Longing for a House in Ghana: Ghanaians’ Responses to the Dignity Threats of Elder Care Work in the United States

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Longing for a House in Ghana: Ghanaians’ Responses to the Dignity Threats of Elder Care Work in the United States

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Abstract

Home health care is a growing occupation in the United States which calls for significant emotional labor. On the basis of interviews and participant-observation with home health workers from Ghana, this paper argues that home health work is different from other kinds of emotional labor in that living and working in the client’s house are central to the conditions of work and the dignity assaults workers experience. Among their strategies for responding to these dignity threats is to long for a house and to direct their energy towards an alternative social field through house construction “at home” in Ghana. Thus, the dignity threats experienced by immigrant home health workers raise concerns about the occupation’s ability to retain workers as well as immigrants’ sense of worth and belonging in the United States.

Key Terms: elder care, dignity, emotional labor, displacement
When Monica, a Ghanaian home health worker in the United States, talked about visiting Ghana, she told me that she chafed at staying in her mother’s house, where her children were living. She would stay for a few days and then decamp to a friend’s house, and then move again, never settling in one place. She said staying with her mother “disgraces” her and “I would not get respect.” “It puts you down.” “It can limit your self-esteem.” Although her mother has a nice house on the outskirts of Accra, it is “horrible. It is not comfortable.” The people around her “make fun of you. Oh yes, little comments. For example, [quoting one of the gossipers,] ’She’s been in the US all this time and she doesn’t have a place.’ They are making comments like this. Everyone is praying for a house of their own.” For Monica, a house of her own represents many things, but is primarily connected to her sense of self-worth.

A house is, in Annette Weiner’s words, “a dense object.” She elaborates,

Objects obviously do not stand alone outside the processes that make them into commodities or treasures. As cultural constructions, some objects become symbolically dense—so dense with cultural meaning and value that others have difficulty prying these treasures away from their owners. Such density accrues through an object's association with its owner's fame, ancestral histories, secrecy, sacredness, and aesthetic and economic values. (Weiner 1994, 394)

For Ghanaian live-in home health workers, houses become dense with symbolic meaning because they live and work in others’ houses in the United States. In particular, they connect being in other people’s houses to the dignity assaults that they experience at work. This paper argues that they recoup their sense of self-worth assailed by these dignity threats through building a house of their own in Ghana, or dreaming of doing so.
Elder care is different in kind from the work of those considered “the emotional proletariat” (Macdonald and Siriani 1996): front-line service workers who are required to display friendliness and deference—emotional labor—to customers and are often subject to employers’ attempts to monitor and control their affect. In contrast, live-in home health workers work relatively autonomously from their supervisors, living in their client’s home for weeks or months on end. Jason Rodriguez (2014) argues that the widespread sociological literature on emotional labor is “less relevant for the increasing number of workers who have face-to-face interactions with individuals over long periods of time” (165). My research participants spoke neither about the difficulties of emotional labor, nor the ways that their supervisors attempted to monitor their emotional displays.

Instead, they talked about dignity. Dignity, or “face,” is established relationally and needs ongoing validation from others (Goffman 1956, Rodriguez 2011). Dignity threats are most psychologically damaging when they impact multiple social fields in which a person operates; thus, one way to manage dignity threats in one social field is to expand one’s networks and change social fields. I argue here that Ghanaian home health workers respond to dignity threats where they feel they have little power by investing in another social context of family and “home.”

In particular, they turn to house-building to attain some of the self-worth that is threatened by their work in the United States. For many migrants from Ghana and elsewhere (Cohen 2001, Cole 2014, Fletcher 1999, Pauli 2008), house building is a major goal. Although building a house is considered the typical, culturally-appropriate project of a migrant, for home health workers it becomes a particularly emotionally fraught and desired goal because of the conditions of their work. From working in others’ houses, they understand at a visceral level
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what a house of their own means for their status and worth as a person. These emotional responses to their home health work have implications for their sense of belonging in the United States, and for the ability of a growing occupation of care work to attract workers.

I first discuss migration from Ghana to the United States and the involvement of Ghanaians in home health work as an occupational niche; before turning to the meaning of houses in the United States and Ghana, including the ways that they become invested as signs of personhood. I then discuss the ways that houses, because of these features, become entangled with the dignity threats experienced by home health workers, and their strategies for recouping their dignity—including by longing for and building a house in Ghana.

**Migration and Home Health Work among Ghanaians**

Transnational migration has been a known and valued phenomenon in Ghana since the colonial era, as Ghanaians traveled for work and education in West Africa, Europe, and North America, processes that continued after independence. As transnational migration increased in the 1980s and 1990s, a broader swathe of the population, including students, teachers, lower-level civil servants, and skilled blue-collar workers like mechanics and electricians, has become increasingly involved in transnational migration (Manuh 2006: 24). As a result, migration has become more characterized by migrants’ struggle (Lucht 2011), and some of the expectations of migrants—like building a house—have not kept pace with the increasing difficulties of many emigrants to make a living abroad, much less remit to their relatives and accumulate money for house construction.

The fact that home health work requires only a few weeks of training and is in high demand means that it is open and attractive to recent immigrants, whose educations and work...
experiences may have been substantial in their own countries but require re-licensing and re-
training to pursue those same occupations in the United States (Choy 2003). With the increase in
migration from Africa to the United States since 1990, new African immigrants have entered the
field of elder-care employment disproportionately (Leutz 2007). My previous ethnographic
research with the Ghanaian community in Philadelphia and more broadly along the East Coast
found that health care more broadly, and nursing assistance in particular, is a niche employment
sector for Ghanaians, a self-reinforcing pattern, because their social networks help them find
employment in these fields.¹

This paper is primarily based on half-hour phone conversations over six months
(December 2014-May 2015) with seven Ghanaian live-in home health aides working for an
agency in homes and facilities in northern New Jersey. Two of my research participants are men,
and five are women. The conversations were mainly in English, although I conversed in Twi
with one caregiver. I spoke with them once (for forty-five minutes) to thirteen times (eight
hours), with an average of seven times and four hours. The agency helped set up the initial
contacts with the home health workers and was interested in the research because their live-in
home care workers are increasingly African, whom they value as dedicated and caring workers.
They no doubt directed me to their most stable and long-term workers, although they did not
necessarily direct me to the most cheerful and compliant, as some participants were quite angry
about the agency’s policies and pay rates. The agency’s clients were relatively wealthy, paying
for home health care out of pocket or through long-term care insurance. Accompanied by the
agency social worker, who had made the arrangements with the client and her family, I was able
to visit one home health worker and her client in the client’s apartment in an assisted living
facility for about forty-five minutes. I did not have any other interaction with clients. I also had a
long three-hour lunch with one of the home health workers at a McDonalds in Newark who was between jobs. The phone conversations are supplemented with many long-term interactions with three other home health workers I met independently of the agency through my networks in the Ghanaian diaspora in the United States, and from ethnographic research in southern Ghana, comprising a total of 27 months since 1997.

