

“Man, Woman, and Chore Boy”:
Transformations in the Antagonistic
Demands of Work and Care on Women in
the Nineteenth and Twentieth Centuries

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ON JANUARY 20, 1904, MRS. U., THE WIFE OF A laborer suffering from tuberculosis, applied for aid from the New York Charity Organization Society. Because her husband had been forced to quit work, Mrs. U. had supported the family for two years by cleaning offices and taking in washing. Six weeks prior to her application, however, her husband had become so ill that she had dropped her jobs in order to nurse him full time. As a result, she could not afford to pay the rent or buy food, fuel, or clothing (Community Service Society 1888–1918).

The simultaneous increase of women’s labor force participation and the aging of the population has encouraged policy makers to focus on the competing demands of work and care for elderly relatives. Mrs. U.’s experience reminds us that, if we broaden our focus to include care for sick and disabled family members of all ages rather than just the elderly, the conflict between work and care has a long history, especially in the lives of less privileged women. This essay traces the ways various groups of women wrestled with the antagonistic pulls of work and care as the content and meaning of both phenomena changed between 1820 and 1940.

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As usual, it is important to begin with qualifications. Although I note the problems of women caring for sick and disabled husbands, I have chosen not to discuss the situation of men assuming responsibility for sick and disabled wives. The experiences of that group overlapped with those of the women I examine; nevertheless, their stories deserve separate analysis.

Working and Caring between 1820 and 1890

During most of the nineteenth century, caregiving was more likely to conflict with domestic work than with paid employment. Household labor for most women was extremely arduous. Although manufacture of textiles, soap, and candles moved into the factory early in the century, indoor plumbing did not reach most households until the twentieth century (Arnold 1985; Cowan 1983, 16–68; Strasser 1982). Laundry alone was a day-long ordeal, demanding that women carry gallons of water, lug pails of wet clothes, scrub and rinse each item and hang it on the line, exposing their hands in the process to lye and other caustic soaps (Dudden 1983, 106; Strasser 1982, 195).

Some of the tasks women performed when family members fell ill were indistinguishable from their routine household labor. Sickness, however, also imposed extra burdens, such as cooking special food, washing sheets and bedclothes more frequently, and preparing medicine. Because hospitalization rarely was an option, women had to provide personal care, even for critically ill patients. “It is hard to have the care of a poor sick man day after day, week after week,” wrote Mary Ann Webber, a Vermont woman, to her son in 1871 when her husband lay dying (Webber [June] 1871). Dressing him, getting him in and out of bed, helping him walk, and bathing him consumed time and energy she previously had devoted to her daily chores. As he grew progressively weaker, her burdens multiplied. Although she was familiar with heavy farm work, lifting a bedridden man several times a day taxed her strength (Webber 1871). Marian Louise Moore, an Ohio homesteader, remembered her experience nursing her mother:

In the Spring of the year 1872 . . . she was sick three months, part of the time helpless, typhoid inflammatory rheumatism . . . This sick-

ness of hers brought more work upon me, washing and other work, when I had more work of my own than I could possibly do well. (Lerner 1977, 176-7)

In many cases, women provided what we now might consider skilled nursing services. When Emily Gillespie, an Iowa farm woman, was sick in the 1880s, her daughter Sarah gave her catnip tea, bathed her hip in smartweed water, cleaned her bedsores, and "sat up" many nights in order to forestall "sinking spells." Despite these responsibilities, Sarah had a staggering amount of other work. Even when caring for her mother "night and day," Sarah rose at 5:30 A.M. to prepare her brother's breakfast, fed over 200 turkeys, baked bread and pies, mopped the kitchen, washed the family's clothes, and took berries to the market (Gillespie 1885-88).

Some caregiving obligations were even less compatible with household labor. Most women routinely cared not just for immediate family members but also for an extensive network of kin, friends, and neighbors. Sickness among members of this broad community pulled women away from home, often for extended periods. Mary Wilder Foote wrote that, when her baby was very ill, "My kind friend, Mrs. Pierson, sat with me *four* days, leaving all her family cares. Nobody ever tended a child so exquisitely, and in her lap I could place my darling, and feel at ease" (Tileston 1918, 92-3). Other women performed the same tasks in their neighbors' homes that they left undone in their own. Abby Bright was a young woman living with her brother on a Kansas claim in 1871 when she learned that her neighbors were ill. Arriving at their house, she "fixed to bake bread next day, then commenced at the dishes which sat around in confusion." The following morning she "washed dishes, pots and pans, I had not found the evening before, dressed a chicken, browned coffee, and what not. Had chicken and sweet potatoes for dinner. It was long after noon when the bread was baked, and house tidied up" (Snell 1974, 411-12).

In some cases, women who responded to pleas for help were able to draw on the system of mutual aid for their own work. When Emily Gillespie was summoned to assist her sister Harriet in childbirth, Harriet's sister-in-law Lilly went to Emily's house to bake her bread and cook her husband's dinner (Lensink 1989, 164). More often, the caregiver's housework accumulated in her absence. In January 1891, Nannie Stillwell Jackson, an Arkansas woman, and her husband watched a sick

woman throughout most of one night. When they returned home, Nannie's husband "laid down & took a nap." Her work, however, could not wait. "I churned & cooked breakfast & had it ready before daylight," she wrote in her diary (Bolsteri 1982, 67). A week later, Nannie noted that she had spent most of the day caring for another sick friend and, as a result, had "done no work" (Bolsteri 1982, 71). A mission of mercy had more serious consequences for Effie Hanson, a North Dakota farm woman. Writing to a friend about the caregiving services she and her husband rendered when her mother-in-law died, Effie noted, "We lost some chickens those cold spells as we wasn't home to take care of them as we should" (Wold 1981, 30).

When husbands were the recipients of care, wives typically added their husbands' chores to their own. Mary Ann Webber was in her early sixties when her husband's health began to decline. In January 1865, she wrote to her children, "Your Father and myself, or rather, I perform our daily round of chores. I am able to cope, but he feels it a great burden many times. His health is not very good" (Webber [Jan. 15] 1868). A few months later, he injured his ankle in a fall on the cellar steps and was unable to walk without crutches. "This has been a great disadvantage," she wrote. "It has also made it very hard on me, as I have to be now Man, woman, and chore boy" (Webber [June 1] 1865).

