Care across Distance

7. SOME LIMITS OF CARING AT A DISTANCE
Aging and Transnational Care Arrangements between Suriname and the Netherlands

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THIS CHAPTER EXPLORES THE WAYS in which shifting practices and regimes of care across the disparate, though connected, spaces of Suriname and the Netherlands play a critical role in aging and older people's quality of life. Following Sarah Lamb (2007, 2009, 2013), my main objective is to examine how old age is organized in a migrant context, in which we see an ongoing transnational dispersal of individuals and families, a rising occurrence of living alone, a proliferation of old age and nursing homes, and, simultaneously, a deinstitutionalization of care of the elderly. Although older persons and providers of care are innovative agents in these processes of change (see, e.g., Lamb 2009), I argue that especially those who have problems reproducing their "traditional model" of aging and care increasingly experience social-emotional isolation, neglect, and loneliness in old age.

Contrary to anthropologists who challenge or counter ideas of abandonment and loss, particularly in institutional (government-run or market-based) care settings, I thus aim to stress the problems and predicaments of care that arise in transnational spaces and lives, leading to what I will call "the loneliness of aging." Some of my observations and thoughts are based on snippets of my own ethnographic fieldwork in Suriname performed between 2011 and 2015.[1] Others, especially those related to the Dutch situation, are mainly provoked by secondhand accounts and thus lack ethnographic thickness. To make a stronger argument, I therefore build heavily on ethnographic and theoretical work of other anthropologists, such as Diana Brown, Elana Buch, Michelle Ruth Gamburd, Arthur Kleinman, Sarah Lamb, and Anne-Mei The. In doing so, I show how emic cultural and moral imperatives to caregiving are challenged and how this, in turn, affects people's old age in both Suriname and the Netherlands.

This contribution probes people's ideas and expectations regarding how "best" to age and have "proper" care—and what happens when these expectations are not met. Although I do not want to impose my own ideas about what is right and good practice (see Kleinman in Fassin and Lézé 2014: 233, 256ff.), I do believe that questions of morality are critical to our understanding of aging and care. I therefore conclude this chapter with some thoughts on ethnographic research and ethics of care.

Who Cares? The Predicament of Aging

Worldwide, as Sarah Lamb (2009: xi) argues, "there has been a dramatic transformation, from the multigenerational family to the individual, the market and the state, as the key sites of aging and elder care." Such transitions entail remarkable shifts in the understanding of growing old, becoming frail, and the organization of care. This applies even more to the contemporary context of long-distance migration and the transnational dispersal of families. As I have encountered in my long-run fieldwork research in Suriname, many older persons have children and other relatives living abroad (many of them in the Netherlands, the Dutch Caribbean, or the United States), resulting in novel ways of organizing life, finding meaning, and receiving care in old age (see Lamb 2009). At the same time, numerous elderly migrants with a Surinamese background in the Netherlands are confronted with shifting care regimes and emerging trends of living alone.

These trends are not isolated, but connected through postcolonial geographies and transnational life-worlds and transactions. Due to their historical, colonial, and postcolonial ties, relations between Suriname and the Netherlands are strong. Large-scale migration waves, especially after the independence of Suriname in 1975, resulted in the presence of a large Surinamese-Dutch community in the Netherlands, in particular in big cities such as Amsterdam. Currently, of the approximately 850,000 to 900,000 Surinamese people, some 350,000 live in the Netherlands, half of whom were born in the Netherlands (they are the children of Surinamese who migrated to the Netherlands in the 1970s). Dispersal of families and people having relatives on both sides of the Atlantic is a well-known feature, resulting in much transnational movement between the two countries, including high physical mobility, economic remittances, transactions of material support and services, sociocultural exchanges, and partnerships.

In their transnational lives, Surinamese people are increasingly confronted with the predicaments of aging and care. Most of the immigrants

that came to the Netherlands in the 1970s have reached retirement age and are growing old with all its consequences. From the few quantitative studies conducted among these elderly immigrants, there emerges a pattern of underuse of healthcare services, chronic conditions, limitations in activities, and mental health problems (Denktaş 2011; Denktaş et al. 2009). It also appears that they are more likely to be at risk of poverty and social exclusion than nationals without a migrant background (Denktaş 2011; see also Smits et al. 2014). In addition, these studies stress that "the assumption that informal care through the family will remain a substantive part of care … may be wrong" (Denktaş 2011: 107). We will see that this has serious consequences for Surinamese first-generation migrants in the Netherlands. Yet, the observation also applies to the elderly in Suriname. As I will show, a rapidly growing group of elderly people (especially in the country's capital) is deprived of family-based care, and other forms of care are out of reach. A significant number of these people are retired returnees from the Netherlands.

