

# Feeling Frail and National Statistical Panic: Joan Didion in *Blue Nights* and the American Economy at Risk

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“I find myself increasingly focused on this issue of frailty,” writes Joan Didion in her memoir *Blue Nights*, published in 2011 when she was seventy-seven (106). How might we understand this “issue” of frailty? Turning first to Didion’s portrayal of her experience as an older widow who has recently lost her only child, and second, to the dominant rhetoric in the United States regarding population aging, I suggest that the all-pervasive discourse of risk provides a productive way to frame two distinct yet intersecting issues of frailty: risk in relation to the health of individuals who are old as well as risk in relation to the economic health of “advanced” nations—the United States in particular—in the context of globalization. Risk references a certain temporality; it points to the future from the perspective of the present. We are . . . at risk, and today virtually everything seems to be a risk factor—especially age itself. Among many other conditions, age is a risk factor for disability, and I will close with some thoughts about aging and disability through the lens of frailty.

Aging is a “normal” process. Aging is also understood as a risk factor that, well, increases with age. Indeed, age is itself a mega-risk factor (and yet, generally, the best “outcome” is to increase our age, revealing the contradictions in the discourse itself). Associated with advanced old age, frailty is a condition of vulnerability—one, I will suggest, that can be intensified by the discourse of risk.<sup>1</sup> Risk underwrites, or overwrites, frailty, producing feelings of fear.

Like aging and old age, frailty has a history. Over the past thirty-five years frailty has emerged as a biomedical concept, understood not as a

disease but as a syndrome; in a clinical setting, key indicators of frailty include muscular weakness and bone fragility.<sup>2</sup> As the sociologist of aging Amanda Grenier has shown, today frailty is associated predominantly with the discourse of disability as functional impairment *and* as risk.<sup>3</sup> Frailty is thus an example of what Foucault has termed a “dividing practice,”<sup>4</sup> a way of categorizing people and creating policy, thus channeling the actions and reactions of the state, clinicians and social workers, family and friends, and strangers; in certain medical systems and long-term care insurance programs, being labeled frail—*diagnosed as frail*—can result in benefits, among them, home assistance. If people are divided from each other (the frail old from the healthy old, for example), one can also be divided from oneself (not recognizing oneself as frail, for example). Being labeled frail can result in stigmatization by others as well as by oneself, with elders internalizing the identity of being frail and coming to inhabit frailty as a circumscribing condition of their lives. Not surprisingly, frailty can be a defining element in the representation of older people in the media (consider the TV commercials in the United States that exhort older people—who of course do not look frail—to purchase an emergency alert system, with the tag line “I’ve fallen and I can’t get up!”); what is being sold is largely the feeling of security.

Frailty is thus understood simultaneously as an impairment in function in the present and as a risk factor for developing an impairment in the future.<sup>5</sup> When frailty as a bodily impairment and old age converge, temporality contracts, the future grows short, and the *chronic* and the *acute*—two medical categories habitually kept separate—can converge, with the fear of the possibility of a critical event occurring at any time increasing, perhaps exponentially. What does it mean for individuals to inhabit the ambiguous and confusing condition where, temporally, in medical terms, these once clear-cut categories of the *chronic* (arthritis, for example), the *acute* (a heart attack, for example, or a stroke, or an infection), and the *critical* (an injury due to a car accident, for example), have lost their specificity as separate experiences, coming together?<sup>6</sup> Risk threatens to swallow up all affective experience, with discourse converted

into feelings of fear, even panic. As Joan Didion writes in *Blue Nights*, for her the once-invisible passing of time had become paradoxically *aggressive*: “this permanent slowing, this vanishing resilience—multiplies, metastasizes, becomes your very life” (17).

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Joan Didion’s *Blue Nights* is a first-person narrative that takes the form of a diary-like chronicle in which she meditates on the life and death of her daughter, their intertwined lives and feelings, and her own frailty. It is testimony to what her experience, grounded in her body, feels like—a grief for her lost daughter and a disbelief that she herself has definitively aged, both of which are so heavy as to seem terminal, as if her frail body were weighed down with stones even as she is terrified of falling. Written in the aftermath of her daughter Quintana’s death at the age of thirty-nine, the deceptively brief *Blue Nights* departs from the subject of grief at its midpoint to address directly what Didion calls “this issue of frailty”:

I find myself increasingly focused on this issue of frailty.