The home health aides I interviewed earned $100-$120 a day through this and other agencies in northern New Jersey. They were paid for ten hours of work, although they lived full-time with their client and were on call for twenty-four hours a day. Nationally, median wages for home health aides were $10.01 an hour, with an annual median income of $20,820 in 2012 (Bureau of Labor Statistics 2014). Although the pay is low, it pays better than many other jobs available to those without a college degree (Ducey 2009). Not only is the pay low, but full-time work is not guaranteed. Jobs can end unexpectedly and quickly, with a client’s death or hospitalization, and sometimes workers struggled to find another job quickly.

The low pay makes it difficult to build or buy a house, whether in the United States or Ghana. Monica estimated that to build a one-bedroom house in Ghana would cost her $30,000 to $40,000. Monica said, “When will you get that money from this job? Only if you have two incomes.” She said that one of her friends had been building a house for twelve years and was still not finished. However, building a house in Ghana is more possible than buying a house in northern New Jersey. ² My research participants were absorbed by dreaming about and planning for a house in Ghana: land acquisition, construction, and saving money for these activities. In the next section, I discuss the cultural meanings of houses in the United States and Ghana as a way of understanding the meanings of houses for my research participants, as an assault on their dignity in their work in the United States and as a route to obtain dignity in Ghana.
Houses and Personhood in Ghana and the United States

Selves become entangled with and implicated in objects like houses for several different reasons. The visible consumption and presentation of objects is significant for identity and personhood, because identity and worth are established through others’ recognition (Goffman 1956, Pugh 2009). Furthermore, to the extent that houses are modified and decorated by people to suit themselves, “the total context of artifacts in a household acts as a constant sign of familiarity, telling us who we and our kindred are, what we have done or plan to do, and in this way reduces the amount of information we have to pay attention to in order to act with ease” (Czikszentmihalyi and Rochberg-Halton 1981: 185). The domestic space re-affirms the selfhood of the owner, thus easing the cognitive burden of maintaining personhood (Czikszentmihalyi and Rochberg-Halton 1981). Objects are thus important ideologically in establishing personal worth symbolically and socially, to oneself and others.

Secondly, objects and spaces create capacities for particular kinds of actions, including social relations. For example, in his analysis of urban migrants’ use of public areas in the city of Antofagasta, Chile, Alberto Corsín-Jiménez (2003) argues that space carries value and meaning in the discrete capacities it conveys or distributes to persons, such as the ability of parents to spend time with their children in outdoor playgrounds. As in his discussion of urban space, houses are significant because they grant capacities to persons. “Things mediate, actively shape, and constitute our ways of being in the world and of making sense of the world. Things also bring people together and provide channels of interaction. Things envelop our minds; they become us” (Malafouris 2013: 44).

Because of their significance ideologically (in maintaining a self) and materially (in terms of the social capacities they generate), houses are integral to the “economy of dignity” by which
individuals claim their self-worth to others (Pugh 2012). Houses in the United States are often conceived as an extension of the person and central to the identity of an autonomous, independent individual. Property rights have long been the basis of autonomous personhood in Western philosophy on liberty, freedom, and the role of the state. “Kant argued that property is crucial for human agency and for full political participation (Ryan 1994) and Hegel (1967) similarly maintained that property makes a key contribution to the self” (Busse and Strang 2011: 6-7). The U.S. Constitution based its formulation of the limited role of government through rights in property, which it sought to protect, and thus property has functioned mythically and powerfully in Americans’ views of what freedom and autonomy mean (Nedelsky 1990).

Jan Cohn argues that historically and culturally in America, “ordinary homes are at once homes and property, the center of family values and a membership card to responsible citizenship, a defense against personal immorality, and a fortress against social and political radicalism” (1979: 61). Some characteristics of personhood—such as responsibility and morality—are thus signaled by the possession of a house. The owner of the house also has an illusion of and sense of entitlement to freedom and privacy concerning what happens inside the house. Housing also has become an expression of personal identity through its decoration, form, and location, and thus become subject to individuals’ psychological processes (Hummon 1989).

Because of continued residential segregation by race and class, place of residence codes social class and race. Housing also codes a person’s position in the life course: young adults are expected to establish their own residence separate from their parents; while the elderly may try to remain in their houses to thwart the symbolic implications to self that such a move would entail (Hummon 1989). “Owning a home for middle-aged Americans has been a sign that a person not only is ‘making it’ financially but also is ‘biographically on schedule’” (Hummon 1989: 218).
Because of the centrality of home ownership to stable and middle-class adulthood in the United States, owning a home has been supported by the federal government, particularly for whites, through publicly-backed loans (Freddie Mae and Mac).

Houses also have affective dimensions through the word “home.” Emotions attach itself to a house, the materially built space. Historically, they are connected to families; to the private, warm, emotional dimension of life rather than the cold, brutal world, to the space of reciprocity rather than market-based relations, although feminist scholars have noted the false division between the market and the home (Folbre 2001, Zelizer 2005). Privacy allows the individual to be his or herself, and to put aside other selves which feel false and social (Hummon 1989). The house helps bolster a particular view of self which is buffered by the threats of the larger social world. As I describe later, these two dimensions of houses in the United States—as sustaining an adult, autonomous persona and as a place for nurturing the self and private, intimate social relations—have implications for the personhood of home health workers, who work in other people’s houses.