Drawing on two ethnographic encounters from the field, I analyze how these precarious situations are shaped and linked across the disparate spaces of Suriname and the Netherlands, and how they relate to wider processes that contribute to the predicament of aging and care under globalizing conditions.

First Encounter: Stella's Burden

During my fieldwork in Suriname's capital, Paramaribo, in 2011, my friend Humphrey called. "Did you hear the news?" he asked. Something terrible had happened in his neighborhood. A forty-year-old man hanged himself after setting his mother's house on fire. In all probability, he wanted to be consumed by the flames, but the fire brigade was in time to save his lifeless body. The house, however, had been burnt out, leaving Humphrey's neighbor and childhood friend, Stella, with a dead son and a condemned house. Humphrey took care of the shocked woman, as almost none of her family members were around; most of them live abroad. One brother, who lives far away in West Suriname, managed to come within a few days. But he left after a short visit; he had to go back to work. Stella was therefore dependent on her overseas relatives and awaited their arrival. Eventually, eight family members came to Suriname from the Dutch Caribbean islands Curaçao and Aruba, and from the Netherlands, to finance and organize the funeral. A week after the burial, however, she was "on her own again." At least, that was what she said when her family members had left Suriname: "They helped me and Lloyd [her dead son] … spending a lot of money, but now I am on my own again: without a house, without personal belongings,

even without something that reminds me of the boy. I don't know what to do."

Second Encounter: Storytelling in Elderly Care

In 2012, I attended an expert meeting on "Storytelling and Empowerment" that took place in Amsterdam, the Netherlands. Amsterdam has a large Surinamese-Dutch community that faces a rising need for specific care facilities for its aging members, like nursing homes and hospices. The meeting was part of a larger project of the Dutch Storytelling Center that promotes the conscious use of storytelling in these institutions and their environment, with the aim of supporting social participation and the quality of life in vulnerable neighborhoods and districts, such as Amsterdam Southeast, a highly diverse area known for its relatively low standard of living, including silent poverty and social-emotional isolation of old people with a migrant background.[2] During a day of workshops, presentations, and stories, the practice of "compassionate listening" turned out to be crucial in understanding the power of storytelling as a method in elderly care. However, several participants, caregivers themselves, stressed that the time and means to put this into practice were limited, although they all felt a growing need to apply this approach. In the roundtable discussion on "Storytelling in Elderly Care," it transpired that half of the participants worked with elderly migrants with a Surinamese background. They all mentioned problems of loneliness, neglect, and alienation among them.

This observation is important, because it challenges common-sense beliefs about family intimacy and values of intergenerational care within so-called migrant communities. As I will show below, social-moral relations, as well as larger economic and political structures, are changing rapidly within and outside these communities, affecting both ideas about proper care and people's experiences of growing old. Despite relatively good medical care in homes for the elderly in the Netherlands, the quality of life of these migrants deteriorates progressively as they reach old age. Not infrequently they face social death.[3] But unlike the family members in Stella's case, their relatives are usually not abroad. According to some workshop participants, "*den pkin*" (these children) "dump" their parents in nursing homes and they feel "too uncomfortable to come and visit" on a regular basis. In their disapproval, the participants explicitly pointed to the quandary of institutional care: it often turns people into isolated, passive patients, taking away their responsibilities and joy of life. Of course, these experiences do not necessarily suggest that the practice of "dumping parents" is widespread, and the workshop participants' views may not be

widely accepted. Yet others describe similar trends (see The 2005 and note 3), which are part of larger processes that will be explored below.

The Myth of Family Care

How are the two aforementioned encounters linked? I recognize the ways in which they are different, of course. The first one involves a single event (principally affecting one single individual) that took place following the dramatic action of a psychiatrically disturbed person.[4] The second one involves many more actors and refers to a generalized situation that concerns a considerable number of people. The first takes place within the confines of family and neighborly relations. The second occurs in the context of an institutionalized care regime. The first is a clear instance of the precarious situation of care-over-distance, while the second involves the murkier notion of relatives who are physically close, but nevertheless fall short in care. Yet despite the differences, the two events are connected through postcolonial geographies and life-worlds, and they are both a consequence of societal transformations, changing social-moral relationships (see Lamb 2009), and shifting care regimes. To explore this link, we need to work through a series of shifts that has led to contemporary forms of aging where isolation and loneliness set in—even if unintentionally. But, first, we need to consider the concept of care itself.

