Caring (in) Diaspora

Aging and caring experiences of older Turkish migrants in a Swedish context

Öncel Naldemirci

UNIVERSITY OF GOTHENBURG
DEPARTMENT OF SOCIOLOGY AND WORK SCIENCE

Abstract

This thesis investigates Turkish migrants' aging experiences and their understandings about care by concentrating on the accounts of a group of first-generation Turkish immigrants who settled in Sweden in the late 1960s and early 1970s. The aim is to explore how older immigrants' lives have been marked by the experience of migration and re-establishment in another country, how the impact of having once lost caring relations affected their decisions and desires about care in old age. This study examines some common patterns about aging in a host country, ideals of care in old age, encounters with medical institutions, interpretations of formal care facilities, and identity and community construction processes. Rather than generalizing and categorizing cultural, ethnic, or even religious expectations in the case of elderly care, it seeks to grasp the complexity of the migrants' ideals of care and caring relations by focusing on the positions they take in diaspora space. This study is based on ethnographic research which extended over two years (2011–2013). The empirical material consisted of observations and semi-structured in-depth interviews with 20 older Turkish people, 10 women and 10 men, who live in Sweden.

By focusing on medical care stories, the study highlights the importance of looking at previous experiences of being cared about and cared for in the deliberation of future care needs and expectations. By elucidating how older Turkish people understand formal care facilities such as home-help services and elderly care homes, the study underlines ambivalent attitudes towards these options. This ambivalence is anchored in ways of perceiving "the Swedish" as modern but uncaring as well as in their understandings of family members as caring others. The study also shows how the Turkish family is imagined and done through three emotions: *merhamet* (compassion/pity), *vefa* (loyalty/ faithfulness), and *şefkat* (concern/affection). Emotionalization of the family is not about reinforcing, but, rather, about negotiating the filial duty towards older parents. Of note is also that these emotions circulate inside and outside the family and that a caring diasporic community is imagined.

By exploring older Turkish migrants' experiences and understandings, this study contributes to the growing research field of care for people with a migration background. It critically assesses older Turkish immigrants' aging experiences, and their understandings about care options, not through cultural differences that are supposed to be unchanging and homogeneous, but based on the positions that they take in diaspora space. This study contributes by showing that, in order to understand the possible expectations of older migrants when it comes to decisions about and needs for care, it is crucial to consider their experience of having lived and aged in diaspora space. Designing, deliberating on, and deconstructing particular ideals of care become possible only if we take these experiential, mnemonic, and relational meaning-making processes into account.

Key words: Care, aging, diaspora, Turkish migration, emotions, family.

Contents

In the memory of my grandmother,
Cemile Yeşilova

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Introduction

In February 2012, in the middle of my fieldwork with first-generation Turkish immigrants[1] in Sweden, I was invited for the first time to the annual meeting of a network that aimed to gather older people from different ethnic communities to improve dialogue and collaboration on issues of special concern to older people in Sweden. The official theme of the day was to meet "young voices," to listen to young representatives of political parties. As "young voices" were absent and I was the only younger participant, the program had to be altered at the last minute. The presenter invited some participants from different communities onto the stage. Older participants took their places with some hesitation, but the mood was convivial. While they were preparing to talk about their experiences of being older, the presenter asked, "When did you come to Sweden?" and he continued, "Tell us about your first years in Sweden." First, a septuagenarian, originally from a Middle Eastern country, shared his life story. He was well known for his humorous way of storytelling and his story was artfully composed and performed. His ease was remarkable and his quick juxtaposition of anecdotes greatly entertained the audience. Obviously he had told the same stories many times. The next participant was apparently tired of telling her own story repeatedly and was impatient to answer the main question, which was about aging and everyday life. Thus, she gave only a short account of her immigration and early years in Sweden. The last participant was an ethnic Swede, and as he obviously had no immigration story to tell, the presenter immediately invited him to talk about his aging experience and political concerns about the age of retirement.

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[1] Throughout the book, the terms "migrants" and "immigrants" are used interchangeably. I also use "diasporic" when it comes to identities, discourses or practices enacted or imagined in diaspora space. As the focus of this research is on the first-generation Turkish immigrants, I use these terms to highlight the very experience of migration that they consider an important landmark in their sense of identity and life stories.

Older migrants have often been invited to narrate their migration stories in order to make their experiences, needs, and wishes intelligible to a wider audience. Attending this unplanned performance, I came to ponder my own research about my Turkish informants' aging and caring experiences. For a different purpose, I posed similar questions to my informants. I was interested in their life stories and migration within the scope of my research and I was also personally curious as a newly arrived immigrant. I also began to rethink how some people are continuously interpellated to give a coherent and performative life story that would legitimize their very presence in a particular narrative environment whereas some others are exempt from this narrative obligation. Migrants, regardless of their motivation behind their movement and/or mobility, are endlessly asked to tell their life stories as if to legitimize their emigration and immigration and contextualize their experiences, not only in social life and within institutional encounters, but also for research purposes.

However, when it comes to discourses, policies and practices about aging and care, there is some reluctance, if not resistance, to calling in life stories that have been marked by migration. The tendency in culturally competent or adjusted care is to presume that migrants' understandings and expectations are dictated by their culture. Moreover, as Sandra Torres (2006) argues, there is a tendency in both social research and policy to homogenize the older immigrants and attribute "special needs" to them, even though the empirical base for these concerns is limited. Instead, older immigrants, regardless of their biographies and of their differing positions in the society, are doomed to a "problematic" subjectivity.

The increase in the number of older people in Europe paved the way for debates and research concerning a wide range of topics about an aging population (cf. Phellas, 2013). Older migrants have also become increasingly visible in social policy and research. As Warnes et al. (2004) argued nearly a decade ago, the number of older people with a migration background and who are culturally and ethnically different from the host population has continued to increase. Like many European countries, Sweden faces the challenges of an aging population and increasing ethnic and cultural diversity. The migrant population in Sweden is relatively young compared to native Swedish people, but the number of foreign-born people aged 65 and over has increased over time and continues to increase (Albin and Albertsson, 2005). The heterogeneity of older migrants is based not only on their cultural and ethnic differences but also on a number of factors, from the age at migration to the levels of inclusion in the host society (Torres, 2012). One salient group of older migrants in Sweden is both European and non-

European labor migrants, since many who settled in Sweden in the 1960s and 1970s have started to reach older ages.

There is a rich and growing body of research about immigrants from Turkey in Europe, especially in countries like Germany and France, where most of the communities are located (see for instance Soysal, 1994; Abadan-Unat, 2002), and there is a wide range of research agendas, varying from changing family patterns to the second generation, from remittances to return migration. The scope of research about immigrants from Turkey in Sweden has also varied widely, including ethnographies (Engelbrektsson, 1978), urban segregation (Erder, 2006), health care encounters (Sachs, 1983; Bäärnhielm and Ekblad, 2000), changing family patterns (Akpinar, 1988, 1998), integration of the second generation (Eyrumlu, 1992; Engelbrektsson, 1995), and associational and political life in Sweden (Alpay, 1980). Research has also been done on different ethnic and religious communities originating from Turkey (cf. Björklund, 1981).

However, there has been limited research about Turkish immigrants' aging experiences in Sweden and their understandings about care options (an exception is Songur, 1992, cited in Torres, 2006). This study, by bearing in mind the heterogeneity of the immigrant community originating in Turkey (cf. Engelbrektsson, 1995) and the relevance of age on arrival in Sweden (cf. Torres, 2006), concentrates on the accounts of a group of first-generation Turkish immigrants, mainly labor migrants, who settled and aged in Sweden. It is worth noting at this point that in saying "Turkish immigrants" I am referring to my informants, who define themselves as Turkish. As different migratory life courses may lead to different understandings, expectations and senses of belonging at older ages, my focus is on self-defined Turkish labor migrants, who have not been directly expelled from Turkey because of their political engagements, ethnic, and/or religious identities and who have not been deprived of their rights to return to Turkey. Therefore, it comes to grips with a particular set of understandings and accounts rather than providing an overarching view of all immigrants in Sweden who emigrated from Turkey. However, it can help to elucidate some convergent ideas and understandings among a larger group of people who define themselves as Turkish.

The increasing ethnic and cultural diversity of the aging population will require gerontologists, social workers, policy-makers, and social scientists better understand and seriously consider how to formulate, design, and conduct research among older migrants. The increasing curiosity could reinforce culturalist and othering discourses and practices. To avoid this, examining the life course of older migrants would be more relevant and

insightful than belaboring the cultural and ethnic markers (Torres, 2008, 2012, 2013). As Warnes argued:

> Over the next three decades, if we are to understand the material, social and welfare circumstances of older people, it will increasingly be necessary to have knowledge of their biographies or individual life courses, for neither their country of residence nor their birth dates or last occupation will be as reliable predictors of their social and experiential positions as they were in the past (2006: 216).

Transnationalism has been studied as an important phenomenon that shapes migrants' biographies as well as their aging and caring experiences (cf. Bryceson and Vuorela, 2002; Baldassar, 2007; Zechner, 2008; Torres, 2013). This study, by harking back to discussions around diaspora, suggests that aging and caring experiences in diaspora space (Brah, 1996) also constitute an important source of information, and it seeks to contribute empirically to the literature about older migrants' understandings of their aging and caring experiences. It also reinforces the relevance of taking into consideration a wide range of identifications, positions, emotions, and ideals that have been shaped in diaspora space.

Caring (in) Diaspora, drawing upon accounts of a group of first-generation Turkish immigrants in Sweden, explores how cultural repertoires around caring about and caregiving are shaped in diaspora space, and which ideals, practices, and expectations of care emerge in their working out of options at the threshold of old age. It speaks by questioning how older immigrants' lives have been marked by the experience of migration and regrounding in another land, how the impact of having once lost caring relations has reinforced an aspiration to be "cared about" and "cared for," and how decisions and desires about care are discussed and understood in old age. This study explores first-generation Turkish immigrants' understandings about care at older ages. Rather than generalizing and categorizing cultural, ethnic, or even religious expectations in the case of elderly care, it seeks to grasp the complexity of their ideals of care and caring relations by focusing on the condition of diaspora.

In the remainder of this chapter, I will first articulate the aim and main research questions of this study. I will then briefly contextualize Turkish immigration to Sweden, and will also give a snapshot of elderly care in Sweden, referring to changes that have been made to it and significant challenges for migrant communities. Finally, I will describe the structure of this study.

Aim of the study

Caring (in) Diaspora lies at the intersection of migration and care studies and aims at understanding care in a migration context by taking emotions into consideration. This study seeks neither to document the "special needs" of Turkish elderly nor to provide a care plan to address their cultural expectations. It is, rather, an endeavor to make room for the voices of first-generation Turkish immigrants who have carved out new lives for themselves in Sweden, and to delineate some common patterns about aging in a host country, ideals of care in old age, encounters with formal care facilities and medical institutions, and identity and community construction processes. In doing so, I concentrate on the accounts of a small group of people who settled in Sweden before the more massive flow of immigration from Turkey began. The focus of this ethnographic research, which extended over two years (2011–2013), has been on the ideals of care in old age and on how my informants relate their long life stories, which are replete with individual and collective experiences of inclusion in, and exclusion from the host society, to their present and future expectations of care. It is, therefore, a kaleidoscope of their understandings and identifications rather than an exhaustive analysis of different care regimes and practices.

By exploring older Turkish migrants' ideas and understandings, this study contributes to the growing research field of care for people with a migration background. It critically assesses older Turkish immigrants' aging experiences, and their understandings about care options, not through cultural differences that are supposed to be unchanging and homogeneous, but based on the positions that they take in diaspora space. Another contribution of this study has been to explain Turkish immigrants' particular ways of "doing belonging" (Skrbiš et al., 2008) and understanding old age and care through an analysis of emotions that have a crucial place in their expectations and meaning-making processes.

Research questions

In order to understand how ideals of care, care relations, and responsibilities are negotiated by early-in-life Turkish immigrants, I formulated a set of research questions:

§ How do early-in-life Turkish immigrants make sense of their aging and caring experiences marked by migration and settlement in Sweden? What do they think about aging generally, and aging in Sweden in particular?

§ How do they experience old age, and how do they imagine their care needs and arrangements in the future? How do they assess their prospects of receiving elderly care in Sweden? Whom do they expect to care for them in old age?

§ How do first-generation Turkish immigrants understand, experience, and negotiate their sense of belonging to Sweden at older ages?

Turkish immigration to Sweden

Prominent Turkish associations in Sweden laid the groundwork for the celebration of the 50th anniversary of Turkish immigration to Sweden in 2015. Their milestone is the mid-1960s, the period in which Sweden became an immigration country. Recent immigration to Sweden started during the post-war period and accelerated in the late 1960s, mainly as labor force immigration. The majority of migrants to Sweden were from other Nordic countries, like Finland, and from the southern parts of Europe, however some came from Turkey. These migrants were part of the Turkish exodus to Europe in the late 1960s and early 1970s; while most went to Germany, where labor migration agreements had been made (cf. Abadan-Unat, 2002), some Turkish migrants chose Sweden as a destination where they would seek employment and a better life. Some traveled around the northwest European countries, partly as an adventure at the heart of Europe, a modern and industrial region that had captured their dreams and curiosity even before their emigration, and partly as a strategy to find the most receptive labor markets. Turkish migrants came to work in big industrial cities like Stockholm and Gothenburg, where they found jobs mainly in the manufacturing sector as blue collar workers (Alpay, 1980; Lundberg and Svanberg, 1991; Bäärnhielm et al., 2005). They were pioneers, launching a more massive immigration from Turkey in successive decades, through chain migration and unofficial channels of recruitment. Even though Sweden had signed a labor force agreement with Turkey in 1967, its effect was small and recruitment was mainly through unofficial networks (Alpay and Sarıaslan, 1984). This led to a relative homogeneity of Turkish migrants in terms of points of departure in Turkey. Kulu, a small town in Konya, in the Central Anatolia, for instance, was the home town of many immigrants who settled in Sweden (Lundberg, 1991). The heterogeneity of Turkish pioneers in the 1960s changed over time due to the chain migration organized around kinship networks that occurred later.

Relatively easy immigration to Sweden came to an end after 1972 (Westin, 2003), when Sweden suffered an economic crisis and increasing

unemployment rates. After 1975, immigration to Sweden became largely limited to family reunification of the former immigrants and asylum applications. In the 1980s, Kurdish and Assyrian people from Turkey came to Sweden as political and religious refugees, and this further diversified the community of Turkey-born migrants. Today, there is a highly heterogeneous community including individual students, highly skilled workers, refugees, large families originating from the same towns in Turkey, and descendants of more or less urban individual families.

After five decades, some of the first-generation Turkish immigrants have passed away, and some have returned to Turkey in their old age. When they arrived in Sweden many Turkish migrants were planning to return to Turkey after some years of work (Eyrumlu, 1992; Engelbrektsson, 1995); however a definitive return to Turkey has become improbable for many early-in-life immigrants. Deteriorating health (chronic illnesses, medical routines, familiarity with and appreciation of the Swedish health care system) has played a significant role in their decision, as well as their well-established families and the social and economic rights they have gained in Sweden. As health care is heavily subsidized in Sweden (Klinthäll, 2006) and old age may bring about frequent medical routines, less healthy people are more likely to stay in Sweden as they get older.

A snapshot of elderly care in Sweden

The Swedish welfare regime expanded and developed in the post-war era when the immigrant labor force started to contribute to the accumulation and redistribution of public savings and expenditures. As Swedish naturalization was relatively liberal (Castles et al., 1984) and the model citizen was the "citizen worker" (Hernes, 1988), many labor migrants who settled and worked in Sweden became entitled to permanent residence and citizenship (cf. Hammar, 1980). This increasing ethnic and cultural diversity started to pose new challenges to the way the Swedish welfare regime has been imagined. The welfare regime was shaped around the ideas of equality, solidarity, and social sharing and it was built on an imagined community whose members were supposed to have similar needs, rights, and duties. It was historically rooted in the political and cultural legacy of post-war social democracies. Therefore, a double agenda has been at stake: encouragement of a multicultural society and, at the same time, protection of a welfare system. The cultural heterogeneity of the Swedish society was compartmentalized into specific associations and regulated from above, through representatives (Ålund and Schierup, 1991). This

compartmentalization, while refining the ethnic and cultural boundaries of migrant communities, defined the limited points of entry to the imagined community. This double agenda has worked to functionally integrate immigrants. "Functional integration has been defined in terms of the immigrants' adaptation to the institutions, norms and culture of the 'majority society' to the extent 'necessary for the group's members to function in the society while at the same time keeping intact its own ethnic identity'" (Widgren, 1980: 75, cited in Ålund and Schierup, 1991: 14). Similarly, the formal care has been designed to increase the agency of older migrants and their participation in the Swedish society (Albin and Albertsson, 2005).

As Jamieson (1991) argues, "service provision and policies in all countries are formulated within the context of long-established welfare traditions which pervade attitudes and expectations and which have resulted in particular arrangements regarding the role of the state and the extent and criteria of welfare provision" (1991: 286–287). The Swedish welfare model is based on two basic principles, namely equality and solidarity (Johansson, 1991), which are rooted in Sweden's social democratic ideology. These principles are enacted to reinforce public and state responsibility for those who are in need of care. Accordingly, elderly care has become ideally and ideologically a public responsibility. It is also imagined to relieve women from caring duties and to allow for more personal and independent relationships between the elderly and their families (Blackman, 2000). Needless to say, it is also a vision that supports the ideal Swedish citizen as a "citizen worker" (Hernes, 1988) in the case of dependent family members and gender equality politics. In practice, this ideal of publicly assumed formal care has paved the way for a broad range of formal care facilities. Even though people continue to care for their next of kin with such care taking new forms (Johansson, 1991; Szebehely, 1998; Rauch, 2007), caregiving by family members has become less visible (Trydegård, 2000).

Defamilialization of care is thought to be one of the main characteristics of the Swedish welfare state (Bambra, 2007). It can be defined as "the degree to which individual adults can uphold a socially acceptable standard of living, independently of family relations, either through paid work or through social security provisions" (Lister, 1997: 173). Social services for dependents are publicly financed and regulated, and access to care services is based on citizenship rather than labor market participation (Esping-Andersen, 1990). This system not only helps women to "have the capacity to form independent households and (…) to engage in paid work" (Björnberg and Kollind, 2005) but also constitutes an ideal of family in which family members can negotiate their rights, responsibilities, and obligations.

Starting in the 1970s, home-help services have gained more attention and significance in elderly care provision. The ideal has been to support older individuals so that they can stay in their own homes as long as possible. This agenda of aging in place paved the way for public home-help services (*hemtjänst*). These services have been provided based on assessment of needs, and the scope and frequency of services have been decided accordingly (cf. Trydegård, 2000: 32–33). Public home-help services are designed in detail, according to the individual's care needs, and they are continuously assessed by experts. They also include a wide range of activities, from medical care to hands-on care, generously designed for the well-being of dependent individuals so that they remain autonomous *vis-à-vis* their family members, relatives, and friends.

When the ÄDEL reform in 1992 brought about an administrative reorganization of Swedish elderly care, long-term medical care of older people became a municipal responsibility (cf. Trydegård, 2000; Söderberg et al., 2012). However, since the 1990s, the financial assessment behind care provision has become more restrictive, and this has led to a more selective admission to residential and care homes, while home-based care has begun to be more emphasized than household services (Szebehely, 2005). These changes have started to restrict home-help services and admissions to care institutions to individuals with the greatest care needs (Trydegård and Thorslund, 2010). They have paved the way for the increase in privately funded elderly care alternatives, and a crystallization of class, gender, ethnicity, and education inequalities (Trydegård, 2000; Blomberg et al., 2000; Brodin, 2005) as well as increased expectations on adult children and other relatives (Szebehely, 1998; Rauch, 2007).

One significant impact of these changing trends on many migrant families is that they have little knowledge about the rules and regulations underlying the Swedish elderly care system (Forssell and Torres, 2012). As the assessment of needs requires knowledge, language skills (Olaison, 2009) and a particular type of social capital (Forsell, 2004), many have difficulty achieving eligibility. Moreover, the needs of older migrants are homogenized and understood as "special needs" since their main difference is assessed on their non-Swedishness (Torres, 2006; Forssell and Torres, 2012). Significant trends concerning older migrants includes the provision of special housing or care homes according to their ethnic and cultural backgrounds (cf. Emami et al., 2000; Heikkilä, 2004), provision of home-help services with culturally competent, native-speaking care workers, and employment of family members as caregivers.

Older Turkish migrants in Sweden

Older Turkish migrants in Sweden do not have widespread elderly care institutions where they can receive care in their native language (except for a special small elderly care unit in Rinkeby, Stockholm) unlike, for instance, the Finnish (cf. Heikkilä, 2004) and Iranian (cf. Emami et al, 2000) communities. While some Turkish older people employ their family members as caregivers through care grants, some others have turned to private companies to receive care from native-speaking Turkish home-help caregivers. There are two main reasons for this. The first is a demographic one; Turkish immigrants form a relatively small group among other migrant groups in Sweden, unlike the large Turkish communities in Germany and France (Murat, 2000). Moreover, as many first-generation Turkish immigrants were young when they arrived in Sweden, they have recently started to reach older ages, and those who are functionally impaired are mostly cared for at home by their families. The second reason is their ambivalent attitude towards formal care. I suggest that this attitude stems from different positionings in diaspora space. The very idea of formal care is still anchored in the way many people think about their families, society, and the welfare system in Sweden. In Sweden, care is imagined to be something that is publicly shared, that is the state ought to bear the main responsibility for providing care to individual citizens. As Jönsson et al. point out, "the historical background of welfare systems also means different attitudes towards state responsibility and intervention, involving different patterns of values and norms relating to family responsibilities and gender roles" (2011: 634).

The ideal of individuality and independence, at least from a family member in need of care, and the imagined availability of formal care facilities is where most of my Turkish informants consider themselves to have acquired the basic prerequisites of being modern, well-integrated immigrants in Sweden. By "imagined availability," I mean that many are unaware of changing patterns in bureaucratic and financial procedures, such as "the lack of service guarantee and the widespread use of restrictive admission tests" (Rauch, 2007: 260), the refamilialization of care to some extent, and increasing care work performed by family members. As the majority of my informants have not demanded any elderly care services from institutions, they envision elderly care based on their previous experiences and encounters with medical care institutions.

INTRODUCTION

By embracing the option of public care services and endorsing the ideal of self-reliance and independence in frail old age, my informants present themselves as modern, well-integrated, middle-class immigrants, similar to older Swedish people. They idealize both Swedish public elderly care and its clients. On the other hand, they also refer to this ideal of modern, independent, and individual family members as being detached, too individual and uncaring and at odds with their understanding of caring relations. Meanwhile, the solitude and high degree of individualism that they anticipate in old age haunt their idealization and pave the way for the doing of an "emotional" Turkish family. This ambivalent positioning becomes possible when they compare themselves to some other Turkish migrants who have not succeeded in emancipating themselves from oppressive and backward traditions and who still rigidly rely on their families, especially adult children. In other words, some of my informants, who present themselves as having succeeded in their long story of inclusion in the Swedish system, as having gained rights and knowledge and been good, modern parents with successful adult children, appear to be keen on having formal care in frail old age. Other informants with similar dispositions but who are in close relationships with those who are considered to be less successful ("backward") migrants are more cautious about the future.

Older people whom my informants may have encountered during their stays in Turkey are also seen as significant others, whose attitudes to family responsibilities and formal and informal care are harshly criticized in order to reinforce the modern values they have gained as immigrants in Sweden. Some see themselves as holders of a privileged position, which allows them to compare and contrast different care practices and institutions and simultaneously think about familial responsibilities, their rights to care, and their identities. The memory of Turkey and continuous relations with both it and Sweden bring about particular ways of understanding old age and care in old age. Let me briefly mention that health care policies in Turkey do not attempt to imagine and construct a strong alternative to relatives taking responsibility for the elderly. Thus, care centers, nursing homes, and home-help services for the elderly are neither abundant nor seen as alternatives to family care (Tufan, 2003). However, this very familialism, especially in the domain of care, is not an essential character of Turkish identity or culture; it has been discursively and historically constructed. During the building of the nation-state and the launching of the modernization project in Turkey, the family has been imagined by technocrats to fill the voids of the welfare state; it has been part of a political and economic agenda (Sirman, 2005). Family has been considered to be the ideal institution for the provision of care for

children, the elderly, the sick and disabled. Especially after recent health reforms undertaken to decrease health expenditures (Keyder et al., 2007), family has been reinforced as the "natural" environment for giving and receiving care.

Outline of the study

The following chapter will give the theoretical underpinnings of the ethnographic research upon which this dissertation is based. By suggesting a speculative play on words, "caring (in) diaspora", I discuss key contributions of care and diaspora studies to delineate how caring in the context of migration becomes important. I will also elaborate on *gurbet* – a concept widely discussed in the context of Turkish migration to Germany – as a "longing for belonging" (Ilcan, 2002), not only as dwelling in a new environment that is materially different from the place of departure but also a practice and wish to construct caring ties with new people, and an endeavor to feel "cared about." The main argument in this chapter is that the experience of distancing oneself from caring relations in a migration context brings about an emotional endeavor to embrace available others –institutions, other migrants, and friends – as caring relations.

The third chapter will delineate the methodological framework of the research by presenting methods, methodological reflections, and the fieldwork with 20 Turkish people who settled in an industrial city in Sweden in the 1960s and early 1970s, all of whom are now over 60. It will discuss the limits and advantages as well as ethical problems of conducting ethnography as a caring relationship. A discussion of narrative will show why a narrative approach is useful for understanding old age and elderly care.

The fourth chapter highlights how medical authorities in the country of settlement became primary actors in the quest for caring others. Many women were hospitalized briefly after they arrived in Sweden in the early 1970s when they gave birth. These hospitalizations were their first encounter with the health care system in Sweden. The women thought that the care they were given was drastically different from that in Turkey – caring and holistic. In the absence of caring family members, they emotionally invested in the medical teams that cared for them. Similarly, when they were ready to retire, mainly because of debilitating illness but also to take up their demanding caring responsibilities at home, doctors were available not only to mediate the process of disengagement from the labor market but also to listen to their life stories and care about them. These two lines of accounts point to a trust

relationship on which migrants dwell as they imagine their future health problems and care needs as well as their elderly care arrangements.

The fifth chapter, drawing upon informants' medical encounters at older ages, aims to decipher two main narratives. First, I show how the medicalization of old age has become influential in their understanding of themselves in old age and how it shapes their everyday lives in a positive way, allowing them to continue to exist in the social life in Sweden. Doctor visits, check-ups, hospitalizations – all of these invite them to partake in the public life, to come out of their closed environments. Second, by pointing to two men's stories, I discuss how belonging to and continuing to live in Sweden appears to be a medical necessity, an embracing of rights as rewards of their long participation in the labor force, and a good decision in calculating their needs in frail old age.

The sixth chapter points to the migrants' ambivalence towards using elderly care facilities. Medical care is widely and strongly trusted, and other care facilities, namely home-help services and care homes, are perceived as equal to medical care in terms of quality and availability. Embracing those as good options in frail old age becomes a way in which the migrants present themselves as modern and well-integrated by focusing on the independence they grant their children and thus explaining their openness to considering formal care. My informants consider themselves more modern than their counterparts in Turkey as well as some other Turkish migrants in Sweden, who, in their view, are backward and not modern enough. However, many affirm and hope that, despite their openness to formal care, their adult children would not let them actually use these care facilities, partly because they have been socialized to Turkish and Islamic values towards elderly care, but mainly because doing so would be at odds with their emotional way of doing the Turkish family in a migration context.

