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"Чего тебе не хватает в твоем возрасте? Сидела бы"
"What do you need at your age? Sit quietly"

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From the Editor

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AAQ Volume 33 has represented a revitalized effort on the part of AAGE to create a high-quality venue for work of scholars and researche rs of aging in anthropology. Despite our rigorous peer review standards, the number of published articles in AAQ over the last year alone matches the number for the previous four years combined. This feat could not have been accomplished without the hard work and dedication of the AAQ editorial board and the many reviewers who generously donated their time and expertise. Likewise, AAQ is grateful to all of the contributors for their excellent work, helping to make AAQ an important resource for scholars, students and researchers around the world

The articles in this issue serve as an excellent example of the kind of work AAQ strives to showcase. Each of them explores the ways that "care" reshapes the embodied meanings of the social life course and the felt experience of old age. Anna Corwin (121) examines the dynamics of care in a Catholic convent infirmary in the Midwest US, where the domains of spiritual and profane, faith and practice, become entangled with age in a setting where even everyday social interactions and experiences take on aspects of the sacred. Susan Rasmussen (131), too, is concerned with a religious and symbolic world that lends meaning to the care of elders. Among the Tuareg, the seclusion of frail elders coexists with beliefs of enhanced spiritual power, a source of meaning that links them to small children. Mary Alice Scott's article on Mexican grandmothers caring for grandchildren shows how economies of care extend far beyond local communities, and offers an intimate portrayal of the hard decisions and harder consequences faced by families of migrants. As aging grandparents become exploited bodies, care can quickly create other burdens, what was a source of value becomes a form of structural violence.

This issue also features the first AAQ "Portfolio" section, a visual commentary on issues related to anthropology and aging. These photos, taken by Malik Alymkulov for HelpAge International, are powerful images of the intimate spaces of elder abuse in Central Asia. The signboards displaying the words of perpetrators are not "hidden transcripts," but signal the all too visible failure of care in the everyday world. They are potent reminders that our work is not done, but we are in the right place. Thank you to everyone in AAGE for a wonderful year.

Jason Danely
Editor-in-Chief

Thank you to the AAQ Editorial Board, the reviewers, and all of the contributors to Volume 33

Let Him Hold You
Spiritual and Social Support in a Catholic Convent Infirmary

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Abstract

American Catholic nuns have been found to age more 'successfully' than their lay counterparts, living longer, healthier, and happier lives. Two of the key factors contributing to the nuns' physical and mental wellbeing are the spiritual support they experience from the divine and the social support they provide for and receive from each other in the convent. I argue that by integrating the divine into their everyday interactions, the nuns engage in phenomenological meaning-making process through which mundane care interactions are rendered sacred. This communicative process, I argue, contributes to the nuns' overall wellbeing by providing an enriched form of care and support, thereby enhancing their end-of-life experience.

Keywords: Aging, Care, Prayer, Wellbeing, social support, Catholicism

INTRODUCTION

My third summer as a researcher in the infirmary wing of the Franciscan Sisters of the Heart Convent , I found myself sitting in Sr. Theresa's small room[1]. Sr. Theresa was in her mid-eighties and had lived in the infirmary for two years due to trouble walking and her limited ability to navigate the convent hallways and to negotiate physical tasks of daily living. We spent the afternoon as we'd spent many afternoons together. She spoke to me about the spiritual books she'd been reading and she talked about the spiritual connection she felt with God in nature. She spoke for quite a while, stopping often to laugh with reverence about the mystery and beauty of the world. After a pause, she began a story about speaking to Jesus:

> The other night I was sitting here, and I said, "You know what Jesus? I feel like an old married woman and you're an old married man." And I said, "We're sitting in a swing on a porch. That's where I see us right now." And I said, "And I get the idea that you're thirsty," I said, "So, I'm going in to get you some lemonade." So I come out with a big glass of lemonade, and He nearly drinks all that then He looks at me and smiles and said, "How did you know I was thirsty?" And I said, "'Cause I love you."

At the end of this story, Sr. Theresa erupted into a bout of contagious laughter that punctuated all of her conversations. She ended the story with the statement: "so that's my spirituality." I asked her how often she talks like this to Jesus, and she exclaimed, nearly exasperated by the naïveté of my question: "OH! All day, all day! We're inseparable."

Although Sr. Theresa was a joyfully unique personality in the convent – certainly the only person who mentioned sharing lemonade with Jesus – her relationship with the divine is nonetheless representative of the relationship many of the nuns have with the divine. A majority of the nuns in the Franciscan Sisters of the Heart describe experiencing the divine as an enduring presence in their everyday lives. They engage Him[2] in conversation, watch television with Him, or hold His hand as they walk the convent grounds. They experience Him variously as a spouse, a companion, a spiritual presence, and a caretaker. For almost all of the nuns in the convent, the divine is an enduring presence who accompanies them in every activity and shapes their experience of the world.

In this article, I examine the caretaking interactions between the nuns in the infirmary wing of the Franciscan

Sisters of the Heart convent to show what social and linguistic tools elderly nuns use to integrate the divine into their everyday interactions and how these interactions render all health-care interactions in the infirmary sacred. I argue that these care interactions impact the nuns' wellbeing in three major ways: First, the care interactions include blessings through which the caregivers offer both social and spiritual support; second, the nuns invoke the divine in conversational care interactions in such a way that Christ emerges as an engaged caretaker; finally, the nuns summon the divine into their lives by living the powerful trope of "being God" for each other and receiving others as the divine. These three practices, I argue, provide spiritual and social support that impacts the nuns' quality of life.

THE SISTERS OF THE HEART

The Franciscan Sisters of the Heart convent is a Catholic convent in the Midwestern United States that is home to more than 200 nuns. Approximately 100 of them, having worked as teachers and missionaries outside the convent walls, have returned to the convent to retire. They now live in the convent full time where they have access to nursing care. This article draws on data collected in the convent over ten months beginning in 2008. During the summers of 2008, 2009, and 2010, I lived in the convent with the nuns for a period of one to two months each summer. For a period of five months in the winter and spring of 2011, I lived in an apartment near the convent and spent my days in the convent with the nuns. The corpus of data includes over 100 hours of recordings of naturally occurring events in the convent such as meals, social events, and care interactions. In addition, I conducted over thirty person-centered interviews (Levy and Hollan 1998). Analysis in this article focuses on a corpus of over twenty hours of care interactions between a retired caregiver and the recipients of her care, many of whom are her contemporaries, recorded in the convent infirmary in 2011.

BACKGROUND

In her article Communication and the Institutionalized Elderly, Karen Grainger describes the communicative exchanges between elderly individuals and their institutional caregivers. Grainger describes an isolated communicative landscape in which individuals are often left alone (1995). When they are communicatively engaged, their concerns are often demeaned or ignored. This bleak communicative landscape with few "confirmative and stimulating adult-to-adult encounters" is unfortunately common in end-of-life care and has been found to negatively affect elderly patients' cognitive function

(Williams 2011:9). Grainger suggests that the "most important move" for the future of institutional care for the elderly, would be "for elderly long-term care to take place in an environment in which the status of caring (vs. curing) is elevated to the level of a valued occupation and skill" (1995: 433). The convent employs a palliative model of care, with the goal of providing ongoing holistic care to all of the sisters, attending to not only medical needs, but also the emotional, spiritual, and social concerns of each of the individuals in the community. The elderly Catholic nuns examined in this article experience the type of care Grainger envision as ideal, elevating "caring" over "curing," prioritizing and implementing multiple modes of care at the end of life.

Epidemiologists have identified American Catholic nuns as a group that lives longer healthier lives than their lay counterparts, experiencing less anxiety, pain, and depression at the end of life (Butler and Snowdon 1996, Snowdon 2001). Quality of life questionnaires (designed by Cohen et. al 1997) I administered in this convent confirmed that, like their peers, the Franciscan Sisters of the Heart report less anxiety and psychological distress and greater feelings of social support than their peers. In addition to education, nutrition, physical activity, and optimistic outlook, spiritual and social support have been found to significantly contribute to the nuns' wellbeing. It has been found that there is a statistical connection between social support, including social interaction (Cacioppo and Patrick 2008), receiving the help of others (Maton 1989, Reichstadt et al. 2006) and the act of caring (Corwin 2005) foster physical and mental health in elderly individuals. However, there has been little previous exploration of how these interactions unfold in situ.

In addition, an increasing number of studies suggest that religious practices including prayer, meditation, and participation in religious services aid the mental and physical health of the practitioner, promoting physical well-being and protecting against depression (Koenig et al. 1997, Koenig 1999, Newberg 2006, Strawbridge et al. 1997). Through meditation, for example, Tibetan monks are able to neurologically train their brains to reinforce "positive feelings and well-being" (Newberg 2006: 187). In the convent, prayer organizes Catholic nuns' daily lives, represents and encodes moral and ideological tropes, and impacts the nuns' subjective and embodied experiences in the world (Corwin 2012, Lester 2005). Pevey et al. (2008) argue that religion provides a supportive relationship with a divine being (2008: 55). Although these studies have shown a quantitative connection between spirituality and wellbeing, this study is one of the first to document

spiritual and social support interactions as they unfold in ethnographic context.

In this article, I examine caretaking interactions in the convent infirmary to argue that: First, for the nuns, these two processes of social support and spiritual support are interactionally intertwined such that they jointly unfold in caretaking interactions. Second, I show how spiritual support is communicatively established in caretaking interactions. I find that three activities within the caretaking activities: blessings, summoning the divine, and the trope of "being God," contribute directly to the nuns' spiritual and social support.

I argue that through these processes, in which the nuns invoke the divine in everyday activities, the nuns engage in a phenomenological reality-shaping process outlined by Alfred Schutz in his article "On Multiple Realities" (1945). Schutz argued that individuals pass through a number of experiential domains throughout the course of everyday life, each of which is associated with a particular cognitive style and a particular "accent of reality." Each of these "accents of reality" or particular ways of being in the world is contained within its own "finite province of meaning" that "would appear as merely fictitious, inconsistent and incompatible" (Schutz 1945: 553) in another context. I follow Schutz's model to argue that this process contributes to the nuns' overall wellbeing at the end of life.

CARE IN THE CONVENT

Care in the convent provides a contrast to that of most institutional care facilities. First, and perhaps most significantly, the nuns chose to enter this institution long before they were in need of care. The nuns joined the convent as sixteen- to twenty-year-old girls, choosing to dedicate their lives to service to the Church as teachers, missionaries, and nurses. They have lived and worked as part of this community for all of their adult lives. The majority of the nuns live in small convents near Catholic schools or parishes where they work and return to the central convent or motherhouse for summer retreats and meetings. By the time they enter the convent infirmary, they feel as if they are "coming home." Sr. Carline, for example, spoke to me about her experience coming "home" to the motherhouse when she retired. She describes her return home as an experience of "coming full circle":

> I came home here four years ago. And in the dining room we have these round tables, you know just sit wherever, and so I had no trouble adjusting when I came, retired, no trouble whatever, I mean

it was like I started here full circle and I come here all the time you know for any kind of celebration full circle and I'm coming home. And so I've known these people for sixty-seven years, you know, so it's not like I'm coming into a nursing home of strangers, these are friends.

In many ways, this return "home" is the opposite of the move experienced by most lay individuals who must give up their homes when they enter assisted living or nursing homes. Although the nuns may not know the individuals who live with them in the infirmary, the infirmary is part of an institution they've been part of for most of their lives, and they share a sense of community, history, and common life experience. Sr. Rita, who worked as a pastoral care minister in a hospital before she retired reflected on the convent infirmary. She describes it as a unique setting that maintains a deep sense of community, which she contrasts with a hospital or nursing home setting:

> I think that maybe in the hospital, nursing home, [the employees] don't want to be attached, in the sense that it means that when that patient dies or goes, (you know) won't be seeing (her) again, but here we have a continuity because this is our Mother House, this is our home, this is home. So when you come here, we're all going to be here.

Because the nuns take their peers in the infirmary to be an extended family, and they are cared for by people with whom they have a shared history, the nuns do not experience the same level of loneliness, isolation, or abandonment that many elderly individuals in long-term care facilities endure. In addition, since they have taken the vow of poverty, almost all of the income they generate throughout their working lives goes directly to the convent. The convent administrators manage the group finances and plan for the housing and medical care for all of the nuns. Although many convents are struggling financially to manage the end-of-life care of their members, none of the members has the sole responsibility of financing her individual retirement and end-of-life care.

The nuns, however, do not always find the transition into retirement to be easy. In this way, they share a few significant similarities with lay individual entering a long-term care institution. The majority of the nuns have not lived in the convent since they were novices. They have worked their whole lives, often much more than 40 hour weeks, and are deeply involved in the local communities in which they work and with the small usually multi-generational convent in which they live. These women rarely choose

on their own to leave these busy lives in which they are important contributors to local communities, often in positions of authority as teachers or community organizers to come to a convent infirmary. Most of the nuns work until physical or mental deterioration makes it impossible for them to continue. Even then, many of the sisters retire to the convent only after they are asked, or sometimes required, by the convent authorities. When they do return to the convent, the nuns, again like their lay counterparts, must give up many of the freedoms and responsibilities they held outside the convent. In the small convents where they work, the nuns cooked, cleaned, and generally were in charge of themselves and their small community. In the motherhouse, they are served three meals a day in a cafeteria or in their rooms in the infirmary. They can travel the five miles into town only when someone with a car is scheduled or persuaded to bring them. If they are not mobile, they rely on nurses or aides to clean their rooms, and to clothe and to bathe them. For women who have spent their lives caring for others, and striving to ask for as little as possible, the transition from an active, working life, to a retirement in which they are dependent on others, can be very difficult.

When the nuns retire to the convent, they live in one of three types of living quarters, which range from independent living, moderately assisted living, and full-time care in the infirmary. Active and working sisters, including newly retired sisters who can live independently, live in rooms with shared dormitory-like bathrooms and, in some cases, shared kitchens. Even the nuns who are most independent adjust to reduced independence and self-sufficiency. They are no longer responsible for their own cooking or transportation, and now must fit into an institutional schedule of community prayers, meals, and daily activities and duties. The nuns who are primarily self-sufficient and require minimal physical assistance live in a three-floor wing of the convent that has been converted to offer private bathrooms that are handicapped accessible as well as easy access to the dining room and nursing station in the infirmary. The infirmary, which has full-time nursing care for those who need it, is a three-floor wing of the convent, housing 45 to 80 individuals at a time.

Nuns in the infirmary have private rooms with televisions connected to a closed-circuit channel that broadcasts community activities from the chapel, including daily prayer and mass. There is a nurses' station on each floor as well as a dining room. Nurses and aides, employed from the local community, care for the nuns' daily personal and medical needs. In addition, each floor has a pastoral care minister, a nun in the community who cares for the

nuns' spiritual needs – making sure she is able to take communion, access spiritual books or materials, receive spiritual direction or confession if she desires. The pastoral care minister also helps with personal communication, opening and answering mail, and she organized group activities, such as special prayer meetings, in the infirmary. The convent also employs a wellness director who is in charge of physical activity, keeping the elderly nuns active, and assisting with any physical therapy.

The care interactions in the infirmary are organized around meeting the physical, social, and spiritual needs of the elderly nuns. They do not receive medical care in the convent, and must be driven to doctor's appointments. There are a number of retired sisters who volunteer to drive those who cannot drive to medical appointments. There is a large network of volunteers among the retired sisters, living both in the infirmary, and in the larger convent, who visit the sisters in the infirmary, pray for them, and who visit those who are in the hospital for surgery or other major medical treatments.

The majority of the nuns in the infirmary are there for chronic conditions, most often those associated with old age and will therefore live out the rest of their lives in the convent. The majority of the sisters do not expect to be "cured" or "healed" of the particular chronic conditions from which they suffer, however they do strive for physical and mental wellbeing, with as little pain and physical/mental suffering as possible. The concept of healing is rarely invoked in the infirmary. Instead, the nuns see themselves engaged in an ongoing process in which they strive for wellbeing. This wellbeing includes acceptance of whatever may come, including the unpleasant experience of illness. Sr. Carline, who had an advanced form of bladder cancer, spoke about this process of acceptance and surrender:

> I know that physical healing isn't gonna last forever; it doesn't last forever for anybody, but for me it's more imminent and I know it's not gonna [last]. … The main kind of healing is spiritual healing; you know that your whole body can accept whatever is coming in your life. You know if somebody says 'do you want to die', no I don't want to die, I mean you know it's not that I'm craving to die although sometimes, sometimes when you're feeling kind of sick or you know you don't feel good you thought oh maybe that's not gonna be so bad, you know? But it's not that I'm uh you know sitting here waiting to die but I'm gonna take when it comes, you know, I want to be ready to hand it over, to surrender when that

time comes.

Sr. Carline contrasts physical healing, which she describes as temporally limited, with "spiritual healing" which she describes as a "whole body" acceptance of "what is coming", meaning, in this case, her death. Sr. Carline's model of healing, which is consistent with the model I found in the convent as a whole, exemplifies the nuns' values of serenity and acceptance of the future, which they understand to be God's path for them. Unlike many Christians, the nuns do not rely on the divine to intercede in their physical healing. Although the nuns believe the divine has the power to intercede in the material world, they focus their petitions to the divine on requests for endurance and for spiritual comfort. Instead of requesting the divine to change the material world, to heal them, the nuns rely on interactions with the divine for sense-making and for an enduring sense of wellbeing. Sr. Carline, for example, understands that she has a terminal illness and accepts her oncologist's prognosis. She turns to the divine to help her develop a sense of peace and acceptance, what she calls "spiritual healing."