Thinking Care

Care has different dimensions and meanings, which makes it a multilayered and cyclical concept. To care means to worry (being emotionally affected) or to care about; to take responsibility or to take care; to give care or to care for; and to receive care or to be cared about and to be cared for. Consequently, care is relational (asymmetrical or reciprocal) and a culturally constructed practice that is contained in an institutional context affected by various factors (social, economic, political, ethical) (see Tronto 1993). In that sense, care regime does not only refer to a set of political conditions and social intersections, ensuring complementarity between economic and demographic institutions and processes (Bettio and Plantenga 2004), but also to particular cultural models and values, norms, and assumptions derived from these (Lamb 2009). For example, Euro-Americans deem it normal, even normative, for children to be dependent on and cared for by their parents, but not necessarily for elderly parents to be heavily dependent on their adult children. Sarah Lamb (2009: 20) shows that for Indians the "prevalent cultural model … is that both

parents and children will care for each other reciprocally in turn: just as children are naturally and appropriately dependent on their parents when young, so are parents naturally and appropriately dependent on their children when old." We find this model in many parts of the world. For example, West Indians and many people with a Surinamese background share the same idea/ideal of reciprocal, mutual, and intergenerational care and dependency.

Hence, care is to a large extent the result of cultural norms, normative practices, and familial strategies. As such, care is not only a consequence of Foucauldian biopolitics in which the state (and the regime of the market-place, as we will see below) regulates the conduct and wellbeing of subjects both as a population and as individuals. Care is also part and parcel of familial regimes that normalize roles and relations of daughters, sons, and other relatives (see Ong 1999).[5] But there is the rub: under the force of modernization, individualization, and globalization—particularly mobility and migration—we witness a rapid decline of the joint family. This is what Sarah Lamb (2009) calls the crisis in families or, as I call it, the myth of (extended) family care: multigenerational joint families increasingly fracture into nuclear units, and a younger generation of children fails or refuses to care adequately for their parents. There are different, though often interconnected, reasons and motives for this. Because of transnational migration, children might be unable to provide care for their parents at home. But also when families are not (transatlantically) dispersed, children—in pursuit of individual growth, careers, and other more self-centered, materialistic ambitions—might be less likely to agree to care for their elders, especially in a shared family home. This does not mean that families simply do not care anymore; care might still be there, albeit transformed in novel ways, in new spaces of home and diaspora. "Myth" rather refers to an imaginary care situation or a relic from the near past that no longer can be realized, causing not only feelings of nostalgia and disappointment, but also social-emotional isolation, physical neglect, and severe loneliness.

Along the Surinamese-Dutch nexus, we then see that the aforementioned movements in space (postcolonial migration) and ideology (regarding family and generation) affect in one way or another previously "sacred" values, such as mutual care and intergenerational intimacy. Returning to Stella's case, we saw that Humphrey immediately took care of Stella. As she was homeless, he took her into his house. He was used to supporting her now and then, since Stella's small pension allowance was not enough to cover the vital means of existence. She was a retired head nurse, but holding an odd job (selling lottery tickets) to keep her head above water and to take care of her unemployed son, who was mentally ill. They lived together

until that day Humphrey caught her on her way home to inform her of the terrible news. From then onward, Stella stayed at Humphrey's place, while neighbors, friends, and colleagues dropped by to pay their respects and to help out a bit by bringing food, drinks, clothes, and funeral items. Stella's overseas relatives, in the meantime, were busy with the preparations for Lloyd's funeral. They were quite eager to make this ritual parting a success, spending a great amount of money on a surprisingly lavish funeral. "They never had very much interest in our *hebi's* [burdens] before," Stella entrusted to me one night.

The latter refers to a commonly expressed lament. Families, especially those with relatives abroad, often spend more money on funerals (postmortem care) than they do on care for poor, sick, elderly, or frail relatives (premortem care) (Van der Pijl 2016). Related to this, relatives do not necessarily continue care after the fulfillment of their ritual duties, leaving people like Stella, who could hardly make ends meet and was in poor health, alone. One sister insisted that Stella should come and live with her in the Netherlands, but not having a Dutch passport, this offer meant nothing more to Stella than a kind gesture (or a life in illegality). She was dependent on Humphrey's neighborly concern, which would not last forever. After a few weeks sharing his home with Stella, Humphrey wanted his privacy back. Moreover, commuting between the Netherlands and Suriname like many retired Surinamese migrants do, he was afraid that Stella would "squat" his property after he had left for the Netherlands. Ultimately, he found a cheap house in which Stella could stay for the time being, in the insecure expectation of the insurance indemnity that would compensate her for the loss of her burned-down house.

