hostility toward such a basis of nursing authority (Armeny 1984b; Reverby 1987). While the position of women such as Candor helped articulate a way for nurses to begin to assert the right to care, it did not constitute a full-blown ideological counterpart to the overwhelming power of the belief in duty.

By mid-century, the disputes between worker/nurses and the professional leadership began to take on new forms, although the persistent divisions continued. Aware that some kind of collective bargaining was necessary to keep nurses out of the unions and in the professional associations, the American Nurses Association reluctantly agreed in 1946 to let its state units act as bargaining agents. The nursing leadership has continued to look at educational reform strategies, now primarily taking the form of legislating for the B.S. degree as the credential necessary for entry into nursing practice, and to changes in the practice laws that will allow increasingly skilled nurses the autonomy and status they deserve. Many nurses have continued to be critical of this educational strategy, to ignore the professional associations, or to leave nursing altogether.

In their various practice fields nurses still need a viable ideology and strategy that will help them as they are increasingly caught between the continual demands of more acutely ill patients and an ever-more bureaucratized, cost-conscious, and rationalized work setting. For many nurses, even those who work as practitioners in the more autonomous settings of health maintenance organizations or public health offices, it is still in an ideological sense the nineteenth century. In the face of shortages, some administrators have tried a variety of methods to keep nurses: increasing primary nursing responsibilities, improving the hours and nursing's control over shifts, and offering competitive wages. But even these approaches have failed to confront the problem of the valuing of caring in a meaningful way.

Armed with a sense of obligation, nurses have tried in various ways to articulate a series of rights that will allow them to care and to force our society to revalue caring. The acknowledgment of responsibilities, however, so deeply ingrained in nursing and American womanhood, as nursing school dean Claire Fagin has noted, usually drowns out the nurse's assertion of rights (Fagin 1975:82). Nurses are continuing to struggle to obtain the right to claim rights. Nursing's educational philosophy, ideological underpinnings, and structural position have often made it difficult to create the circumstances within which to gain such recognition. However, it is not so much a lack of vision that thwarts nursing as it is, and often continues to be, the power to give that vision substantive form (Smith-Rosenberg 1985:296).

Much has been transformed in nursing in the last forty years, and the current cry about shortages suggests this may also be a crucial time for change. The severing of nursing education from the hospital's nursing service has finally occurred as the majority of nurses are now educated in colleges, not trained in hospital-based diploma schools. Many hospitals, in the face of shortages, are experimenting with numerous ways to organize the nursing service that provide the nurse with more responsibility and sense of control over the nursing care process. The increasingly technical and machine-aided nature of hospital-based health care has made nurses feel more skilled.

In many ways, however, very little has changed. Nursing is still divided over what counts as a nursing skill, how it is to be learned, and whether a nurse's character can be measured in educational criteria. Technical knowledge and capabilities do not easily translate into power and control. Hospitals, in search of cost-cutting measures, have forced nurses to play "beat the clock" as they run from task to task in an increasingly fragmented setting (Boston Nurses' Group 1978; Hull 1985). In turn, nurses have responded by often refusing to work in situations that are dangerous and life-threatening to patients, and where they themselves are undervalued and underpaid. Many hospital administrators, however, are still more willing to blame nursing, and women, for abandoning caring than to think about what it will cost, financially and politically, to value the caring of nurses.

Nursing continues to struggle with the basis for, and the value of, caring. The fact that the very first legal case on comparable worth was brought by a group of Denver nurses suggests nursing's ongoing role in the political effort to have caring revalued. As in the Denver case, contemporary feminism has provided some nurses with the grounds upon which to claim rights from their caring (Bullough 1978). Feminism, in its liberal form, appears to give nursing a political language that argues for equality and rights within the given order of things. It suggests a basis for caring that stresses individual discretion and values, acknowledging that the nurse's right to care should be given equal consideration with the physician's right to cure. Just as liberal political theory undermined more paternalistic formulations of government, classical liberalism's tenets applied to women have much to offer nursing. The demand for the right to care questions deeply held beliefs about gendered relations in the health care hierarchy and the hierarchy itself.

Many nurses continue to hope that with more education, with explicit theories to explain the scientific basis for nursing and even caring itself, with new skills, with a lot of assertiveness training, and with the increasing demand for their services, nursing will change. As nurses try to shed the image of the nurse being ordered to care, however, a nursing school dean had to remind a graduating class "not to undervalue [their] particular ability to care" (Fahy quoted in Witcher 1985). Unable to find a way to "care with autonomy" and unable to separate caring from its valuing and basis, many nurses find themselves forced to abandon the effort to care or to abandon nursing altogether. More ominously, nursing is having increasing difficulty attracting young women or men into the field.

These dilemmas for nurses suggest the constraints surrounding the effectiveness of a liberal political strategy to address the problems of caring, and therefore of nursing. The individualism and autonomy of a rights framework often fail to acknowledge collective social need, to provide a way for adjudicating conflicts over rights, or to address the reasons for the devaluing of female activity (Eisenstein 1981; Jaggar 1983; Petchesky 1984; Schneider 1986). Thus, nurses often reject certain forms of liberal feminism, not just out of oppression and "false consciousness," but because of some deep understandings of the limited promise of equality and autonomy in a health care system they see as flawed and harmful. In an often inchoate way, such nurses recognize that those who claim the autonomy of rights often run the risk of rejecting altruism and caring itself.

Nurses, as have others in similar positions in our society, may have to find a way to use the language of rights in a communal rather than an individual sense. Nursing needs to share in the rethinking of rights as "infused with values of community, compassion and solidarity," and not merely as a "zero-sum game" in which the gain of nursing rights is measured in the loss for others (Lynd quoted in Schneider 1986:612). In making a cultural claim for the right to care, nursing must, as attorney Martha Minow has suggested for other struggles, focus on a "right to connection" by emphasizing "the social and economic preconditions for rights" (1986:24).

Just as Candor and her sister nurses tried to articulate a different political understanding of the caring work of nursing in the 1880s, late twentieth-century nurses will have to redefine the rights involved in doing caring work. In order to redefine this rights discourse, nurses will have to find ways to create the conditions under which it is possible to value caring and to understand that the empowerment of others does not have to require self-immolation. To achieve this, nurses will have to develop both a new political understanding for the basis of caring and find ways to gain the power to implement it.

Nursing can do much within itself to have this happen through research on the importance of caring on patient outcome, studies of patient improvements in nursing settings where the right to care is created, or by implementation of nursing control of caring through a bargaining agreement. Transforming the political discourse around caring might be possible only now as individuals in our society slowly come to terms with the personal cost of ordering nursing to care.

Nurses, however, cannot make this kind of change alone. The dilemma of nursing is too tied into the broader problems of gender, race, and class in our society to be solved solely by the political or professional efforts of one occupational group. Nor are nurses alone in benefitting from such an effort. If nursing can achieve the power to practice altruism with autonomy, all of us have much to gain. Nursing has always been a much-conflicted metaphor in our culture, reflecting all the ambivalences we give to the meaning of womanhood (Fagin and Diers 1983). Nursing may now be able to give this metaphor, and ultimately caring, new value in all our lives. But this will happen only if we acknowledge the problems created by nursing's history and the undervaluing of caring as we work collectively to make possible a different future.

DOCUMENTATION

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7

Caring for the Institutionalized Mentally Retarded: Work Culture and Work-Based Social Support

Rebecka Inga Lundgren and Carole H. Browner

Recent feminist scholarship has shown how workers in a variety of settings create semiautonomous spheres of action that can mediate formal authority in the workplace or distance workers from its impact. Termed *work culture*, these informal rules and shared values and understandings can be strategically used by workers to redefine the conditions under which they work (Benson 1978, 1983; Melosh 1982). Work culture has been shown to facilitate collective action and resistance by, for example, negatively sanctioning those who exceed worker production quotas or who in other ways undermine informal work strategies (Browner 1986; Lamphere 1984, 1987; Roy 1952; Shapiro-Perl 1984).

Work culture, however, is not only subversive in intent. It can also enable workers to adapt to tedious or depersonalizing work conditions by legitimizing social solidarity on the job or promoting self-defined standards for workers to value their work (Lamphere 1985; Sacks 1984; Westwood 1985; Zavella 1985, 1987). In cases such as these, managers are typically aware of subordinates' efforts to redefine the terms of employment, but they are powerless to unilaterally impose their own point of view. Work culture, then, is neither a direct reflection of management policy nor a set of rules, values, and behaviors created by workers in a vacuum. Rather, it is the product of interactions among competing interest groups.

Subordinated workers of both sexes create and use work cultures to establish autonomy and control they otherwise would be denied. For example, several classic accounts show how work cultures furthered the efforts of nineteenth-century skilled male factory workers to retain control over production processes (Braverman 1974; Montgomery 1976); others document how predominantly male informal work groups shaped production activities in the 1930s (Mayo 1933; Roethlisberger and Dickson 1939). More recently, however, feminist researchers have produced penetrating analyses of past or contemporary work cultures of female workers (e.g., Costello 1985; Joffe 1986; Kessler-Harris 1982; Sacks and Remy 1984; Sacks 1988). Many women's jobs, which are unskilled and low-status by nature, provide rich opportunities for the elaboration of work culture because they offer few direct opportunities for advancement, self-expression, or self-determination. In such settings, work cultures enable subordinated workers to counterbalance the powerlessness otherwise inherent in their status and position.

In the following account, we use the notion of work culture to examine the daily activities of the predominantly female nursing staff who work in a state hospital for the severely and profoundly mentally retarded. The notion of work culture is particularly useful for understanding how psychiatric technicians (or psych techs) operate within the constraints that a "total institution" provides (Goffman 1961). In contrast with many other jobs where peer support is primarily expressive in nature, psych techs also routinely depend on one another for instrumental and material help. The stressful, physically demanding, and sometimes dangerous nature of their work makes it essential that there be shared rules and understandings governing psych techs' activities and on-the-job social support.

We describe how psych techs' definition of what is important about their work differs sharply from that of the administration, and show the way the administration's definition inhibits the psych techs' ability to provide the kind of care they feel the resident patients (or residents) need. We also show that psych techs' work culture enables them to oppose, to some degree, institutional policies that they feel retard the delivery of good care, while also allowing them to advance their own interests as workers.

Previous discussions of work culture seem to imply that it serves as either a force for resistance *or* as a means by which workers adapt to managerial imperatives; we hope to demonstrate that it can be both. By designating caregiving as their highest priority and viewing each retarded resident as a unique and valued human being, psych techs explicitly ally themselves with the residents, not with the institution. Although their resistance only occasionally alters institutional policy, it is nonetheless transformational because it allows psych techs to imbue their work with personal meaning: the respect psych techs manifest for some of society's most utterly forgotten—the severely and profoundly mentally retarded—enhances their own sense of self-worth. Psych techs see themselves as tough, resilient, and compassionate people who lovingly perform a job few others would willingly endure.

This chapter's first sections describe the study's background, setting, and research methods. We next discuss constraints on caregiving, showing how the needs of the institution inhibit psych techs from providing the kind of care they feel that residents deserve. We then consider the components of the work culture to which psych techs subscribe, the ideology on which it is based, and the informal work strategies that emerge. The chapter's final section describes the circumstances under which psych techs' ideal work culture cannot endure.

BACKGROUND

The setting for this study, Southern California Hospital and Developmental Center (SCHDC),[1] is a large state facility that provides care for severely and profoundly mentally retarded adults. Its 494-acre campus contains approximately seventy major buildings, most of which are built in the California Mission Style of red-tile roofed, low stucco structures. The buildings are connected to one another by an internal network of roads and are surrounded by well-maintained lawns and park-like areas.

Founded in 1927 as Southern California Colony, its "inmates," many of whom were only mildly or moderately retarded, were charged with cultivating state-owned farmlands under a policy that provided little more than custodial care. That tradition was radically revised in the early 1950s when administrative policy shifted to an emphasis on treatment and rehabilitation. The *colony* came to be known as a *hospital*, the *cottages* became *wards*, and the *inmates* became *patients* (MacAndrew and Edgerton 1964:313).

The 1970s saw another sharp shift in California's policy for the mentally retarded, as patient advocacy groups united with those who favored then-Governor Ronald Reagan's cost-cutting measures. The mentally retarded were granted the right to be cared for in the "least restrictive setting"; all who did not absolutely require total care were released into "the community." With deinstitutionalization, treatment goals came to emphasize "normalization." The basic human rights of the retarded were recognized, and state institutions were required to provide care in settings that affirmed these rights (Alaszewsksi 1986; Bercovici 1983). Southern California Hospital was rechristened a *developmental center*, *wards* became *units*, and *patients* became *clients* or *residents*.

These new policies did not necessarily mark gains for the retarded populations they were intended to serve. In many cases, the changes that followed were more symbolic than real (Taylor and Bogdan 1980. SCHDC, for example, continues to operate largely according to a medical model of treatment: daily life is highly structured; medications are fully in use; and the rigid hierarchy of administration, staff, and patients prevails. However, one radical consequence of the normalization movement concerned training requirements for direct-care staff. Prior to the 1970s, no special training was required. Today, as we describe below, caretakers must undergo at least one year of specialized training and pass a state licensing exam.

THE SETTING

The vast majority of SCHDC's 1,100 resident patients are adults older than eighteen years of age; about 60 percent are male. Nearly all are either severely or profoundly mentally retarded. This means that the IQs of 99 percent of the residents fall below 50, and 50 percent have IQs below 9. As a result, residents require total staff supervision at all times. Most must be dressed and fed, many cannot walk, most cannot talk, and few have either bladder or bowel control. Some also have multiple physical handicaps and multiple chronic medical conditions, or are prone to seizures, aggressive outbursts, or self-abusive behaviors such as head banging, finger gnawing, or chronic masturbation. Many of the residents also suffer gross physical deformities. Some have bodies that are stunted or otherwise misshapen; the heads of others are massively swollen by hydrocephaly or attenuated by microcephaly. Residents' faces may be asymmetric, or their mouths, noses, ears, or eyes distorted as a result of a faulty developmental process, self-mutilation, or both.

Some residents' behaviors are highly unpredictable; others are monotonously routine. On some units, residents may sit motionless for hours on end, unable to communicate even their most basic needs, while others loudly and relentlessly insist on constant staff attention or incoherently babble with no apparent communicative goal. On other units, residents manifest frequent, unexpected aggressive outbursts; on the most violent units, there are several violent incidents or attempts each day. During these outbursts, other residents or staff may be bitten or hit, have their hair pulled, be dragged to the floor, or have objects thrown at them. On occasion, the assaults are severe enough to break bones. Some residents also manipulate others with their unpredictable potential for violence because they know they are feared by other residents and staff. Others stalk only certain staff and hit or bite them alone.

Residents are assigned to one of seven treatment programs based on their developmental and medical needs. Each unit is staffed by approximately thirty-five direct-care staff, the majority of whom are psych techs. (However, on the few units where most residents have chronic medical conditions, licensed vocational nurses and registered nurses constitute a greater proportion of the staff.)

Psych techs are state-licensed employees who have completed high school and obtained approximately one year of training in basic and psychiatric nursing. On most units, psych techs are responsible for overall nursing care and supervision, including the administration of medications and treatments; observation of residents' conditions, behaviors, and vital signs; charting; grooming; habit training; and first aid. Units are supervised by psych techs who have advanced through two levels of oral and written exams and demonstrated proficiency in all unit duties. A varying number of other support staff, including teachers, rehabilitation therapists, and social workers provide treatment or care on an intermittent basis. Of the hospital's total staff of approximately 1,700, about 1,100 have direct-care responsibilities.

Our study population consisted of the psych techs from two of SCHDC's seven treatment programs. Personnel in Program G were asked to participate in the study because that program was considered by administrators and staff to be the most stressful as a result of the unpredictable and often violent nature of its residents' behavior. To contrast Program G's psych techs' experiences with those of a more typical treatment program, data were also collected on Program C.

The unit supervisory staff on the two treatment programs were typical of the developmental facility's psychiatric technicians as a whole. They had been drawn from the ranks of the hospital's psych tech population and were generally representative with regard to gender, race, and social class. Their supervisory styles ranged from one who was a strong advocate for her staff in conflicts with the administration, to others who were regarded as competent but noninterventionist, to still others who were seen as incompetent, disengaged, and lazy. We demonstrate that, despite this variation, the psych techs on none of the units studied felt any less powerless in conflicts or confrontations with hospital administration.

The following discussion will not discriminate between Programs G and C because the psych techs who worked on them reported very similar experiences, with the exception of the issue of violence on Program G, which created its own set of stressors and staff responses.

RESEARCH METHODS

Data were collected between February and May 1984 on Program G and from July 1984 through March 1985 on Program C. Participant observation and in-depth interviewing were the study's main research techniques. With participant observation, researchers engage directly in many of the activities of those being studied (Pelto and Pelto 1978; Taylor and Bogdan 1984). In this case, researchers assisted in routine direct-care tasks, including grooming and feeding, and in educational and recreational activities. After informants have become relatively indifferent to a researcher's presence, the researcher can observe an uncensored version of daily life. Participant observation is especially well-suited for studying a diffuse phenomenon such as work culture, which by definition is oral and informal.

Participant observation was conducted on four of Program G's five units and two of Program C's five units approximately twice each week for one to two hours throughout the data collection periods. Each unit had its own participant observer: five were senior psychology majors; the sixth was a master's-level social work student. All had received ten weeks of training in qualitative research techniques. Participant observation data were collected in different parts of each unit and at various times of the day and evening so that the range of psych techs' work experiences could be documented. Detailed field notes were recorded away from the field site immediately after each observational session.

After several weeks of observational data had been collected and good rapport established on the units, semistructured interviews were conducted with sixty-four psych techs. Questions were asked about their backgrounds, why they chose and value their work, sources of perceived stress and satisfaction at work, and social support on and off the job. How work culture provided the techs resources to deal with the stresses of their jobs had not been an original focus of the research. Instead, it emerged in the course of our efforts to understand the nature of caregiving at SCHDC and the constraints that techs faced on their efforts to deliver care.

At the conclusion of the data collection period, a system was created for filing and cross-referencing the observational and interview data. Numbered coding categories were developed, and all data were assigned one or more numbered codes. Data were coded by the field worker who collected them and cross-checked by at least one other member of the research team. Content analysis (Glaser and Strauss 1967) was then performed to determine patterns and trends. This involved reading all data within each coding category and noting the themes, concepts, questions, and hypotheses that emerged. As tentative generalizations became apparent, they were systematically tested by assessing the data to support and refute them. Negative instances were used to modify, refine, and expand the first-stage generalizations. Broad themes pertaining to the basic research issues were thus derived.

A BRIEF HISTORY OF CARE FOR THE INSTITUTIONALIZED RETARDED

The sparse literature on caregivers for the institutionalized mentally retarded is consistent in reporting caretakers' lack of interest in patients' general welfare. It is also consistent in demonstrating the disrespect, insensitivity, and even brutality with which caretakers relate to their handicapped charges (see, for example, Bercovici 1983; Bogdan and Taylor 1975; Bogdan et al. 1974; Hall 1983; Taylor 1977). Taylor, for instance, observed the following incident while conducting research in a state hospital for the severely and profoundly retarded:

> Sherman [a resident patient] sat down on the floor in front of Bill [an attendant]. Bill handed him a burning cigarettee. Sherman took it and popped it into his mouth. The ash sizzled as it touched Sherman's saliva.
>
> Bill tapped Sherman on the leg: "Swallow it, Sherman. Go ahead. Swallow it." Sherman looked uncomfortable, but swallowed. The attendants laughed at the sight of him swallowing a burning cigarette.
>
> Laughing, Bill remarked, "It doesn't even hurt him. He loves to eat them." (Bogdan and Taylor 1975:159)

Also common in the literature are references to the fact that nursing attendants for the severely and profoundly retarded see their responsibilities as primarily custodial. They are said to avoid spending time with patients, either to further residents' intellectual or social development or in purely recreational pursuits. Instead, they are reported to prefer socializing with one another or passing time at work by playing cards, reading newspapers, or otherwise engaging in personal activities (Blatt 1970; Blatt and Kaplan 1966; Bogdan et al. 1974; Morris 1969; Taylor 1977).

We were therefore surprised to discover that the attitudes of the psych techs at SCHDC about their jobs and the residents with whom they worked differed sharply from those reported elsewhere in the literature. They placed the highest priority on meeting residents' emotional and physical needs, and they resented anything that interfered with their ability to do so. Instead of seeing the residents as objects of ridicule and scorn, the overwhelming majority treated them with sympathy, love, and compassion. Rather than seeing their responsibilities as primarily custodial, SCHDC's psych techs sought ways to increase the time they spent with the residents, both in unstructured interaction and in educational activities. In their own descriptions of their jobs, they emphasized the expressive aspects of their work and deemphasized the clerical and custodial. As a result, however, psych techs found themselves in constant struggle with the institution, which held the more conventional view that psych techs' primary responsibilities were above all custodial and clerical.

We suggest that differences between attendants described in the literature and the technicians with whom we worked are both historical and structural. In the past, nursing attendants were expected to provide only custodial care, largely because it was felt that little could be done to rehabilitate the institutionalized mentally retarded. Attendants were thus required to keep the wards clean and sometimes also to prepare meals and do laundry. Hall, who studied attendants in a Canadian institution, reports, "Because the staff role was historically much broader with an emphasis on caretaking and custody, front-line workers usually had little time to do much else" (Hall 1983:130).

In addition, unlike today's techs at SCHDC, nursing attendants of the past had no formal training in caregiving or mental retardation; most had not even completed high school. Few attendants described in other studies chose their jobs for altruistic reasons or because of any inherent interest in the mentally retarded. As recently as the mid-1970s, Bogdan and Taylor wrote, "The typical attendant possesses neither special skills, nor ideologies, nor plans for the future" (1975:199). But today, at least in California, psych techs are skilled individuals, many of whom choose their careers because of concern for the mentally retarded.

Finally, most of the attendants described in other studies were men, which may have contributed to their impatience and perhaps their brutality; by contrast, approximately 80 percent of SCHDC's psych techs are female. In our society, as in many others, women may be more nurturing than men; many derive deep satisfaction from nurturing activities (Lengermann and Wallace 1985). Taylor supports this impression when he contrasts the cynicism of the male attendants he observed with the more caring attitude of some of the female ones. He writes, "In particular, women attendants who work with children express fondness and even love for their charges" (1977:104; cf. Hall 1983:134). In sum, unlike nursing attendants described elsewhere in the literature, SCHDC's psych techs sought to provide empathic care to the severely and profoundly retarded residents; as we next show, they gained enormous satisfaction from doing so.

THE IDEOLOGY OF CARE

What most sharply differentiated SCHDC's psych techs from the attendants described in other studies was the techs' ideology and attitudes regarding resident care. While other studies emphasize the importance of extrinsic sources of job satisfaction such as wages, benefits, a relatively light work load, or relative freedom from supervision, SCHDC's psych techs were unanimous in asserting that their main source of job satisfaction came from direct resident care. This is not to minimize the value psych techs placed on the instrumental rewards of their jobs, which also contributed to their satisfaction. Nor, as we later show, do we mean to say that all psych techs felt equally positively about caring for the severely and profoundly retarded. But, for most, the chance to provide care for severely handicapped people was what made their jobs worthwhile.

Techs' attitudes about the importance of caregiving was consistent with their reasons for choosing their work. Many stressed altruism when they talked about why they became psychiatric technicians. Said one, "This work is closer to the ideal that I had set up for myself when I was younger. I went to a Catholic school and we were raised to desire a vocation—how you serve humanity and how you serve mankind. . . . I find coming in and trying to make someone's life more comfortable much more satisfying than other jobs I have had in the past."

Another said, "Something in our life seems to lead us to this type of work. You know, wanting to help people . . . it's kind of our nature." Many had previously worked in fast food chains or in other low-skill, low-paying jobs. In comparison, work as a psychiatric technician provided both economic security and emotional satisfaction. Expressions of emotional attachment to the residents were common. "The satisfaction you get here is giving," said one tech. "Most of these kids[2] can't give back to you. When they do, you feel very lucky. I'm probably happier in my job than most people I know."

Inherent in the concept of work culture is workers' own definition of a good day's work: "their own sense of satisfying and useful labor" (Benson 1983:186). For most psych techs we interviewed, a "good day's work" meant "meeting the residents' needs," emotionally or physically. Face-to-face interaction with residents provided particular satisfaction for some techs: "I have fun here, actually, but I make it fun. . . . I come in, I greet my kids, I hug them and kiss them, you know. I play my music with them. I dance on the table top out there. I do. I bring them cake or candy or bake for the kids. Barbecue. I have fun. I try to make the best possible times I can." For others, the opportunities for meeting residents' emotional needs provided the deepest satisfaction. Said one psych tech, "I think I find talking to the kids most satisfying, even though a lot of them can't talk back. Talking to them and seeing them smile and laugh. I like to tease certain kids and see them laugh and say funny things."

Other psych techs emphasized the more instrumental aspects of caregiving when they discussed what made their jobs worthwhile. As one psych tech explained, "At work, things that satisfy me are things I do for other people. And the thing is, I have to look at it from another angle and think that, 'gee, I do it for other people because that makes *me* feel worthwhile and feel needed and feel successful.' I've had a successful day when I've managed to get somebody's brace repaired or something. To me that's a great day."

This ideology of caring was reflected not only in the ways psych techs talked about the residents but in their interactions with them. On all units where observations took place, psych techs frequently touched, hugged, and held the residents; they often initiated eye contact or in other ways routinely sought to engage even the most physically deformed. In addition, they decorated their units with paintings, drawing, maps, and wall coverings. They provided stuffed animals, dolls, pillows, and bedspreads to make the units more comfortable. And they usually purchased these articles on their own time and with their own money. In these and similar ways, SCHDC's psych techs personalized their relationships with those for whom they cared.

SCHDC psych techs' ideology of caring led them to be critical of those who valued only the extrinsic rewards of their work. It may also have led them to minimize their own ambivalent feelings about their job. Said one, "If I ever get to the point where I know I really can't do a good job and I'm not giving the residents what they need, I'll quit, because I don't want to do that. I love them. I don't want to be one of those people who is here just to collect a paycheck. The residents deserve better."

In contrast with caregivers of the severely and profoundly retarded described elsewhere in the literature, SCHDC psych techs derive deep satisfaction from the expressive aspects of their work. Intrinsic to their work culture is an ideology which values the nurturing aspects of care, above all else.

CONSTRAINTS ON GIVING CARE

> The job itself, really it's not that bad. The work that we have to do can be...monotonous but any job can. And the kids here are good....It's just having to deal with fellow employees and the state itself...because we don't really have any say in what happens here.... (A SCHDC psych tech)

The psych techs at SCHDC were unanimous in their view that their primary function was to meet residents' emotional and physical needs. Moreover, they felt they knew best how to do so, because of their constant close interaction with them. This ideology, however, often puts techs in opposition with the SCHDC administration, which, the psych techs felt, did not necessarily place the highest priority on direct care. As one psych tech said, "Our priorities are often different than the administration's—like you think you should spend more time with the residents, and the administration says no, you should be spending more time on paperwork."

The psych techs felt the institution was primarily concerned with custodial care and clerical tasks, such as recordkeeping, because it is on these criteria that the SCHDC is evaluated and accredited by the state. But psych techs found the relentless burdens of paperwork onerous. "There is no time to promote the good things, like buttoning, if you are busy with paperwork and working on decreasing [antisocial or self-abusive] behaviors," explained one psych tech.

For some, it was not simply the amount of time spent in paperwork that bothered them, but its quantity, repetition, and disorganization, and their lack of adequate training to handle the multitude of tasks. For seemingly every action involving a resident that took place on the unit, written reports, notes, and progress sheets had to be completed. And much of the same information had to appear in several different files, so repetitive charting added to the burden (Browner et al. 1987:34–35).

From the psych techs' perspective, the other chief constraint on the delivery of care was the way the institution regarded them and their work. In this sense, psych techs identified deeply with the residents whom they saw as similarly powerless to effect any control over their situations. Techs felt that their own special knowledge and extensive practical experience with the residents was devalued or ignored by administrators because they lacked more impressive credentials. "I feel like a pawn shoved around. My input is hush-hush and not considered intelligent," said one psych tech. Another agreed, "They have no idea that these are individuals, not sacks of potatoes.... They just see us, they see the staff, they see the residents just as numbers on a piece of paper." In contrast, the psych techs believed that their input was critical to the residents' appropriate care and well-being. To illustrate, one psych tech told of the time the professional staff decreed that one of the residents should have an electric wheelchair. It was only with difficulty that the psych tech succeeded in convincing them that such an acquisition would be useless to the resident, who lacked all manual control.

But psych techs were dismayed by their inability to influence institutional policy not only because it hurt the residents, but also because they felt it degraded them and their work. As one tech explained, "If my input into the total care of this patient is not considered valid, what am I doing here? Then I'm useless! I'm just an aide. And I think of myself as a lot more qualified than an aide. I think that's the feeling of a lot of us."

THE DEVELOPMENT OF WORK CULTURE

According to Benson, work culture will develop if there is informal socializing on the job, relative freedom from supervision, and opportunities for coworker solidarity (Benson 1978). These conditions were all present at SCHDC during the time of the research. They enabled a work culture to emerge that provided the psych techs some measure of on-the-job autonomy while enabling them to redefine their work according to their independent view of good resident care.

SCHDC's psychiatric technicians enjoyed ample opportunities for socializing during working hours. There were extended, relatively uninterrupted periods for interaction while the residents were in school. In addition, many of tasks for which psych techs were responsible, such as feeding, dressing, and toileting, were routinely performed in the presence of other techs. Also, on some units, responsibilities for small groups of residents were shared by two psych techs, who often became close friends.

Psych techs at SCHDC also experienced relative freedom from direct supervision. For one thing, supervisors were often absent from the unit. Moreover, even when they were present, they could exert only limited control over psych techs' daily activities because these activities depended, in large part, on the individual characteristics and moods of the residents and on the day's events. As one tech remarked, "We are more free here, more independent. I can deal with my group the way I want. I'm my own boss." In such an environment, psych techs had ample opportunity to develop in conjunction with peers their own definition of work and style of working.

Psych techs identified primarily with the unit to which they were assigned, not with the larger treatment program or institution. Such identification fostered feelings of unit-based solidarity. Each unit's identity grew out of the type of residents assigned to it and the personalities and work styles of supervisors and staff. The residents' physical and functional characteristics that differentiated units also encouraged group cohesion.

Psych techs' work culture provided them not only with norms for their own behavior at work, but also with a common definition of what was best for the residents and a collective means to advocate for it. For example, when a new policy reducing the use of psychotropic medications was initiated, psych techs on several units united in opposition. They insisted that lower dosages would necessitate the use of harsher physical restraints, and they knew that they would be required to administer them. They believed that physical restraint was not only wrong, but that it interfered with residents' developmental goals. Those techs who were most troubled by the new policy repeatedly lobbied the administration through their supervisor, and they succeeded in reversing it.

As we demonstrate in the next section, working conditions at SCHDC promoted the development of a work culture that mediated between the institution and the psych techs, allowing them to redefine their work according to their own standards of good care. The particular conditions described here did not precipitate a militant work culture that could evoke structural change (cf. Costello 1985). However, the work culture that did emerge enabled techs to forge a better working environment for themselves. It further allowed them to elevate the act of caregiving from the mere provision of custodial services to care offered with affection and respect. In so doing, psych techs transformed the residents from social outcasts to human beings with special qualities of their own.

WORK CULTURE STRATEGIES

The psych techs' work culture provided them with a system of meaning that challenged the institution's. It affirmed the importance of empathic care for severely and profoundly retarded people. In addition, psych techs' work culture offered a set of behavioral strategies that facilitated their efforts to provide such care. As we show below, some of these strategies did not concern caregiving per se, but rather were means psych techs used to reinterpret the institution's requirements of them as workers. These informal strategies enabled the psych techs to regain control when the stresses of their jobs became temporarily unbearable and prevented them from feeling overwhelmed by residents' constant and enormous needs.

Covering for Coworkers

Psych techs could depend on their coworkers to "cover" for them when they bent or broke SCHDC rules. Extreme negligence or other misbehavior was never tolerated, but before reporting more minor infractions, psych techs followed an unwritten protocol. If an incident only occurred once, they would ignore it; they would assume that the person in question was simply having a difficult day. If the problem persisted, the psych tech would confront the individual directly to discuss the concern. If that, too, failed, the psych tech generally would report the matter to the supervisor.

Psych techs, for instance, would cover for others when they witnessed single acts of resident abuse. Although this may seem to contradict the precept that residents' needs came first, techs realized that even the best-intentioned of their peers occasionally felt overwhelmed. Said one psych tech, "If it's something that's just affecting somebody's day, you can relieve them and maybe they just need a break or something, or to get away. But, if I saw some type of continued verbal or physical abuse, then I'd report it." In this way, psych techs acted to protect both residents and fellow techs.

This was consistent with techs' belief that they should allow one another room for error because of the stressful nature of their work. For example, on one occasion a psych tech complained that she had gotten into trouble simply for arguing with another staff member. The other psych techs present agreed that they should be allowed occasional lapses as a result of the stressful work conditions they endured. Temper tantrums, slacking off, or not following protocol were all overlooked and covered up if they occurred infrequently or with cause.

Psych techs were especially willing to cover for one another when administration policy seemed arbitrary or when a tech's actions obviously benefitted the residents. For example, although rules stated that all residents should be bathed after dinner, one evening a psych tech was observed to shower one-half of her group before dinner so that they would be ready for their Boy Scouts meeting. A fellow psych tech helped bathe the rest of her group before the supervisor returned from her dinner break. Other techs on the unit refrained from notifying the supervisor of the infraction.

Responses to Scheduling

Periodic spending freezes left nearly all the SCHDC's units chronically understaffed. This added to the job pressure the psych techs endured, for they were frequently required to work extra hours or shifts. In return, they accrued cumulative time off, which could be used for personal health days. However, all requests for time off had to be made at least two weeks in advance, and, because of staffing shortages, they were usually denied. As a result, when job demands became temporarily overwhelming, psych techs could not easily use the time off that they had earned. When this happened, calling in sick was considered an appropriate occasional course of action. Although fellow psych techs did resent the action because it added to their responsibilities, they would accept the absence without complaint if they felt that it was justified. They would also cover for late arrivals, long lunch hours, or early departures if they felt the person involved genuinely needed the extra time.

Walking

When work stress became temporarily unbearable, psych techs would "walk," or abruptly leave the unit. They most often did so in response to interactional difficulties with residents or administration, which in some cases were intensified by problems at home. Psych techs would walk for only a few minutes, or for the remainder of their shift.

Many techs indicated that walking was their primary means for dealing with work frustrations. Said one, "As long as I can take five minutes away from what I'm doing, I can maintain control. It's real easy to get away when you need to here. Betty [her supervisor] and the other staff are real good about it. They encourage me to walk it off." A psych tech on another unit similarly indicated that she dealt with intermittent problems on the unit by "getting away from the situation and reevaluating it all alone." When asked whether her absence would be noticed, she replied, "Yeah, it is, but I think we pretty much have an understanding, a time to be alone, to get away and cool down. We pretty much respect that."