The seventh chapter treads another path and delineates how this Turkish family is done, through emotions that stick to particular moral subjectivities. *Merhamet* (compassion/pity), *vefa* (loyalty/faithfulness) and *şefkat* (concern/affection) were named by some informants as descriptive ways of understanding their expectations of their offspring and of their filial responsibilities in regard to elderly care. Adult children are said to have been socialized in a caring environment where they cultivated their moral subjectivities through these embodied emotions. In other words, for the first-generation Turkish immigrants, Swedishness is perceived as rooted in the modern, individual, and rational choice to praise formal elderly care facilities, whereas their Turkishness becomes apparent in their emotionalization of family and care responsibilities. Family care is not an

obligation imposed on their adult children; rather, it is deemed to be a response deriving from their emotional and moral subjectivity. Therein lies their perceived difference from native Swedish people.

The eighth chapter is a brief but important annex to the seventh chapter, explaining how these emotions are stretched outside the family and circulated to imagine a diasporic community around caring about each other. Drawing upon the story of an elderly man who was deprived of family care, it highlights an alternative way of aspiring to diaspora as a caring community in *gurbet*.

The final chapter contains a summary of the chapters, concluding remarks, and further discussion about caring (in) diaspora – not as a solution but a further question in seeking to understand older migrants' needs and expectations.

2
Theoretical Underpinnings: Caring (in) Diaspora

Introduction

"Caring (in) diaspora" is a dangerous play on words; it may easily lead us to romanticize diasporic communities as homogeneous ethnic, cultural, and religious enclaves where group members spontaneously engage in mutual care. It can also gloss over the traces of "diaspora space" (Brah, 1996), and the exclusionary and internally oppressive practices of community-building processes (Young, 1995), thereby reproducing hegemonic forms of belonging. Community building is a process that implies a plethora of practices, discourses, and imaginaries around inclusion and exclusion, belonging and non-belonging, solidarity and ostracism. Here, by putting forward the expression "caring (in) diaspora," I will delve into a specific theoretical discussion: rather than overestimating ethnic, cultural, religious, and historical ways of defining the boundaries of diasporic communities, I will pursue how experiences of "uprootings and regroundings"[2] (Ahmed et al., 2003) bring about a creative way of thinking about diasporic community around caring about and caring for each other. Migration removes people from their existing caring relations, and new collectivities can be imagined and built in the places of settlement. As Amit argues, "existing collectivities cannot always be reproduced, and efforts to mobilize new ones can fail, but the imagination of community is always fundamentally oriented towards the mobilization of social relations" (2002: 10). Care remains an important component in this imagination of community.

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[2] Ahmed et al. argue that "*Uprootings/Regroundings* is concerned with the ways in which different bodies and communities inhabit and move across familial, national and diasporic locations" (2003:1).

CARING (IN) DIASPORA

While "caring diaspora" is a tautological statement since every community, including diasporic communities, is imagined around differing degrees of caring responsibilities towards one another, "caring *in* diaspora" can envision the creation of a local, particular, caring attitude, practice, or disposition, one that derives from the remembered or actual hardships of being abroad, away from a (real or imagined) homeland. As the following chapters will discuss in detail, caring practices also stipulate ideals of good or good-enough care, which are partially distilled from previous experiences of being (or not being) cared about and for.

By using "caring (in) diaspora," I argue that the experience of having once distanced onseself and been away from caring relations in a migration context brings about an emotional and locally produced endeavor to embrace available others –institutions, other migrants, friends, or family members– as caring relations. Therefore, I use the term "care" to refer both to institutional care such as health care services and formal care facilities and caring relations between family members, friends, neighbors and people who inhabit diaspora space.

To explore this, I also focus on a specific term that is widely used by Turkish migrants for being abroad or away from home, *gurbet*. The term *gurbet* refers to a multifarious condition, as "the perceived state of exile and a longing for belonging" (Ilcan, 2002: 7). This not only affects the interpretation of present and future care needs but it also shapes the contours of how certain ideals of care are imagined, expressed, and circulated among older Turkish immigrants living in Sweden.

When it comes to defining and enacting elderly care for older people with a migration background, cultural differences and expectations are reduced to the agenda of multicultural sensitivity on behalf of the dominant cultural scripts and ideals of care. By ideals of care, I mean the complex set of expectations and practices of care that are deeply anchored in a particular social, economic, and political context. Previously, Hochschild (2003) analytically differentiated four ideals of care, traditional, postmodern, cold modern, and warm modern, to examine different actors and collaborations in the field of care and how these ideals are enacted in reality. While it is analytically helpful, this categorization is too neat for the bewildering array of intertwining expectations and interpretations that form the basis of what and how people really think about care.

In recent decades, culturally competent care has become a salient response to the diversity issue in multicultural Western societies. However, the difficulty remains that culture is not "an object to be described, neither is it a unified corpus of symbols and meanings that can be definitively

interpreted" (Clifford, 1986: 19). This becomes particularly clear in the context of care. While certain cultural patterns are demanded as an important component of caregiving and receiving, there are also significant divergences from the cultural norms, depending on biographies and contexts in which care encounters happen (see for instance Fereshteh, 2001; Torres, 2006). Even though cultural competence provides care professionals with some important guidelines, culturally competent care fails to do justice to "the messy, hidden and intangible dimensions of caring relationships" (Gunaratnam, 2008: 10).

I suggest that the condition of diaspora is a significant constituent of how particular ideals of care are created, challenged, appropriated, and/or rejected by people who dwell in diaspora spaces. Therefore, this chapter is an invitation to think about (the condition of) diaspora and (the ethics of) care not around abstract, philosophical debates, nor within pragmatic and policy-oriented goals, but as a political and moral possibility to understand how "caring" lies at the root of any diasporic imagination, and how this imagination is locally produced and reproduced and invoked when it comes to demands and ideals of care in old age. Designing, deliberating on, and deconstructing particular ideals of care become possible only if we take experiential, mnemonic, and relational meaning-making processes in diaspora spaces into account.

Sketching the contours of complexity

The broad definition of care as "a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible" (Tronto, 1998: 16) embraces a wide range of activities. There is a plethora of definitions and debates around care and it is difficult to give a single and exhaustive definition. As Fine argues, care "refers at once to an ideal set of values and a series of concrete practices" (2007: 2). On the one hand, care means disposition, concern, readiness to act for the well-being of another, and it also entails emotional labor. On the other hand, it consists of a wide range of concrete, physical, and sometimes professional practices. In this section, rather than narrowing down care into specific analytical categories, which I do later through my empirical material, I attempt to strategically collect and discuss some key contributions to theories of care in general, and feminist ethics of care in particular.

Revisiting care: Caring about and caring for

Care has been a contested subject since the early years of feminist struggles and scholarship. While some feminists embrace care as a practice or node where women develop their ethical subjectivities and knowledge (Gilligan, 1982; Noddings, 1984), others problematize the gendered dichotomy between ethics of care on the one hand and morality on the other, seeing that the feminization of care can lead to the further exploitation of women in reproductive and unpaid care work and the confinement of care to the private sphere (Tronto, 1993; Sevenhuijsen, 1998), whereas the public is reserved for abstract, disembodied, rational, and male morality.

Historically, care has been delegated to women, confined to the private sphere, and made invisible in the margins of the capitalist market economy. The inclusion of women in the labor market has neither eliminated women's caring responsibilities nor prevented their being inclined to enter professions that require caring attitudes and knowledge (Molinier, 2003). Therefore, initial theoretical and political struggles against the feminization of care have tried to render care visible and politically and economically important (Williams, 2004). The argument that "care is work" has been an important stance to be defended both theoretically and politically. The main response of relatively more women-friendly welfare regimes has been to institutionalize care and increase the social mechanisms for sharing caring responsibilities so that unpaid, mainly female, care work becomes visible and remunerated. In such regimes, public institutions have also alleviated women's caring responsibilities to some degree, and paved the way for women to take full-time jobs. "Care as work" has been and still is indicative of the extent to which reproductive labor is valued in a particular system.

Not necessarily at odds with the political agenda of this tradition, some feminist scholars have criticized the attempt to deem care only as work. Care obviously requires work, but it is more than work. As Finch and Groves (1983) argue, care involves a "labour of love" and cannot be reduced to physical, unidirectional activities between a caregiver and care recipient. Caring for someone can sometimes be traced to previous emotional attachment (Hollway, 2006) and it can also create strong bonds between the caregiver and the care receiver who have come to know each other through a caring relationship (Qureshi and Walker, 1989). This argument, rather than underestimating the importance of physical, technical, and knowledge-based care work, highlights the intersubjective, contextual, and multilayered aspects of care. Fine summarizes this discussion as follows:

> Necessary as the "labour of love" that care is, it cannot be reduced to the practical activity of the work involved in providing support. Neither can it be comprehended solely as an attribute of families or of close personal or professional-client relationships, or as an ideal form of personal commitment that does not have significant costs and dangers for all of the parties involved. Rather, care is a complex, contested, multilayered concept that refers not just to actions and activities, but to relationships and to values and attitudes about our responsibility for others and for our own being in the world. (2007: 4)

In order to apprehend the multilayered, complex, and intersubjective nature of care and the controversy between care as work and care as a labor of love, some scholars drew upon the special grammatical and semantic uses of the word "care" in the English language by distinguishing different patterns of care (Graham, 1983[2000]; Fisher and Tronto, 1990; Skeggs, 1997; Sevenhuijsen, 1998). Hilary Graham underlines "caring about" as concern for another by stipulating the act of caring as being about "human experiences which have to do with feeling concern for, and taking charge of, the well-being of others" (Graham, 1983[2000]: 13). That includes feelings of attachment, love, and a sense of moral and personal commitment. "Caring for" someone is mostly about the work and activities needed for his or her well-being, although Graham argues that these two do not always go hand-in hand. Similarly, Skeggs clearly separates "caring about" from "caring for":

> Caring *about* which involves social dispositions that operate at a personal level and assume a relationship between the carer and cared for, and caring *for* which involves the actual practice of caring, involving specific tasks such as lifting, cleaning and cooking, and does not necessarily relate to caring about. (original emphasis, 1997: 67)

Tronto (1993) adds new distinctions such as *caring about*, noticing the need to care in the first place; *taking care of*, assuming the responsibility for care; *care-giving*, the actual work of care that needs to be done; and *care-receiving*, the response of the recipient to the care provider. These distinct components of care entail specific dispositions such as attentiveness, responsibility, competence, and responsiveness. These elements are linked, and their separation can raise questions concerning the relative value of each (Fine, 2007: 36).

Caring about and caring for may not be interdependent, however; as Lynn Froggett points out, "both (caring for and caring about) are necessary but it is the latter that lifts caring out of the mire of condescension and abuse of power with which it has sometimes been tainted" (2002: 125). "Caring about" creates an ethical orientation to the world and others, and seeks to

undermine the power inequalities that can occur between the care giver and care receiver.

Moreover, care is rarely considered a unidirectional activity; rather, it is understood as an active, collaborative activity of relationships (Bowden, 1997; Lloyd, 2000). While investigating family responsibilities, Finch and Mason (1993) underline that the act of providing care creates a relationship between family members rather than family relations designating particular caring responsibilities. Similarly, Morgan coined the term "a caring nexus" to highlight how "the identities of women and gender are constructed and shaped within the caring process" (1996: 11). These critical assessments dismantle the neat categorization of care into "care for" and "care about" and highlight how these intermingle in the relational and contextual understanding of care.

For the last two decades, feminist scholars have discussed the ethics of care as a valuable analytical and theoretical framework used to make room for the complexity of care situations without reducing it to dichotomies, clear-cut solutions or rigid rules. According to "second wave[3]" theorists in the field of the ethics of care, like Joan Tronto and Selma Sevenhuijsen, care as a practice involves physical and emotional labor as well as ethical knowledge that can transcend the false dichotomy between the private and the public. This ethical knowledge that develops through relational, intersubjective, and contextual encounters should also have a say in political domains and in people's everyday lives. Feminist ethics of care have therefore been deployed to challenge the confinement of care into private, domestic, and gendered areas, while also questioning the dominant values such as independence and individualization that the patriarchal capitalist modernity endlessly implies as its unique and prestigious attributes and/or goals. These values are products of complex historical processes of social transformation and power relations (Fraser and Gordon, 1994). Independence runs counter to the reality of intertwining caring relations and practices. Contradicting this belief, the ethics of care stipulate that we are all interdependent in a society. Thus, ideas, discourses, and practices around care show how a particular community and membership in this community are imagined and built.

Following these discussions, I suggest here that how and by whom one wants and wishes to be cared for is rooted in how one has been cared about in society, in everyday life, and in institutions, and how one understands previous care encounters and ideals of good care that prevail in a particular

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[3] The "second wave" scholars in the ethics of care, by critically following Gilligan's work (1982), attempt to go beyond the ethics of care and the ethics of justice as a gendered binary (Williams, 2001).

context. In other words, care needs and ideals of good care are deeply rooted in the complex and ongoing processes of creating a sense of belonging. These processes are not only about personal feelings of being cared about, but they are also related to the emotional assessment of "caring for" experiences and projections in a social, legal, economic and institutional context. That is why it is extremely relevant to take individual experiences of being cared about and for into consideration in order to understand how particular care practices and ideals are assessed and understood.

Care and citizenship

Care has also been an important topic in debates concerning citizenship as a special type of community building. Who will care for whom, in which ways, and how this will be organized is discussed in relation to citizens' rights and duties. The now classical work of Thomas Marshall defines citizenship as full membership in a community, "a status bestowed on those who are full members of a community" (1950: 14). This membership is designed around rights and duties, but also the idea of a model citizen. The model citizen has been generally imagined to be independent, bodily integral, and disciplined, ready to cooperate with the productive forces as the citizen worker (Hernes, 1988) or the male wage earner (Pateman, 1988). Not all regimes marginalize and exclude citizens who are dependent on others. Social democratic welfare states in particular attempt to provide them with the formal care services to which they are entitled as citizens. As Knijn and Kremer underline, "despite a variety of care arrangements among welfare states, a common characteristic in the post-war period is that care was acknowledged as an important factor in citizens' well-being, and accordingly an important factor in social stability" (1997: 330).

Nevertheless, the ideal citizen remains the independent citizen, while the others (children, people who are ill, people in frail old age, and others who need care) are seen as deviations from this model. As theorists engaged with feminist politics and care issues underline, the ideal of independence is a myth. We are all dependent on each other, even though some dependences are not deemed as such (Fraser and Gordon, 1994; Knijn and Kremer, 1997; Sevenhuijsen, 2000). A working man's dependence on his wife is not considered to be dependence. Independence is nothing but a "male capitalist myth" (Fraser and Gordon, 1994) and in such a myth, dependency and care are seen to be obstacles to fully fledged citizenship, where women have long been prevented from fully participating in the labor market and from claiming full citizenship rights, and confined to private, domestic, emotional

spaces of care (Yuval-Davis, 1997). Even though they participate in the labor market, their "carer" citizenship is unseen. Nevertheless, living in a community means that we are interdependent on each other and care is one of the bases of this community. Rather than obscuring the reality of care, there is a continuous effort to challenge the ideology of independence. As Knijn and Kremer highlight:

> At some point within a citizen's life, people have to care for young children, and at other times close friends or elderly parents need personal care. Such demands of "significant others" can nowadays only be fulfilled at the cost of what is perceived as the most vital aspect of social citizenship: labor participation. Hence, caregiving leads to a reduction in citizenship status. Rather than focusing on labor-participation alone, we argue for a re-conceptualization of citizenship which acknowledges that every citizen will be a caregiver sometime in their life: all human beings were dependent on care when they were young, and will need care when they are ill, handicapped, or frail and old. Care is thus not a women's issue but a citizenship issue. (1997:332)

It is relevant to reconsider care as a citizenship issue since it can pave the way for a more inclusive way of imagining community, rather than prioritizing those whose dependences are unseen. This is an ongoing debate and political struggle which has already had many applications. However, this attempt does not directly answer the questions about whose care needs and ideals may be incorporated and how this "caring" stance will be taken into consideration within the imagination of a community.

Tronto criticizes the fact that care has long been confined to the field of privacy, to the particular, and to values, and deemed to be incompatible with "politics" (in the sense of what concerns the "polis"). However care goes beyond these false dichotomies of moral versus political, particular versus universal. Tronto's contribution is thought-provoking and worth quoting at length:

> As a type of activity, care requires a moral disposition and a type of moral conduct. We can express some of these qualities in the form of a universalist moral principle, such as: one should care for those around one or in one's society. Nevertheless, in order for these qualities to become part of moral conduct, *people must engage in both private and public practices that teach them, and reinforce their senses of, moral concerns.* In order to be created and sustained, then, an ethic of care relies upon a political commitment to value care and to reshape institutions to reflect that changed value. (my emphasis, 1993: 177–178)

How do different life experiences and subject positions reflect on private and public care practices? How do people with a different sense of belonging to the society bring their care ideals and practices into descriptions, discussions, and decisions? How is caring about another framed and how does it reflect on particular expectations and practices of caring for? As the critical contribution of Hollway (2006) highlights, this approach does not really delineate how, when, and why engaging in care practices will develop moral concerns. Hollway argues that "Tronto draws implicitly on a more simplistic model of social learning to account for moral conduct, reinforced with the idea that practice is a sufficient conveyor of moral values" (2006: 10). Here, following Hollway's discontentment with the unexamined assumption that all people would naturally and eventually care if existing boundaries were shifted, I argue that experiences of being cared about and for emanate from particular subject positions. Therefore, it is also relevant to concentrate on how diasporic subjects understand care, and how their citizenship and diasporic subjectivity intermingle when it comes to articulating an ideal of care. This ideal is anchored in their previous experiences of being cared for and cared about. This study, by drawing on first-generation Turkish migrants' memories, stories, and accounts of care, investigates how one thinks about and plans for care, caring relations, responsibilities, and facilities at the crossroads of these subject positions. Their life stories were marked by experiences of uprooting and (re)grounding, and a search for caring others in diaspora space. This leads to complex expectations of care which, in turn, shape their identifications, senses of belonging, and their continuous imagination of citizenship and diaspora as longing for belonging.

Like citizenship, ideals of care stem from a particular social imagination, become dominant in a specific context, and are translated into more or less defined practices, institutions, and actors. Many actual practices fall short of these ideals and it is easy to spot and problematize these shortages and misfits. However, it is also instructive to see how particular ideals are imagined and/or embraced by those who did not have a sense of belonging to the constituent community in the first place. One can ask the question: How are a social democratic welfare regime's ideals of good care for its welfare subjects imagined and/or experienced by foreign-born immigrants? Did this imagined scenario bring about an enhanced sense of belonging or was it met by a different interpretation of care institutions, practices, and ideals? In the next section, I will discuss how care is imagined in various ways and the relevance of understanding the imagination of those who are, or feel, included but differently from people in the mainstream of society.

Imagining care

All societies seek to arrange care, although it takes different forms; not all similar structural needs lead to the same care institutions, practices, and ideals, since those are imagined differently. The seminal work of Cornelius Castoriadis (1987, 1994) stipulates that structures and institutions do not stem from functional needs and rational considerations, but from social imaginations. The imagined qualities attributed to a collectivity are connected to the kind of social structures that arise and there is a central imaginary accompanied by peripheral imaginaries. Ideals of care also arise from a social imagination of collectivity, caring relations, and responsibilities. The central imagination of care in welfare regimes appears not only around preconditions like citizenship and labor participation but also around a particular affective economy where members of the collectivity are inclined to share common feelings such as respect, trust, and solidarity and "they are linked by reciprocity ties vis-à-vis common risks and similar needs" (Ferrera, 2005: 2).

Care encounters are replete with emotions, and how people come to feel and express these emotions is in constant dialogue with how they feel cared about by others, institutions, and society. However, we tend to gloss over or fail to see the variety of claims, experiences, and wishes underlying these emotions. For instance, in the following chapters, I discuss how my older informants came to trust Swedish health care, drawing upon their previous medical encounters. Trust can be named, and even longed for, as one of the dominant emotions that reveal a particular imagined relationship between citizens and the welfare institutions, a particular social imagination of formal care, not as customers, but as citizens, free from stigma and based on a balance of individual rights and social duties. A straightforward reading of older migrants' trust stories can lead to confusion about how dominant ways of imagining trust in institutionalized care come to be appropriated by people with different senses of belonging. A recently immigrated pregnant woman's attachment to a medical care team in the absence of caring family members and friends can be easily translated into a well-known discourse of the doctor-patient trust relationship, and as with every translation it loses some of the important traces of its creation. Or the experience of good care at a hospital can be translated as good-quality health care for citizens. It can be imagined as a citizenship right that is deserved after long years of labor participation, but, as is the case for some, it can also turn into an improved sense of belonging, and an example of well-accomplished incorporation into

the host society. Strong appreciation of medical care is rooted in the initial or continuing anxiety of not being cared about and in the gratitude for being cared for. Inconsistencies, divergences, and nuances can easily become unnoticeable and insignificant as soon as peripheral imaginations are contained by the dominant one. Looking after discursive and narrative traces of different understandings of care among migrant people not only offers crucial hints about future misunderstandings, frustrations, and expectations, it also highlights the limitations of particular imaginations of care relations.

The availability of good-quality public care and general health services has been the top echelon of the institutional welfare system (Esping-Andersen, 1990). While welfare systems, especially in the post-war context, were designed according to a generalized set of care needs within an imagined community, based on scientific knowledge, the changing population patterns have been assessed according to a hegemonic imagination. People from a migrant background are continuously invited to take part in this hegemonic imagination. Many willingly and unwillingly adapted to the system and started to express their care needs based on the template they were given. Similarly, the emergence of culturally competent care has been the indicator of successful multiculturalist policies, even as the cultural "rooms" into which people were invited have remained controversially narrow and underestimate the complexity of care needs. There is a tendency in both social research and policy to homogenize the elderly immigrants and attribute to them "special needs" even though there is a limited empirical base for these concerns (Torres, 2006). Instead, elderly immigrants, regardless of their biographies and their differing positions in society, are doomed to a "problematic" subjectivity. Elderly care for immigrants has been "problematized" (Torres, 2006) on different accounts. Several attempts have been made to improve the quality of care for people who are assumed to differ from the majority or the hegemonic in their demands, practices, and expectations. The empirical material presented in the following chapters sheds light on the fact that immigrants try in many different ways to make sense of their ideals of care.

Care in movement

Following the proliferation of scholarship about migration, transnationalism and transnational families, the array of complexities underlying caring relations has also grown rapidly. One significant research area has focused on the care chain, the care deficit, the migration of care workers, and the feminization of migration (Ehrenreich and Hochschild, 2003; Lutz, 2011).

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This area has shown how different care demands and ideals have collided into a global care economy where care has become a good that can be demanded and purchased. This global economy is based on the reproduction of particular gendered and racialized caring subject positions. Another salient field has investigated how transnational families are done and redone across borders around changing ideals and practices of care (Baldassar, 2001, 2007; Bryceson and Vuorela, 2002; Zechner, 2008). Globalization shaped different caringscapes[4] (McKie et al., 2002) through new technologies of communication and means of transport. These have also led to changing frequencies of transnational care visits. Transnational families are rethinking their caring responsibilities and conjuring up new practices.

As this idea of mobility has gained significance, less attention has been paid to caring relations, ideals, and practices that are locally produced and reproduced in diasporic communities. Transnational movements of goods, people, and information have challenged and transformed ways of understanding caring responsibilities and practices across borders. However, the local, situated relations and community-building processes cannot be reduced to long-distance mobility between two distinct locations between "here" and "there" (cf. Torres, 2013). Aspiring to a caring community or family also bears the traces of the local stories of distinct care relations mobilized "here."

In the next section, I will hark back to discussions around diaspora. While drawing inspiration from and minding the contributions of these intersecting research fields, I argue that by looking at ideals and practices of care among migrant groups, we can pursue an understanding of diasporic subjectivity without focusing only on mobility and transnational care practices. While transnationalism thoroughly examines contacts, activities, and mobilities across national borders (Portes et al., 1999; Basch et al., 1994), diaspora designates a "human phenomenon - lived and experienced" (Braziel and Mannur, 2003: 8). Doing so, I will neither deny the relevance of "pre-migration cultural frameworks" (Foner, 1997) nor the transnational mobility of people, ideas, values, and norms. Instead, I will aim to highlight how the memory, interpretation, and expectation of care encounters and caring relations away from the real or imagined homeland can be deployed as a way of claiming diasporic subjectivity.

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[4] This concept reflects on the ideas of landscape and changing patterns of conducting care work.

Diaspora

Diaspora is another key concept of this study. Diaspora has been a widely contested and debated concept that is used for "the dispersal throughout the world of a people with the same origin" (Ben- Rafael, 2013: 1). This dispersal is followed by a collective endeavor to adapt to a new environment by retaining a commitment to a homeland through mobilizing different practices of loyalty and claiming a distinctive collective identity. In this sense, diasporas have often been described as "exemplary communities of the transnational movement" (Tölölyan, 1991: 5). One salient contribution of diaspora studies has been to challenge the teleological, nation-state based, assimilationist story of difference (Brubaker, 2005). Diaspora as a concept has been helpful in making room for understanding cultural differences by studying both "roots and routes" (Clifford, 1997) and analyzing the "historical rift between locations of residence and locations of belonging" (Gilroy, 2000: 124). Therefore, it has brought about a different way of thinking about ethnicity and identity as processes, creating a multiplicity of belongings and identities. Diaspora has been a stance against fixed, substantialist explanations of ethnic differences.[5] Yasemin Soysal's opposition to the confinement of migrants to "ethnic arrangements, transactions, and belongings" (2000: 13) derives from the danger of underestimating the affiliation of migrants to the host society as post-national citizens by overestimating their community-building as subgroups. Parreñas and Siu argue that "migrants *always* experience a process of acculturation and belonging to their host societies. However, acculturation does not necessarily occur in opposition to diasporization" (2007: 4, emphasis in original).

One contested aspect of the term derives from the use of diaspora as a descriptive category (Safran, 1991; Cohen, 1997) and diaspora as a process (Gilroy, 1993; Clifford, 1994). While the former focuses on who, in which conditions, and why people dispersed from the same homeland get together in a new environment, the latter deals with how people come to understand their affiliations with different subject positions. Parreñas and Siu define diaspora in the latter tradition as

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[5] Some prominent scholars criticize such claims. Anthias, for instance, argues that "the perception of diasporas as breaking 'the ethnic spectacles' with which the world was previously viewed, may vastly underestimate the continuing attachment to the idea of ethnic and therefore particularist bonds, to a new reconstructed form of ethnic absolutism" (1998: 567).