Houses in the United States instantiate different visions of domestic relations and personhood than houses in Ghana. In Ghana, a house is about social respect, and less about autonomy, privacy, and individual self-expression. We see this aspect quite clearly in Monica’s comments at the beginning of the paper which focused on “disgrace” and “self-esteem” in the eyes of others. Sjaak van der Geest (1998) argues that houses in Ghana generate respect for their owner-builders because of two factors: they are visible and they increase sociability, by attracting people to the house and the patronage of the house-owner. In the urban areas of Accra, Kumasi, and Berekum, owners had larger households than non-owners, signaling their ability to attract dependents (Tipple et al 1999). A house also reduces the house owner’s dependence on
others, and allows him or her to take care of others in patron-like ways. For example, a retired pastor complained to me in July 2014 about returning to his hometown in Akyem Abuakwa in retirement and having to live in a family house: “Your nephew or some other member of the family has a house and they have to divide it to give you a place to live. So every day you are a burden on the family; they will scold you so much.” In the case of house owners, on the other hand, people who ask to live in the house may help provide personal care for the owner or help with domestic chores like sweeping the compound and fetching water. Additional residents provide security because someone is always around. Most importantly, through houses’ visibility and ability to attract people, they generate respect among others, as a sign that one has made it in life. Houses represent the conversion of economic wealth to social relations, and thus to status.

Most houses in Ghana are built privately by individuals who gain access to land from customary authorities and contract with construction workers to build the structure. Because houses are built out of concrete blocks by individuals from their savings or income, rather than large, well-capitalized developers, houses are built over long periods of time, in fits and starts, as people come into a sum of money. This is one reason one can see many half-built houses in progress.

FIGURE 1 ABOUT HERE

People also use the long-term project of house-building to protect their savings, without distributing it to relatives. For example, if a house-builder comes into the equivalent of $2,000, he or she may use it to buy cement for blocks (used to make the walls of the structure) so that he or she can tell relatives who come asking for money that he or she has no cash on hand. For example, a retired art teacher who was not able to build his own house was criticized by his wife for being too generous with others. Very few people use mortgages or loans to build or buy
houses, because of exorbitant interest rates and banks’ high, nearly impossible, qualifications for a loan (Tipple et al 1999). Because men have historically earned higher income than women (Heintz 2005), they have usually been the ones able to build houses (Van der Geest 1998), but women are becoming increasingly able to build. For example, I know several female nurses in Ghana who have been able to build their own houses in Accra and elsewhere. Husbands and wives build houses separately if they can, and even if a couple lives together, it is usually clear to them and others whose house it is.

Home ownership in Ghana usually happens later in life than it does in the United States (Tipple et al 1999), as part of the builder’s legacy to future generations and because of the amount of time it takes to build a house with one’s savings and without a mortgage. A house should be built in one’s hometown, the place where one will be buried (Korboe 1992). However, some migrants are building houses only in the capital city Accra, which has become the commercial center of Ghana. The wealthiest Ghanaians (whether migrants or non-migrants) build two or three houses: one in Accra, one in the regional capital, and one in their hometowns. Houses are also built late because of difficulties raising the funds until children are grown and old age beckons. Government workers, including teachers, hasten to build a house before retirement, while they still have an income.

Although people who never migrate can build houses, one of the ways that people are able to afford building a house is by going abroad. As Monica’s imagined gossiper illustrates, international migrants are expected to build houses, because migration is associated with money. But what about those who go abroad to insecure employment (Lucht 2011) or low-paid work like home health care? Hummon notes that we know little about “the contradictions and conflicts that people experience through identification with home” (1989: 224). This paper explores some of
those contradictions and conflicts, as Ghanaians seek to convert their domestic work in the United States into the concrete reality of a house in Ghana. This also means converting dignity threats abroad into dignity in Ghana.

**Dignity and its Degradation**

Dignity was a prominent theme in my conversations with Ghanaian home health workers. My participants expressed a concern about dignity through various discourses, including slavery, non-being, and lack of personhood:

“They treat you like a slave.”

“You are like nothing.”

“They treat you like you are not a human being.”

“Don’t treat someone as trash. We all need respect.”

The use of the words “like” and “as” in these statements shows that these discourses are aiming to describe the status degradation and social death they experience in their work (Patterson 1982), but that the available language and categories are not fully adequate to describe the dignity assaults which they experience. These words are very similar to those used by domestic workers (Rollins 1996), although domestics describe being invisible in addition; for example, family members carry on private conversations in their presence, as if they were not there. My participants did not experience invisibility, because they are often the sole companion of an elderly person living alone.

My participants’ language also illustrates that they consider this characterization of them to be unfair and wrong. Like other domestic workers (Rollins 1996) and more generally (Hodson 2001), they have not internalized a degraded sense of self-worth (see Dillon 1997 for an
example). In part, this is because they do not identify with their employers (Rollins 1996). Instead they perceive assaults on their dignity coming from outside (“they”).

The psychological literature has usefully distinguished between shame, in which the experiencer considers the degradation to be deserved and feels guilt, and humiliation, which is characterized by “intense other-directed outrage, low guilt, but intense feelings of powerlessness” (Leidner et al 2012: 4). In the words of Hartling and Luchetta, “the internal experience of humiliation is the deep, dysphoric feeling associated with being, or perceiving oneself as being unjustly degraded, ridiculed, or put down—in particular, one’s identity has been demeaned and devalued” (1999: 264). A neuroscience study showed that humiliation is more intense than anger, happiness, or shame, and quite cognitively complex (Otten and Jones 2014).

The degree to which humiliation is traumatizing depends on several factors, including the public nature and extent of the social fields in which the humiliation is known (Torres and Bergner 2010). The status claims of home health workers may be denied in the context where they are living and working, but such denials do not affect other dimensions of their lives which are more emotionally significant, such as their status with family and friends. Thus, while angered by status humiliations, they fend them off. Although “individuals who have been subjected to the most severe and public of humiliations frequently experience feelings of hopelessness and helplessness” (Torres and Bergner 2010: 200), this is not the case here.