When illness struck men who were wage earners, their wives often were thrust into the job market. Emily Conine Dorsey, an Indiana woman, wrote to her sister in March 1854, "John's health is poor and I fear is likely to remain so. This is the evil wind which blew me again into the school room." Because the school was close by and she could earn a decent salary, "it would not have been bad at all" had she been able to afford a "hired girl" to help with the household chores. But the combination of teaching, housework, and caregiving overwhelmed her (Baker 1973, 146-67).

If family sickness pushed some women into the labor force, it drew others back home. Increasing numbers of single women went out to work during the nineteenth century. But female workers at all levels of the occupational hierarchy quit their jobs when family members fell ill. After Malenda Edwards left her job in the mills to care for her parents, she wrote to a friend that she was serving as "physician and nurse too" and that she would travel west were it not for the need to provide care (Dublin 1981, 85-6). Anxious to establish her economic independence, Velma Leadbetter learned dressmaking. Her work separated her from her

family in Nanticoke Valley in New York, but she was recalled periodically to render assistance during sickness. Her daughter later wrote, "The maiden woman in a country family belongs to everybody in case of illness. . . . [C]all on her and she'd come home and take care of the mother or the father who was ill" (Osterud 1991, 126).

Even entry into a profession did not excuse single women from the duty to care. Mary Holywell Everett was a successful physician when her sister became ill. A male colleague to whom she had written counseled her this way: "Even at the risk of losing your practice entirely, duty commands you to remain by the side of your old mother and help her to carry the burden" (Lerner 1977, 179). At least one of Everett's female patients concurred with this advice. Writing to Everett about her absence from her practice, the patient commented, "Being that you have no husband, your dear mother has the first claim to you" (Lerner 1977, 179).

The history of women teachers in the nineteenth century is filled with stories of women who left their posts to nurse family members. Sarah Gillespie was 19 years old and had just begun her teaching career when her mother, Emily, fell ill in the fall of 1884. As Emily's health deteriorated, Sarah increasingly was torn between her responsibilities as a daughter and as a teacher. After a visit home in June 1885, Sarah expressed her concerns about leaving her mother with only a "hired girl" to help: "Ma has the dropsy to her body. . . She did not sleep she said her feet & legs pain her so badly—Now if I was there Id rub them for her—But there is nothing done for her at all" (Gillespie [June 4] 1885). On May 16, 1886, Emily suffered a stroke, and Sarah resigned her job. Sarah was able to return to school in November, but when a new term began in April 1887, she deferred opening the school to stay home an extra week. Instead of boarding in the community, she traveled the nine miles between home and school each morning and evening in order to tend her mother. When the term ended in June, Sarah returned home and devoted herself to her mother's care. Even when Emily lay dying in March 1888, the offer of a new teaching job sorely tempted Sarah, much as she tried to convince herself otherwise. "No—I can not teach no use to think of it now," she wrote nine days before her mother's death (Gillespie [March 15] 1888).

Slave women faced the cruelest conflict between work and care. A host of illnesses, including dysentery, typhus, diarrhea, rheumatic fever, diphtheria, and whooping cough, ravaged slave communities. Quarters were overcrowded and lacked proper sanitation and ventilation; hard

physical labor, combined with inadequate rest, diet, and clothing, heightened vulnerability to disease. In addition, disabilities frequently resulted from accidents and brutal punishments (see Jones 1985; Savitt 1985, 313–30). Not surprisingly, slaves had higher rates of mortality than whites (Mintz and Kellogg 1988, 73). The conditions of the slave quarters, which abetted the spread of disease, also made caregiving a herculean endeavor. A cabin consisted of one room with a dirt floor, no window, cracks in the walls, and a chimney made of clay and twigs. Two or more families frequently shared such cabins, which measured between 10 and 21 feet square. The great majority of slaves lacked privies and any sanitary means of garbage disposal (Mintz and Kellogg 1988, 73). Slave women could eke out time to care for their families only when they returned at night, exhausted from work in the fields or big house. Care for sick members of slave owners' families had to take precedence over care for the slave women's kin.

Structural Transformations in Work and Care

A constellation of forces between 1890 and 1940 affected the amount and nature of women's caregiving responsibilities in complex ways. Large corporations began to mass produce goods and services for private households; as electricity, gas, indoor plumbing, household appliances, and store-bought foods reached increasing numbers of families, the individual tasks of caregiving became progressively easier (Cowan 1983, 40–101; Strasser 1982, 3–243). Simultaneously, however, new concerns about the importance of ventilation, diet, and cleanliness in health promotion augmented caregivers' responsibilities (Tomes 1991). In addition, urbanization and geographic mobility weakened bonds of kinship and community (Sacks 1984, 15–38; Smith 1985, 107–21). Some women thus were less likely to feel responsible for ensuring the well-being of an extensive network of relatives, neighbors, and friends; those who did render care, however, increasingly found themselves in isolated dyads. The control of infectious diseases meant that women spent less time ministering to seriously ill children. But as chronic diseases replaced acute ailments as the major cause of death (Weindling 1992), caregiving obligations shifted to the latter part of the life course and frequently extended over longer periods.

The growth of formal health care services also profoundly affected family care. The first nursing schools were established in 1873 (Starr 1982, 155). By 1900, there were 3,456 graduates (Cowan 1983, 77); the majority worked as private duty nurses, helping family members deliver care in private households. Other developments moved care out of the home. In 1929, physicians in Philadelphia devoted just 15 percent of their work week to home visits, spending the rest of their time in offices, clinics, and hospitals (Cowan 1983, 84-5). The number of hospital beds doubled between 1900 and 1920, and growth accelerated throughout the 1920s (Stevens 1989, 111). By the mid-1930s, hospitalization had become routine for a broad array of afflictions; over a quarter of all deaths occurred in hospital settings (Stevens 1989, 111).