Despite the tragic character of her son's suicide and the loss of her house, Stella's situation does not represent an isolated case. Cultural imperatives to caregiving within the family remain strong, especially among less privileged or economically marginalized groups, and many older Surinamese persons still live with adult children in multigenerational homes. But this model is increasingly challenged by the erosion of families' capacities for such caregiving, particularly in urban areas like Greater Paramaribo, due to shrinking family size, inadequate housing, individualization, migration, and reduced numbers of potential caretakers (see Brown 2013; see also Gamburd 2013; Lamb 2013). For example, one of my research participants, Culvin Nerot, stayed alone after his wife died some ten years earlier. All his adult daughters lived in the Netherlands. When he had become frail, and having been hospitalized several times for a lung ailment and exhaustion, his daughters traveled back and forth to look after their father. But they had only limited time and money. At the age of 79, Culvin died alone.

During a research visit to Paramaribo in September–October 2015, I interviewed several directors of old age and nursing homes (both long-existing, often large-scale institutions and new, small-scale homes) and other professionals in elderly care. They all endorsed the above observations and expressed their worries about the growing number of elderly, frail people who do not have the support or means for proper care. They pointed repeatedly to vulnerable elders who are dependent on kin for material, emotional, and/or bodily support, but do not receive such family-based care (anymore). Their children and other relatives are either abroad or cannot or do not want to bear "the burden." Many of them lack the financial resources to pay for home care, let alone to put their elders in a market-based old age or nursing home. Furthermore, the notoriously bad conditions in the one and only public home in Paramaribo makes this state-based option an unacceptable alternative for many resource-poor people, leading to precarious cases of isolation, neglect, and abandonment. Consequently, Surinamese society is forced to respond to this absence of care. A Hindustani temple complex, for example, recently started a simple housing project for elderly citizens who are abandoned by their children at the pilgrimage site. Also, hospitals provide a form of "disguised elderly care," as one of my research participants called it. They have to deal increasingly with so-called *langliggers*—bedridden patients who have exhausted all treatment options, but who have nowhere to go.

Remigration and the rising demand for care of older returnees present another series of concerns and challenges. Increasingly, Surinamese-Dutch pensioners return, often without kin, to *switi Sranan* (sweet Suriname) to enjoy their old age. They come with nostalgic images and with small pensions. Usually they live independently with their spouse or on their own, without children, and outside of institutions. Sometimes they pay for home care to preserve their sense of independence. Yet problems arise when they need the kind of extended care that is required, for example, to treat a diagnosed (chronic) disease or to be supported in case of dementia. Many of my interviewees expressed their concerns about this relatively new group of elderly persons who are likely to slip through the safety net, since they are without kin, often not eligible for state support (having Dutch passports), and not necessarily in the financial position to seek private, market-based care. Interestingly, more and more professional caregivers active in private elderly care are returnees themselves—though still fit and healthy. They imagined during our conversations their own old age, wondering whether they would stay in Suriname or return to the Netherlands (where their children and grandchildren often live).

Considering all current developments, Suriname is facing a paradoxical situation. The combined pressure of greater longevity, chronic illness,

age-related diseases such as Alzheimer's, and the absence of adequate public-sector infrastructural support will increasingly place the burden of caregiving for dependent elders upon families. Yet, at the same time, families and individuals, especially daughters and wives, are less able or willing to take on this task. Although we see a proliferation of old age and nursing homes, these (private) alternatives are predominantly within the reach of the middle and upper cosmopolitan classes (see Brown 2013; Gamburd 2013; Lamb 2009, 2013), or of those supported by migrant family members sending remittances (see Hromadžić, this volume). Moreover, there is limited (state) financing available for end-of-life care.[6]

The resulting vulnerability of elderly citizens, especially of the lower classes, becomes apparent not only in the case of Suriname. A parallel structure links Stella's burden (First Encounter) to the predicaments of aging and elderly care in the Netherlands (Second Encounter). In this second case, we are beginning to sense the implications of neoliberal policies that shift the burden of health and elderly care from the state to individuals or informal (family) care, making both health and care more and more a private responsibility (e.g., Smits et al. 2014). At the same time, the myth of family care is also beginning to feature in Surinamese-Dutch migrant life-worlds and care practices. Hence the question looms: how will diasporic families, older migrants, and their children work out aging and elderly care in a context where cultural norms, family, and kinship structures are changing, and values such as individualism move center stage (see Lamb 2009)? In order to explore this further, we need to return to the core of the two ethnographic encounters—that is, the experience of social isolation and loneliness in old age.