Denials of dignity vary in different workplaces and the pursuit of dignity is “limited, channeled, and constrained by the surrounding organizational demands and structures” (Hodson 2001: 20). Working in domestic settings created threats to my participants’ dignity, although it was not the only reason that they felt like they were “not a human being” and “nothing.” That houses and the associations of houses feature prominently in assaults to dignity among home
health workers is another difference between them and other members of the emotional proletariat, illustrating the ways that conditions of work shape assaults on a worker’s dignity. I will discuss the ways that houses create dignity threats to home health workers, before turning to the ways that home health workers try to recoup their dignity through houses.

**Dignity Threats in Home Health Work**

“Home” in the term “home health aide” is directed at the client’s view of the world, not the worker’s. The associations between liberty, autonomy, and “the home” in the United States do not hold for domestic workers. In doing domestic chores, for example, “the paid care worker often does not control her own time the way that a family member might” (Meyer 2015: 5). The human capacities for privacy, intimate social relations, and autonomy supposedly created by the space of home are not afforded to the home health worker.

The home health aides to whom I talked tend to use the term “house,” sometimes metonymically to refer to the client, rather than “home”. For example, aides will often say they are “going to a new house” when they mean that they have a new case and client. Not only does the house stand in for the client, but the house also is metaphorically the source of threats to the worker’s honor and dignity. The house for home health aides signals a loss of autonomy (to do as one would like), in particular the autonomy to make oneself comfortable in sleeping and eating arrangements, and a loss of privacy and intimate social relations. Furthermore, the house contributes to the status of the client, with the worker’s apparent homelessness—the fact that they are living in someone else’s home—signaling their lack of status.
The house is thus central to the relations of domination between client and home health worker. However, as I describe below, this hegemony “entails both coercion and consent and requires frequent rejuvenation, fortification, and modification” (Dickey and Adams 2000: 7).

Accommodation in Domestic Routines: Dignity Threat #1

Because of the assumption of the rights of owners to control their space in the United States, entering another person’s house puts the worker in a subordinate position under the constraints of the rules and regulations of that house. Generally, the worker is expected to accommodate to “the house” and its owner, who is positioned as the employer and client simultaneously. Thus, while housemates might be expected to make reciprocal adjustments to one another, that is not the case for home health aides and their clients. Workers find new cases stressful because they have to adjust to a new set of routines. Monica said, “Sometimes, when you go to someone’s house—everyone is different—you feel lost and need to put one and one together.” Another home health worker said, “You try not to change them. You clean the place but don’t change the way they arrange their things” because the clients get so frustrated and they are used to living independently.

In particular, home health workers have to accommodate to the food and sleep routines of the client, two activities most associated with home. In some situations, they can cook in the clients’ homes; in others, they are only allowed to heat up food that they bring with them (often for several weeks, until they have a day off). One home health worker said, “They may say, ‘Don’t use this. Don’t cook.’ Like with my current client, I don’t cook over there. When the food is finished, I have to come home. I bring my cooked food and re-heat it there. They complain about my cooking fish.” For her, this rule about her cooking indicated larger issues about her own dignity: “They treat you like you are not a human being.” In households in northern New
Jersey which keep kosher, a not unusual occurrence among this agency’s clientele, caregivers may be given their own sets of plates and pots, which can feel dehumanizing, particularly when it is caregivers’ first experience with unfamiliar kosher dietary regulations. Eating and sleeping separately are perceived as abusive, hierarchical signs of domestic service in Ghana (Coe 2013b). In contrast, clients who shared their food or allowed caregivers to cook the food that they liked were considered by caregivers to be more respectful and appreciative of them.

Workers also had to accommodate to the sleep patterns of their clients, particularly if they went to bed late or arose early. Paulina talked about a beloved client whose family often visited, making it hard for Paulina to get enough sleep:

The woman had two daughters and a son…. They would all come [by] at 9pm and drink tea and listen to music and talk. They would stay until 11 or 12 at night. I didn’t know what to do. In the daytime, I can’t rest. My friend said to me, “You don’t have to stay with them [in the evenings, while the children are there]. Go and rest during that time and tell them to call you when they are ready for their mother to go to bed.” I told them [the children], “I am so tired. I will take a nap.” And I did so. I was in the same room as the mother in the night. So she would yell for me, and I would never sleep. But napping in the evening, I was able to get an hour, an hour and a half, or two hours of sleep.

As this incident shows, friends, many of whom are also home health aides, help one another figure out how to take care of their own needs within the constraints of another’s routines. Caregivers did not mind staying up later than the client if the client went to bed early, or rising earlier if the client arose late, since it allowed for private time to pray or make phone calls to friends and family, which allowed for a different kind of self to be sustained.
In disputes, the owner of the house sometimes made overt claims to control what happened in the house, against the aide’s preferences. Ownership, and the accompanying claim to control the space, is not always expressed verbally, but in situations of conflict expressions of ownership arise more often (Busse and Strang 2011) and tend to make the aide feel even more demeaned. For example, Janet felt unsafe in “a house” when she arrived for the first time and learned that the older man she would be taking care of lived with his middle-aged son. Her bedroom was between the bedrooms of the father and son along the hallway. She decided to protect herself at night by placing a chair against the door of her bedroom. On the fourth night of her stay, at 1am, the son knocked on her door and said his father had to use the bathroom. The son asked why she had a chair behind the door, and she responded, “I like it that way.” She told me, “He said I can’t do it, ‘Not in my house.’” So in the morning, I called the agency and said I had to get out today. It was an emergency.” The agency responded such that she was able to leave the house and situation that day. The son’s overt claim to control the domestic space signaled to Janet that her rights to safety would not be respected. The house is an intersubjective space (Jackson 1998), which can also be a place for the denial of intersubjectivity, in that one person’s autonomous personhood reigns over another, thus denying the other’s humanity.

**Physical Enclosure: Dignity Threat #2**

Live-in is like [boarding] secondary school or college; it is like prison. . . . You can’t go visit [your friends]; you can’t do it. Sometimes you can’t talk by phone.

You are not yourself.