The nuns, like many elderly individuals, embody healing trajectories that are not strictly bounded in time. Their healing trajectories are neither restricted to physical transformations, nor are they restricted by the temporal bounds of a healing event. The model presented in the convent by nuns like Sr. Carline is one in which healing is not contained by a bounded medical diagnosis. This model fits well with Csordas and Kleinman's argument that healing is not contained within therapeutic events, but rather "spills" into the larger temporal framework of everyday life (1996)[3]. The nuns do not focus exclusively on physical healing, which is a unidirectional process in which healing events (such as surgeries or therapeutic treatments) are conceptually contained as either "successful" or "unsuccessful" events. Instead, the nuns see themselves as involved in an ongoing day-to-day process in which they strive for spiritual as well as physical wellbeing. This process continues throughout the life course, beginning when the nuns join the convent to begin their spiritual journal as novices (see also Lester 2005).

In the next section, I will show how spiritual healing is constructed in the care interactions between the elderly nuns in the convent infirmary.

CARETAKING

Sister Irma is an 83-year-old nun, who worked in various positions throughout her life as a teacher and community leader before she retired to the motherhouse. Now that she is retired, she spends part of the week providing foot massages to elderly sisters in the infirmary. Sr. Irma spends each Monday and Tuesday afternoon massaging the feet of the elderly sisters in the infirmary and providing acupressure treatment. She goes into each room and offers massage. When she is invited in, Sr. Irma removes the shoes and socks from the sisters' feet; she encourages them to relax; and she massages their feet as they recline in an easy chair or on the bed. In these interactions, Sr. Irma sees herself as contributing to her peers' medical care. She is working to generate circulation in the feet of elderly sisters who are no longer mobile. This form of physical care is essential for the protection of the elderly sisters' limbs, the importance of which the nuns are acutely aware. During the final year I was in the convent, a 99-year-old sister had her leg amputated due to lack of circulation in her limbs.

As Sr. Irma contributes to the nuns' physical wellbeing, she simultaneously engages in spiritual care-taking. Like many of her peers, when Sr. Irma engages with the sisters in the infirmary, she invokes the divine as an engaged interlocutor and caretaker. This is achieved in three ways: First, through prayer which occurs here primarily in the form of blessings, second, by summoning God as a participant in ongoing interactions, and finally through embodying the divine for others and experiencing others as the divine.

1. Prayer

The most common form of prayer in care interactions in the convent is blessings. Blessings are an "invocation of divine favor" on an activity or individual (Bruder 1998:466). As Sr. Irma blesses the sisters, she calls on the divine to care for them, to offer them peace, or to be with them as an enduring presence.

The following excerpt represents a typical blessing in the convent:

Example 1: Blessing
  SI: Sister Irma
  SS: Sister Suzie

  SI: There ya' go. You ready for your blessing?
  SS: Mm Hmm
  SI: Okay. May the Lord bless you and keep you. May He give you courage to live each day knowing He is with you. Amen.

Blessings occur in the subjunctive mood (Bruder 1998: 470). In providing a blessing, the speaker is speaking

directly to the divine, petitioning Him to provide a favor to the speakers. In this way, blessings can be seen as requests to a third party not previously addressed in the interaction.

I suggest that blessings actively shift conversation from a typical dyadic arrangement in which the two individuals in the room are speaking to each other (represented below) to a tripartite interaction. Before the blessing, the two participants are engaged with each other, each as a ratified speaker and listener (Goffman 1979).
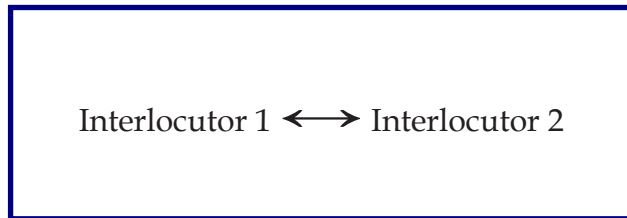
Interlocutor 1 ⟷ Interlocutor 2

Figure 1: Dyadic Interaction

When a blessing is introduced, the participant arrangement of the interaction moves from a dyadic arrangement to a tripartite or multiparty arrangement in which the divine is addressed as a participant (see also Ochs and Capps 2001). As the nuns ask the divine for a blessing, pronouncing an utterance such as "May the Lord bless you," in which they ask the divine to intercede in the room or in the world, the participants involved in the interaction now include both the two original interlocutors as well as the divine:
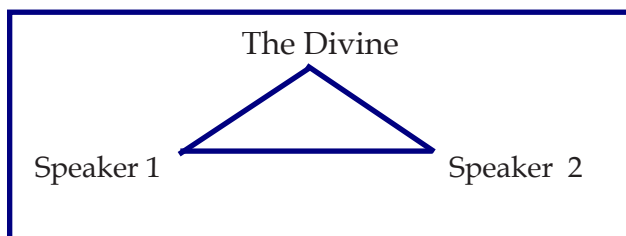
The Divine

Speaker 1   Speaker 2

Figure2: Multiparty Interaction Including the Divine

In this way, the divine is brought into the room as a relevant participant in the interaction.

As Sr. Irma blesses Sr. Suzie in the exchange above, saying "May the Lord bless you and keep you", she is calling the divine into the room as an interlocutor, asking Him to hear her request for Sr. Suzie, and to intervene as He sees fit, presumably blessing Sr. Suzie, keeping her, and giving her the courage and peace of His presence. The blessing achieves three actions. First, it is a way for

Sr. Irma to communicate to Sr. Suzie that she wishes her peace, courage, and an awareness of the loving presence of the divine in her life. In this capacity, the blessing is a form of peer social support through which Sr. Irma can offer intimate support and hope for Sr. Suzie. Second, it is a direct request for the divine to intervene in the world by providing the requested blessing. Finally, the blessing is a way for Sr. Irma to bring the divine into the room as an engaged interlocutor, as a being whose presence becomes engaged in the activity. Through the blessing interaction, the divine becomes an addressed interlocutor, engaged in the communicative activity at hand.

2. Summoning God

Sr. Irma also brings the divine into the room by calling on Him directly as an engaged participant in the interaction. Sr. Irma often reminds people to talk to Jesus. As she leaves a room, she frequently says, "Jesus said to tell you that he loves you." While she is in the infirmary, she regularly calls on Him as an embodied participant in the interactions.

In following example, Sr. Irma massages Sr. Mary Augusta's feet. Sr. Mary Augusta is in her late 80s. She had just explained to Sr. Irma that she is suffering from a "bad heart" and that she "won't last much longer." She has been having bouts of tachycardia for the past few weeks and has had little energy. Sr. Irma had encouraged her to relax while she received the massage, and Sr. Mary Augusta had complained that she couldn't. As Sr. Irma encouraged Sr. Mary Augusta to relax, she invokes the divine. In the example, Sr. Irma encourages Sr. Mary Augusta to call on Jesus to comfort her and thereby to cultivate an embodied relationship with Jesus that might benefit her physically and psychologically.

Example 2: Let Him Hold You
   S.Irma – Sister Irma
   S.MA – Sister Mary Augusta

   S.Irma: And know that the Lord does love you.
   S.MA: I knew that.
   S.Irma: And He wants you to relax. [And,]
   S.MA: [I know]
   S.Irma: And let Him hold you.
   S.MA: I have a hard time relaxing.
   S.Irma: Let Jesus hold you, and don't squirm in
         His arms.

Srs. Irma and Mary Augusta are embedded in an institutional framework in which the divine is understood to be a constant embodied presence. Sr. Mary Augusta, like Sr. Theresa, describes Jesus as a constant companion. She describes watching television with Him each evening, His

hand holding hers. She talks about engaging in physical embraces with Him (a huge hug, as she describes it) each time she passes a crucifix in the convent.

Sr. Irma's directive, imploring Sr. Mary Augusta to let Jesus hold her in his arms therefore emerges in a framework in which Jesus exists to them, if not necessarily visibly, as nonetheless real and embodied. Sr. Irma's directive "let Jesus hold you, and don't squirm in His arms" is not just a metaphor. It is an embodied directive that emerges in a context in which touching Jesus and being held by Him is common and, moreover, possible. In this interaction, Sr. Irma instructs Sr. Mary Augusta to call the divine into the room and to rely on Him to help quell her anxiety.

In addition to encouraging Sr. Mary Augusta to summon the divine, Sr. Irma is also engaging in peer socialization, communicating what she sees as appropriate and expected behavior for a Catholic nun in their community. By suggesting that Sr. Mary Augusta engage with Jesus in a physical way, allowing Him to care for her, Sr. Irma is suggesting that she experience the embodied states the nuns associate with a divine embrace such as peace, love, support, and calm. She redirects her complaints, subtly suggesting that the complaints may not be appropriate. In doing this, Sr. Irma communicates to Sr. Mary Augusta not only that it is expected for her to turn to God in her times of need, but also that that the divine is the interlocutor and embodied caretaker who can offer her the most support and assistance with her physical and psychological ailments.

3. Being God

Finally, the nuns also bring the divine into their everyday interactions through the trope of "being God" for each other. As Sister Irma explained in an interview:
To be there for other people is my greatest prayer. I pray with my community and with other people, through who I am and what I do. So communicating with them, the God in them, the God in me in a peaceful and gentle and just a way of graciously being.

For the nuns, embodying the divine means two things: First that they will model Christ's behavior as closely as they can, serving others with humility and compassion. Second, it means treating others as they would treat the divine. As one nun explained to me, this means communicating with others as if she or he is Christ Himself.

In a talk on prayer that Sr. Irma gave to a group of the retired nuns, she made explicit the metaphor of "being Jesus" for others. In this lecture, she argues that in order

to follow Jesus' command to "Go out and be the light of the world" (line 1), the nuns should embody the physical presence of the divine (line 3) through everyday acts of prayer and compassion. Here, she describes this in detail:

Example 3: Be the Light of the World
S.Irma – Sister Irma
S.Lup – Sister Lupita

1	S.Irma:	If Jesus says, "Go out and be the light of the world,"
2		We are His presence.
3		The physical presence of Jesus among others,
4		and so, it is our vocation as Christians to be that in some way.
5		Whether it's just praying for people,
6		or listening to people,
7		or serving people in any way,
8		but when we're in need,
9		we have to be gracious
10		to allow others to do that for us.
11		To share our pains,
12		to share our needs,
13		to let others listen to us,
14		so it's a two-way street.
15		If I am Jesus for Sr. Lupita today,
16		tomorrow I may need Sr. Lupita to be Jesus for me.
17		Would you do that Lupita?
18	All:	((laughter from sisters))
19	S.Lup:	((Sr. Lupita nods))
20	S.Irma:	She would do that.
21		Alright.

At the end of the passage, Sr. Irma gives the example of "being Jesus" for someone. She suggests that while she might "be Jesus" for Sr. Lupita one day, Sr. Lupita will reciprocate by embodying the divine for Sr. Irma another day (lines 15 and 16). By embodying the divine, Sr. Irma suggests the nuns will continue God's work on earth with Him and for Him by spreading love, compassion, and by serving others. The nuns see themselves fulfilling this goal through everyday activities both spiritual and mundane. For example, many of the nuns serve others by bringing them feeding them or helping them bathe. Others might fulfill the quotidian tasks necessary to keep the convent running, for example, answering the phones or cleaning the bathroom.

One of the ways that Sister Irma strives to communicate the "God in [her]" with the "God in them," as she put it, is through the foot massages she gives. As she sits by the elderly sisters' feet, and takes them into her hands, she, and the other sisters in the community are consistently made

Figure 3: Images of Jesus with the disciples

Figure 4: Image of Sr. Irma massaging her peer's feet

aware of the story of Jesus washing the disciples' feet. In embodying this metaphor, Sister Irma superimposes the trope of Jesus' humility and devotion on top of her own interactions with her community of elderly peers.

The nuns' awareness that Sr. Irma is indexing the interaction between Jesus and the disciples is made salient through the frequent references they make to letting Sr. Irma "serve" them. Sr. Irma also sometimes jokes about the engagement and its similarity to Jesus' washing of the disciples' feet. In the example below, Sr. Irma teases another nun about the work involved in removing and replacing her stockings, saying that Jesus never had to wrestle with the disciples' stockings:

Example 4: In Jesus' Time
    S.Irma – Sister Irma

    S.Irma: I wonder-
              Jesus didn't have to do this, did He?
              'Cause they didn't wear socks then.
              (laughter)
              You just hadda put the slippers back on 'em.
              That's okay, I won't charge you extra.

Through this practice in which she serves her fellow nuns with humility as Christ served the disciples in the Bible, Sr. Irma is performing both a symbolic, metaphorical act and a ritual act. Like all embodied practices, this practice "confirms the reality – not just the symbolic idea – of a ritual act" (McGuire 2009: 7). As the ritual act of being Christ is

overlaid on a mundane interaction promoting circulation, Sr. Irma constitutes a sacred reality in which she, as a divine servant, is humbly serving her peers in the infirmary as Christ served His disciples. The act of massaging the nuns' feet brings the divine into the nuns' tangible daily lives. My corpus of interview data has shown that interactions like these produce a calming, loving experience for the elderly nuns as they receive Sr. Irma's service. In this way, Sr. Irma's embodied ritual produces tangible, subjective and social effects in the world.

CONCLUSION

Through everyday linguistic and embodied practices, I have argued that the nuns engage the divine in three primary ways (1) through prayer, (2) by summoning the divine's presence into the room and (3) through the powerful trope of "being God" to each other. Through these processes, I argue that the nuns constitute a particular reality, or, in Schutz's terms, a "finite province of meaning" in which the divine exists in every interaction as a caretaker, in which other persons are no longer just human subjects, but also representatives and embodiments of the divine. Through these interactions, the nuns create for one another and for themselves a reality in which the divine tangibly exists to them. This "province of meaning" that shapes their reality is distinct from a strictly secular or medical world, and yet is thoroughly integrated into it.

As the nuns constitute the divine as an embodied

participant present in their lives, the social support the nuns receive from each other is dynamically integrated with the social and spiritual support they exchange with the divine. As they receive care and support from their human peers, they also experience the divine healing presence of God. The nuns describe experiencing the divine as a presence that accompanies them throughout the day. When they hold His hand or speak to Him, they describe experiencing various embodied states including joy, peace, calm, and love. As the nuns engage with the divine, the phenomenological reality they constitute, in which they are enveloped in peace and love, impacts their psycho-emotional wellbeing. They describe feeling loved and calmed.

These embodied engagements in which the divine becomes integrated into the nuns' everyday interactions – through prayer, through an embodied presence, and through the nuns' very bodies – shape the nuns' experience of care and wellbeing. As the nuns superimpose this sacred reality onto everyday physical/medical care interactions, the nuns' wellbeing, as well as their overall health trajectories are impacted

These embodied rituals are central to the nuns' enduring wellbeing at the end of life. As the nuns imbue everyday care-taking interactions with embodied engagements with the divine, medical interactions take on sacred meaning, and the nuns experience care, and comfort, and an enduring sacred presence. They are not engaged in a temporal healing trajectory that may or may not be successful and they thus avoid encountering failed healing events. Instead, they are engaged in an ongoing (life-long) process of wellbeing, which shapes all encounters, whether medical or mundane, as sacred encounters with the divine.

Acknowledgments

Notes
[1] All names, including the name of the convent, are pseudonyms.
[2] A note on style: the capitalization of pronouns referring to the divine is consistent with the nuns' usage.

[3] This concept of healing as temporally unbounded has been taken up by recent authors working on chronicity. For example, Smith-Morris argues that the acute/chronic dichotomy is not representative and can be problematic (Smith-Morris 2010).

[4] Of course, if the blessing occurs in a group setting with overhearers the blessing would be a multiparty interaction.

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A Little to One Side
Caregiving, Spatial Seclusion, and Spiritual Border-Crossing in Frail Old Age among the Tuareg (Kel Tamajaq)

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Abstract
This essay examines the meanings of the seclusion of frail elders and the roles of small children who act as their primary caregivers in rural Tuareg communities of northern Niger, and explores the implications of these arrangements for intergenerational relationships. Data suggests that both cosmological and socioeconomic forces shape the seclusion and caregiving of frail elders. It is argued that, despite some physical decline and social withdrawal in these circumstances, particularly on approaching death, nonetheless there is enhanced spiritual power in which these elders and their small caregivers cross thresholds toward new sources of meaning. More broadly, the essay contributes to debates over the meanings of disengagement over the life course and the semiotics of peripheral and secluded spaces.

Keywords: aging and the life course, religion, symbolism, disengagement theory, household cycle, Africa

Peripheral Spaces and Frail Elders
Abjection or Liminality? The Problem of Spatial Seclusion, Caregiving, and Boundaries among the "Old/Old"

In Tamajaq-speaking communities of semi-nomadic, Muslim, traditionally-stratified Tuareg, sometimes called Kel Tamajaq, (after their Amazigh language) of Niger and Mali, many frail elders are lodged separately: outside or adjacent to the household compounds of their married adult children. Their primary visitors and caregivers are small children, who bring them food cooked by the adults. They are rarely mistreated or neglected. Yet most persons of advanced age do appear to experience, on the surface, some social, spatial, and political marginalization in their seclusion. On closer scrutiny, however, there emerge more complex meanings to their predicament, explored in this essay.

The seclusion of young women has received considerable attention in anthropological studies of gender. Less understood is the seclusion of "old/old" persons in aging studies. It is now recognized that age and aging, like gender and sexuality, are culturally constructed, rather than essential categories and experiences, (Cohen 1998; Lamb 2000; Rasmussen 1997; Sokolovsky 2009). This essay examines the expression of aging constructions through residential spaces where frail elders are cared for, how they are cared for in these spaces, and their relationship to their often-primary caregivers—young children usually their grandchildren. Fundamental to understanding the patterns of caregiving and the meanings of seclusion of frail "old/old" persons in Tuareg society, I argue, are intergenerational relationships and spiritual and economic forces, both longstanding and emergent. Longitudinal data from my field research reveal some disengagement, even reversal, of roles of frail elderly physically and economically (Cumming and Henry 1961; Gutmann 1987), but also their active engagement spiritually.