> an ongoing and contested process of subject formation embedded in a set of cultural and social relations that are sustained simultaneously with the "homeland" (real or imagined), place of residence, and compatriots or coethnics dispersed elsewhere. (2007:1)

In line with this definition, I will continue to use "diaspora" to refer to an ongoing process, and as a condition of subject formation. Being diasporic challenges both the idea of a fixed identity, transferred from an "origin" to another environment, and the creation of an unpolluted oasis 'by retaining or (re)discovering substantial characteristics of a group of people. Being diasporic entails actively considering a plethora of sources, encounters, and actors and endeavoring to retain a sense of belonging. In Braziel and Mannur's words, as diaspora tends to be methodologically indistinct and ahistorical, it is quite significant to "giv(e) historical conditions that produce diasporic subjectivities" (2003:6). When Avtar Brah coined the term "diaspora space," she was after a more dynamic understanding of diaspora where different power positions, discourses and actors dwell on the same ground. She understands "diaspora space" as

> a conceptual category [that] is "inhabited" not only by those who have migrated and their descendants but equally by those who are constructed and represented as indigenous. In other words, the concept of *diaspora space* (as opposed to that of diaspora) includes the entanglement of the genealogies of dispersion with those of "staying put." (1996: 181)

Diaspora space is productive of meanings, positions, and points of entry into and differentiation from the host society. It can become a collectively assessed affiliation with or incorporation into the host society by evoking the points of inclusion and exclusion and the limits and possibilities of belonging. In other words, being diasporic in a specific context is about coming to terms with the host country's values, norms, and practices rather than accepting or rejecting them as they come. Diaspora space is where different power positions, cultural, emotional, and ethical scripts, norms, values, and practices are constantly deliberated. Therefore, building or aspiring to a diasporic community generates different interpretations and identifications.[6]

Diasporic communities can be imagined and/or built around a myriad of affiliations, practices, and ideas. People originating from the same homeland

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[6] By identification, I mean a call "upon to identify oneself –to characterize oneself, to locate oneself *vis-à-vis* known others, to situate oneself in a narrative, to place oneself in a category– in any number of different contexts." (Brubaker, 2004:41)

can develop a sense of belonging around a shared (hi)story of (im)migration, a cultural repertoire impregnated by folklore, religion, language, and a specific - or less specific - political agenda as well as transnational ties that continue to reshape the idea of a homeland. New ties in the country of settlement can be deployed through different channels for socialization, economic collaboration, political engagement for a cause in the home country, and struggle against social or institutional marginalization. The sense of community can be based on telling and remembering stories about here and there, past and present, through associations, cultural practices, commemorations, food (Marte, 2007), and religion (Vertovec, 2000). Diasporic communities can also be imagined where members care about each other as they withstand destitution, marginalization, and life's vicissitudes. This can both resist and reproduce hegemonic forms of community-building practices[7]. Caring about each other in diaspora can also be a way to think about more inclusive ways of belonging.

Emotions in diaspora space

Migration overwhelmingly changes the context of social relations, and as Ian Burkitt argues, "emotions have meaning only in the context of relations, involving active bodily states or feelings and the speech genres through which we attempt to articulate those feelings" (2002: 153). Migration brings about changes in how people understand and express their emotions. Not only do immigrants come to notice that their ways of expressing and feeling emotions are deeply entrenched in their cultural identity, but they also interpret emotional scripts they encounter in the host country. Transnational relations and flows of information, stories, and experiences lead to changing meanings of taken-for-granted emotions.

An increasing amount of research on transnationalism and migration has started to take emotions into consideration as a relevant source of information about identities and cultures (cf. Skrbiš and Svašek, 2007; Gray, 2008; Skrbiš, 2008, Svašek 2010). Some emotions that I discuss in this study are also created and endorsed transnationally and attempt to respond to local challenges. Transnationalism has become one of the major conceptualizations in migration studies since the 1990s, strongly linked to the discussions of globalization. It has been praised as a new concept, open to new interpretations of migration experience. Basch et al. define transnationalism as "the processes by which immigrants forge and sustain multi-stranded

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[7] For instance, Aylin Akpınar (1988, 1998) discusses how some Turkish women who got divorced in diaspora and were isolated by their families and friends.

social relations that link together their societies of origin and settlement (1994: 6)." These relationships may vary from remittances to gifts, from temporary visits to return migration, from diasporic mobilizations to new technologies of communication. However, transnationalism is also criticized (cf. Vertovec, 2001) since it covers too much but says too little. One important criticism is that researching transnational families only as imagined communities (Anderson, 1983), and neglecting concrete patterns (Hage, 2005) may cause a romanticized view of human mobility.

As Skrbiš and Svašek argue, "mobile individuals are tied to their families and friends 'back home,' but they also grow attachments to their new surroundings, learn to express feelings in new ways, and have particular hopes and expectations about what the future may bring" (2007: 373). The new surroundings, objects, and ways of doing in the host country as well as memories and information from the country of origin pave the way for a particular imagination, and diverse ways of feeling the world. In Hannerz's words, the multiplicity of experiences in diverse "habitats of meaning" (1996) in which people live lead to cultural repertoires which in their turn shape identities. In other words, in order to grasp what identities are sought and performed in transnational and/or diasporic communities, and what meanings circulate, it is crucial to come to grips with emotions. Emotions involve both meaning and feeling (Leavitt, 1996) in the sense that human beings not only feel bodily emotions but also make sense of specific social contexts through emotions. To put it simply, an immigrant not only adapts her everyday routines, such as cooking, eating, socializing and so forth, but also reconsiders the ways in which she feels, expresses, and understands her emotions in response to the new environment in which she lives and to new emotional scripts that are available. Leavitt mentions translation of emotions (1996: 531); it would be more significant to observe and document how certain emotions are transmuted from one context to another rather than translating them. That is why I attempt to keep all possible meanings open when I work on specific emotions such as *merhamet, vefa,* and *şefkat*. Rather than translating them, I try to see which subject positions they refer to, and how.

Diasporic communities are also conjured up and maintained through a special affective economy. According to Ahmed, "emotions define the contours of the multiple worlds that are inhabited by different subjects" (2004: 25) and "emotions do things, and work to align individuals with collectives" (2004: 26). Emotions shape the boundaries of the collective. What, for, and with whom emotions will be felt not only defines the boundaries of diasporic community but also generates an active

emotionalization of families, friendship, and relations with community members. In the seventh chapter, having been inspired by Ahmed's work (2004), I consider emotions as sticking to bodies and to collectivities in diaspora space, and I give a detailed analysis of how particular emotions are actively used to define the Turkish family in diaspora space, and respectively how these emotions are stretched and imagined to organize the Turkish community in a Swedish context. In other words, emotions not only mark the boundaries of a community but also actively seek to shape subject positions for members in the community. The native, the other, or the hegemonic come to be represented as being devoid of these emotions.

The experience of migration catalyzes a wide range of affects and emotions. In the first years of regrounding in a new environment, the local, sensible conditions such as cold/warm weather, different odors, and new foods are experienced. As Ahmed elaborates, "the immersion of a self in a locality is not simply about inhabiting an already constituted space (from which one could depart and remain the same). Rather, the locality intrudes into the senses: it defines what one smells, hears, touches, feels, remembers" (2000: 89). This intrusion is accompanied by dwelling on discursive categories. Many migrants seek to understand the ways in which they are hailed, they come to think about what "guest worker", "immigrant", "refugee" and even derogatory names mean in the specific context of settlement. The homeland becomes the example against which new encounters are interpreted. From loneliness to solidarity, from nostalgia to homing, a variety of emotions are felt and assessed among diasporic subjects, and this lies at the core of imagination and/or building a sense of belonging and community. Therefore, studying emotions can help us to challenge the essentialist and culturalist ways of defining diaspora. For instance, loyalty to the (real or imagined) homeland is a well-known emotion in diasporic and transnational communities. Loyalty is experienced and demonstrated via a wide range of transnational practices, such as regular visits, sending remittances, and maintaining transnational family and kinship ties. However, loyalty can also gain strength in diaspora space and come to define a Turkish family and a caring (diasporic) community. Here, I seek neither to underestimate practical, concrete, and politico-economic reasons and effects of diasporic community-building processes nor to romanticize people caring about each other in diaspora. Rather, I argue that these cannot be properly understood without the emotions they accompany.

Aspiring to a diasporic caring community for older immigrants is about enhancing their sense of belonging to a group of people who have gone through similar trials and tribulations and who live in the same place. This is

in accordance with Elspeth Probyn's (1996) definition of belonging as community building based on physical and emotional proximity rather than a common identity. Caring diaspora is therefore based on an aspiration to a sociality, communality, collective history, and connectivity (Joseph, 1993) rather than an expectation that their care needs will be adressed by this community. As will become clear later, strong aspirations for a caring diaspora also indicate the absence of a well-organized diasporic community.

Gurbet as condition of subjectivity

In this section, by focusing on the experience of being far away from home (*gurbet*) and feeling the consequent malaise, alienation, and sorrow (*gurbetlik*), I explain this experience as the herald of a diasporic community based on caring about each other. For many Turkish migrants, this feeling peaked in the early years of immigration and was maintained in the following years. *Gurbet* means, in Turkish, anyplace that is far from home. It is used to describe going away from home to a foreign place, often used to describe the Turkish exodus to Europe, mainly to Germany.[8] Suzan Ilcan describes *gurbet* as "a perceived state of exile and a longing for belonging" (2002: 7), therefore a sense of uprooting. As Levent Soysal highlights, *gurbet* is "nondescript, as in anywhere away from home" (2003: 495) and has become a popular theme in films, songs, and poetry and a generic name for the emotional burden of the separation, nostalgia, and homesickness among many Turkish migrants. Schiffauer (2007), focusing on first-generation migrants' religious sentiments, examines *gurbet* as "foreign" and describes its three main facets: first, *gurbet* is a fear of self-loss that consists of feelings and experience of disorientation. Second, it is about a crisis of meaning, deliberating the pros and cons of being in a foreign land. The third facet is about the fear of losing one's children in a foreign land in the sense that "one could no longer, as in Turkey, rely on one's children picking up one's own norms and values from the broader environment" (2007: 72).

Gurbetlik is also poetically used as the equivalent of nostalgia[9] and has been studied as a significant emotion to establish connections between here and there (Fortier, 2000) and between past and present (Mills, 2006) in

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[8] *Gurbet* does not only imply being abroad, in a foreign land. Even in the same country but away from the home or place of origin, one can be in *gurbet*. It is also widely used to refer to the rural-to-urban migration flows within Turkey.

[9] There is another common expression in Turkish for nostalgia, *sıla hasreti*, *sıla özlemi*. *Sıla* means home, home country, place of origin.

migration and diaspora studies. I understand it rather as an affective practice that is motivated by a strong "homing desire." Fortier elaborates "homing desires" drawing upon Brah's work (1996:180) as "desires to feel at home achieved by physically and symbolically (re)constituting spaces which provide some kind of ontological security in the context of migration" (2000:163). In this sense, *gurbetlik* is not only about dwelling in a new environment that is materially and socially different from the home but also consists of a desire to construct affective ties with new people, a longing, an endeavor to feel "cared about" in the new place of settlement. Feeling at home is intrinsically linked to feeling cared about. *Gurbetlik* can therefore be easily equated with *gariplik* (loneliness), having no one to turn to, homelessness, vagrancy, and a lack of caring relations. The experience of distancing oneself from caring relations in the context of migration, therefore, brings about an emotional endeavor to embrace available others –institutions, other migrants, family members, friends –as caring relations in diaspora space. Narrating hospitals as competent and caring institutions, doing and distinguishing Turkish family through emotions and their caring attributes, negotiating public care based on their ambivalent position to identify with the "uncaring" Swedish are therefore also rooted in migrants' understanding of *gurbet.* This feeling of *gurbetlik* is assumed to be shared by many Turkish immigrants, regardless of their backgrounds, thus it becomes a common resource to aspire to a caring community and to mobilize people to care about each other.

If the principal impetus to aspire to a caring diaspora is the experience of being uprooted from caring relations, why does being in *gurbet*, in a foreign land not bring migrants from different ethnic, cultural, and religious backgrounds? It is possible to juxtapose two main explanations for this question. First, imagining a diasporic community and doing belonging without recourse to ethnic, cultural, or religious identifications runs counter to the long histories of power relations and earlier socializations in diaspora space. However, as will appear later in the example about a Turkish seniors' home, the focus is not on the distinctive cultural or ethnic markers but on having immigrated in the same historical period and been in close proximity for years in Sweden. Second, cultural homogeneity is also desired by many immigrants for a successful homing experience. They also wish to get together around the very characteristics that render them different from the native Swedes and from other immigrants.

Conclusion

I started this chapter by evoking some dangers of using the idea of "caring (in) diaspora". Some can argue that this approach is romanticized and it covers over difficulties and problems of building and/or aspiring to a (diasporic) community around care. Others may rightly note that women will be assigned to be the main actors in many care activities organized around diaspora. However, I position caring (in) diaspora not as a solution but as an important question to investigate care relations, assumed care responsibilities, and ideals through the lived experiences of people who dwell within different senses of belonging.

If one wants to look at what increasing number of older migrants are willing to do in future, one should focus not on cultural differences but on their lived experiences, effects of the migration experience marked by homing desires, and their sense of belonging, constantly negotiated in diaspora spaces. This stance will show how, why and which ideals and practices of care are appreciated or contested.

How one hopes to be "cared for" is intricately related to how one feels "cared about" in society. Following San Juan, who argues that diaspora can herald a world that could "embody a peculiar sensibility enacting a caring and compassionate agenda for the whole species that thrives on cultural difference" (2001: 60), intertwining diaspora and care, as I do in this dissertation, enhances the way we understand cultural differences.

3
Methods and Methodological Reflections

Immigrating to a country and conducting research among communities of migrants of the "same" background, as an "insider", poses significant methodological questions. When I decided to conduct fieldwork among Turkish people who immigrated to Sweden early in life, I – as a young, male, newly arrived Turkish immigrant– stumbled through a myriad of methodological challenges. These were related to the age difference between me and my informants; the way we understand ethnicity, national identity, and our class backgrounds; and the lenses through which we look both at our country of settlement and our country of origin. However, I also knew beforehand that my particular personal situation as a newcomer from Turkey, a junior researcher who would spend at least four years in Sweden where I planned to conduct research, could initiate a complex and lasting relationship with my informants. At the same time, I was aware that my interest in their expectations and ideas about care at older ages would require that I establish a trust relationship with them. This led me to think more about advantages of ethnography as a methodology.

Conducting and writing up fieldwork entail critical awareness of the ethnographer's biography, position, and encounters with others. Kirsten Hastrup situates fieldwork "between autobiography and anthropology" since "it connects an important personal experience with a general field of knowledge" (1992: 117). I confess that the way I personally interpret my story of migration, homing desires, and encounters in Sweden has been significantly influenced by my informants' stories. For the first time, I was in a foreign land that was completely unfamiliar, where I would stay for a long time, away from my family and friends, I had not yet begun to establish a sense of belonging and continuity. I started my fieldwork while I was still

grappling with these autobiographical concerns, which were intensified as my older informants were constantly inviting me to judge and evaluate particular positions, ideas, and discourses in Sweden and to tell my own story of migration as a newcomer.

My aim here, however, is not to go into great detail about my own immigration to Sweden and confine my methodological reflection to telling a confessional and charming story of reflexivity. Reflexivity is regarded as "the constant awareness, assessment, and reassessment by the researcher of the researcher's own contribution/influence/shaping of intersubjective research and the consequent research findings" (Salzman, 2002: 104). However, reflexivity accounts tend to be author-centered and rarely offer transparency by acknowledging the parameters that might escape the researcher's consciousness. Therefore, my starting point is not "the self, but the field into which the ethnographer invests her powers of imagination" (Hastrup and Hervik, 1994: 2). I will depict how themes and methods of this study have been created intersubjectively between me and my informants. Interviews and informal conversations were mainly between two apparent subject positions: that of a well-established first generation Turkish migrant and of a young immigrant who is considering settling in their country of residence. These positions were far from monolithic and stable; they were continuously challenged, negotiated and restructured from one encounter to another. They were also cross-cut by diverse positionalities according to age, gender, and the cultural heritage we share. Karsten Paerregaard understands the ethnographic field "as an arena of intersubjective interaction in which the ethnographer and his or her informants struggle to impose social roles and cultural categories on the other, and ultimately deny his or her self-identity" (2002: 331). Social roles that my informants attributed to me and that I reflexively and sometimes willingly or strategically assumed paved the way for the emergence of themes that I had not expected to encounter and that helped me to better understand how and which stories are told and which positions were taken. I can neither separate this confrontational, dialogic aspect from my analysis nor deny its effects on me as a migrant researcher.

In the remainder of this chapter, I will explain the methodological framework of the research first by presenting how I set the field, the family of methods I used, and how our positioning and repositioning have reflected on data collection and analysis. Meanwhile, I will provide the details of the fieldwork I conducted with 20 Turkish people who had settled in Sweden in the 1960s and early 1970s and who are over the age of 60. I will also discuss the limits and advantages to, as well as ethical problems associated with positing ethnography as a caring relationship. A discussion of narrative will

show why and how a narrative approach is useful in understanding old age and elderly care.

Setting the field

Starting fieldwork entails time and patience, and even perseverance if the researcher is completely new to the field. Diasporic communities do not easily open their doors to outsiders, even if those outsiders happen to share the same country of origin, language and cultural habits. Thus, the fact that I was originally from Turkey did not present the possibilities of a field *per se*, even if I am competent in the Turkish language. As a new immigrant myself, I had no previous acquaintances nor relatives within the Turkish community in Sweden. In early 2010, a couple of months after my arrival, I started to participate in cultural events such as film screenings, talks, conferences, and national commemorations in order to get in contact with older Turkish people. I also went to some coffeehouses where mainly middle-aged and young Turkish men socialize and spend their spare time. People I talked to were friendly and welcoming but not very eager to put me in contact with their older friends or family members. In their eyes, I was a timid university student, and they were not keen on taking initiative for the sake of furthering my research. I also came to know about the Turkish association in the city where mostly younger people socialize and organize events. I started to check some on line Turkish newspapers on a daily basis. During these initial attempts to familiarize myself with the Turkish community in Sweden, it became very apparent that, although people had come from many different regions, many were members of larger families from particular towns in Turkey.

I gathered a great deal of information and many initial contacts, but as I was personally unknown to anyone, it was difficult to schedule further interviews or visits. I found that the immigrant and/or diasporic community seemed inviting to potential members; however, for further communication, especially for a study about care, caring practices, and responsibilities, I needed more time, or, ideally, an introduction by an already known member.

Key informants and other informants

In the middle of my initial attempts to make connections in the Turkish community, I came across the name of my first key informant in a book about Turkish immigrants in Sweden. I immediately recognized his name. We had met once in Istanbul and had a brief chat, but I did not know that he

lived in this specific Swedish city, nor was I sure that he would remember me. When I called him, he did remember me and we met for coffee in January 2011.

My key informant has lived in Sweden for more than 45 years, working as an interpreter from Turkish to Swedish. As he had migrated to Sweden in the early 1960s, he had become acquainted with the majority of the first-generation Turkish immigrants in this city. Meeting him was a significant turning point in my research. He welcomed my research since he and several friends and members of the community had been thinking about a project to provide older Turkish people with a seniors' home (*äldreboende*) where they could stay and receive care from Turkish-speaking care workers. This was an ongoing but unproductive discussion resulting in few concrete steps. He thought that my research was timely since, in a decade, there would be many older Turkish people in need of care and they would need to think more about elderly care arrangements outside their families. However, the small association that he and his friends had founded had difficulty organizing since few members were available for association activities. The main reason was that health problems prevented some members from being active, and some were reluctant to engage in this association because of previous unsuccessful attempts.

My informant was the first to point out some of the possibilities and difficulties that might arise in my research project about elderly care ideals and arrangements. For instance, having previously conducted fieldwork in an oncology unit in a hospital in Turkey (Naldemirci, 2009), I was eager to identify and then focus on a specific care home where older Turkish people were living. My informant warned me that there were few people in the community who were in frail old age and institutionalized. Moreover, most of those who were in formal institutions were suffering from severe physical ailments and/or dementia, and it would therefore be practically and ethically problematic to interview them. Nevertheless, he agreed to introduce me to some older Turkish people who might be interested in talking to me. My key informant was a knowledgeable and experienced man and we met at intervals. During these meetings, he asked me questions about how my research was going and helped me to correct some of my contextual misunderstandings.

A couple of days after our meeting, my informant asked some of his friends and acquaintances if they would agree to be interviewed, and he provided me with their telephone numbers. I started to call them individually, present myself and my research, and schedule visits with them. Starting in February 2011, approximately one year after I immigrated to Sweden, I was

regularly scheduling visits and interviews with 12 informants. During these first visits, the informants were surprised to see a young man in his late twenties. It was apparent that they had expected me to be a middle-aged university staff member and had prepared to receive me as a formal guest. My young appearance and timid entrance into their homes changed their formal tone. In their eyes, I was more a university student from Turkey, a guest, a young man who is in need of company than a researcher who wanted to interfere in their private lives. Some had already hosted and helped other Turkish students who had come to study in Swedish universities. This position contributed to shortening the ice-breaking phase but inevitably delayed the interviews since my hosts were more interested in learning about me than in being interviewed by me. During the interviews, I was also invited to give my opinions as a newcomer and to provide further information about how things were in Turkey. My informants mainly saw me as an educated, urban traveler from Turkey, and my interview questions were always followed by questions from them about what I thought as an "outsider" about things in Sweden. The tone of appreciation concerning health care in Sweden that I discuss in detail in the next chapters is anchored in this intersubjective arena.

My informants were a small group of first-generation Turkish migrants who emigrated from different cities in Turkey, including Istanbul, Izmir, Ankara, and Eskisehir. They had come to know each other in Sweden, unlike some later Turkish immigrants who came from the same cities or were affiliated with the same large families. They still keep in touch, even though they were meeting less regularly than in the past, mainly because of health problems. They had all engaged in manual or service work, but now they were retired and had economically self-sufficient households. They had adult children who had studied in Sweden and were employed in jobs either in Turkey or in Sweden. They saw the level of education of their adult children as an indicator of how modern and successful they were as migrants. It was known that many second-generation Turkish people did not or could not continue their studies (Eyrumlu, 1992). My urban background and university education, therefore, had an impact on how the informants wanted to present themselves to me as integrated, modern, middle-class people who had succeeded in their migrant life stories by having invested in raising and educating their children, so that their accomplishments equaled, or even surpassed, my own.

I was becoming more curious about the migrants' stories and their everyday lives. Needless to say, having very few friends in Sweden and few occasions to socialize, I was quite eager to visit them often. In the course of

time, I also started to participate in some of their daily and social activities when I was invited to do so. Long conversations over dinners and tea were full of names, stories, and details and were so instructive and thought-provoking that I was always tempted to schedule further interviews. Sometimes I was told about the city in the 1960s, sometimes I was taught how to manage a bureaucratic procedure in the Swedish bureaucracy, and sometimes I was told a story about the nickname of another informant or a recent check-up at the hospital. As we developed a relationship through my visits and phone calls, I was no longer only a researcher who dropped by for an interview but a young, unmarried, Turkish man who cared about these people and some started to care about me in return, which they demonstrated in many different ways. My female informants always sent me home with food. Even though I was not bad at cooking for myself, they never believed that I could do so, being a man. It was a gendered gift that I never refused. Some others offered help if I needed to go to the hospital since we were often discussing health care, and some gave me books that might be of interest in my research. I began to feel more "at home" with my fieldwork.

However, this feeling at home was not a straightforward and romanticized relationship with the field. I was obviously not assigned the role of either family member or well-known friend. Rather, my relationship with my informants was anchored in a specific diasporic positioning: we were like a community of outsiders with different degrees or senses of "outsiderness" in Sweden. I was not an insider in their local and collective history, but we assumed that we had gone through similar experiences of uprooting ourselves from families and friends, and of undergoing different stages of home-making in another country. Seeing me, a migrant living far away from my caring relations, often reminded them of their own early days in this city. "I was your age, even younger than you," I was told several times. When my informants were together, they mostly talked to each other, I was accepted as a "participant listener" (Forsey, 2010); when I was addressed in conversations, it was related either to this commonality that I share as a Turkish immigrant in Sweden or to my research. Ergun and Eydemir (2010) remind us of diverse ways of negotiating insider and outsider identities. In our case, we were mostly embracing commonalities of being in a foreign land (*gurbet*) by ignoring differences and topics that would disturb this sense and space of commonality. Turkey, as a template, was always implicit in our conversations but the focus was mostly about processes and difficulties on home-making here and now. Many avoided sensitive topics, in-depth political debates, and religious beliefs. One would think that the conversations I participated in were mostly superficial small talk, but coming

from a middle-class family, I knew how people talked about things without really talking about them. A short conversation about the receipt of a meal, for instance, could be interpreted as a long story of successful integration into Swedish society. Or a mundane discussion of finding cheap tickets to Turkey could turn into a longitudinal evaluation of transnational family ties.

A revelatory moment and new informants

The second turning point in setting my field was meeting one of my informants, this time a socially active and energetic woman. We first talked on the phone. As she lived alone and did not know me, she suggested we meet in a coffee shop for the first time rather than inviting me to her home. I was surprised since, up to this point, I had always met my informants in their homes. It was a "revelatory moment" (Trigger et al., 2012) in setting the field. Up until this meeting, I had mainly been in contact with couples and widowed or divorced men and I noticed that I had not had opportunities to meet with widowed or divorced women, not only because my gender position was an obstacle but also because my first key informant, consciously or unconsciously, must have wanted to avoid presenting me with these gendered boundaries.

As an early-in-life immigrant, this informant knew many people in the Turkish community, and after our ice-breaking chat in her favorite coffee shop, she decided to invite me to her home for a dinner with her family members. She also offered her help in contacting other informants, mainly women, who lived alone or with their adult children. She called her friends and acquaintances and accompanied me to their homes. Her presence was comforting both for me and the informants. I was more an unmarried young man away from my family (i.e *gurbet*) than a researcher in her eyes, and this drastically changed my position during the interviews that she initiated. My urban and educated background was less apparent and my solitude and lack of family members became more and more apparent.

Surprisingly, more people became willing to be informants and they also started to invite me to meetings, dinners, and social events. In the absence of well-established friendships and family, I was also eager to participate in these events and socialize with other Turkish people. I started to recognize family names, districts, practices, and stories that circulated among people. I had started to talk to people who had emigrated from less urban areas, and who had different family and kinship relations than the first group. I had also come to see more clearly rifts and convergences within the community.

As I have described, I met my informants through two key informants and snowballing. My first key informant was employed in a full-time job and never accompanied me to my informants' homes, whereas my second key informant was willing to come with me to first meetings to make sure that I was received well. Working with two different key informants helped me to reach informants from different regional backgrounds and family environments. The demographic predominance of migrants from Konya, a city in central Turkey, was balanced by migrants from other cities.

In referring to the people I interviewed, I prefer to use the term "informants" instead of "participants" or "respondents" because, as I was working in a completely unfamiliar context, I was informed by them not only in the research process but also in a broader sense as they helped to become a partial insider in the Turkish community and to become familiar with the Swedish context. As occurs in the course of any fieldwork, I met and listened to people other than my informants; friends and family members of my informants were often present during informal conversations and gatherings. However, I neither formally interviewed them nor neglected the contextual insights they gave me. During these gatherings, I still focused more on my informants' accounts, stories, and situated understandings. One exception is Aylin, a young woman in her twenties. She was born and raised in Sweden by Turkish parents and worked as a care worker. Not only did she provide me with contextual, practical details about elderly care in Sweden and the Turkish community, but she also accompanied me when I went to visit an elderly care home.

