Chapter 2
Social Change and Caregiving

2.1 Introduction

Social change is a continuous process in all societies. Social change refers to any significant alteration over time in political, economic, social, and cultural institutions that result in changes in behavior patterns, cultural values, norms and beliefs. By “significant” sociologists mean changes resulting in profound and extensive societal consequences. Examples include the industrial revolution, the abolition of slavery, the feminist movement, the Civil Rights Act of 1964, and medical advancements leading to increased longevity. Social change results in changes in norms, role relationships, and the distribution of power and resources and affects the way individual members of society define situations.

The causes of social change are usually numerous, cumulative, and interrelated, for example, the rising costs of healthcare, government policy, and legislation to control costs. Social movements play a role in inspiring some members of society to bring about social change, while other members may resist change, especially when individuals with vested interests feel threatened by potential change. All social change has costs and benefits. As a society we are continually challenged to minimize the costs and maximize the benefits of social change (Institute for Health and Aging 1996).

2.2 Trends in Caregiving

From our early history, caregiving in the U.S. has focused around family, kin, and friend/neighbor support relationships (Levine 2004). Close personal ties were observed to govern primary group relationships while weaker ties characterized secondary group relationships. Urbanization and industrialization were thought to reduce the frequency of contact and level of support from kin. Rural residents were expected to have stronger interpersonal ties than urban residents (Glasgow 2000). However, several generations of rural-to-urban migration has changed expected patterns of intergenerational relationships among rural versus urban older residents.
A study of general patterns of urban and rural social relationships found that people in nonmetropolitan networks had known each other longer and more of them were kin (Beggs et al. 1996). Other research has shown that there is strength in weak ties when they are networked (Granovetter 1973).

Anticipated problems of baby boomers during old age are likely to be shared by both urban and rural residents, with neither group having an advantage over the other in caregiving support. An aging society means not only fewer middle-aged adults to care for older people, but also fewer workers to support Social Security and other government entitlements that benefit older people. The challenge is to interface formal and informal caregiving networks so that they support each other (Glasgow 2000).

Caregiving has always been a universal experience of compassion and familial responsibility in American society, but due to the forces of social change, caregiving has become an essential and growing part of healthcare, long-term care, and social service policy-making. Family caregivers provide approximately 80% of all long-term services and support for family members and friends across the lifespan, yet they are the most neglected group in the health and long-term healthcare system (Feinberg et al. 2003; Feinberg 2004).

Caregiving in the United States has evolved from the closed communities evident among seventeenth century settlers where needs and obligations were clearly defined to the twenty-first century where we live in open networks of intimate associations and casual acquaintances, e.g. Facebook (Wuthnow 1991). Sociologist Robert Wuthnow (1998) has said that indifference, rather than caring, is the norm in twenty-first century America where kindness is a social problem because there is not enough of it. He explained, stating that the use and abuse of kindness in American life is not so much a matter of individual failings as it is the way our institutions operate. One of the effects of social change is that not all of our institutions react to change in the same way or at the same time. As a result, many of our institutions have “lagged” behind others and become porous and fragmented, altering the way we relate to one another and allow people to fall through the cracks (Wuthnow 1998). For example, the climate for human embryonic stem cell research in the U.S. is decidedly mixed. President George Bush stopped federal funding for new cell lines in stem cell research in the U.S. in 2001. States and private groups began funding stem cell research in 2004. In California Proposition 71 was approved to distribute several billion dollars in state funds to its universities and research institutions for stem cell research. Court challenges delayed the awarding of monies until 2006. Other states committed funds to counteract restrictive federal policies (Hampton 2006). By executive order on March 9, 2009, President Obama removed certain restrictions on federal funds involving new lines of human embryonic stem cells.

Wuthnow said, because of social changes such as increased diversity, fluidity, independence, and specialization of contemporary life, we favor short-term and sporadic commitments and task-specific relationships. In contrast to our founding fathers, we favor less rigid boundaries and caregiving activities that are loose networks of individuals who come together for a specific purpose such as volunteering, self-help groups, online groups and organizations, and nonkin networks.
A recent report prepared for members of the U.S. Congress stated that “The U.S. is getting bigger, older, and more diverse” (Shrestha and Heisler 2011). Since 1950 the U.S. has experienced rapid population aging. (See Table 2.1.) The population growth is due to the trends of increased births, decreased deaths, increased immigration and increased longevity. The aging of the population is reflected in the proportion of persons aged 65 and over and an increasing median age of the population. Indeed, the fastest growing age group in the U.S. is age 85 and over (See Fig. 2.1).