Running Interference

"Running interference" is an informal strategy closely related to walking. But while walking was initiated by the psych tech herself, running interference was initiated by a coworker or supervisor. And while walking was usually spontaneous, running interference was preplanned. Under the rules of running interference, when a psych tech or supervisor notices that a coworker is under a lot of pressure or about to lose control, a way is found to remove the psych tech from the stressful situation. Running interference was as important as walking in helping techs deal with daily frustrations, as one tech describes in the following incident:

> One time when I was working with a resident he spit on me. I was so infuriated that I started to assault the resident. The supervisor saw what was happening and wrote out a requisition for a box of Kleenex. Then she handed the slip to me to go get it. I knew that the supervisor couldn't do anything to get me off the resident so she redirected my attention instead. By the time I got back with the Kleenex, I had calmed down.

As with other means of social support that psych techs provided each other, running interference was not unilateral; psych techs were expected to let others know when something was wrong: "On the rare occasions when I am not feeling well, I'll let someone know I've got something going on. It's called 'running interference.' Staff will keep everybody or everything off my back during the night, until I get it worked out." This informal system of support provided relief from difficult situations, while communicating to psych techs that they were appreciated by their coworkers and not alone in their frustrations.

Help and Moral Support

The informal understandings through which psych techs elicited and obtained help from coworkers were a source of nourishment and moral reinforcement. Said one, "You can get burned out so easily if you don't have friends at work who will give you a hand. If someone is tired and needs help lifting or if they get behind, usually someone will pitch in and help that person out."

As with other aspects of their work culture, there were informal, yet commonly held rules for seeking coworker support: (1) techs should ask for help when they need it; (2) techs should offer help without being asked; (3) during an episode of violence, techs should rush to help the others involved; (4) techs should help one another out by trading residents or tasks that they cannot handle at a particular time; and (5) techs should offer each other positive reinforcement.

Despite these informal understandings, techs said they often felt uncomfortable asking their coworkers for help. They therefore especially appreciated unsolicited offers of assistance. "Like, yesterday," said a psych tech, "I had a kid that tore up three different areas. And, in the third area, Ann went and cleaned it up for me. And that was just a little thing, but it was a big thing for me... because I just couldn't face another mess. And she knew that, and so she responded."

They also greatly valued the moral reinforcement that coworkers or supervisors could provide, as is described by a psych tech in the following example: "Sometimes Joe [a supervisor] will just walk up and say, 'Gee, Deb [a resident] was so happy today; what did you do?' I don't think he realizes he's being supportive. I wonder if he realizes he really made my day by observing that." Whether supervisors were perceived as sources of help or moral support varied significantly among the units studied. However, supervisors on the more cohesive units were generally considered far more supportive than those on the less cohesive ones.

Humor

Shared humor, primarily about the residents, was another important means the psych techs used for coping with the demands of their job. Although jokes told at the residents' expense might seem cruel to outsiders, such jokes provided needed emotional release. "Joking helps keep down frustrations," said several techs.

Psych techs' use of humor is illustrated by the following anecdote one of them told,

> Susie was all done with her group and one of her boys was making a loud, obnoxious, and continuous noise. Susie said, "Can you take him out of here?" I said, "Sure, where do you want him?" She giggled and said, "Africa, Barbados, the Indian Ocean." I said, "If he likes water, how about the Bermuda Triangle?" She laughed and I pushed him out of the room. When I got to the door I said, "Really, where do you want him?" She said his group area would be fine.

The extent to which psych techs shared humor at the residents' expense varied among units, but it was more common on the more cohesive ones. Solidarity was built, in part, out of shared understandings about residents' limitations and idiosyncracies. Joking was part of a work culture that provided psych techs a means for dealing with the frustrations that caring for nonverbal, incontinent, often-unpredictable adults inevitably entailed. It also gave psych techs the reinforcement they needed to offer empathic care despite institutional obstacles.

Enforcing Work Culture through Sanctions

Psych techs had an arsenal of overt and covert means they could use to reinforce work culture and chastise those who deviated from its precepts. Psych techs controlled nonconformists by criticizing them to their faces or behind their backs, teasing them, ostracizing them, reporting them to management, or refusing to help those who did not conform.

By openly criticizing staff members who deviated from prescribed norms, the psych techs both socialized others into their work culture and punished nonconformists. For instance, one tech was observed seeking to instill in a coworker a greater sense of responsibility to her peers:

> Mary came in and asked Daria if she was going to help Georgia. Daria replied, "With what?" and Mary said that Georgia was by herself and was still getting her group ready. Daria said, "I will when I'm through" and left. Cindy said, "I hope she sits on a snake," and proceeded to criticize Daria for never helping the other techs and not pulling her weight. (Fieldnotes, September 13, 1984)

A more potent form of social control involved refusing to help those who failed to conform. If psych techs consistently asked others for help but refused to provide it in exchange, their coworkers felt no obligation to respond to their call. Similarly, if psych techs perceived someone to be negligent or lazy, they might refuse to help, even when explicitly asked. "Providing help is acceptable only if it isn't continual," said one psych tech. "I don't expect somebody to help me out if I'm piddling around. I resent people piddling around...."

Reporting a coworker was perhaps the most powerful sanction. Although it was not used lightly, there were definite circumstances when its use was considered justified, such as if a psych tech wanted to leave work early because she had gotten drunk at lunch. Psych techs indicated they would not only refuse to "cover" for another psych tech in such a situation, but they would report the colleague to the administration if the behavior persisted. Behavior such as this was considered unacceptable both because it endangered the residents' well-being and caused extra work for the rest of the unit's staff.

IDEAL VERSUS REAL WORK CULTURE

> The ideal is if you need help...call. Well, I can call for help and get it in forty-five minutes. And, at the same time, I'm still expected to be out in that dining room by 7:45 in the morning, whether I've had help lifting [residents] or not. So it's like, yeah, we'll get you some help, and you can go ahead and ask, and if you hurt yourself and you haven't asked, well, it's your fault. (A SCHDC psych tech)

We have described the "ideal" work culture to which most SCHDC psych techs subscribed. Its two main tenets concern providing residents empathic care and freely providing coworkers help and other support. In reality, however, psych techs' work culture was not a monolithic entity; it was expressed and interpreted in a diversity of ways. As we now show, variation in interpretation was a function, in part, of differentiation in the strength of a psych tech's commitment to residents, coworkers, and the job of psych tech.

Relatively minor variation was seen in psych techs' expressed altruism regarding resident care; the overwhelming majority were observed to be consistently compassionate. However, a few techs who worked with the very lowest-functioning residents seemed to subscribe to the ideal work culture to a lesser extent. Said one, "Satisfaction? Not much with nontalking people. There's just no response....If I were working with kids that were functioning—responding more, I might get more." Similarly, some of the "old timers" who had worked in the SCHDC for many years were observed to be more impatient and less nurturing than newcomers. But, for the most part, psych techs' attitudes and behaviors regarding the residents reflected a consistent set of shared attitudes and values.

Greater variation was seen in behavior related to the second main tenet of psych techs' work culture: Psych techs did not always offer help or ask for it when they needed it. As one commented, "I think some people help each other out, but I don't feel that as a rule people are real aware of when other people need help....Usually I have to ask for help, and I shouldn't always have to ask. But also, I don't like it when people get real uptight and really need help and don't say anything." Another echoed that sentiment when she said,

> We could be a lot more supportive of each other. It occurs, but not to the degree it should, or it could. I was thinking about that. I finished my group, and I was sitting down after lunch, and I was doing some writing—correcting charts and such—and Shelly was running around like a chicken with her head cut off. I looked up at her, and she ran by twice, and I thought, "Hum, I really should get up and help her. That would really be the right thing to do. On the other hand, can I deal with lifting another kid...can I physically do it? Well, let's see what I can do without having to put too much physical into it." Well, she's pregnant. Of course I was going to have to help her lift. I wasn't going to let her lift by herself. That was the right thing to do, so I did it. The thing is, as I stood up and was walking toward her area, I was thinking, "Hum, when was the last time someone did that for me?"

From psych techs' perspective, as we discussed above, the institution's bureaucratic priorities made it difficult for them to offer residents the kind of care they wanted to provide. These same bureaucratic priorities made it difficult for psych techs to be as helpful to one another as they would have liked. Inadequate staffing and the demands of frequent evaluations by the California State Board of Accreditation demonstrated to staff that institutional priorities lie with balancing the budget and passing licensing inspections.

Thus, psych techs' ideal work culture sometimes disintegrated under the weight of institutional obstacles. Although psych techs genuinely believed in the primacy of resident care, they knew they could not consistently provide it without help from their peers. And while offering and receiving help better enabled them to achieve their caregiving goals, constraints on their energy and time made it impossible for them always to be available when needed. Had the institution itself made a stronger commitment to its residents and staff, the psych techs would have been more able to do their work as they deemed appropriate. But because the institution failed to provide psych techs the support they needed, their work culture prescribed conditions under which it was excusable for them to break their own rules.

CONCLUSION

Occupying an intermediate position between nursing aide and full-fledged professional, SCHDC's psychiatric technicians seek to imbue caregiving with personal meaning, even in the face of evidence to the contrary from the institution. That facility values psych techs primarily for the custodial and clerical services they provide. In response, psych techs have forged a work culture that regards residents as unique and valued individuals, and places the highest priority on caring for them with affection, love, and respect. Certain aspects of this work culture enable psych techs to resist institutional demands they perceive as in neither the residents' nor their own best interests. Others facilitate psych techs' ability to adapt to what would otherwise be enormously stressful work.

Psych techs thereby refuse to allow the institution to subvert their relationships with those for whom they care. The processes through which psych techs transform their work in a nonconfrontational manner by redefining the nature of the relationships they encounter and by establishing independent job priorities may be particularly characteristic of the political struggles of women. These acts are as much acts of resistance to institutional hegemony as are overt actions such as protesting or striking. Although resistance of this type may not seem revolutionary in that it does not lead to structural change, it raises consciousness and can be transformational: Psych techs' work culture provides them the support and the means to refuse to be dehumanized into mere caretakers, and instead to assert their value as skilled and caring people. The relationships the psych techs strive to develop with coworkers and residents can thus be sources of empowerment as techs learn from others and develop greater confidence in their own self-worth.

On those occasions when the techs successfully assert their right to care for the residents as they see best; when they delight in the pleasure they bring to the residents, are touched by a sign of affection from them, are sustained by the support and appreciation of coworkers, or join together to resist an unpopular policy, the psych techs experience their individual and collective strength. By affirming the work of caring for powerless individuals with love and respect, SCHDC psych techs demonstrate the potential of women to humanize a world that increasingly values quantity over quality, efficiency over caring, and the instrumental over the expressive.

DOCUMENTATION

Authors' Note

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Notes

1. All proper names are pseudonyms.

2. The term *kids* is universally used throughout SCHDC interchangeably with the term *residents* to refer to the resident patients regardless of age. Although others have argued that use of this term patronizes adults (Bercovici 1980; Edgerton 1984), our observations indicated that it was not the intent of SCHDC's psych techs to do so.

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8

Nursing Homes As Trouble

Timothy Diamond

This chapter concerns certain contradictions between the organizational principles of nursing homes and the health and well-being of residents within them. I have encountered these principles in the course of a participant observation project during which I trained as a nursing assistant and worked in two nursing homes in a large metropolitan area.

The principles that I discuss fall under one general theme: the dominance of a medical model in the organization of nursing homes. I have found, as others have discussed (e.g., Bowker 1982; Estes and Harrington 1981; Gubrium 1978), that presuppositions of sickness and medical management are built into the everyday life of nursing homes in ways that can be counterproductive to residents' health. I take up this theme of medical dominance by illustrating four contemporary components of it that had significant influence on my work experiences. These are the increasing formalization of nursing assistant work within a medical hierarchy, the predominance of medical tasks over other facets of this work, the development of inspection systems based on the records of these tasks, and the overarching assumptions of illness, particularly mental illness, that pervade nursing home culture. Each of these components constitutes a section of the chapter. In the conclusion, I speculate about how each one of these reinforces the others as part of the emerging organizational structure of nursing homes and how they influence everyday life in ways that are very different for residents, staff, and administrators. In the process, they create a climate of trouble for some.

This research has been guided by the sociology of mental illness literature, especially Foucault (1965), Goffman (1961), Rosenham (1973), Scheff (1975), Smith (1978), and Szasz (1961). Because the vast majority of nursing home residents are diagnosed as having some form of mental impairment (Butler 1982; Moss and Halamandaris 1977), this literature is relevant for considering how nursing homes create, as well as care for, mentally impaired people. This chapter also draws on a body of ethnographic studies of nursing homes, most notably Bowker (1982), Fontana 1977), Glasscote et al. (1976), Gubrium (1975, 1978), Smithers (1977), and Stannard (1973). The approach taken here differs somewhat from this material by relating the everyday world of nursing homes to certain macropolitical forces that shape them. This is a perspective advocated, for example, by Burawoy (1979), Emerson and Messinger (1977), and Smith (1981). Following Emerson and Messinger, the chapter is an attempt to link the micropolitics of trouble in a social control institution with macropolitical forces. The macropolitical force at issue is capitalist medicine as a defining principle of organization in nursing home culture.

One feature of the two homes where I worked, not unlike the situation throughout the United States, is that they are specifically gendered organizations: the vast majority of residents and nursing staff are women. Most of the following data, therefore, are provided by women. Another feature of the two homes is that the residents are impoverished people. Most are supported solely by Medicaid funds. Therefore the settings from which these observations are drawn do not exemplify all nursing homes. The objective, however, is to portray situations that can arise out of principles that guide nursing home organization in the United States in general. Each section describes one situation in which the context of capitalist medicine is linked intrinsically to the everyday world of nursing homes in ways that create trouble for nursing assistants and residents.

NURSING ASSISTANTS IN THE HEALTH CARE "TEAM" (OR, "HOW DO THEY EXPECT US TO LIVE ON $209?")

While the job of nurses aide has existed almost since the beginning of the modern hospital (Reverby 1979), the position is becoming more fomalized as a certified part of the health care hierarchy. This formalization is coemergent with the growth of nursing homes, which already account for the majority of jobs in this rapidly growing field. Currently, nearly 1.25 million nursing assistants work in the United States, and the Occupational Outlook Handbook (1980–81) predicts 94,000 annual openings at least through the next decade, almost all of which will be in nursing homes.

One trend in this development is the requirement for certification prior to work. Beginning this project, I anticipated that I could enter directly into a nursing home for on-the-job training, but historically I was too late. Now, in order to do this work, one must first be certified through a state-approved training program as a certified nursing assistant (a title that now replaces nurses aide). In classified newspaper columns throughout the country, there are advertisements for vocational schools that offer such training. The schools get many applicants, mostly poor women, who are attracted to the relatively good prospects for employment, the caring-oriented duties of the job, and the possibility—however remote—of moving up in the ranks of the nursing profession. Unless one is formally trained in nursing (many foreign-trained nurses work as nurses aides), this certification procedure is required. Training in the school I attended lasted six months, with classes twice a week and one full day per week of clinical training in a skilled nursing facility. The cost, including tuition, uniforms, and textbooks, was just under $1,000.

School officials and textbooks (e.g., Schneidman et al. 1982) describe this training as a privilege because it gives the worker professional status on the health care "team." When the owner of our school started his first pep talk with a mix of medical and military imagery, we might have taken it as a warning as well as a welcome. "Welcome to the firing line of health care!" he said. Once out in that firing line, our place on the team was made clear in many ways. Surely one of the ways—the most talked-about by nursing assistants—is the low wage. I remember my coworker, Deborah Moffit[1] gasping at the sight of our first paychecks—take-home pay of $209 for two weeks of work, including a weekend: "Two-hundred nine dollars?" she shrieked, "How do they expect us to live on $209?" Deborah's complaint was no idle grumbling over low pay. She was experiencing a contradiction present in certain emerging forms of wage labor. As British sociologist Veronica Beechey (1978) points out, in the service sectors occupied overwhelmingly by women, pay rates fall below the actual cost of subsistence. This appeared to be the case for many nursing assistants with whom I worked. Many, if not most, were sole supporters for a family. At $104.50 per week—which is $3.50 per hour minus deductions—they often complained about not having enough money for food, rent, utilities, and transportation. In short, the wage creates poverty. The newly "professionalized" health care workers become impoverished, even with full-time jobs. For the women (and the small number of men) who work in this new profession, the wage structure creates considerable difficulty in their personal lives and, in turn, a context of constant strain in their work lives. Because nursing assistants are by far the largest category of workers in nursing homes (Occupational Outlook Handbook 1980–81), the wage structure is a significant factor in making nursing homes troublesome environments.

MEDICAL DOMINANCE OF NURSING ASSISTANT WORK (OR, "GET BACK TO WORK, YOU'VE GOT SIXTEEN VITALS TO DO.")

In nursing homes, the work routine is defined in terms of medical tasks. This is seen most clearly in the chart, a record of each resident's care. This is the instrument through which the work process is transformed into administrative discourse, or *documentary reality*, to use Smith's (1974) phrase. The job description manual at one of the homes where I worked indicates unequivocally the central place of charting in the work process of nursing homes: "Remember," it reads, "if it is not charted, it didn't happen."

Apart from the more abstract questions raised by such a mandate (for example, "if it didn't happen, but it is charted, did it happen?"), this instruction frames what is and is not legitimate work. The chart becomes a record not only of the resident but also of the work of the nursing staff and of the formal relationship between residents and staff. And this formal relationship is dominated by medical tasks. As the director of nusing told us repeatedly, "The most important task you have is to get them up and get them to take their meds." The second most important task is the monitoring of what are called "vitals" in medical discourse—blood pressures, temperatures, pulses, and respirations. Vitals have to be taken on every shift for every resident, although some residents are quite healthy and show unvarying vitals for all the years they have lived at a home. After this our job entails, according to our training manual, regimens of bathing and feeding residents, bedmaking and cleaning, conducting an exercise class (called Activities of Daily Living), bedchecks twice a shift, and participation, at the beginning and end of every shift, in the nurse's report on troubles of the day. These are the tasks that were charted on one of the twelve forms I filled out each day. Nursing assistants are quite busy in this medically framed round of activity, frequently under pressure to complete these tasks and document them properly in the charts.

In the course of the work, much that nursing assistants do is not charted or chartable. Not the least of this is the constant social, emotional work of caring for residents who, in the midst of loneliness and confusion, are often in great need of human contact. Yet in the charts, job descriptions, textbooks, and training, caring work remains invisible and unnamed. It is not officially recorded or rewarded; whether and how it is to be done is passed on only in an oral tradition. Sometimes doing it is even cause for reprimand. Under present organizational principles, medical tasks can dominate—or even cancel—caring work. One expressive moment of this for me was when I stopped to sit with Mary Karney, a seventy-seven-year-old resident, who was crying on her bed. Before I could find out why she was crying, I was interrupted by my supervisor who scolded me for sitting down with Mary, reminding me that I had sixteen more vitals to do before bedcheck. My job priorities did not include sitting with Mary Karney.

This kind of incident can be recounted by nurses everywhere. In this instance, the routine taking and recording of blood pressures not only took precedence over, but in effect precluded, tending to Mary's sadness. The point of relating this experience is not to assert that this is how nursing homes are, but rather to ask under what social and organizational conditions can a nursing assistant tending to a crying resident be considered not doing the job? Clearly this "logic" of the work process did not arise from Mary Karney's standpoint, or from mine as I sat there, or even between myself and the supervisor. It descends from an administrative logic that is far removed from that moment. It seems that in this logic the purpose of the work is maintenance and, equally important, the recording of this maintenance in codifiable and quantifiable terms. Marie Campbell (1982), following Dorothy Smith (1974, 1981), discusses nursing in the context of capitalist medicine as being transformed into an "administrative reality" of categories and documents; in the documentary discourse, nursing becomes defined in terms of tasks and abstract management technologies. These, in turn, create nursing as a commensurable and cost-accountable work process.[2]

To return to Mary Karney, it should not be surprising that her blood pressure was high that day—she was upset. There was a place to record her high numbers, but not her crying. Just to sit with Mary Karney to offer her social contact is not a formal part of the work. It is not a quantifiable, cost-accountable component of capitalist medicine, not a gesture that conforms to capitalist administrative logic. In the official view, this presumably "natural" work remains implicit, taken-for-granted, or even, as in that moment with Mary, cancelled altogether. In that troublesome incident an administrative logic, centered on the presumed preeminance of medical tasks, was superimposed on everyday life. To walk away from her at that moment was consistent with the logic of capitalist medicine, but it completely contradicted my sense of health care—and Mary's.

NURSING HOMES AS CAPITALIST INDUSTRY (OR, "HEY, THAT'S NO BAG LADY, THAT'S ONE OF MY RESIDENTS!")

Nursing homes represent a major growth industry at this time (Dunlop 1980). One financial journal describes an investment in nursing homes as "Gray Gold"—a stock of increasingly high value (Blyskal 1981). Growth of this sphere as a capitalist industry provides an example of the transference of social services from state and federal operation to that of private corporations (see Estes and Harrington 1981; Scull 1977, 1981; Warren 1981). One can see the logic of profit entering directly into the everyday life of residency in a nursing home and creating trouble therein. To illustrate this, I consider three incidents from my work experience. One relates to inspection of the wards, the second to the money that is transferred from nursing home administration to residents, and the third to nursing homes' vested interest in bed occupancy.

One day at the intermediate-care facility there was an inspection—a state requirement in nursing homes that receive Medicaid payments. Our inspection was conducted by a multinational medical management corporation, which would then report back to the state. I arrived for the 3:00–11:30 p.m. shift, anxious to find out if we had passed that morning's inspection. We had passed, but the nursing assistants and residents did not seem to care or even notice. After pursuing the issue, I realized that no member of the inspection team had ever entered the wards or spoken with residents or nursing staff. Life went on as normal, which, in this home, included many things that would not legally pass an on-site inspection. Inspection turned out to be purely an administrative process that transpired in the business office. The inspection practices related exclusively to the documentary reality (Smith 1974, 1981) generated within the office in the forms of numbers and costs and information from the medical charts. The documents, not the residents, provided the basis of the inspection. Little wonder that no one noticed; even as the inspection was in process, the wards were hidden from public view. This is not to suggest that wards of total institutions ever have been open to public view; the current procedures signify the current version of a continuing problem of hiding the life of people in total institutions.[3] Now the information that forms the criteria of inspection begins and ends in a computer through various boxes checked by personnel along the way. The state reimburses the nursing home on a cost-per-unit basis, units defined in a computer-adaptable language. Under these conditions, *inspection*—a word derived from the Latin word meaining *to look at*—completely circumvents looking at human beings and their actual living conditions.

In the two homes in which I have worked, almost all the residents are on Medicaid. I use *on* Medicaid because *receive* does not capture the exchange. The state pays the nursing home, not the resident. Currently, this is approximately $1,000 per month per resident. In both homes, residents received a cash allowance of $25 per month. From this they had to buy all personal items (toiletries, stamps, phone, coffee, cigarettes). The money vanished rapidly. If a resident smoked (and nursing homes can be smoking cultures), the entire fund was less than the cost of smoking. A few days after "payday" residents were penniless.

One dramatic consequence of such a structure can be seen on the streets of any urban ghetto. Some nursing home residents are quite ambulatory and are "free" to leave the home at certain times. Yet, what kind of freedom results from such pennilessness? While walking to work one day, off in the distance I saw a woman rummaging through the trash. In my mind, I dismissed her with the typical slur, "Oh, another bag lady." But when I walked closer I realized, "Hey, that's no bag lady, that's June, one of my residents." After a short conversation with her, it became clear why she was exploring the trash: It was only the middle of the month, but her $25 was exhausted. She was looking for something she might trade or sell. Although $1,000 had passed from the state to the nursing home in her name, she was on the streets to barter.

Where I worked, residents were frequently in trouble with police for indigent-type transgressions, such as loitering, shoplifting, or begging. At one point, all residents were barred from a local church because too many took money from the collection plate. All of this occurs while $12,000 per year is passing somewhere over each resident's head. Ralph Sagrello, a resident for nine years, summarized his situation sardonically in a conversation during which I had asked him if he were on public aid. "Public aid?" he responded, "I'd rather call it poverty aid!" In this he expresses another contradiction that is possible under contemporary organizational principles of nursing homes. Left to the "entrepreneurial tendencies" (Emerson, Rochford and Shaw 1981) of privately owned social control institutions, residents can become beggars.

These incidents lead into a third issue, the vested interest in institutionalization that is intrinsic to private social control institutions. It has been well documented that policies of deinstitutionalization (which existed at least nominally in the 1970s) have virtually dissolved (Bassuk and Gerson 1978; Habenstein and Kultgen 1981; Lerman 1982; Rose 1979; Scull 1977, 1981; Warren 1981). The actual history of the closing of state hospitals is better understood as "transinstitutionalization," which is, according to Warren's analysis, "the transfer of responsibility for 'social junk' [Scull's term] from state budgets to various combined welfare-private profit systems that cost the state less and provide numerous entrepreneurial opportunities" (1981:726). The people who were formerly inmates in state mental hospitals now reside in nursing homes, where they and older people who have no other place to go have become "lucrative commodities" (Scull 1981:747). It appears, in fact, that once they enter, people do not leave nursing homes except to go to another or to die. In the two years, 1980 and 1981, only three people left my four-hundred-bed facility for a more independent living situation. In this home, we were even instructed to avoid applying the term *independence* to residents. As the activities director once put it, "We try to avoid using the word independence in this place. Otherwise, we have no purpose here."

These three illustrations identify the residents in the homes where I worked as penniless beggars and as commodities. My intent is not to expose "bad" or "unscrupulous" administrators, or to provide yet another report documenting administrators' abuses in this basically natural and inevitable institution. It is, rather, to question the basic capitalist principles underlying such institutions. Their project, in their own terms, is to provide the most cost-effective health care. For the most part, their administrators do not intend to produce beggars. To argue this would be crude psychologism, not sociological analysis of capitalism in process. Something deeper in the fabric of nursing homes is operating that allows administrative logic to proceed with no recognition of the depraved conditions under which the human products of this industry can come to live. Something mediates and obscures a vision of this impoverishment.

One key to what obscures this vision is implicit in comments offered by my intermediate facility's social service coordinator. Despite the fact that some residents are physically and mentally quite agile, the coordinator frequently described them as patients who will never improve. "Keep in mind," she said, "the more you get to know these patients, the more you know there's always something for them to improve upon." The concept of the resident as perpetual patient reinforces the principle of vested interest in institutionalization and is consistent with the other themes discussed so far—the medical hierarchy, the task-centeredness of the institution, and the medicalized accounting system. But this ideology is more directly an expression of still another principle that pervades nursing home culture. This is the overriding assumption that residents, because they are old or just because they are there, are mentally ill.

THE DOCUMENTARY REALITY OF MENTAL ILLNESS (OR, "YOU KNOW, ROSE, THIS PLACE DRIVES ME UP THE WALL.")

Guiding the everyday treatment of nursing home residents is the presupposition that mental impairment is at least part of a resident's diagnosis. The most prevalent diagnostic categories that describe residents' conditions are senile dementia, Alzheimer's disease, organic brain syndrome, and undifferentiated chronic schizophrenia. The first two comprise 50 percent of all nursing home diagnoses (Butler 1982; Moss and Halamandaris 1977).

In a meeting, the director of nursing once announced the prevalence of mental illness with the claim that "70 percent of our residents come from the state hospital." Such a statistic, I later estimated, was nowhere near the reality. Roughly 35 percent had at one time been state hospital inmates, and most of these had been in halfway houses during the 1970s. In the same presentation, we were reminded that the older one gets, the more one becomes like a little child (an assumption that I soon discovered can be very insulting to some residents). These descriptions were followed with a warning about what kind of behavior to expect: "We expect trouble from these residents; that's why they're here." In this way, the residents become defined not as *in* trouble but *as* trouble. Emerson and Messinger, in discussing the micropolitics of trouble, suggest that "a deviant should be understood not only as one who is morally condemned, but also one who is sided against"

(1977:131). In this meeting, the residents were recreated as troublemakers and the staff was encouraged to side against them.

The point of this is not to indict the director who was, in many ways, a very good nurse. It is to highlight the power of the mental illness model in these settings. The director probably was not intentionally deceiving us any more than the administrators are intentionally creating beggars, but rather was reflecting an overarching ideology in which the notion of "70 percent from state hospitals" seems to make sense within the context of the current operation. As this ideology is perpetuated, mental illness becomes an organizing principle of nursing home culture.

As nursing assistants, we were encouraged to read the charts frequently so we could "get to know the residents better." Each chart has seven sections,[4] all of which spin off the first—the admitting diagnosis. Following this are the psychiatric report, medical consultants' reports, laboratory report, drug regimen, social and medical history, and activities program. The charts define residents in terms of their medical and psychiatric troubles. To read the charts, then, is to get to know the residents better through their sicknesses. With the chart providing the basic documentary reality, the director's warning that we should expect trouble is brought to a full ideological circle: if we want to know why a resident is causing trouble, we need only to look in the chart to find the cause.

Furthermore, after reading a resident's chart one learns almost nothing about these women's and men's lives—the sixty to seventy years that they lived prior to admission. As with caring work, there is no documentary space for residents' personal or social histories. It, too, is passed on only in an oral tradition in informal conversation. Social history is not a part of the formal principles or documents that record the staff-resident relation, and it is not a part of the way nursing assistants are instructed to get to know the residents better.

One could imagine alternative entrees into residents' existence. Suppose, for example, nursing assistants were introduced to residents through a sociological rather than a medical or psychiatric account of their lives. Then Mary Karney would not have been presented to us as having senile dementia but as a mother of three, whose husband died and children moved away, and who lived alone for fifteen years. Then, the little money she had she spent in other nursing homes. The Medicaid home where I met her was, for her as it was for many, the end of a series of homes, after private funds and Medicare had run out. Rosemary Phillips, age sixty-one, would not be a "chronic undifferentiated schizophrenic," but a mother of two, whose husband beat her and took off with the kids. Left emotionally broken and without resources, she struggled along with part-time work and community mental health services. Neither is available any more. Viola Steward, age seventy-seven, has an admitting diagnosis of "mild cataract, mild dementia." She quit her job forty years ago to take care of her parents; thirty years later, both of them had died. Viola, two years later and then penniless, broke her hip. She was in her third nursing home when I met her.

As with these three, each resident has a personal history that can be traced backward from admission to specific relations in a social history. Doing so reveals certain commonalities obscured by presentation in terms of psychiatric disorders. For example, most of the women entered the nursing homes where I worked quite poor, and their existence there is a continuing process of impoverishment. These are people for whom the bottom fell out. Mothers, wives, and daughters whose familes disintegrated over time. Women—and men—who lost both family and jobs. Now they are completely without resources or means of obtaining them.

These are sociological sketches. Whatever their limitations, they provide some kind of explanatory link between admission and former life. By contrast, the psychiatric explanation as embodied in the chart obscures and actually destroys this link. The basic social institutions that formed the contours of these residents' lives—family, parenthood, religion, work—if present at all in the charts are there as boxes to be checked. The resident becomes identified as a patient by the staff, while the psychiatric diagnosis separates the resident as a patient from the staff. There seems, in short, to be a radical gap, a rupture in meaning generated by the medical discourse that subsumes residents' lives upon admission. It separates their identities both from staff and from their own social histories. No sociological linkage is offered in staff discourse as to how the defining characteristics of Mary Karney's life got changed from motherhood, to poverty, to senile dementia. Without this, residents are introduced in the nursing home only as the end point of this progression, only as sick.

To close this section, I want to call attention to the basic technology of this mental illness model—drugs. In my nursing homes, sedatives were used heavily, with profound impact on residents' behavior. I came to realize that the director of nursing was quite serious in telling us that "the most important job you have is to get them up and get them to take their meds." According to the house rules, residents must take the medications that are assigned to them. They can refuse just about everything, including eating, but they cannot refuse medications. Sedatives are prescribed as a matter of course for the diagnoses of most nursing home residents. One result was a culture of sleep. Residents slept so much in the homes where I worked that my conceptions of sleeping and waking were jolted. I had tended to dichotomize the two, thinking of them as distinct states of consciousness. But life as a nursing home resident is, for many, somewhere between the two. It is not uncommon for a resident to fall asleep in the middle of a conversation. Some wake up only for meals and medication.

Once again it was Mary Karney who captured the personal trouble that this environment fosters. Mary is a bright woman, and we had many jovial, animated conversations. Still, she is heavily sedated although she struggles against it. One evening, when she was leaning up against the wall in line for the 8:00 p.m. meds, I overheard her make a comment to another resident. Stupefied and about to become more so, she turned to Rose standing behind her and whispered in the slow voice of a person trying to wake up, "You know, Rose, this place drives me up the wall." In this chilling metaphor of entrapment, she was not only complaining about the troubles of her life, she was attributing active agency to the nursing home in the creation of those troubles. For her, the relevant context in which to understand her feelings of entrapment is the institution, not the senile dementia. In this she disagrees with the authorities and the discourse of the entire organization in which she resides.

Yet Mary's continually imposed state of stupor is not an isolated cause of personal trouble for her; it is part of a climate. The issue is overly simplified if psychiatry and sedatives are isolated as the villains. As a primary mode of therapy, intervention, and control, sedatives provide a mechanism that follows not just from a logic of psychiatry but from all of various organizational principles so far discussed. Drugs are cost-accountable, profitable, and medical; they are easily coded while being quite mysterious to residents and nursing assistants. They are easily inspected, quantified, increased, decreased. It is not adequate to give drugs independent causality, as in the belief that "the trouble with nursing homes is they give too many drugs." Drugs reflect the culture, they do not create it. They are the basic technology of a larger process.

CONCLUSION

In this chapter, I have examined the domination of medical ideology in the culture of nursing homes as expressed through four themes: the increasing formalization of nursing assistant work, emphasis on medical tasks in that work, the development of accounting systems based on these tasks, and the overarching presumption of illness, specifically mental illness. As each one of these becomes more taken-for-granted in the culture, they serve to conceal as well as to reveal. The notion of professionalization of nursing assistants conceals the impoverishing wage structure in which they work. The task-centeredness can hide and prevent the emotional work of caring for human beings. The accounting systems can make wards completely hidden from view even while "inspections" go on regularly. They can also foster a resident population that is begging in the streets by mid-month. They can, in the interest of bed-occupancy, obliterate any chances of a resident's independence. The foundation of all of this is the presupposition of mental illness. Although the concept of mental illness has changed—taking on new syndromes specifically for older people—the label retains its power to reduce a person's public identity to a psychiatric disorder.

To the extent that each of these forces is present in any nursing home, it generates conditions counterproductive to health care. While these have been discussed as somewhat discrete elements, it may be better to see them as parts of a general process. In the two homes where I worked, it was easy to see how they all reinforced one another. Mary Karney shows up so frequently in these incidents not only because I got to know her so well, but because she embodies simultaneously so much of what these troublesome incidents portray. To be with Mary on a daily basis is to come to see her crying, invisibility, poverty, dependence, and drug stupor as indistinguishable. They all appear in terms of each other and reinforce one another.

Similarly, nursing assistants must absorb these troubles as a whole interrelated process. Their subordination in a medical hierarchy reinforces the invisibility of their labor, which reinforces their impoverishing wage. In turn, the cultivation of caring work is suppressed, both by the task-centeredness of the work and the daily strains of poverty.

These processes simultaneously reinforce each other at the administrative level as well. At this level, however, they do not appear as trouble but as a rational model of organization. The medical tasks are carefully monitored by the accounting systems; profit is increased if wages can be kept low and if residents' allowances can be kept to a minimum; inspection is streamlined if it is conducted totally as an analysis of quantifiable data. Permeating these dynamics is the presumption of residency based on sickness and a profitable technology based on drugs.

