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Senses of care: Embodying inequality and sustaining personhood in the home care of older adults in Chicago

Elana D. Buch

Department of Anthropology, University of Iowa, 114 Macbride Hall, Iowa City, IA 52242-1332

Elana D. Buch: elana-buch@uiowa.edu

Abstract

In paid home care—one of the fastest-growing occupations in the United States—low-wage workers help elderly clients living in their own homes remain independent by embodying and then reproducing the elders’ lifetimes of experience. Exploring the bodily and moral consequences of everyday home care practices in Chicago, I show that in this context, sustaining independent personhood depended on and intensified unequal social relations. To sustain clients’ personhood, workers developed a deeply embodied empathy that enabled them to imagine and re-create the elders’ social and sensory worlds. Home care practices involved unreciprocated circulations of bodily experience that led some workers to feel that the needs and preferences of their clients took priority over their own comfort and well-being. Care workers’ bodily practices thus became one way in which social hierarchies shaped individual subjectivities and came to seem morally legitimate.

Keywords

care; body; personhood; morality; aging; inequality; independence

On a snowy Thursday afternoon in late January 2007, Maureen Murphy drank a glass of spoiled milk. Several hours later, she was lying on a gurney in the back of an ambulance being transported from her home to the nearest emergency room on the north side of Chicago. She spent the following seven days in the hospital. Sally Middleton, Ms. Murphy’s paid home care worker, blamed herself for Ms. Murphy’s sudden downturn, for having allowed the spoiled milk to remain in the elderly woman’s refrigerator.¹

Like millions of other older adults in the United States,² Ms. Murphy suffered from chronic illness that threatened her ability to continue to live alone in her apartment. To ensure that she could do so, she had hired Sally to visit her twice a week for about four hours per visit. The Tuesday before Ms. Murphy fell ill, Sally had missed work while recovering from a bout of the flu.

¹All names are pseudonyms. To preserve information about status and hierarchy encoded in naming practices, I refer to research participants using the same forms of address they used for one another. In most cases, clients were addressed by titles and surnames and care workers by first names.

Ms. Murphy was in her early eighties at the time, and like many other older adults, her senses of smell and taste had diminished such that she had difficulty distinguishing spoiled food by its pungent scent alone (Murphy et al. 2002). Pasteurized milk, which spoils before it changes appearance, had thus become a particularly risky source of sustenance for her. Yet Ms. Murphy persisted in drinking several glasses of milk a day because, though she could no longer appreciate its flavor, consuming it evoked her childhood in rural Ireland, where milk played a central role in the culinary rhythms of daily life.

Over the many months I visited Sally and Ms. Murphy, I had noticed that Sally routinely opened and smelled each carton of milk in the fridge, inspecting it for freshness. While she seemed to think that smelling milk was too mundane to be noteworthy, this simple precaution had long made it safe for Ms. Murphy to continue drinking milk, a substance so entwined with her sensibilities that to go without made her feel diminished in both health and wealth. Sally's milk sniffing, along with hundreds of other similarly subtle and mundane acts of care, enabled Ms. Murphy to continue living in the manner to which she was accustomed. But smelling milk did more than keep Ms. Murphy alive, for this simple act of intersubjective recognition also sustained Ms. Murphy's memories and personhood despite her ongoing physical declines and social losses. Sally's milk sniffing is one example, among many, of the ways paid home care workers in Chicago provided embodied care that sustained older adults' personhood. In practicing this form of care, workers regularly exceeded their official job descriptions, which involved assisting older adults who live in private homes with tasks that gerontologists call "instrumental activities of daily living" (IADLs), such as bathing, cooking, cleaning, shopping, toileting, and laundry.

For home care workers and older adults in Chicago, care was morally valued for its potential to sustain elder personhood against the bodily and social threats of aging. In the process of sustaining elder personhood through deeply embodied care, home care workers came to inhabit and reproduce the sensorial and social worlds of their clients. Through their care practices, their bodies became the ground on which moral hierarchies between persons—by which I mean the sense that some people's needs and desires ought to take priority over others'—were built, experienced, and justified on a day-to-day basis. Through this process, home care leads to the embodiment of social hierarchies, shaping individual subjectivities and thereby making those hierarchies feel morally legitimate.

My broad objective here is to examine the ways that the reproduction of particular forms of social personhood might be intimately tied to the intensification of inequality through embodied care practices. I draw on theories of embodied personhood to bring emerging

²Determining categorical terms for the people described in this study is necessarily a political act, and thus I have chosen to primarily use the same categorical terminology that is used by advocates for these groups in the United States. For both care workers and care recipients, a wide variety of terms circulate and are used by different institutions and individuals. In my field sites, *caregiver* was perhaps the most widely used term for those who care for elders. Workers, however, emphasized their professional status. Moreover, advocates argue that the term *caregiver* implies that care should be a gift, undermining workers' already fraught claims to improved compensation and working conditions. The terms *older adult*, *older person*, and *elder* tend to be preferred by U.S.-based gerontologists and advocates for people over 65, though some groups and individuals argue that any categorical term based on advanced age is stigmatizing. Older adults rarely referred to themselves as part of an age group, and workers tended to describe those they worked with in relational terms like *patients* or *clients*. When a relational term is called for, I use *client* because this term can connote a variety of relationships between service providers and users rather than only the medical hierarchy implied by the term *patient*.

research on the ethics of care into dialogue with long-standing feminist concerns regarding the entrenched, intersecting forms of inequality (i.e., race, gender, class, and age) that structure caring labor. Recent anthropological research on caregiving suggests that questions of morality are critical to analyses of care and that care practices play a crucial role in experiences of personhood. Arthur Kleinman argues that “caregiving is a defining moral practice ... that makes caregivers, and at times even care receivers, more present and therefore more fully human” (2009:293). Crucially, caregiving seems to generate new forms of morality and subjectivity through daily practices and the painstaking development of embodied, skillful expertise (Kleinman 2009; Mol 2008).

The labor of caregiving generates more than novel forms of morality and personhood—it also generates and reproduces systematic, intersecting forms of structural inequality. The unequal allocation of reproductive labor—and especially caregiving labor—by gender, race, and class plays a critical role in the reproduction of social stratification (Engels 1978; Glenn 1992; Ortner 1974). Opportunities for social and physical reproduction are highly stratified by these intersecting forms of inequality such that some kinds of people are more likely than others to successfully reproduce both biological life and social ways of living, a process feminist anthropologists have termed “stratified reproduction” (Colen 1995; Ginsburg and Rapp 1995). Exacerbated by the commodification of reproductive labor (such as paid home care work), stratified reproduction does not simply reinforce inequality but also plays a substantial role in “intensifying the inequalities on which it is based” (Colen 1995:78).