My main empirical material consists of observations and semi-structured in-depth interviews with 20 elderly Turkish residents, 10 women, and 10 men, who live in different districts in a former industrial city situated on the west coast of Sweden. All of my informants are over 60, with a considerable variation in age range. The women are generally younger than the men, most of whom are over 70. The common pattern is that men immigrated first, mainly as labor migrants, and the women got married before they emigrated and joined their husbands. All of the informants immigrated to Sweden during the late 1960s and early 1970s. They were retired and naturalized Swedish citizens, and they had chronic illnesses and were familiar with medical institutions in Sweden. All were mentally alert and willingly engaged in long conversations. I met them individually and in groups at intervals between 2011 and 2013. The fact that I reside close to my informants was an important facilitator in arranging meetings, as chronic illnesses, hospitalizations, and vacations postponed scheduled meetings and

interviews. Here, I will briefly present my informants with their pseudonyms, the following chapters will offer more detailed descriptions and accounts:

Pseudonym	Age	Gender	Notes
Selma	sixties	Woman	married to Adnan
Adnan	seventies	Man	married to Selma
Esma	late seventies	Woman	widow
Birgül	late sixties	Woman	married to Ahmet
Ahmet	seventies	Man	married to Birgül
Ibrahim	late sixties	Man	married
Cemil	late sixties	Man	divorced
Samet	eighties	Man	married
Seda	sixties	Woman	divorced
Mehmet	early eighties	Man	was living in an elderly care home; he passed away two weeks after my visit; I collected stories and accounts about him from Seda, Selma, and Aylin, who had come to know him
Zekeriya	late seventies	Man	divorced
Ayse	sixties	Woman	widow
Fatma	sixties	Woman	widow
Elif	sixties	Woman	widow
Melahat	seventies	Woman	widow
Memnune	seventies	Woman	widow
Hasan	late sixties	Man	married
Metin	late seventies	Man	divorced
Nalan	seventies	Woman	married to Abbas
Abbas	seventies	Man	married to Nalan

Ethnography as a caring relationship

In the beginning of my research, I had difficulty considering my research as truly ethnographic. It was true that in the very traditional sense, even in the Malinowskian tradition, I was conducting ethnography. I was far away from my home country, in a completely unfamiliar context, and I would spend even more time in the field than is conventional for fieldworkers. "Going

native" is a trite *leitmotiv* of ethnography. How native the researcher can become is one issue, and going native as a "native" is another one. On the one hand, I was an insider and supposed to know about some characteristics of the community, its language, culture, and religion, but on the other hand, in many ways I was an outsider to the community, but especially in my lack of information about the local history of the people living in it. In other words, for an outsider, I was already in the community and working with my "own" people, but at the same time I was an outsider, waiting at the door, yet to be included.

When I started to think through this ambiguous position, I came to ponder more the experiential character of ethnographic research. According to Hastrup, "the distinctiveness of ethnography lies precisely in its experiential character, which allows for a recognition of both difference and unity" (1995: x). On the one hand, I was invited to share in the experience of being abroad (*gurbet*), united in a space of commonality where we discussed our homing desires, our longing for caring relations, and sense of belonging, and our feelings of inclusion and exclusion. On the other hand, I was different from my informants, not only because I was ignorant of their local history in this city but also because our experiences of migration were different.

When Myerhoff, as a Jewish descendant, was conducting fieldwork with a group of Jewish elderly, she was experienced and dedicated to understanding others who are not really others. She highlighted that "identifying with the 'Other'- Indians, Chicanos, if one is Anglo, blacks if one is white, males if one is female- is an act of imagination, a means for discovering what one is not and will never be. Identifying with what one is now and will be someday is quite a different process" (1979: 18). While acknowledging the wisdom of Myerhoff, I was concerned about personally facing the types of difficulties of migrant life that my informants had described.

That is why I was also very curious about the life stories of my informants. I was not only interested in the specific answers to my interview questions, but also in their lived experiences, life stories, and aspects of everyday life that surrounded these answers. As Hammersley and Atkinson underline, ethnography

> usually involves the researcher participating, overtly and covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and arte-facts- in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry. (2007: 3)

As we engaged in more delicate relationships, I was more and more interested in documenting whatever data were available and reading the interviews in the light of my notes and experiences in these relationships. When I started to feel at home through initiating caring relationships with my older informants, I started to mull over how a diasporic community comes to imagine its boundaries not only through a shared culture, religion, and ethnicity but also around particular care ideals, practices, and responsibilities.

As Wax pointed out, it is in the "areas of mutual trust and sometimes, affection that the finest field work can be done" (1971: 373). A degree of affection and trust was established between me and my informants and this emotional resource was intrinsically abundant in the ways of understanding how they would like others to care about and for by them. Okley argues that "long-term immersion through fieldwork is generally a total experience, demanding all of the anthropologist's resources; intellectual, physical, emotional, political and intuitive. The experience involves so much of the self that it is impossible to reflect upon it fully by extracting that self" (1992: 8). I was very content with the large amount of empirical material I was given during my field work but also concerned about how I could analytically use this emotional relationship and my own experience. The very experience of being in a foreign land (*gurbet*) was obscuring the confrontational and dialectical process between me as researcher and my informants. In one way or another, I was brought into a homogeneous space as an insider regardless of my subject positions in the research process. This did not diminish our age, gender, and class differences but made them less visible and less important. Initially, our differences were minimized by our shared experience of having been uprooted from the same home country and replanted in a foreign land (*gurbet*).

Ganga and Scott argue that "interviewing within one's own cultural community –as an insider– affords researchers a degree of social proximity that, paradoxically, increases awareness amongst both researcher and participant of the social divisions that structure the interaction between them" (2006: 1). I found this to be true and I intended to demystify this very social proximity by harking back to this condition of diaspora and using the self that I developed during my fieldwork as a way to understand my informants' accounts and stories about care. In other words, without denying or ignoring differences between me and them, nor the differences among my informants in terms of class, place of origin, education, and so forth, I came to think more about how these differences were bracketed under the experience of being away from the imagined home country, how people who would not

have cared about each other in another context had come to embrace each other in *gurbet*. As my fieldwork initiated a caring relationship between me and my informants, it also made it possible to trace this relationship to a much more collective experience of migration.

Nevertheless, positing ethnography as a caring relationship brought about many limitations and methodological problems as well. This caring relationship inevitably limited my repositioning in the ongoing field relationship and I began claiming an ideal subject position where I tried to present myself as a loyal, understanding, caring, and respectful young man. Most of the time, I truly cared about my informants, but I was also aware of my limitations. Sometimes I was unwillingly helping them to reproduce some hegemonic forms of belonging as well as some positions in diaspora space, such as imagining the Turkish family as emotional, essentially caring, and different from other types of family. From this position, I started to avoid sharp questions that might disturb informants in their sense and performance of identity, and this might have paved the way for their overestimation and romanticization of some family patterns and values.

Even though this relationship helped to overcome the ethical problems of "compassionate ageism" (Friedan, 1993: 50) because my informants were inclined to be compassionate towards me since I had adopted the position of an inexperienced immigrant who was seeking to establish himself in a foreign land and therefore ought to be informed, I could not find the ways to challenge my position of a "mascot researcher" (Adams, 1999). As my inquiry entailed a degree of access to the private lives of individuals and groups, their family life, their desires and frustrations, I continuously had to be self-reflexive about my position in the field. Ethnography as a caring relationship led me to be emotionally responsive to their demands for privacy and their cultural expectations of a young researcher. For instance, although my young age was an advantage when it came to being allowed to listen to gendered accounts, such as birth-giving stories, which were not generally shared with men, I also had to refrain from asking more detailed questions, not only because I was a man but I also did not want to seem disrespectful.

Therefore, my writing process consisted of two main endeavors: highlighting how increasing knowledge became possible through this caring relationship and also how this knowledge is situated in a particular diasporic imagination. This knowledge not only informs my study but also constitutes how I understand a significant turning point in my autobiography. The self-reflexivity of a migrant researcher transcends the confessional aspects of epistemology and creates pathways to an ontological stance where the researcher starts to understand his or her own experience as a migrant.

Methods

I considered semi-structured interviews to be a suitable method of ethnographic data gathering, which provide a good starting point from which I could begin to understand how my informants thought about care in old age, caring relations, and elderly care facilities around some specific themes, and would allow them to talk about these things in their own words. I identified a list of topics in advance, such as experience of age, family relations, formal care facilities, and decisions in old age. However, I also allowed informants to bring in themes that they deemed significant. I was not initially inclined to systematically collect life stories; however, many informants chose to tell me, a new migrant, their life stories. Their answers to specific questions about care were shaped and expressed in relation to their life stories. Therefore, I used a narrative approach and paid attention to how they related their life stories to particular questions of migration, old age, care, and care practices. I was also concerned that some older people who lived in close proximity to their families, friends, and neighbors might be reluctant to answer structured, in-depth, individual interview questions, yet some were eager to talk in dialogue with their family members or close friends. This led to focus group interviews and helped me to see how a particular repertoire of ideals and practices of care were discussed. I also paid specific attention to the narrative environments (Gubrium and Holstein, 2009) in which stories were told. I took notes during and after interviews, informal conversations, social events, and meetings. These provided me with more contextual information and reminded my informants that I was a researcher. For some sensitive issues, I asked if I could note and use the interview material, and acted according to the informants' wishes.

I gave informants information about the research plan and anonymity before the interview. I also asked permission to include some additional details that had been expressed outside the recorded interview. All but one expressed a preference for anonymity, and therefore all names used in this study are pseudonyms. To further strengthening the informants' anonymity, I have slightly changed some biographical details as well as family stories, and I have avoided naming the city, particular places, districts, and associations. I asked for informants' consent to be recorded, and circulated a consent form with information about the study. I conducted 17 formal interviews in Turkish, and tape-recorded and transcribed them. Five recorded interviews had been planned and started as individual interviews but ended up as focus groups, especially with married couples. Individual interviews lasted between

1 and 1.5 hours, and focus group interviews not less than 1.5 hours. Some interviews were not tape-recorded, but I took notes in order to recall some stories and accounts. I selected and translated quotations from Turkish into English. I also included Swedish loanwords. I did not seek to literally translate some Turkish words that have significant nuances; instead, I elaborated on them in the analysis.

I did not record informal conversations, but I wrote down recurring themes and stories in my notes about field relations. Informal conversations during visits, dinners, and social gatherings went on longer than formal interviews and I was mostly a participant listener to daily conversations, memories, and stories. A visit to a household typically lasted more than four hours, and a visit paid around 5:00 p.m. often ended with a dinner. During the conversations during the meal, I also had the chance to informally check some details that I was not sure about in my transcripts.

In addition to the interview material, I had the chance to make observations in the households, in the course of everyday activities and conversations. I met some informants in the city center for a meal or coffee. I also participated in some association meetings with them. As mentioned earlier, some of my informants were actively involved with a small association for older Turkish people in Sweden. This small association cooperated with a larger network that aimed to gather older people from different ethnic communities for a better dialogue and further collaboration on issues concerning older people. I attended their two big annual meetings and some smaller events.

A narrative approach?

In the middle of my fieldwork, Seda invited me to a reception for the release a newly published book by a journalist who had collected life stories of various immigrants in Sweden. Seda had been one of the participants in that project, and she was very touched by this book. While we were eating our dinner, with a cacophony of various languages all around us, she asked me why I was interested in asking questions about other people's lives. At that stage of my fieldwork I was thinking about how my informants' particular ideas about care were situated in their life stories. I tried to explain this in the clearest way I could, but I was not sure if I succeeded. Her eyes shone, and she recounted this story:

> One woman in the village goes to Seda's grandfather, the only one in the village who knows how to read and write. The woman wants him to write her life story. She starts to tell off all the vicissitudes she has been through, and Seda's grandfather writes them down. When the woman finishes talking, Seda's grandfather reads the story aloud, and the woman starts crying. When asked why she is crying, she answers: Did I really live through these events? (Field note, 2011-11-26)

This anecdote reminds me of the "paradox of Ulysses" that Adriana Cavarero (2000) notes. Ulysses starts to cry when he hears his own story told by another person; he understands his finitude, the time that has passed, and the only thing that he will leave behind when he dies is a story. Similarly, Seda and other informants were telling me their stories because they knew, consciously or unconsciously, that their desires, frustrations, and expectations became intelligible through stories. In the moment that they were sharing these stories with me, they were making a record of not only their past time but also their lived experiences which provided a basis for and a meaning to their ideas and identifications. For instance, one story was about how a migrant woman cared for her mother who joined her in Sweden, and after long years of separation it was tantamount to ideal care in old age. This story is also where a narrative argument for a meaningful caring relationship based on emotions of guilt and loyalty could be formulated.

Narratives have such power. Once stories are told, they invite their audience to a multitude of interpretations and proliferation of meanings. As Stewart notes:

> Narrative is first and foremost a mediating form through which "meaning" must pass. Stories, in other words, are productive. They catch up cultural conventions, relations of authority, and fundamental spatio-temporal orientations in the dense sociality of words and images in use and produce a constant mediation of the "real" in a proliferation of signs. (1996: 29-30)

When I asked my informants specific questions about elderly care arrangements and plans in old age, they always responded by telling me stories. The enigmatic aspect of the future did not respond to rational calculations; instead, it paved the way for more stories about care, sometimes about their own experiences in hospitals, in their neighborhoods, and in the country of departure, and sometimes about other that they had come to know.

A narrative approach to care constitutes a significant way to get at the ideals and practices of care (Sevenhuijsen, 1998; Froggett, 2002). The complexity of care escapes clear-cut generalities, transcends the "standards," "means," and "needs" decided on by experts, and challenges human relations

in an unforeseeable way. A narrative approach catalyzes the singularity of lived experiences into a common repertoire of plots, genres, and metaphors. Thus, it can provide us with a perspective from which it becomes possible to recognize the singularity of people while recognizing some common patterns. Let me illustrate this with an example from my field. The ideal of a Turkish elderly home appeared to be a main theme in some of the interviews. However, this theme was preceded by individual life stories, and these stories were marked differently by homing desires, caring relations, and family stories. The ideal remains the same with converging expectations, but we also come to see how it is differently imagined by people with diverse stories.

A narrative approach is also significant in understanding older migrants' care needs, ideals, and expectations, rather than formulating ready-made sets of cultural guidelines about how migrants or ethnic communities would be willing to be cared for, what their special needs and cultural expectations would be. As Gupta and Ferguson argue, "the fiction of cultures as discrete, object-like phenomena occupying discrete spaces becomes implausible for those who inhabit the borderlands" (1992: 7). Culturally competent care or assessment of special needs for older migrants can only be a viable option if we take their continuous positioning and repositioning in these borderlands. As Rapport argues, "narratives embody a perceived order, and in their telling they maintain this order despite seeming temporal, spatial, experiential disjunctures" (2004: 7). A narrative approach can lead to an in-depth understanding of these disjunctures.

Data analysis

After the above brief discussion of the relevance of a narrative approach, in this section, I delineate how I analyzed my interviews and field notes. Life stories, as "accounts of a person's life as delivered orally by the person himself" (Bertaux, 1981: 7-8, cited in Kaufman, 1986: 21), were specifically significant in showing how my informants positioned themselves and me during the interviews. Therefore, I have attempted to interweave their accounts and stories about specific questions and themes with biographical information. I have also included information about the "narrative environment" (Gubrium and Holstein, 2009) where it was significant in reminiscence, composition and narration of particular stories. Paying attention to Ricoeur's insights (1984), I started with a naïve reading of transcribed texts to grasp their meaning by continuously thinking of my position in the field and checking my field notes. In the parts where I was personally emotionally affected, I moved to structural analyses,

categorizations, and themes. Finally, I attempted to give a comprehensive understanding of what I was told.

Consequently, as presented in the fourth and fifth chapters, I gathered stories that shed light on previous health care encounters. I categorized them under subthemes such as first encounters, sickness-related retirement, and medical encounters in old age. These subthemes are presented in a chronological order. However, I analyzed continuities and ruptures in attitudes and beliefs not chronologically but through how and why the feelings of confidence, trust, and belonging were expressed. I was present at the creation of these accounts as both a newly arrived immigrant who knew about medical care in Turkey and who did not know about the health care services in Sweden. In a sense, the genealogies of these feelings are examined through my presence and the informants' memories.

In the sixth chapter, I have categorized the accounts around two main formal care facilities: home-help services and elderly care homes, and sought to delineate particular subject positions that repeatedly appeared in these accounts and stories. I strategically selected quotations where the expression "the Swedish" appears. I also added observation notes to highlight the disjuncture between actual care needs and expectations. In the seventh chapter, my analysis operates through three main emotions, namely *merhamet, vefa,* and *şefkat.* I selected accounts where these emotions are strategically used to posit the differences between Turkish families and native Swedish families and used them analytically to elucidate how a Turkish family is done around these emotions and the caring responsibilities that they attribute to the family members, specifically to adult children. The last chapter is mainly based on my participatory listening, my observations during a visit to an elderly home, and notes from informal conversations. I have juxtaposed my informants' accounts with stories about an elderly man who lived alone in an elderly care home. I examined how these stories are shaped by the emotions that I discussed in the previous chapter and how the circulation of stories reinforced an idea(l) of (diasporic) community.

4

Remembering Early Medical Encounters and Trusting "Swedish Health Care"

Introduction

This chapter aims at deciphering Turkish immigrants' confidence and trust in the Swedish health care system and how medical authorities, especially doctors, have played an important role in their biographies. When it comes to debates around migrants' arrangements in older ages, particularly after retirement, health care services constitute an important topic in their decision-making, as do policies that include bilateral arrangements between countries. Rights to health care in the country of settlement have been considered an important factor influencing future decisions about whether to stay in, or at least in touch with, the country of settlement. However, the decisions are based not merely on a rational calculation of future care needs; they are also anchored in a complex emotional process. Here, I suggest that the feelings of confidence and trust have direct influence on Turkish migrants' continued relation with and residence in Sweden, not only because health care is heavily subsidized in Sweden but also because they feel more confident in the "Swedish health care system." When I refer to the "Swedish health care system," I am aware that this expression covers many facets, practices, and institutions, and it therefore does not convey various concrete details and vivid nuances. However, I believe it is an accurate reflection of my informants' understanding of health and care. As they do not currently use elderly care facilities, their previous medical encounters constitute an important starting point from which they ponder their future encounters with elderly care facilities and institutions. Accordingly, this chapter will open

with a discussion about the genealogy of these feelings of confidence and trust and continue with the analysis of the migrants' first encounters with hospitals, including their comparisons with hospitals in Turkey in the 1970s. I will also shed light on how sickness-related early retirement has become possible due to medical discourses and examinations, which initiated not only "old age" but also reinforced an ongoing trust relationship with Swedish medical authorities. By discussing these two lines of stories, I will highlight some of the traces of confidence and trust that they perpetuate in projecting future care needs and practices.

Medical encounters

Ideals and expectations around care at older ages are distilled from lived experiences as well as stories and images of both formal and informal care. Care at older ages is also imagined with reference to previous experiences of care. When I asked my informants to explain their views on elderly care facilities in Sweden, all began to describe their earlier encounters with medical care, especially in hospitals. One evident reason for this was that many were less knowledgeable about home-help services and care homes than medical care in hospitals, partly because they had not used elderly care facilities at the time of the interviews and partly because they were not attuned to changing patterns and procedures related to elderly care. For instance, the belief that they would be directly offered any help or service if they asked for it is at odds with the complex and bureaucratic assessment of care needs.

However, one important motivation behind the informants' recollections could be explained by their retrospective interpretation of previous medical encounters. Medical encounters have constituted an important facet of their life stories as migrants. In the first years after they immigrated, many informants came to evaluate the prevalent social morality in Sweden through these institutionalized meetings, and they developed a sense of belonging to their country of settlement. When asked questions about elderly care, they recalled and recounted personal medical stories that had been significant turning points in their life stories. This retrospective interpretation paved the way for a prospective but enigmatic evaluation of the future. They invited me to think with them, and to work out options of staying in Sweden, returning to Turkey, and shuttling between the two countries in terms of obtaining the best health care based on what they imagine will be available to them. These imagined scenarios are anchored in a particular mnemonic endeavor to multiply the pros and condone the cons of medical care in Sweden. My older

informants were eager to mention medical care as an important topic as they considered plans for the future. They easily transferred the quality of medical care to their possible elderly care arrangements. Their confidence in Swedish medical care paved the way for trusting the country's health care system in general and appeared to be a good reason to continue to live in Sweden in old age.

My interviews and informal conversations with my informants included many expressions of admiration of the Swedish health care system, including the informants' long accounts of their encounters with Swedish hospitals as modern institutions, and Swedish doctors and nurses as well educated, competent, caring, and modest. Drawing upon Kleinman's framework (1980), Lisbeth Sachs's ethnographic work (1983) with Turkish migrant women has shown in detail how Turkish migrant women dwell on and vacillate between different sectors of care and it pointed to the problematic nature of medical encounters in a migration context. My fieldwork has brought a more complex set of interpretations. In parallel with Sachs's work, there were references to misunderstandings between doctors and patients due to the lack of a common frame of reference, as will be clear in the case of one of the informants, Melahat. However, one common aspect was "the happy migrant effect" and not necessarily the reiteration of incompatible cultural expectations of health care. When Garrett et al. (2008) coined the term "the happy migrant effect," they were alluding to the complex mindset of migrants in regard to health care in the country of settlement. My informants engaged in "a very positive comparison of healthcare in the new country compared with that remembered, experienced, or expected in their country of origin" (Garrett et al., 2008: 103). It was not a blind eulogy either; rather, it was a retrospective recognition of the health care that they had not expected to receive as migrants in the first place.

My informants were also aware of the current problems occurring in hospitals, such as longer waiting times, queues, staff shortages, and treatment delays, yet they tended to trivialize them. For example, when I asked one of my informants, Hasan, about hospitals, he misunderstood my intention and thought that I was implicitly trying to praise Turkish hospitals while looking for shortcomings in Swedish hospitals. At one point, he raised his voice and told me:

> I went to hospitals in many other countries, I was unwell during my travels. I have not seen better health institutions [hospitals] than those in Sweden. Swedish health care is the paradise that Muslims believe in. I am telling you that: it is *Paradise*!

I was often intrigued by my informants' strong appreciation of hospitals. As I had been checking Swedish news, talking to friends who are doctors and nurses, and hearing from my friends about long queues and waiting times, and treatment delays, my own stance was more critical. In between these two stances, I started to think about this tension and decided to understand how previous and ongoing medical encounters had shaped my informants' desires, expectations and demands around health care, especially in old age. Also, their way of describing it as "paradise," an object of "admiration," and as "the best" in the world had two main aims: First, they wanted to give a full account of their fortunate and appropriate decision to immigrate to and stay in Sweden. Their entitlements to Swedish health care constitute a good way of legitimizing their migration while providing a continued sense of belonging. Second, they wanted me, as a new immigrant, to understand how good our country of immigration was. I had to appreciate the system in general and turn a blind eye to some small problems. In the first years after I immigrated, while I was still experiencing loneliness in a foreign country, I could count on the Swedish health care system regardless of what might happen to me. My informants revealed this to me by drawing on their own life stories, which were marked by many medical encounters.

My informants think that their earlier medical encounters proffer a good reason to continue to reside in Sweden. This is a double process; they not only remember negative stories from Turkey of the 1960s and 1970s but also medical success stories that they experienced in Sweden. Hospitals, together with stories, images, and discourses about medical and social care in Turkey during the 1960s, constitute an important template on which they make sense of their medical encounters in Sweden. This creates an ongoing confidence in the Swedish health care system. The informants' ideas about elderly care facilities are rooted in this remembered, fantasized, idealized, and sometimes anachronic dichotomy. When they work out their options in frail old age, these memories are invoked to justify or illustrate their predicament and the decisions that they made.

From confidence to trust

Hope, confidence, and trust have been considered three main ways of predicting and thinking about the future. Sztompka argues that "hope is a passive, vague, not rationally justified feeling that things will turn out to the good (or to the bad)," while confidence is a "more justified faith that something good will happen (or not)" (1999: 24–25). For Barbalet, confidence is an "assured expectation" (1996: 76). Trust, on the other hand,

is "actively anticipating and facing an unknown future" by "behaving 'as if' we knew the future" (Sztompka, 1999: 25–26). Following this analytical distinction, I would argue that Turkish elderly are confident about receiving proper medical care in Sweden based on their past experiences of being cared for properly and they engage in trusting the elderly care that they may need in the future by actively recollecting these positive experiences. As Luhmann argues, "to show trust is to anticipate the future. It is also to behave as though the future were certain" (1979: 10), and their confidence and trust have a significant influence in their decision to continue to live or at least maintain some presence in Sweden despite the attraction of returning to their country of birth in old age.

Despite its various definitions, trust has been an important issue in sociology and political science (Luhmann, 1979; Gambetta, 1988) as well as in medical research. The trust relationship between doctors and patients has been discussed as an important element of medical encounters (Mechanic and Schlesinger, 1996; Kao et al., 1998). Strauss et al. (1982), for instance, highlight "trust work" as an indispensable component of sentimental work in hospitals. Pearson and Raeke (2000) argue that one key distinction is between interpersonal and social trust. While the former is built through repeated interactions (Mechanic and Schlesinger, 1996), the latter involves trust in institutions, which is reinforced by dominant discourses in a society. These categories, albeit useful in understanding the intricacy of trust relations, do not always offer a simple analytical distinction. For older people like my informants who have had repeated interactions with doctors, these two categories have been complementary and reinforcing each other. They trusted their doctors since they trusted Swedish health care institutions, and they trusted these institutions more when they developed relationships of trust with their doctors. The establishment of a trust relationship is also anchored in the happy migrant effect, as I discussed earlier. Some research in the Swedish context has shown that migrants report high confidence and trust in Swedish health care services (Hjern et al., 2001).

Pearson and Raeke (2008) remind us that there are "many theories but few measures and little data" to understand the trust relationships in health care. The general tendency has been to attempt to measure trust in some fashion. In the following sections, my aim is not to measure Turkish migrants' trust in Swedish health care but to delineate how this trust has been established and how it has affected their life stories.

First encounters

Now it is time to step into "paradise" and to describe how medical encounters in the 1970s gave Turkish immigrants a strong and positive image of the Swedish health care system in comparison and contrast to what they had experienced in or heard about Turkish hospitals. By doing so, I suggest that the image they formed in their early years as new immigrants persists and prevails when it comes to evaluating options in old age, despite changing institutions, practices, and resources in both Sweden and Turkey. Descriptions of hospitals and first hospitalizations always derive from a parallel endeavor between two different settings and medical practices. Here I will center my discussion mostly on older women's first medical encounters, because these accounts are endowed with rich details and insights and they also pave the way for further discussion of trust and desire to use Swedish medical services when on the verge of old age.

The choice of and concentration on the accounts of women is not simply fortuitous as many early-in-life immigrant women were hospitalized for pregnancy and birth-related reasons. These hospitalizations occurred shortly after their arrival in Sweden, and the women retained vivid memories from these periods. Men, on the other hand, consulted medical authorities mostly for work-related health problems and were rarely hospitalized before they reached middle age. Since women's hospitalizations when giving birth also affected their life stories in a significant way, they were narrated at length and with ease. Due to the difference in our ages, some women were less uneasy when it came to talking about intimate details; many were comfortable sharing their stories with a young male researcher, although some were unwilling to go into detail and their accounts were more general. Medical encounters at young ages were not a favorite topic of discussion for the men, as they tended to conceal ailments that interfered with their memories and images of themselves as the young and healthy working men that they had been.

Memnune: Post-delivery care

Memnune gave birth to two children in Turkey before emigrating and three children in Sweden. She did not have any memory of Turkish hospitals since she had delivered her first two children at home with the help of a midwife. She thought that giving birth was not a medical issue unless there was a serious complication. The hospital, in this sense, was viewed as an institution associated with painful medical procedures to fix abnormalities. Still, she was

so impressed with the care she was given during her deliveries in Swedish hospitals that she changed her mind about hospitals. She pointed out the medical conventions around giving birth in hospitals:

> It was great, there was very good care. When you gave birth, even though you were healthy, you would have to stay there six days. If you were unwell, they would not let you go home even then; you had to stay. Besides, if it were a Saturday or Sunday, they would not discharge you before Monday. Nowadays, you give birth and you return home the same day. [*regretting*] I don't understand how it became like that. This old [level of] care does not exist anymore; we lived like kings and queens, in terms of food [served at the hospital], care, doctors who used to call, talk to us, and examine us. Nowadays, if one gives birth, one gets discharged [immediately].