I fear falling in the street. I imagine bicycle messengers knocking me to the ground. The approach of a child on a motorized scooter causes me to freeze mid-intersection, play dead. I no longer go for breakfast to Three Guys on Madison Avenue: what if I were to fall on the way?

I feel unsteady, unbalanced, as if my nerves are misfiring, which may or not be an exact description of what my nerves are in fact doing. (106)

Didion begins *Blue Nights* remembering her daughter’s wedding, events from her childhood, and their house in California. But soon into her memoir she declares that the issue is “fear”; “the actual subject” is the “failure to confront the certainties of aging, illness, death” (54). She recognizes, with a shock, that she is regarded by others—friends, doctors, relatives—as old, frail, and in need of care. She is humiliated by the way she is treated—with condescension, impatience, and, in a seeming contradiction, a strange *lack* of concern. She is not bodily attuned to their world. *The* world. She is *frail*. She is indicted by one of her physicians for having made “an inadequate adjustment to aging” (137). Indeed, she realizes that she has made *no adjustments at all*. She is horrified when

someone suggests that she must be using a walker to get around. She is aghast when people insist that she shouldn't live alone. At this point, being home, alone, is her existential condition, and it is what she prefers. She panics, imagining what might happen in the next hour, the next minute, the next second. What if she won't be able to get up from a chair? What if she is incapacitated by her neuropathy or neuritis or neurological inflammation? (She never received a proper diagnosis.) What if her physical debility extends to cognitive impediments? She is at risk. She *feels* at risk physically—fearful of aging, illness, death. She *feels* frailty. Which is to say that she feels risk. It is the opposite of the feeling of confidence.<sup>7</sup> As she tells us toward the very end of the book, she now spends long hours on all manner of medical matters, including taking medication for thinning of the bones. She suffers through the experience of shingles. She understands what she had never before seriously considered: “That being seventy-five could present as a significantly altered situation” (141). If she resists following the advice of her doctors for what I can imagine are reasons of vanity (*no walker!*) as well as a strong sense of her own self (she has always been thin, and she is still able to walk on her own), she also does the recommended exercises to build her strength and tries her best to gain the weight they insist upon. She deploys her will (she will maintain momentum and avoid complaining) as well as her sharply-honed and drily disarming sense of irony, if not fatalism.

Sociologist Julia Twigg has astutely remarked that “there is no simple answer to the tension between age resistance and age denial” (299). And indeed, Didion both resists being categorized as frail and accepts her condition as being one of frailty.<sup>8</sup> She also expands the meaning of frailty to encompass far more than the fragility of her body. Frailty is the name she gives to her difficulty in writing. Didion tells us that all her life she had had immense confidence in her skills, sketching out paragraphs and pages with ease as if she were blocking scenes. Now she hesitates, she fears she can no longer express herself, she tries to write differently. She uses the metaphor of losing her balance to describe the effort it costs her to try to write; “the correct stance” for shaping her experience in prose,

she says, eludes her (116). In addition, frailty names what she believes her daughter saw in her:

She saw me as needing care myself.  
 She saw me as frail.  
 Was that her anxiety or mine? (101)

Viewing herself through the imagined gaze of her daughter, Didion comes to understand that she herself requires care and that perhaps she has *always* required care. Imagine Didion's guilt. Her daughter was mortally ill. And yet her daughter was concerned about her. Or was that a projection on Didion's part? Didion can no longer distinguish the source of her anxiety. Or rather, her anxiety has multiple sources, issuing from all directions. Including bicycle riders in the street. Children on scooters. Cars. Anything with wheels.

Frailty also describes how Didion judges herself retrospectively—and harshly—as a parent. She was naïve, she was clueless, she was muddled. *She had no idea what she was doing*. She was a failure. Why? Ultimately because she lost her daughter Quintana. Frailty spreads inexorably like a stain to saturate her experience—past, present, and future—virtually totalizing it.

In *Illness as Metaphor*, Susan Sontag cautioned us of the burdens that can result both to the individual and to society from deploying the vocabulary of a disease, such as tuberculosis or cancer, as figures of speech to describe other conditions. In *Blue Nights*, Didion does the very opposite, calling on the word “frailty” to name the proliferating condition of loss—it is a devastation—in multiple spheres in her life; she conveys that sense of loss as desolation, never in the mode of sentimentality. Frailty is the word that marks a *before* and an *after* in her life, a definitive sea change. Frailty is the word she uses to describe her interpretation of her present, one that seals her present into the future, and offers an understanding of her past. Didion thus understands frailty in terms of meaning as well as in physical terms, linking frailty to the death of her daughter as well as to her own body. And in fact it appears that Didion's frailty is a medical mystery. She suffers a serious fall in her apartment. It is a critical event,

an emergency. She cannot get up. Her legs, her forehead, and her left arm are bleeding. She loses consciousness. She wakes up. She finally manages to reach a phone (there were thirteen phones in her apartment!). She calls a friend. They take a taxi to the hospital. Test after test is done. Nothing definitive is found:

Surprisingly, there were no abnormalities to explain why I felt as frail as I did.