The forms of embodied morality and subjectivity that emerge in home care practices also reflect and intensify the long-standing, pervasive inequality that characterizes this broader context. If, as Annemarie Mol and colleagues (2010:14) argue, embodied care practices shape care ethics, it is also through such practices that the many inequalities of home care work are experienced and come to inform the subjectivities of those involved. A deeper focus on the embodied dimensions of care thus links disparate discussions about ethics and inequality by showing that, through intimate care practices, social hierarchies shape people’s subjectivities and come to be seen as moral.

In both my fieldwork and across diverse contexts, care relations and practices have profound moral stakes due in part to their implications for personhood. Following Marcel Mauss (1979), I understand personhood as the social roles and experiences related to one’s membership, status, and relationships in communities. Created through social relations, people’s understandings of personhood are profoundly moral, influencing both their subjective experiences of who they (and others) are and their aspirations for who they (and others) ought to be.

Throughout the life course, but particularly in physically vulnerable moments, care practices play a critical role in making, unmaking, and transforming personhood (Kaufman and Morgan 2005). At the beginning of life, many practices that might be considered forms of care and nurturance, including feeding, bathing, and cooking, play central roles in the constitution of personhood (Carsten 1997; Conklin and Morgan 1996; Gottlieb 2004). Toward the end of life, the social relations that arise around people experiencing neurological changes such as dementia (Cohen 1998; Taylor 2010), brain death (Lock

1996), and vegetative state (Bird David and Israel 2010; Kaufman 2000) often create liminal, situational, and contested forms of personhood. For such people, everyday care practices can play a significant role in either sustaining or eroding personhood (McLean 2007; Taylor 2010).

Home care workers and older adults in Chicago strongly associated the provision of good care with embodied acts that maintain independent personhood. In the United States, full persons— independent persons— are normatively construed as corporeally bounded and mentally, financially, and domestically self-determining (Kaufman 1994). Independent (or individual) personhood has thus productively been contrasted to South Asian and Melanesian forms of “partible,” “dividual,” or “open” personhood (Lamb 2000; Marriott 1976) in which persons are “constructed as the plural and composite site of the relationships that produced them” and bodies are thought of as “social microcosms” (Strathern 1988:13). In the United States, independence is also deeply bound up with individuals’ ability to shape the world around them according to their subjective preferences. Yet, in many cases, enacting such preferences requires the participation of multiple others. While notions of independence in the United States are normatively tied to conceptions of the body as bounded, the experiences of older adults and home care workers suggest that, in practice, independent persons are constituted through the circulation of bodies and substances more commonly associated with partible persons.

Taking the relational nature of personhood seriously requires expanding discussions regarding the social relations and processes that constitute independent persons to include the ways that these processes might also affect caregivers. Claire L. Stacey (2011:12), one of the few scholars to examine the impacts of paid care work on the subjective aspects of personhood, argues that home care workers actively draw on the relational dimensions of their work to both construct and narrate their senses of self. Thus, while workers’ relationships with and subsequent commitments to clients can contribute to their own exploitation (e.g., when they work extra hours without pay), they also play a key role in workers’ experience and understanding of themselves as moral persons and “caring selves” (Stacey 2011). In constructing and publicly articulating identities as caring selves, Stacey argues, workers “reassert skill, reinforce their social value and assert an authentic self” (2011:22), countering public discourses that paint them as dependent or as unskilled and mercenary individuals who may “care for” clients without “caring about” them. Thus, for Stacey (2011:14), exploring their affective ties to clients enables analysis of how workers maneuver within their poorly paid, low-status, and unpredictable jobs. While recognizing the many ways that care workers do assert agency by articulating identities as “caring selves,” I show how daily care practices shape the possibilities for these kinds of subjectivities and understandings of moral action. Even as the home care workers I observed in Chicago understood themselves as moral and socially valuable persons because of their dedication to their clients, these commitments were formed through bodily practices and had embodied consequences.

Home care, in which poorly paid, minimally trained workers help older adults maintain their homes, their sociality, and their bodies, is often initiated as physical decline in older adults increasingly threatens their ability to make their subjective preferences—their will—

manifest in the world. To sustain elders' personhood in the face of this threat, the workers I met used their own bodies to shape domestic and social worlds to reflect their clients' subjectivities. In this process, they incorporated their clients' histories of sensorial experience, or what Andrew Strathern and Pamela Stewart (2011) term "personsapes," into their own bodies and then reproduced them in everyday care practices. At the same time, following their agencies' directions, workers intentionally circumscribed the circulation of their own personsapes. Drawing on phenomenological approaches to the body, which argue that the habits produced through repeated bodily practices form the experiential basis of subjectivity, I show how home care workers' moral judgments and their subjectivities came to reflect their repeated performance of acts that prioritized the bodily dispositions of elderly clients above their own (Bourdieu 1984; Butler 1993; Jackson 1983; Merleau-Ponty 2002).

Home care workers were recognized and saw themselves as moral persons precisely because their embodied performances of social hierarchies enabled them to sustain their older, often wealthier, clients' ways of life and, thus, their independence. In this context, independent person-hood was not so much a consequence of bounded bodies or self-determination but, rather, a deeply relational form of personhood in which the interpellation of subjects and bodies (Althusser 2011; Butler 1988) was intentionally un-reciprocal and inequitable.³ Thus, embodied care practices in the context of Chicago's home care industry contributed to a kind of corporeal hierarchy, in which poor women of color were positioned to literally incorporate and embody the felt values and sensory histories of their clients without the expectation that the moral worlds of their own sensorial landscapes would circulate in similar fashion.

Studying home care in Chicago

Between August 2006 and August 2008, I conducted ethnographic fieldwork with the employees and clients of two home care agencies in Chicago. Chicago's home care industry is a particularly interesting setting to study processes of embodiment and inequality because it draws people from markedly different social worlds into intimate, daily contact. Since Chicago was first settled, its position as the gateway to the U.S. West has made the city a major center of both national and international labor migration (Cronon 1991). Since the early 1900s, this legacy has made Chicago one of the most important sites for urban ethnography and scholarship on the social geography and reproduction of class, ethnicity, and structural inequality (e.g., di Leonardo 1998; Hannerz 1980; Klinenberg 2003; Wacquant 2004; Wilson 1996).