Memnune was satisfied with her post-delivery hospitalization. As she underlined, they "lived like kings and queens"; this saying in Turkish implies material comfort and that one is generously provided with all that is needed. According to her recollection, they were taken care of and given care in the best ways they could ever imagine. Memnune's satisfaction was also linked to her previous deliveries, which occurred outside health care institutions. Her first hospitalization in Sweden, therefore, was an introduction to organized, institutional, and monitored care. She had been pleasantly surprised to be hospitalized for a specific amount of time, regardless of her condition after delivery, and she was now confused about the current changing patterns.

Besides the good care and attention women were given in hospitals, there were two other reasons for this strong appreciation. First, hospitalization helped the women recover: if they had been immediately discharged, they would have returned to their household chores and caring responsibilities at home, mainly caring for their children, as Fatma's story will later hint at that. Women – especially but not specifically when thinking their early years as immigrants – recalled their endeavors to create a home in a foreign country as well as a family environment while participating in the workforce. Willingly or unwillingly, they assumed extra chores to reorganize family life in a migration context.[10] For many, as for Memnune, their post-delivery

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[10] For instance, some women informants reminded me that they started to bake bread daily after they came home from work, in addition to doing their other regular household chores, as they disliked the taste of Swedish bread and felt it necessary to make their own as part of their responsibility in managing the household economy.

hospitalization therefore represented a medically sanctioned break from their double burden, and it hastened their recovery.

Second, being in a foreign land (*gurbet*), far from friends and close kin, they would not have proper help and advice from close female relatives during their post-natal period.[11] In addition to the absence of significant others who could provide help and hands-on care, they were not emotionally ready to go back home as if nothing had happened. In other words, in a migration context, post-delivery hospitalization with good care was perceived to provide new mothers with a beneficial transitional period on the eve of motherhood.[12]

Fatma: Is this country not great?

Unlike Memnune, Fatma gave birth in a hospital in Turkey and was shocked by the unfavorable conditions. Even today, when she recalled her first hospitalization in Turkey, she was deeply disgruntled. After recounting many infrastructural problems in Turkey in the late 1960s, similar to those recounted by many other informants, Fatma launched into an elaborate description of her first medical encounters both in Turkey before emigration and in Sweden after immigration as soon as I broached the subject. Both of her hospitalizations were birth-related. Here, I quote our conversation at length to highlight how the two settings were described in detail:

> Öncel: Do you remember any incidents from your hospitalization?
> Fatma: Of course. For example, excuse me/my language,[13] I gave birth to my child there [Turkey]. While I was wandering around [in the hospital], I noticed some wrapped bed

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[11] The post-delivery period (*lohusalık*) is a significant interval of time in Turkey, during which young and inexperienced mothers are given assistance by close kin, mostly middle-aged women of both maternal and/or paternal lineage. Rituals are shaped around the good care of the newborn as well as the physiological and psychological wellness of the young mother. Sachs (1983) provides detailed ethnographic information about this post-delivery period, particularly among Turkish migrants originating from a specific town in Turkey (Kulu). Needless to say, the young mother is exempt from daily responsibilities at home during this period.

[12] This discussion seems to be at odds with Sachs's (1983) analysis where her Turkish informant felt uneasy in the hospital, anxious and scared of the evil eye and supernatural forces that were believed to attack new mothers and their babies. It should be borne in mind that the background of my informants is heterogeneous, yet a common pattern is that most of my female informants had smaller families than Sachs's informants. This different interpretation can also be linked to the retrospective interpretation of earlier hospitalizations at older ages.

[13] Here, her apology was about me being a man and her mentioning giving birth. Talking about pregnancy and delivery to a man seemed inappropriate to some of my informants. However, my youth was a good enough reason for them to relax this attitude to some extent.

sheets. I laid hands on it, and there was a dead baby inside. It was such a horrible delivery place! All hospitals were alike. You had to wash your own laundry. One hangs out her laundry here, the other there. A lot of food was brought from outside [the hospital], and the hospital stank; visiting hours were respected neither by visitors nor by people inside the institution.

Öncel: Have you been hospitalized in Sweden? How was it?

Fatma: When I came here, it was great as my last delivery was here. I did not speak the language. I was hospitalized two weeks later [after I immigrated].

Öncel: So you emigrated when you were pregnant?

Fatma: Yes. Of course we don't eat pork. They put me on a stretcher; at that time there were no interpreters.[14] They moved me with the stretcher to the kitchen, they showed me all the meals, and asked me what I wanted to eat. Food and everything was very organized. For example, I was unwell after delivery. They take you, move you, and bathe you. It is a huge room, full of patient clothes, you can change. You can even find socks [available for patients]. Beds, I mean everything was very different. At that time, I was thinking about what kind of country this was.

Öncel: What were you thinking about it?

Fatma: I used to say that such a country, such a beautiful country could not exist because I came from the capital [Ankara], and there people used to lie in the corridors. Long, never-ending queues… But you come here, the man [doctor] shows you great respect [*el üstünde tutuyor*]. He comes and sits on your bed, asks you if you have proper accommodation, how spacious your apartment is, if you are worried about anything, if you have enough money. He asks you about everything. Then he informs the social workers; for instance, he says that the patient's apartment is not spacious enough, she gets bored, and to change it immediately. Or if you have something like depression, he says okay, I will send you back home or to Spain so that you get over it.

Öncel: Have you ever been on such a trip?

Fatma: I haven't, but I saw others who have. They told me. I was a little depressed after my third child. They also recommended it for me, but I said no as I had children at home. [*She launches into an account about how orphans get treated in Sweden and returns to the subject of her hospitalization*] I mean, at that time, I was thinking about how beautiful the hospital was. You go to the cafeteria and sit there, you buy and eat a *smörgås* [sandwich] and the doctor comes and sits next to you, there is no problem. But when we were there [in Turkey], at lunchtime, a car approached the entrance [of the hospital], they opened the doors of the car, the doctor got into the car, and they drove, what was it? The doctor went to lunch. You come here, the man sits on your bed, asks you about everything. You sit and drink your coffee here and he sits here. Then, is this country not great?

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[14] There were at least three well-known interpreters in the early 1970s, widely cited by my informants. Here Fatma, as one of the pioneers, may be referring to the limited number of interpreters available in the late 1960s.

In Fatma's account, a Turkish hospital was not an institution that fully responded to patients' well-being. Even though the hospital was in the urbanized and modern capital of Turkey, it was fraught with infrastructural deficiencies and organizational problems. The rules were either absent or not respected. Medical teams seemed unconcerned about the patient's well-being. The institution was permeable in the sense that the outside world (food, clothes, family members, and so on) easily trespassed the lightly drawn boundaries around it. This permeability was needed in terms of routines and services at the hospital. The well-known custom of having family members or close friends as care assistants (*refakatçi*) was established to ease professional care workers' workload and was anchored in the conviction that family members, especially women of the family, should be allowed into hospitals to take care of the patient during her hospitalization.[15] This increased the circulation of people in the corridors of the institution. Turkish doctors[16] seemed to be distant, unreachable, highly venerated, and even pretentious actors who did not care about the patients.

In contrast, in the hospital in Sweden the patient appeared to be highly esteemed: her choices, her well-being, and her needs were at the center of the care plan. The hospital was designed and organized according to patients' needs. The very availability of (a variety of) food, patient clothes, and professional hands-on care turned the hospital into a total institution, in a positive sense. Hospitals were not permeable institutions in the sense that everything that patients could need had been previously thought about and procured by the institution.[17] Swedish doctors were careful about patients' dignity, were caring, and showed an interest in patients' well-being. They did not focus solely on diseases but they were also interested in patients' overall well-being, from psychological wellness to accommodation problems. They were in contact with other bureaucratic actors who could solve problems that were not necessarily related to specific symptoms or diseases. Doctors were significant actors in the provision of holistic care. All in all, Swedish doctors appeared to be down to earth, accessible, and naturally modest rather than condescending.

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[15] Under the section titled "Hospitalization on the verge of old age," I will also discuss how not being in need of a *refakatçi* constitutes an ideal of independence from family members in old age.

[16] Terzioğlu's (1998) work highlights how medical doctors consider themselves to be the voice of authority, and how medicine has been an elite profession, very active in the Turkish modernization project.

[17] Following this conversation, Fatma pointed out that hospitals are designed like rental apartments in Sweden. The necessary items are already available, the tenants bring only their personal things.

In Fatma's account, the subject of the sentences oscillates between "I" and "you." It was not only a stylistic narration to include me in her narration, it also allowed me to take a walk with her in the hospital at that time and understand her appreciation from my own tour. She shifted to the present tense, which highlights the continued belief in the everyday life in hospitals (which may be not the case, as she agrees). From this very first encounter, Fatma came to conclusions about Sweden and its system. "Could such a beautiful country exist?" is a rhetorical question to reinforce the quality and availability of health care in Sweden. It is a retrospective way of meaning-making about care that she was given in the past, and that hopefully she will be given when in need of care in the future.

Elif: From fear to trust

Elif had never been hospitalized in Turkey; however, she had heard only bad stories about hospitals. Both her unwillingness to be operated on and the circulation of horror stories had discouraged her from obtaining a proper medical consultation before emigration. Eighteen days after she arrived in Sweden, Elif, at the age of 19, was very ill. She needed to see a doctor who specialized in gynecology and obstetrics. She sought help from a woman interpreter who worked at the migration office. They went to her appointment together. Everything happened so fast, everything was so impressive that day that Elif's memory was still very vivid and after many decades, she was remarkably animated as she told me the story:

> Elif: I woke up at 7:00 am. I met Miss R. [my interpreter] in front of L. Hospital.[18] We took a taxi from V.[19] The taxi cost 14 *lira*,[20] the doctor's visit cost 7.5 *lira* at the time. We went there. After the examination, the doctor told my interpreter that I should stay there; I didn't understand anything. She told me that I should stay there, and they would urgently operate on me. I shrank back in fear [*korkaladım*] of course. I told them that my husband did not know and that I should let him know. They asked me if I had a phone at home. We didn't. Not even mobile phones at that time. My neighbors had a phone. I called my neighbor [she gives her name], let her know, and asked her to inform my husband. "Don't worry, we will be there, tell me where you are," she said. I told them that I was at Ö.[21] I stayed there and was operated on. They told me to come, I was kept seated, they told me to sit, and I was leaving the room [*she laughed*]. We knew nothing. Nothing! I was hospi-

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[18] A medium-size hospital.

[19] The name of a tram station.

[20] It is common among the first generation to refer to Swedish crown (SEK) as *lira*, the name of Turkish currency.

[21] Abbreviation for a hospital.

> talized during the winter; it was either March or April when I was discharged. At that time, they really took care of you; they gave you such wonderful service.

Elif's first encounter with a medical institution was a dramatic experience in the beginning. She had never been hospitalized in Turkey but she used to see hospitals as strange and scary places. When she was asked to stay at a Swedish hospital, she was triply afraid of being somewhere completely unfamiliar (hospital) where she did not understand anything (in Swedish) for a bodily intervention (operation). She described it with a rare Turkish expression, *korkalamak*, literally "shrink back in fear." It was clear that her use of *korkalamak* was related to her vernacular but it also emphasized her bodily sensation of fear. She was deeply scared of opening her body to medical intervention by people with whom she could not communicate. She felt the need to call her neighbor, partly to let her husband know what was happening and to tell him that he needed to collect the children who had been entrusted to the neighbor, but mainly to feel safe and cared for in case of a complication in the operation. As she did not understand what the hospital staff was telling her, she distrusted the operation. However, in the end, she was healed and properly taken care of and she started to appreciate the institution.

After her first hospitalization, Elif regularly visited hospitals for check-ups. She also learned the language. Even though there was an interpreter, she was determined to avoid being in a similar situation ever again. Her knowledge about institutions and medical routines had become excellent by the time that her husband was severely ill in his last years. Not only did she take care of him, but she also arranged every medical check-up and operation. She came to know doctors, she engaged in repeated interactions with medical teams, not only for her own check-ups and her husband's operations but also when she started to help others who could not speak Swedish or those who were not familiar with medical institutions. The first experience of fear and awkwardness was transformed into a solid confidence in, and self-confidence around medical care in Sweden.

Melahat: Influenza?

In the early 1970s, women were pleased with the material conditions they encountered during their hospitalizations and appreciated the friendly, competent care they received from the medical teams. One common barrier was the language, as they had not mastered Swedish to a point where they could express themselves in it. The other barrier was mainly a feeling of

incongruity, unfamiliarity, and lack of experience. Melahat had always been quite squeamish and careful about hygiene. Sweden in the first place was a foreign land where she felt she could be easily soiled and infected by unfamiliar substances. She had always been sensitive to odors, and she became more so after she immigrated. Sweden smelled different to her; it was how she first described *gurbet* and her unfamiliarity with her new environment.

Hospitals as institutions where many other people were treated felt like "dirty" places to her. This perception triggered her uneasiness during her hospitalization. However, her main trouble was in expressing how she felt, that is, expressing her profound feelings of loneliness and separation from caring others:

Öncel: Did you go to hospital in your first years?

Melahat: I did. I went to the hospital after my first three months. I didn't put my head on the pillow. I had my handkerchief; I placed it on the pillow. The pillow smelled. I felt like that. People had a strange, funny smell to me. When I got in trams or buses, if I put my hand somewhere, I would not put my hand back in my pocket. My hands were like that [*she raises her hands and demonstrates moving her body sideways, as if through a crowd, without touching anything*]. I had to come and wash them, then I could place them somewhere.

Öncel: How did it smell to you?

Melahat: I don't know. There was a strange/different [*değişik*] smell. When I was sick, I forgot about the handkerchief.

Öncel: Had you been to a hospital in Turkey?

Melahat: Of course. I did the same there, I put my handkerchief on my pillow. I was operated on for appendicitis [appendectomy]. [*She laughs*] When I woke up, the handkerchief had flown away.

Öncel: So you saw hospitals in both countries. Was there anything that you thought different?

Melahat: Of course there was. Here is more painstaking. It pays more attention.

Öncel: Do you remember any incidents?

Melahat: Nothing, my son… [*silence*] I used to cry a lot.

Öncel: Why?

Melahat: Because you are unwell in a foreign land [*gurbette hastasın*]. I gave birth to my child. After he was born, I cried. There were no visitors. Who would come? Only Miss. X [a neighbor] came. As I cried, doctors and nurses came and thought that I had influenza and put me in a single room, on my own. At least I used to see other patients in the other ward [*we laugh*]. I failed to make myself understood. I could not say that I did not have influenza; it was because of the crying. Oh my God! Then they decided to discharge me, they told me that they would let me go, and I stopped crying. The virus, the influenza vanished [*she laughs*]. We used to stay in the hospital one week or so.

Even though Melahat was grateful for the care she was given during her first hospitalization, it did not prevent her from affirming her double alienation in the Swedish hospital. Besides her concerns about hygiene, she could not make herself properly understood in a language she had not mastered yet. Fatma was happy to be cared for by professionals after delivery, away from family and kinship networks, whereas Melahat was apparently grieving the absence of significant others who could help or visit her during an important period of her life. She felt lonely, and her loneliness and emotional susceptibility could not be translated into the language of holistic medical care. Her tears were treated as a symptom and the precaution taken by the medical team to place her in a single room made her feel even lonelier than before. The misunderstanding was inevitable and significant since it showed the limits of holistic care when different life stories and emotional scripts were considered. In other words, it was also the first time when medical practitioners encountered Turkish patients, who could have slightly or significantly different understandings, expectations, and needs in such circumstances.

First encounters with medical institutions are remembered with appreciation by early-in-life immigrants. Experience in and/or images of hospitals in the country of origin were considered concurrently with hospitals in the country of settlement. The idealization of Swedish doctors or institutions is made possible due to this comparison but also to the entitlements to good care that the migrants had not expected. The attentive, caring and holistic approach to their problems and demands was a turning point at which trust was established. The articulation of appreciation and trust can be interpreted differently. One important methodological point would be that my newcomer position affected the tone of the informants' accounts; they wanted me to acknowledge the quality of Swedish health care. Another point is that these first encounters were remembered and interpreted retrospectively. For instance, Elif laughed when she remembered her initial clumsiness in front of Swedish doctors; this humorous tone has become possible since she now speaks Swedish.

Many considered their experience in hospitals to be significant encounters with the Swedish health care system and with institutional life in Sweden in general. Beyond the Migration Office that issued the immigrants' residence permits or the work-places that required them to be fit and healthy enough to work, hospitals were where they were seriously cared about and understood to some extent, and where they started to feel a sense of belonging to their country of settlement. These memories of good care induced feelings of trust

and confidence in their future expectations and shaped their ideas about good care later in life. For them, Sweden, as a modern European country, had established the ideal care system, and regardless of everyday life exclusion, they came to see themselves as members of the larger society, their well-being as the aim of the general welfare system. These encounters also initiated them into medical language, knowledge, and routines that they regularly used later in life.

Drawing on accounts about birth-related hospitalization of Turkish women, I highlight that in the early years of immigration, they encountered a modern hospital organization and a holistic health care approach, and they felt secure in the sense that their bodies were respected. Their health, bodies, and care needs were not neglected in this new country of residence. The infrastructural and organizational problems and medical team-patient relationship in Turkey paved the way for a dialogical and critical comparison in support of the Swedish health care system. The migrants' confidence in good medical care was built on the assured expectation that they would get care and attention whenever they needed it and paved the way for trust in other possible care facilities. The next section will focus on accounts around sickness-related early retirement, where migrants' trust in medical authorities was reinforced. Medical authorities, in a sense, continued to care about them.

A happy turn? Sickness-related early retirement

In the late 1980s, when there was a growing incidence of early sickness-related retirement among migrants (Schierup et al., 2006), the majority of my female informants left their jobs on the advice of medical authorities. They had a wide range of conditions, from back pains to major depression, and they were examined, allowed, and sometimes encouraged by medical authorities to retire. Specific doctor names were remembered from those times, especially in focus groups where special characteristics of doctors were recalled. Doctors were considered to be powerful actors able to negotiate with confidence, and they were facilitators who paved the way to retirement.

Melahat had problems with her ears; she used to lose her balance when she worked at a car factory. She also had depression because of her negligent husband and double burden of a full-time job and caring responsibilities at home. Memnune was seriously depressed when she gave birth to her handicapped child. She also had a heart attack in her early fifties. Her doctor decided that she was not fit to continue her strenuous work at the factory. Seda had asthma and chronic respiratory problems. She was reluctant to

blame her work-place even though she was aware that her job was not without risk. She recalled how the job she used to do was replaced by machines later on. However, her main explanation for her sickness was her bad habit, smoking, which she started in her early years to show how emancipated she was. Fatma worked as a welder at the same factory for 19 years, and towards the end of these years she developed serious back pains and had to retire early. Elif used to do intensive cleaning jobs, especially in the meat industry. When she was diagnosed with a clot in her lung and symptoms of spinal disc herniation, she retired. Here, I can continue to cite more examples in line with my female informants' accounts. It has been shown that long-term sick leave and early retirement were more frequent among migrant laborers than among native Swedes (Isacsson et al., 1992; Bollini and Siem, 1995). Yet, rather than focusing on specific medical conditions, their graveness or etiology, I will highlight another common trope, which is the ease and rapidity with which sickness-related early retirement was obtained.

Melahat had been a tailor in a big city in Turkey. In 1969, she married a pioneer migrant who had settled in Sweden. She moved first to a small city, where she started to work in a textile factory. Even though she did not like the city, which was very different from her native city across the Aegean Sea, she was not completely displeased with her new job. The factory environment was nothing like the tailor shop where she used to work, but at least she was still dealing with fabrics and threads. A year later, she and her husband moved to a larger city, and Melahat started to work in the automobile industry. A series of sick leaves started there. When I asked her about her retirement, she told me:

> Melahat: I worked at the mounting unit. I used to deal with car doors. My task was very hard. (…) When I worked there, I was pregnant. I didn't know that I was pregnant when I started. I had this strong earache. My foreman saw me, brought an interpreter to understand why I was holding my ear. The interpreter, the guy who worked with us, asked me why I was balancing my head. "How did you know?" I asked. The foreman said, "You will see a doctor tomorrow." The next day, as I don't speak the language, I came to the factory. The foreman told me to go and see a doctor. I replied that I didn't speak the language and would get better soon. So, he said, "I'll send the interpreter with you and you will go to the doctor tomorrow." I went and got three weeks sick leave. Then, I gave birth to my son, and was off for maternal leave.
> Öncel: When did you retire?
> Melahat: Very bad question. [*She tries to remember*]. It was in 1988, I think.
> Öncel: Was it sickness-related?
> Melahat: Yes.

Öncel: What was your sickness?

Melahat: [*raising her voice*] My sickness, my son? I was the only girl in my family with five brothers. My father was well-off. I knew nothing about farms, factories, had no experience of hard work. I came here after my father passed away. Here I have seen the factory, I have seen the drunkard [*she means her husband*]. I have seen everything. I could not stand all this. I worked as much as I could, then I met this doctor. I told her my life story. She gave me three years sick leave. After a while, she told me that she was going to quit [her job, position], and asked me "Do you want me to give you retirement?" "Do you want to?" I said, "It is up to you, you decide." And I got my retirement.

Melahat's problem with her ears was first noticed at her workplace. The foreman advised, even obliged, her to see a doctor. She was reluctant to acknowledge her health problem and was also leery of a medical encounter where she would not be able to express herself. Opening her body to medical scrutiny and knowledge was doubly difficult for her as an immigrant who had neither mastered the language nor was familiar with the medical institutions. However, over the years, she became less leery of going to doctors even though that reminded her of unhappy times. She was even content with the solution of early retirement. At the time of retirement, she was divorced with two adult sons, but her elderly mother had joined her in Sweden. She now had more time to take care of her and, more importantly, to care for herself. As her anger at my question about sickness indicates, she never considered herself suited, nor trained, for hard industrial work. The very experience of being uprooted from a relatively well-off family after her father's death and then trying to get re-established while living in an unhappy marriage and at the same time dealing with all the hardships of being in a foreign land was already physically and psychologically exhausting. My question sounded interrogatory and the answer, for her, was self-evident. Like some other female informants who came to Sweden through marriages and leaving their families, Melahat suffered from industrial hard work and family troubles.

Regular medical encounters paved the way for Melahat to understand how she had changed in her body and identity over time. Life in Sweden turned out to be much harder than she had anticipated. Awareness of physiological and psychological troubles determined her priorities at the threshold of old age. Early retirement came as a reward, something that she earned after years of dedication and hard work, and it allowed her more time and energy to nurture herself and to care for her mother, whom she felt she had neglected by abandoning her when she emigrated. Early retirement could give her the chance to compensate for that, and to take up her responsibility to care for her mother.

The doctor's final decision about early retirement was instant but rooted in their previous encounters. Doctors were significant actors who listened to Melahat's personal and familial troubles as well as accounts of her experiences at work. In a sense, they translated her wishes, frustrations, and troubles ("I told her my story and she gave me sick leave") into a medical vocabulary, one that she started to trust and use in her life story. Melahat thought that the process of getting her early retirement was easy and quick, regardless of macro changes occurring in the labor market, because not only did her doctor know about her physical and mental exhaustion, she also recognized Melahat as a person. The question "Do you want to?" seems unnecessary in the sense that doctors are decision makers; it is not a question of wanting or not, but sickness-related early retirement is granted on the basis of the procurement of a valid statement of whether or not an individual is healthy enough to continue to work. Even though Melahat was unsure about the question and her answer, she trusted her doctor because the doctor had the power to make decision and knew Melahat's story.

Given the changes concerning early-retirement decisions in the 2000s and the increasing need for more medical and "scientific" rather than socio-psychological evidence, it is hard to believe in the sheer benevolence and relative autonomy of medical authorities at the time. The point is not that "the health-care system not only pursues its own special interests but, at the same time, aligns itself with dominant groups and classes in the society, thus serving their special interests as well" (Mishler et al., 1981: 196). I think the picture is even more complex than seeing medical authorities as autonomous or as aligning with dominant classes or strategies. It is true that the trend was to easily provide working-age people with retirement benefits based on diagnoses of ill health in order to address a labor market surplus, and there was apparently less pressure on doctors to justify their decisions about who was eligible for such benefits. Socio-psychological and physiological symptoms constituted the criteria for early retirement. Here, the point is that there are contextual and changing criteria for defining ill health, and Melahat, like many others, engaged in a trust relationship with doctors, who did not ignore her as a legitimate candidate for early-retirement benefits.

Memnune got her early retirement as smoothly as Melahat had. She was the mother of five children and was exhausted both at work and at home. First, she left her children at day care, but it still proved to be difficult with all the arrangements. Memnune and her husband worked different shifts, and he used to help with collecting the children from day care; Memnune dealt with the rest. First, they left small children in Turkey with their grandmother, then, Memnune's mother moved to Sweden to take care of them until they

were older; she stayed six years and then went back to Turkey. Finally, Memnune gave birth to her last son, who was disabled, and in her view, needed more attention than his siblings.

> Memnune: I was so sad that I could not work. I was crying while I was working. I was thinking, thinking, and telling myself if he had not been disabled, I would have worked for free at this factory. It was so hard on me. Then I could not work and went to see a doctor. The doctor did not allow me to work, "You cannot work," she said, and I got my early retirement.
> Öncel: Why did she say so?
> Memnune: Because of my morale [psychological situation].
> Öncel: When was it?
> Memnune: 1980s, I think it was 1985.

Memnune began to feel out of place at work. She was deeply affected by her son's disability; she had to assume that caring for him would be different from what she had so far experienced with her other four children. She wanted to spend more time with her son and arrange his daily life, school, and later, a job for him. She found it hard to come to terms with her inability to care for him adequately due to her demanding job; both her caring responsibilities and job were time-consuming and exhausting. This double burden triggered a major depression that she had to cope with in the long term. Her doctor's decision to recommend early retirement for her was a response to her dilemma as a mother and worker. She was grateful to the doctor, who recognized that her life had been deeply changed and challenged by emerging care needs.

Elif's early retirement story is similar to Melahat's and Memnune's stories. Elif was under medical observation from the very beginning of her immigration because of her recurring disease. Unlike Memnune and Melahat, she was engaged in the local politics, especially in the municipality, and she had to financially support some of her children. Memnune's and Melahat's children, on the other hand, are employed and support their widowed mothers. Elif came to think about her financial situation more than her peers do. Therefore not only was she content with the choices and benevolence of doctors concerning her illness, but she also came to be critical about her willingness to accept early retirement and the financial aspect of the whole process. Here is her account:

> Elif: I retired, after having been sick. I have not worked since then.
> Öncel: How long have you not worked?