For residents, staff, and administration, then, these processes are present together, although in different ways, as part of the ongoing culture of nursing homes. It may be that these coalesce only in the kinds of homes where I worked, where people are without resources. Surely they appear in particularly glaring ways in such settings. Yet the very depravity of these settings may reveal not so much their uniqueness as the principles and forces underlying the emerging organization of nursing homes. Perhaps these problems are merely muted as we look at homes where residents can afford to mitigate these forces. To the extent that this is true, the sociological and political issue changes from troubles in nursing homes to nursing homes as trouble.

DOCUMENTATION

Notes

1. All names are pseudonyms.

2. For a discussion of similar processes in other organizations, see Altheide and Johnson 1980.

3. For a discussion of nursing homes as total institutions, see Johnson and Williamson 1980.

4. The chart is a document that is carried over into nursing homes from the classical model of the cause-and cure, acute-disease hospital. In this latter setting the presumption is that the chart signifies only a transitory part of patients' lives, their illness. But in nursing homes, because people are there for the rest of their lives, their medical records becomes their life records and their sick role statuses become permanent ones.

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9

Does It Pay to Care?

Karen Brodkin Sacks

Health care is big business—the second or third largest in the nation. In 1983, it employed nearly eight million workers, or one in thirteen U.S. workers. It has been and continues to be a women's world of work. Four out of five health care workers are women, and one in seven of all working women work in this industry. Like most female-intensive industries, the wages are low.

It is an industry so visibly stratified by race and gender that the uniforms worn to distinguish the jobs and statuses of health care workers are largely redundant. Those at the bottom of the pay scale, clerical and service "support" workers, are women and minority men, and conventionally regarded as peripheral to actual caregiving. Those at the top are white and mainly male medical and managerial staff, who together with underpaid predominantly white women registered nurses (RNs) are seen as central to care delivery. The resulting pay and status hierarchy is both rigid and visible, with women and minority men almost absent from its well-paid upper levels, and white men few and far between at the bottom. This individualistic system of rigid rank reflects neither the teamwork required to deliver care, nor the importance of half of those team members. A great deal of health care has always depended on the unremunerated and unacknowledged coordinating, administering, screening, and nurturing work of women clerical, technical, nursing, and service workers. This chapter examines what drives a system where hourly workers who do so much benefit so little.[1]

The first part is about the dilemma faced by those workers: does it pay to care? For many, the knowledge that they do make a difference for patients acts as partial compensation for the poor pay and lack of autonomy they face. These workers routinely step beyond their specific job descriptions to fill a variety of kinds of organizational void in a system based on specialization. Their skills are often more visible to and appreciated by patients than by hospital administrators. Patient gratification is an important incentive and reward in the face of an organizational hierarchy that denies their worth in both pay and recognition.

These workers are aware that finding job satisfaction by caring is a double-edged sword. The rewards are undercut by the fact that management and professionals often claim sole credit and benefits, ignoring the full range of hourly workers' contributions. Personal job satisfaction only partially compensates for lack of pay and public recognition. This was one reason for the strong wave of hospital and nursing home union organizing beginning in the late 1950s. Those struggles were only partially successful, and unionization addressed only one aspect of workers' grievances (Hoffius 1980; Sacks 1988; Sexton 1982).

The second part of the chapter deals with the relationship between the gains that were made as a result of worker and consumer efforts in the 1960s and 1970s, and those that were not addressed. I suggest that the failure of unions in the 1970s to take on the issues of unrecognized skill has come home to roost in the 1980s, weakening their abilities to keep so-called unskilled workers from bearing the brunt of the massive cuts in federal funds that are restructuring health care.

Health care is a business that has long depended on federal funds, and its institutions have been shaped by that funding. From World War II until the mid-1970s, the government reinforced a hospital-based, largely private, expensive fee-for-service system that denied a very large number of people adequate care. In the 1960s, the black freedom movement, grassroots consumer activism, and hospital worker unionization coalitions succeeded in winning federal health insurance for the poor and aged, and wider occupational access for working-class white and minority women and men. To meet these needs, the federal government also increased funding for and affirmative action in health education and training of health professionals and paraprofessionals.

From the mid-1970s, however, the tide of expanding access to health jobs and care began to reverse as big business spearheaded demands for cutbacks in the face of steep rises in the cost to them of employee health insurance. The government responded by cutting back its reimbursement for federally insured patients, supporting ambulatory care alternatives to hospitalization, reducing health worker training, and opposing unionization in a variety of ways. These policies are at the core of the Prospective Pricing System. Instituted in 1983, this system has hit hardest at the jobs and opportunities of minorities and working-class white workers. Because their contributions to patient care and to the organization of health care delivery were not made issues in the period of grassroots activism, they did not gain recognition in work organization. Therefore, these very real contributions have not been factored into federal formulas that set reimbursement to hospitals for care to federally-insured patients, and their jobs are the first to go when hospitals retrench.

HOURLY CAREGIVERS

This section describes some of the daily routines of hospital work to illustrate the skills that so-called unskilled and semiskilled hospital workers routinely exercise and the way these contribute to hospital functioning. It then discusses ways in which the informal rules expect these workers to do what the formal rules prohibit, and the resulting double binds that workers experience in a system that demands responsibility without delegating authority.

Nurses and clericals are key people in moving consumers through the system. They grease the bureaucracy's wheels by coordinating the interactions of many different types of health care workers at many different levels in the hierarchy. Among professionals, coordination is managed by interdepartmental teams of specialists who confer on a structured and regular basis. However, a great deal of interaction between professionals and nonprofessionals and among nonprofessionals also requires coordination, but it is not in anyone's job description to do so.

Most of the responsibility for coordinating treatment of people as whole but ill human beings falls to nurses and aides. Clerical workers, especially receptionists and office and ward secretaries, have to perform the parallel functions on each person's paper or computer record. Both these sets of jobs also demand a wide range of people-coordinating skills because nurses and clerical workers find themselves on the front lines of a bureaucratic void in a health care system that is made up of specialists, each of whom is responsible only for a specific task at a specific station on the health care assembly line.

Head nurses are administrators and responsible for coordinating nursing, but, as most nurses realize, nursing and clerical work are tied together in key places. Carol Brandon, a head nurse, knows that the division of labor separates nursing and clerical work, but she also knows that the separation has to be breached somehow for her clinic to work well. She recognizes that she is pushing beyond the limit of her authority when it comes to clerical workers: "I'm trying to get a situation where secretaries and nursing staff can pick up some responsibilities [outside their areas]. For example, a client was sent to allergy clinic and someone [a doctor] decided they needed to order a theophilin level. But no one asked when he last took that medication. The test will tell you nothing because he hadn't taken any medication for six months."

Ordering tests and making sure they are appropriate is a doctor's prerogative and responsibility, not that of nursing or clerical staff. For smooth running of her clinic, however, Carol opted for a strategy that protected patients from physicians' mistakes rather than intervening directly to correct doctors. While Brandon is an administrator, and credited with a well-run clinic, she is also a nurse, subordinate to doctors. She is aware that picking up physician errors is not part of the jobs of clinic receptionists and that she has no authority to direct nonnursing staff. Still, much of the clinic's smoothness depends on the fact that they have a fair amount of *de facto* medical knowledge, and she wants them to exercise it—which they usually do—even though it is beyond the scope of their authority. As health care work has become more divided, specialized, and rationalized, workers' exercise of such unrecognized and unremunerated skills and knowledge seems increasingly important for successful health care. The hierarchical model jeopardizes clericals who work beyond their job descriptions. Even though the results can be rewarding, it can mean more work, demands by superiors who have no legitimate authority to make them, and hence the potential abuse of authority. Most significantly, clericals are vulnerable to punishment in the form of reprimands and low performance ratings for doing things they have no authority to do.

In the official system of intensely specialized functions, general human concern is no one's specific responsibility. Exercising initiative in this diffuse arena has its most immediate consequences for patients. In one large tertiary care center, clinic receptionists have to exercise considerable judgment and initiative routinely. "Sometimes when a patient is sent as private, and they're from out of town, and [their medical problem] is complicated and expensive, you need to stay attuned. For example, in hematology especially [mainly children with cancer], I know it's going to be expensive, and I route them to Diana to see if there's a sponsored program they qualify for. For example, one child today, started private. We noticed the bills and after a while we routed them to a sponsored program." The concern and initiative of these clinic receptionists are not officially recognized in the hospital's division of labor, but they often are key to clients' treatment and pocketbooks. How do these women know who is likely to need and to qualify for sponsored payment of part of their medical bills? "I like people and we get to know them; it's a sort of sixth sense."

Clinic receptionists also direct traffic—the routine traffic like transferring calls and paging people on the intercom, and the nonroutine. A woman arrived at a clinic for her baby's immunization but without an appointment. She told the receptionist that when she had been in the previous week the baby had had a cold and could not be vaccinated. Her doctor had told her to bring the baby in this week, but had not followed through to make sure she would be seen. The woman had taken a day off work to come in. The receptionist phoned the doctor's office and put the head nurse on the phone with him (only RNs can take doctors' orders over the phone). This way the nurse could immunize the baby right away, and the woman did not have to wait several hours until the well-baby clinic began. Here, too, a shared concern and creative use of protocol helped a patient left in limbo by her doctor.

Clinic clericals often develop backgrounds in the contents and costs of various kinds of lab work and find themselves watching out for patients' pocketbooks in ways that doctors might not. "We order the lab tests the doctors write; but if I think there's a mistake, we need to check on it. For example, where they order a sodium, potassium, and creatin, it costs $23, when they can order a chem 7, which includes all those for $20. We usually ask the doctors about that. A lot of times medical students don't know. Or in July when we get new doctors, where they're used to doing things in a different way, we need to keep up till they learn how it's done."

Nurses, receptionists, and ward secretaries all have to teach housestaff, because they are the main physician providers in most large medical centers. For example, they need to learn how to schedule tests and procedures and who can schedule which ones. Most medical training is on-the-job, and much of it comes from those who know and who are on-the-spot: clericals and nurses. This kind of teaching, while having a less direct impact on patient care, nevertheless runs an indirect interference for patients in large teaching hospitals.

Clerical and nursing staffs overlap in many areas, and both are often called on to patch up the holes that are inevitable in a clinic of specialists, part-timers, and rotators where more emphasis is placed on teaching about specific problems than on delivering health care to people. The latter job, delivering health care to whole people, really falls much more to the nursing and front-line clerical staffs than to doctors. To a large extent, their jobs demand coordinating the activities of higher-ups in the hospital bureaucracy, especially housestaff and attending physicians, over whom they have no authority. This often puts nurses in the difficult and demeaning position of making suggestions to higher-ups indirectly, or of working around them by overstepping their own authority in order to deliver care.

These problems are also structured into many clerical jobs. Ward secretaries coordinate and organize the records of inpatient care as the formal part of their jobs, but they also coordinate the actual people who give this care as an equally central, but unacknowledged, part of their jobs. Formally, they convey the care plans and orders that are doctors' ideas about what a patient needs to the nurses, lab personnel, and dietary workers who put various parts of it into practice. They link the wards or units where patients "live" to the technicians, therapists, aides, and dietary workers who take an active role in a particular aspect of their care. As a result, they have to mesh the schedules of many people, often with diplomacy and some firmness.

Having to coordinate the activities of specialists from top to bottom of the medical center hierarchy without authority, coupled with low pay and status, is a set-up for stress and conflicts. There is no formal recognition that health care teamwork encompassing many departments needs on-the-spot coordinating. Ward secretaries, as well as nurses and receptionists, have to do this job without bossing or ordering because they have neither authority nor high status.

A certain amount of medical screening, informal mediation, patient care (broadly construed), and general nurturance commonly falls to clerical workers even where their formal job descriptions may exclude patient contact and, certainly, patient care. For example, a doctor might ask that a particular patient be scheduled for several tests. Tanya Wilkins, a ward secretary, explained that she has several things to consider in scheduling. First, she needs to know how long each test is likely to take. A liver scan, for example, can take a patient off the floor for up to three hours. Some departments are known for cancelling patients' tests if they are not on the floor when called. While diplomacy may help in stalling for some time, it is better not to schedule too closely. Second, and more important, doctors seldom consider whether or how much a particular test or series of tests can fatigue a sick person, or about how tiring being wheeled around a large, crowded hospital can be. Tanya Wilkins tries not to schedule anyone for more than two or three tests in a day because most of her patients are exhausted after a few. Ward secretaries often need to exercise their judgment to mesh doctors' plans for treating an illness with the state of a sick person's constitution at any given time.

Medical secretaries make appointments, but they do not diagnose. Nevertheless, the two are not entirely separable, and a certain amount of screening is a routine part of many medical secretaries' work, as Diane Evans showed in explaining what she must do in order to set up an appointment. First, she needs to know whether a prospective patient needs her department. If not, she needs to know where to refer them. "I've even made appointments for them; I feel sorry for them when they say 'I've been trying for three days.' I know how frustrating it is." Before Diane makes an appointment, therefore, she asks for the person's symptoms. "I've learned that if they're sick they'll say what their symptoms are; if they won't say, the doctor won't call them back [without any notes on what is wrong]." Diane stressed the need for judgment: "You got to listen or you'll wind up with a whole page of notes of nothing." She feels that most of the time the doctors accept her judgment of what is needed for a particular patient with regard to an appointment and to scheduling tests that seem indicated from symptoms reported over the phone. She has also developed working relationships with many patients' local physicians because she is responsible for forwarding this information to them. Likewise, she is in close touch with people in a variety of other clinics by phone and has come to know them, too. "You wind up increasing your patient load by running your mouth." Nevertheless, the clinic is the "fun side"; it "makes you feel like you're doing something worthwhile."

Coordinating and teaching people who are overworked, high up on the hospital's status hierarchy, and who have not been told that they need to be coordinated or that they are being taught is a difficult and often thankless assignment. Because it is not part of their job description, clericals get no support from administration; housestaff do not recognize it as a necessary part of their training and seldom appreciate it either. Indeed, nurses and clerical workers often complain about the abusive way doctors treat them and the way the whole burden of resisting and "straightening them out" falls on their shoulders.

Clericals and nurses often find themselves spending an inordinate amount of time trying to paper over the cracks of bureaucratic organization to make the system work. Ward secretaries, many regular and medical secretaries, and nurses constitute a kind of invisible administration of the hospital's wards and clinics. Almost by default, they are the ones saddled with responsibility for putting together the many fragments of treatment and transportation, diagnosis and diet, laboratory workups and financial workups to produce some sort of reasonably integrated medical care and to record it for future reference. To varying degrees, all these front-line workers face a common set of structural dilemmas. They are low paid, and, except for RNs, lack authority to do many of the things they have to do in order to make the clinics run smoothly. Yet, when foul-ups occur, they are the ones who are blamed. There seem to be two contradictory sets of expectation about their jobs. One is that their job is to carry out doctors' orders and perform routine hospital functions; this view presumes that doctors and administrators are the creators, coordinators, and decision-makers. The other view of clerical and nursing workers is that they make the impossible possible. Unfortunately, all too often this is the operational view of doctors and administrators when things do not work. The structural position of nurses and clericals contributes to the double bind of their work. They are information keepers and integrators; they are in a central place and cannot easily run away; they are in contact with all parties. In short, they are a captive source of information held responsible for drawing conclusions from it but denied authority to make the decisions that stem from putting two and two together.

Although such double binds were an important contributor to the wave of hospital worker unionization that grew out of the black freedom movement in the 1960s and 1970s, unions never challenged management directly over this issue. As a result, unions undercut workers' ability to express some of their fundamental grievances. The major U.S. health care unions have focused on pay, benefits, and individual advancement opportunities, making these the only legitimate issues for collective action and expression. There was no acceptable bargaining language for demanding that institutional management recognize and respect the caring and coordinating skills exercised by their nonprofessional staff. That could be done if unions were willing to take on issues of job revaluation and work reorganization, but the labor movement has long ago given them up as management prerogatives. The union proxy was to press for better pay, not in recognition for workers' contributions but because labor should be paid enough to live at more than a poverty level. Labor should be paid decently, but in taking this part for the whole, unions unwittingly undermined workers' own (accurate) evaluation of their skills. When management accused unions of neglecting patient care, the latter's bread-and-butter approach put them on the defensive. Instead of arguing that workers' unacknowledged caring saved patients from the organizational deficiencies of the system, unions made the weaker, although still accurate, argument that decent pay and adequate staffing made for better care.

Especially where black workers were in the lead, unions addressed skill in the context of fighting racial discrimination. Here, too, the argument was necessary but not sufficient: that black workers were kept in unskilled positions and not allowed to advance into skilled ones. Although the combination of black freedom and union struggles did open avenues for individual advancement, unions never challenged management's notion that the cooking, cleaning, and clerical jobs in which black workers were concentrated were unskilled. Nor did they question the assumption that jobs had to be defined in a hierarchy rather than as part of a team. The most militant unions did make real gains in affirmative action, but these gains were within what remains a hierarchical system. Minorities and white women were able to gain recognition for their caring and coordinating skills only by gaining entry to occupational levels and specializations that the hierarchical system recognized as skilled.

Instead of insisting that management revalue and upgrade the jobs and respect the people holding them, both unions and the freedom movement stopped with a demand that management revalue minority workers' individual abilities and allow meritorious individuals to be promoted. Job revaluation was a demand that would have followed from the first position; affirmative action in promotion followed from the second. The former could provide a collective remedy for class-, race-, and gender-based prejudice; the latter could provide only an individual one. While affirmative action did lead to significant advancement of black women into clerical and some technical and professional positions, it also left cooking, cleaning, and transport jobs being paid at near-minimum wage and held largely by minority workers.

HEALTH CARE: CHANGING INSTITUTIONAL PATTERNS

Gloria Barnet is a recreational therapist and a beneficiary of struggles for affirmative action. Her job exists in part because of a movement-stimulated recognition that patients need to be cared for as whole people.

On a hall just off the clinic's main corridor are two small rooms; one is nearly filled with a child-sized round table and chairs and packed with crayons, paints, and miscellaneous arts and craft supplies. The other has trucks, dolls, puzzles, games, and various rollables and pushables on an open floor. Some spill into and down the hall between the two rooms. Both rooms will fill up shortly after the clinic desk opens. Right now, only Gloria Barnet, a young-looking black woman, is there, preparing for the day ahead. "Since this is a referral hospital, people are coming from far away and this can be an intimidating place." As Gloria talks I find myself looking at two framed diplomas on the wall. One is an M.S. in recreation administration and the other a B.A. in recreation education. She comments: "I'll bet you thought I was a volunteer to play with the children. [I did.] I'm a play therapist. It's a new field as far as hospitals are concerned. Play is the child's work. Being in a hospital can be traumatic for a child. Recently, hospitals have begun treating children holistically."

Gloria Barnet is a recreational therapist; hers is a new health profession. Both her job and her presence in it as a black woman embody good news in health care policy. The bad news is that the integrative caring skills of so-called nonprofessional workers have still not been given recognition and, worse, that policies in the last decade have gone a long way toward removing even affirmative action gains.

Hospitals employ many kinds of therapists—occupational, inhalation, respiratory, physical, psychological. I was drawn to Gloria in part because a play therapist many years earlier had changed my young son's hospitalization from an ordeal to a holiday. She explained what would happen beforehand and had such a fine crafts program that he refused to leave when he was ready to be discharged. At the time I was impressed and grateful, but did not know enough to be appreciative. Talking with Gloria Barnet added that dimension: "Children act out how they feel in the playroom, as opposed to how they act in the room with the doctor. We try to get the children to talk through their feelings."

Looking down at her pants and flowered blouse, she said,

> Our policy is not to wear white and not to be confused with the doctors, because doctors are often associated with shots in children's minds. Our

> job is to observe the children and to learn what they feel. We also do pre- and post-op explanations to the child of what's going on. For example, we get lots of LPs [lumbar punctures or spinal taps] and bone marrows. So, I get the equipment and demonstrate it to the child on the doll. Children get a great deal of security from knowing when that Band Aid goes on, it's all over. We learn a lot with the doll baby: If a child doesn't talk about his experiences, but stabs the doll baby with a needle, you know something's happening. We work closely with the doctors and clinicians.
>
> Every week, in addition to staff meetings, I go to a special interest meeting. Mine's hematology. It's an interdisciplinary meeting consisting of a doctor, social worker, psychiatrist, nurse clinicians, and play therapists. It's a holistic conference about various children and about the families' interactions. We work out a pre-op and post-op plan and a plan for the child and their family for dealing with the situation.

In many ways, Gloria is a key mediator between people and an intimidating clinical setting, allowing communication to flow along needed, but often blocked, channels. For example, a woman came in from one of the examining rooms and asked Gloria to come down to her child's room and watch him while she went to the bathroom. Gloria asked if there wasn't someone else who could do so. The woman said there wasn't, and Gloria went to the room:

> Sometimes I'm taken for granted. There's no acknowledgement of us talking, or if there's a child in here, that I'm working with them. Sometimes I wish I had an office. On the other hand, this lady needed a break and I was here; I'm qualified and therefore maybe she felt good about trusting me to stay with the baby, whereas she didn't know other people in the waiting room.
>
> I like the work, but the main drawback is that it's lonely. I don't have another therapist to discuss the program with. I have a lot of flexibility—leeway to experiment. I don't see a supervisor every day; therefore, I have to make a lot of decisions on the spur of the moment.

Gloria Barnet stands at a watershed. She embodies important gains won in struggles throughout the 1960s and 1970s: consumer demands for more integrated and humanistic care, and worker demands that their coordinating skills be recognized and that racist and sexist employment patterns be ended. But she holds her job at a time when federal cost-cutting efforts are wiping out the opportunities that allowed her to move up, decreasing the quality of care, and cutting back and intensifying the workloads of health workers in general, and women and minorities especially.

Gloria Barnet's job illustrates a contradiction built into the health care system. One of the ironies of her job's existence is that the holistic care Barnet delivers is recognized only when it is delivered by a professional specialist. It is more than an irony, however. We have seen that similar kinds of integrative care and the coordination of specialists are necessary but unacknowledged functions routinely performed by nonprofessional hospital workers. The fact that their skills are not acknowledged makes their jobs less rewarding and, as we shall see, more vulnerable to cutbacks. To understand this trend we need to look at the history of federal support and the forces to which it has been most responsive.

The shape of the U.S. health care industry is more a creature of government funding and policies than almost any other industry except the arms industry. As with the latter, much of the public shaping of health care has been done by and for private beneficiaries (Starr 1982). Federal funding played the major role in establishing a health care system centered around hospital-based medicine in general, and large medical centers that combined teaching and research with clinical practice in particular. The Hill Burton Act of 1946 stimulated the construction of hospitals, particularly in states with few existing beds. A few years later, the National Institutes of Health began funding medical research and training, as well as the construction of research facilities. Its expansion was meteoric. From a $28-million budget in 1950, it grew to $400 million in 1960, and $2.8 billion by 1975. This sum represented almost two-thirds of all money spent on medical research (Brown 1979:226; Freymann 1977:84–85; USDHHS 1982:156). As a result of these programs, and of Medicare and Medicaid after 1965, the government's share of all health care expenditures jumped from 21.6 percent in 1965 to 34.5 percent by 1970. By the time public spending levelled off in 1975, the federal government was paying almost 40 percent of the nation's total health care expenses (USDHHS 1982:139). Federal funding was concentrated in large teaching and research medical centers, and it spurred their growth over other sectors of the industry. The early predominance of research funding fostered an emphasis on laboratory research, clinical specialization, and hospital-based care, and deemphasized holistic practice and ambulatory care.

Impact of Grassroots Reform Movements

In the late 1950s and 1960s, a powerful black freedom movement, plus the part of a labor movement revitalized by civil rights, together with a broad and multiracial coalition of grassroots groups, fought successfully for access to and improvement of health care and for better conditions for health workers. The roots go back to the 1940s and to the ambiguous gains of organized labor after World War II. Unions successfully bargained for employer-paid health care, and this represented a major increase in the number of Americans covered by health insurance. But American labor's vision of the working class has all too often been limited to those who pay union dues. Even at its peak in the 1950s, organized labor represented only one-third of the work force and restricted its health coverage efforts to them. Compare this to the more comprehensive and successful struggles of European labor in this period, led by socialists and communists for universal governmental health coverage. In the United States, much of the work force, together with most of the very poor and the aged, were left uninsured.

In the mid-1960s, Medicaid and Medicare were, therefore, significant victories of a coalition of working-class-oriented grassroots movements. These were the first federal programs directed to individual health care consumers, and they considerably expanded the population with access to health insurance. Equally important, they gave recipients access to a wide range of facilities for their care, including private ones.

Between 1965 and 1975, consumer victories also bore significant fruit for health workers who were among the most poorly paid sectors of the labor force. That work force expanded to meet the increased consumer demands; because health care was hospital-based, most of that expansion took place in hospitals. Here, minority service workers led other workers in winning improved pay and working conditions, making inroads on racial discrimination, and opening channels of occupational advancement.

In the face of a shortage of primary health care personnel, the federal government stepped in to fund increased training of LPNs, aides, RNs, technicians, and medical clericals, and new health professions such as physician assistants, emergency medical technicians, nurse practitioners, and nurse midwives (Backup and Molinaro 1984).

These occupational opportunities coincided with victories for affirmative action in jobs and education, which gave minority workers effective access to in-school and on-the-job health training programs. They gave minority workers like Gloria Barnet the opportunity to move upward. Barnet's particular occupation, recreational therapist, is partly a response to consumer insistence that the system treat them as whole people who need holistic care, despite the growth of specialists in particular parts, functions, and secretions.

We have already noted some of the successes and the limitations of hospital worker unionization. Unions, especially those organized under the lead of black workers, won gains in pay and benefits, as well as significant advancement opportunities for minority workers. Nevertheless, some of the functions Gloria Barnet now fills at a professional level have long been filled informally by nonprofessional health workers—aides, orderlies, clerical and technical workers—who spearheaded union efforts, and who still receive neither remuneration nor recognition for the integrated caring they give.

Clearly, both affirmative action and the acknowledgement of unacknowledged skill are parts of a larger strategy for health workers' economic and mental well-being and for the health of our health care system. The vitality of grassroots movements in the 1960s and 1970s won expanded and improved access to health care for poor and aged consumers, and better pay, working conditions, and affirmative action for women and minority workers. But the movement's lack of success at raising deeper demands for skill revaluation and work reorganization left both working-class workers and consumers in a weakened position to fight the direction that health care cuts began to take in the late 1970s.

Rising Costs and Prospective Pricing

By the late 1970s, it was becoming obvious that there were major problems in the health care system, and that it would no longer continue to grow as it had for the past twenty-five years. The major governmental reform, the Prospective Pricing System (PPS), responded only to one problem, namely the fear by big business and government about the amount of money they were spending. However, criticism of the health care system came from many quarters. In the face of the 1980–82 economic recession, large corporate employers became increasingly alarmed about the size of their employee health care payments. Individual health care consumers were also caught in a squeeze as the cost of private insurance rose and benefits shrank. By the early 1980s, the elderly were spending a larger share of their income on health care than they had before Medicare (Himmelstein and Woolhandler 1984:14). Critics, many of them health care professionals, also pointed to the degrading circumstances under which many poor, minority, and women consumers received treatment, and to the harmful and sometimes life-threatening ways in which people were treated in modern hospitals. Large "nonprofit" medical centers were also attacked for serving to generate large profits for the bankers, builders, and drug and hospital supply companies that dominated their boards of trustees (Kotelchuck 1976; Rodberg and Stevenson 1977; Salmon 1977; Swallow 1985).

By the late 1970s, however, grassroots movements were on the wane, and business and government began to combine forces to implement cost-cutting policies that undermined the gains of the consumer movement, unionization drives, and affirmative action programs. As a result, these movements no longer could prevail against efforts by the federal government and corporate employers to reduce their employee health insurance costs at a time when U.S. industry was losing its international hegemony.

Instituted in 1983, PPS has resulted in the largest structural reorganization of the health care system in many decades as big business and the federal government attempt to contain and reduce their own layouts for medical expenditures. Prospective pricing, a fixed level of reimbursement for each of some four hundred diagnosis-related groups (DRGs) of medical problems, is a major change for U.S. medicine. This form of reimbursement for federally insured clients confronts the medical profession's monopoly on cost-setting and serves as a lever to lower medical costs: If hospitals can perform more cheaply than the fixed-reimbursement level, they profit; if their performance is more expensive, they take the loss.

PPS is having a direct impact on federally insured Medicare patients. After several years' experience, there are widespread fears that the rates are too low for adequate care and that patients are sent home "quicker and sicker." University medical centers particularly fear that prospective pricing will no longer allow them to recover the costs of advanced medical and allied health training (Culliton 1984). Public hospital reimbursements are also too low to allow them to care for the complex health needs of poor people. These fears seem confirmed ("New Restrictions" 1985). Clearly consumers need to be aware—and wary—of the way costs are being cut and who is most likely to bear the burdens.

While the new health industrialists argue that competition will increase efficiency and employee productivity, reducing waste while maintaining quality care (Cohn 1985:14–15), some analysts and practitioners are alarmed about declining quality and accessibility of care to the poor and uninsured as profitability comes to determine institutional survival in a competitive industry (Caplan 1983; Starr 1982; Starr and Marmor 1984; Woolhandler et al. 1983).

PPS has also directly affected health care workers by encouraging growth in lower-paid sectors of the industry at the expense of better-paid, more unionized ones and by encouraging staff cuts and workload increases as well as more part-time work throughout. PPS has led to a growth in a variety of outpatient care institutions as alternatives to more expensive hospitalization. Recent policies extending federal insurance to home health care services have stimulated the rapid growth of large corporate profit-making ventures oriented to an aging population. Home health care is cheaper than hospital care, in part because of the unpaid labor of largely female family members and in part because of lower wages paid to paid workers (Edmondson 1985; "The Robust New Business" 1983; Sekscenski 1984:8–9). Hospitals, especially public and nonprofit ones (the highest-paying and most unionized sector of the health care industry), have faced declining occupancy and the first cuts in staff in decades.[2] PPS also accelerated the shift of hospital jobs from full-time to part-time employment (Sekscenski 1984:4).

Private hospital chains make heavy use of part-time workers and employ fewer full-time workers per bed than do public hospitals. Humana, for example, attributed its increased profit margin of 50 percent in four years to part-time hiring and moving staff according to shifting patient loads

(AHA 1983:4–7; "The Upheaval in Health Care" 1983). Speed-up and a part-time work force jeopardize more than workers' pay and benefits. They affect their ability to provide continuity of care and the job satisfaction that comes with it. Because PPS rewards institutions that deliver care cheaply, it also reinforces increases in workloads and intense supervision in all sectors and at all levels. PPS has even affected treatment of doctors, as new health care managers seek to reduce these freewheeling and independent professionals to salaried employees accountable to management for productivity and cost control (American Management Assoc. 1957; CED 1973; Eilers 1974; Ellwood 1982; "Employee Benefits" 1976; "Health Costs" 1982; Relman 1984; Thurow 1984; "The Upheaval in Health Care" 1983; Yaggy and Anlyan 1982).

These changes affect minority and white working-class workers most adversely. Hospital cutbacks mean loss of inpatient service jobs, which, despite affirmative action, are still heavily minority. The women in many of those jobs, as we have seen, provided important, although unacknowledged, caregiving. With increased workloads, it will become more difficult for them to deliver that care; their job satisfaction will decline; turnover may well increase, and patient care suffer still further. In contrast, professional nurses and technicians are in greater demand, gaining greater recognition, and the college-educated, mainly white women in these jobs are making gains. Still, their workloads too are increasing greatly, as hospitals try to cut back on staffing and the level of patient acuity rises.

Affirmative action is also under attack. Cuts in funding for basic health education close off low-cost programs that made advancement possible for minority and white working-class workers. Federal funding for basic education (in and out of the hospital) in nursing, medicine, and allied health has been central for minorities' ability to enter these fields. A great deal of clinical education in medical and technical occupations has been provided in hospitals and paid for from insurance reimbursement for patient fees. Because PPS does not allow reimbursement for this expense, hospitals are cutting back these programs, sharply increasing their tuition, or leaving training to private (expensive) schools ("New Restrictions" 1985).

The decline in federal funding for basic health education has occurred just when a B.A. degree is being demanded for more allied health occupations. These occupations sought to defend their jobs by claiming professional monopolies of skill, and they emphasized credentialling and formal schooling. This strategy had a negative impact on a large number of black and white working-class women who had taken advantage of on-the-job training and community college courses in the 1960s and early 1970s to move from cooking and cleaning into technical and nursing occupations.

Requirements for lengthened formal education for both entry-level and advanced positions, coupled with decreasing funds for education generally and health training specifically, work against minorities and working-class white candidates, who had less opportunity than middle-class and white women to gain the education required for an RN degree. In addition, RN efforts to professionalize nursing by limiting the scope of LPN responsibilities decrease opportunities in an occupation where minority women are well-represented. Education is becoming an anti-affirmative action gatekeeper in the health professions, serving to maintain status and professional privilege (Backup and Molinaro 1984; Barocci 1981). In some places, minority workers who came up through the ranks by night courses and on-the-job training are now confronted with having to train the white college-educated workers who will succeed or replace them.

Formal schooling is becoming something of a proxy for knowledge and training as on-the-job programs close. In this context, front-line clerical workers and licensed practical nurses with little access to college may face greater barriers to promotion, and perhaps even less recognition of their skills. The fund of caregiving experience that affirmative action and internal advancement programs tapped is largely being lost by reliance on formal schooling.

CONCLUSION

Where Barnet and the integrated caring her occupation validates were once signs of a hopeful direction, today they appear more as positive exceptions to negative trends. Barnet and the other black women health professionals in her cohort are increasingly lonely, more exceptions than trendsetters, as it becomes prohibitively expensive to get the necessary schooling.

The movements of the 1960s had the potential to radically change caregiving models on three fronts: to dismantle racist and sexist barriers to health care work; to break down a rigidly specialist model of health care and replace it with a more holistic one; and to replace the individualistic and hierarchical organization with one that recognized that teamwork is central to caregiving. Those gains were not realized. Instead, government policies support cost-cutting and profit-making. That combination has hit federally insured aged and poor health care consumers directly.

It has also lead to staffing cuts as well as cuts in salaries and benefits in an industry whose work force is overwhelmingly female, significantly minority, and already among the lowest in average compensation levels. Occupational groups with strong associations, notably doctors, fare better than those with weaker ones such as labor unions or allied health professional associations. The former represent mainly white men, the latter mainly women and minority men. Unfortunately, all of them have fairly narrow visions of job protection. None is struggling to change the health care system. The irony is that worker and consumer unity for massive changes in the way we give care is also the best strategy for job protection.

DOCUMENTATION

Notes

1. The research comes from my book, *Caring by the Hour*, an ethnography and oral history of women's work and union organizing at Duke University Medical Center in Durham, North Carolina. In 1978–79 I was simultaneously a researcher and a volunteer in the last stages of a fifteen- to twenty-year effort led by black service workers to organize a union. Although ultimately unsuccessful, the drive involved approximately two thousand clerical, service, and technical waged workers; about 80 percent were women, approximately one-half black and one-half white. Between 1979 and 1984, I continued to observe women's work lives and to interview them about their work and unionization efforts. Some of the women whom I quote and whose work circumstances I describe I met in the course of the union drive; others were their workmates and friends or people who were interested in the project.

2. Nationally, hospital bed-occupancy rates have dropped (AHA 1982: Table 1; Brisbane 1984; Sekscenski 1984; USDHHS 1982). The labor force in health services grew rapidly and steadily until very recently. Between 1970 and 1983, when prospective pricing went into effect, it increased by 82 percent, from 4.32 million to 7.87 million, much faster than the 28 percent growth of the total U.S. labor force. However, in the latter part of this period, expansion has slowed considerably, and barely increased at all between 1983 and the end of 1984, to 7.9 million workers (Brisbane 1984; BLS 1985: Table 31; Sekscenski 1984:1–3; U.S. Bureau of the Census 1984, unpublished data).