As a consequence of biomedical advances, shifting demographics, policies favoring deinstitutionalization, and the entry of middle- and upper-class women into the paid labor force, home care and home health care are currently the fastest growing occupations in the

³Judith Butler, following Louis Althusser, uses the term *interpellation* to refer to the genesis of the subject as an always already subjectified social being. In the classic example, interpellation describes the process by which a police officer hails an individual on the street, and the intended individual recognizes the hail as calling him or her. Ideology, existing as rituals and institutions of society, interpellates individuals as subjects or members of society in mutually constitutive processes (Althusser 2011; Davis 2012). For Butler (1988, 1993), interpellation compels the embodiment of social norms that both enable and constrain life. I suggest that care may be one practice of hailing that compels and is compelled by the embodiment of different social norms and thus produces different kinds of subjects.

United States (Lockard and Wolf 2012:100). As in other forms of paid care, the demand for home care workers has been matched by a growing “global care chain” (Hochschild 2000) of female workers migrating from poorer nations to wealthier ones. In Chicago, these migrant women are joined by the daughters and granddaughters of women who, after taking part in the Great Migration of southern African Americans to northern cities, found themselves pushed into domestic service in the homes of wealthier white families in the first half of the 20th century. Unlike Sunbelt cities with high proportions of elders who live far from family members, in Chicago, elders often age within communities and homes that they have lived in for many years. Because of this residential stability and policy decisions that expanded home care, at the start of this study in 2006, Illinois served more aged and disabled adults through its Medicaid-funded home care program for low-income recipients than any other U.S. state (Houser et al. 2006:8).

Home care is typically considered a “low skill” job, and home care workers generally earn poverty-level wages. In 2006, the median wage for home care workers in the Chicago area was \$8.41 per hour (minimum wage at the time was \$6.50 per hour). In 2006, the median annual income for home care workers in metropolitan Chicago was \$18,690, rising to \$19,630 by 2008 in response to increases in the Illinois minimum wage (Bureau of Labor Statistics 2006, 2008). While state law provides minimum wage and overtime protections to home care workers, nationally they are exempt from similar federal labor protections because of rules that categorize home care work as a form of social companionship rather than formal labor.

Many home care workers juggle their caregiving responsibilities at work with substantial caregiving responsibilities for multiple generations of kin at home, where, frequently, they are also the primary breadwinners. All of the workers I met lived with substantial and unrelenting financial insecurity in some of the city’s poorest and most dangerous neighborhoods. Workers were constantly trying to figure out new ways to make ends meet, and more than once I lost touch with a worker whose phone had been turned off for nonpayment of service. Workers often spent hours commuting via public transportation to their clients’ homes. This meant that they might only be paid for four or six hours of labor during workdays that took them away from home for twice that time. At the same time, it meant that workers had the relatively unusual experience of routinely moving across the radically different material environments and public infrastructures of Chicago’s infamously segregated neighborhoods.

Though workers’ income from home care employment played a crucial—if insufficient—role in supporting their households, employers rarely provided their workers with health care benefits, paid leave, or retirement programs. According to data published in 2012, nearly half of all home care workers in the United States live in households earning incomes less than 200 percent above the poverty line, over one-third lack any health insurance, and nearly half receive some public benefits in the form of food stamps, housing subsidies, or Medicaid (PHI 2012:4). In part because of the material conditions of home care labor, the industry faces endemically high turnover levels, which have been estimated at between 30 and 60 percent per year (Dill and Cagle 2010:716, 722). Because they are members of the working poor who partly rely on government benefits to support their households, popular discourse

in the United States has long considered care workers “dependent” persons, unwilling to take responsibility for their lives (e.g., Corn 2012). Such discourses threaten workers’ personhood and their status as full citizens (Glenn 2010).

Beyond the opportunity to study the relationship between contemporary home care practices and longer histories of inequality, fieldwork in Chicago offered an opportunity to compare the experiences of economically diverse home care recipients. Thus, I conducted fieldwork with one Chicago area agency that provided publicly funded, need-based home care services and another that provided services to older adults with the means to fund care themselves.⁴ Though a large number of home care workers in Chicago (and nationally) work independently, in most states need-based services are contracted through provider agencies. Workers at the privately funded agency were not required to undergo any training, while those at the publicly funded agency received 40 hours of highly didactic preemployment training plus eight-hour trainings four times per year. Beyond general admonishments that workers adapt to their clients’ households and bathe regularly, the bodily practices I describe here were not discussed in the trainings I observed. At the private agency, clients determined what they would like workers to do, whereas at the public agency, standardized assessment tools were used to create a care plan delimiting the tasks a client needed assistance with. While these assessments formally limited the ability of publicly funded clients to assert their preferences, in practice, workers at both agencies were more concerned with providing what they considered good care than with strictly following care plans. Thus, though there were important differences between the experiences of participants in these two agencies’ programs on a number of matters, the two groups were strikingly similar in terms of the practices and beliefs discussed in this article.

Fieldwork included approximately two months of daily observation at each agency’s offices and six to eight months of participant-observation in the homes of older adults during their home care appointments. In agency offices, I observed supervisors’ daily routines, training sessions, and staff meetings, learning about hundreds of older adults and workers beyond those I was able to observe directly. Supervisors helped me contact potential worker–client pairs for in-home participant-observation, and eventually seven pairs consented to participate. Both my agreements with participating agencies and individuals’ consent forms stipulated that I would not report specific information about individual clients or employees to agency staff. To build rapport and observe fluctuations in relationships over time, I conducted participant-observation in older adults’ homes while the workers were there on a weekly or biweekly basis.

⁴The privately funded agency’s clients were overwhelmingly white, whereas its employees were a diverse mix of Filipino, African American, Puerto Rican, Polish, West African, and white American women. The publicly funded agency’s clients and employees were overwhelmingly African American. All of the workers who participated in my home-based fieldwork were legal residents of the United States. Notably, the elderly clients of the publicly funded agency who agreed to participate in this study had previously held middle-class jobs. Illinois’s home care program determines need on the basis of assets rather than income. Reflecting the “wealth gap” between African Americans and whites in the United States, these clients had not been able to accumulate substantial wealth earlier in life despite having earned middle-class incomes (Oliver and Shapiro 2006). In an effort not to overly abstract individual experiences, I do not explicitly refer to the racial identifications of research participants in this article. In the privately funded agency, racial, ethnic, and class differences obviously influenced relationships, whereas in the publicly funded agency, class, regional background, and generational difference visibly influenced relationships between African American care workers and African American clients.