The goal here is to detach frail elderhood from its

exclusively passive, "deficiency model" connotations. Another goal is to offer critical refinements of disengagement and "old/" old concepts in anthropology of aging. More broadly, the analysis links the semiotics of space and social practice to age and intergenerational relationships.

Historical and Ethnographic Overview

In cultural terms, Tuareg communities display both unity and diversity (Bernus 1981). Today, most are semi-nomadic, and reside in rural, semi-sedentarized, agro-pastoral oases and small towns in the Saharan and Sahelian regions of Niger, Mali, Burkina Faso, Libya, and Algeria.[1] Relations between the pre-colonial stratified social categories of nobles, tributaries, smith/artisans, and former slaves are much modified, and are breaking down in the towns (Bouman 2003; Claudot-Hawad 1993; Nicolaisen 1997).[2] Occupations—of combined livestock herding, oasis gardening, Islamic scholarship, artisanry, caravanning and other itinerant trading, and labor migration—are no longer based strictly upon descent or social stratum affiliation. There is much social interaction between the sexes, and most women enjoy high prestige and independent property ownership.[3]

Regional confederations and smaller descent groups and clans are headed by traditional leaders whose powers were modified first by French colonial and later independent nation-state administrations. Most Tuareg groups now tend toward bilateral succession, inheritance, and descent, with varying degrees of matrilineal influences pre-dating central state and Qur'anic-sponsored patrilineal property laws, rituals, and mythico-histories.[4] Brother-sister relationships remain strong, frequently enduring beyond spousal relationships into late life. Ideally sisters, daughters, and mothers reside near each other, but now some follow husbands to the latters' distant work sites. Most property is controlled by elders through gradual pre-inheritance gifts and endowments. There are threats from recurrent droughts, locust invasions, and armed conflicts between Tuareg separatist dissident rebels and the central state governments of Niger and Mali (Bourgeot 1994; Boilley 1999; Dayak 1992; Keenan 2003; Oxby 1990).[5]

These wider forces have not completely obliterated longstanding property arrangements, social relations, or communal local ritual roles, but have prompted their creative negotiations and modifications. Many widely-held ideals in caregiving still suggest a poetic cosmology of intergenerational complementarity and continuity, and these ideals persist in much practice.

HOME ALONE: A CLOSER LOOK
The Perspective of Sidi (Pseudonym): From Hidden Space and Muted Voice to Active Engagement

Upon my return to a rural community of my long-term research in northern Niger, I noticed that an elder, whom I shall call Sidi, the aged father of a research assistant in my host family, was now much more enfeebled, perhaps terminally ill. He occupied a one-room, adobe mud building formerly used as a guest bedroom in the cold dry season and for storage in the hot season , when tents or the open were used for sleeping. This now-dilapidated small building was located in the now-deserted compound that had once been home to Sidi's extended household. I, too, had stayed there as the family's guest on other visits in the past. But now that compound was abandoned; there were no more tents of married women inside it (though several of his daughters resided nearby). The roofs of a few remaining empty adobe houses had caved in. The central courtyard had become overgrown with weeds, discouraging entry. A broken tin door had been erected in a gap on one side of the back mud wall—perhaps from fear the elderly occupant might wander off, and/or harm himself. Yet few adults made prolonged visits. His married daughters in neighboring compounds cooked his food and occasionally looked in on him. His young grandchildren almost always took the dishes to him, and spent far more time with him than his adult children.

During my visit, Sidi recognized me, warmly taking my hand, but he sat rather dejectedly upon his mat inside the crumbling edifice of what had once been a well-maintained grass building used for guests (*imagaren*—also a term for newborn babies, strangers, and foreigners, such as myself). Was Sidi now in some way a "guest," "stranger," and/or "foreigner?"

The physical facts of fragility and illness are undoubtedly significant here, and partly explain the reclusiveness of these "old/old" elders; but they do not explain entirely why they are lodged apart, secluded, and encouraged to be close to, not their grown adult children, but their small grandchildren. In Tuareg communities, persons at opposite poles of the life course—frail elders and young children—are vulnerable, yet powerful. They, not others, tend to congregate inside a frail elder's residential space. Thus there is a connection between seclusion, marginality, and thresholds across the borders of life and death. What sort, exactly? Here I show that spatial and spiritual transformations in elders' caregiving derive from both cosmological and domestic forces. There are social and

symbolic parallels, and ritual and mythico-historical complementarity between persons of alternate but not adjacent generations.

In semi-nomadic rural communities, chronological age is difficult to ascertain precisely, due to lack of birth records (Rasmussen 1997). Many local residents define age according to not strictly biological or literal markings, but rather, according to social and ritual criteria: for example, one is defined as "old" (masc. *amghar*, fem. *tamghart*) when one's children are ready to marry or are married (Rasmussen 1997,2000). For many elders, there tends to be increasing emphasis upon participating in both Islamic and para- or pre-Islamic rituals.

There are also hints of another age category approximating the western academic category of "old/old": many refer to persons of advanced age who are frail by a different Tamajaq term: *wa wachere* (fem. *ta wacheret*; plural, *win wacharen*), rather than amghar, which as noted, denotes a still-vigorous older adult with married children and also "chief" and "leader." In other words, elders who are frail and/or ill have already passed through their earlier social and ritual elder status of still-vigorous, authoritative and active parents of marriageable or married children. There is also a term in Tamajaq, *takhal*, approximating conventional notions of "dementia" associated with old age. This is very different from *anubzug*, permanently insane, which may be applied to persons of any age, who, as noted, may also become secluded at home, but whose seclusion has very different meanings from the seclusion of frail (though sane) elders (Bernus 1969; Rasmussen 2001b).

Gender constructs are also relevant here, though not the sole determinant of Sidi's predicament. In most rural communities, one can still count the number of households by counting female-owned tents: the married woman brings her tent (*ehan*) as dowry, which she owns, to the household upon her wedding. Elderly female relatives of the bride construct it during the week-long wedding celebration (Brett and Fentress 1997). Since tents are owned by married women, who retain them even on divorce, men can be without their own home in more nomadic communities, though in more sedentarized communities, men build and own most new adobe houses they construct next to the wife's nuptial tent. Sidi was not divorced, however, and his compound earlier had contained both his house and his (now deceased) wife's tent, a typical pattern in that semi-nomadic community. Whether more or less nomadic, very elderly (especially widowed) men and women alike often withdraw from their previous residence, and occupy separate domestic spaces. Houses are usually passed to

sons. Tents are usually destroyed and the land beneath them left vacant for a year as "sacred" space (Ag Soliman 1999). Later, a marrying granddaughter's nuptial tent is constructed there.

Thus, gender constructs do not explain all meanings of frail elders' secluded space. Although aging men are more often without a tent upon widowhood or divorce, once frail, elderly women are also, often, secluded and in advanced age; both tend to move away into similar peripheral spaces.

As Lawrence Cohen (1998) observes in his study of urban Hindu Indian frail elderly persons, dying spaces are not static "things," but are contested, and interpreted from different vantage points. I agree that we need to move from third-person frames to second-person positioned and contested accounts of the "familiar body" in the first-person construction of experience, and to the voices of old people (Cohen 1998:183). I also caution against taking too literally the surface attributes of spaces and built-forms, for example, inferring from them rigid social correlates (Goody 1958). One also cannot ignore personal emotions such as grief (Rosaldo 1991). Within these spaces, do individuals experience their own advanced aging as frail or powerful, and if powerful, in what sense?

The first-person voice is difficult to elicit here. Sidi managed to smile weakly, and greeted me warmly by my name. When I inquired how he was, he chuckled somewhat ruefully, and did not give a direct verbal reply, but gestured vaguely toward himself, and shook his head. He slept intermittently. Sidi's adult children were evasive when I asked about his welfare. Although his adult daughters continued to cook for him in their neighboring kitchens, and occasionally looked in on him directly, they did not linger, enter, or approach, but stood briefly in the door-frame, nodded a greeting, and then retreated. Notably, they did not avoid pausing in the door-frame here, in contrast to their strict practice of this taboo while holding babies. They usually sent small children instead to stay with him longer. In the presence of these children, Sidi, when not too ill, held conversations with his grandchildren on everyday work situations, the weather, and more general concerns such as local history. Thus there was a juxtaposition of living and dying in the same space.

Other fragile elders more explicitly discussed their feelings with me, recognizing themselves as "very old now…lacking strength." Several frail elders lamented that "no one takes me seriously now…I see things I do not like,

but I can only watch." One younger adult woman (i.e., married and of childbearing age) commented, "An elder does not do work or make any decisions. When one is very old, one follows the children." Some explained that, when they want to shield an elderly person, they say he/she is senile (*takhal*), even if not really the case. Dementia, in fact, is often disputed. A wife, for example, disagreed with her husband after he described an old chief to me as senile; she insisted, "No, he is not senile, only his feet are incapacitated, that is why he does not go out." As anywhere, illness and injury prevent motility.

Yet even infirmity does not fully explain frail elders' secluded, peripheral residential space, since such a space is highly formalized and involves specifically very young visitors. Why did adults of the adjacent generation shun entering this space? Persons suffering from non-contagious diseases are not usually secluded; rather, they are surrounded by close relatives and friends who try to heal them. By contrast, persons suffering from contagious infectious diseases and persons undergoing healing of spirit-related illnesses are secluded for varying time periods. What social engagement takes place in this peripheral space? Death could not be entirely polluting, since young children were permitted, indeed encouraged to enter this space.

Local definitions of fragility related to age usually merged unspecified bodily and/or mental decline, disability, and illnesses, or simply advanced senescence. Many Tuareg, for example, described the life course to me with resignation, metaphorically as "like a canopy (*abarkan*) that gradually loses its supports for men, from about fifty years old, for women, earlier." Others asserted that "the body bends." A few organic disabilities—whether they strike at birth, in midlife or old age—are viewed as punishment for past sins (e.g., blindness without a discernable cause), or as the manifestation of parents' breaking of sexual taboos (e.g., babies born with disabilities may have been conceived outside the nuptial tent, under the moonlight, or stolen by the Kel Essuf spirits and replaced with a changeling) (Rasmussen 2000).

Age-related "mental" decline was alluded to in specific contexts, rather than philosophical generalizations. *Takhal*, denoting approximately "senile," (a problematic term) is usually applied to those elderly persons who tend to lose their orientation in the desert, to forget mythico-histories, and lose conversation skills, important in local cultural values. Hence the challenge of translating illness meanings and terms across cultural settings is compounded by age. Several older persons I interviewed were pointed out to me,

away from their presence, as suffering from takhal, but not Sidi and not everyone in seclusion. Most people treated the sufferers of takhal with respect to their face. When they are fragile, the old/old are ideally respected and cared for by their daughters who should cook for them, or at least make sure they are fed. No one ever described Sidi as suffering from takhal to me.

The dying space of frail, dying, but otherwise normal elders can be spatially peripheral to the household while remaining in some ways central, but not marginal. For example, in India, the knotted rope and wood frame bed are often placed near the threshold of the house, or in a courtyard. This suggests a simultaneously liminal and exemplary position of its aged occupant (Cohen 1998:182). Several brief "negative case" examples show how the Tuareg threshold (*temilelt*) can indeed become a place of either alterity and abjection, or, as in the present case of Sidi and many other frail elders, a place of crossroads and becoming. Another frail elder, a woman who appeared suffering from the beginnings of dementia, became much more isolated in her secluded space because of her social disaffiliation. She had disputed with her brother and female cousin over the disposal of their livestock property, and also became estranged from her nephews (brother's sons). They did not linger in the space of her tent or bring her food. She tragically became insane and tried to beat them when they approached. Another woman, though cared for, diagnosed as permanently "insane" (*tanubzug*), remained tied up inside a tent inside her uncle's compound. No small children brought this woman, food, either—in fact, she allegedly seized a small kid goat and ate it whole—thereby indicating possible neglect and hunger (Rasmussen 2001b).

Thus there are distinctions within the category of "frail" elder and variable meanings of seclusion. Seclusion is qualitatively different for those who are considered anti-social or insane. Sidi's and others' residential arrangements were, therefore, more "typical" or "usual" for those elders locally defined as "normal" though frail (i.e., those with declining social and economic powers). How and why?

There is a notion, in seclusion, of some special condition, "pollution," "holiness," and/or "profane," status, or perhaps "sacredness"—concepts notoriously difficult to translate and sort out. As shown in anthropology of religion, these concepts may have both positive and negative connotations (Douglas 1966; Gottleib 2004). As Radcliffe-Brown pointed out long ago, the body of a Polynesian chief is tapou: at once holy and profane (Radcliffe-Brown 1939). The meanings of Tuareg frail

elders' seclusion and their consequences in caregiving are different from those frequently noted in other cultural settings, for example, urban and rural India (Cohen 1998; Lamb 2000). In contrast to what Lamb reports in rural Hindu India (2000), most Tuareg do not consciously attempt to formally become ascetic renouncers in order to prepare for eventual death and/or rupture ties, or detach from the pleasures of life, even those who pursue more intensive Qu'ranic study. Nor is the Tuareg arrangement equivalent in meaning to installing a frail elderly parent in his or her own room in many middle-class US households for the purpose of individual privacy, replicated for other family members when affordable. Nor do these meanings exactly correspond to those of the US hospice. Nor is there an exact parallel to Cumming and Henry's (1961) classical disengagement theory, which argues that upon aging, there is conscious withdrawal from active participation in life in preparation for death. Certainly, the Tuareg case does approximate withdrawal in some respects. But this process is very selective, and moreover, in the partial seclusion of frail elders, there is also a new engagement in the spiritual domain of life: in between humans, the Islamic Allah, and spirits and ancestors, in between alternate and adjacent generations—as in effect, new parents of grandchildren (actual or classificatory, including nieces and nephews—particularly those on the maternal side, children of sisters and daughters, referred to as "children of the stomach"). In effect, one lives with one foot in the social community and one foot in the realm of the afterlife. But how is this Tuareg case liminal and death-denying at once?

Upon advanced and frail aging, the public face of household authority over sons and sons-in-law in managing the domestic economy becomes more difficult to maintain. Frail elders who are respected come to occupy a status very similar to the sacred or "divine" kings analyzed in African ethnography in their ritual status and political succession conflicts and conundrums. In other words, Tuareg elders' declining powers must be hidden, since they are connected to the fertility of humans, herds, and crops.

On another level, frail elders and young children come to occupy symmetrical and complementary statuses in their mediating positions between the spirit and human worlds. These dimensions—socioeconomic, political, and religious—are all at play in the caregiving of frail elders. In other words, there is fragility and weakening, but also, ideally, alternative forms of empowering and connection, embodied in seclusion as a threshold and crossroads.

LIMINAL SPACES IN AGING SYMBOLISM AND THEIR PRACTICAL CONSEQUENCES IN CAREGIVING

Healthy Tuareg elders and their authority have received some ethnographic attention (Claudot-Hawad 1993; Dayak 1992; Rasmussen 1997,2000a,2000b). Frail elders have received less attention. The latters' physically fragile, often ill and dying, state alone, does not completely explain the significance of their seclusion. Many Tuareg believe that frail elders, like very young infants and possessed adults, live in or have close ties to solitude or "the wild" (*essuf*) and its spirits (*Kel Essuf*). It is tempting to posit an equivalence between these social categories based on their shared similar symbolic imagery, but in other ways, they are not equivalent, but complementary. Frail elders' adult children seldom speak to or about them directly, visit them only briefly, and never pronounce their names. Out of respect, Tuareg never mention the names of deceased ancestors. Very young children; however, can pronounce names of parents, but as they mature, adults discourage them from doing so. These practices of spatial segregation and name teknonymy suggest not just respect, but also transformation of social and spiritual personhood. There are cultural efforts to make advanced, frail old age and early childhood symmetrical by situating them on complementary spiritual border-crossings.

As important caregivers of frail Tuareg elders, small children also often tend the fire during the cold, dry sandstorm season. Food to satisfy hunger, and warmth to protect against cold are, of course, physically necessary material resources, but they are also channels of symbolic, ritual, and social communication. Caregiving of frail elders is most closely related to alms offerings or sacrifice, focused on specific age groups: the very young and the very old. One purpose of alms is to promote the satisfactory outcome of a wish or goal. As earlier noted, alms should be given to small children on Fridays in order to avoid misfortune or compensate for a misdeed (Rasmussen 2001a). Other situations require that alms be given to impoverished and/or frail elders in order to ensure their *al baraka* (blessing) protection from dangers such as thieves and lightning storms. Children also receive food in many ritual contexts, defined as "alms offerings" (*takote*), also denoting the commemorative mortuary feasts held at intervals following deaths.

As they weaken physically, elders are ideally cared for, and receive, but also give, alms—both before death, in gradual pre-inheritance gifts, and following death, in the Islamic scholars' distribution of their remaining uninherited property to the poor. Many Tuareg, upon my

inquiring what most comes to mind when thinking of old age, immediately and emphatically exclaimed, "Takote!" Both forms of caregiving and almsgiving—to the very old and the very young—are necessary, in local viewpoints, in order for the givers to obtain Islamic blessing or benediction.

Like frail elders, Tuareg babies and very young children are considered closer to the pre-Islamic spirit world, thus approximating Beng babies' "arrival" from the afterlife (Gottleib 2004). There are also hints that Tuareg frail elders occupy special, respected status as pre-ancestral, as mediators between humans and ancestors. But here, in contrast to the Beng, these connections are less explicit or direct; for mainstream ("official" Qur'anic) Islam discourages too-overt focus on the ancestors as distracting from the monolithic God, Allah. Also, the Islamic paradise is qualitatively distinct from other (pre-Islamic) spiritual abodes: *essuf*, the wild or solitude; *idebni*, the graves of recently deceased persons; and *ibedni*, ruins of more genealogically remote people of the past.