The Loneliness of Aging

While people from Suriname have traditionally seen caring for aged parents in the family home as an obvious element of the reciprocal cycle, nowadays many have problems reproducing this cultural model of aging, care, and family life. Working adult children in the Netherlands who live alone, in a one-parent family, or a nuclear household have little time and/or space to take care of their elders (see Lamb 2007, 2009, 2013; see also The 2005: 51ff.). Especially women, who are expected to be the main caregivers for the elderly, face serious difficulties. In her study on aging in the Indian diaspora, Lamb (2009: 23) refers to the problem of the "sandwich generation": "adult women pressed like sandwich meat between two generations, struggling arduously to care simultaneously for both children and aging parents … while also pursuing careers." Single mothers, who are often

primary breadwinners, might experience the burden of this double care the most. As a result, fewer and fewer Surinamese-Dutch elders (will) live with their adult children in a multigenerational home—the arrangement still considered by the majority of Surinamese-Dutch people to be the most normal and proper form. Although many are opposed to old age homes ("in our culture, we do not dump our elderly in old people's homes"), the site of elder care is shifting from the family regime to the regime of the state and the market, entailing other kinds of moral, cultural, social, economic, and biopolitical principles (see Hromadžić, this volume).

Sometimes these new regimes of care coexist uneasily with older, familiar ones—for example, when people feel that one kind of care (intimacy, time) is substituted by another (efficiency, money) (see Lamb 2007). Yet we cannot simply equate state- and marked-based care with efficiency-driven, cheaply commoditized caregiving, just as we know that family regimes of care are not always warm and affectionate. Often we see a more complex picture of who provides loving care, and how and when; caregivers at institutions may be the persons giving kind attention, whereas relatives may be the ones whose love materializes as abandonment (see Mrs. Scharloo's case below; also see Thelen 2015). The chief problematic of institutionalized care in old age or nursing homes is its inherent cultural ambiguity. As Philip Stafford (2003: 8) argues, these homes possess "many features that draw from the more fundamental spatial and material pattern of the total institution [which] stands in stark contrast to another fundamental cultural pattern, that of home and the domestic environment." In the Netherlands, like in various other Northwestern European and North American societies, many old age homes and particularly nursing homes have evolved in the final decades of the twentieth century as medical models of care, in which the social body has often been transformed into a biological body (see Scheper-Hughes and Lock 1987) and the individual patient's problem has become principally a health problem—although the patient is not actually ill or in need of hospital care, but requires skilled nursing care (Stafford 2003: 5–6). Hence, these homes have become a major modern institution comparable to the total institution, as Erving Goffman (1961) and Jules Henry (1963) have pointed out. Furthermore, because of a rapid growth of technology and bureaucracy in medicine, these institutions have developed into sites of Foucauldian biopolitics or body politic (Scheper-Hughes and Lock 1987), exerting disciplinary control over the life of both the older individualized, bounded body and the aging population—that is, the collective, social body.

Various nursing home ethnographies showcase these processes of disciplining and the resulting helplessness, loneliness, social death, and inert liminality old people experience in "institutional prison-like settings" (Kao

2013: 28). These studies examine how each person's stay in a care home is seen, just like a patient's stay in a hospital, through the lens of "the passage of time"—that is, through the institutional demand to move through time with economic and clinical efficiency (Kaufman 2005: 7). To interpret the liminal position of elderly people who are—in the same way as hospitalized patients—abandoned in the "gray zone at the threshold of life and death" (Kaufman 2005: 1, 8), admission to care homes is even compared to Hertz's first burial or Turner's *communitas* (Henderson 2003: 154; Stafford 2003: 17–18). It is argued that residents of old age and nursing homes "are trapped in a liminal space between a lifetime of meaningful ritual passages, and death as the unwanted final rite of passage" (Kao 2013: 28–29). According to these ethnographies, the driving forces behind the resulting "mortification of self" (Goffman 1961) are invariably biomedicine, market-driven health care, individualism, and efficiency. Their general and quite somber aim is to document how and why persons (full life) come to be institutionalized patients and passive recipients of care (bare life). Anne-Mei The (2005), who did research in a Dutch nursing home for demented elderly people, uses the same approach and discourse, referring to the nursing home as "the waiting room of death," which is also the title of her ethnography.