One of the benefits of conducting regular visits over a relatively lengthy period was that it gave workers a chance to observe my behavior and confirm that I was not passing information to their supervisors. While the older adults who agreed to let me visit them were typically eager to have another person to socialize with, some of the workers were initially reluctant and wary of sharing too much with me. I was concerned that some had consented to participate in the research as a favor to their sometimes-lonely clients. Thus, I typically tried to let workers determine the extent of our interactions by hanging back and staying out of their way while gently offering an extra hand. While observing home care interactions, I alternated between helping workers and sitting and talking with the older adults they cared for. In most cases, I spent more time with clients during the first weeks of fieldwork, shifting to spending more time with workers later on as we built familiarity. I asked each worker to treat me as her trainee, which elicited a great deal of moral and practical instruction on how to be a “good” caregiver as I assisted with cleaning, cooking, laundry, grocery shopping, and other daily tasks. I also accompanied pairs on any outings they made during my visits, including running errands, grocery shopping, and eating at restaurants. Toward the end of fieldwork, I conducted separate semistructured life history interviews with the older adults and the workers who participated in the weekly observations and with a variety of administrators, supervisors, and advocates. Themes of personhood primarily arose during these interviews, which helped give meaning to a range of practices I had observed earlier in fieldwork.

Over time, most (thought, admittedly, not all) workers seemed to come to see me as a pleasant and helpful companion. Eventually, both workers and older adults (though not always both members of each pair) began to confide in me about their frustrations with supervisors and one another. This is not to say that my relatively elite status and relationships with supervisors receded into the background. Indeed, some participants came to see me as a potentially useful ally, occasionally asking me to advocate with supervisors and others on their behalf.⁵ Many workers seemed to hope that by participating in this project, audiences both near and far might come to better appreciate their labor. My findings are thus both animated and limited by older adults’ and home care workers’ broader moral and personal projects.

With both hands: Sustaining lives and persons

Returning now to the incident recounted at the beginning of this article, I consider what was at stake both morally and practically in Sally Middleton’s milk sniffing and other practices of embodied care. Most obviously, milk sniffing improved Ms. Murphy’s physical well-being. Yet this could also have been accomplished by eliminating milk from Ms. Murphy’s diet and substituting the nonperishable nutrition drinks her physician recommended. That Sally continued to purchase and then smell milk indicated that she was trying to do more than simply sustain Ms. Murphy’s life. Sally was also attempting to sustain Ms. Murphy’s way of living. To do so, she cultivated her ability to rely on her own physical senses, emotions, and experience to imagine the significance of Ms. Murphy’s sensory history. She then drew on this embodied imagination to guide her home care practice. As a care worker,

⁵I refrained from making such interventions, reminding participants that my confidentiality agreements applied to all involved.

Sally did not seek to alter the rhythms of Ms. Murphy's daily life in either fundamental or mundane ways. Rather, she sought to sustain her way of life down to the smallest detail, as was typical among other home care workers I observed. Drinking milk, made safe because Sally used her more able body to stand in for Ms. Murphy's aging body, helped Ms. Murphy recognize herself as herself. This embodied care thus helped Ms. Murphy feel that she was still the person she had previously been, despite—or, rather, against—her diminished sense of smell and the ravaging pain of rheumatoid arthritis that had so limited her activity. What usually went unacknowledged was that Sally was the one who made this act of self-recognition possible.

It was many months into fieldwork before I was able to recognize the significance of Sally's seemingly unremarkable efforts. A few months after Ms. Murphy returned home from the hospital, she and I sat down for an interview. As I did during each of our talks, I asked Ms. Murphy to tell me about how she distinguished good care from bad. Though she spoke more poetically than most, Ms. Murphy's answer echoed throughout my interviews with other older adults. She told me, "If I have my senses at all, I'd like to be treated as though I have some. I'd like to be treated as a person, and not as a piece of furniture." Ms. Murphy suggested that care threatened to reduce her to an object—akin to furniture that might be cleaned and fluffed but unable to influence the world around her. Her anxiety about the consequences of "losing her senses," a common euphemism that links fears about mental confusion and dementia to experiences of sensory diminishment, suggests that older adults are all too aware of how precarious social recognition of their personhood has become and how much this recognition is likely to depend on how they are treated by those who provide daily, intimate care. For Ms. Murphy, and many other older adults I knew, bad care meant social death (Biehl 2005). Good care, by contrast, was care that recognized and expressed her subjectivity—both her bodily senses and her sentience—and, therefore, treated her as a person.

Many care workers spoke explicitly about their efforts to tailor care practices in ways that sustained their elderly clients' ways of life. In so doing, they regularly acknowledged that care practices were also acts of social recognition that sustained older adults' personhood. They told me that caring for older adults was in part a matter of compensating for their limited mobility or sensory loss. This required workers to interpret elders' biographies and extend their lifetimes of embodied experience into their present lives. Critically, workers accomplished this by incorporating the sensory aspects of elders' histories into their own bodily practice, making each client's sensorium a part of their own embodied engagements with the world. For example, Maria Arellano explained to me how she tried to practice care in a manner that recognized her clients' personhood:

I always say that your true self comes out when you're old ...everyone is a person of their own. And I always try to find that little thing that person likes. They pretty much tell you what their thing is if you give them half a chance, they tell you what their surrounding was, OK? ...So you find their thing and you work with that, and with Ms. Silverman, you just ask her out for a walk and it makes her shine, even if it's just around the block, it makes her shine.

Illustrating how she found her clients' "things" and worked with them, Maria told me about one man who had spent his career in the navy, and how, after realizing that being by the water made him feel like himself, she began regularly taking him to the beach to watch the boats go by. Another client, a woman who Maria told me "must have been something when she as young—she was spicy!" had particularly enjoyed the company of men. For this client, Maria made an effort to invite a neighbor over for tea or arranged to have one of her own teenage sons join her on her home care visits.

While Maria creatively drew from her clients' histories to plan special social activities that she felt recognized their "true selves," more frequently, care workers drew from their embodied understanding of older adults' biographies and sensory histories to make more subtle adjustments to the daily and mundane tasks of care. Mol and colleagues (2010) describe these kinds of practices as a form of "tinkering" that involves negotiations between multiple goods—for example, between the "good" of sustaining older adults' sen-sorial worlds and the "good" of making medically advised alterations to their homes and routines.