Frail elders' secluded residence partly reflects, I argue, their position partially in paradise and partially in the wild and the other related spaces, thereby reflecting Tuareg dilemmas over Islamic and pre-Islamic cosmologies and rituals surrounding the life course. Many emphasize the need to sever a newborn's ties to the spirit world, fearing that spirits may pull him or her back into their realm of *essuf*. To prevent this fate, a week-old infant's hair is shaved off on the nameday ceremony. The new mother and her infant remain secluded to protect against these jealous spirits (Rasmussen 1995, 1997), only emerging at the baby's nameday held one week following the birth. The newborn baby, like the frail elder and the recently deceased, is not addressed or referred to by a personal name, but is called "stranger" or "guest" (*amagar*, fem. *tamagart*) until the nameday. At weaning age, some mothers style their first-born male children's hair into a small tuft on the top of the head to enable the Prophet to pull him up into Paradise (notably, not to enable the Kel Essuf to pull him into essuf). This idea is the Islamic interpretation of the threat of child mortality. The small boy must now embark on the path to becoming a mature Muslim male.

For both very young and very old, therefore, thresholds and crossroads are ritually significant. Some birth defects, such as mental disabilities, are widely attributed to a mother having paused in a doorframe while holding her baby momentarily in it. Both very young and very old persons are liminal, standing at the interstices of life and death, and have uncertain, disputed and ambiguous ties

to the living and other worlds. In some contexts, both age groups experience literal, as well as symbolic spatial seclusion and similar linguistic marking and tropes.

What are the meanings of these approximately (though not exactly equivalent) symmetrical images and practices surrounding the very young and the very old? How do these beliefs affect caregiving of frail elders in their apparent solitude of residential seclusion, and how do socio-economic predicaments— longstanding, recent, and current—of many Tuareg households interact with these spiritual predicaments? In some respects, these spatial, ritual-symbolic, and social patterns of frail Tuareg elders living "a little to one side" suggest pre-emptive social death—but I never encountered practices Glascock (2009) has termed "death-hastening" as a conscious, overt intention in this seclusion. Adults do appear, however, not to wish to see frail elders. Yet death denial occurs in efforts to preserve living-deceased communication in beliefs, practices, and stories concerning living-dead interaction through almsgiving and other interactions between graves, ancestors, and spirits, as these practices are interconnected. Although there are some hints of "social death" in the spatial and caregiving arrangements for Tuareg frail elders, there are also counter-forces here: in the complementarity and parallels between cosmology and ritual surrounding babies, very young children, and "old/old" frail elders. But Tuareg never expressed an idea of a circular "return" to infantile dependency upon advanced frail old age. Although elders and very young children and babies are all similarly believed to be closer to the spirit world, in other respects, they are not treated as equivalent, in every context.

As Cohen (1998), Kaufman (1986), and Vatuk (1980, 1990) point out, we need to consider the "becoming" as well as the "being" aspects of old/old age. We also need to detach aging from its solely literal frame, not to deny its very real effects, but to understand the cultural means of coping with them (Rasmussen 1997). To some extent, being frail and old/old becomes a source of positive meaning and empowerment in seclusion under children's watch, (or are these child caregivers under frail elders' watch?). Inside secluded space, the mutual gaze and reciprocal voices between these alternate generations collapse living and dying times and spaces.

Relevant here are the changing meanings of crossroads, interstices, and thresholds in a play of power and symbolism, as well as personal sentiments. As Stoller and Coombs (1994) have pointed out, crossroads in many African societies and cosmologies signify danger, but also

opportunity, and a kind of transformative, indeterminate, and suspended identity. Liminal thresholds, entries and exits, and crossroads thus suggest mediation and transition, and offer possibilities of re-inventing the person in ways that empower the person spiritually, if not physically or socially. For example, on the eve of the official nameday, babies are carried by elderly female relatives around the mother's tent, though not through its doorframe. At weddings, on the final evening, the bride enters the tent through the front door, rather than through a side flap in the tent as on previous evenings in the week-long wedding. Smiths accompanying the bride to the nuptial tent enter through its left side. Graves and tombs are located well outside, but on roads connecting villages and camps. The place where a person died is covered with tree-branches, and its ground is considered sacred or taboo, *al hima* (Ag Solimane 1999). Some, but not all cases of placement in outside but connecting non-standard spaces convey pollution. Entrances, exits, and liminal times, spaces, and actions in ritual time and space ritually mark some dangerous state, situating persons in ambiguity, but not always abjection.

Thus, in one respect, the Tuareg data approximate Cohen's findings (1998) in urban India, in the sense that there are more nuanced meanings involved in the placement of dying spaces than marginality or abjection. But in another respect, the Tuareg case markedly differs from the India case in its social consequences and implications. In India, according to Cohen, although this space (of the frail and dying elder) is not quite part of the household, nonetheless, the old person on the threshold is the first person one would encounter in visiting. In India, the *charpoy* bed-platform is "simultaneously that of confinement and repose, restriction and respect" (Cohen 1998:182).

In other respects, there are contrasts between Tuareg spaces and Indian spaces. As observed, frail, disabled, and/or dying Tuareg elders tend to be lodged away from public scrutiny and greetings, and do not often receive many adult visitors. The secluded Tuareg old person is often hidden from view. From whom and why? In the case of the elderly local chief of that community early in my research who was variously described as suffering from dementia (*takhal*) or from a disabling foot ailment, I never saw him, rather, I saw only his still active son, who had taken over his duties. Similarly, after the (now deceased) traditional *anestafidet* (leader) of the Kel Ewey confederation in Agadez became blind in his advanced age, no one visited him; he and his wife always sat alone inside their home.

Yet the secluded frail elder's powers of evoking memory should not be underestimated. Children absorb much oral history, for television is not yet a feature of rural Saharan communities. Moreover, small children acting as intermediaries and caregivers can listen and observe fragility, thereby conferring some empowerment through empathy and communicating wishes indirectly through messages. Sidi's dilapidated and nearly-abandoned compound, though it mirrored the frail elder's physical state, also evoked memories of contrasts there some fifteen years earlier, when it had been a center of lively sociability and storytelling. Although this compound now metaphorically represented the old man's bodily fragility, it also prompted people to remember a happier time of his past "prime."

When my research assistants and hosts (now a married couple) had planned to marry years before, the soon-to-be- groom was constructing this compound nextdoor to that of his father Sidi and mother Tanou. Both were at that time considered *imgharen* with their children grown and marriageable or married, but still vigorous and active. Sidi had been an accomplished Islamic scholar, in a clan of prominent marabouts closely related to the local chiefly family. In his youth, he had gone caravan trading. He owned several oasis gardens and a few livestock, though the latter were diminished from droughts. The older couple had enthusiastically recounted folk tales and legends to me, several with themes of elder/children/alms relationships. In one tale, small children visit and give offerings to the tombs of their patrilineal ancestors. Sidi and his wife explained this tale as reminding youths to visit relatives on a Muslim holiday (Rasmussen 1997). Their voices in the foregoing narratives, though part of the past, continue to "echo" in current cultural knowledge and practice in contexts of ritual, if not secular power.

Many Tuareg explained that "spirits fill places that were once full of people and are now deserted and full of nostalgia (another meaning of *essuf*)," for example, abandoned campsites, sacrificial terrains, and razed markets. There are efforts not to upset these spirits in such practices as almsgiving to obtain al baraka blessing. Essuf is not in every respect a negative place, but is also a place of creativity, for example, the best poets are said to compose their verses in the wild, and herbalists gather their tree medicines there. Spirituality is therefore relevant, indeed fundamental, to the meanings of frail elders' seclusion and their consequences in caregiving.

ATTITUDES TOWARD FRAIL OLD AGE IN RELATION TO HOUSEHOLD DYNAMICS

Also relevant here are the economics and politics of caregiving. What does the current Tuareg household predicament imply about household "exclusion" in advanced aging? Albert and Cattell (1994) have pointed out that modernization and globalization have had enormous impacts in Africa and elsewhere. In Niger and Mali, economies have declined in recent years, poverty has increased, and daily struggles for survival have intensified. Unemployment, monetarization, ecological disasters, and wars have diminished livestock, and propelled many young Tuareg men into labor migration and political exile abroad.[6] Many young men skip the traditional male rite of passage and socialization: the now-disrupted trading caravans for salt and dates across the Sahara under the authority of elderly male relatives, who conduct tests transforming youths into men (Claudot-Hawad 2002). These processes have consequences for frail elders' authority patterns and intergenerational relationships.

Yet elders are not excluded from family support systems. There remains great emphasis upon outward public reserve toward, and on the part of, still-vigorous older parents whose children are of marriageable age or recently married, and their own dignity (*imojagh*), and others' strict respect/ reserve/distance/avoidance (*takarakit*) toward them are necessary for adapting to household transformations and transitions. Following children's marriages, one should increase one's time devoted to prayer and Islamic rituals, for example, in the mortuary alms feasts and in chanting liturgical music, and one should withdraw from more "secular" or "frivolous" festivals, especially in communities where Islamic scholars and icherifan clans claiming descent from the Prophet are numerous and influential. These orientations ideally reinforce still-vigorous elders' important authority positions as household heads: as decision-makers (for example, where to move a nomadic camp), as namers of children and grandchildren, and as prominent participants in rites of passage, and healing specialists (Rasmussen 2006).

Married persons practice a reserve or "shame" or "avoidance" (*takarakit*) relationship toward their parents-in-law involving name teknonymy and refraining from eating in their presence. New bridegrooms must wear the men's faceveil-turban high on the face (over the nose and mouth) before the mother-in-law, bring back food goods and cash from oasis garden produce, trading and labor migration products and cash for their parents-in-law, and

must refrain from looking into the latters' grain storehouse.

By contrast, confirming Radcliffe-Brown's classic observations long ago, as in many other cultural settings, playful joking relationships are frequently practiced in public between alternate generations: namely, grandparents and grandchildren. Grandmothers often mock breastfeed their daughters' babies, and grandfathers—even chiefs and marabouts—often allow young children to play with their face-veil, normally taboo to other persons, as this is a symbol of adult male gender modesty and respect.

Household residential changes, domestic subsistence patterns, and kin relationships also powerfully affect later caregiving of frail elders. Many of these practices respond to wider changes outside the household; in the past, related to pastoral nomadism, and currently related to global pressures, namely (predominantly young men's) labor migration and kin relationships (especially father-son and parents-in-law and children-in-law) impacted by this, state and NGO-engineered pressures on Tuareg nomads to sedentarize, droughts, and sporadic armed conflicts between Tuareg dissidents and national armies in the Saharan region. In semi-nomadic and sedentarized communities, occupations are now diverse within a single household, regardless of the family's social stratum origin. One child may become a gardener, another a herder and caravanner, another may depart on labor migration, and yet another may operate a market stall or small boutique in a town. These patterns cause lengthier, less predictable separations than the older seasonal fission and fusion of households in nomadism and caravanning.

Many youths, returned from travels, but unemployed and unable to raise bridewealth, marry, or reintegrate into Tuareg society, form a post-Tuareg rebellion wave of an age cohort known as *ichumaren* (denoting approximately "the unemployed"). Many elders lament that "reserve (respect) has been abandoned," and relate stories of children refusing arranged marriages with close cousins and/or endogamously within the same social stratum, discarding the men's face-veil, and neglecting Islamic prayers and other rituals (Boilley 1999; Rasmussen 2000a, 2000b).

As a result, intergenerational and kinship roles are becoming more fragmented. This trend is double-edged in its consequences. Youthful men, once dependent upon the mother-in-laws' approval for establishing independent married households with their wives, now enjoy greater freedom if they are able to successfully benefit from the increasingly monetarized economy beyond subsistence

work for parents and parents-in-law. For those youths who are unemployed, by contrast, elders' authority may be less contested. But even these youths still hold many "cards" since they cannot support elders so generously in late life, and elders know this.

In rural, more nomadic households, many older women and men still assert much control over their children and children-in-law. But these sources of authority are dependent upon the older nomadic livestock economy, in which inheritance of herds acted as a powerful source of leverage over youths; and this economy is now threatened by droughts and wars. In sedentarized oases and towns, residents are moving toward farming, labor migration, and cash-based markets. Caravan trade goods—traditionally bartered—are no longer sufficient to support the household and elderly parents.

Wider political events are also relevant here, though not the primary cause of Sidi's and others' residential arrangements. Sidi's predicament is typical in many respects, but atypical in one respect. Traumatic regional violence and dispersal of refugees may have accelerated his physical and mental decline, and also undermined, rather than reinforced, his potential to continue some aspects of the ideal authority role over the heretofore semi-nomadic, seasonally unified household. In the late 1990's, he and his family were forced to evacuate with other refugees from an attack by government army soldiers, who accused local residents (falsely or accurately, I do not know) of supporting and sheltering dissident rebel fighters. This catastrophe undoubtedly traumatized Sidi further, whether he had been frail before that event or not, though he did not mention it to me himself, Friends and assistants away from his presence related sorrowfully, "We had to place our old and sick people on donkeys and camels…until we arrived safely at a distant oasis higher up in the mountains Many people died. One woman spent two days in hiding with her children without food." My long-term hosts in that region joined refugees in flight who temporarily resettled in that mountain oasis, where they had to start new gardens, occupy smaller residential spaces, or camp out in the dried riverbed and rely on local assistance for food and water. Upon return to their village after mediation of that conflict in Algiers, they found that some soldiers had stolen medicines, grains, livestock, and household valuables such as women's jewelry.

There were also gardening land shortages from these demographic upheavals. So Sidi's son (my assistant/host) had decided to farm back in the mountain village where he had fled, where his wife's parents still resided. He left

his aging father inside that compound back in his village, since his sisters and their households were located just adjacent to it. That is how I found him.

How far did the local religious cosmology and how far did the local political-economic trauma each contribute to the seclusion and youthful caregiving of frail elders? It is tempting to attribute much causal connection to the traumatic violence and their aftermath. Yet it should be noted that, except for the refugee flight and return, Sidi's caregiving situation was not new, aberrant, or atypical; for as already observed, during peaceful times, as well, frail elders are almost always housed in removed spaces; recall that even the former (now-deceased) local chief and the anestafidet were earlier in my research, during more peaceful and prosperous times. Sidi would have occupied such as place "a little to one side" in the distant oasis, as well, had he gone there, but the compound of his son and his wife there was considerably smaller; thus it made sense to house him back in their village of origin near his daughters. Indeed mobility and upheavals are not entirely novel; for many Tuareg have longstanding experience of travel in nomadism and caravanning, and suffering from battles in raids. Thus these wider pressures affect, but do not overturn completely, local strategies of caregiving.

Even prior to these far-reaching recent upheavals, moreover, even still-vigorous elders' authority was never uncontested. Some youths, for example, opposed parents' choices of a marriage partner; others accepted this as a first marriage, but later divorced and re-married according to their own choice. Others departed on travel, never to return for years. There is not, and never has been, a guarantee of late-life unified household, support, companionship, or caregiving. Many gossip about (supposedly) rare cases of dire neglect of frail elders, for example, a marabout related disapprovingly how "one invalid elderly parent wanted water, but his family denied him sufficient quantities of this, and they will surely not go to paradise!" Perhaps adults rely on young children as caregivers in part because they can most easily delegate this responsibility to them, and also because alternate generations need not conceal shameful conditions of both very young and very old (i.e., of weakness, illness, dirt). Children are also sent to look in on sick persons.

These practices have to do with the important Tuareg value called *takarakit*, which denotes reserve and shame, in addition to respect. Relevant here are longstanding tensions, contradictions, and dilemmas surrounding youth-elder and intergenerational relationships, both past and present, and their modifications. The ideals of reserve

and dignity can mask a tension between what it means to be an elder as a leader (*amghar*) and simultaneously be a spouse, (if not widowed), grandparent, parent, affine, and pre-ancestor. Still-vigorous elders can and do hold these roles simultaneously, but they must mask this simultaneity in public: they must, in effect, maintain a distance in order to retain authority, but remain visible to exercise that authority. Later, upon decline and senescence, there is the need to conceal elders', particularly chiefs' and Islamic scholars', waning physical strength and official authority. For if this is revealed too openly, their al baraka risks being doubted. These frail elders need to be kept separate from still-fertile young childbearing women. Small children are ideal buffers since they, too, occupy liminal status. Thus socioeconomic and political factors, cosmology, and ritual are all powerful in shaping the interior space and psyche of frail elders' predicament.

Interior Psychic Border-Crossing

Frail elders stand, as it were, at the confluence of mutually-incompatible physical, cosmological, ritual and sociopolitical powers. In this, their spatial separateness and social withdrawal convey their simultaneous disengagement, frailty, but also their newly active spirituality and alternative powers. They are both mediators and bystanders, but risk becoming neither as abject "anomalies."

   Notwithstanding these dangers, in withdrawal from worldly authority, some active aging may nonetheless take place indirectly. Most old/old persons continue some light handiwork—for example, men often make ropes for household and travel uses. Frail elders who are comfortable enough to speak relate tales and reminiscences to children, thereby commenting on local mythico-history. A few remain very alert, and sometimes reveal important healing knowledge (Rasmussen 2006). The peripheral residential space thus bears some resemblance to a "time-capsule" and to the Australian Aboriginal "dreamtime" as a time/space where past and present meet. The close relationship between children, elders, spirits, ancestors, graves, and the afterlife involves a kind of "beforelife" or becoming, perhaps a life review as well. Sometimes, ancestors in graves and spirits near them are believed to greet people on the road or even ask for belongings, especially from children. Children are also believed to often stumble upon Kel Essuf spirits playing miniature *tende* mortar-drums in empty riverbeds. There is a tale about spirits stealing babies, upon mistaking them for goat-hide waterbags.