Surprisingly, there were no abnormalities to tell me why I was afraid to get up from a folding chair in a rehearsal room on West Forty-second Street. (148)<sup>9</sup>

It is as if Didion now embodies what her daughter feared for her. It is as if grief pervades her body as well as her psyche. *As if*. That is too weak a formulation. Grief inhabits her body as well as her psyche. So does the sobering recognition—one that would better be understood as disbelief—that she is aging, that she is old, that she has crossed a line, that if before there were three (her husband, her daughter, herself), now there is one, only one empty space left in the burial crypt.

The medical anthropologist Arthur Kleinman makes an important distinction between disease and illness: disease is the clinical entity, illness, the subjective experience of it (given this distinction, Sontag would have done better to title her book *Disease as Metaphor*).<sup>10</sup> Didion has a keen sense of the history of medicine and is skeptical of the shifting diagnoses—if any!—that she receives. But she focuses on illness, giving us a sense of the feeling of frailty, of being at risk. If frailty marks a before and an after in her life, it also holds a key to continuity. She characterizes her experience in terms both of physical continuity of the self—as I mentioned before, she points out that she had always been thin—and of continuity across generations. She now understands what was before unfathomable to her—the behavior of her own mother when she was older and hesitated to cross the street:

I recognize now that she was feeling frail.

I recognize now that she was feeling then as I feel now.

Invisible on the street.

The target of any wheeled vehicle on the scene.

Unbalanced at the instant of stepping off a curb, sitting down or standing up, opening or closing a taxi door. (139-40)

Didion had to experience frailty herself in order to witness, retrospectively, the feeling of frailty her mother experienced. Frailty: it is an attribute of her entire body, understood as the psychic body, not just a syndrome of the physical body at risk. But it is also her physical body at risk: she feels herself to be a “target.”

Alone, Didion populates her psychic world—the world of this brief memoir—with her daughter, her mother, her husband, and her friends who have died. Her experience is characterized by an aching and chronic sense of loss experienced in the present, projected into the past, and foreseen in the future—a sense of deathliness reinforced by the repetition of phrases. To whom is she profoundly connected? She can't think of one person to name on the ubiquitous form asking who should be contacted in case of an emergency. (I understand this: not long after my husband died, I found myself breaking into tears when a nurse—I had changed doctors, and this was my first visit—asked me the same question.) In *Blue Nights*, it sometimes seems as if Joan Didion is talking to herself; sometimes she speaks directly to us as readers. The two modes of address merge together as soliloquy. The book closes on a note of devastating fatalism:

I know what it is I am now experiencing.

I know what frailty is, I know what the fear is. (188)

The concept of risk entails uncertainty. But at this point Didion is dead certain.

In *Inhibitions, Symptoms and Anxiety*, Freud makes what has become a well-known distinction between fear and anxiety. Fear is attached to a specific object (a car coming toward you in the street) whereas, in his words, *anxiety* possesses “a quality of indefiniteness and lack of object,” an indefiniteness we can relate to risk (165). In her description of her experience at the end of *Blue Nights*, Didion merges the two affective states that are theoretically distinct for Freud: *anxiety*, as an expression of being at risk (but for what? for potentially everything and anything,

with indefiniteness multiplied), and *fear*, as the expression of the palpable certainty of death. She knows unmistakably, she writes, what she is experiencing: under the sign of frailty, anxiety and fear converge into one. Improbably, the passing of time both accelerates and slows down, metastasizing in all directions, spreading into the past, the present, and the future.

Contracting and expanding, time also becomes difficult to comprehend—at least for me as a reader. Here are the rest of the last lines of her memoir:

The fear is not for what is lost.  
What is lost is already in the wall.  
What is lost is already behind the locked doors.  
The fear is for what is still to be lost.  
You may see nothing still to be lost.