Among the care workers I knew, Grace Washington was perhaps the most articulate about the tinkering work necessary to maintain clients' personhood and well-being. When I interviewed Grace, she had spent over a year working in the home of a woman who was considered a severe hoarder. Grace had worked tirelessly and in extremely challenging conditions to render the home both safe and familiar to the client but had frustrated her supervisor by refusing to force her client into completely new routines. Grace argued that maintaining older adults' bodily routines and ways of life was central to maintaining their well-being:

They are old. You can't come in here and say, "Baby, you got to get up at 7:00 a.m. You got to get clean, dressed, whatever." No. I don't do things like that ... I let them keep with their daily routine. It may be modified a little bit but I'm not trying to modify it too much where it gets kind of confusing because, mind you, they are already old, and they got medical problems as is, so you've got to work with both hands: I'm trying to keep close to her regular schedule with bending it just a little bit where as it won't confuse her too much.

Using the metaphor of working "with both hands," Grace suggests that sustaining older adults' cognitive abilities as well as their broader well-being largely depends on keeping daily routines, meals, and surroundings essentially familiar while also making the adjustments necessary to manage serious medical conditions. In the case of the client with whom I observed Grace, these conditions included diabetes and undiagnosed mental health issues related to her hoarding behavior.

In the context of the threats to personhood that attended aging in Chicago, home care workers became strange sorts of liminal specialists, tinkering around the older adults' established routines to sustain their ways of life and personhood rather than facilitating their transitions to ways of life that might unmake that personhood. In so doing, they rendered older adults recognizably independent persons—able to live in their preferred manner—both to themselves and to the broader social world, despite the bodily changes that had precipitated their need for care in the first place.

Sustaining sensorial persons

In many cases, home care workers' efforts to "work with both hands" to sustain elders' personhood were most visible in their preparation of meals for their clients. Loss of smell and taste, senses so frequently associated with memory and nostalgia (Bahloul 1989; Holtzman 2006), meant that food sometimes lost its direct sensorial link to older adults' past lives and, instead, became a sign of earlier signs. Older adults suggested that while this loss meant that they struggled to take pleasure in the act of eating itself, they derived pleasure from eating foods they remembered enjoying or from the sociality of eating with others.

Care workers thus strove to make subtle healthful adjustments to clients' meals, limiting salt or sugar to accommodate dietary recommendations for those with diabetes or hypertension while preserving the basic character of clients' favorite dishes. Yet, while workers worried about the healthfulness of their clients' diets, many felt that maintaining clients' sensory self was equally important. Doing so typically required them to develop a kind of embodied knowledge of a client's preferences and then to empathically apply this knowledge across a range of situations. For example, Grace Washington told me that while she might make minor or undetectable adjustments to her clients' homes and meals, she vigorously challenged her supervisor's instructions to completely alter their diets. In practice, this meant that Grace worked to manage the diet of her diabetic client Margee Jefferson by surreptitiously replacing the sugar in Mrs. Jefferson's sugar bowl with Splenda. However, Grace resisted forcing more noticeable culinary changes on Mrs. Jefferson, for example, continuing to allow her to eat bananas and cereal. Key to the success of these adjustments was Grace's ability to imagine which kinds of sensorial changes Mrs. Jefferson would notice and find threatening and which she would overlook. Thus, Splenda, which mimics sugar's taste, texture, and appearance, could be swapped for sugar without changing Mrs. Jefferson's lifestyle, but bananas could not be eliminated.

Maria Arellano similarly worked with both hands, trying to balance between the value of remembered taste for sustaining Mrs. Silverman's personhood and her worries about the potential health effects of the older woman's sweet-heavy diet. Thus, while she typically tried to purchase low-sugar foods when shopping for Mrs. Silverman, she faithfully bought Little Debbie cakes for her every week at the grocery store. Mrs. Silverman told me that even though she could no longer fully taste the intensely sweet flavor of these prepackaged snack cakes, eating them brought her pleasure by reminding her of previous pleasures. This was not some simple substitution of remembered taste for present taste but a kind of extension of past self into present self. Mrs. Silverman explained that she enjoyed her Little Debbie cakes because "I don't really want to try new foods anymore. I like the foods I have always liked. I don't even really remember what they tasted like. It's just that I know I liked them, so I still like them." For Mrs. Silverman (and the other elders I met during fieldwork), eating her favorite foods, whether she derived physical pleasure from them or not, became a way to link the person she had been to the older person she had become. Maria thus helped sustain Mrs. Silverman's sense of self through her seemingly simple recognition that Little Debbie cakes were more than a sugary indulgence: They were also a form of gustatory recognition, a way for Mrs. Silverman to experience herself as herself.

Maria also used her senses to enable Mrs. Silverman to safely continue to enjoy extremely hot liquids—she liked her baths scalding and her tea nearly boiling. Yet the elderly woman's thin skin had become increasingly prone to burns, and so testing the temperature of hot liquids had become quite dangerous for Mrs. Silverman to do herself. Instead, before Mrs. Silverman took a bath or poured a cup of tea, Maria carefully tested the liquid on her wrist, adding cool water until it reached the perfect temperature—hot but not dangerously so. To do this, Maria calibrated her own body's perception of heat to Mrs. Silverman's perception of heat, using a form of sensorial empathy to determine which temperature would both prevent injury and satisfy her client's desire for warmth. Care workers' embodied and empathic efforts to provide sensory experiences that tasted, smelled, looked, and felt familiar quite literally worked to strengthen older adults' sense of self by recognizing and carefully attending to the ways that embodied interactions with the material world mediated their recognition of themselves as the persons they had been and as persons whose worlds still conformed to their subjective inclinations.

Just as Sally had when smelling milk for Ms. Murphy, Maria and Grace used their senses as proxies for their clients', attempting to preserve sensory pleasures that, if unmonitored, might have proven dangerous indulgences. They thus used their own bodies to make subtle alterations to older adults' daily lives that simultaneously protected their physical health and sustained sensory pleasures. In so doing, workers sustained elders' ability to feel like the persons they had been, against the threats posed by bodily aging.

Sustaining social persons

Sometimes, workers' embodied care sustained older adults' social as well as sensory selves. In many contexts, as Janet Carsten (1977) and others have shown, shared meals have the power to constitute and transform both personhood and relatedness. For the older adults I met during fieldwork, meals sometimes threatened to become incessant and visceral moments of loss, nostalgia, and loneliness, precisely because of the sensory reminders infusing food and the inexorable necessity of eating (Seremetakis 1994). Home care workers did what they could to mitigate these losses, offering themselves as fleshy, imperfect specters of the mothers, fathers, wives, husbands, children, friends, and lovers who had previously prepared and eaten meals with their clients. By consciously comporting their bodies in ways that reflected older adults' previous social relations, by altering their dress, sharing sustenance, and engaging in conversation, home care workers strove to sustain the sensorial and social tenor of older adults' lives.