A common assumption is that the growth of hospitals relieved women of critical responsibilities. James H. Cassedy, for example, writes that "the shifting of the locale of much medical care . . . from the home to the hospital" meant that "some of the family's traditional roles gradually diminished" (Cassedy 1991, 93). Martha Shaw Farnsworth's account, however, demonstrates that the story could be much more complicated. The wife of a postal carrier in Topeka, Kansas, Martha kept an extensive diary throughout her life. On February 2, 1913, she noted that she had hospitalized her niece, Freda, who "had just been taken with appendicitis" (Farnsworth [Feb. 2] 1913). Martha and her husband "waited to see her come out of Anaesthetic, then we came home to do up our work and get a bite to eat" (Farnsworth [Feb. 4] 1913). Martha's "work" involved raising poultry and selling eggs and milk as well as all the household labor. She was back at the hospital by 8 P.M. and stayed until almost 10 (Farnsworth [Feb. 4] 1913). Arriving at the hospital at 8:30 the following morning, she "waited on Freda all day" (Farnsworth [Feb. 5] 1913). Her report for February 7 was similar: "With Freda all day at Stormont Hospital. The Hospital is full, with only 16 nurses, so they neglect Freda's bathing and I had to make a *kick* [fuss]." That evening Martha "went home by car as I was too tired to walk. I did not get to sit down five minutes during the day, but work over her constantly" (Farnsworth [Feb. 7] 1913). Martha continued to go regularly to the hospital until Freda's discharge two and a half weeks later (Farnsworth [Feb. 7] 1913).

To some extent, Martha transferred caregiving to the hospital. Rather than sitting up through the night to watch for troublesome symptoms, she could leave Freda in the hands of institutional staff and return home to sleep. Nurses also relieved Martha of responsibility for at least some

aspects of personal care. If hospitalization released Martha from some tasks, however, it created others. For the first time, she was responsible for supervising the work of paid caregivers. When the nurses' care fell short of her standards, she made a "kick." She also had to travel back and forth between home and hospital. Although she once returned home by car, she typically walked, often through snow (Farnsworth [Feb. 7] 1913). Because she could not intersperse caregiving with farm and household labor, her chores accumulated. And hospital care was expensive. When Martha subsequently had reason to chronicle the various sacrifices she made on Freda's behalf, paying the hospital bill occupied a prominent place on the list (Farnsworth [Sept. 18] 1914).

Not only did the developments between 1890 and 1940 have complex implications for caregivers, they also affected groups differently. White, middle-class people were the first to embrace the new medical advice about domestic hygiene (Tomes 1991). Mutual aid also declined most rapidly among white, middle-class groups (see Cohen 1992, 106-7; Collins 1991, 43-138; Ewen 1985, 203-4; Stack 1974). Privileged women thus were least likely to be able to rely on a broad network of friends and relatives when illness struck. In other ways, caregiving responsibilities were most onerous for poor women and women of color. Although their families sustained the greatest burden of sickness (Technical Committee on Medical Care 1938, 8-11), they had the least access to services. Private duty nurses, for example, rarely were an option. Their average annual salary was \$950 by the early twentieth century and \$1,300 by the late 1920s (Reverby 1987, 98). As Susan Reverby (1987, 98) writes, "Such an expense was beyond the grasp of the average white earner." In addition, consumer goods and services reached low-income households relatively late. Poor women were still lugging pails of water inside to bathe sick family members and wash their bedding long after more affluent women had indoor plumbing (Kessler-Harris 1982, 119-21).

The job of mediating between family members and institutional services also was especially difficult for low-income women. Few hospitals and clinics were located in poor neighborhoods. Nurses at a Cleveland dispensary in 1907 described a mother who walked four miles each way to bring her ailing baby for regular check-ups (Report of the Nurses 1908, 40). According to a 1938 report, mothers in some areas of New York City were "travelling long distances" to take babies to municipal health stations, "in many instances paying two bus fares" (Committee on Neighborhood Health 1938). Travel was even more difficult in rural

areas, where facilities often were farther apart and public transportation nonexistent. Once they reached the clinics or dispensaries, poor people often waited hours to be seen (Davis 1921, 329 and 335).

Visiting hospitalized family members also was onerous. Although Martha Shaw Farnsworth had easy access to her niece in Topeka, Kansas, hospitals serving working-class people in large cities often restricted family visits to two or three hours a week (Board of Health 1907, 465). Carefare was another problem. A Czech immigrant woman who supported three children on her wages as a janitor in New York City in 1918, deprived herself of food in order to visit her husband in the state hospital for the insane at Central Islip (Community Service Society 1888–1918).

The rising cost of health care also affected different groups unevenly. The poor alone benefited from free or low-cost clinics and hospital care. Many poor people, however, shunned free services, which they considered inferior; many others lacked access to such care (W.L. 1935). In the absence of either public or private health insurance programs, most people paid for care out of pocket. But by the 1930s, the incomes of working-class people were insufficient to cover the cost (Technical Committee on Medical Care 1938, 21–9).

Race and ethnicity as well as income level shaped caregivers' interactions with formal health care services. Access to medical care was almost completely blocked to people of color. One prominent African American physician estimated in 1927 that "each white citizen of the United States has fourteen times as good a chance at proper hospital care as has the Negro" (quoted in Hine 1989, 56). Throughout the South, hospital care typically was available only in segregated wards, located in the basements of city hospitals (Stevens 1989, 137–8). A study conducted by the American Red Cross for the Bureau of Indian Affairs in 1924 reported that most hospitals serving Native Americans had too little equipment to provide even rudimentary treatment, and many Native Americans had access to *no* facility (Patterson with Fox 1924). Public health nurses employed on reservations during the early 1930s routinely commented that the nearest hospitals were hundreds of miles away (Field Nurses 1930–9). When African Americans and Native Americans fell ill, they were more likely than whites to remain at home, receiving care from family members.

I have stressed the changes in women's caregiving responsibilities and slighted those in women's work because the latter have received far more attention from historians. Nevertheless, in order to understand the shift-

ing relation between work and care, it is important to summarize briefly the transformation of women's work, both at home and in the public arena, between 1890 and 1940. The goods and services that reduced the burden of caring for sick family members eased women's domestic labor in general (Cowan 1983; Strasser 1982). During the same period, the proportion of women working for pay grew. Most female workers were single, but married women's labor force participation also rose, from 3.3 percent in 1890 to 9 percent in 1920 (Kessler-Harris 1982, 122). Although housework remained most onerous for poor women and women of color, they were most likely to enter the workforce. During the early decades of the twentieth century, researchers consistently found that women's propensity to seek paid jobs varied inversely with the size of their husbands' paychecks (Ladd-Taylor 1994, 30). In 1920, 20 percent of white women, 26 percent of Japanese American women, and 40 percent of African American women had paid jobs (Amott and Matthaei 1991, 299).

After 1890, in short, the conflict between work and care took new forms. Caregiving involved not just delivering services but also arranging for help from formal providers, transporting patients to clinics, doctors' offices, and hospitals, and paying medical bills. The work of growing numbers of women included paid employment as well as domestic labor. Reconciling work and care thus frequently involved balancing a wide variety of activities, each dominated by a different clock and each located in a different site. Because poor women and women of color shouldered the heaviest burden of domestic labor, were especially likely to work for pay, and encountered the greatest difficulties obtaining health care services, they experienced the most tension. The following section will highlight their experiences.