> Elif: I have not worked since I was 40… 41 years old. I did not work regularly. Because my job was cleaning, it was always about dirt and dust. The doctor did not allow me to. When we went to *Sjukkassa* [*in Swedish, sick leave administration office*], we would talk about retirement; I planned what to say, and asked my daughter to help me. We went there; we did not even open our mouths. There was no need to talk about my pain, no need to convince them about my sickness by playing any tricks [*oyun yapmaya gerek kalmadi*]. The lady doctor told me that she understood. She said that it would be difficult [for Elif in future], whereas we were delighted. At that time, everyone used to buy *tårta* [cake] and invite her neighbors to celebrate her [sickness-related early] retirement. Look at this! In fact, we were reasoning wrongly. We understood that, but very late.
>
> Öncel: Why?
>
> Elif: We would lose a lot of money, our union stuff would decrease. For instance, if I had worked until I was 65, I would have had my brut (gross), my yearly *inkomst*.[22] At least I would have had 300-400 thousand (SEK, gross, saved). I retired with only 157 thousand. Do you get it? Since then we have used our savings, we consumed ATP.[23] What happens when you use your savings? What will you receive when you retire? I will get at most 12, 13 thousand and our conditions will change; for instance, I pay 5000 (SEK) for rent, it will be 6000 (SEK) very soon.

As an unskilled female worker, Elif faced the dilemma of staying in the grueling cleaning sector or leaving it without any hope of being employed ever again. At the time, her frail health status and responsibilities at home made her think that it would be the correct decision to make. There was no need to try to trick the doctor by acting sick or exaggerating her ill health, the doctor was level headed and had already made the decision without any drama. As Elif remembered, at that time, many female friends were celebrating these decisions of early retirement as "happy turns" in their life course, as the end of their overwhelming burden and circulation between emotionally and physically demanding home-making and exhausting jobs. With the medical authorities, their embodied life stories spoke for themselves and on this basis, doctors made the swift conclusion. As Elif's story hinted, there was a playful space where the truth had to be told and enacted and doctors appeared to be benevolent, understanding, helpful, and powerful intermediaries who could ease their tormented lives. As some of my informants noted, especially those who continued to work until they were older, there were some people who "tricked" doctors into recommending retirement on the basis of ill-health, and many claimed psychological problems as a tactic to escape hard work. It is very common among working

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[22] Income, in Swedish.

[23] Allmänna Tjänste Pensionen (occupational pension).

people to praise hard work and underestimate the reality and obstacle of psychological problems, and there might be people who used their less significant ailments as a basis for early retirement. However, the point here is that there was a norm of a trust relationship being formed between doctors and patients, which created its own real or imaginary deviations. In other words, the circulation of the discourse of "dishonest and fraudulent" people who fibbed and cheated doctors in order to obtain early retirement reinforces the norm that one ought to develop a reliable and confident relationship with doctors who are to be trusted.

Nevertheless, this happy turn was not actually very happy for Elif when she thought about it in retrospect and not only in terms of her economic calculations of the pension that she would get when she turned 65. She also recounted that the doctor, by precluding her from working, was also marking the end of her economic productivity. Wishful thinking about the doctor's decision corresponded neither to the reality of the labor market nor to Elif's qualifications. Elif, fuming at the thought of never finding a better job in the future, said:

> The woman at the *Sjukkassa* told me and my daughter, "Your mother's ATP is very high, she must not be sad. We have the medical report from the principal doctor at *Sjukkassa*." She said, "Your mother can't work but she should not worry, if she feels better in future, if she finds a good job…" [*short silence, raising her voice*] How could I find a good job? We have never been in civil service, we don't speak [Swedish] properly, we don't know proper grammar, we are old. Even if we find a good job, there are four children at home. We were stuck in an impossible situation.

The early retirement that Elif had at first considered to be a good option was the beginning of her withdrawal from the labor market. She came to understand that she would be unlikely to find a job as an unskilled worker, even if she recovered from her ailments and did not have caring responsibilities. Also, old age would become an obstacle in future attempts to find employment. In other words, she has confidence in the medical knowledge that helped her and others to abstain from hard work and recover from diseases, but she does not trust every decision the medical authorities make.

Conclusion

In this chapter, drawing upon two lines of stories and accounts, I have highlighted how previous medical encounters are remembered and

interpreted by my female informants in ways that actively praise Swedish health care. In other words, I have elucidated the roots of their appreciation of and trust in Swedish health care. I used this narrative retrospection as a way to catch a glimpse of their identification with successful migrants and of their future expectations. Their confidence is a passive but assured expectation that they will receive good, accessible, and competent medical care in old age. They derive their confidence from their earlier experiences with medical authorities and share memories of hospitals in Turkey. However, when it comes to encounters, decisions, and considerations about the present, drawing upon their confidence in medical health care, they actively trust Swedish health care, including elderly care facilities. By embracing Swedish health care, which appears modern and holistic to them, they also find a way to differentiate themselves from their peers who stayed put in Turkey and from other Turkish migrants who could not appreciate the quality of the health care system. Telling these stories to me, a new immigrant, they wanted me to appreciate the Swedish health care system and to turn a blind eye to problems but more significantly they understand their past, present and future decision-making processes. Trusting Swedish health care becomes a significant way to legitimize their stay in Sweden, especially after retirement.

First medical encounters were fraught with a myriad of emotions, such as surprise, confusion, fear, gratefulness, and sometimes awkwardness and resentment. However, the migrants' entitlement to health care, which was well infrastructured and more technologized, communicative, and holistic than those in the country of origin, paved the way for this trust to be established.

My interviews also gave me insight into how the jobs taken by the immigrants were physically strenuous and damaging. It is also possible to speculate about the macro labor-capital relations in the 1980s, about the decreasing need for unskilled laborers, and about how it made sense to grant early retirement to middle-aged, mostly unskilled female laborers, similar to the trends for other immigrant workers. It is also possible to dismantle the very illusion that immigrant women as laborers were emancipated from the double burden, that is, freed from their care responsibilities as mothers, daughters, and wives. In reality, as young mothers to at least two children, they also worked hard at home. Men, as husbands, sons, and fathers, with some exceptions were less oriented to caring responsibilities and household maintenance than women. In other words, in addition to factory or cleaning work, the women also continued to work at home, taking care of children, cooking, baking, cleaning, and so forth. In this sense, early retirement came

to be seen as a "happy solution" that alleviated their double burden. It also marked their passage to old age, and how they defined their old age in medical terms.

However, I suggest here another common theme, which is that the journey from healthy migrant to exhausted migrant is marked by medical actors, institutions, and discourses. Deterioration of the migrants' health initiated a long-lasting relationship with hospitals and doctors, and these repeated interactions paved the way for a trust relationship. The stories that I have presented in this section allow us to formulate how doctors and in general medical institutions became significant for my informants' understanding of their life stories, old age, and the care they received. It is not to say that doctors were abusing their power nor to underestimate the seriousness of the women's health problems, but to think twice about particular doctor-patient relationships and how the encounters with their doctors came to shape the migrants' perception of Swedish health care. According to this, the Swedish health care system does not neglect their medical conditions but rather takes into consideration what they are going through, which is completely at odds with what the migrants experienced in Turkish hospitals in the late 1960s. Similarly, they continue to think that a modern and competent care approach is implemented in Swedish hospitals despite having encountered some actual deviations or problems. Many informants have confidence that, in the future, they will be provided with medical care similar to what they received in their early years as immigrants.

5
Medical Encounters in Old Age: Old, "discarded," but here

Introduction

If migration is a journey in space, aging is a journey in time, which is experienced bodily (Gardner, 2002) and marked by a myriad of discourses. A salient discourse around old age is medicalization. The social construction of old age as a biomedical problem has been widely discussed (Estes and Binney, 1991; Katz, 1996) and challenged by cross-cultural research on aging (cf. Lock, 1993; Sankar, 1984; Anbäcken, 2004), and these discussions and challenges paved the way for different perspectives and criticisms in gerontological research (Tanner and Harris, 2007). It is common for many people to be aware of their bodily aging when health problems arise, and more significantly, through medical discourses that dismiss these problems as "just old age" (Sankar, 1984). The increasing frequency of medical controls and consultations at older ages paves the way for a "scientific" understanding of aging. Old age comes to be perceived, understood, and discussed through the first acute or chronic illnesses and repeated encounters with medical institutions, discourses, and practices. The medicalization of old age affects people's everyday lives, social relations, and economic and legal positions. However, this also triggers, among older migrants, thoughts and considerations about mobility, different options in frail old age based on medical requirements and needs, and reassessment of their sense of belonging. In other words, not only do older migrants come to make sense of their bodily changes and health problems, but, as migrants, they also come to make decisions in their old age about their country of residence or intervals and arrangements for shuttling between two or more countries.

Abdelmalek Sayad (2001, 2004), while distinguishing how immigrants are affected by different types of distancing from work, such as illness (sick

leave), unemployment, and retirement, he discusses *la vacance* (vacation, leave) as a pathology of the immigrant's condition. Being unable to work due to illness or unemployment is imagined to be a source of alienation and a temporary abnormality to be fixed by medical and social authorities, "because the immigrant has no meaning, in either his own eyes or those of others, and because, ultimately, he has no existence except through his work, illness, perhaps even more so than the idleness it brings, is inevitably experienced as the negation of the immigrant" (2004: 180). On the other hand, retirement, or more generally, reaching older ages when people, through medical assessment of ill health, are discouraged, exempt or prevented from working brings about a different type of alienation and contradiction among older immigrants. The myth of return appears once again as a possibility. For many first-generation immigrants, there are limited ways of returning to the role of the wise and experienced member of the community in the country of departure. There also emerge new ways and necessities of prolonging their stay. If "retirement can be legitimized on the basis that it is no more than the final stage of the long history of "the temporary" that has marked the entire life of the immigrant" (Sayad, 2004: 180), medical and care needs gain relevance in assessing the enigmatic feature of the future and constitutes a common motivation and/or alibi to stay in the country of settlement.

In the previous chapter, my main aim was to delineate how a particular trust and confidence relationship with the Swedish health care system is enmeshed with earlier medical encounters. Drawing upon medical encounters in old age, this chapter engages in two main debates. First, it shows how the medicalization of old age becomes influential in first-generation, early-in-life immigrants' understanding of themselves at older ages and how this discourse shapes their everyday lives so that they continue to engage in social life in Sweden. Doctor visits, check-ups, and hospitalizations in a sense invite them into a public life, back from their confined, even isolated environments. In other words, these medical routines organize their everyday lives and provide them with a further motivation and/or alibi to stay in Sweden. Thus, they stay close to their family members and friends in diaspora while they continue to have a sense of belonging to their country of settlement. Meanwhile, these scheduled medical visits mitigate their social withdrawal and/or exclusion from the rest of the society.

Second, by mainly concentrating on the stories of two men, I will highlight how a sense of belonging was negotiated after their bodies began to function less effectively, compromising their ability to work. The impossibility/improbability of the "myth of return" appears to derive from a

medical necessity. In this sense, the migrants' sense of belonging as "a personal, intimate, feeling of being at home in a place" (Antonsich, 2010: 645) is accompanied by a politics of belonging (Yuval-Davis, 2006; Antonsich, 2010) where they see their rights to medical care as a well-earned indication of belonging in terms of citizenship. "Doing belonging" (Skrbiš et al., 2008) becomes possible through this claim to medical rights is granted by political belonging as citizens. However, it is not only an embracing of rights as the reward for participation in the labor force, nor a decision based merely on calculation of their needs for care; it is also a process of working out their social belonging at the threshold of frail old age. As Crowley (1999) argues, belonging, as a concept, is "thicker" than citizenship and it is not enough to see medical rights solely as citizenship rights. This is also anchored in an emotional endeavor to argue for these rights as being congruent with their life stories as immigrants. That is why I will also elucidate how the repercussions of the continuing appraisal of and confidence in Swedish health care constitute a benchmark for future plans, especially plans to stay in Sweden or shuttle between two countries, as well as ideas of belonging and care.

Being aged/old: *Yaşlı* or *İhtiyar*

In this section, I will start by looking at how my informants make sense of their aging and some of their singular accounts of being named *yaşlı* or *ihtiyar*, anchored in their experiences as migrant workers. Then, I will move to the medicalization of old age, and how it has been accepted by many but at the same time has triggered further questions of belonging.

Ahmet is a septuagenarian who is well known in the community for his sense of humor. His mockeries are marked by a serious posture and an arched eyebrow. It is difficult to anticipate his sudden questions and not to be intimidated by his physical presence. At our first meeting, arranged by my key informant, he joined me and his wife, Birgül, in the living room of their townhouse. He is a tall man with broad shoulders, and despite his recent long-term hospitalization and convalescence, his body is massive and impressive. I would learn that he had worked as a welder for many years in the automobile industry. He walked slowly, taking his time, and sat down on his favorite armchair positioned in front of television, as if he were the guest of honor. After turning up the volume on the television, the first thing he asked me was whether my key informant, a good friend of his, had called him *ihtiyar* (old) or *yaşlı* (old, aged). As it was the first question and the first interview, I became tongue-tied and did not know what to say. After a long silence, he noticed that I was speechless. He said, "Don't worry, my son, it is

a joke between us (him and my key informant). When he told me about your research, I told him that I am not *ihtiyar* but *yaşlı*, and if you called me *ihtiyar*, I would kick you out," and he burst into a laugh.

My speechlessness was about a nuance that he made himself and this nuance did not really exist in my current use of Turkish. *Ihtiyar* etymologically comes from Arabic and means old. The origin of the word is about "choice," therefore *ihtiyar* means someone mature enough to make a choice or decision. *Yaşlı* etymologically derivates from *yaş* (age) and literally means aged, old. They are used interchangeably most of the time, but for Ahmet, *ihtiyar* apparently connotes the state of being impaired, decomposed, and a loss in mental abilities. It sounded like senile, fossile, inactive, and it was unequivocally pejorative. *Yaşlı*, on the other hand, refers mostly to the chronological age, connoting or denoting nothing else. In other words, being *yaşlı* was not an identity marker but just an indication of how long one has lived.

This distinction was not clear to me, but I did not insist on further explanation. Was it a particular way of defining old age or just a counter-argument showing that being fit and old are not contradictory? One thing was obvious; Ahmet had worked in many strenuous jobs, and his body was not only his instrument of labor but also an important marker of his manual laborer identity and masculinity. He had never been hospitalized before his retirement, but during the last two decades he had started to frequent hospitals. He was aware of the recent changes in/on his body but he was constantly defying any precaution, restriction, and confinement. Ahmet embarked on a description of the renovations he had made in his summer house in Turkey, and his lonely, Robinson Crusoe like, even romantic, reclusion there. Birgül interrupted and started to tell another story, which Ahmet silently scorned. A couple of years earlier, he had gone alone to his summer house, which was in a deserted area in Turkey, notwithstanding doctors' warnings and family members' requests. Unfortunately, he had a heart attack when he was fixing something; thanks to some neighbors who saw him from distance, he managed to make it to the hospital. Birgül told the story not directly to me but in a sense repeating it to Ahmet so that he could accept his medical condition. Ahmet thought he would not have gone there alone if he was an *ihtiyar* in this sense. Ahmet shushed her none too gently, he turned to me with a look of frustration and said that he was fine; neither doctors nor his family understood his urge to get away, and he would definitely go to "his castle of reclusion" next summer and I could join him there if I wanted to. Birgül was used to his obstinacy. She was not angry, but

worried. She went to bring more tea to let him finish telling me about his summer house.

Ahmet's distinction between *ihtiyar* and *yaşlı* remained obscure for me until I met Metin, another man in his seventies. I visited Metin on a Sunday afternoon, in his two-room apartment. He had been married and divorced twice, and lives alone today. Time flew during our long conversation. Metin was eloquent and talkative while his speech was slow, lucid and compelling. He was complaining about solitude, about having no one to talk with when he listened to his archive of Turkish classical music or read something interesting. I was there not only as a researcher but also a young friend, willing to hear his life story. I asked few questions: there was no need to ask many. He had migrated first to another north European country where he worked for one year in a coal mine, but when a landslide occurred he was trapped in the wreckage. That experience frightened him and it was a turning point. At that time he was told by friends that there were jobs available in Sweden. He also read a laudatory article by a famous Turkish journalist about Sweden[24] and he came to Sweden in 1963. He found a job in the automobile industry as soon as he got official permission to work. He worked there for 39 years, doing the most strenuous tasks, but for him, Sweden appeared to be a country of leisure and self-learning. In his terms he was an "*arbetsnarkoman*" (workaholic) but he never abandoned his quest for self-improvement. He read, listened to, and participated in courses in his free time. He combined his work habits with his leisure time; in his view, time was precious and should not be wasted. He showed me the paintings he had made; he had placed them meticulously on the walls. He wrote poems with his beautiful calligraphy and placed them next to the portraits of his children. When he told me that he could not paint as often as he had imagined he would before his retirement, because he was old, I asked him what he thought about being old, and his answer was distilled from a long life story:

> They ask me everywhere, on the street, on the bus, when I travel or somebody comes and sits next to me in the park, how old I am, when I was born. I say I was born in 1940. They say, oh! I was born in 1940, too. Okay, I say, we are the same age, we are as if we were the same age. I say I am older than you. Absolutely. Why? You were born in 1940, I was born in 1940. But it is not that. I ask them how many hours they sleep per day −8 hours, 10 hours, 12 hours. I sleep only 6 hours. The time you spend in your sleep, I spend reading, thinking, seeing, I become the possessor of something. I say; that's why I am 10

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[24] Çetin Altan's newspaper article about his trip to Sweden in 1963. The title of the article was "Sweden, the country that I could not forget" (Unutamadığım Isveç), republished in a compilation, *Bir Uçtan Bir Uca*, (1965) Istanbul: Dönem Yayınları.

years older than you. (…) *I both live (yaşıyorum) and age (yaşlanıyorum).* I live more than they do. Everything. I see more, I think more, I read more, I get more information.

For Metin, being old (*yaşlı*) was closely related to having lived/living (*yaşamak*). It is a journey through which one develops skills and accumulates knowledge and experience. It was the moral of his anecdote. It was a well-thought argument around the etymology of *yaşlanmak* (being old) and *yaşamak* (live). However, when I pushed the question, bodily changes, diseases, and medical encounters came into his way of understanding old age:

> Öncel: You said that you have aged. Do you consider yourself old?
>
> Metin: Of course, my dear boy, even though I look healthy [*kanlı canlı*]. But look, I am an active person, I cannot sit down and wait. One has to do something. I feel old now. Let me put this way; I am 73 years old, let's go back to [the age of] 50. When I was 50 years old, I felt like I was 25 or 30. But now, I won't name them all, but I have 12 defects/diseases [*arız.*]
>
> Öncel: What are they?
>
> Metin: I won't tell [*he laughs*]. Eyes, teeth… Completely health-related [problems]. But it all ends here [*he points to his head*]. If you feed the mind properly, you keep young.
>
> Öncel: When did you feel that you were becoming old?
>
> Metin: I will tell you immediately. We have this prostate, you know. It started [to cause problems] in my 50s, I think I was 51 or 52. I had never woken up to go to the toilet before. I began waking up to go to the toilet. Then I started to wake up two or three times a night. I went to the doctor. They did some tests. The doctor told me that I had an enlarged prostate, they measured its weight in grams, but I was also told that this frequency of going to the toilet was unusual. I had also urethretis. [It was] a problem with bacteria. I took medication, and I got better. But they started to call me for regular check-ups. I went to prostate check-ups. When I was 70 years old, they told me that there was no more need to call me, because even if it gets cancerous, it would take another 20 years to develop it. They stopped calling me, but I went to check-ups every other year anyway.

For a good worker who had worked for 39 years without any interruption and who had never required sick leave, the onset of bodily problems was alarming. When the tape recorder was off for a pause after a 1.5 hour of interview, Metin slowly rose from his place and walked to the kitchen to prepare some coffee while continuing to talk about his body. Even though he emphasized "keeping the mind young," he was affected and distressed by the changes in his body. He did not want to juxtapose his 12 diseases, not to hide them from a young outsider but to gloss over them as relatively unimportant to his interpretation of becoming old. These "defects" were neither to be discussed continuously nor to be pitied. Metin's bodily problems appeared to

be at odds with his spiritual maturity. He mentioned his prostate because it had launched his awareness of his age, but he resisted equating old age with sickness. Prostate enlargement is a common condition among men, myself included, who could live long enough, as his doctor had informed him about that. However, this diagnosis had inevitably marked Metin's transition from a healthy, working body to one who required monitoring and care. In other words, his body reminded him of itself. He had to go regularly to check-ups. Even after he was freed from obligatory check-ups when he turned 70, he continued to have them. The medical authorities' assurances concerning the low risk of cancer did not prevent him from seeking further check-ups. Even though he wanted to accept his bodily deterioration as a result of a long-lived life, he resisted the idea of getting worse, being unable to continue his daily activities. He was more tolerant when the doctor told him that it was old-age related. As a healthy and hard-working laborer, except for a small operation on his hand in the 1970s because of coal-related inflammation, he had never submitted to a medical examination before. Prostate enlargement and changes in his work and everyday life were a beginning. Once he started to read these changes within the medical discourse, old age became tantamount to having lived, but also to awareness of a changing body, marked by medical discourses and routines.

Metin, upon admitting his bodily changes and diseases and appropriating medical knowledge, precaution, and instruments for dealing with these ailments, was successful in managing his daily life in his tidy apartment which was replete with well-organized bookshelves, meticulously recorded TV programs and CD archives, and paintings that he had created. He was careful in his diet, strictly following his medication and exercising every day. He was a handyman, he continued to be active, and he could not "sit and wait." In a sense, in continuity with his life story, he minimized the effects of health problems on the lifestyle he praised and sought. He had increased his knowledge and awareness about his medical problems and he was proud of managing his daily life in old age independently until now.

The only thing that Metin said he suffered tremendously was the feeling of loneliness. He was divorced, with children who worked full-time and only dropped by for dinner once or twice a month. Many good friends of his with whom he had started his "adventure in Sweden" had passed away. He was reluctant to go often to Turkish associations, which function like coffeehouses where Turkish men socialize in their free time. He recounted that the men there mainly played cards, watched TV, and smoked and he could stand neither the noise nor the smell. He was not connected to an enclave community by kinship ties since he was the only emigrant from his

small town in Turkey. He had a few good friends still living, but they had debilitating health problems. He was a Muslim, but in his own way. For him, religious practice was individual and ought to be based on increasing one's knowledge, by using the mind. Unlike some of his peers, he was not fond of joining other Muslims in mosques for daily prayers or Friday prayer either. To put it bluntly, Metin had some difficulty finding places where there were people to socialize with. Except for daily shopping, brief visits to a few friends, and walks on sunny days, hospital visits constituted the main motivation to return to social life from his isolated everyday life at the periphery of the city. But now, he was managing his diseases himself and he told me that he was seriously considering returning definitively to his native town in Turkey, where he had inherited a family house. He was confident that he could manage his health himself and he would have more company in Turkey. His hope was to have a social and convivial life in old age. He previously wished to have a Turkish seniors center in Sweden, not a coffeehouse, where he could meet his Turkish peers with similar interests. Metin was aware that even though he had his adult children and some of his friends in Sweden, he distinguished himself from the rest of the community and placed himself in a particular position in diaspora space. For him, his nuclear family story marked by divorces and his adult children's successful individual careers, his bodily awareness and self-care as well as his self-presentation as an autodidact working-class man and his older age differentiated him from the rest of the Turkish community. Nevertheless, he was also apart from his Swedish peers in the way that he propounded his cultural, aesthetic, and diasporic background. That is why his yearning for the homeland became strong after retirement and as he did not have any acute medical condition, he was inclined to return to Turkey.

Selma was also aware of the influence of medical check-ups on her routines in everyday life. When I called her a couple of weeks after our first meeting to ask how she and her husband were, she told me: "You go and visit your mother when you go back to Turkey. Now we are old, doctors became (like) our mothers, and we go and visit them regularly." Among my informants, medical health care is not only a way of recognizing their old age, but it is also where they assess their relations with Swedish medical authorities. Doctors become like family members whom they regularly "visit." This analogy was not surprising; doctors became "like family members" because the older migrants see them nearly as often as they meet their friends and distant relatives. As the previous chapter has pointed it out, they tend to trust doctors as confidants who listen to their embodied stories.

On my second visit to Selma's home on a Sunday afternoon, Esma joined us and we started by talking about old age. Selma was 61 at the time, younger than Esma who was in her late seventies. Esma had serious problems with walking, and she slowly took her place in Selma's living room. I did not have to broach the subject; the conversation about old age had already started. Aging, for them, is a process, which is directly marked by their bodily changes, their daily activities, and, unsurprisingly, by the medical discourse that considers old age as the source of particular symptoms. Some anthropologists rightly argue that old age has been constructed as the etiology of diseases and affects the ways in which people understand their aging experience (see Kertzer and Keith, 1984; Katz, 1996). Similarly, in Selma's and Esma's accounts, old age, step by step, becomes the only explanation for their illnesses and complaints. Here it is worth quoting at length the discussion between Selma, Esma, and me:

Selma: You don't age abruptly, it happens slowly. Your movements become limited, you can't rush anymore. While you were climbing up stairs two by two, you start to go one by one. [*She laughs.*] You see these [changes], but when your bodily health is fine, age does not matter.

Esma: Sure.

Selma: Your brain and your heart are still young. Then, your movements become limited, your pain starts. You go to the doctor, "I feel pain here and here," you say. He says it is normal after this age. These things will happen. Then a light goes on and you understand that you are old, otherwise you never say you are old if you are strong enough. Am I wrong?

Esma: No, you are right. "Old age disease, old age disease," they say [*she changes her voice to apparently imitate doctors]*

Selma: They call it old age disease. I had these beauty spots. We hear about them every day, everything is cancer. My mother died from cancer, very recently. So when I went to the doctor, not specifically for these, but I asked anyway, I only showed these spots, the doctor said it was old age spots. [*short silence*] I became old [*she laughs*].

Esma: That means they discarded us, in a way.

Öncel: Who discarded you?

Esma: The Swedish, and everyone else. It is exactly as Selma says; when I tell my complaints, [they say] from now on you have to get used to living like that. But maybe the man is speaking the truth; I don't have anything to contradict him. I say, it is true; I accept it and come back.

Selma: As I said, we don't say we aged, we say that sometimes, but the brain and heart don't say it. The body shows it. Think about a new piece of cloth, it shimmers. You wash it many times, and it wears out, not good for anything anymore, it warps here and there. It is the same thing with us. [*she laughs*]

For Selma, aging is a process, experienced in the body and based on the limits of bodily movements, whereas "being old" is a marker, deriving from mostly medical interpretations of step-by-step changes in the body. Selma's emphasis on duality between heart/brain and body underlines her resistance to seeing bodily changes as ruptures in the continuity of one's feelings and mind. Biological and medical theories of aging do not correspond to how she experiences and understands physical changes in her body. Rather than being able to exhaustively interpret bodily changes, such as the spots on Selma's hands, the medical discourse simply names it old age. The quotation above is a perfect example of how the medical discourse categorizes people: "the doctor said it was old age spots. [*Short silence*] I became old." This also constitutes the paradox of a biomedical approach to aging. The premise that biological aging brings about particular diseases and bodily problems places limits on the possibility of medical treatment. That is why Esma's interruption is indicative. Defining a particular symptom as "just old age" obstructs the conventional modern medical care premise: precaution, and if that is not successful, then intervention. There is a myriad of discourses around anti-aging and successful aging, but once diseases are related to old age, there remains little room and less motivation for intervention. This was understood by Esma as "being discarded" and as a truth claim that she could not contradict but that nevertheless frustrated her. When I pushed by asking "Who discarded you?" she stretched her interpretation from doctors' diagnoses to a sense of general abandonment by the society. Esma felt that doctors whose care and competence she had always trusted "discarded" her and her peers, because their health complaints turned to be old-age related and there was little room for intervention, and so they had to accept and endure some of their ailments. In addition, "everyone else" and "the Swedish" had discarded them because they were old, no longer productive and active, and they had few occasions to engage in social exchanges outside their narrow circle of family members and few friends who were still alive.