Several of the live-in home health workers referred to their work as prison-like because of the restrictions on their movement and activities, the result of having to be present with the client at all times. The house becomes like a total institution (Goffman 1961) in which one’s
everyday routines are monitored and controlled. Some workers felt the need to escape from this space momentarily—whether physically or psychically—and many welcomed my phone calls for the opportunity of mental escape. Monica said that she took a half-hour walk almost every day with one case when her client’s daughter came by to visit her mother. She otherwise felt like a “prisoner.” She emphasized that the house should not be “a cage.” Another home health worker said she left the apartment for a short walk when the client was taking a nap, even though it was against the rules. Some home health workers enjoyed working in a facility more than a private home because they could talk to other workers—even if it was a brief greeting or smile in the dining room or hallway—and feel supported. As studies of workers describe, “dignity can be achieved through camaraderie and solidarity with coworkers” (Hodson 2001: 3). These social exchanges were particularly important for caregivers taking care of clients with dementia, some of whom were no longer verbal.

Paulina spoke about her first job with the agency where the client was constantly calling her, even at night: “The first job was very tough. . . . It was like in a jail. I had no space. There was no privacy, no nothing.” She felt particularly trapped in that difficult job because she needed the money and thus did not feel she could leave the position: “I wanted to go to Ghana to see the kids [her two kids], which I hadn’t done before.” Her emotional pain expressed itself somatically: “I thought I was going to die, because I got chest pains at night.” She ultimately was convinced that the job was dangerous to her health, and that gave her enough of an impetus to leave. Thus, the client’s residential space can become an enclosure—the home as institutional dorm room or jail cell—making the caregiver feel trapped and isolated. The home gives her no privacy, “no space.” Although the income is central to maintaining intimate social relations (such
as supporting and visiting her children in Ghana), Paulina also feels cut off from intimate social relations which might nourish her on a day-to-day basis, recalling her to her own sense of self.

Doing home nursing work in the United States limited certain capacities of the self to sustain social relations and have autonomy, including eating and sleeping as one would like. However, homes were also associated with status in the United States, and this aspect too of houses affected home health workers’ sense of worth.

**Houses & Status: Dignity Threat #3**

Houses are used to indicate wealth and power in the United States and therefore social class, and to a lesser extent, race and citizenship. Lack of housing—homelessness—expresses extreme poverty and desperation, while large mansions signal wealth and power. Furthermore, among citizens of the world, Africans are assumed to be poor, and therefore without homes, or without proper homes. As Dickey and Adams argue, “identities are constantly renegotiated in domestic service interactions and accounts” (2000: 18). One vector of identities under negotiation in home health work was relative status. For my participants, because of the centrality of houses to their work, houses became part of the negotiation of the identities of home health workers and their clients. Both parties were aware of houses as encoding their status and wealth differentials. Descriptions of houses and housing size were part of workers’ descriptions of work experiences of classism and racism.

Live-in home health workers, by definition, were staying in someone else’s home, and thus looked homeless. Paulina reported that one new client with dementia became agitated several hours after Paulina arrived, because she thought Paulina was a homeless stranger who was trying to move into her house. The client tried to drive Paulina out of the house with verbal abuse, at which point the client’s relative was called on to intervene.
Furthermore, the client’s wealth was on display in the residence in which he or she lived. Monica described the daughter of a client who wanted to “dominate” her. “We are human beings. I could see she wanted to mop me on the floor the first time [she met me]. It was a mansion. The daughter was the VP [vice-president] for a company and had a high position. I was a Black girl from Africa. She thought I was nothing; I was from Africa. So when she says “Sit,” I have to sit. It distressed her that I had come to her mother’s beautiful house to be in charge.”

There are several issues going on here in Monica’s description of her client’s daughter. The daughter had attained a high position in society, as indicated by her work role and by her mother’s “mansion” and “beautiful house.” Monica’s lowly status in the daughter’s eyes, as she describes it, is due to her race and origin: Blackness and Africa. Houses are connected in this narrative to wealth and race. Furthermore, the denigration is expressed eloquently in the metaphor of housework: “She wanted to mop me on the floor.” Monica, in this formulation, becomes the mop, the cleaning implement, and not even the wielder of the mop. She is an object, a tool, and not a person. She described in other conversations how her care of the mother was devalued by the daughter, and she was appreciated only for keeping the house clean. In other words, the value of her work became her domestic service to the house rather than her care of a beloved parent, a perspective which in Monica’s eyes would give greater consideration for her personhood and feelings. Thus, Monica’s low status was attributed to her complex and multi-stranded relationship to the house of her client, which made her into a cleaning implement.

The reason why “Africa” is relevant to the issue of houses is clearer in another example. Janet described how a previous client’s daughter asked her questions about Africa.

She asked me, “In Africa, do you eat chicken?” I said, “Yes, we eat chicken.
Why?” Sometimes they think we sleep in trees. Maybe we don’t have a house.
She asked, “Do you have a house?” I said, “Yes. Why are you asking?” She said, “I’m asking because maybe you don’t have one.” I said, “No, we live good.” She asked, “Why did you come here then?” I said, “We came here to work. We have plenty people back home.” She said, “Oh, okay.”

Janet was insulted by the daughter’s implication that “Africa” lacks chicken and houses or that she has not had access to them. In her report, the daughter seems to be positioning “Africa” as being “primitive” and poor, by implying Africans do not have access to one of the proteins most commonly consumed in the United States and do not sleep in houses, but in trees, which many Africans report being asked about in the United States (Awokoya 2012, Coe 2013a, Traoré 2006). Janet responds by speaking not only for herself, but for all her fellow Africans, saying that “we” do not lack but “we live good” and “have plenty”—“plenty people” whom they are supporting “back home.” In the process, she also answers the daughter’s question of why a woman came from Africa to do the work of caring for her aged mother. If not poverty—lack of food and housing—then why?

Houses are salient in assessing status in the United States, and Africans’ home health workers’ apparent “homelessness” and African origins—issues which are sometimes conflated—serve as an indicator of poverty. Studies of frontline service workers find that although all workers in these positions have difficulty maintaining their respect and dignity, it is more difficult for those from disadvantaged social groups (Macdonald and Siriani 1996). That the race and origin of Ghanaian caregivers is brought up in conversations with me suggests that they also are subject to different status degradations than white or non-immigrant caregivers and that they have a different experience, therefore, of working in these occupations. However, in general, houses function as a status symbol for the client and lower the status of the home health worker.
Recuperating Dignity

A number of psychological studies have examined responses to humiliation, which include moving away (e.g., withdrawal, avoidance, isolation), moving against (e.g., aggression, retaliation) or moving towards (e.g., affiliation, joining a gang), to create a sense of self-worth and a feeling of power (Hartling and Luchetta 1999). Furthermore, studies have noted the relationship between a sense of well-being and a desire to obtain material objects. For instance, experimental studies suggest that injury to the self results in greater possessiveness; in contrast, boosting a person’s self-worth elicited more sharing of resources (Diesenbruck and Perez 2015).