Yet there is no day in her life on which I do not see her. (188)

I've puzzled over this last line. It seems to bespeak an impossibility, a vantage point from the present on the past that could not have existed, an ambiguous temporality.

*Blue Nights* reveals how, under the pressure of traumatic events, the discourse of risk—it can take the form of an admonition or the threat of catastrophe—can color all of one's experience: past, present, and future. Frailty comes to provide a key to understanding—everything. A conversion disorder is characterized by the transformation of mental conflict into bodily symptoms. This appears to be the case with the Didion of *Blue Nights*. But conversion also seems to travel in the other direction—from the very *prospect* of the breaking of bones (note that no bones had broken) to unrelenting psychological distress. With Didion it would seem that being at bodily risk exacerbates her anguish over the loss of her daughter (as well as the loss of her husband and friends), converting the *risk* of falling into tormenting guilt at—it seems almost a discovery—having utterly failed as a mother. “Was I the problem? Was I always the problem?” (33). “How could I have missed what was so clearly there to be seen?” (36). “Did I prefer not to hear what she was actually saying?” (133). *Blue Nights* is marked throughout by such self-lacerating rhetorical

questions. It is painful. Sometimes brutal. Reading *Blue Nights*, I can distinctly hear Didion's voice (she read passages from it in TV interviews) echoing in my mind. Her toneless voice registers a dismaying lack of affect even as she writes of grief and fear.<sup>11</sup> And of "severed emotional bonds" (11).

*Blue Nights* offers us a valuable description of what it feels like to be so vulnerable, palpably at risk at virtually every moment for what could be a disastrous fall—or anything else. Didion's description of the feeling of frailty—of frailty as a biological condition as well as a psychic (and social) condition—is especially important because the condition of frailty has not entered widespread personal, public, or political consciousness in the United States. A chronic condition rarely does, unless we suffer them ourselves or there are enormous amounts of money at stake in terms of selling pharmaceuticals or medical procedures, which brings me to the American economy and the next section of this essay. I should add that studies of frailty are framed by the larger context of research on longevity, which in turn brings us to demography, the study of populations, and in particular to population aging.

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How can we understand Joan Didion's account of her experience in terms of a discourse of national security at risk? In a vicious review of *Blue Nights* that appeared in *The Atlantic* in 2012, Caitlin Flanagan accuses Didion of the "crime" of getting old: "Ultimately Joan Didion's crime—artistic and personal—is the one of which all of us will eventually be convicted: she got old. Her writing got old, her perspective got old, her bag of tricks didn't work anymore."<sup>12</sup> Flanagan extends Didion's failure to all of us—if we live long enough. If we reduce Didion's narrative of her experience to a number, understanding her as representing an old body, one that no longer contributes meaningfully to the national economy ("her writing got old"), and if we aggregate the number of old people in the United States, we find a dominant discourse of risk in which aging figures prominently: the national economy at risk as it is inflected by the aging of the U.S. population, providing another frame in which to

understand *Blue Nights* and Flanagan's extreme response to it.

This profound demographic change—a dramatic increase in life expectancy since the turn of the twentieth century, coupled with a decrease in the birth rate—is one of the great achievements of modernity. Yet the aging of the population (an increase in the proportion of older people to those younger) is routinely and vociferously represented in the media and in policy proposals on the level of the nation as a source of ruinous weakness, soliciting what I call statistical panic that an aging society will not be able to successfully compete in a global economy.<sup>13</sup> The aging of the national population is represented as a catastrophe, with the elderly targeted both as its symptom and its toxic cause, and figured as an economic burden. What sociologist of aging Stephen Katz identified as “alarmist demography” in 1992, tracing such views back to Malthusian anxiety about population growth, is alive and well today.<sup>14</sup> Consider the following characteristic pronouncements about the condition of the United States economy: in an op-ed in the *New York Times* that appeared the day President Barack Obama signed the historic health care bill into law—it was March 23, 2010—what does David Brooks single out as the number one reason the “vigor” of the United States is threatened? The United States is “becoming geriatric,” Brooks writes.<sup>15</sup> Aggregating countries in the West, Ted Fishman, in a piece published in the *New York Times Magazine* in October 2010, puts it bluntly: “The high costs of keeping our aging population healthy and out of poverty has caused the United States and other rich democracies to lose their economic and political footing.” That same month the *New York Times* referred to the aging population as “The Financial Time Bomb of Longer Lives.”<sup>16</sup>