Immigration has had an effect on the size and age structure in the population. The increase in ethnic older adults is a significant factor in the aging population. By 2050, 39% of the nation’s older adults will be from minority groups. Cultural differences based on attitudes, beliefs, and behaviors are passed on from one generation to another and are important in caregiving.

Finally, scientific achievements have greatly alleviated the effects of many infectious diseases. The development of vaccines, effective mosquito control, and the introduction of modern sanitation has rendered diseases like polio, yellow fever, malaria, and cholera unheard of in the U.S. As a result, life expectancy in the U.S. has risen from 47 years in 1900 to 78.3 years in 2010.

The aging of the U.S. population will have increasing effects on health and healthcare services due to the increased numbers of persons experiencing some type of health condition. As the U.S. population ages, the social and economic demands on individuals, families, communities and the government will grow with effects on the formal and informal health and social service systems and on the financing of healthcare in general.

In conjunction with the growing numbers of older persons, the U.S. faces changes in the rates and outcomes of various conditions and disabilities. Trends in cognitive impairment and dementia have large policy implications for long-term institutional care. The use of long-term care is expected to increase the longer people live (Shrestha and Heisler 2011). Nearly three quarters of long-term care expenses are currently funded by public programs such as Medicaid. The estimated cost of Alzheimer’s disease to Medicare and Medicaid totaled $50 billion in 2000.
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is projected to be $200 billion by 2012 (Alzheimer’s Association 2012). (See Fig. 2.2). Furthermore, questions arise as to the best ways to organize, access, and deliver services to older adults who have limited financial resources.

Immigration issues also have implications for policy. Pursuing an immigration strategy that favors workers entering for employment reasons may slow U.S. population aging therefore averting or delaying some policy challenges. Immigration may also create a number of policy challenges. For example, immigrants overly concentrated in certain geographic areas may strain local government infrastructure and resources.

Along with increased immigration there are increases in interethnic and inter-racial marriage, which has led to a growing multiracial population. This diversity presents policy and service challenges in a number of areas especially assimilation, income disparities, and poverty. In addition, there are differences in how different ethnic and racial groups use health services. It is essential that caregivers be cognizant of cultural differences among care recipients and their families and tailor expectations and behaviors with respect to ethnic beliefs and values. Caregivers need to understand the value system of elders and assess the extent to which care recipients hold on to traditional values. There are also differences in the types of care sought and utilized by race and ethnicity, differences in health conditions experienced, and differences in mortality rates for specific conditions (Shrestha and Heisler 2011).
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These differences could mean that some groups will experience poorer health and a greater need for caregiving resources at certain ages. Lehman (2009) pointed out, caregivers need to take into consideration the national origin of care recipients, age and gender, and the level of acculturation especially when the cultural origin of the caregiver differs from that of the care recipient. Caregivers’ cultural backgrounds can also influence the relationship between caregivers’ support networks and their personal strain as well as coping strategies.

The effect of a changing age structure will create new and broad changes in American life. According to Kass (2005) we will live differently, work differently, and think differently in a society in which the needs of the old become more dominant.

2.3.1 The Effects of Gender, Rights and Equality Issues on Caregiving

Forces shaping the evolution of gender, rights, and equality issues can be understood historically by examining three models for organizing work and family: the household economy model, the dual breadwinner/female caregiver model, and the male breadwinner/female caregiver model (Boris and Lewis 2006). The household economy model was evident in Colonial America, followed by the male breadwinner/female caregiver model in the nineteenth century, and the dual breadwinner/female caregiver model in the twentieth century. These models overlap in their evolution rather than follow a linear chronology. Table 2.2 shows how major themes of
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Table 2.2 Major themes of caregiving during different eras in U.S. history. (Time periods and historical eras accessed from http://www.U-S-history.com/pages/eras.html)