The Antagonism between Paid Employment and Caregiving, 1890–1940

The illness of family breadwinners continued to push women into waged work (Kessler-Harris 1982, 122). When Gwendolyn Hughes Berry asked 728 working mothers in Philadelphia in the mid-1920s why they had returned to the labor force after marriage, 14 percent responded that their husbands were sick (quoted in Pidgeon 1935, 19). A 1930 study of

women working in laundries in 23 cities reported that 12.9 percent "laid the necessity to the husband's incapacity through illness, accident, or old age" (Best and Erickson 1930, 92). A Jewish immigrant woman later explained her entry into the job market this way: "I worked not because I wanted to but because it was an emergency when my husband got sick. What was I supposed to do—let the children starve?" (quoted in Weinberg 1990, 231). When households depended on the wages of older children, their ill health also could compel women to seek jobs. Women's Bureau investigators spoke to a cigar roller in Allentown, Pennsylvania, who had gone to work when her 23-year-old son became ill and to another who viewed her job as a temporary expedient while her 14-year-old daughter regained her health (Women's Bureau n.d.).

The cost of health care also propelled women into the labor force. Paul Starr notes that workers' lost earnings during the early twentieth century tended to be "two to four times greater than health care costs" (Starr 1982, 245). Because dependents as well as earners incurred medical expenses, however, households with multiple dependents might suffer greatly from health care costs (Starr 1982, 245). Mrs. H., a South Bend woman, told interviewers that she worked in an underwear factory because her husband's salary was inadequate to pay the "thousands" of dollars of medical bills accrued for her son's operations (Women's Bureau n.d.).

Women's work experiences varied by their status within the family. Several historians point out that jobs sometimes helped daughters in European immigrant families to carve out adult identities, releasing them from parental authority, introducing them to new ideas and groups of people, and giving them at least a modicum of financial independence (Glenn 1990, 132–65; Kessler-Harris 1982, 126; Peiss 1986; Weinberg 1990, 190–2). Kathy Peiss (1986) argues that young, white, working-class women in New York City between 1890 and 1920 flaunted their sexuality, violating the precepts of both middle-class reformers and their immigrant parents.

But waged work could retard as well as enhance daughters' autonomy. Daughters whose earnings were central to their parents' support frequently were compelled to drop out of school to go to work; some also faced pressure to postpone marriage until another child could enter the labor force. Because such daughters contributed most of their incomes to the family coffers, they had little to spend on consumption and leisure

activities. And most jobs available to young women were stultifying rather than gratifying (Amott and Matthaei 1991; Cohen 1992; Glenn 1990; Kessler-Harris 1982; Mintz and Kellogg 1988; Weinberg 1990).

Waged work was especially unlikely to serve as a route to independence when sickness visited the household. The illness of principal breadwinners was a major cause of daughters' premature departure from school. Dora W., the daughter of Jewish immigrants, had hoped to go to college but quit high school to work in a shop when her father became ill. As she later recalled, she resented not just the low pay and poor working conditions but also the humiliation of associating with people she considered her social inferiors: "I was with people, poor girls. I was terribly unhappy. They were uneducated, and I had had a bit of, a taste of education, and the better things in life. I used to come home and weep" (quoted in Weinberg 1990, 188). Pressure to forgo marriage also increased when other household earners were ill. Some women had to leave jobs they liked for ones that paid better. Others took second jobs to make household ends meet (Simon 1987, 51 and 61; Weinberg 1990, 157 and 191).

The illness of other earners also tended to increase the proportion of wages daughters had to give their parents. According to Sydney Stahl Weinberg, when Fannie C., a young Jewish immigrant woman, first went to work, "she used some of the money she earned for her own needs. But when her father fell ill and could no longer work, everything went to her parents. 'Even when I had to buy clothes,' she recalled, 'I would go to my parents and ask them for the money because I would give them my whole salary'" (Weinberg 1990, 191). Family sickness could deprive young women of the time as well as the income their friends devoted to leisure. Some had to assist with nursing services on their return from work. Although most working daughters were relieved of responsibility for domestic chores, the illness of mothers transferred the work to daughters (Women's Bureau 1924, 69).

Paid work could have compensations for married women as well as single. Martha Farnsworth's experience again is illustrative. When tuberculosis forced her first husband to withdraw from the labor force in 1893, Martha found a job serving meals at a boarding house. She previously had complained about her inability to spend money on herself. Now, however, she had control over the income. Although she handed over her wages to her husband, she kept the tips. Four months after beginning to work, she noted that she had bought "a *nice Guitar*, in a

Pawn-shop for 5.00." Employment also offered a welcome relief from the stresses of care. If her job was "hard," it was also "a blessing, in that I do not have to be so much with Johnny and run the risk of taking consumption, for he coughs dreadfully and the smell from his body is sickening" (Farnsworth [May 30] 1893).

But most of the rewards daughters reaped from waged work were not shared by wives. Among some immigrant groups, women typically quit work at marriage; wives who returned during crises violated community notions of appropriate female behavior (Cohen 1992; Glenn 1990, 66-7; Weinberg 1990, 196). Because employers routinely discriminated against married women, finding work was especially difficult (Coontz 1992, 157-9). Although responsibility for household chores was the exception among working daughters, it was the norm among working wives (see Pidgeon 1935, 20; Winslow 1924, 4-5).

Child care was another problem. Few day nurseries existed (Michel 1993). Some mothers did home work or worked at night so they could combine paid employment and child care. An Alabama woman interviewed by the Women's Bureau had gone to work to cover a \$752 medical bill resulting from her baby's illness. She "chose night work," which enabled her to be home when her husband worked; although the baby had died, she had two other children under six (Women's Bureau 1924, 70). As Linda Gordon (1988, 98) comments, employment at night "deprived mothers of sleep and often meant that they worked around the clock."