Here, drawing upon the accounts of Ahmet, Metin, Selma and Esma's accounts, I will discuss two main points. First, I will turn to Ahmet's and Metin's resistance to be named "*ihtiyar*" and their wish to return, temporarily or definitively, to Turkey and argue that older migrants' meaning-making processes differ from those of their Sweden-born counterparts (i.e., native elderly working-class people) and has similarities with those of other older labor migrants if we take their sense of belonging into account. It is not to say that native Swedish working-class people do not have similar stories, complaints, or understandings at older ages. They most probably start to

think about their bodies as used once, not needed anymore, replaceable, and marked by and open to medical scrutiny. This is deeply anchored in how capitalist industrial work requires hard-working, well-disciplined, healthy bodies and how it shapes working-class bodies accordingly (cf. Skeggs, 1997; Zandy, 2004). However, as Sayad (2004) argues, the absence of/from work raises questions among immigrants about their sense of belonging. Immigrant ex-workers' residence in Sweden was motivated and legitimized by their participation in the labor force, and was built around their willingness to make a living, save for the future, engage in a genuine family life, and finally return to their country of origin. They were like "the new piece of cloth not yet faded by multiple washings", to use Selma's image. They were young, healthy, and eager to join their native counterparts in undertaking the strenuous industrial work. As bodily problems arose, they started to rethink not only their identities, but also the extent to which they belonged to Sweden (see also İbrahim's story below). They tend to consider themselves not only economically unproductive, as not contributing to the society, but also as displaced and misplaced in terms of social belonging.

It is not surprising that the "myth of return" to the country of origin regains popularity and power after retirement, as in Ahmet's and Metin's cases. There is also an important underlying gender difference. My female informants had emigrated to join their husbands and were relatively younger than the men when they retired in order to fulfill their caring responsibilities, as I described in the previous chapter. While this consolidated men's role as breadwinners, women have developed a stronger sense of belonging through their familial relations, especially with their children. Ahmet's insistence on traveling to his summer house despite his health issues and Metin's casual comments about leaving everything behind are also rooted in their gendered ways of interpreting the extent of their belonging.

However, the myth of return should not be considered a naïve and nostalgic quest for roots or a desire to live in a sunny country where the cost of living is low, as is the case for some middle-class and upper-middle class pensioners (King et al., 2000). The migrants' ongoing work and family life had prevented them from brooding over the extent of their social belonging. The model citizen in the Swedish context was a full-time worker, and as long as they were healthy enough to work, the migrants rarely thought about how fully they belonged to Sweden. They belonged to Sweden in economic and legal terms, and social belongingness was compensated for with more relational, diasporic forms of belonging. Nevertheless, belonging is not a fixed status, but rather a process, a becoming (Probyn, 1996; Ilcan, 2002). Reaching older ages and withdrawing from previous family and professional

activities and other diasporic people trigger new negotiations about belonging. Medical and care needs become an important component of these negotiations. Therefore, being "discarded," as Esma named it, has three connotations for older migrants. First, as their symptoms and diseases are seen to be related to "just old age," there are few possible medical interventions. Second, they are considered to be unproductive, therefore not contributing to the society, similar to their working-class peers, and finally, they feel out of place, or misplaced in terms of social and residential belonging. The latter confronts them with their myth of return and also with the negation of the restoration of the old equilibrium, in which they were "doing belonging" to Sweden. As Esma recalled, "unlike hard but beautiful days*"* when they were young, they had to start to "feel more lonely in a country which is not [their] own." This emotional tone also invokes the first years of immigration when the migrants were trying hard to reground in a foreign land and to make a home for themselves. In other words, aging in diaspora, in *gurbet* is about constantly searching for new forms of being present to combat a sense of loneliness, isolation, and alienation.

The second main point discussed in this section is that the migrants' feeling of belonging to Sweden is also shaped around health care facilities that they are likely to use. Increasing health problems, the need for regular medical checks and interventions, and their confidence in the quality and availability of proper health care mold their sense of belonging in Sweden and their decision to continue to live in Sweden, where they imagine being close to good health care. It is not a mere pragmatic solution or awareness of an "it is my right" argument. Rather, it implies that their bodies will be taken care of by people other than those in their family and community circles, if there are any. Their bodies, once instruments of labor, still exist in public, even though that existence largely entails medical interventions or consultations in a system they have come to believe it is "the best." Sayad (2004) argues that doctor-immigrant relations are full of misunderstandings; however, how the immigrants come to interpret these misunderstandings is contextual. For example, Metin's solitude and relatively successful management of his diseases outside the strictly scheduled check-ups have encouraged him to return to Turkey, but he also does not feel that he belongs to Sweden whereas for many others, the aspiration to live in Sweden in old age is shaped around three main reasons: experience with and proximity to trusted health care, the presence of family and kin relations, and a sense of belonging that they actively reinforce by continuously interpreting their migrant life stories as well as their past and present medical encounters.

The following section will shed light on two men's hospitalization experiences in old age and how a feeling of belonging is reinforced through the good medical care that they received and how these routines weigh on their ideals and desires in old age.

Hospitalization on the verge of old age

As mentioned before, my female informants, following their hospitalization after giving birth and their sickness-related early retirement, appeared to be more in contact with medical authorities and discourses, whereas even though men might have consulted medical institutions, they were less talkative about their health troubles they had when they were younger. They mostly endured work-related health problems and retired later than women. The other fact is that men assumed fewer caring responsibilities and suffered less from combining them with work. However, it is worth noting here that my relatively older male informants are "survivors." My key informant reminded me of this, many times, since he, as an interpreter, took part in the struggle for recognition of the work-related ailments of those migrants who had done the most strenuous works, such as at the docks. Many of them did not live even until retirement age. Therefore, hospitalization on the verge of old age was seen to be luxurious, but also, paradoxically, overwhelming for men, who consequently appreciated Swedish medical care all the more.

Ibrahim was grateful to the medical team that took care of him for 10 days when he was unconscious after a sudden heart attack. He was proud to say that he had never had to go to hospital before. I met Ibrahim in the city center on a weekday for an interview since he had some paperwork to do regarding his recent hospitalization. He was in his late sixties and full of life despite the shock of the newly diagnosed health problem. After this, he had to be more careful about his health than before. We sat in a coffee shop, where he invited me to ask anything I wanted to. He started his immigration story, which began in the same way as many other accounts: He had come to Sweden in 1971, he married a Swedish woman, and got divorced; he remarried and divorced again, and finally, married a Turkish woman with whom he continues to live. After his last marriage, he also decided to move to the district where other Turkish people lived. Prior to this he had kept at least geographically distant from the Turkish community because he had been married to Swedish women. Now, however, he was back to the community (*Türklerin arasına*) not only because his wife is Turkish but because he was starting to feel less physically secure and he felt a greater need for the company of his countrymen and peers.

"Old age has now started," Ibrahim said, by referring to his recent heart attack and hospitalization. He told me that in his everyday life, he had never thought of himself as an old person. Intensive work schedules, successive marriages, children, and family responsibilities had filled his time. With this sudden illness, he started to think differently about his body and ageing. The heart attack and his long hospitalization triggered an identity crisis on three intersecting levels; as a man, he was affected by having lost control over his body and needing hands-on care; this created an overwhelming sense of powerlessness as a father and husband. "I had never asked anything from my children before, not even a simple massage on my tired shoulders," he recounted. As a worker, even as a hard-working laborer as he saw himself, he was uneasy about being unproductive and having to turn to welfare institutions. All in all, he was dependent not on his labor anymore, but on the welfare money, and this was deeply disturbing, rather than shameful. Finally, as a migrant, as I mentioned before, he started to question his affiliation with and sense of belonging to Sweden. He started to think again about his earlier desire to return to Turkey and his father's abandoned house. From this point, he would have no professional attachment to Sweden, while he realized that his health would need more attention and monitoring in the near future.

During his hospitalization, Ibrahim was impressed by the care he was given. Despite the uneasiness, even shame, he felt over losing his bodily control and integrity, he was positively surprised by the hospital care he received. His emphasis was on the hands-on care he received when he was comatose; bodily care, to the extent of collecting feces and urine, was the epitome of good care. When I asked him about it, he echoed Hasan (who, in the previous chapter, likened Swedish health care to paradise) and gave the details of his recent hospitalization and an appraisal of Swedish hospitals by comparing them to hospitals in Turkey. His account is long, sometimes intentionally redundant to ensure that I would adequately appreciate the Swedish health care system, but proffers a common appraisal, worth quoting at length:

> Ibrahim: It [health care in Sweden] is the best, the number one, my brother! [*raising his voice*]. How could anyone not be content? It could bring one to tears! [*gözleri yaşarır*]. God save all of us from hospitals but not deprive us of hospitals. Hospitals are necessary. It's the best here, you can't find any better. You can't find these young women [nurses, care workers]. I was ashamed by the care they gave me. They did what they had to do for seven days [when I was comatose]. Then, when I woke up, I didn't want them to do anything for me. They brought me something, excuse me, for my toilet [a bedpan]. After I came to my senses, I said "No, hold me by my arms and bring me to the restroom, sit me on the toilet seat and leave." They even, excuse my language, washed my butt, they

cleaned my butt. They washed all my body, took away my urine. They would not do the same in Turkey, I don't believe they would. They would not, nothing of the kind. Most probably, they would not. Maybe there are some private institutions where they do these kinds of things. [*Harking back to his hospitalization*] You had to see these youngsters [care team], there is a button there, if you press the button, five of them will come in. If you press the red button, they come in a second, in a minute. [They ask] [*in a lower and gentle voice*] "How are you? Are you fine? What do you want to do? What do you want?" When it comes to health, there is no problem here [in Sweden]. No problem at all. But you wait, you will wait, my brother. For instance, something happened in the morning, you got sick, you would stand in the queue. When you go to *Akuten* [in Swedish, emergency room], what was the name in Turkish?

Öncel: *Acil* [in Turkish, emergency room].

Ibrahim: When you go to the emergency, you get in the queue; you wait there for a couple of hours. This is normal, my brother, you will wait. There are two doctors and they work, it is not a dyer's vat [*Turkish idiom; meaning that it is not as simple as dying something, it needs time and effort*]. Health care is excellent here. No one could deny that. It is perfect. You can find everything you need. If someone tells you that it is expensive, don't believe them. It is even cheaper than Turkey.

Öncel: Have you been hospitalized in Turkey?

Ibrahim: I haven't. But I went there, because my father was ill; he was ill and hospitalized in a hospital in Ankara. It was many years ago. I travelled from here to there, I talked to the doctor, he handed me a prescription, told me to buy the medicine and come back. I am not familiar with Ankara, I said. There is a pharmacy over there, he told me. I went there, they didn't have the medicine. They sent me to another pharmacy, they didn't have it either. They sent me to another pharmacy, I told them that I didn't know Ankara, they referred me to a young lad. I even gave him some pocket money, I will never forget it. We found the drugs. The doctor sent me to find the medicine, I went to three or four pharmacies. Do I have to look after drugs? Maybe it is not the case anymore, I don't know, I have seen the hospital in Turkey in this way. (…) However good Turkish hospitals become, they can never be better than here.

Ibrahim was ashamed by the hands-on care he was given, not only due to the temporary loss of his bodily integrity resulting in the female care assistants having to clean him, but also because he had not expected such care by professionals. As he had never been hospitalized before, he thought that it was an extra assignment for the care team. It is well known today that any institutional care plan consists not only of medical treatments but also of comprehensive hands-on care. His surprise, I argue, was also anchored in his assumption that close family members would have to deal with hands-on care to some extent (*refakatçi*). I do not suggest that he might have expected hands-on care from his wife or children. On the contrary, he strongly wished that his family had not seen him in this vulnerable situation. Rather, my point

is about how the limits of professional care are imagined. As far as medical intervention goes, any care practice appears to be admissible whereas bodily care, including dirty work, is still considered surprising and is highly appreciated as an extra, as an excess of good care. My recent emigration from Turkey and possible familiarity with hospitals in Turkey paved the way for comparison. When Ibrahim switched to an account about how this type of care, namely hands-on care, would not exist in Turkey, not only was he trying to convince me about the quality of care he was given in Sweden, but also to mark the limits of care in other settings and the uniqueness of care in Sweden.

Ibrahim's very positive experience of hospitalization condoned and even muted possible criticisms about hospitals in Sweden, namely about staff shortages, waiting times, and long queues. Harking back to his personal experience, he justified these, arguing that medical care is a complex process and takes time. According to him, one has to be willing to wait in order to receive such high-quality medical care. In other words, it is a question of trust. If you know and trust that you will have "excellent" care, it is worth waiting for it.

When he recollected his journey back to Turkey when his father was ill, Ibrahim made another point similar to one made by Fatma in the previous chapter. In Turkey, he had had to deal not only with disorientation –not knowing the places, routines and people –but also with the permeability of the institution. In this sense, one had to think about particular elements of care (drugs, hands-on care, food, and so forth) in hospitals in Turkey while in Sweden one is provided with all that is needed. According to Ibrahim, even if the number of private hospitals increased, Swedish hospitals would always remain better in terms of care provision.

Ibrahim, after sharing in detail his scary hallucinations and nightmares after his week in a coma, told me that after his discharge, "real" nightmares began. He ended his account by talking about his present difficulties with institutions. After a very positive experience of hospitalization, he then encountered bureaucratic procedures that had been unknown to him until then. His heart attack was a turning point in his life and led to a new acculturation:

> Ibrahim: Things that had never happened to me before are finally happening to me. It is the first time I am "doing sickness,"[25] so to say. I got sick, and for the first time I have to

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[25] *Hastalık yapmak* (doing sickness) is a widely used term that means taking sick leave. Apart from being, becoming, or getting sick, "doing" sickness has two connotations: first,

go to the institutions. My medical reports, and so forth. I am still completing my documents. It is the very first time I am meeting institutions.

Öncel: Have you never gone to institutions before?

Ibrahim: Of course I haven't, why should I? [*in an angry and resentful tone*]. I never went. I earned good money, I gave it to my wife, I paid my installments. I swear, I am a dishonorable man if I lie [*şerefsiz namussuzum*], I never got welfare money, neither sickness payment nor anything else. But now, my pockets are full of papers [official documents]. When I was in this situation, I had to go to welfare institutions. I had to go to *sjukkassa.*[26] How difficult it is! How difficult it is to cope with institutions! I thought that it was difficult to cope with institutions in Turkey, it is also difficult here. I could not complete my documents in four months. I go to the doctor, I go to the hospital, I go there, I go here. I had a lot of difficulties. Now I am slowly getting it done. I get my welfare money, my sick pay. But this is my right in Sweden. That can happen to anyone, today my turn, tomorrow yours. As I was not used to this, I felt it was difficult/was offended by that [*zoruma gitti*]

Öncel: Why were you offended by that?

Ibrahim: It was difficult to deal with.

Öncel: Okay, you thought it was difficult. I thought that you meant you resented it.

Ibrahim**:** No I did not resent it, why should I? [*in an angry tone*] This is my right, I know that this is my right because I paid taxes to this state for 40 years. I know about laws and everything!

His emphasis on the fact that he had never had to go to hospital before is reminiscent of a common pattern of working-class men: hard-working, healthy, masculine bodies are indispensable for the types of work they do, but also for the image, and social dignity they look for. Ibrahim had never thought that he was also vulnerable to illness. His body had functioned and worked very well until recently. He never touched money that he had not earned. It was a question of honor and dignity that he always "turned an honest penny," unlike many others who "do sickness."

Ibrahim's admiration of the hospital team is more than gratitude for the relief of his suffering. There is also gratitude to the Swedish health care system, for the recuperation of particular social rights when necessary as a rightful member of society. That is why the misunderstanding between us is

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it refers to regular work routines, shifts, especially in factories, meaning that you do not "do" anything but sickness; second, it denotes the abuses of the system by some workers who are reluctant to do hard work and so try to escape work by pretending to be sick and claiming sick leave.

[26] He is referring to the institution where sickness allowances are distributed.

thought-provoking. When he said that he felt it was difficult to do the necessary paperwork" (*zoruma gitti*), I misinterpreted this ambiguous expression by asking why it made him feel resentful (*neden zorunuza gitti?*), and he immediately and angrily corrected me by reminding me that he had worked and paid taxes in Sweden, and that health care, sick-leave payment, and other welfare benefits were his right. Rather than drawing attention to his citizenship or long years of residence in Sweden, he preferred to reiterate his having worked and paid taxes. This justification was anchored in the Swedish welfare ideology where citizens are imagined to be "workers" (Hernes, 1988) organized around the ideals of partnership, freedom, and equality. In other words, he was a rightful candidate for all benefits.

After hospitalization, Ibrahim clearly understood that he was at an age of vulnerability, not as strong as before, but he also understood that he would be cared for and in the best ways. His positive experience at the hospital seemed to herald the care and routine medical scrutiny that would continue to be available to him in the future. However, from that point he came to be aware of two things. He had rights in Sweden, based not only on his citizenship but also his contribution to Sweden through his long years of hard work, while he did not have such "earned" rights in Turkey. In terms of medical rights, he did not belong to Turkey. Second, his blurred dream of returning to Turkey had become more distant due to health problems. He knew from the very beginning that he would not return to Turkey as some of his friends had, but now even the dream had become complicated.

Zekeriya went through frustrations similar to those experienced by Ibrahim and others. Zekeriya is infatuated with the idea of long-distance travel and long sojourns in a small town across the Mediterranean Sea in Turkey. However, after the onset of his acute and chronic diseases, he started to spend more time in Sweden than before. As man in his seventies, he was experiencing the very thing that Ibrahim feared: he had to regularly see doctors and he was dependent on medical care. He was afraid to spend time in Turkey, in contrast to his optimistic calculations about old age. His health situation entailed a regular, continual examinations, evaluations, and interventions. In response to my question about plans in old age, Zekeriya gave a self-reflexive account that included a long list of diseases:

> What do I think? [*long silence*] I have diabetes. They put in a stent when I got an infarction. Then, I had a pulmonary disease, and two months ago I had pneumonia. I had prostate cancer, its treatment is ongoing. So I am fastened/connected to here [Sweden]. Willy-nilly I am connected to Sweden for/in regards to health. In the beginning I was thinking about buying a house or renting an apartment in D [a town in the south of Turkey] and

staying there five to six months. If you are a citizen, you have to come back to Sweden every six months. But now I can't stay five months with all these diseases, one of them recurs. For instance, they call me for check-ups for my prostate. (…) Here, it is not like Turkey, they [medical authorities] take care of you and your disease, you don't do anything. You are called in for check-ups, and you have to go (…).

Zekeriya, like Ibrahim was very satisfied with the medical care he received, but also over the years and with proliferating and recurring diseases, he felt more secure and dependent on health care in Sweden. His dreams of mobility came to an impasse since his medical history was already known in Sweden and he was constantly remembered by the medical authorities and called in for check-ups. In other words, his long list of diseases not only occurred during his long life in Sweden, but they were also acknowledged and treated by Swedish medical experts. He felt he was better cared for and about since he was known, recognized by his embodied life story, and he existed in this country, whereas he was a mere visitor in Turkey, where he had no records, no long-lasting care relations, and no hardly-earned rights.

Conclusion

Abdelmalek Sayad's work (2001, 2004) with Algerian immigrants in France called attention to an important issue in migration and diaspora studies: aging and medical encounters in emigration/immigration. In this chapter, by following on Sayad's insights, I have elaborated on how first-generation Turkish immigrants in Sweden understand and negotiate medicalized old age and their sense of belonging. Belonging has been widely discussed as a synonym for identity, such as national or ethnic identity, despite its multidimensionality (Antonsich, 2010). However, belonging is a process rather than a stable, fixed, hegemonic construction (Yuval-Davis, 2006). When old age comes with bodily changes that are medically diagnosed, treated, and monitored, older migrants start to rethink the extent of their belonging to Sweden, not only in terms of their working years and family relations, but also in regard to health care that they imagine they will receive. Their imagined future is anchored in their positive appraisal of Swedish health care as well as in their life stories, shaped in the country of settlement. Their aging stories are rooted in their earlier experiences as migrants, workers, and clients of the medical institution. Sayad's work (2001, 2004) mainly concentrates on male labor migrants. Here, I have insisted on looking at the different gendered trajectories and how these trajectories have affected gendered senses of belonging. While the female informants immigrated

through family reunification and retired earlier than men, they were more concerned about their relational and familial sense of belonging than men like Ahmet and Mehmet who wavered over their myth of return and staying in Sweden and who suffered from alienation after retirement.

Moreover, the migrants' sense of belonging has yet to become congruent with their sense of identity and life stories that are continuously shaped and reshaped in diaspora space. In other words, while embracing the health care in Sweden, they find new ways to understand the myth of return and continue to be well-integrated immigrants who believe in the benevolence of Sweden towards the members of the welfare regime as citizens.

Their regular medical encounters in old age brought about three main consequences: First, they started to understand their aging bodies as they came in contact with the medical discourses and interventions. Many early-in-life immigrants have been acculturated to the Swedish medical system, along with its routines and language. Even though many have some difficulty expressing their symptoms and demands, they know how to proceed in the medical system. Not only do they feel empowered to embrace deservedly the medical services in Sweden, they also feel misplaced in the Turkish system.

Second, medical encounters became where they continue to be visible as rightful citizens when they use their medical needs and expectations as a discursive resource to claim social belonging. These encounters have provided them with routines and practices to justify their presence in institutional relations. Every time they were taken care of and cared about, they thought anew about their belonging to Sweden. Even though they sometimes felt that they had been discarded by medical authorities, in practice they continued to be here and now.

Third, they came to see that their dream of returning to Turkey had become less feasible than they thought it would be. The myth of return had always been a balance in which to weigh their belonging to Sweden or Turkey or both. When this return seemed less probable than before, not by choice but due to medical necessity, they started to think again about their belonging and to adjust their thinking so that their decision would fit with their previous desires. The reward of migration that they had aspired to enjoy in Turkey after long years of working became a right that they now have to justify, illustrate, and argue for as they reach old age in Sweden.

In addition, the idea of being dependent on medical care paved the way for further questioning about frail old age. Many attempted to adjust their expectations about formal care and care provided by family members. In the next chapter, I will present the bewildering array of attitudes, ideas, and desires towards formal elderly care, which oscillate between particular

subject positions, mainly between well-integrated modern individuals of migrant background who trust Swedish health care and interdependent members of Turkish families with emotionally dense relations.

6
Aspiring to Be "Modern" in Frail Old Age

Introduction: Aligning with "the Swedish"

During my visit to the townhouse of my informants Birgül and Ahmet, I was invited into their large living room, which was full of family pictures. When I complimented the decoration, Birgül was pleased that I had noticed her "exhibition." She invited me to have a closer look and proceeded to present her adult children and grandchildren. The photo collection was more than a simple aide-mémoire for happy moments of the family story or a "showcase of the self" (Cristoforetti et al., 2011) marked by diasporic aesthetics. Family members were represented in the context of their everyday lives. It is a common practice to place family photos in a middle-class living room in Turkey, but what was remarkable in Birgül's home was the abundance and meticulous installation of these photographs. Birgül told me that, in Sweden, it was a custom. She proudly smiled and added that after 40 years in Sweden they had acquired some good things from "the Swedish."

At that time, I had uncritically assumed the expression "the Swedish" to be a descriptive category; since as a newly-arrived immigrant, I had bracketed my sociological reflexivity and was trying hard to understand my own encounters in Sweden, sometimes through very homogenizing and generalizing lenses. After conducting a couple of visits and interviews, I came to understand that "the Swedish," as a *leitmotiv,* was more than a simple generalized other with which my informants were continuously in dialogue with; it identified an object of admiration and fear, emulation and abstention. It was the name of a contentious encounter with "real" modernity, a European one, which the informants thought had never been successfully implemented in Turkey. The Swedish came to be perceived as the epitome of

what was "genuinely" modernized, encompassing all technological progress, a high standard of living, and good education and health care but also represented challenges to the interpersonal relations and social skills.

Brah argues that diaspora space "as a conceptual category is 'inhabited' not only by those who have migrated and their descendants but equally by those who are constructed and represented as indigenous" (1996:181). The Swedish was a specific construction which tended to create the indigenous, through which it became possible to for a common "we." "The Swedish" was coined as the name of a typical member of a homogeneous group, often used in the singular rather than plural form (*Isveçli*). This had three connotations. First, the informants always felt they were at a social distance from the native Swedish people. Even though they had had some native Swedish friends and colleagues over the years, they did not or could not stay in contact with them after retirement. They have mainly socialized with others from Turkey from the beginning of their settlement in Sweden. This led to a generalization of the Swedish, drawn in part from the few people they came to know – that is from the "weak ties" that Buonfino and Thomson (2007) define as occasional interactions in public spaces-, and, more importantly, from already circulating discourses about the characteristics attributed to the Swedish people. They also came to understand that they have been perceived as radically different by some native Swedish people, as *blatte*, *svarstkalle,* or basically *Turk*, three different racializing pejoratives referring mainly to non-Scandinavian immigrants.

Second, the Swedish were the actors within an admired modernity and rationality. Many informants came to consider Sweden as the country of rational calculation and pragmatic solutions to every technical and social problem; the Swedish were actors to consult, and ask for help. As I have previously discussed, trusting doctors and hospitals was anchored in the very encounter with these faces of modernity. Finally, the Swedish were also seen as victims of the social damages of the modernity, such as coldness, solitude and high individualism. Therefore, the Swedish were role models to emulate in many ways, by always keeping a distance. The Swedish, in other words, were not friends, neighbors or colleagues, but others that the informants had imagined in order to understand their oscillating identifications with particular subject positions in diaspora space.

In this chapter, my main endeavor is to highlight how Turkish early-in-life immigrants concoct their identification with Swedishness, including what they see as its characteristic norms and values. For this, rather than lingering over particular norms such as autonomy and/or independence, self-sufficiency, individualism, and so forth, I tread another path and focus on the

immigrants' attitudes towards formal elderly care facilities. As the subject of elderly care arrangements brings about ambivalent and even contradictory stances towards formal care, it will delineate their relational positioning in diaspora space and highlight the contours of how good care is imagined. I will concentrate on two main subjects: home-help services and elderly care homes.

Home help

Swedish elderly care has been designed to minimize dependence on family members (Trydegård and Thorslund, 2010) in old age and public home-help services are believed to enable older people to age in place and live independently (cf. Hammarström and Torres, 2010, also for a critical assessment of dependence and independence). Nevertheless, as became evident in the 1990s, due to cutbacks in public home-based care family members have been more involved in helping their next of kin (cf. Johansson, 1991; Szebehely, 1998). While older people in need of practical help with tasks such as shopping and cleaning have started to turn to the private companies (cf. Johansson et al., 2003; Brodin, 2005), or those who have "someone to turn to" (Dunér and Nordström, 2007) have begun receiving support from family members, these changes have paved the way for a much more complex family involvement in elderly care as well as various negotiations about family responsibilities and further care arrangements (cf. Söderberg et al., 2012). Therefore, public elderly care in Sweden is less straightforward than my informants believe it to be. The majority of my informants have once encountered the welfare state characterized by a universal distributive system (Titmuss, 1968), and they were not knowledgeable about the welfare state's changing organizations, procedures, and challenges (cf. Forsell and Torres, 2012).