The contamination implied in “becoming geriatric” at the level of a national population resonates with a theory of biological aging at the molecular level, with the “accumulative waste theory of aging” serving as a chilling metaphor for the alleged potential destruction of a nation at the hands of population aging.<sup>17</sup> Population aging is singled out as the primary determinant of putting the United States at economic risk;

an aging America is represented as an America in decline. In terms of population aging, then, it could be said that from the point of view of neoliberalism, we are in pathological overproduction, overwhelming the national body, producing waste in a process akin to cancer.<sup>18</sup> An aging society is what I call the *hyper-risk society*. It is a society considered *out of balance* for maintaining a strong national security, which entails economic growth. In a mordant irony, what population could be said to be most at risk? Those who are old. Indeed, in a calculation of costs and benefits, people who live longer can be said to be *increasing their time at risk*. Living longer = increasing time at risk. This is literally how one letter writer to the *New Yorker* coldly put it, calculating cost. In a response to an article by the physician Atul Gawande showing how health costs could be reduced significantly by focusing on those who use medical services the most, Aaron Walton pointed out that benefits of such cost containment would be reduced because the patients would live longer, thus counteracting “their reduced frequency of hospitalization with an increase in their time at risk.” Clearly we must not allow the meaning of old age in general and the lives of older people to be cast in blunt-edged economic terms as if this were the only value at stake. The real challenge—it is a moral one—arises from the collision of the needs of the elderly with the values of neoliberal political economy, based as it is in great part on calculations of risk and the shift of risk from the state to the individual. Indeed, we might indict global capitalism for *disabling* entire populations of older people. The elderly are convicted of being unproductive in an economic sense and for consuming far too many resources, health care in particular.

In his biting installation *Nursing Home (L'Hospice)*, the French artist Gilles Barbier brilliantly captures this view of America as an exhausted power, its once famed superheroes now old and tired and incapacitated. Exhibited at the 2003 Whitney Museum show “The American Effect: Global Perspectives on the United States, 1993-2003,” the installation consists of six hyper-real life-size sculptures of American pop cultural figures—Wonder Woman, Superman, the Incredible Hulk, Mr. Fantastic,

Captain America, and Catwoman.<sup>19</sup> Heroes and heroines in their youth, they are now confined to wheelchairs and gurneys, unengaged with life, products whose shelf-life has expired (the statement accompanying the installation reads, “Superheroes represented in bodies aged to correspond to their copyright date”). Here we forcibly see portrayed the close association between aging and obsolescence in the United States. Imagine a tableau vivant of American authors—frail American authors in their late seventies, eighties, and nineties. In Caitlin Flanagan’s venomous view, Joan Didion would be one of them.

Political scientist Timothy Mitchell has recently argued that the post-World War II idea of the economy established a new kind of temporality, one in which the future is dominant. Growth—of the *economy*, not of resources or of populations—came to be considered preeminent for national security. Mitchell’s argument is both subtle and strong, and I cannot engage it here.<sup>20</sup> I do want to note, however, that he links the historical emergence of this idea of the economy—Mitchell deploys the term “economy” in analogy to the Foucauldian concept of governmentality—with the response of the United States government to quell the unprecedented labor struggles that occurred postwar, both in the United States and in other locations around the world. Today one of the perceived threats to national security is from population aging; the population is growing, but it is represented as the wrong kind of growth, ruinous growth. It should not come as a surprise that the economy has been described as frail. As Ben Eisen noted in the *Wall Street Journal’s MarketWatch* in June 2014, exuberance in the financial markets is incommensurate with the “frail economy.”

How can we understand the relation between population aging at the national level and the economic process known as globalization? As sociologist Brett Neilson writes in an essay on the biopolitics of aging and globalization, “population aging places a glacier-like pressure on the nation-state, slowly but surely eroding its centralized apparatuses for managing the production and reproduction of life” (163). The metaphor of glacialization is striking, pointing to the radically different

temporalities at stake in globalization and population aging. On the one hand, the temporality of globalization is future-oriented and associated with rapid change and the movement of goods and information and people; globalization is a process that is emerging.<sup>21</sup> On the other hand, population aging is associated with glacialization, with slowing down at the level of the nation-state, just as it is linked with slowing down on the biological level of the individual.<sup>22</sup>

There are contradictions here, however, that can only be understood through the lens of global capitalism. On the one hand, there is the national fear that the frail elderly (or the “unproductive” and useless elderly in general) will live too long, consuming far too many resources, health care in particular. Some might think Joan Didion one of them. Imagine: Joan Didion as a threat to the economy! On the other hand, there is the desire on the part of the globalized medical industrial complex to develop and market expensive drugs and treatments that can extend life expectancy, if only for relatively short amounts of time.<sup>23</sup> And where do the funds come from to develop these drugs and treatments? As the astute economist Robin Blackburn has pointed out, capital is derived in large part from the huge pension funds—so-called gray pension funds—that are accumulating in countries worldwide and are themselves at risk.