In a few instances, married women who replaced sick or disabled husbands in the workforce were able to rely on them to watch children (Pidgeon 1932, 125; Women's Bureau n.d.). More commonly, women paid neighbors and friends (Women's Bureau n.d.). A few working mothers resorted to the drastic solution of sending their children away. Evelyn Nakano Glenn (1986) interviewed an Issei woman who had sent two children to relatives in Japan when her husband became seriously ill and she found work in a laundry. The case records of a Jewish social service agency in New York contain information about the family of Mr. S., who entered a sanatorium in 1936. His wife returned to her occupation prior to marriage, placing their three-year-old son with an aunt in Maryland (Altro n.d.). Social workers at Bellevue Hospital in New York viewed themselves as helping the wife of a man who needed hospital care when they sought to "dispose" of her children to enable her to find work (Bellevue Hospital 1908, 8). Other women took children to work or

left them alone during the day (Ladd-Taylor 1994, 31; Mintz and Kellogg 1988, 129).

Although the experiences of daughters and wives diverged in some respects, they coincided in others. As a result of the wage differential between men and women, neither daughters nor wives could replace the lost earnings of male breadwinners (see Glenn 1990, 117–22). Some daughters and wives who worked because of illness shared financial responsibility with other family members. But women who were the sole family earners often engaged in desperate struggles for survival. A 1916 study of the families of patients at a tuberculosis clinic in New York examined several cases in which women entered the labor force in place of sick husbands. “In no instance,” the study concluded, “are the earnings sufficient to maintain a decent standard of living unless supplemented by children’s earnings or relief” (Association of Tuberculosis Clinics 1916, 25).

Both daughters and wives also faced the problem of fulfilling competing demands during working hours. The options available to such women were even narrower than those of working mothers with small children. Seriously ill patients could not easily be left with neighbors. Day nurseries refused to accept sick children. A New York mother who described herself as “a poor woman working for the W.P.A.” wrote President Roosevelt in 1938, requesting assistance in finding an institutional placement for her daughter; all day nurseries had rejected the girl because of her heart ailment (S.S. 1938).

Not surprisingly, some of the strategies caregivers adopted resembled those of working mothers. Martha Shaw Farnsworth, for example, sought a job that enabled her to return home at midday to tend her sick husband (Farnsworth [March 20] 1983). Other women found remunerative work they could do at home, taking in boarders, laundry, and piece work (Brown 1930, 6). A 23-year-old New York woman who left factory work when her mother developed a heart problem wrote President Roosevelt, “I *had* to take in home work to help pay doctor bills. It wasn’t hard & enabled me to take care of mother at the same time” (A.J. 1934).

But caregiving was not always compatible with waged work at home. As fears about germs spread, upper-class people occasionally refrained from bringing washing or sewing to women whose family members suffered from contagious diseases (Community Service Society 1888–1918). Home work consumed time and energy needed for care. The mother of a severely disabled seven-year-old boy complained in a letter to Eleanor

Roosevelt in 1938 that, when she added sewing for pay to her normal housework, she lacked "time to give him the attention & care that he should have." She feared that she would "have to leave the sewing alone," although "every little bit helps" (C.R.S. 1938). In addition, labor performed at home paid very poorly. The Women's Bureau concluded in 1937 that 80 percent of homemakers earned less than 20 cents an hour (Pidgeon 1937, 67-8). Testimony at a hearing conducted by the National Recovery Administration in 1934 cited the example of an Italian woman who had taken in piecework to help support her bedridden son. Her earnings for 96 hours of work were 15 cents less than the amount needed to pay for medicine prescribed for the boy (National Recovery Administration 1934). And some women undermined rather than promoted family health when they brought work home. Investigators in the early twentieth century attributed the high rate of lung infections among homemakers' children to the chemical fumes and fabric particles they inhaled (Cohen 1992, 105). Accidents resulted from sewing machines, hot irons, and boiling water (Boris 1994; Boris and Daniels 1989). Work that involved children's participation deprived them of time for play and sleep (Community Service Society Records 1888-1918).

Just as many mothers employed outside the home left children unattended, so many working caregivers left sick or disabled family members alone. A physician employed in the New York City Department of Health noted in 1915 that some working mothers locked children with whooping cough in the home (Dickson 1916, 19). The correspondence of Eleanor Roosevelt during the 1930s contained letters from two employed mothers whose children with long-term disabilities lacked supervision. One locked two "feeble minded" daughters in the apartment during the day (N.A.T. 1938) The other reported that her son wandered into town during her absence; twice the elevator at a nearby mill had nearly crushed him to death (L.M. 1938). I have noted that caregiving increasingly included transporting family members to medical appointments and visiting hospitalized patients. But those tasks, too, were impossible for many women in the labor force. Most offices and clinics were open only during regular working hours; hospital visiting hours often conflicted with laborers' working day (Peter Brent Brigham Hospital 1931).

The difficulty of caring for sick family members was especially great for domestic servants. Between the mid-nineteenth century and 1930, more women entered domestic service than any other occupation (Glenn

1986, 99). Excluded from many forms of paid employment, African American, Mexican American, and Japanese American women were especially likely to work as servants (Glenn 1992). As Phyllis Palmer (1989, 87) notes, "Domestics were envisioned as single women, young or old, cut off from any attachments except those to the employer's family." Those who lived in had virtually no opportunity to care for sick relatives. Day workers, too, complained bitterly about their long hours. One wrote to the NAACP in 1931: "I leave home quarter of 7 every morning. I finish 9:30 P.M. When I get home it is 10 o'clock. . . . The people treat me as one of their family and I suppose I should not kick. But—I certainly would like to know more about Domestic rules and laws if there be any" (quoted in Palmer 1989, 74). The lack of clear limits to the work day further restricted servants' ability to fulfill obligations to their own families.

In the twentieth century, as in the nineteenth, caregiving not only pushed women into the workforce but also drew them back home. Some women took off days without pay or relinquished their jobs to nurse family members (Women's Bureau 1926, 71 and 194). The records of a Jewish social service agency discussed a young woman whose father died after a long struggle with tuberculosis and whose mother remained "in bed as a complete invalid." Although the daughter "was an excellent student and was graduated from high school," the mother "depended entirely upon her, kept her at home and there didn't seem to be any way for the girl to get ahead" (Altro n.d.).

Other accounts emphasized the economic consequences of withdrawal from the labor force. For example, a Women's Bureau report on women's employment in slaughtering and meat packing noted the case of a 32-year-old Polish woman in Kansas City who supported two schoolchildren and an invalid husband. She had a \$400 hospital bill in addition to doctor bills, had mortgaged the house, and was "in debt beyond her courage." Nevertheless, approximately nine months prior to the interview her husband had become so ill that she had stayed home for two months (Pidgeon 1932, 125). When jobs were scarce, women who left the workforce found it difficult to return (Women's Bureau n.d.).