However, alternative discourses emerge as well. They focus on new social environments and organizational settings for the elderly (Kao 2013: 29), such as person-centered, market-based resident and home care. These kinds of care are the result of growing private initiatives and recent policies favoring deinstitutionalization. In the Netherlands we are faced with policy-induced transitions from a welfare state to a society based on individual responsibility (participation society) and informal care (*mantelzorg*). Simultaneously, "increasingly well-educated and financially well-off elderly people wish to exert more control over their own lives [and deaths]" (Smits et al. 2014: 1). These trends are strongly associated with (the promotion of) autonomy, self-determination, and independence, which are also key terms in end-of-life issues and topics such as living wills (*niet-behandel verklaring*), palliative sedation, and euthanasia. However, elderly persons from lower classes "may have fewer options and have to rely more on relatives and the government" (Smits et al. 2014: 7). Moreover, in stressing autonomy, self-determination, independence, and, accordingly, the "individual body-self" (Scheper-Hughes and Lock 1987) as normative and also heuristic concepts for understanding, we tend to overlook other conceptions that influence the ways in which care is delivered, experienced, or desired (see Buch 2013).

Let us return once more to the second vignette to see what this means. It was indicated that, perhaps contrary to widespread beliefs, Surinamese

migrants in the Netherlands (will) increasingly spend their old age in nursing homes. At the same time, it appears that this non-family-based form of eldercare is often viewed ambivalently and is even perceived as abandonment. Both elderly and caregivers with a Surinamese background stress the downfall of cultural customs, values, beliefs, and a way of life that results in severe feelings of loss and desolation (see Lamb 2009, 2013; The 2005). The latter might involve mundane aspects of everyday life. For example, meals (strange, tasteless food) can evoke deep-rooted feelings of loss, nostalgia, and loneliness (see, e.g., Buch 2013). At a more abstract level, it addresses the "mortification" or "disculturation" (Goffman 1961) of migrant residents and the way they feel subject to particular ideological, normative, and sometimes ethnocentric constructions of care. In fact, residents with culturally different backgrounds often share a double experience of homelessness: both their institutionalization and "disculturation" might trigger feelings of alienation, particularly toward the end of life, and sometimes even more so when experiencing neurological changes such as dementia (see Taylor 2010; Lock 2013).

Alienation and loss systematically crop up in The's (2005) analysis of nursing home care in the Dutch "color changing society," as she calls it. Remarkably, Surinamese-Dutch caregivers in her ethnographic study state that migrant residents are visited more than their "autochthonous" housemates, because "for them it is natural to be taken care of by their family" (The 2005: 50).[7] Nevertheless, The (2005: 50ff.) also gives examples in which the opposite is the case and family members do not care at all. The case of Mrs. Scharloo ("Mrs. Scharloo gives up") is striking (The 2005: 72–87). Her children did not inform her about her impending admission to the nursing home. Mrs. Scharloo was angry with her children; she felt abandoned. From a cheerful old woman she became transformed into a depressed frail person, a patient who was medicated to ease her somberness. She refused to eat and drink. Meanwhile her children did not bother that much. Despite the efforts of the staff to improve her situation, she died not long after her arrival in the nursing home. Again, this is not an isolated case. Yvonne Penig, a Surinamese-Dutch professional caregiver who worked in various nursing homes, repeatedly emphasizes that elderly migrants "feel very lonely in these institutions." According to Penig, these feelings often result from different cultural preferences—for example, with regard to food and hygiene—that are not recognized by managers, caregivers and/or other residents (see interview mentioned in note 3).

These examples bring to mind the great work of the sociologist Norbert Elias ([1982] 1985). At the age of eighty, he wrote *The Loneliness of the Dying*, which focused on one of the greatest problems confronting modern

society: when death has become less familiar and people die in a more sanitized manner than ever before, the dying also remain in almost complete social and emotional isolation, experiencing extreme loneliness. Now, we are not only confronted with the loneliness of the dying, but the loneliness of old age—a condition many people fear toward the end of the long life they hope for. Of course, loneliness may be present through the whole lifespan, yet loneliness in old age seems more painful. This might be related to the frequently mentioned outcomes of market-driven and efficiency-based institutional care, reducing older people to objects of medical and professional gaze (see Biehl 2005; Buch 2013; Scheper-Hughes 2010; The 2005). However, especially for elderly migrants, the suffering also involves the turning away from a cultural practice of lifelong intergenerational family transfers and related values of mutual dependency or reciprocity. Such values are very different from non-family-based ideologies of aging and caregiving, which are grounded in a highly individualized, bounded conception of the body-self (see Scheper-Hughes and Lock 1987) and associated with the highly valued notions of independence, autonomy, and self-determination.