   Moreover, the spatial symbolism of frail elders' seclusion

recalls, but also diverges from, the symbolism of Tuareg smith/artisans' marginality. Both figures are mediators, though smith/artisans are social mediators. Smith/artisans act apart from, but also centrally as go-betweens for other Tuareg, lack dignity and reserve, and convert natural into cultural substances. Frail elders nearing death are, their physical seclusion notwithstanding, also mediators, albeit in a different sense: the old/old convert cultural persons into spiritual beings (living and deceased)—for example, in their participating in naming of children and in telling histories to and about small children portraying ideal values of heroes' resistance to oppression, protection of life, and generosity between the generations. In feeding the frail elder, small children in effect are giving them alms—the reciprocal counterpart of many other occasions when adults give alms to small children.

Conclusions

The space of the frail old/old is not shrinking. Rather, it has always been peripheral and central at once. This article reveals more nuanced and dynamic multigenerational relationships, semiotics of space, ritual and social practices on advanced aging. The essay also challenges some representations of frail, even dying elders as entirely disengaged or passive. The Tuareg data indicates that, although there occur some physical and political-economic disengagement and withdrawal from official political authority contexts, there also occurs, despite pain and suffering, alternative empowerment of the person—not always realized by everyone, but available as cultural possibilities.

   Secluded space can isolate elders from family and production, as in the peripheral hospices in Western Europe, the United States, and urban India. In many "occidental" societies, segregated physical space and built form can disempower persons and erase memory. The Tuareg data suggests that elders' association with both ancestors and children in a space of creativity forges a subtle power that, when not radically disrupted, confers meaning to declining physical and social personhood.

Notes

[1] Most Tuareg remain predominantly rural, but many have been pressured toward sedentarization and migration to towns, first by French colonial administrations and later by some independent central state governments and aid programs.

[2] In the past, social stratum affiliation was inherited, based on descent. Aristocatic *imajeghen* controlled most large livestock, weapons and the caravan trade, tended to be more nomadic,

and collected tributes and rent from more sedentarized farming and other peoples of varying client and servile status (*ighawalen* and *iklan*). Iklan were owned, often war captives, and were liberated on independence at mid-century. Tributaries, imghad, some former nobles defeated in battle, raided and traded for imajeghen in exchange for military protection, usufruct rights, and part of the booty in war. *Inaden*, smith/artisans, manufactured tools, jewelry, recited oral histories, officiated at rites of passage, and acted as important go-betweens for their aristocratic patron families. Islamic scholars (*ineslemen*, popularly called "marabouts") interpreted the Qur'an, and continue this role as well as divination, counseling, and medico-ritual healing.

[3] There are some challenges to these gendered arrangements in groups more influenced by Qur'anic law, Islamic scholars, and Islamist-reformist movements, as well as in sedentarized oases and large towns more influenced by nation-state family code laws and other ethnic groups.

[4] Many Tuareg groups now practice bilateral or "double" descent, combining to various degrees, matrilineal and patrilineal legal systems of inheritance and secession. But in most groups, most women inherit property through endowments called *akh ihuderan* or "living milk" intended to compensate them for the male bias of Qur'anic inheritance in which two-thirds of property go to male heirs and one-third go to female heirs. Most women go about unveiled, may travel and visit freely and receive unrelated male visitors, even after marriage, and may initiate divorce.

[5] The post-colonial Tuareg armed rebellions began in 1963 in the northern Kidal region of Mali over food distribution and taxation, and have recurred in both countries sporadically between 1990-1996, in 2007 in the northern Arlit and Iferouan regions of Niger over uranium mining contracts, and most recently, in January 2012 in northern Mali. Until recently, the northern and more nomadic regions of these countries were marginalized politically and economically. Peace accords promised semi-autonomy, greater economic aid for these regions, as well as greater integration of Tuareg into the national armies, higher education, and jobs in the new infrastructures. But national budgets are limited, and control over policies and events in the peripheral border regions has been uncertain.

[6] There have been a series of droughts: in 1913, 1969-1976, 1984, and more recently, also locust invasions around 2005, as well as resurgences of the Tuareg rebellion against the central state governments of Niger and Mali and national unemployment problems throughout these countries, as well, which have propelled refugee flight and exile out of Tuareg regions. Most recently, the 2011 war in Libya caused an influx of refugees into some Tuareg regions, particularly Niger.

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Paying Down the Care Deficit
The Health Consequences for Grandmothers Caring for Grandchildren in a Mexican Migrant Community of Origin

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Abstract
While significant research addresses global chains of care work from the perspective of female migrant workers engaged in low-paid, unstable domestic labor in "receiving" communities, little research has focused on those who substitute for migrant workers to provide care in communities of origin. This article addresses that gap by focusing on the health consequences of care work for grandmothers in southern Veracruz, Mexico who assume the primary responsibility for caring for their grandchildren when the parents migrate out of the community. Based in the literature on care work and transnational families, this ethnographically-based article argues that grandmothers suffer consequences for their own health in three ways. They must deduct from their own health care resources – including time and money – to provide for their grandchildren. They must concede to the exploitation of already ill bodies to engage in the physical care of children and the household. Finally, they must transfer energy for self-care to caring for others thereby exacerbating their own existing health issues in order to meet the physical and emotional needs of their grandchildren. The article calls for further research in this area that aims to develop solutions to the problem of "care substitution" in transnational families.

Keywords: Intergenerational relationships, family, migration, care, Mexico

INTRODUCTION

"When are you going to start having babies?" teased Sara[1] as we ate breakfast one morning in her house in Los Cañales, a small town in southern Veracruz, Mexico. I hedged, "I'll start thinking about it when I finish school." I was uncomfortable with the question because as we became better acquainted, Sara began to hint – subtly at first, and then directly – that she would be happy to travel to the United States to care for my children once I started a family. I could then help her husband find work and her children learn English while she took care of my children and house. There were benefits on all sides in her estimation. While certainly aware of the potential for exploitation in this kind of labor arrangement – Sara had worked in the informal labor sector of the tourist industry in a resort town in Mexico – she trusted that I would ensure at the very least less exploitative arrangements. For me, it was not quite so clear cut. My academic training in anthropology and women's studies included critical

analysis of global care work chains, and I did not want to become part of those chains as an employer. I also recognized, however, that the imagined benefits of living and working in my house in the United States reflected the intense lack of resources that Sara and other families like hers experienced. In the United States, she imagined, her family would have steady income from both parents. Her children would go to school in a place where education makes a difference in the kinds of jobs a person can achieve. They would live in a house with consistent running water, heat, and air conditioning – among other things. Sara was certainly acting in the best interests of herself and her family, and her expectations that life would improve in the United States were not necessarily unrealistic.

My academic study, however, shows a darker side to this kind of arrangement. Rather than an individual, mutually beneficial relationship between anthropologist and research participant, Sara's suggestion points to one

relationship within a system of exploitation in which immigrant women work for low wages and limited benefits in jobs rendered "unskilled" through a belief in women as "natural" care givers. These difficult personal interactions with Sara were likely part of what drew my attention to grandmothers' care work. In Sara's envisioned world, her children would accompany her as she traveled to another country to perform domestic work for white, middle-class women like me. The reality for many migrant workers, however, is that they go alone, leaving their children in the care of others – often grandmothers.

While extensive research interrogates the exploitative conditions for immigrant women engaged in domestic labor in the global North, it often only hints at the consequences of care work for those who remain in communities of origin. My discussion of the health consequences of care for the women who engage in this care work contributes to research that seeks a more complex understanding of global care work chains, in particular health consequences for aging women with prolonged burdens of care. Grandmothers' experiences shed light on some of the lesser-studied consequences of transnational migration. This article begins with an overview of the research setting and methods. It then situates the study in the literature on care work and transnational families, and finally incorporates case studies from research in Los Cañales to rethink care work in the context of transnational migration. As I explain in more detail below, I argue that focusing on "care deficits" that are left when women migrate and leave their children in communities of origin only offers a partial theorization of global chains of care work. Examining the practice of "care substitution" allows for a more complex reading of transnational migration and care, in this case elaborating the health consequences of such substitutions.

Setting and Methods

Since approximately the year 2000, sugar-cane producers in Los Cañales have seen a steady decline in income, an issue that has left many with few options but to migrate for work. The majority seek employment in nearby cities or Gulf of Mexico oil rigs. In such cases, they often either move their entire families with them or travel between work and their homes in Los Cañales. Some, however, head to Mexican border towns like Ciudad Júarez and to the United States. In these cases, female migrants often leave their young children in Los Cañales. This incorporation of transnational migration as an economic strategy reflects the general increase in migration in the south-southeast region of Mexico until 2009. Between 1987 and 1992, 8.8% of the migrant population originated from

this region. Between 1997 and 2002, it increased to 12.9% (Leite et al. 2009). The actual number of migrants from Los Cañales itself is difficult to determine, but it is common to see several houses on a block boarded up because an entire family has left, seeking work elsewhere. The current global economic crisis has significantly reduced international migration to the United States; such migration from Mexico alone decreased 27% between 2007 and 2009 (INEGI 2009). However, the number of Mexicans living in the United States continues to increase (Leite et al. 2009), likely signifying an increase in length of stay for multiple reasons, such as increased border enforcement, repayment of increased debts incurred in crossing, or completion of financial goals made at the outset of migration (Massey and Riosmena 2010; Passel and Cohn 2009). Initial plans to remain in the US for a short period to earn money to build a house or start a business shift to longer term visions, as does the necessity for longer term care of young children in origin communities.

The data presented below were collected between 2007 and 2009 as part of a larger ethnographic study of gendered health and illness experiences that involved 72 women in Los Cañales (representing approximately 10% of households) both with and without migrant family members. Data collection methods included participant observation in women's homes, in health clinics, at community events and meetings, and during transport to larger health care facilities outside of town and in-depth interviewing that included questions about household migration status and experience, household earnings and expenditures, personal and family member health issues and illness experiences, research participant involvement in household reproduction activities, and research participant social network resources. All research participants orally consented to participation using protocols approved by the University of Kentucky Institutional Review Board. In this article, I focus in particular on the illness experiences of grandmothers who are caught up in the flows of migration through their care work. My research shows that in Los Cañales, when their children migrate to the United States, grandmothers often become the primary caregivers of their grandchildren and experience health consequences as a result.

Theorizing Care Work: Gendered and Generational Perspectives

I follow Zimmerman and colleagues (2006: 3-4) in understanding care work as "the multifaceted labor that produces the daily living conditions that make basic human health and well-being possible." All people, at some

point, have been and will be dependent upon the care of another person (Meyer et al. 2000; Tronto 1993). Therefore, many analyses of care work seek not to problematize the act of caring itself (Bubeck 2002), but rather to unmask the naturalization of care as women's work, particularly the work of women who are marginalized by race, class, and nationality (Feder and Kittay 2002) and to examine care work as a site of social reproduction of the labor force and the basis for maintenance of social and economic institutions (Litt and Zimmerman 2003; Zimmerman et al. 2006). Feminist studies of care work and reproductive labor have proliferated alongside the increasing feminization of (undocumented) labor migration and globalization (see for example Anderson 2000; Chang 2000; Hochschild 2000; Mills 2003; Parreñas 2001b; Romero 2002). Care work is a commodity that the wealthy can purchase cheaply in a labor market that relies heavily on immigrant women. While the shift to paid care work increases job opportunities in general for women, it also pushes them towards exploitative care work.

As Anderson (2000) has argued in detail, national immigration policies frequently lead to informalized, undocumented care labor. Women who perform such labor may, for example, be required to relinquish passports and other legal documentation to employers. They are then tied to those employers and whatever conditions of labor the employers impose for the duration of their residence in the country, unless they wish to risk the possibility of being deported. That they often perform care work for middle-class or wealthy white women highlights the ways in which globalized care chains further stratify people by gender, class, race, and nation (Feder and Kittay 2002; Zimmerman et al. 2006).

Women's labor migration in such situations often initiates the creation of transnational families – families that are spatially and temporally separated through migration (Hondagneu-Sotelo and Avila 1997) – where care becomes distributed across national boundaries (Baldassar et al. 2007; Boehm 2008; Dreby 2006; Parreñas 2001a, 2005; Raijman et al. 2003). Hochschild (2000) has argued that migrant women often leave "care deficits" in their home communities when they travel for employment in other countries. Many women have children or aging parents who require additional care. While some migrant women are able to fill those deficits by employing another woman to perform care work in their homes, many lack the resources to hire a caregiver and instead must rely on unpaid female family members (Meyer et al. 2000). Research on care work has focused more attention on migrant women than on those who fill the so-called "care

deficits" migration leaves in its wake[2]. Research focused on the site of "care deficits," such as the following analysis, reveals that the concept of "care deficits" risks obscuring the care work activities of women who fill in these gaps. In fact, the care "gap" is in some sense fictional because female kin often immediately fill it.

To illuminate the process of filling the care gap, I suggest thinking in terms of "care substitutions" (to borrow from Erel 2002). In such substitutions, gendered divisions of labor remain intact, but there is a generational shift in responsibility for doing care work at home. Instead of providing local care for their children, migrant women provide care for middle-class women in other countries. Instead of receiving care as they age, grandmothers in migrant communities of origin provide care for young children. The consequences of care work substitution for grandmothers include the production and exacerbation of chronic illness, an issue that underscores the need to deconstruct and work against not only the naturalization of care work as women's work, but also the ways in which such naturalization burdens particular women in specific global contexts. In the following analysis of several case studies, I explain some of the health consequences of "care substitutions" involving aging (although still relatively young) grandmothers by examining how they (1) deduct from their own resources, (2) exploit their own bodies; and (3) transfer care from themselves to others in order to eliminate the "care deficits" that children of female migrants might otherwise experience.

"I'M TOO OLD FOR THIS": DEDUCTING FROM HEALTH CARE RESOURCES

"I'm too old for this,"[3] said Patricia, age 55, sitting on the couch in a house filled with the cacophonous sounds of her four grandchildren. The five-room house was packed with gifts from Patricia's daughter Susana who was working in Ciudad Juárez and her son Emiliano who was working in the United States. The living room housed an entertainment center with a large TV, a DVD player, and a stereo; furniture including a small couch, two overstuffed chairs, a rocking chair, and a coffee table; and a motorcycle that Patricia recently bought with remittances from Emiliano. The motorcycle sat in one corner of the room underneath a hammock that Patricia often used to rock her youngest granddaughter Teresita to sleep. As the grandchildren loudly maneuvered through the living room and out the door, Patricia ran her hands down her face and sighed. She felt *acabada* – which could be interpreted as both "used up" and "finished" with caring for young children – but had limited alternatives and little

support[4]. Patricia's younger daughter Ofelia had recently developed complications of kidney disease. In addition to caring for Susana's two children, Patricia added the responsibility of taking care of Ofelia and her two children. Patricia's sister lived next door but was often working in a city several hours away. Although Patricia experienced a significant increase in material possessions through gifts from Susana and Emiliano, she, like other grandmothers in Los Cañales, also experienced an intensification of carework as she became the primary care giver for her four grandchildren and Ofelia.

Patricia often spoke of this caregiving as a burden, particularly because she saw herself as aging rapidly due to type 2 diabetes. I use Patricia's experience here to illustrate the ways that grandmothers frequently must deduct from their own health care resources in order to support the grandchildren in their care. Although in Patricia's and others' cases, the parents sent money for the grandchildren's expenses, it was often not enough. For example, Patricia's older granddaughter Eva had started kindergarten, and Susana (Eva's mother) pledged to cover educational expenses. However, she could not always estimate the costs accurately nor could she always send money when Patricia needed it:

> There are things that [Susana] is not able to pay, and we help her. Like right now, what [Eva] takes to school, her food. What I have to put in, I put in. And it's daily…a juice, a packet of those things…about 10 pesos goes.

Patricia supplemented these frequent expenses – snacks for school or supplies for a specific school project – that Susana did not calculate in her remittances. To cover household expenses , including those of her granddaughters, Patricia sold homemade candies and other food items. Her husband had also recently acquired a job as a security guard, which paid less than what the family needed to move out of poverty, but did provide a more stable source of income than many families were able to obtain. Therefore, Patricia did usually cover extra expenses, but her responsibilities extended beyond financial support.

She frequently expressed the tension she felt in having to choose between her granddaughters' care and her personal, including health, needs. During one of our conversations, she said:

> I told [my daughter] that she should come back[5] because I am going to give back her daughters. Can't you see that I am worn out? …because

imagine, I have to raise them…to wash for them, cook for them, give them food to eat… And [my children] got married and made their lives. I stayed here with my old man, and it's as if I were recently married [raising children again]. And now in bad health.

Patricia understood herself to be "too old" to shoulder additional caregiving responsibilities, a perception that was highlighted by her deteriorating relationship with her husband (who she was convinced had a younger girlfriend because Patricia's age made her no longer attractive to him). She additionally recognized the connection between her additional caregiving responsibilities and the decline in her own health. One day she told me, broom in hand, that she was too exhausted to even sweep the floor. She sat down on the couch rubbing her knee to alleviate the pain that the doctor told her was a result of diabetes-related poor circulation. The accumulation of care work for four grandchildren and her ill daughter left her unable to get up from her chair.

However, Patricia did not feel that she had a choice in whether to take care of her grandchildren or not – her responsibility as a grandmother left her no other viable options. Day care centers existed where Susana worked in Ciudad Júarez, but they were expensive. Patricia additionally felt that placing the children in a day care center would constitute neglect because she did not trust the child care facilities in the city. She recounted a conversation with Susana:

> She told me, 'Mom, will you take care of them for me?' And I told her yes. I can't force, I don't want her to put them in daycare…better with me, with their grandmother than there. They rob them from you.

Rather than place her grandchildren in the care of strangers, in a place about which she had heard frightening stories, she preferred to take care of her grandchildren herself.