Many women who needed paid jobs also were kept home by caregiving obligations. In 1939, a separated New York woman whose husband was too ill to work justified her request for financial assistance this way: "In the past I have supported my family with out help and I was happy in doing so. Now my child is to [sic] sick for me to leave. His diet has to

be watched and he can't go out in all weather" (F.F. 1939). The same year, a Louisiana widow explained her inability to work: "I have a little afflicted baby. She is 3 years old and can't talk and I have to tend to her like a little tiny baby" (G.C. 1939).

In short, many women faced stark choices when illness visited their households. They could work, earn little, and leave sick family members alone, or they could decline work to provide care, and suffer extreme poverty.

Conclusion

Because work and care are neither static nor uniform within the population, their relation continually shifts. Throughout the nineteenth century, caregiving was especially likely to involve labor-intensive activities. We have seen that women's domestic chores were grueling even in the best of times; when household sickness imposed extra burdens the total workload frequently was unbearable. Women who added ill husbands' tasks to their own or left home to nurse members of their extended networks sometimes slighted work they considered essential.

It has become commonplace to note that the growth of social institutions such as schools, prisons, and hospitals removed critical functions from the home. But caregiving obligations, rather than disappearing, changed form as health care services expanded between 1890 and 1940. Women increasingly engaged in what Laura Balbo (1982) has called "servicing work," mediating between family members and formal service providers.

The entry of women into the labor force also transformed the relation between work and care. Paid employment occasionally offered benefits to caregivers, muting the emotional consequences of tending sick and disabled family members or placing limits on caregiving responsibilities. But because waged work and family care frequently involved incompatible demands, many women had to sacrifice one or both. Some quit their jobs, often with dire economic results. Others left seriously sick or disabled family members unattended.

Changes since 1940 have continued to alter the relation between work and care. Because life expectancy has grown and fertility dropped, caregiving increasingly is focused on the frail elderly population. The elderly were just 4 percent of the population in 1900, but they increased to 8

percent in 1950 and 12 percent in 1984. It is projected that those 65 and over will constitute approximately 17 percent of the population by 2020 (Feldblum 1983; Siegel and Taeuber 1986, 115). One recent study found that more than 60 percent of women care for elderly relatives at some point in their lives (Moen, Robison, and Fields 1994). Women's labor force participation also has increased dramatically. In 1990, 58 percent of women were working for pay (Ries and Stone 1992, 306).

The growth of disability insurance, public funding programs for health care, and private health insurance has alleviated some of the problems encountered by the women we have examined. Nevertheless, this history has contemporary parallels. Because health insurance remains tied to jobs, responsibility for medical bills continues to shape employment decisions (Cooper and Monheit 1993). Despite the rise of a vast system of health care and social services, the burden of care for sick and disabled people still rests overwhelmingly on private households. For example, relatives deliver approximately three-fourths of all long-term care to the disabled elderly (Stone, Cafferata, and Sangl 1987).

These responsibilities also continue to be divided unequally between men and women. Women represent 72 percent of all caregivers to frail elderly people and 77 percent of the children providing care (Stone, Cafferata, and Sangl 1987). Daughters are more likely than sons to live with dependent parents and to serve as their primary caregivers (Stone, Cafferata, and Sangl 1987; Wolf and Soldo 1986). Sons and daughters also choose different solutions to the conflict between waged work and informal caregiving. Sons are more likely than daughters to reduce the amount of time they devote to caregiving; daughters are more likely than sons to curtail labor force participation, quitting jobs, forfeiting promotions, and taking unpaid leave (Stoller 1983; Stone, Cafferata, and Sangl 1987). The Institute for Women's Policy Research estimates that adult children caring for disabled elderly parents lose an annual total of \$4.8 billion in earnings (Spalter-Roth and Hartmann 1988, 7).

The clash between caregiving and waged work has noneconomic features as well. As a result of the expansion of the service sector, women increasingly have entered caring occupations, where they provide the same services to strangers that they previously rendered only to neighbors and kin. Workers who continually meet the needs of others on the job may feel especially overwhelmed when expected to fulfill caregiving obligations in the home (Marshall et al. 1990).

The competition between work and care remains most intense for women in low-status occupations. Because such jobs tend to have rigid schedules, these women suffer greater penalties if they phone disabled relatives from work or take time off to help them during working hours. Data from a government 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 (U.S. Congress 1987). Evelyn Nakano Glenn (1992) demonstrates that poor women and women of color, who previously might have worked as domestic servants, increasingly enter low-level service occupations. Although many women prefer these jobs to domestic service, the work is very poorly paid; long and often unpredictable hours make these jobs exceptionally difficult to combine with private caregiving responsibilities. Caregiving also is especially onerous for low-income women because they cannot purchase medical equipment and supplies, retrofit their homes, or "buy out" of their obligations by hiring other women.

A historical perspective thus reminds us that the problem of reconciling employment and caregiving obligations is not novel and that it traditionally has been most serious for poor women and women of color. As policy makers begin to address the conflict between work and care, it is essential that they direct special attention to the needs of those women.

References

- A.J. 1934. Letter to Franklin Roosevelt, September 4. Records of the National Recovery Administration, record group 9. Washington: National Archives. (unpublished)
- Altro. n.d. Records of the Committee for the Care of Jewish Tuberculous of the United Hebrew Charities, Montefiore Home, and the Free Synagogue. New York: YIVO Institute for Jewish Research. (unpublished)
- Amott, T.L., and J.A. Matthaei. 1991. *Race, Gender, and Work: A Multicultural Economic History of Women in the United States*. Boston: South End Press.
- Arnold, E. (Ed.). 1985. *Voices of American Homemakers*. Bloomington: Indiana University Press.
- Association of Tuberculosis Clinics and the Committee on the Preven-