These notions are, moreover, increasingly incorporated into present-day understandings of care, as well as into popular discourses of successful, active, and healthy aging. Whereas dependency entails a loss of dignity and is more and more envisioned as a failure (Lamb 2013; Scheper-Hughes 2010), independency—normatively tied to conceptions of the body as bounded (Buch 2013)—seems to become an end in itself. Such an autonomy-centered approach of aging is likely to contribute to a polarizing paradigm of normality (healthy, active, and autonomous) and abnormality (frail, passive, and dependent). Its discourse categorizes old age, on the one hand, as affirmative, even productive, and on the other hand as negative, risky (costly), and lethal (see Saltes 2013). As a result, it neglects other appropriate visions and needs of human interdependency (Lamb 2009; 2013) that are also necessary ingredients of care (Buch 2013).

In her research on home care of older adults in Chicago, Buch (2013: 639) found that independency is "not so much a consequence of bounded bodies or self-determination but, rather, a deeply relational form of personhood." She argues that normative understandings of "independent persons as corporeally bounded" might threaten elders "whose bodies cannot sustain the façade of autonomy" (Buch 2013: 647). Her study shows how caregivers' bodies serve as extensions of elders' bodies "mediating social and material interactions so that elders could continue to shape their material worlds according to their will" (Buch 2013: 647). This is, of course, not only the responsibility of professional, paid caregivers, but also of informal caregivers in or outside institutional settings. The lack or loss of such

intimacy and, importantly, *interdependence* is precisely what caused the suffering of Stella, Mrs. Scharloo, and many others.

Buch (2013) pushes researchers in the field of aging and care to examine the role of bodily relations more carefully. It is my belief that, in addition, we should incorporate cross-cultural notions of bodily experience, subjectivity, and interdependence into the analysis of care situations (see, e.g., Hockey 2008). Furthermore, we should remain critical with regard to Foucault-inspired anthropological analytics. They usually tend to ignore "life force seeking" and generative forms of subjectivity (Biehl and Locke 2010: 335; see also Biehl 2005). Finally, if we consider aging and care to be more than just discourses or objects of institutional, medical, and familial gaze, we should include both questions of subjectivity and morality in our research.

Conclusion

This chapter explored how transformations in care regimes and care practices in the context of migration might lead to the isolation and loneliness of older persons. Objectification and depersonalization, as the products of cheaply commoditized caregiving, are often considered driving forces in these processes of change (see Scheper-Hughes 2010: 337). But trends related to overseas migration and the transnational dispersal of families also have considerable impact on the conditions and quality of living and dying in old age. By offering two ethnographic fragments, I hinted at some problems and predicaments of aging and care in two different though historically connected parts of the world: Suriname and the Netherlands. Dominant discourses, in both academic and popular fields, often consider family-based care as a feature of so-called developing nations, such as Suriname, while supposedly developed countries, like the Netherlands, have advanced to offer individual-, state-, and market-based eldercare options (Lamb 2013: 180; Lamb 2009: 250–251). However, this picture (whether it is true or not) is no longer tenable.

In Suriname, a country that is marked by migration and profound societal transformation, we see a growing need for non-family-based, formal (affordable) infrastructural support. Yet, this observation clashes with the "traditional" visions that people (particularly migrants or children of migrants who consider remigration) continue to cherish with regard to family intimacy and informal, neighborly care. In the Netherlands, on the other hand, the withdrawal of government funds is putting pressure both on older individuals who will seek market-based home and residential care, and on formal state-supported care institutions that have to accommodate

the less-well-to-do. Just as in Suriname, and in accordance with the rapid decline of the extended family worldwide, older Surinamese migrants increasingly cannot live with their adult children in a multigenerational home. Moreover, many of them migrated to the Netherlands at a later age, as a result of which they receive a relatively small old-age pension and live in relative poverty, even suffer in silence. This means that they have fewer options and, when informal care is lacking, they have to rely more on the whims of the state and the marketplace (Smits et al. 2014).