Patricia's diabetes was worsening, though. The doctor had recently prescribed insulin; diet and exercise alone was no longer an option. This new treatment would add to the long list of medications she was taking for hypertension, high cholesterol, and asthma. Already, she took her medication only sporadically due to limited supplies in the free health clinic and her inability to pay for medications at private pharmacies, largely due to the additional expenses incurred in caring for her grandchildren. In order to get an appointment at the public health center, she would have to arrive at the clinic before five o'clock in the morning

with four children in tow to wait in line for one of the few available daily appointments. There was no guarantee that she would get an appointment, nor that the medicine she needed to take would be available in the clinic pharmacy[6]. Therefore, she usually did not even try.

Patricia directly related her caregiving responsibilities to the deterioration of her own health and indirectly suggested that it was unjust for her to have these responsibilities at this point in her life. Yet, she did not refuse to take care of her grandchildren. Even further, she took in her adult daughter Ofelia, in spite of the fact that Ofelia's husband lived and worked in the community. In the context of gendered concepts of care, his responsibility was to provide economically for the family, not to assist in the daily work of home dialysis and childcare. Like other grandmothers in my research, Patricia felt she had no choice but to take care of her family even at the expense of her own health. On numerous occasions, she intimated that she was frightened of meeting the same fate as her mother, who suffered the amputation of her leg and later died due to diabetes-related complications. The pain in Patricia's knee reminded her daily of that potential for herself. Unable to limit her care giving responsibilities out of both love and duty, Patricia, like other grandmothers in this study, deducted from her own health care resources – material, physical, and emotional – to invest them instead in her children and grandchildren.

"WHO WAS I WAITING FOR?" EXPLOITING THE BODY OF THE CAREGIVER

Tamara, age 44, was raising her granddaughter with significant difficulty. She, like other grandmothers, considered her advanced age (in comparison to the young age at which many women in the community become mothers) a factor in her frequent fatigue and inability to muster the energy that she could as a young mother of three. Tamara became the primary caregiver for her one-year old granddaughter, Rosita, when her daughter and her son-in-law migrated to the city of Veracruz. Although they were within a day's trip from Los Cañales, they left Rosita in Tamara's care several days each week. Tamara woke up throughout the night to feed Rosita, change her diapers, or comfort her. The activities were similar to those of raising her own children when she was in her late teens and early twenties. However, the experience was more difficult. She recalled being able to take care of her own children while still having time to attend to other household duties as well as to relax at moments during the day. She would carry one child on her hip and allow the other to cling to her leg while she was cleaning up the

house or preparing food. Then, she still had the energy to play with them when she was finished working. She didn't have the same energy to take care of her granddaughter. The lack of energy made her feel old even though she was only in her 40s.

Additionally, Tamara's husband had recently awoken, unable to move due to a temporary paralysis from a chronic back injury. He had experienced this paralysis before, and Tamara knew that this time would be no different. She would have to help him do everything. When he was sick, she told me, he was like a child himself. The caregiving responsibilities she had now not only for her granddaughter, but also for her husband, increased her fatigue, pain, and nervios[7]. When I visited her, she would regularly tell me that she could not even pick up her granddaughter because her back was hurting so badly. Tamara was not relieved of caregiving when she was in pain, unlike her husband who demanded attention and care when in pain.

Like Tamara, Jesica similarly dealt with pain that left her exhausted, but she had limited options for relieving herself of care work in order to address her own health issues. Jesica was 62 years old and lived about one kilometer from the center of town where health facilities were located. She lived with her husband, her son (who is deaf), and two of her grandchildren. Her husband had what doctors (according to Jesica) said was dementia. Her grandson had developmental disabilities. Jesica's two daughters were both migrants. They lived in the city of Veracruz during our interviews, but one previously worked in Canada for several years.

Without her daughters present in the household, Jesica shouldered the majority of the caregiving responsibilities, reflecting the gendered relations of care common for all the grandmothers in this study. Her husband's dementia required Jesica's constant vigilance and daily care. Jesica was often kept awake at night because he experienced insomnia, and in his confusion tried to leave the house. Due to his incontinence, she had to frequently wash his clothes by hand, as the family had no washing machine. She also had to assist him in getting dressed, eating, and going to the bathroom. Her grandson's developmental disabilities kept him out of school and in Jesica's care.

Jesica's health issues were intertwined with her extensive caregiving. She had experienced the sometimes debilitating pain in her leg for more than 30 years and, although it was reduced with treatment from herbalists and medicine from the Social Security clinic[8], when she worked a large

number of hours the pain returned. However, she could not rest. As she explained,

> Well, before, yes, it hurt quite a lot because I couldn't walk. It was a sting, a suffering…I did my daily chores because it doesn't matter, well, who was I waiting for? …and, like that many years I raised my children and I was sick…

Who could Jesica wait for given the gendered dynamics of care work that structure her daily lived experiences? That her son or her husband could be of assistance was in many ways inconceivable. Although her husband was likely physically and mentally unable to provide assistance due to his illness, Jesica never recalled him – even before his illness – engaging in the daily care work that sometimes left her unable to walk. I often observed her son return from a day of work (which was sporadic) to sit down at the table waiting for Jesica to serve him a meal. He did, however, frequently run errands into town for Jesica, who could not walk or ride a bicycle such a distance. That Jesica consistently held the major burden of care work in the house reflects the normalization of this work as women's work.

In an ideal world, Jesica would like her daughters to return to Los Cañales. If they did, Jesica would not be burdened with such substantial labor. Her daughters could take on some of that burden for her. When Jesica's daughter was in Canada, she sent significant remittances, but even from Veracruz, she provided more economic support than she would be able from Los Cañales. Such support has allowed Jesica to own a refrigerator and to pay for her husband's medical bills. Therefore, while she enjoyed the economic support she received from her migrant daughters, she was also concerned that the distance (particularly if her daughter returned to Canada) precluded the kind of support that requires her daughters' physical presence. They would be unable to accompany her to her husband's health care appointments or to periodically relieve her duties around the house, for example.

Tamara's and Jesica's situations reveal how the normalization of care work as women's work leads to the exploitation of aging bodies in the context of migration. Their daughters, who would likely share the burden of care work in a different situation, had migrated, leaving Tamara and Jesica with sole responsibility. Both women felt that their older bodies could not do what they could when they were younger, but neither could count on assistance from men present in the household – whether husbands or sons. Their chronic pain issues, then, are not simply a manifestation of the aging process. They result from a particular positioning of grandmothers as care workers in migrant-sending families.

"I Think A Lot": Transferring Care from Self to Other

Many grandmothers experienced the exacerbation of illnesses due to caring for grandchildren when parents migrated out of the community as we saw in the cases above. Patricia, Tamara, and Jesica struggled to address their own health issues while also serving the needs of their grandchildren. While they also often transferred care from themselves to others, Alicia's situation most clearly represents the transfer of care I elaborate here. Alicia has, in many ways, abandoned her efforts to address her diabetes because her doctor has told her that she must focus on herself in order to improve her condition – something she feels that she cannot do because she must focus her mental energy on her migrant children and on her grandchildren. Alicia, age 57, lived with her husband Alonso, her youngest son (age 23, single and unemployed) and her granddaughter Veronica, age 12. Her oldest son, Veronica's father, was working in the United States. When he first migrated, he took his wife and two daughters. After some time in the US, the couple thought that Veronica was being exposed to too many "negative influences" – pressures to drink alcohol and use drugs, to have sex, to exhibit bad behavior at home and at school, and to drop out of school. When her older sister confirmed their fears by becoming pregnant at age 16, their preoccupation with Veronica increased. They sent her to live in Los Cañales with Alicia and Alonso. At the time of my interviews with Alicia, Veronica's parents could not send sufficient money for Veronica's care. Her father was sick and unable to work. Her mother only earned enough to cover their basic expenses in the United States. Therefore, Alicia and Alonso were responsible for all the costs associated with their granddaughter's care.

Alicia and Alonso had long dealt with complications in securing regular household incomes. Alonso's severe knee pain kept him from working in his former profession as a bricklayer. He could now only sell snacks from a tricycle in front of the elementary school. Alicia contributed from time to time with the sale of chickens. Alicia and Alonso's economic situation was more difficult during school vacations – he couldn't work at all, and she had to seek out temporary work like washing clothes to make up the difference.

Alicia also had advanced diabetes. When I asked her about her illness she said

> I am not afraid of death. Do you know what I'm afraid of? Leaving my kids. I know they love me a lot, you know? They love us…they love both of us. But they think about me more because of this illness that I have. He, I'm not going to tell you that he is healthy. He is also sick, but it's a slower illness. In me, I feel that it is advancing very rapidly. And the doctor tells me that it is because I think so much…and that I have to take care of myself because my illness is advancing. Recently I lost more weight…Look how much weight I lost! I can't control it, I feel badly; like I get the shakes, I shiver…And it's because of that same illness, the sugar [diabetes], that's what the doctor has told me.

In that context, she also worries about providing for her family, including for Veronica. Without remittances from her son, Alicia and Alonso need to feed themselves as well as finance the education, nutrition, clothing, and food for their granddaughter.

Just before I arrived in Los Cañales, Veronica contracted dengue when, unfortunately, it was also a difficult time financially for Alicia and Alonso. Dengue arrives regularly with the rainy season when the reproduction of mosquitos in standing water facilitates its propagation. But the rains also brought difficulty to Alonso in selling his snacks at the elementary school. Fewer children went to school because mudslides often blocked several roads, and sometimes Alonso could not ride his tricycle through the mud of the unpaved streets in his neighborhood. His knee pain weakened him, and he was unable to push the tricycle through the mud. Alicia was preoccupied about providing for her family in these conditions. She needed cash to buy daily necessities. Even though she could get credit at the stores, she was aware that credit has limits. She needed to maintain control over the debt to be able to pay it back during the rainy season when sales were more limited. If Alicia felt pressure when she needed to buy basic household items at the store, it is perhaps obvious that her worry would be even greater when someone in the family was ill. When Veronica contracted dengue, Alicia and Alonso took her to the doctor, but the only medicine they could give her was acetaminophen and juice to drink. They had to monitor her constantly to ensure that she did not develop a more serious form of the disease, which is more common in older children like Veronica.

As Alicia and Alonso often had difficulty obtaining money for their basic needs, an illness like that of their granddaughter creates an even more delicate situation. When they were younger, they were in a better position to look for work. Now, in addition to being limited by age and chronic illness, they have financial responsibility for their granddaughter. The lack of money and the well-being of their dependents are preoccupations that became part of their daily lived experience. For Alicia, as I mentioned earlier, it had the grave effect of worsening her diabetes – what makes her "think", said Alicia, would quickly bring her to death.

The migration of Alicia's son left a major burden of reproductive labor on Alicia and Alonso, who stayed in Los Cañales, and this is not an uncommon phenomenon. In fact, what permits migrants to stay in the United States in spite of having poorly paid jobs is, in part, that much of the reproductive labor and support of the family of the migrant happens in communities of origin. Even though migration did not produce Alicia's diabetes, it is evident that the situation in which she found herself resulted from the vulnerability that accompanies the migrant and his or her family members. Alicia's "thinking" emerged from the particular structure of undocumented migrant lives that shifts care onto grandmothers thereby exacerbating illness, diminishing well-being, and increasing the potential for early death.

Conclusion

The research presented here suggests that gendered and generational notions of care – who should give what kinds of care, and who is competent to provide that care – place strains on women who have to move beyond the roles they feel competent to fulfill, particularly in the context of poverty and labor migration. Establishing new roles (ones which they have no real option but to engage) creates worry, stress, and fear for their own well-being and that of their children and grandchildren.

This examination of how caregiving creates such stresses contributes to ongoing cross-disciplinary and cross-cultural discussions of the health implications of grandmother caregiving. For example, there is no clear consensus that caregiving itself necessarily increases poor health outcomes for grandmothers. Some studies have shown, for example, an increased risk for coronary heart disease (Lee et al. 2003) and increases in stress that contribute to greater health vulnerabilities (Cross et al. 2010); while others have shown no significant differences in health outcomes (Chen and Liu 2012). Still others demonstrate a positive effect on grandmothers' health and well-being, particularly in cases where children are old enough to

provide assistance with household duties and where they provide emotional support (Alber 2004; Ice et al. 2008). However, the context and circumstance of caregiving does have an impact (Hughes et al. 2007; Ingstad 2004), a finding that supports the research presented here. Significantly for this discussion, studies have shown that when it is parents' difficult circumstances – including drug abuse, incarceration, serious physical or mental illness – that lead to custodial caregiving of grandchildren, the grandparents are more likely to experience negative consequences (Goodman and Silverstein 2002). In the cases described here, the circumstances frequently include not only the stresses of migration but also caring for grandchildren and other ill family members. The health consequences of the tensions that arise in the context of parental migration and increases in already significant burdens of care are at some times more obvious than at others; however, the consequences are real. The grandmothers' life experiences presented in this article show the ways in which the global process of "care substitution" to aging women who live in circumstances of poverty and chronic illness act to diminish their quality of life.

In order to minimally fulfill their responsibilities of care, grandmothers in Los Cañales must shift their resources – including time and money – into caring for grandchildren rather than using those resources to address their own health issues. As we saw in Patricia's case, waiting in line for a doctor's appointment is nearly impossible because time does not allow both seeking health care and taking care of grandchildren. Additionally because remittances are variable, Patricia and other grandmothers have limited financial resources to purchase medication like insulin when supplies are not available in local free clinics. Instead of "taking care" of her diabetes, Patricia spends time with her grandchildren, buys their snacks for school, provides their meals, and maintains their health. She must, however, deduct from her own resources to do so.

Although the relationship of power between women and their migrant children is far more equal than that between migrant women and their domestic employers, "care substitution" still places grandmothers in a situation of exploitation. Tamara and Jesica exemplify this condition, although all the grandmothers experienced it to some degree. Both Tamara and Jesica lived with daily chronic pain that required rest and relaxation, not prolonged care labor. Given their responsibilities for their grandchildren and their husbands, neither had the luxury of rest. As I argued above, the normalization of care work as women's work contributes to this exploitation of ill bodies. In both cases, men were present in the household who could have contributed to the care labor required to satisfy the needs of the very young and the very ill, giving Tamara and Jesica time to rest, but they did not.

In all cases, women transferred self-care to care for others. Alicia is a particularly good example of the ways that such a transfer happens. Her preoccupation with her family – including both her migrant children and her grandchildren – led to a decline in her own health. Her doctor repeatedly emphasized the need to reduce stress so that she could better control her worsening case of diabetes. A combination of poverty, migration, and illness limited Alicia's ability to experience moments free of stress. In a particularly insightful analysis of the consequences of migration and care, Alicia argued that she would ultimately die because she "thinks too much."

In spite of, or perhaps because of, care substitution that normalizes women as always already appropriate caregivers, grandmothers sometimes felt that they were inadequate to the task of mothering because they were too old or too ill to take care of children. Grandmothers also judged themselves against a notion of motherhood that they were unable to fulfill. Migrant mothers could not fulfill it because of distance from their children. For grandmothers, it was fatigue, the potential for health crisis, and pain in particular that limited their abilities to take care of their grandchildren. This tension drew energy away from grandmothers' self-care, whether that be through preparing diets according to doctor recommendations, attending appointments in the health clinic, or simply getting adequate sleep.

However, grandmothers also resisted the idea of being inadequate mothers in multiple, although partial, ways. They pointed out their poor health conditions as unavoidable limitations to mothering and refused to blame themselves for their poor health. Fathers and grandfathers were complicit in the construction of inadequate mothering because they offered little if any assistance that might improve care and relieve grandmothers. Their resistance to fully accepting the consequences of care work as natural and unavoidable was only partial, and perhaps necessarily so, because such resistance did not lead to changes in the situation of care work. The lack of economic resources grandmothers and their families experienced left them little option but to send some family members away to work while others remained in the community to fill in for the absent laborers. Women's longstanding relationships with their husbands and other family members – in which women were consistently the primary caregivers – left little practical or strategic way for women to shift any

responsibility for care work onto others. In light of the case studies presented here, I would argue we need further research about care substitutions in the context of global migrations in order to deepen our understanding of the situation of grandmothers like Patricia, Tamara, Jesica, and Alicia. It is my hope that this research can help direct us towards programs, policies, and other solutions that allow older women to live the lives that they had hoped they could.

Acknowledgements

Notes

1 Names of research participants and of the research community are pseudonyms.

2 There are important exceptions in studies focused on grandparents caring for grandchildren whose parents have died of AIDS (see for example Ice et al. 2008; Upton 2003).

3 All interviews were conducted in Spanish. English translations are by the author.

4 It should be noted that the narratives of suffering that I present in this article could be read as constructions of a gendered personhood defined and in some ways strengthened by suffering. Malkin (2004), for example, describes how Mexican migrant men use stories of suffering to enhance their own status as providers for their families. Stephen (2001) also argues that women in the Co-Madres movement in El Salvador strategically deployed their roles as suffering mothers to effect productive international political action. In my research, many women focused on narratives of suffering to the exclusion of other kinds of life stories. Women's lives are not wholly defined by suffering, and their narratives are strategic and partial presentations of lived experience (see Hunt 2000). However, these partial representations do have real consequences for grandmothers' health, which is my focus here.

5 Susana did, in fact, return to the community at about the time I completed my fieldwork. It was unclear whether she planned to stay or had only come for a visit.

6 Elsewhere, I have written in detail about the practical barriers to health care access for women in Los Cañales who rely on the public health facilities for care (Scott 2010).

7 Nervios in this context is a chronic illness often characterized by anxiety, headaches, and high blood pressure (Davis and Low 1989) brought on by continual life stresses (see Baer et al. 2003). Low (1989) and others (Doyal 1995; Jenkins 1996) have argued that this idiom of distress expresses confrontation with social, political, and economic exploitation and violence.

8 The clinic is part of the Instituto Mexicano del Seguro Social or IMSS which provides care in Los Cañales to cane growers both active and retired.

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"Who are you to teach us?" Elder Abuse in Kyrgyzstan

Photographs by Malik Alymkulov
HelpAge International

The photos were exhibited on June 15, 2012 in Bishkek, Kyrgyzstan to mark UN World Elder Abuse Awareness Day.