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Part IV

Unaffiliated Providers

Preface

Because researchers typically equate paid caregivers with employees of bureaucratic organizations, they ignore the vast network of unaffiliated providers. The first two chapters in this section examine the way in which family day care workers balance affective and contractual relations. Nelson's chapter focuses on relationship between providers and the children in their charge. Using both survey and interview data, she argues that family day care providers experience these relationships within a contradictory set of expectations and possibilities. Family day care providers share with their clients the expectation that they will achieve close bonds with the children they tend. Because they work at home and do not receive occupational socialization, providers are especially likely to develop strong attachments to these children. However, the relationship between a family day care provider and a child is contractual; moreover, the provider lacks the privileges of motherhood. She has limited authority and responsibility and can lose children to whom she has become attached. If she identifies too strongly with the model of mothering, she may find herself unable to request the fees and impose the limits that are part of paid work.

Although family day care is the prevalent form of out-of-the-home care for very young children, it is also much maligned. Critics acknowledge that family day care homes can offer excellent substitute care, but they argue that there are wide variations in quality and that parents are not always able to assess the level of care. To such observers, regulation is the obvious and necessary solution. Although almost every state now has some system of licensing or registration on the books, more than 60 percent of all family day care remains unregulated (Kahn and Kamerman 1987). Enarson discusses the factors that hinder the regulation of family day care providers. Relying on interviews with "underground" providers, she argues that typical explanations—economic constraints and ideology—cannot account for either the intensity or extent of provider resistance to regulation. She suggests instead that providers' attitudes toward regulation reflect major conflicts that are built into their occupation. She examines three issues—the desire of providers to control their work, their defense of traditional mothering, and their need to negotiate a delicate balance "between love and money."

If family day care providers view regulation as a constraint, other unaffiliated providers consider it a form of protection. The lay midwives interviewed by Weitz and Sullivan sought to formalize their status in order to avoid the disadvantages of working illegally. Nevertheless, regulation proved to be a mixed blessing. Lay midwives originally wished to provide alternatives to the established health care system, by furnishing holistic care and breaking down barriers of authority and status. But licensed midwives tend to adopt a medicalized definition of childbearing and reestablish hierarchical relationships with clients. (In their examination of the power of the medical model over health care providers, Weitz and Sullivan reiterate themes explored by Diamond.) Weitz and Sullivan conclude by noting that the pressures on lay midwives to abandon innovation and adapt to the mainstream resemble those encountered by radical social movements, other marginal occupations, and voluntary groups providing nontraditional services.

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10

Mothering Others' Children: The Experiences of Family Day Care Providers

Margaret K. Nelson

As increasing numbers of women work outside the home, many of the tasks that formerly constituted a housewife's daily unpaid labor are transferred to the open market. While some of the tasks are shed quite easily, the transfer of child care (and the care of other dependents) remains extremely problematic. Working women receive mixed messages: although economic realities often make employment an absolute necessity, expert opinion is divided about such critical issues as the best kind of care to choose and the long-term consequences of placing care in nonmaternal hands (see, for example, Wallis 1987a). Many of the popular and academic discussions about these issues address the needs and concerns of the working mother; many more focus exclusively on the "best interests of the child" (see Wallis 1987b; Zigler and Gordon 1982). Only recently have scholars begun to ask questions about the experiences of service providers (Enarson 1987; Saraceno 1984).

In this chapter, I consider what it means for women to engage in caregiving as paid work. The particular site for this investigation is family day care, defined as "non-residential care provided in a private home other than the child's own" (Fosburg 1981:1). Family day care illustrates the recent trend of transferring services from home to the market. The need for child care is created by the entry of women into wage labor.[1] Although this need is met in a variety of ways, family day care is the most common form of out-of-the-home care for very young children; it is also a significant form of care for children between the ages of three and five (Kahn and Kamerman 1987). Thus, much child care still relies on the labor of women and continues to be located in the private household.[2] Yet, because it has become a paid service, it is an appropriate issue with which to examine the question of how caring for nonkin as paid labor differs from caring for one's own as a "labor of love."[3]

The following first discusses the methodology on which this study is based. The findings have four parts:

1. Family day care providers align themselves with mothering (rather than with a more professional stance) as a model for the care they give;
2. This alignment creates structural dilemmas that family day care providers must resolve, at least tentatively. Family day care providers cannot respond to children as mothers do: they lack the authority, responsibility, and permanence inherent in the relationship between a mother and her child; they must also place limits around, and charge fees for, the care they offer;
3. The fragility of these resolutions is reflected by the ways in which family day care providers handle the issue of choice; and
4. Certain groups of more "professional" family day care providers can be described as "deviant" on the basis of their activities.

In the conclusion, I suggest some implications of these findings.

METHODS

The data for this paper come from two complementary sources. In the summer of 1986, I mailed a questionnaire to each of the 463 registered day care providers in Vermont; responses were received from 225 providers (a response rate of 49 percent).[4] The following summer I distributed questionnaires to 105 unregistered family day care providers located through snowball sampling techniques.[5] The questionnaires covered a range of issues, including the number of years the women had been providing child care, reasons for opening a day care home, characteristics of the children in care, working conditions, income and expense of child care, attitudes toward child care, future plans, problems, and background information. In this chapter, unless otherwise indicated, all numerical descriptions derive from these data.[6]

The bulk of the analysis relies on another methodology. Over a two-year period, I conducted lengthy semistructured interviews with twenty-eight registered day care providers (twenty-one of whom had also completed questionnaires) and thirty-six unregistered day care providers (ten of whom had also completed questionnaires). Questions in the interview dealt with a wide range of issues, including relations with children and parents, the impact of the work on members of the provider's family, and sources of stress and satisfaction. Each interview was conducted in the provider's home and lasted at least one hour; many ran for several hours. Interviews were also conducted with nineteen mothers with a child in a family day care home and with seven husbands of family day care providers. Unless otherwise indicated, all quotes are taken from one of these sets of interviews.

Most of the questionnaire respondents (83 percent) were caring for at least one of their own children along with at least one nonresident child. Most of the women were married (86 percent). The respondents ranged in age from twenty-one to seventy-one with a mean age of thirty-two. One-half of the women had at least some education beyond high school. The number of years of involvement in the occupation ranged from recent initiates who had been working for less than a year to one woman who had been offering care for twenty-three years; the median number of years as a family day care provider was three.

ALIGNMENT WITH MOTHERING

Two Models

In the private domain, women care for young children as mothers. Our cultural ideal of mothering assumes intense bonds between the mother and her child; it also assumes a mother's willingness to respond to the child's emotional and physical needs even when it means making personal sacrifices.[7] A mother's obligations are balanced by rights: state intrusion into the private domain exists (especially for poor families), but it is limited; mothers have enormous leeway in defining appropriate morality and discipline. Children "belong" to their mothers.

The public world of paid caregiving offers an alternative model (Freedman 1987; Lightfoot 1978). While teachers, nurses, and institutional child care workers might engage in many of the same activities as mothers, ideally they accomplish their tasks without becoming overly attached to, or identified with, their clients. Drawing on Parsonian terminology, Lightfoot, for example, distinguishes between the appropriate attitudes of parents and teachers:

> Parents have emotionally charged relationships with their children that rarely reflect interpersonal status or functional considerations. Children in the family are treated as special persons, but pupils in schools are necessarily treated as members of categories. From these different perspectives develop the particularistic expectations that parents have for their children, and the universalistic expectations of teachers. (1978:22)

Similarly, Scarr suggests in *Mother Care/Other Care*, professional caregivers should maintain an emotional distance from their charges: "A teacher is not fulfilling her role of impartial instructor about the world outside of the parent-child bond if she spends her time on affection and comfort for individual children" (1984:192). While some observers proclaim the functional necessity for this distinction between the roles of teachers and parents, others suggest that drawing these lines may serve the interests of caregivers who are claiming professional status. As Saraceno notes, the creation of a distinctive stance might be a critical element in this process: "In order to maintain a professional image and to avoid the 'feminine vocation trap' evoked by working with young children and promulgated by employment policies, [some workers] stress their expertise and professional handling of children, focusing on the more formally educational aspects of their work" (1984:20–21). Thus, workers in these areas struggle for rights involving working conditions and the exercise of autonomy. But they are not supposed to—and they may choose not to—make emotional claims with respect to the children in their daily care.

If it were easy to find an appropriate stance, to bridge these diametrically opposed cultural injunctions, day care providers might be able to talk easily about what they do and how they feel about children. They cannot. Their descriptions of their activities are suffused with literal *but's*. They say, "I love these children *but* they're not mine." They also say, "I enjoy caring for children"; they add, "*but* it is a job for me." These *but's* suggest an uneasiness about loving children who are not one's own and transforming this activity into paid work.

In fact, however, day care providers easily dismiss the professional model of caring: they simply find it irrelevant. Only 24 percent of the questionnaire respondents said that it was "very important" to offer children a "structured or planned day"; only 39 percent of the respondents indicated that they thought it was "very important" to include any "educational activities" in the daily round of events. When women were asked questions about the concrete differences they perceived between the care they give and that offered to children in a day care center, they were quite articulate and insistent: day care centers do not encourage the "warmth, love, and intimacy" that can be found in a family setting; centers do not offer the "one-on-one" care of a home. Some providers further suggest that because day care centers, like schools, follow a schedule of activities, they do not allow for a free-flowing responsiveness to the individual child's needs and interests. Almost all family day care providers believe a home to be the preferable location for the daily care of young children.

On the other hand, family day care providers do not easily dismiss mothering as a model for their involvement with children. The women view the development of personal and intimate relationships as an essential component of family day care: 75 percent of the questionnaire respondents agreed with the statement, "A family day care provider should be like a mother to the children in her care." In discussing their feelings about the children, the women use familial analogies: "They are my part-time kids"; "I'm like a second mom"; "I think of them as extended members of my family"; "These guys are like my own kids"; "I'm offering closeness and security—my motherhood." Moreover, most family day care providers want to give the children in their care the same round of daily activities they would get at home. Eighty-one percent of the questionnaire respondents felt it was "very important" to provide "a home-like atmosphere." Interviews confirmed this approach. "What are you trying to provide for the children in your care?" I asked. The responses were surprisingly consistent: "I try to make the child comfortable here"; "They should be at home here"; "I like this being just like a home."

Structural Factors Conducive to Alignment with Mothering

This alignment with mothering has its roots in several structural factors. By definition, family day care providers remain at home. Consequently, paid and unpaid care is merged in a single setting. There is no physical separation between private and public work spaces: children color at the kitchen table and nap in the provider's bedroom. Nor is there a temporal separation: a woman might put in her family's laundry or prepare the family dinner while keeping an eye on nonresident children. Moreover, the women simultaneously care for their own children and those of increasing distance: stepchildren, foster children, and the children of relatives, neighbors, friends and "clients." Because the family day care provider performs her job in isolation from others who are similarly situated, she has no access to a distinct occupational identity. And some women have to deny that they are working at all to keep their husbands reassured of their status as the breadwinners. For all these reason, a family day care provider has difficulty distinguishing what she is doing as a job from what she is doing for "love."

The merging of paid and unpaid care has deeper sources as well. For the majority of family day care providers, the immediate impulse to care for other people's children is rooted in a desire to stay home and continue caring for their own while earning a living: 68 percent of the questionnaire respondents gave as the most important reason for beginning to offer family day care, "I wanted to stay home with my own children." Thus, the majority of the women define themselves as mothers who are committed to mothering as a primary role.[8]

Second, family day care caters especially to very young children; this situation might encourage further a maternal attitude. Nationwide, 40 percent of children younger than age one and 37.6 percent of one- and two-year-olds are in family day care; this contrasts sharply with the situation for three- to five-year-olds, only 12 percent of whom are in this kind of care (Kahn and Kamerman 1987:6–10). Within my study as well, young children predominate: 60 percent of the women have in their daily care at least one child younger than age three.

Third, client expectations further discourage an identity distinct from mothering. Parents repeatedly say that they choose family day care because it provides intimate care by a surrogate mother. As are the providers, they are suspicious of institutional care that they perceive as lacking in opportunities for genuine affection. They fully expect the day care provider to care about their children.[9]

Experiencing Caregiving as Mothers

The structural factors identified above suggest reasons *why* the family day care providers more closely align themselves with the model of mothering. There is also evidence that they *experience* caregiving much as mothers do—they learn to love the children in their care, they find rewards (and face problems) similar to those identified by mothers, and they exercise the same kinds of skills.

As they give the children the security of a home, five days a week, for eight or nine hours each day, sometimes over a period of several years, family day care providers "learn to love" the children and they genuinely become attached to their charges: 77 percent of the questionnaire respondents agreed with the statement, "I get emotionally involved with the children in my care."

Not surprisingly, therefore, family day care providers speak about the rewards and satisfactions in their work in language that is similar to that of mothers. From her interviews with fifty-eight middle-class and fifty-six working-class mothers, Boulton (1983) identified the ways in which mothering gave women a sense of meaning, value, and purpose. First, she noted that, while a child's dependence might be a burden, mothers derived enormous satisfaction from being needed. Family day care providers also speak about being relied on and loved by the children in their care, and they present this as a positive feature of their work: "Cassie left the other day and told me she loved me. Things like that are the reward. What can you have more than a child who loves you?"

Second, Boulton noted the rewards a mother derived from the opportunity children give "to relive experiences from the past altered to be as she would have liked them to have been" (p. 110). Many day care providers also find fulfillment in rectifying the past:

> Well, my child care style is very different than when I grew up. I wasn't getting...the things that I'm giving these kids I baby-sit for. . . . My mother was not loving, she wouldn't cuddle or hold me or much communication at all. . . . I guess I just realized if I can help the next kid not to get into the kind of situations I did, more power to me. I want to show some of these kids there's somebody out there who cares because there wasn't anybody for me and I don't want that to happen to other kids.

Conversely, some find occasions for reciprocity. They can repay others for the care they received as children. Those women who were themselves reared by baby-sitters or foster parents proudly carry on a tradition of surrogate care.[10] The women also take pride in the children and find rewards in "accomplishments" they can directly attribute to their care. Many have a story to tell about change in a specific child's behavior: one child learned to trust physical affection; one acquired sophisticated social skills; one was potty trained. And family day care providers spoke, as did Boulton's mothers, of the pleasures derived from observing the children "doing all the cute things children do." Similarly, some women did not indicate a specific gratification of caregiving, but when asked, simply said, "the same rewards a mother gets," as if without elaboration anyone could understand what was meant.

Family day care providers also discussed the same kinds of problems that Boulton and many others have identified (Comer 1974; Friedan 1963; Graham and McKee 1980; Kitzinger 1978; Lopata 1971; Oakley 1975; Rich 1977). The contemporary organization of child care relies on a single individual with full responsibility for that care. Family day care providers, like mothers, find not only that this responsibility is burdensome, but also that it interferes with their attempts to engage in other pursuits.[11] Boulton's mothers also indicated that a private setting resulted in isolation from rewarding company: few people came to visit, and the mothers found it hard to pack up their children to go out. Family day care providers make the same complaints. Finally, the more middle-class respondents in Boulton's sample felt that, as the children monopolized their attention, they lost a sense of individuality. And again, a parallel exists with family day care providers who say that because they are constantly dealing with "kid stuff," they feel their own integrity and awareness of a larger world to be threatened.

Finally, family day care providers talk about the skills on which they draw in ways that make little or no distinction between being a caregiver to others' children and caring for one's own children. A woman can begin offering her services as a family day care provider without receiving any specialized training. Indeed, many providers think training is irrelevant. Because they see the work as an extension of mothering, they feel equipped to handle the job by drawing on their personal childrearing experiences:[12]

> I've been told—and I feel—that [my own children] are great kids. . . . The way I raised them is what I do with the kids I baby-sit for . . . and [my children] are doing fine so far.

> Some of the new mothers, so many of them, go by the book. And I just threw the book out. . . . I threw the book away. You don't need to go by the

> book. Just let your child grow, and out of common sense you should know what to do.

But for many women, locating the source of skills in the experience of mothering is tantamount to a denial of expertise. Perhaps because in our culture mothering is trivialized, providers denigrate their own (often considerable) abilities: "I don't have any skills," said one women. "Anyone who has been a mother can do this," added another. In further discussions, however, the women have clearly refined the skill Ruddick defines as "maternal thinking" (Ruddick 1983). For example, when asked how they have changed over time, many women say they have become more patient. And although they may think of patience as a natural attribute, their own definitions belie this ready dismissal:

> Patience is understanding the individuality of all of these children.... I could have another 181 [children] and each one of them would be different again. There's no two that need the same amount of loving or need the same amount of reprimanding. Each one needs a little extra something of some sort, which is fun finding with that individual. I think [that is part of the challenge].

Given this alignment with mothering, providers not surprisingly resist an outsider's attempts to get them to differentiate between how they feel about their own children and how they feel about children who are not their own. "Do you feel differently about your own children and the other children in your care?" I naively asked. The question got a uniform nonanswer: "I treat them all the same. If my child gets a treat, they all get a treat. If my child does something wrong, she is punished; if another child does something wrong, she is punished in just the same way."

In part, of course, in emphasizing treatment, the family day care provider is attempting to reassure the questioner that she does not let an intense bond with her *own* children stand in the way of fairness. However, I do not think that this is the entire explanation. The evasion is also a form of public denial that her feelings are different.[13] Having dismissed professional caregiving, she embraces mothering. Having done so, she cannot easily speak about the manner in which she deviates from this ideal.

MOTHERHOOD AS A THREAT: ESTABLISHING THE FEELING RULE

A contradiction is present. Mothering is also something a family day care provider cannot achieve and something she does not want to achieve. Motherhood confers rights to claim, to mold, to keep—other people's children cannot be claimed, molded, and kept. To think that one can do so with other people's children creates a situation where one can only be hurt.

Motherhood denies a financial calculus and limits: as a day care provider, to refuse reimbursement or to fail to establish limits to the care one will give creates a situation where one will be exploited. The family day care provider cannot answer a question about feeling easily because there is no simple answer for threading one's way between a stance that is both an ideal and a threat. I now explain how the alignment with mothering is interrupted by emotional and economic realities and how family day care providers resolve this dilemma by establishing a "feeling rule"[14] of detached attachment.

Mothering Interrupted

If we hold open the possibility that intense affection can emerge from daily caregiving, and if we believe the providers when they say that they want to be "like a mother," then we have to recognize that they are in a difficult position. The situation is ripe for intensity.[15] Whereas institutional settings offer a staff to share the caregiving, family day care providers are solely responsible for nine hours each day. They attend to all the children's needs. And the children sometimes remain with them for many years. As noted, they expect that they will become close to these children, and they see the development of love as appropriate; they are also expected by others to achieve a strong bond.[16] But they have to face certain realities.

Limited responsibility. The first reality is that of limited responsibility. One of the most painful aspects of mothering is the realization that the capacity to protect one's child is limited. A mother cannot watch every move or inoculate her children against every hurt. A mother has to rely on the hope that she has equipped her children to deal with life's vagaries. But for day care providers, the limits of protection are narrowed. The day care provider can ensure a loving and safe environment for specified hours; she cannot ensure that the child is being adequately clothed, fed, and nurtured during the hours that the child is with his or her parents. Children go home at the end of the day, and the parents may or may not attend to the cough properly. Children leave for good after a couple of years, and the parents may or may not complete the job of teaching a child to share or to have good manners.

Limited authority. Competent and successful caring for children relies on certain skills. Because the family day care provider is dealing with many children at once, discipline and the imposition of routines are not just matters of individual style, but practical necessities. All children have to nap at the same time, eat the same food, and follow the same rules.[17]

The women find enormous satisfaction in exercising their managerial abilities, but they are often thwarted in their attempts to do so. Feminist analysis has uncovered the many ways in which the development of "maternal thinking" is undermined by the authority of male experts (Ehrenreich and English 1978; Jaggar 1983). Family day care providers, perhaps, experience even more "interruptions" in their attempts to exercise their highly developed skills. First, parents give explicit instructions pertaining to the care of their own children. These instructions can undermine a provider's confidence; they can also serve to remind the provider that her authority is limited: "[I don't like it when] they're saying, well, I'm still in charge even though I'm not here; therefore, I'm going to tell her like I would tell a teen-aged baby-sitter the rules."

Second, Vermont defines appropriate care for children through regulations concerning such issues as numbers and the use of corporal punishment (Vermont Department of Social and Rehabilitation Services 1985).[18] Third, providers are aware of a "public" which judges their actions. As one women said, "You don't yell out the back door to the children because someone might hear you."

The awareness that one's authority is limited appears most clearly in discussions about discipline. Most providers feel that it is wrong—and even cruel—to spank someone else's child, even though many of them find it an appropriate disciplinary technique for their own children. The concern also appears up at the other end of the spectrum. Some providers worry about showing too much physical affection. Thus, although providers say that they do with others what they did with their own children, probing suggests that their common-sense response is challenged by the consciousness that the child is not their own.

Loss. The final and most painful emotional reality is that of loss. Mothers go in and out of the work force, parents change jobs, children outgrow the need for daily care. The constant awareness of potential loss makes becoming too attached to the children a risky proposition.

Financial constraints. There is an economic reality as well. Family day care providers do this work because they need the money. If they become too attached to the children in their care, that is, if they identify too strongly with the model of mothering, they cannot ask for money at the end of the week, nor can they impose restrictions on the hours of care they provide.

The Feeling Rule: Detached Attachment

The resolution to the dilemmas I have identified is found in the creation of a feeling rule, which I call *detached attachment*. It is characterized by a less claiming, less self-confident, and less intense affection for the children. This differentiated feeling is necessary if providers are going to draw limits around and charge fees for the care they provide. It is not, however, the emotional detachment professional caregivers strive to achieve. Attachment persists. But the particular attachment they develop relies on the ongoing work of creating a space, a distance which "saves" them from an overwhelming emotional engagement and allows them to ask for money.

Providers refer to this detachment they created and the emotional labor involved frequently (and perhaps unconsciously): "I reserve something, knowing that they're not mine"; "I hold back a little"; "I don't want to get too attached." Sometimes, they have learned to create this space because of an earlier "mistake." Almost every provider can talk about one child to whom she became overly attached; almost every provider speaks about not letting this happen again: "I won't take one on from six months and watch it grow up like that again if I've got any feeling that they're going to be taken away from me. . . . I felt that I was doing a good job and I enjoyed [the child] just as much as [the parents] did, watching it grow up and being a part of its life. Maybe I did get too attached. I don't know."

Many providers can also speak about a time when they allowed intense involvement to interfere with establishing limits and claiming reimbursement:

> I had one parent who owed me money when she left. It was as much my fault as it was hers because I just let it go on and on for six months. But she was in the process of a divorce. It was really affecting the child I had. I just could not put that child through one more trauma of having to go to a new sitter on top of everything else he was going through. He was three years old, and I could just see what this divorce was doing to this little boy. . . . It was really my fault. I should have given him up. I just couldn't because I wouldn't put him through not knowing where he was going to go.

Of course, some relief exists in the limits that providers create. As one woman said, "I have the pleasures of caring for them without the full responsibility." But this relief is contingent on a perception that the children are receiving competent care from their own parents. No such relief is possible when parents are seen as being inadequate.[19] And even when a child has parents assumed to be warm, loving, and capable, the provider's emotions are not easily turned off at the end of the day. In order to feel good about what she is doing, the day care provider has to feel that she is offering something meaningful to the children. Because she denies that she has unique skills and abilities, and because she denigrates her own expertise, she can only achieve a sense of significance by establishing a bond.

Yet she wants to keep a distance. The attempt to find the proper stance, and the dilemmas entailed in doing so, are illustrated by the comments of one woman who had just agreed to care for a baby:

> I don't think I want that emotional attachment—again. And the worrying and thinking about the baby like it's your own and then suddenly realizing you have no say. And when the baby's gone from your door you have no say in what happens to it. That's kind of hard to deal with because I invest a lot of emotional time with the kids to try to keep them happy and secure and everything. And then you wonder. They leave. . . . I think with the baby I'm trying to not get attached because I don't want to have to think about it or worry about it . . . but I know it's not going to work. . . . And I know after a matter of time it will be the same thing all over again. I'll be attached and thinking why's that mother doing that. And then thinking, you have nothing to say about it. It's not your kid. But, in a way, when you have them for so many hours, it's hard to find that balance.

We can hear that providers have been successful in the emotional labor of creating a distance when they talk about the way they feel about their own children in contrast to those they care for who are not their own. Although, as I noted above, they resist making these distinctions, when pushed they admit that caring for others involves a lowered affect and identification.

One of the first surprises of motherhood is the overwhelming love one feels for a new infant. To her dismay, a mother may soon come to realize that not only does she love this new being, but also that her very identity is wrapped up in it: the child becomes a reflection of the mother. If the child is praised, the mother feels gratified; if the child does not conform to social expectations, the mother feels she has failed. Day care providers successfully resist this identification with children who are not their own. As a result, some situations are eased. Providers often speak about how well the other children behave for them. Many find in the excellent behavior of the nonresident children evidence that they are "better" than the real mothers; they delight in reporting how the child who was an angel for them threw a tantrum as soon as her mother walked in the door. But some are aware of what must be the truth of the matter: that the children are expressing anger at having been left and that the children behave well for them because they are not engaged in the same kind of emotional relationship:[20]

> All the developmental hurdles—moving from bottle to cup, giving up the pacifier, becoming toilet-trained, eating a variety of foods, learning to cooperate, accepting discipline—are relatively easy to accomplish in day care, because these are not my own children. We are not engaged in a life-or-death power struggle, which I believe mothering entails. Because I'm not their mother, they don't have to relinquish any power to me in the process of toilet-training, nor do I "win" anything. It is just my job. (Dendy 1981:78)

Providers put the mother into the space created by detached attachment. The mother is a prop the family day care provider can draw on to remind the child that his or her loyalties must rest elsewhere; in the process, the provider deflects the *child's* attachment. Family day care providers feel strongly that to do otherwise would be wrong, that the child has to be encouraged to bond with the mother:

> I know Sarah really likes me. I know she does, I can tell. And I like Sarah. She's a nice little girl. But her mother has to be there for her.... I can't give what Sarah needs. I can give her the attention, I can care for her, I can make her feel good about herself, but I'm not her mother.... You want to give the child what he needs without giving so much that you are interfering with the way he or she feels about his own parents.

If the family day care provider fails to do this, she may find herself encouraging expectations that she is unable to fill. At the same time, the family day care provider is protecting herself. The daily transfer of the child from the mother to the provider and back again, and the weekly exchange of money, are concrete reminders of her limited role. In the intervals of the mother's absence, her image is drawn on to deflect the *provider's* attachment. The failure to keep this image alive can have devastating emotional consequences:[21]

> With my nieces, I'd have to stop and say to myself, "You're not their mother." For an example, the older one...had long hair, and she wanted her hair cut. She wanted me to cut her hair. And I said, "Are you sure you want your hair cut?" And she said, "Oh, I'm sure I want it cut." And I said, "All right, after your bath tonight I'll cut your hair." And I did it and I never thought about it. And I put the kid to bed and I was upset all night. I said, I don't believe I cut her hair without asking her mother.... All night I just tossed and turned.... I just agonized all night long about how I could do that *without even thinking of the mother.* Those girls were becoming more and more my own.

The manner in which providers talk about the emotional labor involved in bringing feelings in line with the feeling rule of detached attachment makes it clear that the process is a difficult and continuous one:

> Q: Can you talk about your feelings toward the children?
> A: I get very attached and yet I try to keep myself somewhat removed. The first year was hard because I got frustrated...because I cared for them so much. I wished I could go home and tuck them in. You know, you see a little guy come in at 7:00 in the morning and you know he's not going to bed until 10 o'clock, it breaks your heart. Or to wake him up (at the end of nap time) when he's the first one to go to sleep. That's the caring I feel for them. I do. I like to hold them if they cry. They need that. They don't get that if mom is working....

> Q: You said you hold yourself back a little from loving the children, can you talk more about that?
> A: I'm afraid to get too emotionally involved with them because it hurts if I see things happening in their private lives. I try not look at them as my own kids because if I do... it's hard to explain. I want to love them and treat them with lots of care, but I want to hold back a bit and not mother them too much because if I do, the mothers resent that to some degree.
>
> Q: So how do you hold back?
> A: It is hard to describe. Maybe I don't hold them as much as when I had my own kids because there are six of them. I guess I don't hold back as much as I think I hold back. To me, what happens here is just like when my three were at home.... But I can't put them in the car and take them into the grocery. It's as much a family setting as I can give, but it's still not a family setting.... They have responsibilities just like my own girls do upstairs. And I'm doing with the kids what I did with mine. So maybe I'm not holding back as much as I think.

The emotional tensions are not easily resolved. In each situation, with each child, the provider has to find the proper balance between attachment and distance. The distance is constantly threatened by the daily interaction with the children and the development of affection over a period of years. It is threatened as well on occasions when parents abdicate responsibility. The distinction has to be re-created daily if the provider is not going to be consumed by concern or overstep her boundaries; it has to be sustained so that the provider can prepare herself to lose the children.

THE ISSUE OF CHOICE

Above I noted that the context of family day care is similar to that of mothering. However, family day care providers, unlike mothers, can freely choose whether or not to care for a child.[22] Because the notion of choice is so fundamentally opposed to the ideal of the good mother, the manner in which family day care providers handle this possibility lends further insight into the central dilemmas I have discussed.

The providers' fragile emotional stance is threatened, from opposite directions, in two kinds of situations. First, their efforts to keep a distance are threatened when they are asked to care for a child who is neglected or abused by his or her own parents. This situation shifts the burden of responsibility to the day care provider. Not claiming a child depends on having the parent there to offer emotional and physical security. If that security is lacking, the provider's attempt to insert the mother into the gap is impossible. In most of these situations providers try to say no. Sometimes they offer justifications that conceal the real agenda. They say it is not good for a child to be with others who have so much more, that the child is disruptive to the group, that they cannot be fair to everyone in a situation where one needs so much. But they also reveal that the pain is too great, and although guilt is involved in making these choices ("I could have done him some good"), fundamentally they feel they have no option but to rescue themselves from a situation that is too costly in emotional terms:

> One time I did have a child [whose care was paid for by the state]...and it just pulled at my heart....When the little girl came she just reeked, and I bathed her. You know, I had fixed her up so cute. But I can't do that every day. I just don't have the time. And the next day she said to me, "Would you bathe me again?" I just cried over her but...I thought, I really can't do this. It's too hard alone.

If abused and neglected children threaten "detachment," other kinds of situations threaten "attachments." Because family day care providers define their worth through their emotional relationships rather than through the exercise of a distinct set of skills, and because they draw on the satisfactions of their relationships as *part* of their compensation,[23] they have to make the choice of not providing care for children they cannot learn to love. Dismissing "unlovable" children is also justified by claiming that this kind of situation is bad for the child. However, providers clearly are protecting themselves as well:[24]

> I had a little boy once. He was about three years old. And he was a totally obnoxious little kid. He was really smart but he was...I don't even know what it was, but we definitely had a personality clash and I kept him about three days and I told his mother that I had too many, I couldn't handle another....But he was just a little boy that I didn't feel comfortable with....I wouldn't take care of a child I didn't like. It wouldn't be fair to the child or to me.

A DEVIANT GROUP: "PROFESSIONAL" FAMILY DAY CARE PROVIDERS

The dilemmas described above might be rooted in the fact that family day care is an emerging occupation; this process is full of contradictions and uneasy resolutions. If this is the case, then, it is worthwhile to consider, briefly, women who have a clear professional identity. A group of nine women stood out from the majority because they offered what they explicitly termed a *preschool* in their homes.

Some of the women offered this program for only part of the day; the others combined it with full-time child care. Two of the women hired an assistant who came in at least once a week. Only two of the women had their own children present during the day; the remainder either had grown children (six women) or no children at all (one woman). None of the women accepted infants and toddlers into the group of children for whom they provided care. All except two of these women were registered with the state: one of the women had dropped her registration status as a result of difficulties with the state licenser; another was planning to be registered as soon as she had completed some renovations on her home. Thus, the structure of the work was different for this subgroup than it was for the majority of family day care providers.[25]

Implementing some kind of preschool program with a careful selection of activities appeared to help these women find a more professional definition of their services:

> The work that I see hanging up there—it's production, it's something I can see. All of my children can write their names. Some of them couldn't even hold a crayon when they came here. I just love it. I guess it's all in the art of teaching...and that's why I like the preschool age.
>
> I do not baby-sit. It is true I do child care, but I believe in a total program. I do kindergarten with the older ones, and I provide a total preschool program. I feel strongly about structure. . . . We have a theme each week, and everything centers around the theme.

They conceived of themselves as teachers with a more distant relationship to the children in their care:

> I guess I wondered about that, have I come on in too much of a distant way with them. [But] I think that even though I do come on as a teacher quite a bit—it's just my style—that they still like the security that I provide. They like the stimulation. What I'm lacking...in the more casual, less structured, motherly-type provider, maybe I make it up in all sorts of fun things to do and bringing some beauty into their lives.
>
> I definitely do not feel like their mother. There's no struggle with that at all....I had my own children and that was plenty.

This stance enabled them to be free from some of the tensions facing other family day care providers. The limits of responsibility were felt less acutely because they defined their own province more narrowly. Losing children was rationalized as progress; a new group could be anticipated joyfully. They could draw on their training and professional identity to assert their authority during the (often more limited) time they had charge of the children. They also drew on these skills to demand higher wages and more regular payment. And these women were among the clearest about exercising their option to select carefully the children for whom they would provide care.

SUMMARY AND CONCLUSION

The context in which family day care providers work aligns them with mothering. "Real" mothers find their work to be isolating, overwhelming, coerced, and devalued; they also find enormous satisfaction and rewards in the activity of caring for their own children. Family day care providers experience both sides of the coin. But the model of mothering is particularly threatening to them: the ideal of deep emotional involvement and selfless giving draws them into too great an intensity and a denial of their own needs as workers. However, they can not completely withdraw: too great a distance from children deprives them of satisfactions; overtly charging places them in the contradictory position of defining their worth and reaping too little. They resolve these dilemmas through a stance of detached attachment and a bifurcation of the value of caregiving. These fragile resolutions are threatened daily.

The turnover among family day care providers is high; 37 percent of the registered providers in 1986 were no longer involved in this kind of care in 1987;[26] 63 percent of the questionnaire respondents say they view the work as temporary. The women give a variety of reasons for moving on, the most common of which is the growth of their own children and the consequent loss of the original motivation for becoming involved in the occupation. However, when the women are pressed to talk about their feelings about leaving the work, many women explicitly mention the term *burnout*. And they make it clear that the contradictions lie at the root of this phenomenon: the pain of separating from children to whom they have become attached and the effort to keep a distance from needy children; wanting to give freely and not receiving enough pay to make it worthwhile. And the burnout is a tragedy for the women who are good at this work, who reap enormous pleasures from doing it, and who give a service that is greatly needed in our society.