In the United States, frail older people are largely out of sight and out of mind even as they are identified as potent risk factors to our national security. They are largely immobile. Mobility and temporality are intimately related. Globalization is associated with movement of populations across national borders and with the young, while the frail elderly are by and large place-bound, immobile. A frail economy is one at risk. Of what? Of slowing down, of weakness, ultimately of mortality. I turn to my closing thoughts on disability and aging, through the lens of frailty.

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I was prompted to develop these reflections on frailty by Erin Lamb, who invited me to participate in a roundtable devoted to “Age and/as Disability” at the Modern Language Association’s 2014 convention. I

framed my brief remarks as addressing *aging* and *disability* through the lens of *frailty*, with *risk* a key component. My plan was to focus on the convergence of aging and disability, especially in relation to temporality and a certain experience of debility—frailty. But in expanding my short talk, I found it difficult to hold these four keywords together. “Disability” receded.

Interestingly enough, research in the social sciences reveals that older people rarely describe themselves as frail.<sup>24</sup> It thus strikes me as all the more remarkable that Joan Didion draws insistently on frailty to describe her experience. I regard her as courageous in addressing “this issue of frailty,” as she puts it. Granted, she is a powerful presence in American culture and so we might not have expected the stigma of frailty to be applied to her, as it so stridently is in Flanagan’s review.

I also find it fascinating that in *Blue Nights*, Didion never invokes the words “disabled” or “disability” to describe her condition, never mind as a dimension of her identity. Frailty and disability are kept strictly apart. And indeed I have come to conclude that frailty and disability should be separated as carefully as they can analytically.<sup>25</sup> Frailty as a biological condition and disability belong to different orders: in this small lexicon of two terms, frailty is an example of a disability. I also think that the word “disability” should be replaced by “impairment” when what is at stake is biological. Frailty is an impairment, just as is blindness; it is biological.

It is well known that in disability studies, aging and old age are often invoked as the horizon of disability.<sup>26</sup> In *Bending over Backwards*, for instance, Lennard Davis underscores the fact that everyone can become disabled, reminding us that the “baby boomer generation is fast heading toward disability” (4). One of the pernicious effects of this rhetorical rallying cry is the reinforcement of the damaging and dominant stereotype of aging as solely an experience of decline and diminishment, although I’m confident that is not the intent. It is altogether common to find the three terms—old age, frailty, and disability—often used interchangeably.<sup>27</sup> But these terms are not synonyms for each other.<sup>28</sup> They are unstable; they tend to multiply; *old age* is associated with *aging*, a process, not a

state, and *disability* is distinguished from an *impairment*. As a biomedical syndrome, frailty is not inevitable, even in the oldest old.<sup>29</sup> An older person can have an impairment—failing eyesight, for example—and not be frail. In terms of temporality, I am mindful of the important insight of Chris Gilleard and Paul Higgs. They point out that the temporality associated with aging is different from the “atemporality” associated with the representation of people who are disabled. “Although there is increasing interest in this history of disability and disability organisations,” they write, “the contextualization of disability has been set against social, not personal, time scales” (81).

The relationships among the three terms—frailty, disability understood as an impairment, and aging and old age (I am expanding old age here to include aging)—are all the more complex, not to say confusing, because they are all risk factors for each other and ultimately for mortality. They could be considered co-risk factors. Aging and old age are risk factors for frailty. A disability (for example, blindness) can be a risk factor for frailty (for falling, breaking a hip, and its aftermath). And frailty is a risk factor for other impairments. What emerges is the extent to which risk is the common denominator holding all of these terms together. Risk reverberates seemingly endlessly among all these variables, increasing—risk! As we have seen, Didion’s fear of the risk of falling intensifies her experience of the loss of her daughter. She comes to see her life as a series of risk factors, as do her doctors and others in her life. The discourse of risk intensifies statistical panic that our aging population will weaken our economy to the point of frailty.