"Сага эмне керек? Биз сени багып атабыз"
"What else do you need? You eat and drink at our expense"

"Сага эмне керек, алжыган кемпир?"
"What do you want, you old crow?"

"Акчаңдан бер. Болбосо өзүмө жооп бербейм!"
"Give me money otherwise I can't guarantee what I'll do!"

"Качан сенден кутулабыз?"
"When will we get rid of you?"

"Ты – обуза для семьи"
"You are a burden for our family"

"Чего тебе не хватает в твоем возрасте? Сидела бы"
"What do you need at your age? Sit quietly"

"Ты выжила из ума"
"You are senile"

«Ты кто такая, чтобы нас учить?»
"Who are you to teach us?"

About the Photos

Eppu Mikkonen-Jeanneret, Social Anthropologist and Regional Director in Central Asia for HelpAge International

There has been a rapid societal change in Kyrgyzstan during the post-Soviet era. Up to 20% of the population has migrated overseas for work as unemployment and the weak economic situation remain serious problems. The latest World Food Programme report is esimating that up to 25% of the population in the country is food insecure due to high food price increases and high levels of poverty - this is a shocking figure that unfortunately compares to many more 'classical' development countries. In short, there is a lot of tension and a lot of families struggle to survive.

What we aimed to do was to document the impact of these tensions on older people. The project interviewed a number of older women and men who told stories of every-day abuse that they encounter at home. The focus is mostly material; they are told they are a financial burden, that they are useless, that they don't contribute. As you see, the context of the abuse is a home, in most cases a lovely well cared for home. This 'normalcy' is what most viewers find so difficult about these pictures - myself included.

Most of the people in the photos are the actual persons presenting the words they hear from their families. In some cases people were not prepared to give their face as well as their words to the project, and in these cases their friends stepped in. So in cases the photo is of a person who does not personally experience abuse but who wants to give his/her face to the cause of a friend. There was an astonishing sense of solidarity among the group working on this piece.

The full set of photos and other galleries from HelpAge International are viewable online.
 http://www.flickr.com/photos/agehelps/

For more information about HelpAge International visit http://www.helpage.org

Rethinking Aging and Daily "Difficulties"
From Functional Bodies to Functional Communities

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Common sense allows that persons unable to handle a difficult problem can be labeled "disabled" . . . Cultural analysis shows that disability refers most precisely to inadequate performances only on tasks that are arbitrarily circumscribed from daily life. Disabilities are less the property of persons than they are moments in a cultural focus. Everyone in any culture is subject to being labeled and disabled. -- Introduction from "Culture as Disability" (McDermott and Varenne 1995: 5)*

The measurement of ability has always played a central role in our understanding of aging. In some ways, the loss of ability is assumed to be a sign of aging itself. But, the relationship between the two is complicated. A greater degree of self-reflection is now changing the ways that we look at the tools and methods used to assess disability in aging studies. From the habits of clinical practice, to the assessment of function in community-dwelling elderly, and to the planning of "age-friendly" communities, I would argue that an anthropology of functional assessment is needed to examine the cultural constructs and practices at work in each domain.

For many older adults in the U.S. today, optimism for new ways of aging is still mixed with lingering fears of physical decline. Associated Press polling data (2012), show that the majority of "baby boomers" are "upbeat" and not really feeling "old," but when asked to rank their fears, loss of independence due to physical illness leads the way (45%) ahead of "running out of money" (41%) and "worrying about dying" (18%) (Cass and Anderson 2012: 2). In the study of population health and aging, the achievement of increased longevity is often overshadowed by the projected prevalence of "disability" with age. In 2006, for example, the Population Council observed that "a fundamental question surrounding the increase in survival is whether the extra years of life are being spent in good health or bad health" and " . . . subject to the most disagreement has been the trend in abilities to perform personal-care activities. . ." [my emphases added]. Similarly, demographic projections from the SCAN Foundation on the need for long-term care, suggest that while "70 percent of seniors will be unable to live in their own homes without some kind of help" only "37 percent. . . understand how likely they are to need assistance" (Weintraub 2011).

Yet, many have labeled this focus on physical decline and dependency as "ageist" (Butler 1975) and a tool for generating "alarmist" population demographics (Dant 1988; Longman 1999; Peterson 1998). In clinical practice, function and health are almost synonymous. The assessment of functional ability has been called the "lingua franca" of geriatric medicine (Mortimer 2003) where care is aimed at both assessing and preventing functional loss. As Gubrium (1993) observed, "the aging body" is both the subject and object of biomedical

encounters where "as subject, I describe; as object, I am described" (1993: 53). However, while the inevitability of decline and dependency seems so certain, it appears that after years of research on aging daily life through the assessment of ADLs (activities of daily living) and ADLs (instrumental activities of daily living), we are now in the midst of an intellectual and methodological crisis over the measurement and classification of disability in population studies.

In January 2009, the National Research Council (NRC) and the National Academy of Sciences (NAS) sponsored a summit meeting among experts in the field to improve the measurement of late-life disability in population surveys "beyond ADLs and IADLs" (NRC 2009: 1). With so many tools, scales, and variations in national survey items, it was concluded that there was "no standard for ascertaining the occurrence of disability" (2009: 20) and "substantial differences "in prevalence rates due to a diversity of "conceptual definitions" measures, wording, sampling, and modes of data collection (Wiener et al 1990). In other ways, the tools are not keeping up with the social transformations among older adults. The NRC participants, for example, cited data from the Health and Retirement Study (2006) showing that: 14 to 20% of those over age 65 were using "some kind" of assistive technology regardless of task difficulty, and that by the mid-1990s, almost 50% had already adapted their homes to reduce barriers (NRC 2009: 69-70).

At the root of this current debate, according to NRC, is also a growing ideological conflict over terminology and methods. On the one hand is the "medical view" where disability is seen as an "attribute" of the individual due to an underlying condition or impairment (2009: 6). On the other, is the "social view" where disability is seen as "the product of physical, organizational, and attitudinal barriers in society" (2009: 7). As the NRC participants noted, applying a more synthetic view would mean seeing that "disability is experienced when the person with functioning limitation interacts with the cultural expectations of the physical environment" and given that there are "far fewer measures of this type" to document this dynamic interaction, they recommended that this is "probably the direction that measurement should take to understand the full effects of functional limitations" (NRC 2009:16) [my emphases]. In further discussion about ways to improve measures of disability, a number of suggestions emerged including: 1) greater attention to the conceptual meanings of quality of life, coping, well-being, and social participation, 2) self-reflection not only on "what can be asked" but how, as well, and 3) the use of "vignettes"

and other qualitative measures to better understand the dynamic "pathways" to disability in different populations (NRC 2009: 85-86).

In the anthropological study of aging, the body, and disability, these suggestions should sound familiar and obvious. However, I would argue that this self-reflective turning point in the study of functional assessment is also an important opportunity for the role of anthropological inquiry in this growing debate between the "medical view" and the "social view" (NRC 2009: 6-7). The limitations of bio-medical approaches to ''the body" (Burroughs and Ehrenreich 1993, Foucault 1978, Turner 1992), are familiar as cross-cultural studies in medical anthropology have challenged the naturalization of certain somatic states associated with aging including: senility (Cohen 1998; Traphagan 2000), menopause (Lock 1993), and urinary incontinence (Mitteness and Barker 1995). Again, as McDermott and Varenne (1995) have argued, "disabilities are less the property of persons than they are moments in a cultural focus" (1995: 5).

Where might this anthropological inquiry lead for improving the measures of "daily activity"? It means more than creating new surveys. It requires a deeper exploration of the concepts whose meanings are too often taken for granted. A number of recent works are doing just on terminology that shapes assessment including: independence (Portocolone 2011), autonomy (Leece and Peace 2010), neglect (Iris et al 2010), and lifestyle behaviors (Albert et al 2009). It requires, what one expert calls listening to the meanings "behind the words" of participants in the assessment process (Brody 2010). It also requires paying more attention to the ways in which "environments" (physical, social, and natural), can enable or disable individuals (DelaTorre et al 2012; Glass and Balfour 2003; Golant 1984). Over the years, my own work has taken me across different domains of function and activity from: 1) broadening the scope of "comprehensive medical assessments" in medical education to 2) the qualitative assessment of individual function in communities to 3) the assessment of "age-friendly" (WHO 2007) community capacity in the midst of urban planning and urban renewal. I would argue that these domains of analysis should not be seen as separate and that each is crucial terrain for a critical anthropology of functional assessment. For a more complete review of geriatric assessment tools and methods (see Gallo et al 2006: 193-240); for more on the classification of "disability" (see Nagi 1991 and WHO 2002), and for more on the status of "disability studies" (see Albrecht et al 2001 and Davis 2006).

Limitations in the Assessment of Daily Activity

Over time, institutional and administrative demands (for example, a lack of time in clinical practice) have changed the ways the tools have been used and have led to a loss of specificity when assigning the status of disabled. Even though the ADL index (Katz 1963) was originally designed to assess the rehabilitation process of hospitalized patients "with fractures of the hip" (1963: 915), to this day, the Katz Index remains the standard for assessing general "functional disability' for older adults in the community as well. Since it was first established and promulgated, several clinical investigators have remarked that the scoring system is one of its principal weaknesses (Gill and Kurland 2003, Philip et al. 1998). On paper, the scoring form itself encourages observers to make subtle distinctions in performance (unassisted and assisted) for a variety of tasks (eating, getting dressed, grooming, walking, getting in and out of bed, bathing, and using the toilet), but then the final scoring process reduces these distinctions to binary opposites (independent and dependent) (Bennett 1999). Kane and Kane (1981), for example, noted that "the individual who needs a corrective device to perform the function or who requires the help of another person is assigned an intermediate position between independence and dependence. [Yet] sometimes, these two forms of dependency are equated and receive the same score" (1981: 43). This simplification has tended to increase over the years, thus eliminating much of the variability of the data (Bennett 1999:23), as the original index has been modified for use in clinical practice (Hartford Institute for Geriatric Nursing 2007), where individuals receive scores of 1 for independent and 0 for dependent. For example, while Katz originally allowed for some types of mechanical or personal assistance in his definition of "independence" with bathing and toileting (Katz 1963:916), this has routinely been lost in translation over time.

Similarly, for the tasks in the IADL index (use of the telephone, shopping, preparing a meal, cleaning house, doing laundry, using transportation, managing medications, and managing finances (Lawton and Brody 1969, Lawton's 1971), the assessment options included a variety of intermediate scenarios between fully able and fully unable. For example, when using the telephone, options include: 1) being able to "answer" the phone and dial a "few well-known numbers" or 2) "answering" the phone, but no longer "dialing numbers." For shopping, an individual might: 1) be able to do "small purchases" on his or her own or 2) need to be accompanied (Lawton 1971: 473). Yet, in clinical practice, a simplification in scoring is often accepted. Citing "no systematic study of the relative frequency of the use of different scoring methods," Graf (2008), suggests that one "common" option is to rate each item "dichotomously" (0 = less able, 1 = more able)" (2008: 54). Similar patterns are seen in population studies (for example, the National Long-Term Care Survey), where the criteria for "disabled" includes "any type of assistance, human or mechanical, for any ADL . . . or for any IADL, that had lasted or was expected to last, for a minimum of 90 days" (NLTCS 2007/1999). However, when put to the test, items in the IADL index exhibit much more variability in performance than do the items in the ADL index owing to social, cultural, and economic factors (Diehl 1998, Horgas et al 1998, Jette 1994, Miller 2005). Cross-cultural uses of the index (Avlund et al 1996; Martin 1989) have shown that the universality of these items should not be taken for granted and that performance on each is highly variable. In Avlund et al's (1996) study of English, West Indian, Asian, and Danish individuals, they observed that "nearly all [ADL] activities were performed by everybody, while none of the [IADLs] were performed by everybody" (1996: 10) due to "cultural differences in washing habits and types of clothing" as well as "actual differences in health as well as differences in gender roles" (1996:12).

In my own research in New York City (Costley 2008) with 64 community-dwelling older adults between the ages of 69 and 91, an assessment of their ADLs and IADLs using open-ended interviews (in addition to a semi-structured survey), revealed a number of issues that should challenge the use of these standard indexes and give insight into the social worlds of aging bodies. Even when individuals agreed to be interviewed, it was clear that many had a critical view of the index questions and the scoring options. All the informants resisted being misrepresented as old or frail on scaled items that did not allow them to explain their answers in more depth. In some cases, certain questions about needing help with basic activities (like getting dressed or using the bathroom) were also seen as stigmatizing, or even a bad omen. For example, when I asked "Mr. Wilson," a 75-year-old African-American man, living alone, whether he ever needed any help to get dressed, he replied, "No, no. I don't need no help. You're trying to make me old, before I get old. I'm pretty fortunate. . . . I can hold my own. So far, so good." This reaction, I would argue, was not just avoidance and it should remind us not only to listen to others, but also to imagine how these questions sound to others. This reflexivity has always been a strength of anthropological inquiry. When Maria Vesperi (1998) explored the ways in which older adults became defined as a social problem in an economically challenged urban neighborhood in Florida, she also argued that we need to

move past examining what it is like to be old and examine what it feels like to be regarded as old, where old age is not a discrete physical state, but a cultural "concretization" of abstract and often unexamined assumptions and everyday social interactions (1985: 22) [my emphasis].

In my interviews, individuals routinely made important and meaningful distinctions between "needing help" and "having difficulty" that made scoring their functional status challenging. These distinctions of did not always match with many examples of lived experience. One woman, "Mrs. Porter," (at age 77), exemplified what I called "collaboration as an extension of self." She was candid about needing help with walking (away from home) and bathing, but she said that managing her finances (normally considered a more complex task) was "easy." She said. "I have a checking account. . . . I can pay my bills by check each month. But, I ask my home attendant to mail my bills for me, and sometimes, I ask my brother to go to the bank to get me spending money. Sometimes, I need my home attendant to look at my insurance statements with me, too." When I asked her whether, in her opinion, she felt she had any difficulty managing her own finances, she said, "No."

In other ways, the scoring system itself often seemed irrelevant to many participants' lived experience. In one memorable encounter, for example, when I asked, "Mrs. Ivan" (at age 82) to describe (on a scale from 1-10) the level of difficulty that she was having while getting dressed in the morning she shot back at me, saying: "I manage. I have to do it. It's not easy, okay. Put whatever number you want. . . I have to get dressed every day, so what's the use to cry over it. I have to do it; that's it. Listen, I had a very tough childhood, and there was no feeling about it. I never cried about things. You have to do it. I manage. I don't make a big deal out of it."

"I can manage" was a phrase that I heard repeatedly during the interviews. It came to be a defining and revealing response on many levels. On one hand, it reflected a fundamental, vital effort to be recognized and acknowledged as a competent being. On the other, I came to realize that it revealed a participant's resignation that social networks were weaker than expected. Many participants in their retirement were actively caring for other family members, both younger and older (e.g. grandchildren and parents), yet had very low expectations for receiving daily support from family members in the future. Proximity to kin was no guarantee of support

when extended families were struggling with their own burdens and limited resources. While 72% of participants indicated that they had grown children and close kin in New York, 56% said that no one would be able to help them with daily activities "on a regular basis" if needed. When I asked several people to imagine a future where they could not manage on their own, many sat silently, not answering. Some invoked the reluctance to become a burden to others. But, every participant's story, I learned, had its own logic and revealed a carefully crafted calculus of his or her unique situation.

Functional Bodies and Functional Communities

The assessment of disability must account for the social and material world in which people live and the numerous factors (psychological, social, environmental, and geographic) that affect function. The fact that older adults can be made vulnerable by their social and physical environments, especially in times of extreme heat, has been well documented (Klinenberg 2002). In many cases, we can also see that the greatest challenges to disability do not always begin with the individual. In my own study, an earlier community needs assessment, commissioned by a local non-profit agency (Rosenthal and Rubel 1989) had already estimated that over 4,000 of the neighborhood's elderly residents were "to some degree disabled" according to criteria from the Health Resources Administration. But, by suggesting that "problems of isolation were caused, in part, by a changing social environment, fear of crime, and a challenging physical geography," they argued that physical weaknesses were not the greatest limitations (1989: 6).

As more and more individuals, especially in large urban areas are now viewed as "aging-in-place" (AOA 2005), the qualities of our physical and social environments are getting more attention. Population aging is now an issue for urban planning and public health and a catalyst for a number of initiatives to develop: "age-friendly" cities (WHO 2007), "lifespan communities" (Stafford 2009), neighborhoods for "successful aging" (Abbott et al 2009) and more "walkable" communities to promote daily physical activity (Glicksman 2011). In 2010, Portland Oregon became the first U.S. city to join the World Health Organization's Global Network of Age-Friendly Cities (DeLaTorre et al 2012). New York City was second (NYAM 2008). In each case, substantial coordinated efforts are needed to ensure access to affordable healthcare and housing, safe and affordable public transportation, and opportunities for

employment and social relations. The common goal is to "create good place[s] to grow up and grow old" (Stafford 2009). But, with each of these initiatives, I would argue that we also need to stay focused on the ways in disparities in geography, income, and homeownership patterns can lead to disparities in the distribution of these municipal investments and resources.

We also need a variety of ways to explore the relationships between individuals and their environments. In the NRC workshop, it was observed that while IADLs have typically been described as "concerned with a person's ability to cope with his or her environment" (NRC 2009:22) a focus on the body, per se, has led to a "neglect" of the home environment with few measures to assess how "features" of the environment and home affect individuals (NRC 2009:72). We know that the physical environment can affect behavior and activity, but it would be mistake, I believe, to focus solely on the development of new objective measures of the physical environment.