Family day care providers are not alone in facing these kinds of dilemmas. As others have shown, many paid caregivers are attracted to their jobs by the desire to provide a service, and they derive satisfaction from real attachments to clients. They also often find that the context in which they work impedes the full expression of their concerns. Some workers find a partial solution in professional detachment. As discussed above, such a position entails certain gains for family day care providers: they resolve the conflicts and reconceptualize the work in a more manageable way. But it also means certain losses: because many of these women do not take toddlers, fewer openings exist for the younger children, and the older ones miss the experience of receiving care in a mixed age group; intense bonds between the provider and the children form less frequently. In any case, although more family day care providers might assume this stance in the future, this approach probably will not become the norm. First, most family day care providers lack the training that would engender a self-designation of *preschool teacher.* Second, most of the family day care providers have responsibility for their own children; as one woman in the deviant group found, it is difficult to provide this kind of structure while attending to the needs of your own child.[27] Finally, many family day care providers do not feel that this kind of formal, educational experience is appropriate for very young children. Even less extreme solutions, such as regulation, networks, and training, are slow to develop (Click 1981; Kahn and Kamerman 1987; Sparkes 1978). Many women still resist regulation (see Enarson in this volume). They feel pressed for time already; participation in support groups and attendance at workshops appear as unwanted burdens.

If the solution is not going to come from within the occupation, then perhaps it has to come from outside, from a redefinition of *motherhood.* If motherhood were not so claiming (children as private possessions) with the whole burden for emotional security placed on mothers, family day care providers might more easily conceive of their role as *one* of a number of caring adults responsible for children; they might also have more legitimacy with respect to the exercise of skills; and they might finally be recognized as individuals with an ongoing relationship with the children—parents would have to recognize that the link between providers and children could not be severed at kindergarten.[28] If motherhood were seen as valuable and worthy of payment, then surrogates could also be paid a living wage, and they would not have to deny the importance of money.

Consequently, I suggest that the market can only replicate the functions of the private domain, if the latter (as well as the former) is transformed. Without this transformation, individuals who are asked to provide the services that were formerly the preserve of the family (and who are judged by standards that were appropriate to that domain) (Hochschild 1983) will continue to find themselves in impossible and contradictory positions.

DOCUMENTATION

Author's Note

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Notes

1. In 1985, the labor force participation rate of women with children younger than age six was more than 53 percent for both married women and female heads of households (Hayghe 1986).

2. Family day care is so dominated by women that the summary report of the National Day Care Home Study (Fosburg 1981) does not discuss gender at all. Only two of my questionnaire respondents were men.

3. This term is used as the title for a collection of essays on the effects of unpaid caregiving in the domestic domain (Finch and Groves 1983).

4. In the course of distributing questionnaires to unregistered providers, I picked up an additional 10 registered providers, bringing the total for that group to 235.

5. The organization of family day care in Vermont offers three legal alternatives. Licensing is required of providers with more than six full-time nonresident children. Because almost all licensed day care occurs in formal centers rather than private homes, no licensed providers are included in this analysis. Registration is required of those who offer care to children from more than two different families and may legally include six full-time children of preschool age and four part-time school-aged children. Women caring for (any number of) children from no more than two different families may remain unregistered. Those who care for more than this number and fail to register constitute the "illegal" population of family day care providers (Vermont Department of Social and Rehabilitation Services 1985). A recent study of child care in Vermont estimated that approximately 75 percent of all children younger than age six with parents in the labor force were in (legal or illegal) unregulated care (Davenport 1985).

6. Because I am interested here in a *general* discussion of the attitudes of family day care providers, I do not distinguish between registered and unregistered providers.

7. In spite of much recent talk about "parenting," the burden for a child's well-being still rests on mothers (Peterson 1983; Smith 1984).

8. A good characterization of this kind of woman can be found in Kristin Luker's *Abortion and the Politics of Motherhood* (1984). Family day care as an extension of mothering is presented differently, although equally concretely, for a substantial minority of the women who see in the provision of child care a way to further satisfy a thwarted maternal impulse. Women who could not afford a larger family, women who could not (physically) bear more children, women who longed for a daughter and had only sons (or vice versa), and women whose grown children have left them pining over an empty nest, all located their motivation in an as-yet unfulfilled need to mother.

9. They also place limits on this caring; no mother wants to be displaced as the primary object of her child's affection (Nelson 1989).

10. Interestingly, several women who had been cared for by baby-sitters did not want to duplicate the same experience for their own children.

11. In fact, for family day care providers, the conflict between child care and other activities may be more intense than it is for mothers. The

demands of the former are greater; the larger number of children creates both more housework and higher standards for that work.

12. Even those who had undergone extensive training to become nurses or teachers, when asked what skills they drew on, mentioned motherhood before their occupations.

13. Alternatively, the nonanswer might be taken simply as an indication of the difficulty of separating treatment and feeling. Caregiving involves instrumental tasks and emotions. We care for someone because we care about them; when we care about someone, we take care of their needs. But if it were just this difficulty, we might find that mothers could not separate the tasks and the emotions. However, most mothers can separate the two easily: I love my child but I hate changing diapers, getting up in the middle of the night, losing contact with the adult world, and so forth.

14. This term comes from Hochschild (1975, 1983). She defines a *feeling rule* as a culturally defined script for appropriate feeling, and she speaks about the emotion work (in the private domain) and emotional labor (in the public domain) necessary to bring one's feelings into line with these scripts.

15. Those who emphasize infant bonding suggest that this emotional intensity is not possible. For similar statements, see Balint (1949) and Winnicott (1966). For more critical discussions of this perspective, see Arney (1980) and Boulton (1983).

16. I will deal later with those situations in which strong feelings do not develop between the provider and the children in her care.

17. Providers and parents both speak about the ease with which children adapt to this group life. What they fail to note is that group living disempowers children. (See Enarson [1987] for a useful discussion of this issue.) As a result, children make fewer of the kinds of demands for attention and immediate need fulfillment that might lock the provider into an intense, personal struggle.

18. While unregistered providers do not receive these instructions directly, they are, perhaps, even more vulnerable than the others. None of the providers has institutional protection against a complaint about mistreatment.

19. I discuss these situations later.

20. Similarly, when they report, as many of them do, that their own children are the most difficult members of the group, the providers unconsciously reveal that the intense bond creates equally intense struggles.

21. By inserting the mother into the relationship, thereby implicitly drawing a distinction between what she provides and what a real mother offers, the day care provider is also re-creating a notion of mothering as something that exists only between a real mother and a child. This kind of relationship she reserves for her *own* children. Thus, mothering is not

cheapened (which, paradoxically, it would be if it involved a monetary fee) by being confused with something different.

22. In this way, they also differ from public caregivers who have to care for all those assigned to them.

23. Family day care providers also claim other compensations besides the satisfactions of their relationships. Money is one obvious "reward." Others include the savings from not having to go out to work (e.g., not having to pay for business work clothes, transportation, and child care), the benefit of being able to stay at home with their own children, and tax advantages (either from not reporting income or from deductions).

24. The manner in which the dilemmas are resolved allows little room for accommodation to the needs of children (and parents) who do not fit easily. Difficult and "deprived" children are thus denied the security of a family day care home.

25. The women also differed from the others on a number of background issues. They were among the most highly trained and educated women (78 percent were trained as teachers or nurses, compared to 9 percent of the others; 78 percent had completed some education beyond high school, compared to 50 percent of the others). They were, on average, older than the other family day care providers (median age of thirty-eight versus a median of thirty-two). They had been providing child care in their homes for a median of 3.5 years, compared to a median of three years for the questionnaire respondents.

26. This figure derives from a comparison of the state lists of registered family day care providers for two consecutive years. A recent analysis of child care in Vermont gave a somewhat lower figure (Davenport 1985). For turnover rates among other family day care providers see Groves 1983 and Fosburg 1981.

27. The conflict became so intense for this woman that she sent her daughter to another family day care home during lesson time. This option would not be acceptable to the majority of family day care providers who find their motivation for providing care in the desire to be home with their own children.

28. As the generation of children who were raised in this kind of care reach maturity, they might have different conceptions of the roles of mothers and child care workers.

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11

Experts and Caregivers: Perspectives on Underground Day Care

Elaine Enarson

A recent Gary Trudeau "Doonesbury" cartoon points a finger at family day care. In one frame, Joni picks up her young, enthusiastic son after his first day with a new home caregiver, whom he pronounces "the best day care lady in the whole world." When Joni inquires where she is, he nonchalantly replies, "She went out to get us some donuts."

The humor touches a nerve. Although some observers glorify family day care providers as the professional mothers of the future, many social service professionals, educators, and parents portray them as unskilled and untrained "baby-sitters" who casually warehouse children in the privacy of their homes.[1]

Although Americans have qualms about the quality of day care, they increasingly rely on it. One-half of all mothers of young children currently are employed. Family day care dominates out-of-home child care for very young children. More than 105 million women furnish family day care; three-fourths are not related to the children they tend.[2]

Variously defined as a vocation, a craft, a cottage industry, and a home business, family day care enables providers to fulfill family responsibilities while increasing household incomes. As Abel and Nelson (Chapter 1) suggest, however, women providing home care rank among some of the most vulnerable caregivers in our society.

Currently, pressures for regularization and professionalization threaten to transform the lives of family day care providers (Adams 1984; Morgan 1984). Although 90 percent of family day care providers are now unregulated in any way, social service agencies throughout the country seek to enforce assorted forms of regulation on the vast underground network of family day care homes. In the United States, more than one-half of the states impose mandatory licensing, requiring that providers meet certain conditions in order to operate legally. These generally include limits on the number of children allowable, requirements for home safety, and background police and health checks; licensing may also require providers to carry insurance, attend training, or meet other conditions designed to ensure quality care. Fifteen states provide instead for simple registration, which encourages but does not mandate providers to meet similar standards; this system also may depend on random spot-checks to encourage compliance. Registration in some states is required only of providers subcontracting services with local welfare agencies.

In many communities, providers have organized to fight local restrictions on both home day care in particular and home work in general.[3] Some also evade whatever regulations have been imposed. One critic of regulation summarizes the issues this way:

> The "discovery" of family day care was a mixed blessing. While providers were no longer called baby-sitters and were accorded the verbal respect they deserved by many early childhood professional groups, the family day care territory was open to the missionary zeal of professionals who wanted to change the service in their image. Just as Henry Higgins wanted Eliza to be more like a man, so unknowing child development professionals and government policy makers wanted family day care providers to be more like center providers—this kind of care is so much neater, so much more controllable, and so much more accountable. (Sale 1984:31)

Advocates of regulation emphasize the need to safeguard quality of care. Although providers agree that good quality is critical, they argue that other means can be found to ensure it. Their opposition to regulation typically is explained in two ways. First, economic concerns are critical. Regulation, for example, often requires that providers purchase insurance. As the malpractice crisis intensifies, however, the cost of such insurance escalates; many low-income providers simply cannot find any plans they can afford. Many women also want to be able to earn tax-free income. Second, many providers are ideologically opposed to state intervention in private affairs; this ideological stance is bolstered by the belief of many providers that bureaucrats invariably are inefficient and inflexible.

But these factors cannot adequately explain either the intensity or extent of provider resistance. This chapter argues that the depth of this resistance can be understood only by examining three key issues—the desire of providers to control their work, their need to negotiate a delicate balance between affective and contractual relations, and their defense of "traditional" mothering.

METHODS

The chapter is based on interviews with a sample of providers in the area of Washoe County, Nevada, which recently sought to tighten licensing requirements. Providers who advertised under the heading *child care* (as opposed to *licensed child care*) in Sunday editions of the major local newspaper between June 1986 and July 1987 were contacted by phone. Because underground workers were asked to release their names and addresses, I expected the response rate to be low. Of the 104 providers contacted, thirty agreed to participate in the study.[4] Sixteen completed a mail questionnaire and fourteen others were interviewed at home.

The majority of respondents had worked as family day care providers for fewer than two years, and most intended to pursue this occupation only a few years more. They typically charged $1.00 an hour for each child and cared year-round for three to five paying children (on both full- and part-time bases). Their gross weekly incomes from child care ranged between $100 and $200.

With two exceptions, these providers were married or living with male partners; most had young preschool children at home. Although they ranged in age from twenty to sixty-five, most were in their late twenties or early thirties. The majority were high school graduates with some college study or vocational training. Their own work and educational backgrounds, as well as the nature of the jobs held by their male partners, tended to place them within the lower middle-class or working-class; however, the group included one affluent woman and two women who were living beneath the poverty level.

The providers typically began to offer family day care for at least one of the two following reasons—to avoid the high cost of child care if they held outside jobs, and to be able to provide direct at-home mothering to their own small children. The majority had held waged jobs outside the home but concluded that family day care was preferable at this point in their lives.

Twenty-two of the thirty providers were unlicensed at the time of the study. The eight licensed providers had worked for a period ranging from a few months to several years before complying with local regulations. They had obtained licenses either because they had been reported to local authorities or because they feared they would be reported. The sample thus can be considered to include unlicensed and reluctantly licensed providers.

Nevada has no uniform state regulations governing family day care, and county regulations vary widely. Before 1986, Washoe County required only those providers who were caring for four or more paying children to obtain licenses. Responding to highly publicized local sexual abuses cases, as well as to national trends toward increased regulation, local authorities imposed licensing requirements on providers caring for at least two paying children, whether part- or full-time. Licensed providers are required to secure appropriate business licenses from one of the two major cities in the county, comply with local fire and zoning regulations, and pay annual fees.

The county refers parents seeking child care to licensed family day care providers but offers no other direct services to providers. Nevada does not participate in the federally subsidized food program, which underwrites costs for meals served in a day care setting. Although the state gaming economy creates the need for 24-hour child care, no comprehensive information and referral center existed at the time of the study. An association of licensed providers, which had actively challenged increased licensing requirements, was inactive when the interviews were conducted.

RESULTS

The Defense of Autonomy

Issues of control and autonomy are central to the northern Nevada family day care providers I interviewed. As home caregivers providing direct personal service, they expect to set the patterns and rhythms of the work day; structure activities, routines, and meals on their own; and negotiate independently with employing parents. Nevertheless, their independence is circumscribed in a variety of ways.

First, because they rely on their earnings from day care for a substantial part of their household incomes, they often cannot afford to be selective about the children they accept and may have to provide care to children and parents they dislike.[5] They sacrifice control for income and accept more drop-ins and part-time children than they would like, advertising in papers for "24-hour loving care, all days, drop-ins OK." Second, they cater to husbands who wish to limit the impact of day care on their own lives. Some providers report that they must hastily organize and clean their homes each day in preparation for their husbands' return. One respondent remarked of her clean home, "This is for him. This is the other job I have to take, with my day care. It's like taking two jobs." Third, employing parents have the power to reject a particular provider's care, pay for services irregularly, and pick up children late. Some seek to impose their wishes about how the provider spends her day. Because they can report unlicensed providers, parents also have enormous latent power.

But such factors are dwarfed by the threat to autonomy posed by officials charged with enforcing local county welfare licensing requirements. Licensing of child care brings new levels of public visibility and control to what providers continue to view as autonomous home-based self-employment.

The underground Nevada providers I contacted expressed enormous frustration at "harassment" by regulators. Some also complained about the class bias built into state regulation; one woman, for example, related stories about licensing professionals who are "always talking condescending, always, like I'm low class, trying to get away with something, that I don't know what I'm doing." At the heart of their opposition, however, is their belief that licensing robs them of the autonomy that initially attracted them to family day care. Once licensed, they no longer can decide how their homes will look, what forms of discipline to employ, what nutritional and safety standards to enforce, and what routines to follow. Instead of summoning neighbors and friends for assistance, they must rely on certified back-up substitutes when they are absent from the children they mind. In addition, they must accept unannounced visits by welfare workers. An unlicensed twenty-seven-year-old provider protested: "No one's going to go through my closets! This is my *home*. I'm not doing anything wrong, and unless there's a reason that you suspect I am, don't come around—that's invading my privacy."

A second woman, visited by authorities who had received a tip about unlicensed care, exclaimed, "I want them *off my back*. That's why I'm getting licensed, to get them off my back." Ironically, however, she will be subject to more unannounced visits once she obtains a license. As an underground worker, she had been able to refuse admittance: "I made her come back when she *called* me. But once I get licensed, I can't do that anymore."

Still another unlicensed provider (a thirty-nine-year-old) speaks for many when she distinguishes between checkups by local authorities and daily visits by parents:

> I think it's kind of an intrusion—dealing with a stranger, which could be on a bad day. I mean, I do have bad days. And here's this person going, "My goodness, they're leaving their kids with her." But mothers, I tell them to walk in. That doesn't bother me at all. I'm checked up on every day, by them. . . . I think they should spend more time educating parents on what to look for—pay more attention to your child.

As this comment suggests, these providers do not reject the need to control quality.[6] But they propose a model of accountability based on self-regulation and parental responsibility. Some pointed to their own personal characteristics, which, they asserted, equipped them to care for children. One woman who works underground has a college degree in social work and is confident that she would surpass any requirements necessary for a license; another woman noted with pride that she and her husband, a police officer, have been approved as potential adoptive parents; many others are confident that they can render good care because their services have been in great demand from satisfied parents for a number of years.

In addition, these providers accepted and encouraged parental oversight. Although they expressed resentment at some of the ways parents controlled their lives, they urged that parents be educated to detect signs of child abuse or neglect, and they maintained open-door policies for their own employing parents. Most also feel they and parents are best able to judge quality care, based on their particular relations with the child. One thirty-one-year-old unlicensed provider sums up the majority view:

> The simpler things are kept, the better off everyone is. Child care should be between the parent and the caregiver. I do not feel that the Social Services Department actually knows what it is like to do day care in a home.... I do not want to be regulated in my own home by someone outside my home and the children I watch. If a parent brings a situation to me, I'm more than glad to listen and cooperate. Let it be the parent—not some outside agency that has a firm set of rules for everyone, no matter what the set-up is. If parents are happy, the county should leave sitters alone.... Quality care comes from the make-up of the individual. Licensing provides externals like fire extinguishers, medicine up high—very good ideas—and some overly cautious regulations for home care. As far as warmth, concern for a child's well-being, hugs, and understanding—that comes from inside a person, and no one can regulate one's thoughts.

These underground providers believe the role of the state should be very limited. Licensing jeopardizes their autonomy and sense of how family day care should be evaluated, and they resist it accordingly.

The Family Business of Day Care

The Nevada providers I interviewed tried to maintain a delicate balance between affective and contractual relations with both parents and children. Regulation threatened to upset this balance by emphasizing one side alone.

One young woman expressed the ambivalence of many about whether they were engaged in a "labor of love" or a home business. Although she stressed her commitment to "running my house, not a business," she also doubled her fee after 5:30, explaining, "It's my home, but it's also—I punch a clock, in my mind. And 5:30 is when I quit. If I work longer, I get overtime."

Economic need compelled these providers to establish appropriate rates and ensure that they receive prompt payment. But they also see child care as a service rather than a commodity. Several women noted their anger at mothers who sought to purchase extra hours.[7] Assuming that money is the only issue, they picked up children late. One provider complained, "You know, it's like, 'Well, I'm paying her, so she should sit until I'm ready to come and get them.'"

Some women stated that they attempted to be "hard-nosed" in dealing with parents about payment. But they also acknowledged that their bonds to the children in their care made them wary of enforcing their end of the bargain. One thirty-nine-year-old unlicensed provider explained her predicament this way: "You can't just say 'Go find somebody else.' Especially when, you know, you develop an attachment to these kids, and you hate to see them have to go to someone else."

Another woman feared that the children she tended would suffer if their household incomes were reduced when she raised her rates. She mused, "What if the kids wanted something? The kids I watch are like my own."

But these women were painfully aware that their attachments to the children in their charge were rooted in economic relationships; the termination of the latter invariably ruptured their ties to the children. One woman was deeply hurt when a child she had tended for three years was removed from her care because the parents moved away. She felt that she no longer had any claim on the child; although she wished to phone the parents and learn how the child was faring, she assumed that such action would be viewed as inappropriate. She wondered aloud whether the parents appreciated or even noticed the Father's Day cards she helped the children prepare and described her work as a "thankless job," comparable to that of a maid. Regretfully, she concluded, "I am not working for myself. I am working for these people. . . . They're my boss." Licensing seemed to her to reinforce this unwelcome self-concept as an employee.

Attachments to parents inhibited other providers from enforcing the terms they set. Some providers who needed higher incomes refrained from requesting additional payment from parents they had come to regard as friends.[8] Many also identified closely with employing parents. As noted, most providers previously had worked outside the home; they knew from personal experience how difficult it was to pay for child care from the low wages women receive from their jobs.

In short, these providers continually sought to negotiate a tenuous balance between love and money. Regulation, they argued, would compel them to emphasize the economic aspects of their endeavor. They would be forced to adopt more formalistic relationships with parents and present themselves as businesswomen rather than disinterested providers. They were reluctant to enter the ranks of licensed providers, whom they portrayed as "greedy" and less caring than themselves. In fact, a few women accused such providers of seeking licenses primarily in order to accept the maximum allowable number of children. Many women in this sample avoided licensing because they associated it with providers who were simply "in it for the money."

Traditional Mothering and Professional Care

Providers also resist licensing because it threatens their vision of good mothering. Although these Nevada women cater to mothers who seek paid employment outside the home, they glorify "old-fashioned" maternal care.[9] Many express distrust of the emerging professional model of home day care. Experts increasingly exhort providers to seek formal training, introduce educational activities into daily routines, and adopt professional self-images. Some states are considering awarding the Child Development Associate degree (a competency-based credential), which they view as a means of bringing family day care workers within the orbit of the public education system.

The providers in this study carefully distinguish between the care they offer and that available in child care centers and preschools. This distinction rests on the belief that institutions cannot provide the same kind of flexibility, responsiveness, and individualized attention that they believe is the hallmark of good family day care. They are firmly convinced that the kind of care offered in a home is preferable for all children—their own as well as others: "I don't think the little ones should be in a day care center. I think they should be in a home." They also deride the current emphasis on preschool activity for young children, whether it comes from parents or professionals.[10] In part, their opposition is rooted in an awareness of their own limitations. They rarely have the training that would equip them to assume the identity of a preschool teacher or to follow through with the provision of educational activities. They also view such activities as an unwanted burden in a day already filled with paid and unpaid work. More significantly, however, most providers consider such activities inappropriate and unnecessary for the very young. These issues are all combined in the following quotation by a twenty-seven-year-old unlicensed provider explaining why she declined a mother's request that she work on skills with her child:

> I said, "I'm not qualified, and I have all these other children, and my day care home is run like a home, so I still have dinner and housecleaning to do—the kids come out and help me hang the laundry." . . . I know there's a lot of people that want their kids to go into home environments and be *taught*. But there are certain places for learning, and they're so close to it anyway, at five years old. They're going to get it in school. And I think you can over-teach.

Providers thus defend a particular style of care. And they insist that formal training is irrelevant preparation for this work.[11] Their claim to expertise rests on their own experiences as both providers and recipients of care. A thirty-four-year-old unlicensed provider said, "When you're a mother, you're a mother. You just kind of know basically what to do. . . . I just don't think you need to read it. . . . If you can be any decent kind of mother, you can watch kids."

This is a realm of expertise and knowledge only recently being reclaimed (Ruddick 1989) and one that remains invisible to those intent on state control of home child care. Providers stress their ability to anticipate and meet individual needs and the patience and flexibility they bring to their work. They can maintain their own schedules, accommodate individual tastes, and provide the kind of intense personal care associated with relationships among family members. These unlicensed providers resent pressures to make "mini-centers" of their private homes and the notion of credentialled expertise in mothering.

Although the providers in this sample share the widespread concern about quality child care, they articulate a model of nonprofessional expertise. They resist licensing in part to confirm their self-concept as traditional mothers in an era of uncertainty about what good mothering means.

FUTURE DIRECTIONS

State regulation of family day care is designed to safeguard quality through public oversight. Yet it has been strikingly unsuccessful in bringing underground providers into public view. Ironically, the attempt to impose regulation may undermine public control of quality by encouraging providers to withdraw from public scrutiny. Regulation imposes an overly simple definition of good quality and, by implication, a false dichotomy between "good" and "bad" child care based solely on regulatory status. Most parents express satisfaction with family day care and support their providers' decision to evade local regulations.

If regulation fails to respond to the needs and concerns of providers, other developments should be encouraged. The formation of communities among providers can serve to erode their sense of isolation and enable them to publicize their concerns. In San Diego, a one-day strike to protest rising insurance rates helped motivate state officials to develop alternatives to private insurance plans. The wide support of parents in this strike highlights the necessity of forging partnerships with parent groups.[12]

Providers also welcome help from professionals when they perceive such help as supporting rather than undermining them. Professionally-designed programs that have attracted provider participation include mobile resource vans visiting provider homes (Sparkes 1978) and scheduled visits of both providers and children to resource centers where good child care is demonstrated, while providers share experiences, receive individual counselling, and utilize toy and book libraries. Respite care is among the most helpful services professionals can provide and may help to motivate underground providers to participate in training programs they otherwise might avoid.

This study suggests that three key factors explain why underground providers resist regulation: they seek to defend their autonomy as home workers; they are torn by ambivalent feelings of caring and profit-seeking; and they embrace a nonprofessional model of mothering and quality child care. The depth of their resistance to regulation suggests that, in the absence of positive incentives for providers to become registered or licensed, family day care probably will remain underground. We thus must seek to fashion creative and effective alternatives to mandatory licensing and registration. Because family day care probably will continue to dominate the nation's child care system, we also must listen to the views of underground providers and engage them in the national debate about future directions for day care.

DOCUMENTATION

Author's Note

I would like to gratefully acknowledge the critical reading this work received from editors Margaret K. Nelson and Emily K. Abel. In addition, I owe a great debt to the women who freely gave their time to interviews in the hope that the study might help improve communication between family day care providers and regulators.

Notes

1. This article draws on previous work in which I explore family day care theoretically, focusing on changes in mothering and other forms of housework (Enarson 1986). See also Groves (1983), Nelson (1988, 1989, this volume), and Sale (1984).

2. The source of background data on family day care is the National Day Care Home Study, conducted between 1976 and 1980 in three urban areas. It focused on unregulated, regulated, and sponsored family day care homes. The National Day Care Home Study confirms that most parents prefer home-based care for children younger than age three; however, many black parents prefer center care (Fosburg 1981:67). Although early studies painted bleak portraits of home day care (e.g., Ruderman 1968), more recent investigations, including the federal study, report high levels of parental satisfaction (Collins and Watson 1976; Winget, Winget, and Popplewell 1982).

3. Like the Vermont home knitters organizing against modern protective legislation (Boris 1987), providers defend their right to earn income at home; like lay midwives in Arizona (Weitz and Sullivan 1986, this volume), they also assert a model of care grounded in the lived experience of women as mothers and an oral female tradition.

4. Because the sample is small, and the population of day care providers has not been studied adequately, evaluating the validity of the sample is difficult. Nevertheless, it does resemble the profile of white unregulated home providers in the National Day Care Home Study: "young white mothers in their late twenties and thirties with their own young children" (Fosburg 1981:46).

5. Women who are compelled for financial reasons to care for children they consider unacceptable may be more likely to view child care as alienating labor. Such women nevertheless may try to provide at least the appearance of "loving care," the equivalent of the "managed smile" which Hochschild (1983) notes is required in many service jobs.

6. Defining and measuring quality in child care is very controversial and often reflects class bias (Greenman 1984; Stallings and Wilcox 1978).

7. Nelson (this volume) suggests that providers resist commodifying care to help maintain their identities as *caregivers*. Relations between child care providers and parents in both centers and homes are complex and often conflictual (Nelson 1989; Saraceno 1984; Zigler and Turner 1982).

8. This discussion focuses on relationships between female providers and mothers. Research is needed on the role of men in family day care as providers, parents, spouses, and participant observers. Although men often have limited responsibility for direct child care in the family, their power to establish, maintain, and terminate child care arrangements may well be substantial.

9. British researchers Hoy and Kennedy (1983) interviewed childminders in urban and suburban London and found that most identified primarily as mothers; they viewed their wage work as being secondary and "by implication not being a measurable day's work because it is fitted in around the household needs" (p. 214). In pilot interviews with New England providers and their children, Squibb (1983) found providers' children defining their mothers' home day care as parenting, not "work."

10. For example, the Better Baby Movement stresses intensive infant and toddler education and certifies "Professional Mothers" equipped to provide it (Traub 1986). Although the seminars appeal most to those able both to pay for them and to afford full-time at-home mothering, the ideology touches all mothers.

11. The National Day Care Home Study found that employing parents also perceive experience rather than formal training as the most important qualification for providers (Fosburg 1981:68).

12. For further information on the growth of family day care associations and provider organizing, see Click 1981, Collins and Watson 1976, and Jackson and Jackson 1979. The National Day Care Home Study found that 60 percent of employing parents are willing to pay higher fees for home day care (Fosburg 1981:24).

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12

Licensed Lay Midwifery and Medical Models of Childbirth

Rose Weitz and Deborah A. Sullivan

As recently as the turn of the century, childbirth in the United States generally occurred at home under the direction of a midwife. As physicians' role in childbirth grew, and as a medical model stressing active management of childbirth was adopted, some of the health risks of childbirth diminished. Physicians took credit for this reduction in risk and argued for increasing medical control over childbirth. Over the last several decades, however, a growing number of consumers, activists, and scholars have argued that the benefits physicians provide to most childbearing women are minimal and are offset by the physical and emotional hazards those physicians create (e.g., Arms 1977; Ettner 1977; Gaskin 1977; Oakley 1980; Rothman 1982; Shaw 1974; Sullivan and Weitz 1988). As a result, many activists have pressed for radical changes in the medical management of childbirth.

As these activists have learned how difficult it is to create true alternatives within the medical system, a small but growing number of women have decided to escape that system rather than try to change it. These women now choose to give birth at home. However, almost no physicians or certified nurse-midwives in the United States are willing to attend home births. To meet the demand for attendants at home births, the occupation of lay midwifery has reemerged.

Lay midwives either are self-taught or have attended one of the handful of unaccredited schools in the United States (Baldwin 1978). Unlike certified nurse-midwives, they have neither nationally established training standards nor a code of professional practice, and they almost always practice in the home. Lay midwives do not necessarily have any training in either medicine or nursing. In this chapter, the term *midwives* refers to lay midwives unless otherwise noted.

In most states, lay midwifery is illegal or legally nebulous (Sullivan and Weitz 1988). As a result, midwives are constantly vulnerable to legal harassment, and they have been prosecuted on charges ranging from practicing medicine without a license to manslaughter (when babies have died following home births). Moreover, midwives who work illegally fear that the quality of care they can provide is limited, because of the difficulties they face in obtaining good medical backup in those situations when problems develop.

These factors have led midwives around the country to lobby for licensure. Licensure presents a paradoxical situation for midwives. Unlike many unaffiliated providers, midwives work outside of the system by choice. They do so because they want the freedom to put into practice their philosophy of childbirth—a philosophy that puts them at odds with the medical world. Yet the constraints of working illegally can make it difficult for midwives to implement their philosophy. Conversely, the constraints of licensure regulations can also pressure midwives to compromise their philosophical beliefs. Thus, midwives must sacrifice some freedoms to gain others.

In this chapter, we describe how the practice of lay midwifery changed in Arizona during the first five years of a licensing system reactivated in 1978. We explore the ways licensure can combine with other factors to push midwives both toward and away from the medical model of childbirth.

The medical model involves both *medicalization* (Conrad 1975)—a definition of the situation in medical terms—and a set of guidelines for appropriate interactions between practitioner and client (see, for example, Szasz and Hollender 1956). This model defines pregnancy and childbirth as potentially pathological situations. As such, these biological processes are believed to require active medical management (such as breaking the embryonic sac or fetal monitoring) in the normal course of labor and delivery and a readiness for medical intervention if any problems arise. In addition, the medical model stresses treatment of clients' physiological systems rather than holistic treatment of individuals. Treatment is expected to occur in the context of hierarchical authority relations between practitioner and client, with the practitioner assuming responsibility for the treatment of his or her "patient."

THE RESEARCH SETTING

In 1957, Arizona passed a law allowing the licensing of lay midwives who met certain minimal qualifications. The midwives licensed under this law were predominantly members of minority religious, ethnic, or racial groups who practiced in isolated rural areas. By 1977, only three licensed midwives continued to practice in the state.

A rise in requests for licenses from women practicing midwifery illegally—one of whom was able to force the state to grant her a license—prompted the Arizona Department of Health Services to adopt new rules and regulations in January 1978. Under these new rules, prospective midwives must show evidence of formal training in midwifery; provide evidence of birthing a minimum of fifteen women under the direct supervision of a physician, certified nurse-midwife, or licensed midwife; and pass a qualifying exam. Thirteen women who had applied for licenses prior to the formal adoption of these rules passed the qualifying exam and obtained licenses without having to meet the other requirements. Another twelve fulfilled all the requirements established under the 1978 rules and regulations and obtained licenses by mid-1982.

Arizona provides a particularly good setting for investigating the pressures midwives face to adopt a more medical model of childbirth. As one of the first states to revise the criteria for and to reactivate midwifery licensing, Arizona has a readily identifiable population of midwives. Most of these midwives have been practicing for five to six years under the scrutiny of the Arizona Department of Maternal and Child Health. Many other state health departments and legislators have requested information on the rules and regulations surrounding Arizona's licensing system. Some are considering adopting or have already adopted policies modelled in part on the Arizona program.

METHODOLOGY AND DESCRIPTION OF SAMPLE

During the second half of 1982, we conducted intensive interviews with twenty-seven of the twenty-nine women who had been licensed to practice midwifery between 1977 and August 1982. The exceptions were one woman who had left the country and another who lives out of state and never practiced in Arizona. The semistructured questionnaire contained open- and closed-ended questions about the background, training, motivations, and experiences of the licensed midwives; the size and nature of their practices; their attitudes about pregnancy, childbirth, and midwifery; their interactions with medical personnel; and their perceptions of obstacles to the practice of midwifery. The interviews, which averaged about three hours and ranged from two to five hours, were tape-recorded, transcribed, and coded for content analysis. In addition, the director of the state licensure program was interviewed regarding her background and perceptions of the program. All quotations are from these interviews.

All twenty-seven respondents were white women, and most were between the ages of twenty-five and thirty-five. The majority practiced in or near metropolitan areas. The women attended from two to sixteen births per month, not including those in which they assisted other midwives. Ten were registered nurses, including one with a master's degree in maternal and child health, two were nurse-practitioners, and two were state-certified midwives from Great Britain. Two others were licensed practical nurses. Nine, including one registered nurse, had attended the now-defunct private and unaccredited Arizona School of Midwifery. The rest had no formal training in midwifery or nursing. However, for all but three women who had been initially licensed prior to 1977 and who practice in an isolated religious community, the adoption of midwifery represented an active rejection of western medical practice, rather than the perseverance of an older folk medical tradition.

FINDINGS

Our research has identified a number of factors pushing licensed midwives both toward and away from the medical model of childbirth. The most crucial aspect of the medical model, upon which the rest depend, is medicalization. In the case of midwifery, the two aspects of medicalization—the definition of the situation and the requirement for active management and intervention—must be separated in order to do justice to the complexity of the situation.

Changing Definitions of Childbirth

Statements made by our respondents show strong ideological support for a nonmedical definition of childbirth. All of the midwives state that they view pregnancy, labor, and delivery as natural, healthy events. In contrast, they believe physicians generally view pregnancy and childbirth as fraught with dangers. As one midwife stated, "Most obstetricians don't...trust the woman's body. . . . In their gut they expect disaster to happen any minute."