In spite of this somber analysis, elderly are of course also vitally involved in processes of social-cultural change: seniors engage in fashioning new modes of life for themselves and their relatives, as Lamb (2009) for example has shown in her study of Indian elders in India and abroad. In other words, although I presented some very harrowing examples, the people I write about are not reducible to bare life that easily (see Biehl and Locke 2010). Neither do nursing homes necessarily have to be "zones of social abandonment" (Scheper-Hughes 2010: 237). Lamb (2013, 2005) shows, for instance, that institutionalization in the case of Indian elders in India or abroad is not uniformly a negative experience (see also Rowles and High 2003; Stafford 2003: 18–19). Care is also not naturally opposed to technology (see Mol 2008: 5ff.), and the rise of new care arrangements like assisted living, residential care, cluster housing, and adult foster care (Stafford 2003: 19) may offer positive alternatives for the "institutional prison-like settings" (Kao 2013: 28) that many fear. Yet, these alternatives usually fall within the range of options of the financially well off and those who can claim their vital rights as citizens. Moreover, "interventions of governance and care [especially in resource-poor settings] remain epistemologically myopic and are not systematically structured to work *with* people and to incorporate their practical knowledge [and experience]" (Biehl and Locke 2010: 336). On the contrary, orthodoxies of care often remain institutionalized along with existing ideologies of aging. Due to this, institutions of care can be "twisted into instruments of power, [even] violence and abandonment" (Biehl and Locke 2013: 336). But if care practices shape care ethics, as Annemarie Mol and colleagues (2010) argue, it is through such practices that dominant and normative conceptions of care can be contested as well. Care is, after all, a relational practice, not a product.

In his more recent work, Arthur Kleinman (2009, 2012, 2013) appeals to such an understanding when he states "caregiving is a defining moral practice" (2009: 293). This aligns with current ethnographic research on care and caregiving, suggesting that questions of morality are critical to analyses of care (Buch 2013: 638). Buch (2013: 638) shows, for example, that caregiving generates new forms of morality and subjectivity "through

daily practices and … embodied, skillful expertise" and, hence, demands attention not only for people's lived experiences, as Kleinman (e.g., 1988) stressed decades ago, but also for human interdependency (see Lamb 2013). Caregiving, as Kleinman later on realized (resulting from his personal experience of caring for his wife, who suffers from Alzheimer's disease), is "a deeply interpersonal, relational practice" (2012: 1551), and is about "responsibility and emotional sensibility, even if it is also about technology, biomedical science and markets" (2013: 1377). A key aim of ethnography is then to understand these relational practices and interdependencies—or lack thereof—especially since caring at distance is clearly moving center stage, and different generations face the task to make their transnational care arrangements work.

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Notes

1. My fieldwork in Suriname dates back to 1999 and 2000, when I stayed, mostly, in Suriname's capital Paramaribo for Ph.D. research into death, dying, and disposal. Since then, I have returned for ongoing research. During my time there, I was confronted by the deteriorating situation of people in old age and have expanded my research activities to issues of aging and care.
2. In recent years I have been doing fieldwork in Amsterdam Southeast and its environs, including a long-term research project that focuses on the development of a multicultural funeral home.
3. See interview with Yvonne Penig, a Surinamese-Dutch residential counselor and professional caregiver in Amsterdam Southeast. "Eigen cultuur oudere migrant vergroot risico op eenzaamheid" (Own culture older migrant magnifies risks of loneliness), 20 November 2014, accessed 2 December 2016, https://www.samentegeneenzaamheid.nl/blog/strijders-tegen-eenzaamheid/eigen-cultuur-oudere-migrant-vergroot-risico-op-eenzaamheid.
4. But, as Bruce Kapferer (2010) notes, these atypical events or strange happenings might serve as a new point of origination producing aspects not seen before.
5. Michel Foucault uses "regime" to refer to power/knowledge schemes that seek to regulate and normalize power relations. These schemes define and control subjects and normalize their attitudes and behavior. Following Ong (1999), I apply this idea of regime not only to the operations of the state, but also to kinship and family, and

the marketplace. So, the regimes that will be considered throughout the rest of this chapter are the regime of the family, the regime of the state, and the regime of the market.

6. See "The Quality of Death: Ranking End-of-Life Care across the World" (2010), a report from the Economist Intelligence Unit, eiu.com, accessed 4 December 2016, http://www.eiu.com/sponsor/lienfoundation/qualityofdeath.

7. These nurses are quite critical of the Dutch system of institutional care. Holding onto the mythical Surinamese model of family intimacy and care, many of them express the wish to (re)migrate to Suriname to spend their old days over there in the midst of an imagined caring community.

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