Gao et al (2009) argue that when a person is shaken in their self-confidence, one of the coping mechanisms is consumption of symbolically significant products. Thus, material objects can function like affiliation, in providing “existential experiences in being good in oneself and support[ing] a subjective and intersubjective sense of self-efficacy” (LaMothe 2012: 111).

Three routes to recuperating dignity came up in my conversations with home health workers: leaving the house (moving away), gaining status through a caring self (re-signification), and building a house in Ghana (affiliation). I did not hear of moments of “moving against” or retaliation. These strategies are shared within the work culture of home health aides, who maintain connections to one another through phone calls and face-to-face interactions in facilities.8

Escape

One response to assaults on dignity is leaving the house of the client and the case itself. In order to leave, home health workers need a place to go which is always available, since they may leave in a moment of emergency or crisis, as in the example given above with Janet’s being
afraid of the client’s son. Some have a room in the house of a friend or relative in the U.S. where they may also not feel “at home.” I visited one unmarried and childless home health aide several times over eight years of our friendship. Mabel lived in a decrepit basement apartment, shared with a relative of the owner, where she felt unsafe. Her bedroom was filled with boxes of materials she was planning to take back to Ghana long before she actually returned in 2013. She kept these boxes in her bedroom because she was afraid that her roommate would steal her belongings if she left them outside her room. She did not keep toilet paper or any of her toiletries in the shared bathroom. She did not like to talk to me in the public spaces of the apartment because she was concerned her roommate would overhear us, instead taking me into her bedroom to sit on her queen bed and chat. Whatever its condition, all the home health aides I know have a landing pad because of the need to “get out” quickly, as an escape from a humiliating or dangerous situation.

Paulina told me of giving advice to a friend, also a home health worker, who called in a moment of crisis. The client had asked her friend, “Do you know what you’re here to do?” Paulina’s friend replied, “To take care of you.” He said, “To clean my shit!” She said, “Why do you say that?” He said, “I’m the boss. You have to listen to what I say. When I am inside the bathroom, you have to wait outside.” The friend told Paulina on the phone, “I can’t do this.” Paulina reported that she told her friend to “shut her mouth [keep quiet with the client] and go home.” Paulina commented, “At times you listen to people and hear sad things.” Paulina herself noted times when she left quickly. One home health worker I have known for a long time reported to me that luckily, she has never been so desperate for money that she can’t leave a situation, but she knows other women through her social networks who are more desperate and stay in humiliating circumstances.
Leaving depends on the agency’s ability and willingness to find a replacement. Leaving a client without permission can result in suspension of the aide’s license, a point emphasized forcefully in the agency’s orientation which I attended in November 2014. Some agencies are more responsive than others to requests to leave, and sometimes workers have to invent stories of sick children and emergencies to put pressure on the agency to let them leave. Home health workers also tend not to tell the client that they are leaving permanently nor do they complain to them about the inappropriate behavior that makes them want to leave (they “shut their mouths”), but instead act as if they are leaving for a short break or for personal reasons. Generally, they do not complain or negotiate; they leave. As Judith Rollins discusses, “domestics’ ways of coping with employers’ degrading treatment have been effective, then, in protecting them from the psychological damage risked by accepting employers’ belief system but have not been effective in changing the behavior themselves” (1996: 241). Leaving is a sign of powerlessness consistent with the feeling of humiliation, in that one recognizes that one cannot change the situation and does not directly confront the client. Leaving also has another cost in that it means that one loses income, and cannot contribute to children’s wellbeing and house-building projects, putting one’s dignity in jeopardy in other social contexts.

**Caring as Status-Creating**

Some home health workers use their caring skills to create a new kind of status for themselves, oriented around a caring self. Clare Stacey (2011) found that this perspective was quite common among the home health workers she interviewed, as did Jason Rodriguez (2011, 2014) in a nursing home, who found that workers used emotions to maintain their self-worth (see also Lopez 2006).
I visited Millicent, a home health worker, while she was on a visit to Ghana in June 2015. There, she showed me pictures of her former client, including a photo of different dishes laid out on the client’s dining room table. She had been with her client for almost a year and spoke of her with great affection. She described making her client’s house into a place where her client’s children and friends would want to visit, by keeping it tidy and clean and by having delicious food ready to serve. Similarly, Monica is very proud of her cleaning abilities and said about one client’s residence, “I keep that house together like my own house.” A third described her caring work as a spiritual calling, in which she was learning to love humanity more deeply. Through their caring, they create for themselves a sense of control and autonomy. Thus, some caregivers transform the meaning of care from the degradations of domestic service to a spiritual calling or a source of pride. They put their energy into maintaining their client and their client’s home as a place where the client can maintain strong social relations and a sense of dignity.

**Building a House in Ghana**

If I have money, I would like to go home. . . . I still have a dream: I am living in a house, with a successful husband. But how will it happen? It is like a fantasy, but I have been seeing it. It’s like I am living it. [In the dream.] I have a successful husband, with the kids jumping up and down on the couch, and I am busy, just coming home from work, and I need to clean and cook. You are not living in it, [but] you are seeing it. So I work hard and hope. I just want to be home, with a nice house, working hard, with an intelligent, successful husband.—Monica

The third approach is dreaming of a house at “home,” in Ghana. A house in Ghana operates in complex ways for home health workers in the United States. First, the house is a sign of success after the years of degradation in others’ houses. It shows that the degradation was
“worth it.” A house represents the fruits of their labors. Secondly, a house in Ghana signifies the end of work, a time of rest and being at home, for many (if not Monica). “Ghana” in general signals sociability, including time with children and other relatives in Ghana, in comparison to the isolation and long hours of home health work. Millicent, anticipating her visit to Ghana, said she would spend all her time visiting her friends and relatives and cooking for those who visited her. Ghana was thus associated with sociality, a sociality enabled by houses, in comparison to the work-dominated time-stressed world of the United States (see Rouse 2005 and Smith 2006). For Monica, Ghana is imagined as a space for family, with happy, energetic children and a supportive, income-generating spouse. It is a space where she imagines cooking and cleaning for her family. The house, for those older than Monica, symbolizes a sociability associated with retirement.