The experiences of these licensed midwives, however, have created in them a greater awareness that childbirth can become a medical problem. As the total number of babies delivered by each midwife has grown over the years, each has gained greater exposure to the potential hazards of childbirth. One midwife, for example, when asked if her feelings about the responsibility of being a midwife had changed over time, responded:

> I think I've become more aware of it with every birth I do. I think that when I first started it was like a game and I wasn't really thinking that much about it, and now I think it's come to be a major thing. Part of the reason for that is the fact that I'm a licensed midwife, and that I operate under a lot of regulations. If something goes wrong, it's my head that goes on the chopping block.

Although the midwives are restricted by state rules and regulations—as well as by their own desires—to working with a "low-risk" population, a few of the babies they have delivered were physically depressed, traumatized, deformed, or stillborn. Similarly, some clients failed to progress during labor, tore, or hemorrhaged. In the first four years of the reactivated licensure system, 14 percent of mothers were transferred to a hospital before delivery. Of those delivered at home, 15 percent of mothers and 3 percent of newborns required postpartum outpatient care and 3 percent of mothers and 2 percent of babies required postpartum hospitalization (Sullivan and Beeman 1983). Thus, while the typical delivery confirms the midwives' definition of childbirth as a natural, healthy process, they increasingly see the potential for medical problems to arise.

The effect of each midwife's experience with medical emergencies is compounded by her knowledge of emergencies that other midwives have faced. Except for one small group, which worked as a team, the midwives did not know of each other's existence until the process of reactivating the licensing system began because their practices were hidden, geographically dispersed, and restricted to their own subcommunities. In describing the way the licensing program became reactivated, the midwives recounted their surprise at learning that others were practicing in the state. The development of a licensing system increased organization and communication among the midwives: as a result, when a medical emergency occurs in one corner of the state, most if not all of the midwives eventually hear about it. Thus, the midwives' "experience" of medical problems is greater than their actual observation of such events.

Midwives' faith in the natural childbirth process is further strained as they learn the difficulties in predicting who among their low-risk clientele will safely deliver at home. Although they express confidence that 90 to 95 percent of all women can safely deliver unaided, the midwives still fear the risks they take when they cannot completely screen out the other 5 to 10 percent. Because of this fear, 85 percent of the midwives refuse to accept potential clients who meet the legally prescribed health requirements but whom they regard as poor candidates for home delivery (e.g., women who have not given birth before, do not intend to breastfeed, or do not seem psychologically prepared for home birth).

In sum, the midwives' initial views about the safety and naturalness of childbirth are being tempered by experience. Although they retain their definition of childbirth as a normal process in the typical situation, they acknowledge the need to move to a medical definition when warranted by specific, nonroutine circumstances.

Increasing exposure to medical systems as a result of licensing also has tested—and in some cases weakened—the midwives' faith in natural childbirth. Our data show that at least two-thirds of the midwives initially had practiced without licenses. Before licensing, only a minority had interacted with the medical world. Five women had collaborated as lay midwives with sympathetic physicians, while two had worked with physicians as state-certified midwives in Great Britain, where midwives are accepted caregivers. One midwife was exposed to medical definitions of childbirth through her work as a labor and delivery room nurse, while another midwife had been a labor coach. This work taught these women how physicians dealt with childbirth. In these circumstances, however, physicians did not directly address—let alone attack—the women's belief in midwifery and home birth because they did not know the women's views. Thus, the only midwives who experienced the full brunt of physicians' disapproval prior to licensing were the two women who routinely followed their clients into the hospital when problems arose.

Midwives are now required by law to accompany all cases transferred to medical care. Unless the hospital bars midwives from entering (as happens occasionally), they remain to provide emotional support and act as patient advocates after their clients are admitted. As identified midwives, 92 percent of the women have experienced direct personal attacks on themselves and their clients for their "foolishness" in attempting home births without physicians in attendance. Most commonly, these attacks consist of harangues from nurses and physicians regarding the hazards of home birth. Enduring these lectures seems to be the price for receiving care and is sometimes exacted before care is provided. As one midwife noted, "If you were in a car accident for drinking, the doctor wouldn't lecture you for a half hour about drinking first—he'd treat you right away. And that can happen [with our clients]."

In a few cases, the price for attempting a home birth is considerably higher. One midwife described how physicians occasionally are rough when they do not need to be. "I think they're doing it because they are so opposed to home births that they want to hurt her [the client]. . . . If they need to use a [fetal] monitor, fine, I can understand that. But when they are doing a vaginal exam, they don't need to jam their hand up to her neck. I've seen that done—I'm saying that from experience."

Recognition of physicians' extreme disapproval of home birth may significantly lower midwives' views of themselves and their work. As one reported, "I'd have to say that it [physician disapproval] affects me. I guess when you have someone who is questioning what you do, you listen and you question yourself. And so it's undermining. It doesn't do anything for my confidence and it does undermine my confidence." Another stated:

> I guess maybe a lot of it [physician disapproval] is why I'm in nurse-midwifery school now. Because they used to always throw that on me and say, "Well, I have nothing against nurse-midwives." A lot of doctors used to say that it would be real different if I were a nurse-midwife, how they would treat me, versus if I was a licensed midwife. I think I didn't cope real good if I had bad experiences [with doctors]; I really let it get me really bad. I would really be shattered for a long time if someone got on

> my case. . . . I think that's another reason I went to school. I just, I couldn't stand that. It was just too awful for me. I don't know, I just really wanted to know what I was doing, and really have my trip together, so they couldn't find anything wrong with me.

To protect their clients from the potential wrath of physicians against homebirthers, the midwives feel they must act obsequiously. Unlike the labor coach, who never expected to do more than facilitate a basically medicalized hospital birth, the midwife must make the transition from being in charge to being clearly subordinate. Once in the hospital, the midwife can do little to maintain nonmedical definitions of childbirth and to avoid active medical management or intervention. Thus, in this setting, the midwives must acknowledge and accept physicians' authority and the prevailing medical model of childbirth.

The licensing system has directly increased the midwives' exposure to the medical model through the institutionalization of an examination process. Except for the four midwives who were grandmothered in under the 1978 legislation, the midwives have had to pass a licensing exam written and administered by certified nurse-midwives and physicians. The director of the state licensure program—a nurse-midwife and the person most responsible for writing the exam—strongly believes that the exam focuses on proper midwifery care of normal childbirth and on recognition of problems requiring medical assistance. The two midwives who have most recently taken the exam, however, claim that it places undue stress on pathological problems and medical intervention:

> There's a lot of questions you could ask about good midwifery care, and they don't. They ask a lot of things about hospital care and what kinds of medicine are they going to give her. . . . They had fetal heart monitoring really good, but it was all with like electronic heart monitoring like at the hospital. And we don't have one of those. So it was good having the stuff, but it was all hospital procedures. And they went into a lot of lab tests. Just a lot of numbers that we don't really work with. We just get the results back. . . . And they have a lot of questions about fetal problems that we won't find out unless we go to the doctor and the doctor finds them. So how are we going to know if there's no fetal kidney unless we went to the doctor and they said it? And there's . . . six questions on it.

To pass the exam, the women found it necessary to use obstetrical as well as midwifery textbooks in order to study pregnancy, childbirth, and postpartum care from a medical perspective. Such a course of study may significantly alter the midwives' perceptions of childbearing and may push some midwives toward a more medical definition of the situation.

The training midwives have received since licensing also reinforces a medical perspective. (See Rothman [1982] for similar developments among certified nurse-midwives.) In the last few years, the state has organized a series of continuing education programs for the midwives, run by physicians and nurse-midwives, on topics such as newborn resuscitation and management of maternal hemorrhage. These workshops, along with "mini-residencies" organized for and by some midwives, reinforce a medicalized view of pregnancy.

The director has encouraged licensed midwives to obtain nursing training because she believes the future of midwifery lies in nurse-midwifery. The strength of the pressures toward medicalization is suggested by the fact that, after five years of a licensing system, five of the twenty-seven midwives had entered degree programs in nursing or nurse-midwifery.

Active Management and the Readiness to Intervene

In spite of these pressures toward a more medicalized definition of childbearing, the midwives on the whole continue to define pregnancy and childbirth as healthy processes in the average situation. They therefore express concern about the risks to health caused by physicians' active management of normal labor and delivery:

> [Obstetricians are] not as willing [as midwives] to let the natural process take its course. I've seen it. I've seen "Well, you're forty-two weeks by date, see you in the hospital in the morning to induce your labor." It's like they're just too ready to get in there and do things. They're too ready to break the water. They're too ready to just do all their little things that they can do.

The midwives feel that they have more faith than obstetricians in the woman's ability to deliver successfully, if allowed to do so in her own way and on her own timetable. Both the midwives' ideology and the restrictions imposed by their licensing guidelines push them toward "natural" assistance to the childbearing woman rather than active medical management. Instead of using drugs to induce labor, the midwives encourage women to walk, take hot baths, engage in sexual stimulation, and feel relaxed and comfortable:

> We don't have them on a fetal monitor, so you don't just sort of leave the woman on a fetal monitor by herself, you know. You're perpetually coming in and checking on the condition of the baby. You're making sure everything's fine with it. So there's a lot of touching going on. You're rubbing her feet, you're getting her to walk around, which they don't do in the hospital. Giving her light food in early labor, which they don't do. Making sure she's drinking juices. Letting her have music, lighting, you know. Whatever she wants, she can do, which isn't true in the hospital. And making her feel loved and safe and, you know, secure and taken care of, really.

Physicians almost invariably perform an episiotomy during delivery—cutting the area between the vagina and anus (the perineum). Midwives, on the other hand, will generally use nonmedical means to ease delivery: "I don't perform episiotomies. I use a lot of support on the perineum. I use hot compresses and olive oil [for massaging the perineum]. I really bring the head down really slow and birth the shoulders very gently. I try and have the mother birth the head and shoulders without a contraction so she is not as likely to tear."

Minor perineal tears do occasionally occur, however. Six midwives—reflecting both their philosophy of health care and the difficulties in obtaining cooperation from doctors—mentioned that they and others with whom they work allow such tears to heal naturally rather than have them sutured. (Undoubtedly others do the same, but did not mention it because they were not asked directly about this illegal decision.)

Although the midwives emphasize natural methods in routine births, they do not categorically reject interventionist techniques. Almost all want the skills and legal ability to intervene when problems arise. For example, only one midwife stated that she would not want the right to use antihemorrhagic drugs. The state midwives' organization has consistently lobbied for the right to suture perineal tears, use antihemorrhagic drugs, and perform episiotomies in emergency situations. One of the midwives who operates closest to a medical model reported, "I have pushed for emergency episiotomies, the carrying of antihemorrhagic drugs. I've begged for the opportunity for us to carry I.V.'s for emergency situations because I know that they do happen. . . . I'm not comfortable with people who are total noninterventionists." Although the legality of their actions is questionable, some of the midwives mentioned performing episiotomies in emergencies and arranging to have antihemorrhagic drugs available for their clients.

The midwives believe strongly, however, that these interventionist techniques should be restricted to emergency situations. They recognize that physicians over time incorporated various procedures initially developed for emergency use into the routine active management of childbirth. Three women mentioned a fear that a similar routinization of emergency procedures might occur among midwives and hence have argued against expanding their own rights to perform such procedures.

Religious and philosophical beliefs also influence the degree of medical intervention that each midwife feels is appropriate. During the course of the interviews, three midwives expressed fatalistic attitudes toward childbearing. (No one was asked specifically about this topic.) One midwife stated, "Basically one of the things I object to about the medical profession is their 100 percent rule, their unwillingness to accept the fact that sometimes people are just supposed to die or babies are just supposed to die or that there is a place for less than perfect and less than 100 percent."

Two other midwives expressed "providential" attitudes toward the dangers of childbearing, believing that if "bad" things occur during a birth, perhaps they are meant to serve some purpose that cannot be known at the time. One midwife stated, "I do the best I can, and if... she needs a caesarean or something, that's okay.... People sometimes have to go through certain experiences in their lives for whatever reason." Another described with equanimity her own childbirth experience, after which she bled until near death. She did not obtain medical assistance because she believed that God had a reason for her troubles. As this example demonstrates, when midwives hold fatalistic or providential beliefs, the potential for medical intervention is limited.

Commitment to Holistic Care

Besides defining childbirth as a potentially pathological process requiring active management, medicalization also involves identifying organic factors as the primary if not the sole source of various problems. Based upon this definition of the situation, the medical model emphasizes treatment of patients' physical conditions and downplays connections between individuals' psychological, social, and physical problems (Cockerham 1978; Hingson et al. 1981). In contrast, the midwives in our study adhere strongly to an holistic philosophy (cf. Rothman [1982] regarding nurse-midwives). They strive to provide their clients with "more of a whole care—emotion ..., diet..., exercise. They are all considered instead of just the heart rate and [fetal] position."

To facilitate holistic care, the midwives schedule prenatal visits lasting from one-half to two hours. These visits give the midwives time to learn about the client and family, counsel them regarding any psychological concerns, and prepare all participants psychologically for the home birth:

> I think the biggest part of what I do, the most important part, is getting to know the patient and letting them get to know me, so that my prenatal visits average about an hour, each one.... I think my prenatal care is totally different [from physicians']. The urinalysis, the blood pressure, the heart tones, and the fundal height take about ten minutes, so I feel like there is a lot more like counselling involved than technical.... If they're having problems in their relationships, we'll talk about how pregnancy affects relationships. We talk about parenting. We talk about a lot of things...."

In the same way, the midwives use lengthy postpartum visits to help the mother and family adjust both physically and psychologically to the presence of the newborn:

> We come back at twenty-four hours [after birth]. The 24-hour visit is really an amazing visit because... there's so much that the women want to talk about, about their feelings about how they did, and what happened and

> their experience and everything. They want to talk about that. And I feel . . . in the hospital they don't get the chance to as much, and they need to. . . . And we do a three-day visit. And usually at that point, the high is starting to wear off, the milk's coming in, and they may be uncomfortable. They may be exhausted because they haven't slept. And again, they need to talk. And they have that opportunity to talk one-to-one with someone who was involved in the experience with them.

Providing such time-intensive care becomes problematic, however, when midwives must support themselves and their families on their earnings. Except for one British-trained midwife, none of the women viewed midwifery as a primary source of income before the licensing system was reactivated. As requests for their services grew, however, the burden of being on call for clients twenty-four hours each day made other employment difficult. Yet with fees ranging from $200 to $650 for prenatal through postpartum care, the midwives would have to increase their average client load dramatically to earn a marginally comfortable income. To cope with such a large practice, a midwife would have to limit the amount of time spent with each client and routinize care. The midwife with the largest volume of practice essentially has done so—occasionally renting motel rooms so that she can deliver several women at once. Although she takes pride in her successful business, the other midwives have stigmatized her for no longer providing family-centered holistic care, rather than emulating her financial success.

The balance between commitment to family-centered holistic midwifery and profit for services rendered is not easily achieved by the midwives. As one reported:

> To make [midwifery] pay means that . . . you have to become more medical than your intuition and your desires send you. And it's hard to go for years and years without making money. . . . I have done it and I am tired of it. . . . I am a single mother and I have the responsibilities of keeping my phone paid, and my beeper paid, and my paper work up, and my car going and my kid fed. . . . I try and be as businesslike as I can and still keep in touch with their spiritual, psychological, financial, health kind of needs, and that's hard to balance.

Six of the midwives acknowledge that they actively limit their practices, while others have no desire to develop larger practices because of the time demands inherent in providing quality midwifery care.

The Move Toward Hierarchical Relationships

The final component of the medical model is establishing a hierarchical distribution of authority and responsibility between practitioner and client.

Despite recent changes resulting largely from consumer pressure, physicians still typically either make treatment decisions for their patients or guide their patients to cooperate with physicians' judgments (Cockerham 1978). Treatment generally involves an active physician and a passive patient (Szasz and Hollender 1956).

The midwives do not want such godlike authority and responsibility. They are highly critical of obstetricians who "are too ready to take the power that a woman naturally gives to her care provider... [and who] manipulate to get that power." Instead, they feel that "a constant responsibility of being a midwife [is] throwing [the clients] back their power."

The midwives attempt in various ways to keep their clients from adopting a passive, dependent role (cf. Peterson 1983). Some have their clients monitor their own urine and weight and keep their own charts, to emphasize clients' responsibility for their own health and that of their babies. One midwife reported "purposely on at least one [prenatal] visit [coming] on as just a normal person that is just as untogether as anyone else in this town ...to keep them from giving me their power."

The midwives see their role as facilitating rather than directing the birth. They consider themselves simply "an extension of the birthing team. The doctor, by and large, is someone who comes to catch a baby. We're there to share labor—the end result being birth."

Thus, midwives are generally open to clients' ideas about how to conduct birth. Almost all encourage the father to catch the baby, cut the umbilical cord, and in other ways take an active role in the birth process. If the baby looks healthy after the shoulders are born, the mother is asked to reach down and bring the baby up onto her belly. In these ways, midwives achieve their goal of "making sure that in the end, they [the parents] feel like they did it. That's the most important difference [between midwives and doctors]—they delivered their baby, we didn't."

The midwives' language reflects their desire to maintain egalitarian relationships. They are careful to refer to the women they attend as *clients* or *ladies* rather than as *patients*. One who used the term *patient* during an interview quickly corrected herself. Most describe the mother as "delivering" the baby which the midwife only "catches."

Despite the midwives' ideological commitment to egalitarian relationships with clients, licensure has pressured them toward a more hierarchical style. As licensed practitioners, the midwives are aware of their legal responsibilities in assisting women in childbirth. Although they are neither supervised nor observed, they must file reports with the state after each birth. In addition, their work becomes observable to a largely hostile audience whenever they must transfer a case to medical care, either before or after delivery. One midwife who had initially worked illegally explained that licensing made her responsibilities more burdensome

> because [now] it's open to the public.... There are doctors wanting to know about it. There are nurses wanting to know about it. There are nurse-midwives wanting to know what you're doing. There's a consumer that wants to know what you're doing. You as a midwife have a greater responsibility because you have all these people to consider. Before then, you only had to consider and cover up your own fanny and that person that you were helping at that time.

During the last four years, 29 percent of midwives' clients have been transferred to medical care (Sullivan and Beeman 1983). One of these incidents led to the suspension of a midwife's license. The midwife involved delivered an unexpected breech baby, contrary to regulations, because she felt medical assistance would not be available in time. Another midwife had her license revoked for falsifying records. She did so to cover the fact that she had, against regulations, allowed a couple to deliver at home a baby which had died *in utero*.

Although most midwives state that the couple has the responsibility for any decisions made during pregnancy and childbirth, all but one add that they would either override those decisions or terminate care if safety or their licenses were threatened: "When it comes down to it, I decide, 'cause it's my ass. It's their life and their baby, but it's me and I have to protect my license. One baby—taking a chance for one mother—putting myself out there is not worth it. I want to deliver a lot of babies."

The midwives generally have clients sign agreements acknowledging that midwives must work within the state's guidelines and accepting their judgment regarding the need for consulting or transporting.

Licensure also has contributed to a more hierarchical style of practice by facilitating changes in the nature of the clientele. According to the midwives, when midwifery was an underground activity, midwives and their clients were more likely to come from the same subcultures and hold similar values. Persons choosing home birth with an illegal midwife generally were committed to their decisions and motivated to study, prepare, and take responsibility for their births. Now that midwives advertise in newspapers, telephone books, and with bumper stickers proclaiming that "Midwives Deliver," clients represent a broader spectrum of society. The midwives complain that, unlike in the past, many clients now choose them simply because they are cheaper than the alternatives. Hence, clients may come to midwives with the same expectations for handing over control that they would normally take to physicians. The midwives feel that they must constantly struggle to force such clients to take back responsibility for their births; one midwife cited this problem as the major reason she has reduced her practice significantly. At the same time, the lack of a shared set of values between client and midwife may increase the psychological distance between them, thereby increasing the likelihood of more hierarchical interactions.

The setting in which many of the midwives now practice and their changing self-presentation also can reinforce hierarchical patterns. Some midwives find that they can no longer operate efficiently in the informal settings of their homes or those of their clients. Six have established offices in their homes or elsewhere with waiting and examining areas and medical equipment, including three who run a fully equipped clinic and provide all basic medical care for their isolated rural community. Another seven provide all prenatal care at the local free clinic. The medical appearance of these offices may encourage both clients and practitioners to fall back on hierarchical patterns of behavior developed in past experiences with medical personnel.

Hierarchical patterns also can result from the midwives' changing self-presentation. Several report conscious attempts to dress and act more professionally, in order to inspire confidence and respect in clients and medical personnel: "I was from the hippie era. And I didn't dress so nice and a lot of people were offended by that when I was a student midwife.... So I've started changing that since I've been licensed.... If I think I'm going to go to the hospital..., I put on some white pants. If I think it's going to be a transport, I dress a lot straighter." Such behavior may unintentionally encourage more hierarchical relationships with clients if clients are now more likely to view midwives as professional authorities.

The midwives are aware of the potential costs of moving toward a more professional self-presentation. One woman quoted above went on to state, "I try to look professional and carry myself like a professional, but I feel like in midwifery you can be so professional, and have the touch not be there. You can be like a doctor and do fifteen to twenty births a month, and I never want midwifery to be like that."

Most of the midwives are working to find a balance between the realities of their everyday situation as licensed practitioners and their belief in quality, nonhierarchical care.

DISCUSSION AND CONCLUSION

Previous literature on lay midwifery has tended to equate midwifery with demedicalized care. Our research shows a more complex pattern. In the fifth year of an active licensing system for lay midwives, we find that the midwives have moved in some ways toward a medical model of childbirth.

Licensing has been a major force pressuring midwives to change their patterns of care because it has increased the midwives' exposure to medical definitions of childbirth and made them legally accountable to the medical-dominated state Department of Health Services. As one midwife explained, licensing

> has made me transport people that I wouldn't have, that I normally would have been more willing to just stay at home. As I have seen in my very early days [before licensing], some of the things that we practiced then, the women come out just fine. Just fine. And it [licensing] has made me be paranoid about certain areas—meconium staining, prolonged labor, and postpartum hemorrhage, and using any kind of herb at all that I could have in the past.

Licensing is not solely responsible for the move toward a medical model of childbirth, however. This process also seems to derive from (1) the midwives' cumulative experience with handling obstetrical problems, augmented by their knowledge of problems faced by other midwives, and (2) the growing social acceptance of midwifery, which has led to changes in their clientele, the need for bureaucratic practice settings, and the desire to earn a living at midwifery. To the extent that the experience and growing social acceptance of midwives are not dependent on either licensure or legalization, similar movement toward the medical model and away from radical beliefs and practices may occur in other states.

The pressures toward changes in practice and ideology faced by licensed midwives are by no means unique. These pressures toward more conservative styles parallel those encountered by radical social movements, other marginal occupations, and voluntary groups providing nontraditional services. Whenever groups promoting radical ideas gain or attempt to gain broader acceptance, the potential for cooptation exists. As social movements grow, for example, their membership usually broadens to include individuals with more conservative ideas and motivations than the movements' founders (Turner and Killian 1972). This parallels the change in clientele faced by licensed midwives. Additionally, as social acceptance increases, movements may become institutionalized and bureaucratized, and their leadership may develop into a professional hierarchy. This, in turn, pressures movements toward conservatism, because such professionals typically have a vested interest in maintaining the existing social structure, from which they obtain some status, power, and financial rewards.

Osteopathy provides a model of a health-related occupation which has been largely coopted in the process of gaining social acceptance (Coe 1978). To be accepted by the medical profession and, in turn, by the public, osteopaths have revised their ideas regarding disease etiology, deemphasized spinal manipulations, and modified their college curricula to resemble that of schools of medicine. The similarities now so far outweigh the differences that California grants a medical license to any Doctor of Osteopathy (personal communication, Arizona Osteopathic Medical Association, March 1983).

Parallel developments have occurred within voluntary groups providing nontraditional services. For example, as feminist consciousness-raising groups became more socially acceptable and their membership broadened, the emphasis of many groups shifted from political growth to personal growth (Nigg 1976; Weitz 1982). Similarly, as the need for shelters for battered women gained greater recognition, they became more socially accepted and garnered increasing government and foundation support. Consequently, many shelters became bureaucratized and professionalized. At the same time, the shelters abandoned their original goal of changing patriarchal society and instead aimed to provide therapy for individual women (Schechter 1982; Tierney 1982).

The midwives in this study are conscious of the potential for cooptation in their current situation. They are wrestling with the conflict between their beliefs and the realities of practice under licensure and are attempting to find a balance which will allow them to provide the best possible care for their clients.

DOCUMENTATION

Authors' Note

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Part V

Overlapping Responsibilities

Preface

Although previous sections of this volume focused on caregiving in specific domains, the first chapter in this section examines women with dual caregiving responsibilities. Like other authors in this collection, Marshall, Barnett, Baruch, and Pleck note that women provide more domestic caregiving than men and that they are more likely to enter paid caregiving occupations. Relying on quantitative measures, Marshall et al. demonstrate that caregiving in each domain can have a negative impact on mental and physical health. Although some studies argue that paid work shields women from domestic strains, these researchers contend that women who assume caregiving obligations both at home and at work are especially likely to report symptoms of anxiety and depression. The authors conclude that only a broad transformation of both the domestic arena and the structure of paid employment can ensure that women who care do not pay a heavy price for their efforts.

The following two chapters focus on relationships between caregivers in different domains. Many observers believe that family responsibility for the frail elderly ends with institutionalization, but Bowers shows that relatives do continue to provide care for nursing home residents. Family members believe that their participation is particularly important because they retain primary responsibility for "protective care," designed to protect or preserve a person's sense of self. Some relatives seek close collaboration with paid staff in order to teach them to provide this type of care. When cooperation falters, family members devise strategies to alter the behavior of nursing assistants: they tell stories that illustrate their relatives' unique personalities and demonstrate explicitly the way specific tasks should be performed. Because Bowers relies almost exclusively on information furnished by family members, she cannot reveal the attitudes of institutional staff. This chapter should be read in conjunction with two chapters in Part III. Lundgren and Browner suggest that low-paid chronic-care workers often have their own motivations for delivering the personalized care families demand. Diamond highlights the structural impediments that retard the ability of nursing assistants to render such care.

While Bowers concentrates on the goals of family caregivers, Wrigley analyzes the ideology guiding the actions of two groups of formal providers. Her essay reminds us that factors of social class determine the balance of power between paid and unpaid caregivers. Like most other Progressive reformers, the charity workers who established day nurseries at the turn of the century viewed the poor with hostility and suspicion and sought to inculcate middle-class values. Because low-income women desperately needed the services these nurseries offered, they had no option but to subject themselves to moral scrutiny and place their children in the care of women whose culture clashed sharply with their own. Although the founders of nursery schools in the 1930s viewed their predominantly middle-class clientele more favorably, these parents, too, were subject to censure because they lacked expert knowledge. Most clients currently have more power vis-à-vis workers in both nursery schools and day care centers; nevertheless, Wrigley argues, issues of class continue to shape interactions between parents and staff. Moreover, child care workers who seek to advance their own status by laying claim to professional expertise implicitly devalue the experientially-based knowledge of parents.

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Double Jeopardy: The Costs of Caring at Work and at Home

Nancy L. Marshall, Rosalind C. Barnett, Grace K. Baruch, and Joseph H. Pleck

Traditionally, women have had primary responsibility for caring for others. Although many women find this responsibility gratifying, it can also be a source of stress and thus have negative consequences for women's mental and physical health. Women are also vulnerable to the stresses of caring in the labor market. Many of the women now in the labor force are employed in the expanding service sector of the economy as direct service providers in the fields of health and social service. This chapter examines whether women responsible for caring both at home and at work face a double jeopardy.

Numerous researchers document women's greater involvement in caring for significant others, including members of their immediate families, extended family members, and friends. In studies of marriages, husbands are more likely to rely on their wives as confidants than wives are on their husbands (Lowenthal and Haven 1968; Veroff, Douvan, and Kulka 1981). Historically, women have been the primary caregivers of young children, the elderly, and the ill. Studies of social networks show that women are more likely than men to be named as counsellors, companions, and providers of emotional support (cf. Fischer 1982). Women often do the daily work needed to maintain extended family networks (Bott 1971; Stack 1974; Young and Willmott 1962) and are responsible for establishing and maintaining larger social networks from which they can draw resources for themselves and their families (Gilligan 1982; Kibria 1985).

Not only are women more likely to be engaged in these "network caregiving" activities than men, but they appear to be more vulnerable to psychological distress because of their involvement in the lives of others.[1] Kessler and McLeod (1984) compared women's and men's reports of major life events. Men and women responded in similar ways to marital disruption and income loss, but women reported more events occurring to others in their networks, and they were more vulnerable to these events. Kessler and McLeod demonstrated that much of women's greater vulnerability to depression and anxiety can be explained by their greater exposure to other's stress and their greater emotional responsiveness to other's difficulties.

Many women also have caregiving responsibilities at work. Almost one-half (43 percent) of employed women hold jobs in the service industry, the majority as nurses, teachers, social workers, housekeepers, and members of other caregiving occupations. Although women represented just 44 percent of the labor force in 1985, they constituted 61 percent of the employees in the service industry (professional, personal, business and repair, and entertainment and recreation services). The service industry's share of the labor force almost doubled between 1950 and 1980, growing from 13.7 percent to 24.1 percent. As the U.S. economy continues to shift from a concentration of jobs in goods-producing industries to jobs in service-producing industries, we can expect the employment of women as caregivers to increase.

Research on mental and physical illness related to "stressors" on the job has identified the importance of job demands such as work load, deadlines, or conflicting tasks (Caplan et al. 1975; Quinn et al. 1971; Theorell 1976). Although much of the research on occupational stress has focused on men (Baruch et al. 1987), employed women also experience this type of stress. However, caregiving occupations can be expected to differ from other occupations in the *nature* of the demands. The demands of such jobs may include the following:

1. Working with clients or patients in crisis;
2. Dealing with issues, such as abuse or death and dying, over which the care provider may have little control;
3. Being asked to give more than the provider is capable of emotionally;
4. Seeing little change as a result of the caregiver's actions;
5. Being responsible for a large number of people in need of care.

To some extent, these demands are inherent in the nature of caregiving; caring means responding to the needs of others. However, the demands of caregiving occupations can also arise from, or be increased by, the conditions of the job. Women in caregiving occupations who are also responsible for network caregiving may experience a double burden, with adverse consequences for their mental and physical health.

THE STUDY

The research reported in this chapter is part of a larger study of occupational stress and health among 404 women employed as social workers or licensed practical nurses (LPNs). The sample was randomly drawn from women who were between the ages of twenty-five and fifty-five, living in eastern Massachusetts, and listed in the registries of these two occupations. Black women were oversampled; 15 percent of the respondents were black. The sample also was designed to include a variety of household types. As a result, 30 percent of the women were parents and married or living with a partner, 27 percent were single parents, 18 percent were married or living with a partner and did not have children, and 25 percent were single (never married, separated. or divorced) women who did not have children.

This chapter describes the experiences of the 326 respondents who reported that their jobs always or almost always involved responsibility for clients or patients. The interviews lasted an average of two hours and included both closed- and open-ended questions about each woman's job, her family and friends, and her mental and physical health.

The Burden of Social Network Caring

Jane Wilson is married to a man who had a massive heart attack last year and is still very sick. In addition, her own parents are in their late seventies; her father is ill, and Jane has been involved in his care. Jane worries about having to take care of her mother when her father dies.

Marsha Smith's father died this year after a long illness. She too is concerned about her mother's health and her own responsibility to care for her mother. In addition, a close friend of hers is sick with bone cancer, and Marsha visits her regularly and accompanies her to the doctor.

Susan Brown lives with her mother and her younger brother and sister. Her older sister and her sister's child came to live with them recently after their home burned down. Susan's older sister is not employed. Susan is concerned that her mother, a diabetic, will have to stop working and that Susan then will be the only wage earner in the household.

Pat Murphy says "love is hard work." She and her husband raised three children, one of whom had a serious illness a few years ago. Two children are still living at home. Her father-in-law has Parkinson's disease and recently had a stroke. She has been visiting him daily in the hospital; her in-laws will come to live with her when he is released from the hospital.

Each of these women is experiencing a high level of burden from her caring responsibilities for people in her network of significant others, including immediate family, parents and parents-in-law, and friends. We measured this burden using a Burden of Network Caring Scale, which asked respondents to evaluate how true each of the following items was for them, when thinking about the people who are important to them:

1. "People ask more of me than I can give."
2. "I feel that I don't really get all the help I need."
3. "The people I care about make too many demands on me."

This scale is internally consistent, with a Cronbach's alpha of 0.81. (The Cronbach's alpha test is a measure of the extent to which a given respondent responds in similar ways to all items in a scale.)

Contagion Stress

Women's greater involvement with others can negatively affect their mental and physical health when they experience a sense of burden from the demands of caring; it can also expose women to others' stresses. Exposure to others can lead to "contagion stress" in various ways, including worrying about other people's problems, feeling unable to help important others, or blaming oneself for others' difficulties. We measured the respondents' exposure to people in difficulty using the Contagion Stress Scale, which included the following two items:

1. "Some of the people I care about have problems I can't solve."
2. "Some of the people I know are having difficult times right now."

This scale is internally consistent with a Cronbach's alpha of 0.60.

The Contagion Stress Scale is different from the Burden of Network Caring Scale. Women may have high scores on both scales—Marsha Smith is one example. However, other women who experience high burden because of their involvement in caretaking may feel that they actually can help with the problems of others and so have lower Contagion Stress scores; this is true for Jane Wilson.

A low score on the Burden Scale does not necessarily ensure a low score on the Contagion Scale. Some women who are not involved in regular caretaking for friends and family still have family and friends with difficult problems and therefore may have high Contagion Stress scores. Rachel Jones, for example, has three children in their twenties. Only the middle one is doing well. The youngest was in reform school during adolescence and continues to have "serious problems." Her oldest is currently serving a jail term. Because the children live far away, they do not burden Rachel with requests for assistance. Nevertheless, her children are a source of serious concern to her.

The Costs of Caregiving at Work

Karen Barnes is the leader of a team of clinicians who provide assessment and treatment for victims of child sexual abuse, their families, and offenders. Her clinical work requires her to deal with emotionally difficult situations and respond to families in crisis. She also must interact with a complex structure of agencies involved in the identification and treatment of child sexual abuse. As the supervisor of the team, she also must help other clinicians respond to difficult situations and crises.

Mary Connors is an LPN on a medical-surgical floor with thirty-four patients. She is personally responsible for between eleven and seventeen patients each evening and only occasionally has a nurses aide to help out. Mary is responsible for complete care for these patients, including treatments, teaching, medications, feeding, physical therapy, and chest physiotherapy, as well as for documenting the care of each patient. Because the hospital is short staffed and has recently hired many new inexperienced nurses, she often has more responsibilities than she can manage and must provide on-the-job training for new nurses. Supervisors and administrators recognize the problem of overload but tell Mary to do the best she can and just keep the patients breathing during her eight-hour shift.

Joan Matthews is an elementary school guidance counsellor. She provides individual counselling to students with social and emotional needs, and group counselling to students about self-awareness, drug and alcohol abuse, sexuality, and death and dying. Joan is responsible for identifying special needs children and serves as a case manager for these children, advocating for programs to meet their needs. She also provides support to teachers with classroom problems and counsels the parents of the students.

Chris Price is a social worker in a community health center. Her caseload consists primarily of clients with serious psychiatric diagnoses. She says about her job: "Emotionally, it's draining. The cases I see are so difficult, and handling all the paperwork is impossible."