<table>
<thead>
<tr>
<th>Historical era</th>
<th>Major theme of caregiving</th>
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<tbody>
<tr>
<td>To 1630</td>
<td>Simple, direct, informal, technologically and knowledge-limited, family-focused</td>
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<tr>
<td>Early America</td>
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<tr>
<td>1630–1763</td>
<td>Women as primary caregivers, home-based care, low life expectancy, aging parents used contracts to guarantee their support in old age</td>
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<tr>
<td>The colonial period</td>
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<tr>
<td>1763–1783</td>
<td>Women giving care to soldiers in their homes and field hospitals, women from religious orders giving care to soldiers</td>
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<td>Revolutionary America</td>
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<tr>
<td>1783–1815</td>
<td>Boundaries and roles for women debated; a Bill of Rights was drafted by Congress and submitted to the states</td>
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<tr>
<td>The young republic, first industrial revolution</td>
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<tr>
<td>1815–1860</td>
<td>Domestic slaves used as caregivers, reform of mental hospitals and use of caregivers</td>
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<tr>
<td>Expansion, political reform, turmoil</td>
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<tr>
<td>1830–1876</td>
<td>Social obligation of reciprocity to guarantee care in old age, first nurse training school established</td>
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<td>Sectional controversy, civil war, reconstruckion</td>
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<tr>
<td>1871–1914</td>
<td>Germ theory of disease improved public health and sanitation, reduced infection and death, life expectancy 48 years</td>
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<td>Second industrial revolution</td>
<td>Healthcare moved to hospitals; women’s political movements</td>
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<td>1880–1920</td>
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<tr>
<td>Political reform II</td>
<td>Women enter workforce in great numbers, women veterans as caregivers; disabled veterans with chronic care needs; licensing of group child care homes</td>
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<td>1914–1933</td>
<td></td>
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<td>World War I, prosperity, depression</td>
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<tr>
<td>1933–1945</td>
<td>Traumatic stress disorder appears; Holocaust experiences of survivors</td>
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<tr>
<td>The silent generation, World War II</td>
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<tr>
<td>1945–1960</td>
<td>Studies of caregiving contexts; Migration away from parents and families, population of 65 and over increasing; many baby boomers are caregivers for spouses</td>
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<tr>
<td>Postwar America</td>
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<tr>
<td>Korean war</td>
<td>Studies of role strain and role conflict; 60% of older Americans lived at or near poverty, 80% relied solely on Social Security; end of life issues, the care of HIV/AIDS patients</td>
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<tr>
<td>1960–1980</td>
<td>Advent of hospice in U.S., importance of patient’s culture in caregiving; Alzheimer’s and dementia major problems; women represent one half of workforce.</td>
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<tr>
<td>The Vietnam era, civil rights</td>
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<tr>
<td>1980–2000</td>
<td>Care in institutional settings more common, but at high cost, care given by a network of providers; group homes common; Veteran’s Care Act of 2005; working caregivers; Patient’s Bill of Rights</td>
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<tr>
<td>End of twentieth century, Persian Gulf war</td>
<td></td>
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<tr>
<td>2001–</td>
<td></td>
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<tr>
<td>The new millennium, Iraq-Afghanistan wars, terrorism, economic downturn</td>
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caregiving have evolved and changed during different eras in U.S. history from the Colonial Period to the present day to the twenty-first century.

2.3.2 The Household Economy Model

During Colonial America work and family life was organized so that all members of the household shared responsibility for household maintenance. Men took
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Responsibility for most tasks outside the home while women worked largely within
the home preparing meals, laundering, cleaning, and caring for children. Women
also joined neighbors to assist at sickbeds, weddings and funerals. Some women
worked as professional midwives and provided social support in times of need.
Women’s roles overlapped and continued this way throughout the nineteenth and
into the twentieth centuries. Men were heads of households and of their communi-
ties. Women’s work was highly valued and while they were not seen or treated as
social, political or economic equals to their husbands, they were recognized as con-
tributing valuable labor to their households (Boris and Lewis 2006).

Gender roles in America changed little in the early nineteenth century despite so-
cial changes that accompanied industrialization and urbanization. There was greater
participation by women in farm work and in industrial work that produced goods for
sale at the market and yielded earned wages. The household economy model also
was followed by African American families throughout the nineteenth and early
twentieth centuries.