- tion of Tuberculosis of the Charity Organization Society, New York City. 1916. *Tuberculosis Families in Their Homes, A Study*. New York: Charity Organization Society.
- Baker, D.E. 1973. The Conine Family Letters, 1840–1851: Employed in Honest Business and Doing the Best We Can. *Indiana Magazine of History* 69:320–65.
- Balbo, L. 1982. The Servicing Work of Women and the Capitalist State. *Political Power and Social Theory* 3:251–70.
- Bellevue Hospital. 1908. *A Glimpse of Social Service in the Hospital*. New York.
- Best, E.L., and E. Erickson. 1930. *A Survey of Laundries and Their Women Workers in 23 Cities*. Bulletin of the Women's Bureau no. 92. Washington.
- Board of Health of the Department of Health of the City of New York. 1907. *Annual Report for the Year Ending December 1931, 1906*. New York: Martin B. Brown.
- Bolsteri, M.J. (Ed.). 1982. *Vinegar Pie and Chicken Bread: A Woman's Diary of Life in the Rural South, 1890–1891*. Fayetteville: University of Arkansas Press.
- Boris, E. 1994. *Home to Work: Motherhood and the Politics of Industrial Homework in the United States*. New York: Cambridge University Press.
- Boris, E., and C.R. Daniels. 1989. *Homework: Historical and Contemporary Perspectives on Paid Labor at Home*. Urbana: University of Illinois Press.
- Brown, E.C. 1930. *Industrial Home Work*. Bulletin of the Women's Bureau no. 79. Washington.
- C.R.S. 1938. Letter to Eleanor Roosevelt, August. Records of the Children's Bureau, record group 102, file 4-9-1-1. Washington: National Archives. (unpublished)
- Cassedy, J.H. 1991. *Medicine in America: A Short History*. Baltimore: Johns Hopkins University Press.
- Cohen, M. 1992. *Workshop to Office: Two Generations of Italian Women in New York City, 1900–1950*. Ithaca: Cornell University Press.
- Collins, P.H. 1991. *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. New York: Routledge.
- Committee on Neighborhood Health. 1938. Child Health Services, New York City, A Survey of Child Health Facilities and Recommendations of the Department of Health for the Development of More Adequate Services. New York: Department of Health. (unpublished)
- Community Service Society. 1888–1918. Case files. New York: Rare

- Books and Manuscripts, Butler Library, Columbia University. (unpublished)
- Coontz, S. 1992. *The Way We Never Were: American Families and the Nostalgia Trap*. New York: Basic Books.
- Cooper, P.F., and A.C. Monheit. 1993. Does Employment-related Health Insurance Inhibit Job Mobility? *Inquiry* 30:400-16.
- Cowan, R. S. 1983. *More Work for Mother: The Ironies of Household Technology from the Open Hearth to the Microwave*. New York: Basic Books.
- Davis, M.M., Jr. 1921. *Immigrant Health and the Community*. New York: Harper and Brothers.
- Dickson, A.J. 1916. Social Service in Relation to Contagious Disease Hospitals. *Monthly Bulletin of the Department of Health* 6:19-20.
- Dublin, T. (Ed.). 1981. *Farm to Factory: Women's Letters, 1830-1860*. New York: Columbia University Press.
- Dudden, F.E. 1983. *Serving Women: Household Service in Nineteenth-Century America*. Middletown: Wesleyan University Press.
- Ewen, E. 1985. *Immigrant Women in the Land of Dollars: Life and Culture on the Lower East Side, 1890-1925*. New York: Monthly Review Press.
- F.F. 1939. Letter to Eleanor Roosevelt, November 14. Records of the Children's Bureau, record group 102, file 4-9-1-1. Washington: National Archives. (unpublished)
- Farnsworth, M.S. 1882-1922. Diary. Kansas State Historical Society, Topeka. (unpublished)
- Feldblum, C.R. 1983. Home Health Care for the Elderly: Programs, Problems, and Potentials. *Harvard Journal on Legislation* 22:193-254.
- Field Nurses. 1928-55. Monthly Reports. Records of the Bureau of Indian Affairs, record group 75, file E-7-7-9. Washington: National Archives.
- G.C. 1939. Letter to Eleanor Roosevelt, September 15. Records of the Children's Bureau, record group 102, file 4-9-1-1. Washington: National Archives. (unpublished)
- Gillespie, S. 1873-1952. *Diary*. Iowa City: State Historical Society of Iowa.
- Glenn, E.N. 1986. *Issei, Nisei, War Bride: Three Generations of Japanese American Women in Domestic Service*. Philadelphia: Temple University Press.
- . 1992. From Servitude to Service Work: Historical Continuities in the Racial Division of Paid Reproductive Labor. *Signs: Journal of Women in Culture and Society* 18:1-43.
- Glenn, S.A. 1990. *Daughters of the Shtetl: Life and Labor in the Immigrant Generations*. Ithaca: Cornell University Press.

- Gordon, L. 1988. *Heroes of Their Own Lives: The Politics and History of Family Violence, Boston 1880–1960*. New York: Penguin.
- Hine, D.C. 1989. *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890–1950*. Bloomington: Indiana University Press.
- Jones, J. 1985. *Labor of Love, Labor of Sorrow: Black Women, Work, and the Family from Slavery to the Present*. New York: Basic Books.
- Kessler-Harris, A. 1982. *Out to Work: A History of Wage-Earning Women in the United States*. New York: Oxford University Press.
- L.M. 1938. Letter to Eleanor Roosevelt, April. Records of the Children's Bureau, record group 102, file 7-6-1-3, Washington: National Archives. (unpublished)
- Ladd-Taylor, M. 1994. *Mother-Work: Women, Child Welfare, and the State, 1890–1930*. Urbana: University of Illinois Press.
- Lensink, J.N. 1989. "A Secret to be Buried": *The Diary and Life of Emily Hawley Gillespie, 1858–1888*. Iowa City: University of Iowa Press.
- Lerner, G. (Ed.). 1977. *The Female Experience: An American Documentary*. Indianapolis: Bobbs-Merrill.
- Marshall, N.L., R.C. Barnett, G.K. Baruch, and J.H. Pleck. 1990. Double Jeopardy: The Costs of Caring at Work and at Home. In *Circles of Care: Work and Identity in Women's Lives*, eds. E.K. Abel and M.K. Nelson. Albany: State University of New York Press.
- Michel, S. 1993. The Limits of Maternalism: Policies toward American Wage-Earning Mothers during the Progressive Era. In *Mothers of a New World: Maternalist Politics and the Origins of Welfare States*, eds. S. Koven and S. Michel. New York: Routledge.
- Mintz, S., and S. Kellogg. 1988. *Domestic Revolutions: A Social History of American Family Life*. New York: Free Press.
- Moen, P., J. Robison, and V. Fields. 1994. Women's Work and Caregiving Roles: A Life Course Approach. *Journal of Gerontology: Social Sciences* 49:S176–S187.
- N.A.T. 1938. Letter to Eleanor Roosevelt, November. Records of the Children's Bureau, record group 102, file 7-6-1-0-0. Washington: National Archives. (unpublished)
- National Recovery Administration. 1934. Hearings on the Pleating, Stitching, and Bonnaz and Embroidery Industry, November 20. Transcript of hearings, 231-1-06, record group 9. Washington: National Archives. (unpublished)
- Osterud, N.G. 1991. *Bonds of Community: Lives of Farm Women in Nineteenth-Century New York*. Ithaca: Cornell University Press.
- Palmer, P. 1989. *Domesticity and Dirt: Housewives and Domestic Servants in the United States, 1920–1945*. Philadelphia: Temple University Press.