These women all hold jobs with heavy caregiving demands and all experience high costs of caregiving at work. We took a slightly different approach in measuring the costs of caregiving at work; we asked the respondents not only whether certain statements about their job conditions were true, but how concerned they were about these job conditions. Respondents' concerns about their jobs focused on the demands of the job, poor supervision, discrimination and lack of respect, low wages, and hazardous working conditions. The Costs of Caregiving at Work Scale measures how concerned the respondent is about the following items:

1. "Having to deal with emotionally difficult situations."
2. "The job's taking too much out of you."
3. "Having too much to do."
4. "Having to juggle conflicting tasks or duties."
5. "Other people being dependent on you."

It was impossible to separate concerns about work load from concerns about people and their problems. This is an important feature of caregiving jobs; the work load is a direct reflection of caregiving responsibilities. The extent to which each of these items is related to others is reflected in the internal consistency of the scale, which had a Cronbach's alpha of 0.76.

The Impact of Caring on Women's Health

We measured mental and physical health in four ways, including the depression and anxiety subscales of the Symptom Checklist (SCL–90), as a measure of the level of psychological distress (Derogatis et al. 1974); a fourteen-item subjective well-being scale developed by the Rand Corporation (1981); a measure of the frequency and discomfort of twenty—nine physical symptoms; and a single item, asking respondents to compare their health to that of other women their age.

The social workers and nurses who reported greater costs from caregiving at work, greater burden from their social networks, or greater contagion stress had poorer mental and physical health than did other women (see Table 13.1).[2] The relationship of each of the costs of caring scales to each of the measures of mental and physical health is statistically significant. In other words, these findings are not the result of chance. If we were to examine other women who are employed as social workers or LPNs, we would find that those women who experience greater costs of caregiving also would have poorer mental and physical health. Because health can vary with age, race, and income, the analyses reported in Table 13.1 control for these factors. That means we can say that, holding the impact of age, race, and household income constant for all the women in the sample, greater costs of caring at work or at home are related to poorer health.

TABLE 13.1
R SQUARES OF REGRESSIONS OF THE COSTS OF CARING ON MENTAL AND PHYSICAL HEALTH, CONTROLLING FOR AGE, RACE, AND HOUSEHOLD INCOME

	Psychological Distress	*Subjective Well-Being*	*Physical Symptoms*	*Health*
Burden of Network Caring	0.12 ****	0.15 ****	0.12 ****	0.05 *
Contagion Stress	0.07 ***	0.04 *	0.05 *	0.05 *
Costs of Caregiving at Work	0.21 ****	0.11 ****	0.05 *	0.05 *
N	307	306	303	306

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ **** = $p < 0.0001$

The R square values reported in Table 13.1 are statistics derived from the regression analyses. Each R square represents the proportion of the variation in mental or physical health that is explained by the given measure of the costs of caring, plus age, race, and income. For example, the costs of caregiving at work, along with age, race, and income, explain 21 percent of the variation among women in psychological distress, while the burden of social network caring, along with age, race, and income, explains only 12 percent of the variation in psychological distress.

The next question we asked was: given a certain level of cost from social network caring, does cost from caregiving at work have an additional impact? Our analyses show that, holding constant the level of costs from network caring, women with greater costs from caregiving at work experience greater psychological distress and poorer mental and physical health (see Table 13.2). Conversely, holding constant the level of costs from caregiving at work, women with greater burden from network caring experience greater psychological distress and poorer health and well-being, and women with greater contagion stress experience greater psychological distress and poorer health.

Table 13.2 shows the unstandardized regression coefficients, which are the weights assigned to each of the costs of caring measures; unstandardized coefficients are not adjusted for differences in scale metrics and cannot be compared to each other. The coefficients that are asterisked are statistically significant at the level of probability indicated. For example, the coefficient for the Costs of Caregiving at Work in the regression on psychological distress is significant at the $p < 0.0001$ level. That means that there is less

TABLE 13.2
UNSTANDARDIZED REGRESSION COEFFICIENTS
FOR REGRESSION EQUATIONS WITH ALL THREE COSTS INCLUDED,
CONTROLLING FOR AGE, RACE, AND HOUSEHOLD INCOME

	Psychological Distress	*Subjective Well-Being*	*Physical Symptoms*	*Health*
Burden of Network Caring	1.13 ***	−1.55 ****	1.62 ****	−0.07
Contagion Stress	1.05 *	−0.28	1.28 *	−0.02
Costs of Caregiving at Work	1.58 ****	−0.89 ****	0.52 *	−0.02
N	307	306	303	306

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ **** = $p < 0.0001$

Note: High scores on Psychological Distress and Physical Symptoms indicate poor psychological or physical health. High scores on Well-Being and Health indicate good psychological or physical health.

TABLE 13.3
UNSTANDARDIZED REGRESSION COEFFICIENTS
FOR EQUATIONS WITH SIGNIFICANT INTERACTION TERMS

	Psychological Distress	*Subjective Well-Being*	*Health*
Burden of Network Caring	3.50 ***	−3.78 ****	−0.20 *
Contagion Stress	1.08 *	−0.31	−0.07
Costs of Caregiving at Work	2.96 ****	−2.18 ****	−0.13 ***
Interaction of Network Burden with Caregiving at Work	−0.20 ****	0.19 *	0.02 *
N	307	306	306

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ **** = $p < 0.0001$

than one chance in 10,000 that the Costs of Caregiving at Work is not significantly related to psychological distress, after holding constant the other costs of caring, as well as age, race, and income.

Not only do the costs of social network caring and of caregiving at work have significant, independent effects on mental and physical health, but women with high costs of caring at work and at home were at greater risk than women with high costs in only one domain. To examine this issue statistically, we added the interaction of the Burden of Network Caring with the Costs of Caregiving at Work to our equation. As Table 13.3 shows, this interaction term is significant for the regressions on psychological distress, subjective well-being, and the single item measure of health. (Because the interaction term did not significantly increase the R square for physical symptoms, these data are not included in Table 13.3. Similarly, the interaction of the Costs of Caregiving at Work and Contagion Stress is omitted from the table because it did not significantly increase the R squares.)

Figures 13.1 and 13.2 demonstrate graphically what happens to women's mental and physical health when they experience high costs from both caregiving at work and network caregiving. Women with both low costs of caregiving and low network burden have the lowest levels of psychological distress. As Figure 13.1 shows, at moderate or low levels of the Costs of Caregiving at Work, an increase in the Burden of Network Caring raises the level of distress.

Figure 13.2 shows that the reverse is also true. At moderate or low levels of the Burden of Network Caring, an increase in the Costs of Caregiving at Work raises the level of distress. As both figures show, when

FIGURE 13.1

EFFECTS OF BURDEN OF SOCIAL NETWORK CARING ON PSYCHOLOGICAL DISTRESS AT VARYING LEVELS OF COSTS OF CAREGIVING AT WORK

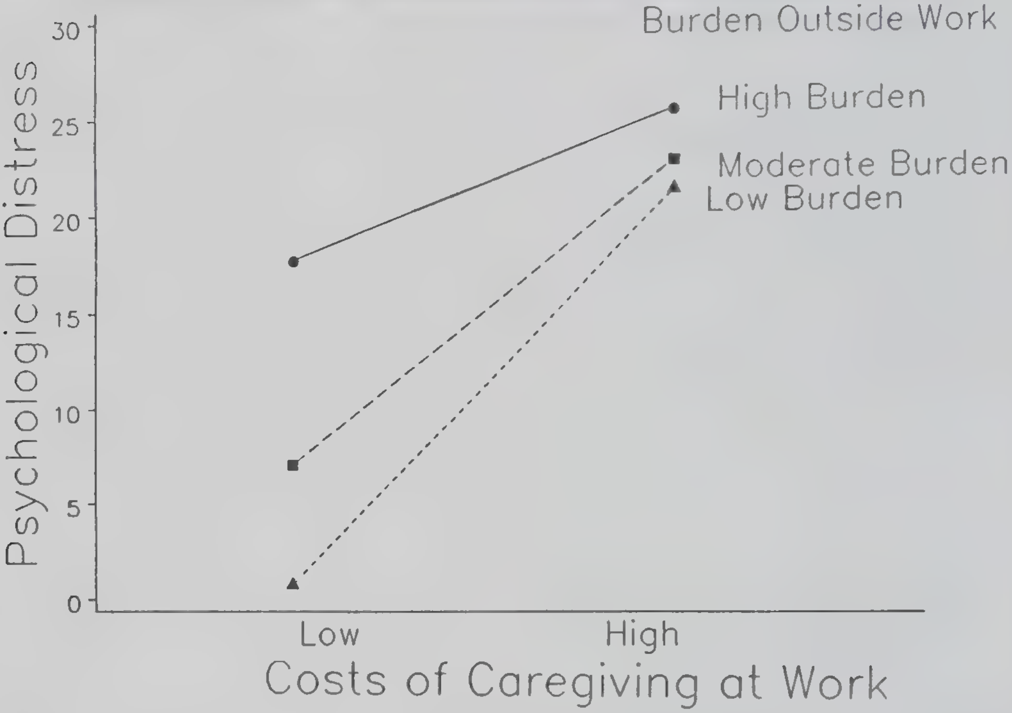
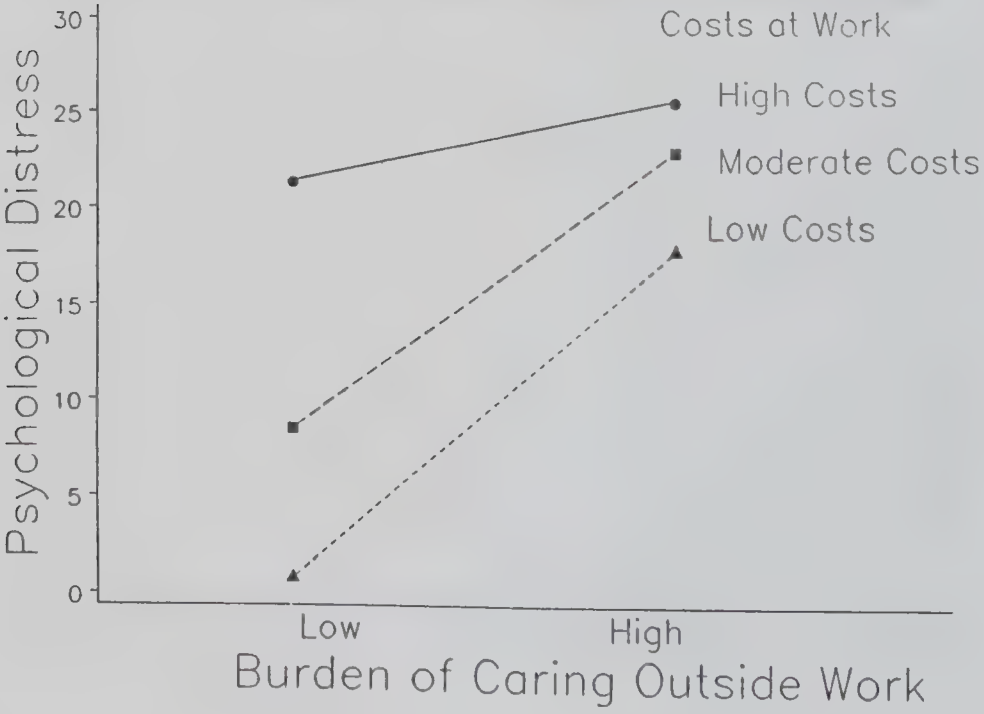


FIGURE 13.2

EFFECTS OF COSTS OF CAREGIVING AT WORK ON PSYCHOLOGICAL DISTRESS AT VARYING LEVELS OF SOCIAL NETWORK CARING



either cost is high, the other cost adds relatively little to an already high level of distress. However, women with high levels of costs of caring at work and at home have the highest levels of psychological distress. Similar patterns hold for subjective well-being and health.

DISCUSSION

Like many other women, the nurses and social workers we interviewed care for children, parents, other relatives, and friends. When this caring taxes their personal and material resources, or when they experience contagion stress from exposure to the problems of others, they are at high risk for psychological distress, poor health, and reduced well-being.

In addition, the women in this study are employed as caregivers, helping others through counselling, advocacy, and direct physical care. Other segments of our research have demonstrated that paid employment is "good medicine" for women because it buffers them from the strains they experience in the domestic arena (Barnett, Baruch, and Marshall 1987). But when women face overwhelming demands from caregiving at work, their mental and physical health suffers.[3]

It therefore is imperative that we find ways to reduce the costs of caring. Some of these costs are inherent in the activity itself. Caregiving means *responding* to others and thus is not as easily structured or limited as other types of work. But many of the costs of caregiving result from heavy work loads and limited resources. In addition, direct service jobs typically are poorly paid and offer limited autonomy and challenge. Women often find network caring difficult because they shoulder much of the responsibility alone and receive little emotional and material support.

We thus can reduce the costs of paid caregiving by limiting caseloads and providing adequate resources and supportive supervision for service workers. In addition, we should work to ensure that caregiving jobs offer decent pay, autonomy, challenge, routes for advancement, and opportunities to make a real difference in clients' lives (see Marshall et al. 1988).

We can reduce the costs of network caring by providing caregivers with adequate support and by distributing this work more equitably between women and men. Employers should recognize that men as well as women occasionally must reduce their work hours or take time off to care for ailing parents and sick children. In addition, our society should stop relying on the unpaid, and often unacknowledged, labor of network caring and provide paid caregivers when the burdens become overwhelming.

These changes are necessary to ensure that women such as Pat Murphy and Karen Barnes no longer face a double jeopardy.

DOCUMENTATION

Authors' Note

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Notes

1. It has been argued that women are not more vulnerable to depression and anxiety, but simply more willing to report it. However, Kessler and McLeod's findings that women and men respond in similar ways to marital disruption and income loss, but not to network events, suggest that this is, at best, only a partial explanation of the high levels of depression and anxiety found among women.

2. Our theoretical model posits that greater costs from caregiving at work, and the other independent variables, cause poorer mental and physical health. However, it is possible that women in poorer health are more easily overwhelmed by difficulties at work and in their networks. Longitudinal analyses are necessary to untangle the direction of effect.

3. It may be that the combination of any job and network caregiving is stressful. However, jobs that involve caregiving have been identified as among the most stressful. The resolution of this question awaits investigation of the costs of caring among women and men in different occupations.

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14

Family Perceptions of Care in a Nursing Home

Barbara Bowers

Although family members frequently experience care for the frail elderly as an individual problem, it rapidly is becoming one of our most pressing public issues. But public debates about long-term care tend to be framed in terms of finances rather than human needs. Because emphasis is placed on containing costs, families are encouraged to provide additional care. Political and religious leaders chastise family members for not caring for elderly relatives, citing the increasing use of nursing home beds as evidence of declining familial obligation (Gilder 1981; Hatch 1982a; Hatch 1982b; *San Francisco Chronicle* 1983).

In response, several scholars have documented the existence of an extensive informal caregiving network. They have measured the dollar equivalents of labor provided by family caregivers, assessed the number of nursing home placements prevented, and chronicled the emotional and physical consequences of informal care for family and friends (Archbold 1980; Brody 1981; Cantor 1983; Finch and Groves 1983). These studies, however, have focused on caregiving within the domestic arena. Few examine family care rendered in institutional settings. One reason for this oversight is that placement in a long-term care facility frequently is equated with the termination of family care. According to a widely held assumption, families simply abandon the elderly persons they transfer to nursing homes (Bengtson 1978; Bowers 1988; Brody and Spark 1966; Chenitz 1983; Dobrof and Litwak 1977; Fauerbach 1984; Gitelson 1977; Montgomery 1982; Simos 1970; Smith and Bengtson 1979; Tobin and Lieberman 1976; York and Caslyn 1977). But many relatives of nursing home residents do continue caregiving work. This type of family care is even more invisible than that provided at home.

Although research on such family caregiving is scanty, the little that exists suggests that the quality of relationships between caregivers and care recipients mirrors that of relationships before institutionalization (Chenitz 1983; Hook, Sobal, and Oak 1982; Smith and Bengston 1979). Because the move to a nursing home relieves family members of the burdens of heavy physical care, however, some families experience renewed closeness and affection after transfer to a nursing home (Black and Bengtson 1977; Chenitz 1983; Dobrof and Litwak 1977; Smith and Bengtson 1979). The precipitator of nursing home placement typically is deterioration in the health status of either the frail elderly person or the caregiver, rather than a decline in familial commitment (Bengtson 1979; Brody 1966; Brody and Spark 1966; Miller and Harris 1965). The majority of family members providing care are elderly themselves, and some suffer from debilitating chronic illness. Many caregivers simply are unable to continue providing care that is physically demanding and emotionally exhausting. Because Medicare, Medicaid, and private health insurance rarely reimburse home care, family members often can obtain relief only through transfer to a long-term care facility.

Nursing home staff typically welcome family involvement. However, this type of care can create tensions and conflicts. Some staff members perceive family involvement as interference with their own work and unhelpful to the residents. Many researchers thus recommend that family and staff clearly separate their obligations (Bennett 1980; Black and Bengtson 1977; Dobrof and Litwak 1977; Fauerbach 1984; Lieberman 1969; Litwak 1981; Reifler, Cox, and Hanley 1981). For example, they suggest that staff should assume responsibility for such instrumental tasks as bathing, feeding, and dressing, while family members retain responsibility for affective tasks, such as providing emotional support, reminiscing, and visiting (Chenitz 1983; Fauerbach 1984; Rubin and Shuttlesworth 1983; Shuttlesworth, Rubin, and Duffy 1982).

In a recent study of adult daughters caring for aging parents, however, I challenged the usefulness of distinguishing between caregiving tasks in this way (Bowers 1987). The women I interviewed conceptualized their caregiving work in terms of purpose rather than tasks. The adult daughters in my study placed a priority on protective care (protecting or preserving the parent's sense of self and the parent-child relationship).[1] This was especially true when their parents had either a mild or moderate form of dementia. In many cases, the women preferred to risk physical harm to their parents rather than confront them with the reality of their growing cognitive impairments. This emphasis on fostering their parents' dignity accounted for much of what professional health care providers simplistically have labelled *noncompliant behavior.*

METHODS

This chapter reports the results of a study that sought to understand the experience of family members providing care in nursing homes. The study demonstrates the extent to which family members continued to be concerned with protective care and investigates how this concern shaped their interactions with staff members. The study took place in a moderate-sized nursing home located in an urban area in Wisconsin. The facility resembles others in the area in terms of patient characteristics, staffing patterns, and reimbursement sources. During the week, five professional nurses work on the day shift, four on the afternoon shift, and two on the night shift. Most of the direct patient care is provided by nurses aides. There are sixteen aides on the day shift, eleven on the afternoon shift, and six on the night shift. In addition to nurses and nurses aides, the nursing home employs one full-time physical therapist, one part-time recreational therapist, and one full-time social worker.

All of the eighty-five family members listed as "first contact" in the patients' records were invited to participate in the study. The twenty-eight relatives who agreed included nine daughters, six wives, four sons, four nieces, two husbands, two nephews, and one sister. The majority (71 percent) of first contacts and those who agreed to be interviewed were women. Daughters constituted the largest percentage of both groups. The majority of these daughters did not also have young children to care for or jobs outside the home. Because the average age was over 60, most were retired from former jobs and had grown children. When compared geographically, the family members who agreed to be interviewed were similar to those who did not respond. Only three of the eighty-five family members lived farther than fifty miles from the nursing home. Another characteristic shared by both those who responded and those who did not was their working-class status. About one-half of the families lived in an urban working-class neighborhood, while most of the rest were from farms in the surrounding area. All families were white. Only a few caregivers (but none of the residents) were from upper middle-class homes or employed in white-collar occupations.

According to the director of nursing, sixty of the eighty-five family members contacted were frequent visitors. All twenty-eight family members who agreed to be interviewed fell within this group. Some visited daily, others weekly. Ten of the first contacts visited less than once per month. The remaining fifteen contacts were decribed as visiting rarely (less than once per year) or never.

Fourteen family members stated that their relatives were not confused. Of the rest, seven described their relatives as mildly or occasionally confused, four as moderately confused, and four as severely mentally impaired.

Interviews lasted between one and three hours and contained a number of open-ended questions. Caregivers first were asked to discuss their general perceptions of the care provided by the staff, the nature and extent of their own involvement in their relatives' care, and the quality of their relationships with the staff. Early interview questions included (1) "What is it like to have a relative in a nursing home?" (2) "How are you involved in your relative's care?" and (3) "Have you had any problems with the staff?"

Caregivers next were asked a series of questions about the purpose of the care they provided, such as (1) "Is your involvement in your relative's care important?" (2) "If yes, how?" (3) "What would happen if you stopped providing that care?" and (4) "Is the care you provide different from that provided by the staff?"

Because just four interviews were conducted with members of the licensed nursing staff and none with nurses aides, this study primarily reflects the perspectives of the family caregivers. In order to gain a deeper understanding of relationships between formal and informal caregivers, we also must hear the point of view of formal health care providers.

RESULTS

Like the adult daughters in my earlier study, the relatives of nursing home residents with whom I spoke drew a distinction between protective and instrumental care. They viewed themselves as being primarily responsible for the former, nurses and aides for the latter. But they also insisted that the two types of care were closely linked. They stated that their ability to render protective care depended on staff cooperation. Conversely, they asserted, staff members needed family participation and input in order to provide care that was not only technically proficient but delivered in such a way as to protect residents' dignity or sense of self. Family members thus sought to monitor and evaluate the quality of the tasks staff members performed, teach the staff how to render better care, and compensate for what they viewed as deficiencies in the care their relatives received. According to the perspective of these family members, high-quality care rests on close collaboration between family and staff, not a division of labor. The family members I interviewed engaged in four types of protective caregiving—maintaining family connectedness, preserving their relatives' dignity, bolstering their relatives' hopes for recovery, and helping their relatives assert control over their environments. Each type required a variety of tasks.

Relatives sought to maintain the residents' sense of continuing familial ties by visiting the nursing home, taking residents on day trips, and placing memorabilia in the room. Family members were eager to engage in such activities, and they described few tensions between themselves and the staff in relation to this type of care. The other types of protective care, however, often brought relatives into direct conflict with members of the staff.

Family members sought to preserve the dignity of their relatives by helping them maintain a sense of competence and personal uniqueness. More than one-half of the family caregivers to whom I spoke were distressed by the messy personal appearance of their relatives, the release of intimate information to outsiders, or the lack of respect paid to individual differences, all of which they considered assaults on their relatives' dignity. Family members described humiliating situations that occurred in relation to difficulties surrounding such routine activities as eating, dressing, and toileting. For example, families believed that staff members were insensitive to the impact of spilled food on the elderly residents. They thus wanted their relatives to receive greater assistance at mealtimes. Conversations with nursing home staff, however, revealed that the nurses saw themselves as fostering rehabilitation by encouraging the residents to be as independent as possible in self-care activities; they interpreted family demands for increased help as undermining such efforts.

Projecting a competent sense of self into the future by maintaining relatives' hopes of recovery also was very important to many families. They tried to protect their relatives from full knowledge of their deficits, and they criticized staff members who confronted the residents with the reality of their conditions. As one daughter said about the nursing staff, "We have no complaints with the [technical] care. I think they're real good, but I don't know why they have to keep telling her that she's confused. It just makes her feel so bad...like she's not worth anything."

Although families were troubled by consequences of encouraging independence in routine activities, such as eating, family members viewed the formal rehabilitation program as crucial to bolstering the residents' hopes. One-half of the family members interpreted a reduction or termination of the physical therapy program as a signal that the staff had given up on their relatives, and they feared that their relatives would assume that their situations were hopeless. Interviews with staff members suggested that, in fact, problems with third-party reimbursement or staffing levels more frequently were responsible for the inability to continue a program of aggressive rehabilitation.

Family members also described their attempts to increase their relatives' control over themselves and their environments. They insisted that their relatives alone decide what to wear, when to get up, when to visit friends, and whether to accept medication. Many family members expressed anger when staff schedules or medical orders conflicted with the residents' preferences for timing of activities. One daughter stated, "No one ever told her that she had a hair appointment at ten. They just came and got her! She had asked for an appointment, so she wanted it, but she was terribly upset that she hadn't known about it. I mean, here it is, three minutes to ten, and they come in, grab her without any warning, 'Time for your hair appointment.' They couldn't understand why she was upset."

In short, much of the protective care rendered by family members involved attempts to undo the damage they believed had been inflicted by institutional constraints. In addition, however, family caregivers sought to prevent harm from being done to their relatives' sense of self by improving the overall quality of care provided in the nursing home. Although family members were disappointed to discover that nurses aides rather than registered nurses delivered the bulk of direct care, they generally agreed that the technical quality of this care was adequate. But they also insisted that technical care could not be divorced from protective care, meaning that the staff should provide care in a way that was not experienced by the residents as insulting, demeaning, or upsetting. It was imperative, family members stated, that their aged relatives not be made to feel that they were nuisances, or difficult to care for, or that they made silly and unreasonable requests. One caregiver remarked, "She went through times where all of a sudden she started having bladder problems, and one would say, 'Gertrude, you've got to drink more water.' And that night another would say, 'Gertrude, you've got to stop drinking water,'—because they didn't want to change her. And now she won't drink after supper because she feels she'll be scolded."

Family members did agree that technical and protective care required different types of expertise. Technical expertise was acquired through prolonged experience caring for the sick, formal training, and education. Families expected staff members to have knowledge about medications, disease processes, insurance regulations, and nutrition as well as the skills necessary for managing equipment, performing medical procedures, and physically transferring patients with limited mobility. But such technical expertise alone was not enough. High-quality care required both technical and protective care. In order to deliver protective care, caregivers also required biographical expertise. Only family members could supply this because of their intimate knowledge about the lives of their older relatives and what made them unique. Many family members described their continual efforts to personalize the staff's care of their elderly relatives, believing that the staff viewed old people as "all pretty much alike." For example, one caregiver complained:

> In my limited observation, they have never come and talked one-on-one on a regular basis—or an irregular basis—with the patients. . . . I don't think they have any more idea if my uncle was an attorney . . . or a factory worker or an astronaut before he came here. I don't think they have any idea about their interests. I don't even think they go through the motions of having interest in the person.

The staff's tendency to see residents as "all pretty much alike" was extremely upsetting to family members who perceived this as erasing the residents' personal biographies. Families talked about this in relation to how care was delivered rather than the care itself. When asked about the care rendered, family members, like most providers, focused on the technical tasks, although the *process* of caring was as significant to families as the content (tasks).

Family strategies for teaching the staff how to deliver high-quality care were primarily informal and subtle. For example, family members often told stories illustrating a particular way in which their relative was unique and where special consideration was necessary. Relatives typically presented such stories as part of casual conversation; only if staff members failed to understand their import did family members make the message more explicit.

A second, more direct, strategy was to demonstrate to staff how specific tasks should be performed. Some family members planned certain activities and conversations to coincide with staff members' scheduled appearances in their relatives' rooms. One daughter, for example, timed her visits to her mother to occur during the weekly bath. This gave her the opportunity to help her mother's aide while demonstrating how her mother liked her bath organized. The daughter thus presented herself as being helpful to staff while increasing the possibility that the quality of care her mother received in the future would improve.

A third strategy employed by families was to share with the staff the emotional consequences of inadequate care. If a resident was depressed or upset, family members sometimes reported their concerns to the staff. Once staff members were made aware of the consequences of their inadequate care, family members hoped, the staff would strive to render better care. Several family members who used this strategy described the caution with which they initially approached the staff. They simply told nurses or aides that their relatives looked depressed or agitated, thus informing them that the family was aware of the situation. If this subtle strategy failed, some family members questioned staff directly about what had happened. When staff members still did not respond in ways the family deemed appropriate, families were unsure about how to proceed. Some families brought their complaints to the attending physician, believing (mistakenly) that he or she had considerable power over staffing patterns, personnel decisions, and internal policies. Said one family member, "I finally decided the only way to fix it was to go straight to the top. So I called her doctor. I figured he could straighten [the nursing staff] out. He'd make sure they did what they're supposed to."

Others, however, refrained from pursuing a direct course, fearing the retaliatory anger of nurses and aides. One family member explained, "Once when my mother's medications were up, and they wouldn't call to check on an extension, Mother called my brother. He called to tell her doctor that the nurses wouldn't call, and the nurse went back and yelled at Mother. Mother feels she can't make waves because of repercussions."

Family members also employed a variety of strategies to acquire information about the quality of care provided by staff members. Significant by its absence was the sharing of information among visiting families. None of the family members I interviewed reported that they attempted to gain information from members of other families. Instead, family members directly observed the affective messages communicated by staff, the pace at which they worked, and the extent to which they seemed to acknowledge details unique to the older residents. In addition, families observed the quality of care provided to residents whose families were absent. A few family caregivers asked their relatives directly about the care they received when family members were not present. Because many of the elderly residents suffered from depression or dementia and several received sedating medications, however, this strategy was often ineffective. Far more frequently, family members evaluated the quality of care by assessing the outcome. If they found their older relative to be depressed, withdrawn, or agitated, they assumed that the quality of protective care was deficient. Conversely, if the residents appeared relatively cheerful, energetic, and emotionally engaged, family members assumed that they had received good protective care.

Family members repeatedly stated that they were distressed by the staff's failure to provide protective care. They perceived staff members as being narrowly focused on technical aspects of care and lacking appreciation for biographical information. About one-third of the family members complained that, although staff members routinely communicated medical information to each other and to the families, they failed to convey other crucial information about the residents. Families had assumed that biographical information given to members of one shift would be shared with others and that the staff would assist in the education process.

In the absence of effective communication among staff members, family members had to start anew with each staffing change. To further complicate the process, the unpredictability of the changes in staff and the variations in skill levels required constant monitoring and supervising.

CONCLUSION

Although earlier researchers have suggested that formal and informal caregivers can minimize conflicts and frictions by clearly dividing tasks between them, this study suggests that the boundaries between health care professionals and family caregivers cannot easily be drawn. Family members viewed technical care as being integrally linked to protective care, and they evaluated the quality of care in nursing homes against a dual set of standards. Rejecting the notion of a division of labor between themselves and nursing home staff, family members sought to promote a collaborative effort.

Because the findings from this study were based on a small sample in one nursing home, we should be cautious about generalizing to other populations. Family members may have focused on protective care as a critical component of care because they were relatively confident about the safety of their relatives and the adequacy of the technical care. Families who fear that their relatives' health or safety is at risk might believe that a concern with protective care is a luxury they cannot afford.

We also should seek to understand the experiences and perspectives of nurses and aides. How do they respond to the efforts of family members to alter their modes of behavior? Are they as unwilling to acquire biographical information as family members assume? To what extent do the conditions within which they work retard their ability to render protective care? Family members portray nurses and aides as being narrowly focused on the technical aspects of care and deficient in their ability to respond empathically to the needs of residents. From this perspective, the only hope for better care lies in giving staff members access to biographical expertise and encouraging them to incorporate this knowledge into their work. But studies of formal caregivers in a wide variety of settings suggest that many attempt to forge emotional attachments to the clients they tend. We thus can assume that some staff members in nursing homes have their own motivations for rendering personalized care, quite apart from the wishes of family members. They may attempt to meet the needs of residents because they derive gratifications from doing so, not because they wish to do the bidding of relatives.

Public policies aimed at containing the cost of nursing home care may make it more difficult for staff members to provide the type of care family members demand. When resources are limited, staff members are compelled to place greater emphasis on efficiency. Moreover, staff members who are overworked and underpaid may have little desire to offer choices to individual patients or cater to their particular preferences. Like the residents they serve, nurses aides have little control over their daily lives in institutions. They typically are assigned a group of patients, are rotated periodically to new wards, and can take breaks only at prescheduled times. These workers also are paid at or near the minimum wage, receive few fringe benefits, and have no routes of advancement. Not surprisingly, attrition is high. Families and residents who seek to form attachments to staff often discover that these workers remain on the job only a few months.

The current media focus on fraud and abuse in nursing homes further demoralizes and stigmatizes the formal caregivers who work there. Family members and other consumers concerned about the quality of care in nursing homes should direct more attention to the structure within which such care is delivered and seek adequate funding for our system of long-term care.

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Note

1. Other kinds of care provided by adult daughters included preventive care (preventing physical harm to the parent), anticipatory care (anticipating and preparing for what might happen to the parent), supervisory care (coordinating and supervising the care provided by others), and instrumental care (performing direct physical care tasks).

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15

Children's Caregivers and Ideologies of Parental Inadequacy

Julia Wrigley

In modern societies, children do not have economic value for parents (LeVine 1987; Zelizer 1985). With this change has come another, the shift in children's care and socializing from families to institutions, particularly schools. Children are economically dependent on their parents for longer than ever before, as schooling has lengthened, but much of their actual care and socialization has shifted outside the family (Coleman 1987).

The shift in socializing functions from parents to schools has often been chronicled. Like most social changes, it did not occur smoothly, but rather was a product of many specific and often sharp social conflicts. The most bitter contests over expanded school roles took place in the late nineteenth and early twentieth centuries (Reese 1986; Wrigley 1982). Although some issues, such as sex education, still spark conflict over family versus school roles, few question the legitimacy of public schooling.

The more recent shift toward the care of preschool children outside the family has yet to acquire this broad legitimacy (Dreskin and Dreskin 1983; Fallows 1985; White 1975). Even as formal institutions increasingly took over the care and socialization of older children, parents and policymakers assumed preschoolers needed their mothers' care. The 1960s, however, brought two social changes that accelerated preschoolers' placement in child care: the rise of the feminist movement and mothers' increased entry into paid employment (Scarr 1984).

In stratified societies, upper-class mothers have routinely employed nannies and maids to look after their children (Fairchilds 1984; Hecht 1956). The modern shift toward extrafamilial care of preschoolers differs in both the scope of the change and the development of an occupational group of professionally trained caregivers. Mothers of all social classes now leave their young children with others. While many caregivers remain untrained, at child care centers and nursery schools at least a top layer of caregivers usually claims some professional training and expertise. The twentieth-century shift toward group care of preschoolers is historically unprecedented in the elaborate development of a caregiving ideology rooted not in maternal norms, but in ostensibly scientific knowledge of young children's development.

In this chapter, I trace the ideological rationales that prepared the way for the shift from family to institutional socialization of young children. This change did not occur in a unitary way across social classes, but had two distinct roots. To explore both, I focus on the development of day nurseries for poor children in the first decades of the 1900s and on the rise of nursery schools for middle-class children in the 1930s.

The analysis shows the very different terms in which group care for poor and for middle-class children was advocated. Caregivers thought they had something distinctive to offer young children, compared to what they received in their homes, but they defined their contributions differently for children of different social backgrounds. These distinctive approaches were a product of the strong class segregation of group care for children. This segregation remains a prominent feature of the child care world.

In the early decades of the 1900s, proponents of institutional care fought a pioneering battle and had to explicitly confront the question of why family socialization of young children would no longer suffice. This they did, and with vigor. The following suggests that the poor faced moral condemnation as parents. They also faced a measure of social coercion from their children's institutionally-based caregivers. The denigration of parents and elevation of caregivers were two sides of the same coin. Middle-class parents faced no such moral denigration or social coercion. They did, however, have to pay a certain price to have their children enter the world of nursery care. Such mothers sometimes had to face charges of lacking the technical skills and expertise to provide good care for their preschool children. They had far more power vis-à-vis their children's caregivers than did poor parents, but they, too, could find themselves on the ideological defensive.

The echoes of the earlier arguments are with us still, and point up the importance of thinking about how social class affects the particular balance between family and institutional care and the power relations between parents and their children's caregivers. Although standards of care for children are not static (Wrigley 1989), poor parents face consistent denigration of their culture and childrearing styles. Group care is seen as particularly valuable because it introduces middle-class norms and standards of care to children who otherwise experience only their parents' devalued culture. While the denigration is constant, however, the specific deficiencies identified vary with changes in the prevailing norms of childrearing.