Doris Robinson worked to counteract Mr. Thomas's waning appetite by joining him for breakfast at Seven Brothers, Mr. Thomas's favorite restaurant, at the start of every visit with him. When I met him, Mr. Thomas had been widowed less than two years and said that he forced himself to eat but took no pleasure in it. Cooking had become a painful reminder both of the meals he had prepared for his wife during her long illness and of his wife's tentative attempts to cook as a newlywed 64 years earlier. However, Mr. Thomas and his wife had had a long tradition of eating breakfast at Seven Brothers every Sunday before church, and so he began going there daily after her death.

Recognizing that this meal was the highlight of Mr. Thomas's day, Doris regularly wore a skirt and high heels to breakfast, imitating the formality of those earlier breakfasts he had shared with his wife. When they returned to his home, Doris changed into flats and scrubs to clean. During the meal, Mr. Thomas mostly sat quietly and listened to Doris talk about her children, grandchildren, distant relatives, and neighbors. As I learned later from Mr. Thomas's son, Mrs. Thomas had been something of a gossip, and Doris had recognized that, though Mr. Thomas was not much of a conversationalist, he took great pleasure in being able to listen to a woman discuss the problems of her relatives and neighbors. Through her dress and gossip, Doris attempted to sustain the social and material tenor of Mr. Thomas's prior relationships.

Mrs. Silverman had been widowed for nearly 30 years by the time we met and no longer yearned for meals with her husband. Instead, she grieved the loss of her regular lunches with friends and neighbors—many of whom had died or whose mobility was as limited as her own. Being able to get out of the house to run errands and eat lunch at McDonald's was the highlight of her visits with Maria (and me). Maria had the routine for lunch at McDonald's down pat—she would help Mrs. Silverman find a quiet seat away from any noisy children, so that the older woman would be able to participate in conversation even if she had “forgotten” to wear her despised hearing aids. Maria and I would then go to the counter to order our meals. Maria detested the food but always ordered a sandwich and ate it so as not to offend Mrs. Silverman, who seemed to take great delight in “treating” us to lunch. While eating, Mrs. Silverman would give us updates about her family and friends and pepper Maria and me with questions about our families. Whenever another resident from her building came into the restaurant, Mrs. Silverman would lean over to us conspiratorially and share with us any personal details about the individual she thought we would find interesting. At these meals, Mrs. Silverman and Maria reproduced the chatty and intimate gossip Mrs. Silverman missed from days gone by. Yet these leisurely meals were costly for Maria, since they caused her to stay with Mrs. Silverman longer than her scheduled shift, working extra time for which she was not paid. Nevertheless, she regularly agreed to join Mrs. Silverman at McDonald's. As I describe below, for most of the workers I met, good care was a matter of simple common sense and entailed subordinating their own tastes, judgments, and material needs to those of their clients.

For Mr. Thomas, Mrs. Silverman, and many of the other older adults I knew in Chicago, eating had become a daily reminder that they were no longer sharing meals with people who nevertheless continued to inhabit their emotional lives. The shared meals that had so characterized previous relationships and had marked the passing of days earlier in life had ceased to exist except as memories of gossiping with friends or of a wife's tentative steps toward domesticity. Without these rituals, which home care workers sought to continue—inevitably altered but still recognizable—older adults struggled to feel that they were the same people they had previously been.

Moral and sensorial hierarchies

Home care workers articulated a sense of their own moral value as stemming from their willingness and ability to prioritize others' bodily needs and desires over their own. Though

workers recognized that providing this form of “good care” might require them to experience bodily discomfort, disgust, and even danger, they also accepted that their own sensorial preferences and backgrounds should not circulate into older adults’ homes. In this way, everyday home care practices ordered hierarchies of sensation such that care workers felt themselves using their bodies and their senses to sustain their clients’ lives and ways of life, even when doing so conflicted with their own bodily needs, habits, and preferences.

Care workers frequently relied on idioms of the body to describe their ability to prioritize their clients’ social and sensory worlds over their own feelings and to argue that these bodily accommodations were at the heart of good care. Grace Washington, whose client Margee Jefferson showed early signs of cognitive decline, told me that while many people might get frustrated with someone who expected them to listen to the same stories and complaints over and over, she would “[be] sitting there like I’d heard it for the first time. And I don’t have a problem with that. When you are in this kind of life, they get like that and you got to learn to bend a little, take a little and adjust.” When Samson George insulted his home care worker Kim Little or acted in a manner she found condescending, Kim focused on empathically understanding his point of view rather than growing upset. As she told me, “I try to control myself and say [to myself] ‘What is going on?’ ‘What is he thinking about?’ I have to catch myself.” Doris Robinson told me she had offered similar advice to her daughter, who was considering entering elder care. Doris described the ability to adjust to clients’ sensory worlds as good care, recounting the conversation with her daughter as follows: “I told her, ‘If you don’t care about these people, don’t do it.’ Then she said, ‘What if they shit all over themselves?’ ‘You clean them up.’ She said, ‘I can’t stand the smell.’ I said, ‘You get used to it. You smell yourself, don’t you? You can do it.’” In using the language of bodily manipulation—“bend a little,” “catch myself,” “smell yourself”—workers highlight the embodied nature of the empathic practices that enable them to tend to elders’ needs and preferences, even when these come into conflict with their own bodily needs, comforts, and preferences.

Consider, for example, Maria Arellano, who regularly ate at McDonald’s because she understood how important shared meals were to Mrs. Silverman. Yet, while Maria and I stood in line to purchase our meals, she would regularly complain about how much she disliked fast food, and once she mentioned that she often struggled with indigestion after these meals. She told me that she assiduously avoided fatty and fried foods and never ate at fast food restaurants in her nonwork life. She did her best to accommodate Mrs. Silverman’s desires while protecting her own health by always ordering the fish sandwich, which she said was the “least unhealthy” item on the menu. Maria never refused to eat with Mrs. Silverman, telling me that doing so was just another aspect of making her client “shine.” She told me that, to provide good care, a caregiver needed to “put a little more of what they need and not how you feel” into the effort and that learning how to prioritize her clients’ needs and her own bodily concerns had been critical to her development as a care worker.