After the Civil War, African Americans sought social, political, and economic
independence. Freed women sought a balance between work and family responsi-
bilities. The household economy model also held for immigrants coming to the U.S.
during the late nineteenth and early twentieth centuries; the typical first generation
immigrant family worked as a productive unit, yet women assumed responsibility
for domestic duties, while men’s efforts were primarily wage earning.

Family caregiving was the model in the United States during its colonization by
European settlers in the latter part of the eighteenth century (Manring et al. 2009;
Scharlach 2008; Tanielian and Jaycock 2008). Caring for sick family members
was considered to be part of a woman’s job. Almost all caregiving was done at
home. Lacking formal knowledge of disease, women provided care based on their
own personal experiences. It wasn’t until the Civil War (1861–1865) that formal
caregiving was established in the form of professional nursing in the United States
(Domrose 2011).

When the Civil War broke out there were no military nurses and most caregiving
duties were assigned to convalescing soldiers who were well enough to perform them
and to women in religious orders who cared for soldiers on both sides (Egenes 2009).
The Civil War soon became too large on both sides to limit women who were willing
to work for the military. Some historical accounts estimate there were 2,000 nurses
on each side. Union hospital documents show at least 21,000 women on the payroll.
Some women volunteered with aid organizations or religious groups, others followed
their husbands or brothers to the battlefields, still others were freed and escaped slaves.

Women cared for sick and wounded soldiers on the battlefields, in field hospi-
tals, in hospitals away from battle sites, and even in their own homes. Many wom-
en, widowed and without income, worked as hospital or field camp relief workers.
Their titles and pay varied according to race and social class. The work of Civil War
“nurses” proved that women could provide excellent care for men they were not
related to without damaging their reputations. The Union Army added a small corps
of 100 female nurses who were trained by Dorothea Dix who was named Superinten-
dent of Union Army nurses during the war, already famous as a reformer and advo-
cate for the mentally ill, and Elizabeth Blackwell, the nation’s first female physician.
The work and writings of Florence Nightingale, a British nurse, who elevated the role of caregiver to that of a professional nurse during the Crimean War in 1854 when she brought standards of care and infection control to wounded soldiers, became known in the U.S. Nightingale’s teachings about sanitation proved helpful in preventing the spread of infection and disease, which killed more soldiers than wounds. A combination of Nightingale’s work, advances in medicine, and growth of hospitals, and the inspiration of Civil War nursing stories created a climate for professional nursing education. The U.S. Sanitary Commission lobbied for the establishment of the country’s first nursing schools in New York, Connecticut, and Massachusetts (Larson 1997).

2.3.3 The Male Breadwinner/Female Caregiver Model

Urban industrialization in the mid-nineteenth century in America created a dramatic reorganization of home and work that developed a model with sharper distinctions between men’s and women’s work and family responsibilities. Men were clearly the economic providers; wages became a standard for manhood. Women’s work that did not earn a wage was considered non-productive. Women’s domestic labor was termed “care” rather than work. This transformed the meaning of domesticity especially among the middle class and among white women. As Boris and Lewis (2006) stated, “household work became invisible” p. 79.

Wage work that women engaged in outside the home was considered temporary and circumstantial. Women who were permanent wage earners were disparaged because they were unable to live up to fulfilling their domestic role as caregivers. Women’s work was not given the same value as a man’s. This point of view extended to all women including immigrants. Women, especially those from the educated middle-class, increasingly sought work outside the home and initiated social reforms. They called for public recognition to legitimatize their work. Women’s work became regarded as failed responsibility of men to support their families economically.

Some mothers delayed entry into the work force until their children started school. For others childcare became an issue. Some middle-class reformers established day care nurseries to help poor wage-earning mothers. Mothers’ petitions of the 1910s and 1920s evolved into Aid to Dependent Children (ADC) under Social Security in 1935.