Subjective views also matter in ways that require more study. For example, in Albert et al's (2006) study of variations in "clinician-rated and self-rated disability" with IADLs, among 33% of respondents there were "discordant cases" where clinicians rated individuals as having "inefficient" performance, but where individuals had no self-reported disability. In other cases where individuals had self-reported IADL disability, clinicians saw them as "competent" (2006: 829). The authors discovered that "respondents who considered themselves disabled in IADLs, but who were rated as competent by clinicians, lived in home environments that were rated as more cluttered and in need of repair . . . less adequate in space and comfort . . . and less secured for preventing crime…compared to the other [respondents]" (2006: 829). These results should challenge us to critically examine the impact of the environment not just on behavior, but also on the perception of culturally-constructed ideas of disability and competence. When individual perceptions, preferences, values, and expectations matter, the focus on measuring what "bodies can do" is inherently incomplete, especially when it seems to reinforce a western and a U.S. preoccupation (Portacolone 2011) with maintaining "independence" at all levels. As a cultural value, it has reached the level of a social fact (Durkheim 1966) as both socially reinforced and deeply internalized by individuals.

An anthropology of functional assessment is needed in multiple domains. It is need to explore the degree to which older adults struggle with the imperative of dependence and the ways in which existing measures fail to match lived experience. It is needed to explore the extent to which we reinforce the expectation of independence in existing tools and methods through a "medical" model that appears to be losing its primacy. It is needed to build "community" and explore the dimensions of the environment in multiple ways beyond the physical that can become enabling and disabling for older adults. This current period of methodological introspection is an opportunity not just for building better tools, but for developing more interdisciplinary and critical approaches to functional assessment.

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Information and Submission Guidelines

Anthropology & Aging Quarterly is the official publication of the Association for Anthropology & Gerontology (AAGE). It is published quarterly (March, June, September, December) by AAGE. AAGE is a nonprofit organization established in 1978 as a multidisciplinary group dedicated to the exploration and understanding of aging within and across the diversity of human cultures. Our perspective is holistic, comparative, and international. Our members come from a variety of academic and applied fields, including the social and biological sciences, nursing, medicine, policy studies, social work, and service provision. We provide a supportive environment for the professional growth of students and colleagues, contributing to a greater understanding of the aging process and the lives of older persons across the globe.

AAQ welcomes submissions of new and engaging work that contributes to the anthropological study of aging. This may take the form of original ethnographic or experimental research, or work that applies anthropological methods and perspectives to the study of aging more broadly.

Submission Process All manuscripts should be submitted electronically, via e-mail attachment. *Anthropology & Aging Quarterly* accepts four types of submissions--*Research Reports*, *Policy and News Reviews*, *Commentaries*, and *Articles*.

AAQ invites unsolicited contributions in several forms. *Research Report*s are brief discussions of ongoing or recently completed study and should be no longer than 2,000 words. *Policy and News Reviews* are pieces which offer thoughtful and reflective commentary on current events or social policies pertaining to aging and culture. *Commentaries* provide authors with an opportunity to discuss theoretical, ethical and other time-sensitive topical issues which do not lend themselves to a full-length article. *Policy Reviews* or *Commentaries* may range from 1,000 to 4,500 words.

Articles are peer-reviewed and manuscript submissions should include the following: a cover page with the author's full name, affiliation, mailing address, and manuscript title; a 200 word abstract; the text; references cited; and tables or figures (*Chicago Manual of Style*, 16th edition). Endnotes are permitted but should be used sparingly and with justification. *Articles* should not exceed 9,000 words, including all materials. Published materials will publically accessible and protected by a Creative Commons copyright.

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All submissions should be submitted via e-mail to the Editor-in-Chief, Jason Danely jdanely@ric.edu.

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Book Reviews

Aging and the Indian Diaspora. Sarah Lamb. Bloomington, IN:Indiana University Press. 2009. ISBN 978-0-253-35343-6, 360 pp. Price $65/$24.95 (Hardcover/ Paper)

Sarah Lamb's ethnography, Aging and the Indian Diaspora, critically explores changing systems of aging and care provision in India and among Indians in the U.S. By examining the needs and desires of Indian older adults across three constructions of aging: living in an old age home, living alone, and migrating to the United States, the ethnography reveals how understandings of the person, family and the state also are shifting in contemporary India. Lamb unpacks cultural assumptions regarding the "proper" way to age and probes deeply into the multiple meanings of "modernity."

Older adults in India traditionally reside in multigenerational households. Lamb's earlier ethnography, White Saris and Sweet Mangoes, explores the conflicts surrounding aging in such settings, particularly for women. Although multigenerational households remain a cultural ideal, India's economic liberalization, the employment of women outside of the home, and increasing global ideological, financial, and human flows have sparked the development of other forms of aging. Most alarming of these trends to the general public is the growth of private "old age homes" for the urban middle class and the increasing number of older adults living alone, i.e., independent of their adult children.

Although old age homes and living alone are commonly presented in the Indian media as symbols of Western immorality and as "unnatural," many of Lamb's interlocutors view living in an old age home as "liberating." Old age homes provide a sense of security, social support, and the opportunity to engage in culturally valued roles, including extending blessings, receiving "seva" or service, and entering a "forest dwelling life," the third of four life stages in Hinduism that requires a withdrawing from worldly ties. Living alone similarly provides a sense of freedom and an opportunity to form new friendships. As old age homes carefully employ cultural tropes and maintain a construction of seva as a non-economic exchange, Lamb argues that old age homes are not simply a U.S. export, but have become uniquely Indian phenomena.

One of the strengths of Lamb's writing, both here and in White Saris, is her ability to capture the complex, and at times contradictory, viewpoints of her interlocutors.   For example, even as interlocutors explain the benefits of living in an old age home or living alone, Lamb makes clear the presence of unresolved feelings regarding such living arrangements. Her interlocutors are disturbed by the disconnect between their long-held expectations of aging in the context of their family, and their present situation of aging seemingly outside of the family.

Lamb also successfully captures the emotional conflict surrounding migration to the U.S. Although parents often view their children's migration as important for material advancement, they lament that migration frequently results in children no longer having time for intimacy and service, even in the form of a simple cup of tea. Joining their children abroad can require inverting traditional exchange flows, with older adults being expected to care for the family, e.g., in the form of childcare or housework, rather than receiving care, and when needed, accepting social service and economic support from the state.

Aging and the Indian Diaspora makes important contributions to understandings of aging and globalization. Lamb challenges conceptualizations of aging as passive, arguing instead that older adults "craft" the aging experience and the meaning of modernity. By revealing the multiple forms of modernity that exist, Lamb further questions assumptions that globalization is leading to the cross-cultural rise of a generic, free-market, western-styled, form of aging.

As in her earlier work, Lamb employs language that is accessible to undergraduate audiences. She clearly operationalizes her major concepts (e.g., modernity; agency, intergenerational reciprocity) at the outset of the text. I would have liked to have seen more discussion on human subject protections, for example, the reasoning surrounding the inclusion of Mr. Datta, who indicated that he did not want his information recorded (p. 107). Such a reflection would be useful for classroom discussions on ethics in qualitative research. However, this is a minor point. The ethnography's solid theoretical grounding also would make it appropriate for graduate courses on cross-cultural aging.

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Anthropology off the Shelf: Anthropologists on Writing. Alisse Waterston and Maria D. Vesperi. Malden MA: Wiley-Blackwell. 2011. ISBN 978-1-4443-3879-9, 232 pp. Price $34.95/$79.99/$94.95 (Paper/E-book/Hardcover)

I was a writer long before I became an anthropologist. I wrote my first story when I was eight, turned to poetry in my teens, majored in English literature in college. Anthropology came in midlife. So this exploration of anthropological writing is especially intriguing—no, exciting! for me.

The book's big question: How can we write so that our books fly "off the shelf" into the hands of informed readers? Into the hands, that is, of readers who don't (and won't) read the sometimes impenetrable dialect of academe, with its citation conventions and dense language ("too many syllables and not enough content," Brodkin, 22). The short answer: tell readable stories and avoid "academic high jargon" (Introduction, 4). The dilemma: if you tell stories this way, your academic audience—the "judges of epistemology" (Nordstrom, 36)—may scorn you. But this book's authors do not want to abandon anthropological writing, so there is always tension between writing to impress other academics and writing for the informed reader. So, another big question: how can we be both anthropologists and writers?

Writing anthropology also involves ethical issues: How do we represent those about whom we write? What is our responsibility to them? Are we trying to bring about change, or even, should we think in terms of bringing about change? Is it okay to just tell our stories, "to document carefully and clearly what is happening" (Farmer, 188)?

The book is organized into three parts. Part I, Conceptions, puts forth basic ideas. We can't trace the impact of most writing, but changing the consciousness of individuals is the first step to change (political scientist Zinn). Avoid "lardballs of jargon" with polysyllables galore and "genuflection-by-citation" (Brodkin, 21). Write like The Bard "…who translates the unfettered wilds of raw experience and human interaction into philosophical story" (Nordstrom, 36). Try to reach understanding through anthropological concepts such as race and culture (Baker). Write well, tell stories, use specifics–and publicize (what?! the "M" word? marketing???– see journalist Barnes).

The authors in Part II, Creations, tell stories about writing particular books and their struggles with the academic canon and publicizing (to no avail: Waterston). Signithia Fordham tells of being forced to write "out of voice" and developing her "counternarrative voice." Arthur Spears relates his difficulties in publishing a book about racism in America and how the university press which published it subtly sabotaged it. Ruth Behar used to write for teachers, now writes for her mother "so I could write for the world" (111). And Sharon Ball reminds us of her friend Octavia Butler's advice: "Write your passion"— something anthropologists are likely to do because "our imaginations are in service to real communities we know firsthand" (Behar, 115).

Part III, Reflections, considers the impact of our writing. We write. Then what? Mostly dull thud. Paul Farmer and Eben Kirksey combine their writing with advocacy and activism. For them, just writing isn't enough.

But don't expect your activism to change the world. It rarely does.

The final chapter by Maria Vesperi, journalist and anthropologist, serves as an epilog which sums up themes threaded through earlier chapters. Think about style, voice, audience. Tell stories. Give details. Use dialog. Make statements (as a friend of mine says: "Save your anxieties for your shrink"). Stay away from jargon. Get critiques from others, join a writer's group, take workshops. And above all: WRITE! Write regularly, for a defined time—then walk away for that day. And write creatively, daringly: take chances, leap and soar.

Blessedly, all the chapters are short and non-jargony. They tell stories, mostly without footnotes and minimal or even no references. They are easy to read but offer much food for thought. So, if you're wishing or hoping to become a better writer of ethnographies (or anything else), I recommend this book.

I'll be thinking about the issues these authors raise as I work on current writing projects, which include my spiritual autobiography and family memoirs. How does anthropology enter them? I'm sure it does. I am, after all, an anthropologist and a writer. But that's another story. Meantime, let's all become better writers of ethnographies which might have at least a chance of flying off the shelf. Anthropology Off the Shelf gives us plenty of inspiration for that kind of good writing.

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Book Reviews

Alzheimer's from the Inside Out. Richard Taylor. Baltimore, MA:Health Professions Press. 2007. ISBN 978-1932529234, pp 224. Price $19.95 (Paper)

Dr. Richard Taylor, trained as a psychologist, was diagnosed with early onset Alzheimer's type dementia at the age of 58. He opens by stating that the book was not originally intended for commercial consumption, rather, he writes for himself to process his experiences (or as he calls it, "therapy without co-pay")(pg xvii). What is produced reads more like an autoethnography than an autobiography. While he acknowledges that his own experience will not capture nor reflect everyone's experiences with the disease, he offers these writings to provide insight from an "insider's perspective".

Through the use of voice recognition software, Dr. Taylor shares his experiences, ranging from the limbo of the diagnosis process (which took over a year of testing), through the loss of his identity as an academic, and eventually, the loss of his status as an independent adult. Though this is only one man's experience with the disease, his work touches upon powerful themes that have appeared elsewhere in the literature (though other sources are commonly from the caregiver or researcher's viewpoint). This book addresses the need for more research that incorporates the direct voice of those with Alzheimer's and related dementias.

The book is divided into four parts: 1) What is it like to have Alzheimer's Disease?; 2) From the Inside Out; 3) From the Outside In; and, 4) Dear Doctor. Also worth noting is the Appendix, which is titled: What You Can Do. Each section includes essays, wherein Dr. Taylor reflects on his experiences, thoughts, and emotional interactions with his caregivers and his environment. Interwoven throughout Dr. Taylor's collection of essays are several themes that an anthropologically minded reader might identify and find useful. Some examples of these themes are the following: 1) The Role of Technology; 2) Curing versus Healing; 3) The Social Construction of the Disease; 4) Changing Social Roles, Identity, Personhood with a Diagnosis of Alzheimer's or a Related Dementia; 5) Recognition and Advocacy.

The Role of Technology
Anthropologists have long been interested in humans and their evolving use of technology over time. Use of online sources is prevalent throughout the book. The use of online sources emphasizes the Internet as a powerful source of information and understanding of the disease for both caregivers and persons with the diagnosis. Not only is the internet used to cite statistical trends, but it is used as means of communication with online support groups, and literature from which he finds context, connections, and meaning. Though some of the online sources for information on Alzheimer's disease may have become dated, even in the short 6 years since the book's first publication, the quotes used are often timeless. Even the references from Dante's Inferno (used to define purgatory and limbo as Dr. Taylor waits for test results) are attended by an online citation.

Curing versus Healing
Dr. Taylor emphasizes the inability of science to "cure" his disease and the complexity of the treatment of his symptoms. In one essay entitled "We Have a Pill. Alzheimer's Can be Treated!"(41), Dr. Taylor distinguishes between treating an illness and curing it. While there is no "cure", Dr. Taylor refers to writing the book as a "therapy", to sort the painful experiences that accompany "what is going on between [his] ears" (3). In this way, he is treating himself by reflecting on his personhood, ("Am I My Brain? Or Is My Brain Me?"(113)), his spirituality ("My Flesh Is Weak(er) but my Spirit is (Still) Strong (108)), and the shifting social roles played by himself ("Am I to Be My Spouses Son?"), his caregivers ("My Champion or my Hero?" (163), and his doctors ("From My Heart to My M.D.'s Ears" (233).

The Social Constructions of the Disease
Dr. Taylor illuminates the limits of science when explaining the causes and halting the symptoms of Alzheimer's disease. He writes, "there are no accepted norms for people with Alzheimer's on these tests. There is no agreement on the exact number of stages of the disease. There is no agreement on how long each stage lasts…" (38). In another essay, he describes the variation in the number of stages the disease might have (ranging from three, seven, or nine stages) (21). This variation highlights the contested construction of the disease, as Graham (2006) argues that "[a]nthropologists underline how scientific activity is not always about uncovering 'nature'. It is a fierce fight to construct reality" (83-84).

Changing Social Roles, with a Diagnosis of Alzheimer's or a Related Dementia
Social Roles and Productivity: Early in the book, Taylor describes the loss of his career as successful psychology professor (who continued to work for three years before he was politely asked to retire) (22). He writes about the transition from being an academic to "wandering around the lobby (my house)" (22). There is a genre of

anthropological writings examining disabilities and/or the life cycle that have connected the ability to work and acquire income with social roles such as "adulthood", "personhood" "valuable citizen" in American society. Taylor's book is an interesting addition to this genre because it is evident from his writings that he also sensed the loss of his identity as not only an "academic", but that of "adult" (186). Dr. Taylor explores the loss of his social roles as he begins to require more and more help with his daily activities. He recounts the frustration of losing his highly valued autonomy in essays such as, "Give me your money, your car and…" (181). Social Roles within the Family: Dr. Taylor's writings add to the concept of social roles; he observes his shifting role (and those of his caregivers) an insider's perspective as he describes his growing dependence upon his wife and adult children. He writes, with much chagrin that he feels that his spouse and children are taking on a parental role (164; 189). He writes several essays pleading with his caregivers to see the person that remains within him, such as "A Silent, One-Sided Conversation with My Caregivers" (174) and "Once Again, My Children Believe They Know More Than I Do" (166).

Recognition and Advocacy
The framework, of "recognition," has been recently applied in medical anthropology (see Janelle Taylor 2008) to explore the shift in a person with dementia's ability to recognize family and friends, as well as a person's recognition within the socio-political arena. This framework argues that when a person with Alzheimer's disease or a related dementia loses their ability to recognize their caregivers, it is often equated with an inability to reciprocate, express affection, or have a voice. Likewise,

Dr. Taylor writes about his family's search for mutual recognition; that his family, friends, and doctors are seeking to recognize the person he used to be before his memory loss: "Physicians, friends, and family are forever asking me, 'How is it going? Do you still feel ok?...The measures used to evaluate my answers seem to grow from the unstated questions, 'Are you still like me?'" (176). Dr. Taylor insisted upon recognition in the political arena, where people with Alzheimer's disease or related dementias are often neglected. He remains an active member of the Dementia Advisory Committee of the U.S. Alzheimer's Association, "looking at how to better integrate individuals living with the diagnosis in the leadership; program development, and delivery function of the Association and its local chapters" (xiii). Dr. Taylor continues to be a speaker at professional conferences. He also gives informal talks to caregivers, organized chat rooms for people with dementia and caregivers alike. In addition he publishes his own newsletter of, by, and for people with dementia. This is significant as there have been questions about the number of organizations that actively include people with Alzheimer's disease or a related dementia in their decision making and advocacy process. Dr. Taylor, through this book and the aforementioned, brings recognition of the person behind the diagnosis.

This book is relevant for anthropologists, students in healthcare professions, gerontologists at both the undergraduate and graduate level. This book can be used to augment the more scientific or heavily theoretical writings that present ideas about this disease in a more distanced manner. It might be especially helpful outside of the classroom as a resource for support groups, for families affected

by Alzheimer's disease and related disorders (including a person in the early stages of dementia). Dr. Taylor brings a very human element to the disease experience, which might offer a more complete perspective of those experiencing the disease.

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