Finally, their work in the United States emphasizes the lack of autonomy, status, and privacy which occur when they live in someone else’s house, fueling the desire for a house of one’s own. Building a house in Ghana is thus a kind of displacement, to use Freud’s terms, a shift to a new set of goals or emotions to allay anxiety about the original, unwanted feeling (for Freud (1977), aggressive or sexual feelings). Accumulating a status- and affiliation-generating object in Ghana is one form of displacement. All these psychic processes orient Ghanaian home health workers’ attention and sense of belonging to Ghana, rather than the United States.

Those without status in one social field can try to use their status in another social field to try to offset their lack of status in another. Transnationalism provides one way that people might do so. Elena Theodorou (2011) discusses how Pontian children in Greek-Cypriot primary schools used their parents’ transnational actions, properties, and networks as a shield against their local social marginalization. Yet there are limits on the extent to which transnationalism can
mitigate the lack of status abroad, if lack of status in one social field does not enable one to gain
the social and financial resources to obtain honor in another social field.

**Building a House as another Dignity Threat**

Most displacements are ultimately not as emotionally satisfying as one dreams. Fantasies
may be more satisfying than the messy reality (Frank 2002). Although *having* a house generates
status, *building* a house involves humiliations for people already sensitive to status threats from
their work. In June 2015, I accompanied Millicent, age sixty-two, on a visit to her building site in
Kasoa, a suburb of Accra. With us were her youngest daughter, age twenty; her sister’s son who
was helping her with the building management and oversight; and his wife. The sun beat down
on the scrub lands of half-completed houses and empty plots of land. The sandy road we walked
along was occasionally filled with large pools of water that we had to bypass by going through
the tall grass on the side of the road. Millicent had come to Ghana for two months to supervise
the building of her house and to enroll her daughter in SAT preparation classes in anticipation of
her coming to the United States to start college. The building of the house and the launch of her
children into successful adulthood were the two legacies she was concerned with at the moment,
and as a result of the emotional significance of these goals and the limited time available during
her two-month stay in Ghana, she was deeply affected by the ups and downs of these projects.
On the way to the building site, Millicent was full of lamentations about all she had gone through
and the financial expense these problems had caused: the delivery of sand to make concrete
blocks on poor roads made worse by the rainy season, and an unexpectedly high water table
which meant the foundation had to be reinforced.
When we arrived, Millicent and her nephew inspected the site, pleased that the foundation had been completed the day before. Her daughter and her nephew’s wife, who had never visited the site before, lessened the sense of accomplishment by commenting on the small size of the plot of land. Although I was impressed with the plot and foundation, they knew “the cultural code to ‘read’ the local hierarchy of wealth” (Hatch 1987: 49). They all seemed able to imagine what the three-bedroom house would look like better than I did. Again, sufficient by my standards, the house seemed small to them for attracting dependents and indicated that Millicent was not as successful as they hoped. I took pictures of the family and the daughter standing on the wall of the completed foundation. The photo seemed to me to bring the future into the present (Nielsen 2014) by focusing on the people who hoped to enjoy the completed house: Millicent planned to retire in it; the nephew and his wife might be the caretakers of the house in her absence; and her daughter with her siblings would probably inherit the house.

As we were leaving the building site, a muscular man called to us, running down the road after us until we stopped and turned around. Known locally as a “land guard,” who guarded plots of land from being illegally built on, he had prevented work from proceeding on the site a week or so ago and was threatening to take away the workers’ tools the following morning unless he was paid his protection money. The nephew placated the land guard and called the person whom they had paid the equivalent of almost $1000 that the land guard needed his share of the funds. During these negotiations between the nephew and the land guard, Millicent complained to me—quite upset and not very quietly—about how the man was just taking her money without doing any work for it. In essence, she saw him as demanding protection from his own capacity for violence. It was as if she was seeing the money she had accumulated over the past few years
through her many hours of labor fritter away before her eyes, taken without cause by a man whose only labor was to run after us on a hot day and act in threatening ways.

After the land guard left, somewhat satisfied that his money would be forthcoming, the nephew’s wife complained that he should not have called after us without any honorific or salutation because it was disrespectful; he had used the equivalent of “Hey!” Millicent’s status as a migrant did not gain her respect in this interaction, but rather seemed to initiate unfair, blatant, and disrespectful attempts to gain access to her wealth, in the eyes of Millicent and her relatives. And yet, despite these depredations to her status and her money, Millicent remained excited about making progress on the building of a house. She was glad that the land guard had stopped us on the road, rather than stopping the workers in their progress the following morning. She was willing to undergo a certain level of degradation, so long as the house was built. And yet, she also responded with ambivalence: perhaps she would rent out the house rather than live in it because of its many problems.

Millicent’s experience showed that building a house can make one subject to other kinds of humiliation; or perhaps, one must submit to humiliation to gain status (Lucht 2011). It showed that Ghana is not always a space of sociality, characterized by visits among friends and family. Instead, Millicent spent much of her time in Ghana managing the construction in the hot sun and feeling anxious about how things were proceeding, without the progress being in her control. Home health workers seek to recoup their dignity transnationally, by building a house in Ghana, but the process of house building generates its own dignity threats.

Conclusions: Where is Home?
Live-in home health work is a particular kind of emotional labor which differs from those of service workers in the emotional proletariat in that “the house,” rather than emotion management, looms large in structuring the conditions of the job. The dignity threats emerge from working in someone else’s home and the implicit and explicit claims made by owner-clients to control the domestic space. The worker does not have autonomy and privacy because the living space is also a workplace. Furthermore, relative status is visible and on display through the residence, enhancing the status of the client and highlighting the worker’s relative poverty.