Because of their commitment to sustaining clients’ physical health and personhood, care workers accepted that they would frequently work in homes that were uncomfortable and sometimes unhealthy. For example, they repeatedly told me about their frustrations when

trying to accomplish daily cleaning and cooking in apartments whose older adult residents routinely kept extremely warm and unventilated, even on warm summer days. Aware that lowering the temperature or opening a window might make older adults uncomfortably chilly or even lead to illness, workers tried to manage their own discomfort as best they could, wearing lightweight clothing and carrying large bottles of cool water with them from home.

While working in overheated homes was a nearly universal experience for home care workers, on occasion, the sensorial discomforts and bodily risks posed by an elder's home were much more severe. An extreme but telling example was Grace Washington's experience in Margee Jefferson's home. As noted above, Mrs. Jefferson was labeled a "hoarder" by her home care agency because of the extreme proliferation of material items that covered nearly every surface inside her home. The agency had been hired by Mrs. Jefferson's daughter not only to provide care but also to render the home habitable. While a significant amount of cleaning occurred before Grace began working with Mrs. Jefferson, the home remained a very unpleasant place. Grace questioned her supervisors' motives for accepting such a high-risk case, suggesting that the agency was more concerned with making money than with the appropriateness of Mrs. Jefferson continuing to live in a dangerous environment. In our interview, Grace recounted the state of the house when she first started working in it:

I'll tell you point blank, the goddamn house wasn't fit for a dog to live in ... You got a room literally with garbage damn near filled to the ceiling. If she was supposed to go up there and take a shower and we're in the dining room, you literally got the bathroom tub leaking on the floor on the living room table ... Baby, if a dog went in that bathroom, the dog would turn around and walk away. I swear to God. You got mold coming out the sinks whereas it looks like spiders is in infestation ...

Nevertheless, Grace told me, even though her supervisors "put me in this hellhole, I didn't complain and I didn't have a problem with that because when I go into a senior's house, I take it as if this is my grandmother or my grandparent. How would I feel if my grandparent would be living like this? I would be devastated and it immediately touched my heart ... in two days I had that place turned around."

Motivated by a metaphorical sense of kinship obligation, Grace suggested that her willingness to work in even this dangerous and difficult environment was evidence of her commitment to care. Grace's articulation of a "caring self" was thus deeply intertwined with her willingness to sacrifice her own bodily comfort and safety to sustain her client's life and personhood. As she told me,

Any other person in their right mind would say, "Hell, with this job. Hell, I ain't taking this shit. This is a goddamn garbage place." This is no damn house. This is a place where you come and throw garbage because that's how bad the house looks. Mind you, in a week's time, that house was livable, clean, and sanitized. You can walk through there and you can take a dust test and you couldn't find a thing. When I got there, she was in such a depressing stage. She wouldn't talk. I just found a

way to get around. I'm like a persistent person ...As long as I got to be here, I'm going to make you happy. I'm going to make sure you are all right and I'm going to do things.

In describing the physical discomforts and dangers of working in Mrs. Jefferson's home, Grace obliquely critiqued her employers' unreasonable expectations and failure to provide her with adequate support. Noting that only the rare individual would be willing to work in such conditions, Grace also positioned herself as an unusually moral person for providing what she called "high-quality care" despite the physical discomforts and dangers of the situation. By couching a critique of her working conditions in her concern for her client's well-being, Grace employed a variety of the same rhetoric used in national campaigns by home care unions and advocates who link improved working conditions to improved care, such as the Service Employees International Union's "United for Quality" care campaign and PHI National's "Quality Care through Quality Jobs" campaign.⁶ These campaigns, like Grace's critique, mobilize the moral and political credibility that workers gain from their selfless commitment to clients.

While Grace understood her ability to adjust to the sensory discomforts of Mrs. Jefferson's home as a critical aspect of care, it was also widely understood at both public and private agencies that clients should never be exposed to their workers' personscapes. Care workers thus not only labored among and consumed their clients' sensory worlds but also actively endeavored to limit the intrusion of their own habits, preferences, and even odors, into those worlds. Thus, in training sessions and employee manuals, workers were exhorted multiple times to make sure to bathe everyday and never to wear the same clothing twice before washing it, so that clients would never be exposed to their body odor.⁷ In hot weather, many workers carried deodorant sticks and moist cleaning towelettes with them from home to home to eliminate the bodily odors that might accumulate as they traveled long distances by bus. Concern about the strange odors workers might bring into clients' homes extended to worries over the smells live-in workers might generate cooking dishes native to their homelands— one supervisor recounted multiple clients refusing to accept Filipina workers for fear they would cook food that would permeate their homes with the strange smell of fish sauce. While this particular supervisor, who was also Filipina, found this reasoning racist and insulting, she nevertheless felt clients' were within their rights to refuse the workers.

Unlike this supervisor, care workers themselves betrayed neither surprise nor anger that clients were unwilling to partake in their sensorial worlds. This highlights the ways that, for them, caregiving meant subjecting their bodies to their clients' sensory worlds without any expectation of reciprocity. For example, the week before Thanksgiving 2006, Grace Washington cooked a massive feast for her large family, making many of the recipes she learned as a young girl from her mother. It was clear that, for Grace, cooking these foods,

⁶The Service Employees International Union is the largest labor union organizing home care workers in Illinois and nationally. PHI (formerly the Paraprofessional Healthcare Institute) is a leading advocacy and research organization dedicated to the direct-care workforce. Another campaign using similar language is the Robert Wood Johnson Foundation's "Better Jobs Better Care" campaign.

⁷These concerns echo Ann Laura Stoler and Karen Strassler's (2000) findings that Dutch colonists' prohibited Javanese domestic servants from holding Dutch children for fear of contaminating them with their sweat, pointing to long-standing anxiety about the circulation of bodily substances in Euro-Americans' intimate interracial encounters.

which included ham, fried turkey, and ribs, as well as “all the fixings”—cornbread stuffing, corn-bread, macaroni and cheese, collard greens, candied sweet potatoes, pecan pie, and several cream pies—was an extremely important expression of love and care. The day before Thanksgiving, knowing that Mrs. Jefferson’s favorite restaurant would be closed the next day, Grace carried plates of this feast with her on her 90-minute bus ride Mrs. Jefferson’s house, so that her client would have a home-cooked meal for the holiday. Grace figured that at least her roast ham and southern-style macaroni and cheese would be similar enough to the dishes’ German versions, which Mrs. Jefferson was accustomed to eating, that she might be willing to try them.