The discourse of risk is totalizing. Risk is a noun, both hard as a rock and a mirage. Risk is a verb and seems to have a voracious life of its own, circulating everywhere, reproducing itself, autotelic, synthetic, polyvalent, swallowing everything up in its wake, impoverishing our experience. Risk is an adjective, creating risk factors out of virtually everything, including aging and old age, frailty, and disability. Risk requires a future to exist. But risk can radically foreshorten time. What Didion writes of the passing of time bears repeating: “this permanent slowing, this vanishing

resilience—multiplies, metastasizes, becomes your very life” (17).

## NOTES

<sup>1</sup> Frailty is not necessarily associated with old age. People may be frail at any age (frailty, for example, may be associated with such illnesses as anorexia and HIV/AIDS), and people who are chronologically among the very old—ninety and above—may not be frail.

<sup>2</sup> See Robine and Michel: “Frailty is a biologic syndrome of decreased resistance to stressors causing vulnerability to adverse outcomes, independently of disability and comorbidity” (595). For other accounts of frailty from biomedical fields, including public health, see Walter Bortz and Linda Fried; the latter article provides clear distinctions among the concepts of disability, frailty, and comorbidity. See as well philosopher Sally Gadow’s essay on aging.

<sup>3</sup> In her superb article “Construction of Frailty in the English Language,” Grenier studies the meaning of frailty in three different domains—the *Oxford English Dictionary*, academic research, and older women’s accounts. See also Grenier and Hadley: equating “frailty” in Canada with “homebound” in the United States, they argue that frailty is “a powerful discriminatory concept used to ration public services according to biomedical or functional classification” (213).

<sup>4</sup> Foucault summarizes: “I have studied the objectivizing of the subject in what I shall call ‘dividing practices.’ The subject is either divided inside himself or divided from others. This process objectivizes him. Examples are the mad and the sane, the sick and the healthy, the criminals and the ‘good boys’” (208). I would add that the subject can be divided both inside herself and from others.

<sup>5</sup> I am employing the distinction made in disability studies between an impairment and a disability: “impairment” refers to a corporeal limitation whereas a “disability” is socially constructed, with people unable to participate in the normal activities of society on an equal footing with others because of physical and social barriers.

<sup>6</sup> Stephen Kiernan offers these distinctions: “Health care is typically delivered using one of three clinical models: critical care, for people with traumatic injuries such as those from a car crash; acute care, for people in a physical crisis such as a heart attack; and chronic care, for people who have an ongoing illness that is not in crisis but requires sustained treatment and attention” (172).

<sup>7</sup> “Confidence,” psychologist Daniel Kahneman writes, “is a feeling, which reflects the coherence of the information and cognitive ease of processing it” (212).

<sup>8</sup> See Grenier and Hadley, who focus explicitly on the resistance of older women to being categorized as frail, including *collective* resistance.

<sup>9</sup> Risk appears in another frightening form for Didion; in April 2009, doctors, looking for something they never found, discovered instead an aneurysm at the base of her brain.

<sup>10</sup> The distinction between disease and illness can be mapped onto the distinction between corporeality and embodiment; see Gilleard and Higgs, especially the chapter on “Disability, Ageing and Identity.” See also medical anthropologist Annemarie Mol who, noting the distinction between disease and illness, critiques it, and focuses instead on practices, materialities, and events.

<sup>11</sup> See “Didion’s *Blue Nights*, A Memoir of Love and Loss,” *CBS News*.

<sup>12</sup> In Elizabeth Povinelli’s terms, we would say that Didion is accused of failure. Povinelli focuses on suffering that is “ordinary, chronic, and cruddy rather than catastrophic, crisis-laden, and sublime” (3); the experience of frailty could be considered such a form of suffering.

<sup>13</sup> See Woodward, *Statistical Panic*.

<sup>14</sup> Ellen Gee and Gloria Gutman have referred to this as “apocalyptic demography.”

<sup>15</sup> Interestingly enough, only two weeks later, in a piece entitled “Relax, We’ll Be Fine,” Brooks takes comfort from national comparisons, judging other nations to have more depressing futures because their populations will be older than that of the United States. “Over the next 40 years,” we read, “demographers estimate that the United States population will surge by an additional 100 million people, to 400 million over all. The population will be enterprising and relatively young. In 2050, only a quarter will be over 60, compared with 31 percent in China and 41 percent in Japan.” This is a perfect case of statistical *schadenfreude* on the level of the nation, the taking of satisfaction in what is understood as the worse situation of others.