- Patterson, F. with E. Fox. 1924. *A Survey of the Need for Public Health Nursing in Indian Reservations, Made for the Bureau of Indian Affairs of the Department of Interior by the American Red Cross.* Washington.
- Peiss, K. 1986. *Cheap Amusements: Working Women and Leisure in Turn-of-the-Century New York.* Philadelphia: Temple University Press.
- Peter Brent Brigham Hospital. 1931. Report of the Social Service Department. *Seventh Annual Report for the Year 1930.* Boston.
- Pidgeon, M.E. 1932. *The Employment of Women in Slaughtering and Meat Packing.* Bulletin of the Women's Bureau no. 88. Washington.
- . 1935. *Women in Industry: A Series of Papers to Aid Study Groups.* Bulletin of the Women's Bureau no. 91. Washington.
- . 1937. *Women in the Economy of the United States of America, A Summary Report.* Bulletin of the Women's Bureau no. 155. Washington.
- Report of the Nurses. 1908. *First Report of the Babies' Dispensary and Hospital of Cleveland for the Fifteen Months Ending September 30th, 1907.* Cleveland: Hospital of Cleveland.
- Reverby, S.M. 1987. *Ordered to Care: The Dilemma of American Nursing, 1850-1945.* New York: Cambridge University Press.
- Ries, P., and A.J. Stone. 1992. *The American Woman, 1992-1993: A Status Report.* New York: W.W. Norton.
- S.S. 1938. Letter to Franklin Roosevelt, July 3. Records of the Children's Bureau, record group 102, file 4-9-1-1. Washington: National Archives. (unpublished)
- Sacks, K.B. 1984. Generations of Working-Class Families. In *My Troubles Are Going to Have Trouble with Me: Everyday Trials and Triumphs of Women Workers*, eds. K.B. Sacks and D. Remy. New Brunswick: Rutgers University Press.
- Savitt, T.L. 1985. Black Health on the Plantation: Masters, Slaves, and Physicians. In *Sickness and Health in America: Readings in the History of Medicine and Public Health*, eds. J.W. Leavitt and R.L. Numbers. Madison: University of Wisconsin Press.
- Siegel, J.S., and C.M. Taeuber. 1986. Demographic Perspectives on the Long-Lived Society. *Daedalus* 115:77-118.
- Simon, B.L. 1987. *Never Married Women.* Philadelphia: Temple University Press.
- Smith, J.E. 1985. *Family Connections: A History of Italian and Jewish Immigrant Lives in Providence, Rhode Island, 1900-1940.* Albany: State University of New York Press.
- Snell, J.W. (Ed.). 1974. Roughing It on Her Kansas Claim: The Diary of Abbie Bright, 1870-1871 — Concluded. *Kansas Historical Quarterly* 38:194-428.

- Spalter-Roth, R.M., and H.I. Hartmann. 1988. *Unnecessary Losses: Costs to Americans of the Lack of Family and Medical Leave* (executive summary). Washington: Institute for Women's Policy Research.
- Stack, C.B. 1974. *All Our Kin: Strategies for Survival in a Black Community*. New York: Harper Colophon.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books.
- Stevens, R. 1989. *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. New York: Basic Books.
- Stoller, E.P. 1983. Parental Caregiving by Adult Children. *Journal of Marriage and the Family* 46:851-8.
- Stone, R.I., L. Cafferata, and J. Sangl. 1987. Caregivers of the Frail Elderly: A National Profile. *Gerontologist* 27:484-506.
- Strasser, S. 1982. *Never Done: A History of American Housework*. New York: Pantheon.
- Technical Committee on Medical Care. 1938. *The Need for a National Health Program*. Washington: Interdepartmental Committee to Coordinate Health and Welfare Activities.
- Tileston, M.W. (Ed.). 1918. *Caleb and Mary Wilder Foote: Reminiscences and Letters*. Boston: Houghton Mifflin.
- Tomes, N. 1991. The Private Side of Public Health: Sanitary Science, Domestic Hygiene, and The Germ Theory, 1870-1900. *Bulletin of the History of Medicine* 65:509-39.
- U.S. Congress. 1987. *Exploding the Myths: Caregiving in America* (pub. no. 99-611). Prepared for the Subcommittee on Human Services, Select Committee on Aging. Washington: U.S. House of Representatives.
- W.L. 1935. Letter to Children's Bureau, June 24. Records of the Children's Bureau, record group 102, file 4-12-6-3-1. Washington: National Archives. (unpublished)
- Webber, M.A. 1859-84. Letters to Family. In possession of Marianne Parker Brown, Los Angeles. (unpublished)
- Weinberg, S.S. 1990. *The World of Our Mothers*. New York: Schocken Books.
- Weindling, P. 1992. From Infectious to Chronic Diseases: Changing Patterns of Sickness in the Nineteenth and Twentieth Centuries. In *Medicine in Society: Historical Essays*, ed. A. Wear. New York: Cambridge University Press.
- Winslow, M.N. 1924. *Married Women in Industry*. Bulletin of the Women's Bureau no. 38. Washington.
- Wold, F.M. (Ed.). 1981. The Letters of Effie Hanson, 1917-1923: Farm Life in Troubled Times. *North Dakota History: Journal of the Northern Plains* 48:20-43.

Wolf, D.A., and B.J. Soldo. 1986. The Households of Older Unmarried Women: Micro-decision Models of Shared Living Arrangements. Paper presented at the Annual Meeting of the Population Association of America, San Francisco.

Women's Bureau. 1924. *Women in Alabama Industries: A Study of Hours, Wages, and Working Conditions*. Bulletin no. 34. Washington.

———. 1926. *Lost Time and Labor Turnover in Cotton Mills: A Study of Cause and Effect*. Bulletin no. 52. Washington.

———. n.d. Survey material for bulletins nos. 91 and 92. Records of the Women's Bureau, record group 86. Washington: National Archives. (unpublished)

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