The New Deal in the 1930s institutionalized the country’s commitment to the male breadwinner/female caregiver model as the appropriate relationship between men and women. Relief programs such as the Works Progress Administration (WPA) reinforced gender and racial hierarchies by employing men over women and whites over other groups. Programs under the New Deal linked work to benefits so that some people would get benefits by virtue of their gender or paid employment. Aid to Dependent Children (ADC) also became a means-tested stimatized program which was run by the states and varied greatly in requirements and amount of aid. During World War II the federal government increased child-care funding for wage-earning mothers, most working mothers found other forms of child care.
Some corporations and industries reimbursed employed mothers for meals and laundry to ease their burden. By the end of World War II the male breadwinner model/female caregiver model was institutionalized in public programs and in cultural expectations.

### 2.3.4 The Dual Breadwinner/Female Caregiver Model

Post-World War II social policies encouraged mothers to enter the labor force and work overtime while fulfilling their family and domestic responsibilities. The 1950s were recognized by historians as a period of wage-earner mothers, overlapping models for combining work and family. Nonetheless, the male breadwinner remained the ideal, with whites as the norm. Only during the 1960s did the rights movement come to dominate discussions of women and employment (Boris and Lewis 2006). With half of the employed women married and a third of married wage earners with children under age 18 in 1953, the U.S. Women’s Bureau sought to improve the income, benefits, hours, and working conditions of women wage earners. The President’s Commission on the Status of Women, created by John F. Kennedy in 1961, had as its task to recommend ways to overcome discrimination in government and private employment on the basis of sex, but also enable women to continue their roles as wives and mothers while making a contribution to the world around them. Women tended to see themselves as workers and mothers, breadwinners and homemakers; they refused to choose breadwinning over caregiving or equate equality with assimilation to the male sphere (Boris and Lewis 2006). The public agenda also ignored how women from other racial and ethnic groups managed to combine work and family.

The Civil Rights Act of 1964 was a landmark piece of legislation in the U.S. that outlawed major forms of discrimination against African-Americans and women, including racial segregation. It ended unequal application of voter registration requirements and racial segregation in schools, in the workplace, and in facilities that served the general public. Among some of the first complaints filed by the Equal Employment Opportunity Commission (EEOC), the federal agency formed to administer the law, were charges of pregnancy discrimination. It was claimed that management forced pregnant mothers to quit their jobs, took away their seniority, or deprived them of sickness and accident benefits. The Pregnancy Discrimination Act (PDA) of 1978 held that pregnancy would be treated not as a disability but in terms of its comparability with other conditions that impacted employment. After the PDA labor unions, for example, could negotiate paid pregnancy leave and non-paid child-care leave with large employers and airlines permitted flight attendants to apply sick leave to pregnancy rather than terminating them. State laws offered other treatments for pregnancy.

The Family and Medical Leave Act (FMLA), introduced in 1985, became law in 1993; it permitted men and women, in companies with 50 or more employees, 3 months of unpaid leave for birth, adoption, or care of an ill family member and
the leave taken was with guaranteed job and health benefits.\(^1\) The Act was seen as having the potential of providing relief to women who face the stressful demands of multiple roles (Jenkins 1997).

In the period since the FMCA Act the conventions about what it means to be a man in today’s workplaces and families have changed. Traditional gender roles have become more egalitarian and challenging. Surveys have found that this change has not been easy for men to adjust to (Galinsky et al. 2009). A man today is someone who is not only successful as a financial provider but is also involved as a father, husband/partner and son. Men who work long hours in demanding jobs and are work-centric or are fathers in dual-earner households, are at-risk for work-family conflict. Men are now experiencing what women found when they first entered the workforce—the pressure to do it all and have it all (Thomas 2012). See Fig. 2.3.

Aumann et al. (2011) suggest that change needs to occur in individual attitudes about work and family and workplace design as well as cultural change that dispels the mystiques for both men and women.

When men and women both experience more equality in the workplace in terms of pay and career advancement opportunities they will have choices in how they can better manage breadwinning and caregiving roles.

\(^1\) Since the passage of the Family and Medical Leave Act (FMLA) in 1993, 21 states have dropped the family component of the original law and, instead, reduced coverage to baby care or parental leave. This shifts the emphasis on family, including care of elderly parents, to parental, baby care only. With the baby boom population aging the demand for family care will increase and employers will be pressured by employees for release time to assist aging parents. See Wisensale (2003).
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