<sup>16</sup> See Natasha Singer. As I argue in “From Virtual Cyborgs to Biological Time Bombs,” there is a gendered dimension to population aging, with older women representing a threat to capitalist culture. See the special issue of *Feminist Review* on frailty and debility (Wearing, Cunaratanam, and Gedalof).

<sup>17</sup> The entry for the accumulative waste theory of aging in the *Encyclopedia of Aging and Public Health* makes this explicit: after explaining the cellular theory of aging, author Jessica Diggs concludes, “As is a common theme in the prevention of cellular damage and aging, every individual (young and old) should strive to live a healthy lifestyle including regular physical activity and endurance training, with a balanced diet, rich in antioxidants and essential nutrients. Even small positive lifestyle modifications have the potential to result in significant improvements in the health, well-being, and longevity of our population” (75). While this kind of behavior will surely strike us as common sense, we must also be alert to the metaphor that underlies this advice: aging as the accumulation of waste, a metaphor that, as we have seen, easily maps onto aging at the level of a population and can work to produce policies inimical to the wellbeing of older people.

<sup>18</sup> In *Life as Surplus*, Melinda Cooper discusses the biological theories of the pathological (the cancerous cell is the paradigm) in the work of the early twentieth-century phenomenologist Aurel Kolnai, arguing that Kolnai understands that “the pathological production of surplus does in fact constitute a kind of life, [but] concludes that it is life devoid of any true productive power” (139). See also Cooper’s essay “Resuscitations: Stem Cells and the Crisis of Old Age.”

<sup>19</sup> For an image of *Nursing Home* at the Whitney Museum, see [nymag.com/nymetro/arts/art/reviews/n\\_8958/](http://nymag.com/nymetro/arts/art/reviews/n_8958/).

<sup>20</sup> The vocabulary I am using here is inadequate to Mitchell’s argument. I use the word “idea” of the economy; he carefully notes that the economy is not “a new object” (483); rather it is “an effect” (484).

<sup>21</sup> As Leerom Medovoi writes, “If the nation is emplotted by way of an origin, producing a useable past for a present-day national self, then the globe is emplotted by way

of a destination. The future orientation of this narrative is inherent in its form. We talk not about the ‘globe,’ but about the process of ‘globalizing’ or of ‘globalization’” (174).

<sup>22</sup> Neilson is not the only one to draw on this metaphor. In *Gray Dawn* Peter Peterson writes, “The challenge of global aging, like a massive iceberg, looms ahead in the future of the largest and most affluent economies of the world” (3).

<sup>23</sup> See Ted Anton on the financing of laboratory science of longevity over the last thirty years.

<sup>24</sup> See Grenier and Hadley who refer as well to Sharon Kaufman’s important work.

<sup>25</sup> Robine and Michel sketch a general theory of population aging, one that distinguishes between disability and frailty in relation to aging. To summarize if not oversimplify, *disability* is associated with “younger” older people (we might use the term “the third age,” although they do not) and, depending upon the national context, has been decreasing or increasing with chronological age, while *frailty*, a biological condition, is associated with the oldest old (or “the fourth age”). They point to new populations of older people—nonagenarians and centenarians. “At the oldest ages, from now on,” they write, “frailty is added to functional decline and comorbidity” (595).

<sup>26</sup> I advocate for not conflating frailty with disability. However, I also recognize how beneficial the material effects of the disability movement have been for an aging population, with universal design—consider curb cuts and electrically-powered doors—as a prime example.

<sup>27</sup> For a consideration of relationships among aging, disability, and frailty, see the first chapter of Susan Wendell’s *The Rejected Body*, where she addresses “the controversial question whether people with illnesses and people experiencing the frailties and limitations of old age should be considered disabled” (8): “When disability is carefully distinguished from the expected frailties of old age, we lose the main benefit of the insight that aging is disabling. That insight enables non-disabled people to realize that they are temporarily non-disabled, and that in turn enables them to see that it is in their own direct interest to structure society so that people with disabilities have good opportunities to participate in every aspect of social life” (19). Here Wendell is using “frailty” as a global term to refer to many possible infirmities, not frailty as a biological syndrome.

<sup>28</sup> I was chagrined to see that I came very close to doing exactly that in an essay published in 1984 under the title “Frailty and the Meanings of Literature”; I also tended to equate frailty and disease.

<sup>29</sup> Geriatrician Walter Bortz II concludes that “the state of frailty is largely separable from the process of aging and should thereby be susceptible to active intervention and reversal” (M283).

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