When I came for my visit nearly a week later, the plates that Grace had brought remained virtually untouched. Mrs. Jefferson told me that I should help myself to them, since she had no intention of trying them. When I looked to Grace to see if this was OK with her, she just shrugged and told me that someone should enjoy the food. Mrs. Jefferson’s rejection of Grace’s home cooking can be read in two ways: first, as an attempt to avoid threats to her personhood and, second, as an assertion of the primacy of her own sensory world. Grace’s comportment suggested that she was disappointed and a little hurt that Mrs. Jefferson would not try her cooking but also unsurprised. While Grace spent nearly 70 hours a week working in Mrs. Jefferson’s sensorially overwhelming home, neither woman felt that Mrs. Jefferson was in any way obligated to reciprocally partake in meaningful parts of Grace’s sensorial experience. The structures of paid care are such that the worker uses her body to partake in and reproduce the sensorial landscape of her clients’ worlds without ever expecting a similar engagement in return.

Conclusion

In the aftermath of the spoiled-milk incident, Sally Middleton quit her job. While we waited for emergency-room doctors to examine Ms. Murphy, Sally admitted to me that this episode was the final indication she needed that she was no longer able to do her work in the manner she considered necessary. Sally, who was in her sixties and had spent at least four decades caring for both relatives and paying clients, was still recovering from the flu that had caused her to miss work a week earlier, and she was simply too exhausted to keep working long days with clients who were so vulnerable. Throughout our conversation, Sally repeatedly remarked that Ms. Murphy’s sudden illness was her fault— if she had checked the fridge for old food or had smelled the spoiled milk, Ms. Murphy would never have become so ill. She was wracked by guilt and told me that, although she had been thinking about leaving home care for awhile, Ms. Murphy’s illness was the deciding factor. She could not risk endangering any more of her clients.

Quitting was, in Sally’s nonconfrontational way, a deep critique of the demands of this labor, the toll it took on her body, and the lack of support she received in return for her dedication. Yet, even in voicing this critique, Sally emphasized that quitting was itself a form of care, in that this act would enable Ms. Murphy to receive care from someone with the bodily stamina to sustain her. By the end of my fieldwork, three of the seven workers with whom I conducted intensive fieldwork had quit or been fired for reasons related to the toll care work took on their bodies. In leading to their loss of employment, the bodily costs

of caring labor also threatened the economic security of their families and households. The home care industry has endemically high turnover rates, and it seems likely that many who try care work quickly leave it because they refuse to choose between their own well-being and that of their clients for the low wages involved.⁸ That was not the case for the workers in my study, who generally saw themselves as providing “good care” that sustained elders’ personhood, and thus their moral and bodily commitments provide us with a sense of the broader social consequences of local understandings of personhood and care.

The case of paid care in Chicago pushes us to more carefully examine the role of bodily relations in sustaining independent personhood and the moral consequences of these processes. Because of their potential to either sustain or unmake personhood, seemingly mundane care practices had profound moral stakes for both older adults and care workers. For older adults, home care workers, and their agencies, the goal of home care was to render elders recognizably independent. Normative understandings of independent persons as corporeally bounded threatened elders whose bodies could not sustain the facade of autonomy. At the same time, older adults’ desire to be recognized as persons still capable of making their subjective preferences manifest in the world led them to hire home care workers in the first place and then to assert the priority of their subjective dispositions. To sustain elders’ lives in ways that reflected these dispositions, workers developed embodied knowledge of their clients’ histories of sensory and social experience. They then used their bodies to stand in for elders’ bodies or to mimic elders’ past relationships. In this way, workers’ bodies served as extensions of elders’ bodies, mediating social and material interactions so that elders could continue to shape their material worlds according to their will. Yet, even as workers sustained older adults’ independence, they were publicly constructed as “dependent” and thus as lesser persons by virtue of their need to supplement paltry wages and nonexistent benefits with government assistance. Through these processes, independent personhood appeared in practice (if not conception) to be constituted through “open” bodily relations that were both highly circumscribed and dependent on intimate and deeply hierarchical embodied relations.

These relations also had profound implications for care workers’ subjectivities, and particularly for their understandings of themselves as moral persons. Home care workers were willing to experience disgust, discomfort, and exhaustion to provide care in the manner they considered moral. Through intimate and daily acts of care, they repeatedly enacted broader social hierarchies within and on their bodies—they came to feel that their immediate bodily needs were less important than the needs of those they cared for. Positioned in such a way that they sometimes felt they could not both prioritize their own needs and provide care in a moral manner, these workers consistently chose to act as moral persons and caring individuals.

While home care practices sustained elders’ personhood, they also positioned home care workers as persons whose social value lay in their willingness to suppress their subjective

⁸As I discuss elsewhere, life-history interviews with the home care workers in this study showed that they often learned embodied ethics of care from family members who had been domestic workers (Buch 2010). However, research comparing home care leavers and long-term workers would be necessary to determine what factors distinguish the two groups.

preferences in deference to those they cared for. Many of the workers I knew were generally highly aware and critical of the ways in which the structuring of home care labor contributed to their economic struggles, arguing that their profound moral commitment to providing good care should bring them greater status, respect, and compensation. Home care workers' and their advocates' critiques of agency policies or the broader structural conditions of this labor thus frequently highlighted workers' dedication to sustaining older adults' ways of life. Yet workers and advocates justified their calls for improved working conditions as a means to improve the quality of care that elders receive, suggesting that workers' well-being was not seen as a rhetorically and politically viable goal on its own merits.

Viewed within the limited domain of the care interaction, the hierarchies of sensory knowledge generated in care practices appear legitimate, particularly since they play a significant role in maintaining elders' well-being and personhood. Yet these intimate hierarchies have broader consequences when viewed in the context of the inequalities that structure paid care work. While workers come to intimately experience their clients' socially inculcated dispositions (always both sensorial and moral), the circulation of their own personscapes is intentionally limited. Not coincidentally, this form of care reflects and intensifies broader social patterns in which the value of women—historically constructed as “natural” caregivers—is measured by their willingness and ability to subjugate their bodies and deny themselves bodily pleasure to meet the expectations and desires of others. Moreover, in Chicago, home care workers are predominantly poor women of color and immigrant women, who come to know and embody the everyday experiences of a wide variety of households and communities. Yet those who control workers' labor, including older adults, agency personnel, and policy makers, are not similarly positioned to develop empathic knowledge of the embodied toll exacted by home care labor and magnified by the instability produced by low wages and lack of benefits. Through the daily, intimate labor of paid care, hierarchies between persons become embodied by workers and incorporated into their subjectivities, thus reinforcing broader processes of stratified reproduction.

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