DAY NURSERIES AND THE MORAL SCRUTINY OF THE POOR

In the early 1900s, charity workers established day nurseries in America's large cities. They viewed only severe economic hardship as justifying mothers' enrolling their children. Even those who supplied group care often suspected parents' motives for using their services. Critics charged day nurseries undermined the family. Their supporters responded that nurseries served mothers who had no other options and who otherwise might lose their children to full-time institutions or to foster care. The alternative to the day nursery was a still more radical dissolution of the family (Steinfels 1973:40). As Marjory Hall, the secretary of the National Federation of Day Nurseries, wrote, "The day nursery stands, first, for the preservation and maintenance of the home" (1904:764). For this rationale to be persuasive, however, the day nursery directors had to establish that mothers indeed wished to look after their children themselves but had to go out to work.

Day nursery advocates argued that hard-pressed mothers needed help. They based their arguments on both charitable and political grounds. Mrs. Arthur Dodge, a wealthy patron of the day nursery movement, wrote that if left untended, "the children of the unfriended working woman are a serious menace to the state" (1912:113). Administrators operated day nurseries on a social case work model, seeing it as their moral and bureaucratic duty to investigate applicants for places. The nursery matrons had "in charge much of the investigation which the proper conduct of the nursery requires. An ounce of information counts for many a pound of reformation where the preservation of the home and the interests of children are at stake" (Hall 1904:765).

One author, writing in *Good Housekeeping*, suggested that day nurseries did more harm than good. She reported that Alice Higgins, general secretary of the Associated Charities of Boston, had found it necessary to close the Tyler Street day nursery because of assorted abuses and disadvantages, including the nursery's power to draw women across the ocean: It "developed that over in Syria the Tyler Street nursery was not unknown, and ambitious Syrian women were packing up to come to this delightful America where the child can be dropped into a sort of pound and the mother is free to make good money peddling drawn work in the streets" (Hartt 1911:23). She charged that nurseries sometimes made it easier for men to live off their wives; they sometimes led wives to the "pathetic blunder" of taking on work outside the home; and they sometimes led women to favor the interest or variety of street peddling over the tedium of looking after their children (1911:24). Another critic more temperately concluded that day nurseries too often served to perpetuate bad family conditions (Devine 1900:264). The case work model, once chosen, required that parents face moral scrutiny.

The existing literature provides little information about how mothers came to the nurseries and what they thought about the care their children received (Steinfels 1973). There is some reason to think, though, that many poor immigrant women might not have turned to day nurseries as their first choice for care of their children. In working-class communities, women traditionally had far stronger ties to family and friends than they did to formal institutions (Diner 1983). Leaving their neighborhoods meant leaving much that was familiar and entering a world that operated on other assumptions and where their own culture and values might be suspect. Even needy mothers might have left their children with some ambivalence, a possibility suggested by one veteran nursery worker: "And just here let it be said that, in a nursery experience covering many years, the writer has not found the mothers of the children committed to its care, toppling over one another in their anxiety to rid themselves of the responsibilities of motherhood. The giving up of the child, even for a day, to strangers, covers for the most part a need so desperate that no other opening for relief seems possible" (Hall 1904:765)

Day nurseries, which protected, fed, bathed, and sometimes clothed children, offered a very practical kind of service. The shift toward institutional, group care of children had a powerful impetus where families lived on the economic margin. A 1920 survey in Philadephia showed that widows comprised 30 percent of the total using the day nurseries (Colbourne 1920:129). They formed a subset of the larger group of women who had lost their husbands through death, separation, desertion, or divorce; this larger group of mothers comprised 69 percent of the day nursery users. The study's authors reported that unmarried mothers represented a "surprisingly low" 19 out of 864 users of the nurseries. The absence of a male provider in the household forced many mothers out to work, but smaller numbers worked because of their husbands' unemployment, illness, or disability.

From the beginning, mothers seeking to enroll their children were in a one-down position vis-à-vis nursery matrons. Before their children entered the day nurseries, the mothers had to submit to questioning about their finances and their husbands' whereabouts. The matron in charge, warned Mrs. Dodge, should "be a sufficiently keen observer to detect ordinary fraud, and experience has proved that the right kind of matron is the best possible investigator" (1912:114). Charity workers wanted to root out those mothers who they thought might be fleeing from the responsibilities of child care. As bureaucratic institutions, the day nurseries kept careful records, and the more conscientious secured the aid of other charitable organizations in investigating mothers' circumstances (French 1902:180). Such investigations required a "keen eye. Mothers seeking admission for babies are quick to learn the ropes. And with foreign standards of veracity to consider, even a trained social worker may be put to it to arrive at facts" (Hartt 1911:25).

THE INVIDIOUS COMPARISON OF HOME AND NURSERY CARE

Moral scrutiny did not end at the point of application. Not surprisingly, the nurseries, usually established and presided over by the wives of wealthy men (Steinfels 1973:41), adopted standards of care that echoed the priorities in middle-class households. The day nurseries extended notions of care that had been developed for private homes and applied them on a larger scale. In so doing, they provided at least an implicit and often explicit critique of the childrearing practices of the poor (see, for example, Gorman 1911). Mothers had to face a daily invidious comparison between their methods and those of the institution.

In the early 1900s, childrearing experts stressed the hygiene and scheduling of infants and young children (Weiss 1978; Wrigley 1989). In an era when infant mortality rates were high, doctors, who provided most of the advice, inveighed against parental practices that endangered children's health and safety. Many issues that later seemed matters of taste or judgment were treated as matters of high medical concern. In this, the great era of babies' hygienic management, spontaneity had no legitimate place. Cleanliness outweighed playfulness; order outweighed warmth.

We do not know to what extent mothers followed these practices. Whatever experts advised, mothers could follow their own ideas, and presumably many did so. Only very well-organized households could have operated with the strict attention to the clock mandated by the doctors. In institutions, however, expert opinion could more fully govern daily operations. In declaring themselves qualified to undertake the management of large numbers of small children, nursery directors could point to the way their practices accorded with those recommended by experts. While household routines might be upset by unexpected events, from the intervention of brothers and sisters to crises in the kitchen, institutions run on principles of order and efficiency. This is not to say that all nurseries could or would have operated smoothly, but once children left the sanctity and the individual variety of the home, caregiving ideologies could loom large, less mediated as they were by individual attachments and family circumstances. And, as it happens, what the experts recommended did not require the most labor-intensive forms of care. In downgrading play and cognitive stimulation, the experts recommended a type of care that could be provided even when child-to-adult ratios were high.

Information about the way day nurseries actually operated is scanty, but clearly not all were run according to the approved childrearing ideology of the time. In some poorly run day nurseries, children were kept in dark and dirty rooms, crammed together with very little supervision and nothing to do (Colbourne 1924; "Mushroom Day Nurseries Unchecked" 1918). Such nurseries flourished particularly during World War I, when women entered the industrial work force. In the philanthropically geared day nurseries, however, order and hygiene were stressed above all else. One author extolled the hygienic nursery: "Consider the perfection of a properly organized day nursery. No germ may enter the immaculate precincts and live. A watchful woman physician stands guard at the door that no incipient contagious disease may sneak into the fold. Milk of the most approved modification, a dietary planned by scientific baby experts, find their way down little throats hitherto hospitable to everything from beer to raw turnips" (Hartt 1911:21). The day nurseries largely provided custodial care (Clarke-Stewart 1982:30; Joffe 1977:5; Steinfels 1973:47–49). In keeping with prevailing opinion that babies should sleep nearly around the clock, waking only a few hours a day, infants spent nearly all day in their cribs. Older children had a more varied program, but it, too, was rigidly regulated by the clock. One nursery worker of the time reported that "regimentation was the rule rather than the exception" (Beer, quoted in Steinfels 1973:49). Those who described the nurseries emphasized the regular routine and the striking contrast between the presumably disorganized lives of the children at home and their lives at the nurseries. In some ideal sense, the home was always to be preferred, but in practice, the expert management of the nurseries struck many as providing a far higher standard of care than the children received at home. The nursery rescued children from the incompetence or irresponsibility of their mothers.

NURSERIES AND THE TRANSFORMATION OF THE HOME

Some nurseries assumed the goal of trying to transform not just the children but the families themselves. If families used the nurseries, they were, by definition, needy ("below normal," in the words of one worker in the field [Gillam 1921:109]) and could benefit from expert intervention. Two truths stood out to nursery advocates: the child could only be helped if the family condition were bettered and the child could become the instrument of family improvement ("Scope of Day Nursery Work," 1902:546).

Caregivers could use the daily contact with the child as an avenue for reaching the mother (Devine 1900). The child could be introduced to new standards and new habits; these could then revolutionize the methods of the home (Hall 1904:764). According to one nursery worker, the new habits "are carried into the home through the mother, who is usually most eager to learn why her baby is no longer skinny, pale, and cross. . . . She is more than pleased when all her shortcomings have been undone and her baby is a natural healthy youngster" (Gillam 1921:111).

Mothers could learn by watching how the day nursery cared for their infants. Although on principle nursery workers disapproved of taking babies, in practice they saw some advantages. It is, Mrs. A. M. Dodge wrote, "often through this tiny one that the nursery has its opportunity to furnish the mother, perhaps for the first time in her life, with systematic instruction in the first principles of hygienic care of the child herself and the home" (1912:115). Looking after older children offered still greater avenues for change. The children themselves could become missionaries:

> As the child grows into kindergarten age his powers for influence in the home increase with the development of his powers of observation and his growing experience in the comforts of nursery life.... Superhuman efforts have been made by many mothers to overcome old habits and ignorance and to supply some refinements of home life that the critical eyes and tongue of the child may not draw too sharp contrasts between home and nursery. Most mothers, too, are sensitive to the improvement in cleanliness, good habits and manners acquired by their children, and frequently a moral and social uplift is evident in a desire to live up to the higher standards in which their children are being educated. (Dodge 1912:116)

Not only did children's caregivers try informally to introduce new habits to the family as a whole, they also initiated special lectures for mothers on hygiene, cooking, sewing, and general baby care (French 1902). Matrons also helped mothers find work, usually as washerwomen, laundresses, or day workers in private homes (Hall 1904:766). Mothers were encouraged to switch from factory to domestic work, where they could learn housekeeping skills and benefit from the friendly supervision of their mistresses (Dodge 1912:117). The day nursery thus became a focal point for a range of services geared to mothers.

Because day nurseries provided care as a charity rather than as a right, mothers were placed in a dependent position. Beneath the talk about furnishing services, discussions of the day nurseries in social service journals made clear the weapons that could be used against recalcitrant mothers. If mothers resisted suggestions from caregivers about child management, or if they failed to meet the nursery rules, the nursery could withdraw services. Using rhetoric about friends and helpers, one author put the matter plainly: "In its role as friend and helper to a family in distress, the day nursery is in a position to secure prompt and complete acceptance of advice as to what is and what is not best for the child. It can have very appreciable effects on family standards where the children are concerned. It can justifiably discontinue care, if full and complete co-operation is refused" (Gillam 1921:111).

The practice of forcing recalcitrant or morally questionable mothers to withdraw their children caused painful dilemmas for some caregivers and nursery directors. What, they asked, were they supposed to do when investigation revealed husbands who wasted their family's money on drink? The case work model was ambiguous about whether wives in such situations were victims or active agents, sharing moral responsibility with their husbands. The women might be forced to work to support their children, but the families' problems were, in a moral sense, of their own making. The hard-liners suggested barring children of such families from the day nurseries; the more tender-hearted worried that the children paid the price of the fathers' irresponsibility ("Ex-Worker" 1902; Hall 1902; Higbie 1902).

Many nurseries had a rule that children who arrived dirty could no longer attend. The secretary of one facility wrote, "The very hardest task of my life was being one of a committee to tell a little frail women, whose big eyes still haunt me, that her very unsanitarily dirty children could not come any more, and had it not been for much greater offences I know I would not have done it" (Higbie 1902:542). Her article inspired two other nursery workers to respond that the nurseries had to think first of the children. The children, if helped, could possibly improve the home as well as themselves; if dismissed, the family would continue its decline unchecked ("Ex-Worker" 1902; Hall 1902; Higbie 1902). Yet, although some nursery workers undoubtedly were sympathetic to hard-pressed mothers and their children, the threat always remained that moral deficiencies or failures of cleanliness could result in children's exclusion.[1]

NURSERY SCHOOLS AND MIDDLE-CLASS PARENTS

Although social workers and caregivers believed day nurseries provided a higher standard of care for the children of the poor than did the parents, these institutions were not deemed suitable for middle-class children (Cleveland 1923). With the frankness characteristic of the era, Mrs. A. Levitas wrote in 1913:

> The public nurseries are charitable institutions for the children of the poor. The middle-class working women, who earn enough to pay a little for the care of their babies, are not permitted to leave their little ones in them. But even if they were given this permission, no intelligent mother would be willing to do so. For these nurseries attempt to minister only to physical wants. Although the needs of the child at infancy seem to be largely physical, we know that from the day of its birth, the infant is getting impressions and forming habits. (p. 150)

In the 1920s and 1930s, such ideas bore fruit in the establishment of nursery schools for middle-class children (Joffe 1977:9).

Levitas had couched her argument for "baby gardens" in terms of the needs of middle-class employed mothers. The overwhelming majority of middle-class mothers, however, did not work outside the home; instead, they looked after their children. In the 1930s, nursery schools that would assume part of this care and socialization became an ideologically acceptable, and even approved, option. We have seen that day nurseries for poor children had two main ideological justifications: Their advocates argued they actually kept families together, as desperate parents no longer had to lose their children to full-time institutions, and they provided a standard of care above that supplied by the parents. Neither rationale could be extended to extrafamilial care of middle-class children. These families did not face economic crisis, and their culture was not subject to wholesale denigration.

There were, however, two important respects in which the arguments for nursery schools resembled those made earlier for day nurseries. First, the mothers' interests received little or no attention; children's group care was not proposed for the benefit of either poor or middle-class mothers. Second, group care was intended to provide a model for mothers to follow. Mothers could learn much about child management from watching trained nursery teachers. New practices based on scientific knowledge would be exhibited for them on a daily basis by their children's teachers. The children themselves would gain in social maturity by playing with their peers (McCarthy 1933:13; Washburne 1934).

As early as the 1920s, some advanced thinkers had already begun arguing that even the most conscientious mothers could not expect to do a good job of raising children without expert help. In 1923, Elizabeth Cleveland, reflecting Freud's influence, wrote that a child's early years were critical. Yet this was the very time in which children were left to the "mother's inexpert and unaided care" (Cleveland 1923:445).

The theme of mothers' lack of training and caregivers' expert knowledge sounded louder as child development became a recognized area of scientific study. In 1918, the Laura Spellman Rockefeller Memorial Foundation began funding university research projects designed to identify the physical, mental, and emotional characteristics of the "normal child" (Richardson 1987). At Yale University, Arnold Gesell undertook extensive research on patterns of maturation among young children (Fowler 1935:32). Infancy became a new frontier of scientific knowledge, with ideas of passive, sleepy infants giving way to a new view of babies as learning, curious, temperamentally varied beings (Wrigley 1989). In the first decade of the 1900s, childrearing experts had laid claim to mastery of child management routines. By the 1930s, they claimed a higher order of knowledge and superior understanding of children's natures and developmental needs.

Once child development became a specific field of study, nursery school directors and teachers received training in this specialty. Teachers took courses in child psychology, physical growth, physical and mental hygiene, nutrition, family relations, and methods of teaching in nursery schools (Kitchen 1935). This meant that for the first time, mothers of young children and professionally trained experts had their own unique claims to special insight into preschoolers. Although the family held unquestioned primacy, mothers could, and did, find their turf shrinking. Their equipment for their jobs came into question as a new body of experts arose.

Because the nursery school was a new institution, however, mothers needed to be persuaded of its benefits for their children. Many expressed initial skepticism. Dorothy Canfield, a noted writer, later confessed that at first "I clutched at my little children with as primitive a grab as many mothers of my age did" (1933:12). She visited nursery schools expecting to see overstimulated children rushing wildly about. Instead, she found calm, purposeful activity. The teachers did not exhibit the frazzled behavior common to mothers of preschool children. How, she wondered, did they keep their serenity? The answer, she concluded, lay in the teachers' training for their jobs. Before starting their work, they had studied little children, and armed with this knowledge, they planned each day's program. Children ate better, acted more independently, and were less nervous than at home.

Canfield, a new believer, asked "Why then did we so passionately object to putting children under the care of the trained, intelligent, mature and responsible women in charge of the nursery school, and secretly determine to circumvent its intention of separating children from their families?" (1933:13). She attributed mothers' hesitation to the normal fear of the new and their (historically shortsighted) view that only mothers should care for young children. Canfield urged mothers to leave behind their doubts and try the new institution that had so much to offer their children. Her article stressed the positive benefits of nursery schools, while other authors focused more on maternal failings.

Popular magazines carried increasing numbers of articles in the 1930s suggesting that, in a comparison of nursery school and home care, nursery schools won (Wrigley 1989). Experts argued that it was intrinsically difficult for mothers to develop their children's emotional lives. Mothers had to walk a fine line between indulging their children on the one hand and harassing and controlling them on the other (Washburne 1934:17). To achieve the proper balance, care and skillful handling were required. Busy mothers, working without training and in homes where they had to meet obligations to other family members, could not always supply this level of care. Furthermore, because mothers lacked both scientific knowledge of young children and experience with large numbers of children, they were not in a position to know what was normal behavior, a problem that could be remedied by the nursery school (Miller 1933:805).

CAREGIVERS AND THE POWER OF EXPERTISE

While the earlier day nurseries, organized on a charitable basis, could keep mothers in line by threatening to withdraw services, middle-class parents paid for their children to attend nursery schools and thus had no reason to fear their children's exclusion. But, if middle-class mothers were not one-down in an open power relation, they could find themselves in a quasi-student role vis-à-vis their children's caregivers. Such parents often themselves held jobs that required professional training; they respected scientific knowledge and, while often of higher social standing than their young children's teachers, did not have a cultural tradition that would lead them to dismiss readily the teachers' claims to expertise.

As child development experts touted the nursery schools for the professional expertise of their teachers, mothers found their own home-based knowledge devalued. Articles in popular magazines advised mothers that they should learn from their children's nursery school teachers. In nursery schools, mothers were told, teachers did not engage in unseemly wrangles with young children about what foods they ate; they did not have to cajole children into washing their hands or taking naps (Johnson 1934); they spoke positively to children and secured ready cooperation (Justin and Snyder 1933). An early article on nursery schools made the point emphatically: "But is it not better for mothers to train their own little children? No doubt, when they know enough of what experts know about the mental and physical hygiene of little children, are wise and patient, and have plenty of time for patience!" (Howes 1923:34).

Teachers relied on their expert training to secure their successes. One of the most widely read child care experts of her day, Gladys Shultz, the author of a regular column in *Better Homes and Gardens*, stressed the amount and variety of equipment nursery schools offered. "Even granted that a home can offer all these things," she wrote, "there still remains a special technique for handling children, as definite as the technique of a doctor or dentist, which nursery-school teachers learn by study at a few selected schools, and of which nursery-school teachers appear to have a monopoly" (1934:79). By putting themselves into the role of students, mothers could learn at least some of the special skills of their children's caregivers.

We have seen that caregivers who looked after needy children in day nurseries also emphasized how much mothers could learn from them. The heavy didacticism of the day nurseries for the poor, however, differed from the education offered middle-class parents. Teachers instructed middle-class parents through example and frequently shared their professional expertise through special evening classes. Rather than instructing parents about home administration, teachers focused on the need for parents to understand young children. As trained caregivers, they had professional knowledge to share, not a mastery of children's routines and hygiene. In the 1930s, nursery schools commonly encouraged or required mothers to observe their children at play and take notes on what they saw. Mothers were to become students of their children's development, with trained nursery-school teachers serving as guides to the new field. While the nursery school provided a scientific laboratory for Gesell and other researchers, it provided a kind of practical laboratory for mothers.

Nursery school teachers specialized in observing the children in their care with an expert eye to see where and how they differed from the developmental norm. They believed they knew how children should behave and possessed the skill to alter personality traits which required correction (Johnson 1934). Mothers could not hope to attain this level of objectivity and skilled intervention, but they could learn more about managing their own children at home.

The emphasis on written records, either notes taken by mothers or records made by nursery school teachers, highlights the parallel to scientific investigation. These records were expected to reveal patterns of development and, possibly, problems, that might otherwise escape attention (Miller 1933:805). One cooperative nursery school in Berkeley had new mothers spend one day a week for three weeks taking notes on the way trained nursery supervisors dealt with the children (Dick 1934:16). Another cooperative nursery, this one in Seattle, required each mother to attend bimonthly meetings to discuss child guidance principles and, perhaps more difficult, "to interest her husband in studying the needs of preschool children and attend the meetings for fathers" (Taylor 1944:324). On some mornings, the mothers kept diary records on individual children, allowing them to "come to sense the needs and impulses working themselves out in these small personalities" (p. 325).

One mother wrote an article for *Parents' Magazine* explaining how she had come to enroll her child in a nursery school. When the family moved to a new city, her child had trouble adjusting and making friends. A sympathetic minister suggested the local nursery school and explained, "It's more than a play school, it's a parent's laboratory" (McElravy and Van Note 1944:26). The mother confessed, "Frankly it had never occurred to me that perhaps I needed special training in my career as a mother" (p. 26). She tried the school, however, and found that it operated according to the parent education principles of Dr. Gertrude Lawes. Lawes believed that parents needed to observe their children carefully and make records while they watched. The nursery director had a degree in child psychology and had done extensive research work. The mothers, far from leaving their children at the nursery and pursuing their own interests, stayed with the children: "The group assembles around 9 A.M., and the mothers sit informally around the edge of the group and each spends her time recording what her child does and says. If a child asks for assistance with a toy or in the settling of a dispute, his mother responds" (p. 92). A photograph with the article shows an earnest group of mothers writing notes while their children played around them. "Each mother," the author continues, "is there because she wants to learn effective ways to help her child handle certain tendencies which, if not curbed, may warp the pattern of his living with other children" (p. 94).

At 11:30 each morning, the mothers met with the trained nursery director to review the records. The author commented, "We all look forward to this half hour. A twelve-weeks record reveals how definitely Skipper has gained security in the play group. It also shows how many of my own problems of child training have been resolved" (McElravy and Van Note 1944:97). This did not constitute the whole of the mothers' study efforts. Although not required to do so, the author continued the recordkeeping at home, making a chart of her child's behavior. In addition, there were more formal meetings. "Supplementing the work at school is a study group for parents which meets one night a week. At this time we discuss with the director such subjects as fears, anger, thumbsucking, overcompliance versus aggressiveness, and kindred subjects" (p. 97). For middle-class mothers, the complexities of children's behavior increasingly demanded expertise from outside the home.

CAREGIVERS AND PARENTS

Advocates of group care of young children no longer need to present their case solely in terms of the children's welfare. With the rise of the women's movement and middle-class mothers' increased entry into paid labor, child care has acquired a legitimacy based on family need (see "Deaths of Unattended Children" 1987:B9; Kahn and Kamerman 1987:243). This has helped, on the one side, to reduce the stigma attached to day care as a service for inadequate families and, on the other, to free mothers of nursery school children from their tutelage at the hands of caregivers. Joffe found in the early 1970s that Berkeley parents refused to take parent education programs at child care centers seriously (Joffe 1977:55). Employed parents lacked the time to watch their children play at nursery schools or to observe the skills of the staff. Instead of learning techniques from child care staff, mothers depended on day care to enable them to work.

Previous sharp distinctions between day care for the poor and nursery schools for the middle class have blurred (Clarke-Stewart 1982:34). The convergence of types of care, however, has not brought integration of services for young children of different class and race backgrounds (Kahn and

Kamerman 1987:244). The social welfare model continues to undergird public policy, with government programs largely reserved for children from neglectful, abusive, or what are considered educationally inadequate homes (Greenblatt 1977:103). Experts have redefined the inadequacies of poor families; while those of the early 1900s focused on hygiene, experts after the 1960s focused on cognitive stimulation (Wrigley 1989). In both eras, charity workers and government officials have seen group care for young children as a way to correct family deficiencies of the poor.

Parents of children in government programs have more power vis-à-vis their children's caregivers than parents whose children attended the early charity day nurseries. Arbitrary and intrusive matrons have given way to teachers who work in bureaucratic government settings. Government-funded programs usually mandate parent participation (Joffe 1977:46–54). As with required participation in the public schools, however, this participation is often more pro forma than real (Bauch, Vietze, and Morris 1973; Zigler and Turner 1982:175–176). With a clientele selected for poverty and trouble, caregivers are likely to be better-educated and have higher status than parents. Caregivers also gain leverage from representing an institution mandated to help children by combatting the inadequacies of their families.[2]

Caregivers for poor children can find themselves in a double bind. Regardless of their own views, such caregivers represent the employing institution and must to some extent uphold its values. This can lead to situations where the caregivers are in basic sympathy with the childrearing methods and goals of the parents, but undercut them because of the need to put forward the officially approved methods of the institution that employs them.

In an ethnographic study of two child care centers, one serving middle-class children and one a Head Start program serving poor children, Sally Lubeck (1988) found the teachers in the middle-class center were far freer to express their own values than those in the Head Start program. At the Head Start center the teachers, all black, were themselves subjected to heavy doses of middle-class childrearing ideology. To keep their jobs, they had to accept this ideology at least publicly. Lubeck details the ways the teachers were forced to conform:

> First, the teachers were expected to go for training frequently, training which was unidirectional . . . and which presupposed middle-class norms that violated strongly held values. Second, the supervisor would drive by in the morning to scan the parking lot for the teachers' cars or arrive unexpectedly to observe their teaching. The teachers' jobs were defined by demands of the system, and they also were required to visit the children's homes and to "rate" them. Their ambivalent relationship with parents, at least in part, was created by this extension of the monitoring role. (1988:53)

On a more subtle level, however, clients do influence institutions, particularly when caregivers believe that satisfying clients bolsters their own authority (Joffe 1977). For example, many black parents favor formal instruction for young children; such instruction reinforces the caregivers' status by emphasizing their role as teachers (Joffe 1977; Kahn and Kamerman 1987; Lubeck 1985; Ruderman 1968).[3]

Middle-class parents, whose children frequently attend child care centers and preschools, generally have more resources than child care providers. With good educations and jobs, they often take an active role in fostering their children's learning and try to select child care centers that provide middle-class peers and well-trained staff (Ruderman 1968). But even well-educated parents can find caregivers who emphasize their own childrearing expertise. In the 1930s, child development experts stressed the psychological harm well-meaning but untrained mothers could do to their young children. By the 1960s, attention had shifted to children's cognitive development (Greenblatt 1977; Wrigley 1989). Caregivers serving middle-class populations began to acquire standing as the first adults outside the family to evaluate young children's social and academic capabilities, including their readiness for school.

While many black parents value formal instruction in child care centers, such instruction is much less popular among middle-class parents (Kahn and Kamerman 1987; Lubeck 1985; Ruderman 1968). The emphasis on an informal style does not, however, mean middle-class parents are less concerned about their children's intellectual stimulation. Those in professional occupations often are deeply invested in their children's schooling, partly because their own route to occupational prestige and social advance has come through educational credentials (Anyon 1980; Carnoy and Levin 1985; Collins 1979). With the new emphasis on cognitive development, nursery schools have evolved into preschools, which are increasingly seen as the first link in the long chain of the child's schooling. Very young children are now in an institutional setting where caregivers evaluate their social and academic competencies.

Professionally-minded children's caregivers emphasize the evaluation of children as an essential component of child development expertise. Recordkeeping signals professionalism, with trained caregivers preparing "developmental checklists, weekly reports, parent conference notes, and formal measures of behavior and ability..." (Cataldo 1983:8). Directors of elite preschools can channel children into selective private schools, giving their evaluations of children (and their families) added force. Those directors and teachers who serve a somewhat less elite clientele are likely to have less influence over where children attend school, but they can influence when they start. Many child development experts warn parents not to send their children to school too early, on the grounds they might suffer lasting academic and social disadvantages from being among the younger students in their classes (Uphoff and Gilmore 1986). This movement to hold children back if they have fall or even summer birthdays has affected mainly middle-class parents, who are particularly concerned that their children compete well and who have the resources to keep them in child care for an extra year (Walsh et al. 1987). Increasingly, child care professionals, including trained teachers and directors, help middle-class parents make the choice about whether their children have the emotional and intellectual maturity for the start of schooling. Child care has become the testing ground for entry into the serious world of academic performance.

Seen from the other side, caregivers need what resources they can muster to deal with parents. They are members of a "weak" profession, where they have little or no control over occupational entry and standards (Joffe 1977). Where they can claim professional expertise, they have something to counterpose to educated parents' economic resources and social standing. Caregivers without such resources can quickly join the ranks of the country's most exploited workers, including those minority and immigrant women who work in employers' homes. By differentiating the professional from the maternal care of children, caregivers can lay the groundwork for struggles to get decent wages and working conditions. Furthermore, research suggests that trained caregivers are in fact more sensitive to children's needs and emotions than those who have no training in child development (Scarr 1984). It is understandable that caregivers want to claim some professional expertise, and their training probably does bring them some heightened skills. The problem arises, however, when professional ideologies are narrowly interpreted and applied. In the absence of a social movement demanding child care as a universal right, a segmented child care market will continue to provide one set of stigmatized services for the poor and other services geared to preparing middle-class children for entry into the competitive world of schooling. With such strong segregation of the children being served, caregivers can develop narrow ideologies that exacerbate the educational anxieties of one part of the population and emphasize the parental inadequacies of another.

CONCLUSIONS

The shift toward extrafamilial care of preschool children did not occur in the same way for all groups of parents. Poor parents faced one set of conditions that led them to place their children in day nurseries, and middle-class parents faced another. Once their children were enrolled in group care, they also faced different types of relations with their children's caregivers. The power of the day nursery workers vis-à-vis the impoverished mothers comprising their clientele rested on their conviction that they knew the principles of good child management and hygiene, backed up by the ability to make mothers conform to their directives. The power to withhold services, while leniently exercised by some nursery workers, meant that suggestions could have the force of commands. The mothers' childrearing culture was profoundly devalued. The areas where they might have had strengths, as in warmth and attachment, counted for little in the childrearing climate of the early 1900s. Only hygiene and routine mattered; here experts and day nursery workers viewed working-class families as deficient.

In the early 1900s, middle-class mothers fared better in the eyes of the experts. While some doctors decried the nutritional ignorance of even the most educated mothers (Wrigley 1989), overall the homes created by such mothers were viewed as the best possible places for young children. By the end of the 1930s, however, child development experts increasingly argued that mothers needed help in raising young children. Although no one suggested removing children from the home, experts did recommend that children spend part of each weekday in the care of professionally trained teachers. Mothers fell into the status of students—and not always very apt ones.

Child care in the 1980s continues to bear the stamp of its origin. Programs for the poor still receive funds on the grounds they help overcome their families' deficits (Levitan and Alderman 1975:47). Poor parents thus begin the relationship with their children's caregivers from a disadvantaged position. Middle-class mothers no longer have to justify group care by an earnest insistence on its educational value for them; gone are the days of hard-working maternal notetakers. Professionally trained teachers can still brandish the weapon of their expertise, however, and middle-class parents feel the deficiencies not of their culture, but of their knowledge.

The power relations between parents and caregivers are complicated because parents' resources can allow them to afford caregivers who have considerable resources of their own. Many middle-class parents choose caregivers on the basis of convenience or cost, but others seek out caregivers who boast some level of professional expertise. They voluntarily cede some autonomy in exchange for enlisting caregivers who can operate with initiative and professional confidence. The caregivers' qualifications free the parents to leave their children each day. Because the mothers are generally employed themselves, they do not have time for the type of anxious daily watchfulness shown by the mothers of the 1930s who enrolled their children in nursery schools. Caregivers provide them, however, with evaluations of their children's potential for coping with the educational world that awaits them.

As more childrearing shifts from families to institutions, it is important to recognize that changing currents of professional thought are likely to have greater impact in institutions than in homes. Caregivers are trained in the dominant professional ideologies; most parents receive such messages only indirectly, sometimes through the caregivers. Early childhood educators are members of a profession "on the make," and they have an incentive to develop what professional content they can (Joffe 1977). They are more linked than are most parents to the world of "experts" that has traditionally devalued women's contributions and experiential knowledge (Ehrenreich and English 1978). A content analysis of popular literature directed toward parents from 1900 to 1985 shows great swings in opinion among the experts from decade to decade (Wrigley 1989).

Those trained as professionals are bolstered by the claim to expert knowledge, but it is striking how the specific content of the expertise changes over time. Historical review suggests that caregivers might do best not to cling too tenaciously to the belief that there is one best way to raise children. Such a viewpoint is likely to be far more damaging to the poor than to more prosperous parents, but in each case, expanded caregiving has been legitimated by a claim of parental inadequacy. Families and institutions now share the socialization of even the youngest children, and this time-sharing needs to be accompanied by a tolerance of diverse cultures and modes of childrearing. Such tolerance would more likely arise if child care were viewed as a universal social right, instead of as a service provided to populations segregated along lines of class, race, and ability to pay.

DOCUMENTATION

Notes

1. Linda Gordon (1986) has perceptively pointed out that some women learned to use social service agencies to their advantage; it is simplistic and one-sided to emphasize the social control aspects of such relations to the exclusion of their genuine service aspect. Further, Louise Tilly and Joan Scott (1987) have shown in their studies of France and England from the eighteenth to the twentieth centuries that working-class families needed to make hard choices about children's care and labor in order to survive economically. Services that made mothers' employment possible could make the difference between managing and being on the streets. The day nurseries provided care that was otherwise unavailable. Mothers used to overcoming hardships could learn to maneuver around their rules and could try to ignore their ideology of parental inadequacy. Because the nurseries were run as charities rather than as public institutions, however, mothers could not do much to change their practices or precepts.

2. There is a limit to the social class divergence between children's caregivers in institutions and the families they serve. As a rule, the class and race of caregivers tends to roughly parallel that of the children who are enrolled (Clarke-Stewart 1982). The same rough class correspondence also holds true in most of the informal child care market, with parents seeking family day care providers from their own neighborhoods (Ruderman 1968) and the providers having family incomes typical of their settings (see Nelson 1989). The sharpest class differences between caregivers and parents are found where parents hire caregivers to work in their own homes (Wrigley 1987). In most other settings, the restricted class differences help reduce value differences between parents and caregivers. Because of the segmentation of the child care market into subsidized and paying portions, however, many caregivers for children from low-income families work for institutions whose values they must also express, whatever their own backgrounds.

3. Ethnographic studies have shown that working-class parents tend to defer to teachers, while middle-class parents are far more likely to believe they and the teachers should be partners in promoting their children's learning (Carnoy and Levin 1985; Lareau 1987). In this sense, it is easier for poor and working-class parents than for middle-class parents to arrange a division of labor with their children's caregivers. The division of duties between parents and caregivers, however, rests on an assumption that the caregivers have a kind of expertise the parents lack. The parents themselves accept an ideology of professional expertise, reinforced by children's teachers and caregivers, that emphasizes the inadequacy of parents' childrearing.

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This work examines the experience of women providing care to children, disabled persons, the chronically ill, and the frail elderly. It differs from most writing about caregiving because it focuses on the providers rather than the care recipients. It looks at the experience of women caregivers in specific settings, exploring what caregiving actually entails and what it means in their lives.

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