Ghanaian home health workers displace the humiliation, powerlessness, and anger they experience at work into a longing for a house of their own, “at home” in Ghana. This house is considered the polar opposite of the houses where they work: as full of sociality, rather than long hours of isolating work; as restful, as opposed to exhausting and sleepless; and as enhancing their dignity, rather than degrading. That houses become the object of workers’ fantasy life is not surprising given houses’ significance within the economy of dignity in Ghana and in the Ghanaian diaspora. The feelings of humiliation, which cannot be expressed to the client except indirectly through flight, can be mitigated and channeled through trying to attain the culturally designated goal of one’s own house in Ghana.

Thus, their energies and finances become oriented towards house building, and their low wages go into land payments, cement, reinforcing iron rods, iron roofing sheets, and protection from the violence of land guards. Through these houses, they hope to achieve what they are deprived of in houses in the United States: a sense of dignity. And yet, sometimes, building those houses generates its own dignity threats, particularly because as low-wage workers, they cannot build mansions on large plots in Ghana.
Ghanaians’ niche employment in elder care has implications for their sense of worth and belonging in the United States. My participants’ work in domestic spaces leads them to speak nostalgically of Ghana and home, as places of sociality, relaxation, and family. Transnationalism helps mitigate the dignity threats they experience in the United States by allowing them to locate their sense of self in another social context where their sense of self is buffered. Yet, this research also speaks to the limits and semi-failures of transnationalism in mitigating migrants’ dignity threats, when fantasies are brought into being, messily and anxiously, by actually building.

This research adds to our understanding of what home health workers in the United States consider difficult about their jobs and how they cope with dignity threats. This is significant because concerns have been raised by healthcare analysts that there are not enough direct care workers for the anticipated future growth of elderly persons requiring care in the United States (Institute of Medicine 2008); this labor shortage is one reason why immigrants work in this field. This research points to some of the reasons why care workers seek other spaces and social fields for the recuperation of dignity through escape and home building, and what, beside exigency, might need to change to encourage care workers to stay in the workforce and with a vulnerable client long term.
Notes

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1This finding is supported by wider survey data: Ten percent of those born in Ghana who were surveyed by the 2006-2008 American Community Survey worked in the healthcare industry in general, and another eight percent worked in the single occupational category, as defined by the Bureau of Labor Statistics, of “nursing, psychiatric, and home health aides” (American Community Survey 2006-2008, my analysis).

2Even in Newark, one of the cheaper places to live in northern New Jersey, although it is possible to buy a foreclosed apartment or house for $50-60,000, the average home price was around $200,000 (Zillow 2015a, 2015b). In the rest of Essex County in 2014, the average home price was $485,000 (State of New Jersey 2014).

3Land prices in urban areas in Ghana have increased exponentially, between 460-1300% between 1995 and 2005 (World Bank 2015).

4Tipple et al (1999) find that the median length of time to construct a house in Kumasi varies between 28 and 54 months, with a range of 15 to 82 months.

5In Twi, house and home are referred to by the same word fie as the physical structure where one resides. The sense of home is less than an emotional one (as in Home Sweet Home) whose sentiments would be associated with the hometown, not the house per se.

6Technically, the agency is the employer, but aides are aware that if the client is not happy, then they will lose the job. Although they may be given a job elsewhere, they may also have to wait
or go through a series of temporary or relief jobs before finding a permanent position. Leidner (1996), Lopez (1996), and Fuller and Smith (1996) discuss how customers become involved in managing workers in service-level work.

She did not think this request was legitimate because the father could usually go to the bathroom on his own.

Workers who overlap briefly in the care of a client, as one replaces the other, often exchange phone numbers so that the new aide can ask the more experienced aide questions about how to care for the client. Conversations with other workers (in the dining rooms of facilities, for example) or social intimates also were helpful, as a social interaction in which one’s value as a human being is supported.

Scholars have noted that plots of land tend to be large in Ghana compared to other countries (Korboe 1992, Tipple et al 1999).

References


Choy, Catherine Ceniza

Coe, Cati

Cohen, Jeffrey H.

Cohn, Jan

Cole, Jennifer

Corsín-Jiménez, Alberto

Czikszentmihalyi, Mihaly and Eugene Rochberg-Halton
Dickey, Sara and Kathleen M. Adams


Diesendruck, Gil and Reut Perez


Dillon, Robin S.


Ducey, Ariel


Fletcher, Peri L.


Folbre, Nancy


Frank, Katherine


Freud, Sigmund


Fuller, Linda and Vicki Smith

Gao, Leilei, S. Christian Wheeler, and Baba Shiv

Goffman, Erving

Hartling, Linda M. and Tracy Luchetta

Hatch, Elvin

Hegel, Georg

Heintz, James

Hodson, Randy
Hummon, David M.


Institute of Medicine


Jackson, Michael


Korboe, David

1992 Family-houses in Ghanaian Cities: To Be or Not To Be? Urban Studies 29(7): 1159-1172.

LaMothe, Ryan


Leidner, Bernhard, Hammad Sheikh, and Jeremy Ginges


Leidner, Robin


Leutz, Walter N.

Lopez, Steven H.


Lucht, Hans


Macdonald, Cameron Lynne and Carmen Sirianni


Malafouris, Lambros


Manuh, Takyiwaa


Meyer, Patti

2015 Relations of Care: The Contexts of Immigrant Care Workers in Northern Italy. Anthropology of Work Review 36(1):2-12.
Nedelsky, Jennifer


Nielsen, Morten


Otten, Marte and Kai J. Jones


Patterson, Orlando


Pauli, Julia


Pugh, Allison J.


Rodriguez, Jason


Rollins, Judith

Rouse, Roger

Ryan, Alan

Smith, Michael Courtney

Stacey, Clare L.

State of New Jersey, Department of the Treasury

Theodorou, Elena

Tipple, Graham, David Korboe, Guy Garrod, and Ken Willis

Torres, Walter J. and Raymond M. Bergner

Traoré, Rosemary

Van der Geest, Sjaak

Weiner, Annette B.

World Bank

Zelizer, Viviana A. Rotman

Zillow

Figure 1 caption: A house-in-progress in Akropong, Ghana.