Broaching the subject of elderly care arrangements was not pleasant, and it was emotionally difficult to talking about frail old age and an unknown future. Some informants had even avoided talking about their future care arrangements with their adult children. Many informants began by talking about home-help services, which would apply to less acute care needs, and I followed their lead, asking my interview questions from where they started. Home help is the most visible elderly care service and many of my informants had observed that some neighbors received home-help services on a daily basis. Many expressed a positive view of this type of formal care practice, since it neither uproots older people from their homes nor imposes extra duties on their family members.

Needless to say, home is significant for many older people as a place where they can maintain a sense of continuity (cf. Cristoforetti et al., 2011). Relocation to an elderly home can cause a loss of their sense of autonomy and control (Percival, 2002). It is associated with depersonalization and separation from familiar surroundings and material objects imbued with a lifetime of memories as well as degradation of integrity and privacy (Twigg, 2006). The ability to continue to live at home in old age can be extremely meaningful for people who have already lost a home once. The experience of migration has been articulated and understood around the loss of one home and creation of new homes in different settings. A wide range of research by sociologists, geographers, and gerontologists has shown that for older people with migrant backgrounds, attachment to a place not only provides them with emotional and practical support but it also enhances their well-being and sense of belonging (cf. Becker, 2003; Bolzman et al., 2006; Lager et al., 2012). As the following accounts make apparent, home is also imagined as a place that is in close proximity to caring others, such as adult children, friends, and neighbors. Home is not only a place where a sense of identity and privacy is retained, but it is also intertwined with already existing caring relations.

A remedy for care deficit and loneliness

Memnune was one of the informants who thought that home help would be a good option in frail old age, especially for those who were lonely. If she "really" needed help, she would accept some so that she could continue to stay at home and be a "good" mother to her children. For her, being a good mother is about being caring, regardless of how old the mother or children are. She was very proud to tell me that her adult sons were very fond of her (*bana çok düşkünler*). Even though they now had their own family responsibilities, they would do everything to ensure that their mother did not need any help from outside the family circle. However, Memnune thought that there were limits to what an adult son could do; she had chosen to stay in Sweden with her sons rather than with her only daughter, who had moved to Turkey, and she indicated that she would rather have home help than rely too heavily on her sons. Memnune asserted that home help would be good for her in that it would allow her to continue to share "quality time" with her sons, but she felt that, for the Swedish, it was indispensable. She had the impression that the Swedish were lonelier than people, like her, who had emotionally invested so much in their children. In her opinion, the Swedish are destitute of caring relations. Their adult children have their own separate,

very individual lives and they only get together as a family during Christmastime, their friends are few, and they have not invested in caring neighborhood relationships. She summarized her neighbors' attitude with the saying "*Hej hej, o kadar*" (Hi, and that's all). According to her, not only older people but also the Swedish people in general suffer from solitude and a lack of caring others. After juxtaposing these stereotypical generalizations, which were repeated many times by others, she spoke about her Swedish neighbor:

> I had a neighbor, my Swedish neighbor. She used to live next door to me. We always greeted each other. One day, I noticed that she was unwell. She kept holding her mouth. I asked her what happened, and good heavens, she said she got tongue cancer! She was treated and sent back home. She had no one [to care for her]. I sometimes cooked and brought food. There was no one at home. When she died, all her sons and daughters came. [Addressing neighbor's children] Where have you been until now? I felt so sorry. *These people are very lonely (*garip*) here. They are lonely in their home country.* I don't know why –because they haven't shown love and affection to their children? They are disconnected; they live separate from each other. They don't give anything to their children, and their children don't give anything back either. We are always giving, we love and protect. They are not like that. This is the big difference.

For Memnune, her neighbor's loneliness while she was dealing with a serious illness was a dramatic situation. She wanted to intervene in the ways she knew best: cooking, bringing food,[27] and visiting. Receiving home help would have at least alleviated the neighbor's solitude. Home-help services, according to Memnune, were mainly for lonely (*garip*) people like her neighbor.

Garip is an emotionally loaded adjective in Turkish that is not easy to translate; it is vibrant with strong images of vagrancy, loneliness, and homelessness. It also alludes to people who have experienced the austerity and uncertainty of life on their own. In the current usage, it is widely used to refer to people who lead an extremely precarious life, or people who are devoid of caring family members. It refers to someone who is deprived of caring relationships. Being *garip* represents a particular type of solitude; one can be with others but still doomed to be *garip*.

Being in a foreign land (in *gurbet*) is imagined to be an important phase of life where many informants once felt "*garip.*" The migrants were far away

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[27] Cooking and giving food is still considered to be a significant and meaningful caring practice in Turkey. It can be used both to care for and care about someone. If one cares for someone who is unwell, the belief that a variety of nutrious foods will be helpful is still salient. A striking example of caring about someone is when, in the event of a death in a household, female neighbors bring food during the mourning and condolence period.

from their families and friends, had difficulty building new relationships and invested emotionally in people with similar backgrounds. Remember that, as a newly arrived, unmarried man with family living in Turkey, I was "*garip*" to some degree in Sweden and that is why some informants chose to take care of me, not only by providing practical knowledge and help, but also, with dinners, regular telephone calls, and so forth. Many agreed to allow me interview them in order to help me get my research done as quickly as possible so that I could return to my family in Turkey or start my own family here in Sweden.

In other words, being a migrant can easily be translated to being *garip* in their repertoire. What is striking is that Memnune reversed this and used it in reference to the Swedish, those who stayed put, who were imagined to be at home while remaining lonely and far away from their caring relations. As *garip* suggests, feeling at home is not only about being attached to a place but about having caring people around. In this sense, Memnune saw home help as indispensable for the Swedish, who have no one to "knock on the door," whereas she invested emotionally in her children and so she felt assured that she would be always cared about, even though the caregiving, ideally, could be shared by some professionals. All in all, Memnune considered home help to be a good option for the elderly, but this service was imagined to be primarily a remedy for Swedes' lack of caring relations. For her, home help was not a necessity but a support to balance her possible care needs in such a way that would enable her to maintain her role as mother.

Home and boundaries

Esma was living with her son and her daughter-in-law, who had recently migrated to Sweden through marriage. Her son was employed full time and her daughter-in-law was taking Swedish courses at the time of the interview. Both were absent from home during the day. Esma suffered from many chronic diseases. Her legs were the most affected and her movements were restricted. Household chores requiring physical strength, such as cleaning, shopping, and laundry, were done by her daughter-in-law. However, Esma, despite her physical difficulties, tried hard to take care of the cooking. Although her home was looking more and more like a hospice room, with many devices recently installed for her well-being and safe movement, the kitchen was where she felt most "at home" and useful to her family.

Esma lived in the same building as Selma and Adnan, her family friends and beloved neighbors. Along with another younger Turkish neighbor, Esma and Selma would get together every morning for coffee. The visits gave them

a chance to exchange small talk, and also to "check on each other" on a daily basis (*birbirimizi yokluyoruz*). On one of my visits to Selma's home, Esma was ruefully told me that a couple of days earlier, she had lost her balance and fallen down in the middle of her living room. She could not move and so she remained there, alone and helpless. She was horrified by the idea of being and dying alone at home. Fortunately, she managed to crawl and reach the telephone to call Selma, who had extra key to Esma's apartment. This unfortunate event and the feeling of helplessness in her home were alarming to Esma. Even though she lived with her son, she was beginning to think about having proper home help that would be life-saving in this kind of situation. However, she was concerned about the boundaries of her home. Selma, as a trusted neighbor and a family friend, was welcome, whereas lending the key to a complete stranger did not feel right. Despite the possible advantages of having regular home help, especially when other family members were not at home, Esma was reluctant to open her door to strangers. She said:

> I would take home help if I wanted to. I have even got my special car [service]. I make a call, I have a card, they come and take me wherever I want to go and bring me back home. I use many facilities here. I was ill and they gave me everything. My place is full of devices, even this walking frame. The Swedish don't say, "We don't or can't care for you." Why should I be ungrateful? How can I say that they don't care for me, my son? Even at this moment, if I want home help, [they told me that] I could have some home help even though I live with my son. Even though I live with my son! But I don't want to allow a stranger to enter my home. I have my daughter-in-law, who is young. [*short silence*] What would that [having home help] do to my daughter-in-law, though? They[her son and daughter-in-law] would be disturbed. Otherwise, if I want home help, they can come and fix everything, they can care for me.

For Esma, the meaning of home was already being challenged by her changing body, and she was concerned about her future care needs. She was also aware that she was in need of support from her neighbors and family while she continued to regard herself as independent. The expression "the Swedish" appears in her account as the ultimate recourse in which she had confidence since she had already received some support. Esma thought that the assessment of her care needs would be straightforward, even though it could be more complicated for her to receive public home help than she imagined. She expresses gratitude towards the Swedish but is still reluctant to submit to such an arrangement. Receiving public home help would terminate her sense of independence by reinforcing her status as someone "being" dependent on care (Hammarström and Torres, 2010). The problem

has been expressed in terms of the "capacity to exclude strangers and non-residents" (Twigg, 2006: 125). Esma describes the boundaries of her home in relation to how she comes to define strangers. It is well known that when it comes to home-based care, many older people react negatively to interference from outsiders. Home-help services can be experienced as an intrusion on one's privacy and a source of discomfort (cf. Milligan, 2009). In Esma's account, the home-help care assistant was imagined to be a man, which could be a source of discomfort to her young daughter-in-law. The short silence shows that she also knows that this way of thinking sounds strange and surprisingly backward in the sense that the young woman's sexuality is purportedly at stake. Therefore she gives another reason to postpone receiving home help, which is the protection of the privacy of her son and daughter-in-law. As she lives with them, the intrusion of a stranger is imagined to disturb their privacy rather than hers. On the other hand, the assumed availability of public home help gives her some feeling of independence from her son and daughter-in-law. The vacillation between this feeling of independence and concerns about being dependent on both formal and informal care enables Esma to present herself as different from other Turkish older people who appear to more comfortably assume their roles as the elderly members of their families and similar to her Swedish peers whom she perceives as independent and individualized.

Fatma pointed out and criticized a similar pattern among older people in Turkey. She said that many mothers-in-law used their power over their children and daughters-in-law in old age, and they enjoyed their status as elderly persons. However, it reverses the power dynamics, as in a master/slave relationship; when they delegate all the work to the daughters and/or daughters-in-law, they become less competent and capable, and this leads to reclusion, inactivity and frailty in the end.

> Fatma: If I can manage on my own, why should I be a burden on my children? If there is an emergency, my children will come and care for me anyway. I see, for instance, my neighbors in Turkey. They are the same age as me, they sit at home, they don't even pre-pare their own food, and their daughters-in law serve them. The daughter-in-law does everything. She [the elderly woman] only sits, and says, "I am old."
> Öncel: How old are they?
> Fatma: 59 or 60. They don't do anything. I do everything, all my chores on my own. Maybe others don't see as wrong, but I do. For instance, you are my son, you are married and I am staying with you. I just sit and say that I am old while my daughter-in-law serves me. Why don't I do anything? Because I am old. I don't think that way. Why should I not do anything? But if my hands don't hold, if my eyes don't see, then I am old.

While criticizing power relations between mothers and daughters-in-law in Turkey, Fatma differentiated her own way of thinking about household chores from that of others, who supposedly continued to follow more traditional and hierarchical role models. Her remark was significant in that it emphasized autonomy in old age and questioned the rigid rules that were supposed to define the traditional Turkish family. The idea of home-help services therefore creatively challenged the ways in which family responsibilities were negotiated. It reinforced not only the ideal of autonomy at older ages but also the fact that she thought differently, almost as the Swedish did, from her peers in Turkey. Home-help services appeared again as a good way to retain one's dignity as an older Turkish mother by assigning caring responsibilities to different actors at different stages.

When Fatma described home help as a good option that would make it possible to be independent from the family in frail old age, her attitude was as positive as it had been when she talked about hospitals earlier. In her account, home-help workers follow the rules of a well-established system. Drawing upon her observations, she described home-help services as such:

> I have lived in this neighborhood for many years, I see the old people here. They [home-help assistants] come, they bring the elderly outside, they go together to the supermarket, they comb their hair, tie it up, they even put a hair pin! Were we at their place, we would laugh, we would say, "Look! They put in a hairpin on the old woman" [*she laughs*]. My neighbor used to take home help, she had everything she needed. They even gave her a device. When she fell, she pushed the button and they came to her rescue immediately. Her home help came three or four times a day and took care of everything. However, I don't say that all of them are good. Of course there might be bad people, pitiless [*merhametsiz*] people, among them. But the state established a rule and educates them accordingly. There are rules in everything, in hospitals, in everywhere, and care workers are educated accordingly.

According to Fatma, home-help services were well organized and consisted of well-educated professionals who took care of every detail. The Swedish appeared to be collaborating in the scrupulous care plan, even though there were some practices that might seem bizarre to Fatma, like putting a hairpin on an older Swedish woman, something that seemed appropriate only for a younger person. As Fatma lived mostly alone, with only sporadic visits and stays of her adult children, the boundaries of her home appeared to be more flexible, and tele-care devices that stretch beyond the boundaries of the home were appreciated since they provide an enhanced feeling of security.

Seda also appreciated the home-help services. Her account was similar to Esma's, with a strong emphasis on being a woman and on her religiousness.

As she lived alone in a relatively large apartment, she sometimes rented one of her rooms out, always to female students. Especially after her pilgrimage to Mecca, she had reorganized her life and the boundaries of her home. She started to wear a headscarf, practice her daily prayers, and be more careful of physical encounters with men outside her close family.[28] Seda reserved her home for and organized it around her religious practice. The first time I was invited to her home, she told me:

> I say my daily prayers (*namaz*), I have some religious routines. I am also unveiled at home; I would not easily let a man into my house, I would not feel comfortable. You are like my son, I don't feel intimidated by you (*çekinmiyorum*).

Although Seda seemed positive about the availability of home-help services, she was also concerned about the boundaries of her home, which were more gendered than before, and she would obviously prefer a female home-help care assistant so that she could continue to see her home as home.

For Elif, the order of things, routines, and assumed gendered responsibilities at home were more important than religious or gendered boundaries. Shenk et al. (2004) in their study about older women's home-making highlighted how routines and rituals become significant in their sense of feeling at home. After Elif told me about her observations of home help as a good option in frail old age, I asked her if she would like to have home help should she need it.

> Öncel: Would you like to have home help if you need it?
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> Elif: If my daughters want to help me, they will help me. If they don't, I will take some home help. They are today's children; we don't have any guarantee with children, and we can't easily count on them. For instance, I took care of my husband. I was told to bring him to a care home or to take some home help. But I also had my children. He would put his laundry there, he would wash it, I would put mine here and wash it myself, and home help would wash my husband's laundry. We don't accept these kinds of things. I said, "I will take care of my husband." If I get ill or very old, one of my daughters lives very close to me, if she wants to care for me, she will. Otherwise, our place is at an elderly home, God save us, I am already afraid of it.

Elif's account points to a subject position of a caring wife and mother. She had always taken charge of household chores on her own. When her husband

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[28]As a young man, I was assigned to the role of son, which then made it possible for her to invite me to her home.

was severely sick, she refused to have home help since she thought that it would disturb the way things were done in her home. Changing routines for the sake of her comfort seemed to cause more problems in her everyday life than before. This would also challenge her subject position in the caring nexus.[29] She also knew that her adult daughters have had a different life from hers and that they are less invested in care than she is. Therefore, she was not sure if one of her daughters who lived nearby would assume the role of care provider. Elif's daughter was already helping her with cleaning and shopping. Elif did not consider this help to be a response to an intensive care need, and she did not even think that she could apply for public home help. What Elif was worried about was the deterioration of her health and her potential need for hands-on care in the future.

Drawing upon this wide range of accounts, I will highlight that many of my informants are already dependent, to some degree, on existing caring relations (neighbors, wives, daughters). However, they do not see the type of assistance they get from these sources as being the same as what formal care services can provide for older people. Esma, like some others, lived in a narrow caring circle consisting of her neighbors and her adult children. This circle already provided her with what regular home-help services, at least in terms of practical and social support, could offer. Similarly, Elif's daughter helped her mother with cleaning and shopping.

Home-help services appeal to most of my informants as a "modern" solution. By putting it this way, they differentiate themselves from their peers in Turkey or those who live in Sweden but are not modern enough. Their peers in Turkey were mainly described as people who accepted their dependent status as befitting their position as honorable elderly members of their families. Those living in Sweden were depicted as either late-in-life immigrants who had not learned about how things are done here or as older people who had been confined to their enclave community and were determined to keep things as they were in Turkey. These prevailing views have two main effects: first, the informants position themselves closer to the Swedish, in the sense that they know and are open to options for care outside the family. Second, they regard home-help services as a good way of balancing family responsibilities should caring needs arise. The imagined availability of home-help services also paves the way for a sense of empowerment in old age, and a reconsideration of traditional family

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[29] Morgan (1996: 11) proposes the idea of "a caring nexus" that is "both constituted by and constituting the ideas of family and gender. Thus, women may be found to be engaging in caring practices within the home and elsewhere, but it is also the case that the identities of women and gender are constructed and shaped within the caring process."

responsibilities. As Fatma underlines, it is where they start to differentiate themselves from "backward" Turkish people in Sweden[30] or from their friends in Turkey by showing their interest in the ideal of independence from family and their compassionate attitude towards the younger generation. This heterogeneity in positions taken by my informants towards other Turkish people with different backgrounds, viewing the Swedish both as modern actors and *garip*, highlights once more how diaspora space is extremely meaningful in delineating older migrants' attitudes to formal care facilities.

Moreover, the boundaries of home are subject to a complex negotiation. Home is the area of privacy, with gendered and religious boundaries as well as personal routines and rituals. As Milligan (2009) highlights, to receive care within the home is thus to negotiate boundaries of privacy and intimacy. For older people who have already received care marked by a shared sense of being in *gurbet*, it can also lead to negotiation of their sense of belonging, since receiving home help can reshape and/or jeopardize their existing care relations within their family and among close friends.

Here, I should also refer to another well-known feminist debate concerning home help. As the choice of accounts by women suggests, questions concerning home help are mostly answered by women informants. The men's silence, reluctance to talk, or relative ignorance of men about home help is anchored in the gendered division of labor. Women are generally younger than their spouses in married couples – even divorced women live close to their ex-husbands in some cases – and caring activities that a formal home-help worker would do, such as shopping, cooking, and cleaning, are done by wives and in some cases by daughters and daughters-in-law. This undermines the significance of home help for men as it is framed in the gender roles of women in the family. My male informants talked briefly about home help as a health service that could not be given by family members. As Waerness (1987) contested two decades ago, "for older women the home-help service is primarily a *health service*, while for older men it is to a greater extent a *social service*, substituting the help and services which otherwise wives and other female family members would provide" (1987: 142). Medical home help, on the other hand, is considered to be task-oriented, brief, and non-interfering in the boundaries and order of the home, whereas daily caring activities are imagined to be carried out by family members. This view of partly embracing home help by separating medical

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[30] At this point, it bears repetition that the early-in-life Turkish immigrants whom I interviewed see themselves as well-established middle-class families. The "backward" Turkish people they categorize and criticize are from mostly from rural areas of a particular region in Turkey, and include late-in-life immigrants who joined their families in Sweden.

from non-medical care conceals the assumed and/or performed roles of women of the family in everyday life.

All in all, receiving home-help services is thought to be a "good" option in diaspora space, and this understanding is derived from the ideal of independence and individuality but also the perceived solitude of the Swedish. Evidently, this picture is distorted, and the reality of caring relations among native Swedish people is far more complex than assumed. For instance, Emilia Forssell (2004) related attitudes towards home-help services as a form of social capital. Migrants expressed their cultural distinctiveness as an asset and at the same time they appreciated the Swedish system. Concordantly, I suggest that this cultural distinctiveness is also shaped by different positions in diaspora space.

Moving to an elderly home

For my informants, the idea of living in an elderly care home and being cared for by people outside the family continues to present opposing views and desires. Openness and a willingness to be institutionalized in frail old age is the criterion of being "modern" *par excellence*. For many, the question is a test to show that they still care about their children, a wish to articulate their individual separateness from the rest of the family, mainly from adult children and also to delegate the burden of care work to professionals. However, they also think (and hope) that it will not be the case for them since their decision about such a solution will be contested by their adult children. The common trope is that the older informants, as good and caring parents, seek to relieve their children from the burden of care, while children, as modern but caring subjects, would reject such arrangements. While older parents consider family ties to be meaningful, entailing that family members care about each other, this confidence is sometimes at odds with the values of autonomy that they want their children to adopt. In her groundbreaking ethnography with the Jewish elderly, Myerhoff elaborated this tension as follows:

> The elders claimed that they had realized their most cherished ideals in life by producing children who were educated, successful, and devoted to them. They realize, they often say, that children must leave their parents, that they left their own families to emigrate when it was necessary, and so they understand the distance between them and their own progeny is inevitable. But the truth is that they counted family ties as the only completely trustworthy relationship, and it was excruciating to them to be so cut off from kinship bonds (1979: 106-107).

In this section, I will first highlight how elderly care homes in Sweden are imagined as cold *but* warm places of care. The paradoxical positioning of cold and warm is anchored in how modernity is understood. Consequently, the appreciation of the care institutions goes hand in hand with independence as *self-abnegation* for the sake of individual children. Then, I will delineate two different options as responses to possible shortcomings of cold but warm care in Sweden, namely, moving to a care home in Turkey and establishing a Turkish elderly center/home in Sweden.

Cold *but* warm

Relocation to an elderly care home is full of ambivalence and agony for both the older people and their families, and there are various ways of adapting, representing, and avoiding institutionalization (cf. Söderberg et al., 2012). One of the prominent anthropologists in the field of aging, Haim Hazan, discussed these homes as "cosmological niches" where older people become "nonthreatening controllable 'others'" (2002: 341). It is also a dramatic decision for families in Turkey to place their elderly into formal care institutions, but the agony is thought to intensify since according to the ideal, elderly care is imagined to be undertaken by the family, especially by women of the family. Another trend among middle-class families in Turkey is the employment of live-in care workers (cf. Akalin, 2007) as an alternative to institutionalization. Not only is the number of institutions far below estimated needs (Tufan, 2003) but also the idea that families should take care of their elderly is reinforced by the dissemination of news of mistreatment and abuses in elderly care facilities, and by the circulation of emotions such as fear, pity, and disgust.

This arrangement, like medical encounters, is imagined with previous and present ideas of institutional elderly care in Turkey. As all of my participants have access to Turkish television channels, many mentioned these images to me before giving their views about moving to an elderly home. Selma told me once:

> We see on the television, these elderly houses…They have no pity, they wash people with brushes…Can you imagine, with brushes? Are there not any good institutions [in Turkey]? Of course there are some, but it depends on your money. If you have money, it's different.

The horrible images and discourses from Turkey haunt them, shaping their ideas of what elderly care homes are like. Even though they accept that such atrocities also happen in Sweden, they imagine elderly care homes in Turkey to be cold institutions where people are not cared for but are left to die. Many were also worried about the quality of care in the private care homes since these were thought to focus more on making profits than on providing good care.

Elderly homes in Sweden, on the other hand, are imagined to be warm and caring. A. R. Hochschild described four models of care: traditional, postmodern, cold modern, and warm modern (2003: 332). Accordingly, my informants imagine a typical elderly care home in Sweden as combining the cold-modern and warm-modern models in a significant way. In Hochschild's categorization, the cold-modern model consists of impersonal institutional care, where institutional control is at a maximum. The warm-modern model, on the other hand, seeks to combine institutional care by sharing it with men and women, and with family members and volunteers. Needless to say, these are analytical categories that may intermingle in the everyday practice of care work. For instance, caring relations in an institution can involve varying degrees of emotional attachment (Qureshi and Walker, 1989). However my informants' understanding of cold *but* warm is based on the already existing caring disposition of professionals. The common trope among my informants lies at the intersection of these models. Accordingly, many imagine elderly care homes in Sweden to be like the cold-modern model, an exhaustive and holistic form of institutional care, but with care workers who are well educated to provide personal care. For instance, Hasan said:

> I see old people here. I go to elderly homes, I visit them, I observe people's and the personnel's perspectives. There is a 90-year-old guy for instance, she [the care worker] is not disgusted. She is educated, well educated. She takes the dish, feeds him, and wipes his mouth; she takes care of him cleanly and properly. She cares for the elderly, the patient, in a way that an ordinary person couldn't.

This ideal of good-quality of care provided by well-educated caregivers is also rooted in the informants' previous hospitalizations. Some, like Fatma, even attributed a particular emotional skill to those who are professional: they were educated to be "merciful." Professional care workers are well educated, indoctrinated into the benevolent care regime of Sweden but also continuously controlled; the institution is a modern, clean place that should appeal to modern people. However, it is still an institution in which care is provided by complete or relative strangers. The genuineness and limitations

of this cold but warm modern institution is an ongoing debate on which I will also elaborate in the chapter under the heading "*Şefkat*."

Elderly home as self-abnegation

When I initiated the discussion about moving to an elderly care home, many informants affirmed that they would be very keen on such a solution in frail old age. Their wish was to free their adult children from the burden of care, allowing them to realize themselves as independent individuals. However, this enthusiasm was followed by some hesitation when the questioning turned toward the topic of their children. Their adult children had acquired more characteristics of the Swedish in terms of education and acculturation. They were also presented as naïve and honest like the Swedish and unlike their peers in Turkey. Nevertheless, they had been born into and raised by a caring family and, they would never abandon their care responsibilities as adults. Many of the informants legitimized their long years of residence in Sweden as providing improved opportunities for their children's future.

Esma said that she would immediately move to an elderly home if she needed hands-on care, as she did not want to be beholden to her children. However, she also said that her daughter, who lives in Turkey, would disagree and would not let her take such a decision. She also informed me that her opinions were completely unknown to her adult children and that she would not even be able to discuss this option with them since they would feel very offended by it. The presentation of adult children as devoted and caring and against any option of institutionalization was again a balanced position between her wish not to be beholden to her children and her expectation that her children would not allow her to move to an elderly care home.

Seda, on the other hand, was eager to talk about these kinds of decisions with her children. According to her, this was also her way of showing how determined to demonstrate her position as a well-integrated immigrant. She told me:

> My daughter tells me, "Hopefully you will be demented first and think that you are at the elderly home. I will never let you go to such a place," she says. She says so to stick with me. But I don't want it, everyone has her own life. I am a difficult person, my opinions are different, the political party I support is different. I don't know, I am a different person. That's why living alone is good, as long as my health is good.

Seda's daughter appeared to be a devoted child who would make personal sacrifices in order to look after her mother. Her ironic remark about Seda's being demented suggests an ongoing tension between Seda and her daughter. Another tension was apparent in Seda's way of understanding caring responsibilities. On the one hand, she presented herself as different from the larger Turkish community. She lived alone, she was economically independent and fluent in Swedish, and she had more Swedish friends than her Turkish peers did. On the other hand, as will be seen in later chapters, Seda was also adamant about caring responsibilities among people in diaspora and within families, and about assuming traditional caring responsibilities towards the elderly in frail old age, especially towards parents.

Women discussed elderly care homes more than men. For my male informants, especially those living with their wives, the idea of moving to an elderly care home is a topic that they have neither thought about in detail nor discussed with their families. For men, frailty and dependence appear to be where their masculine roles as fathers or husbands come to an end. Ibrahim, for instance, told me:

> I don't want to be very old, paralyzed, and bedridden; I don't want to be a burden to anyone. When I was hospitalized, I didn't let my children in. I didn't want them to see me in this situation. I want them to remember me as my former self. Like Cüneyt Arkın,[31] who says "I will die on my feet," I want to die on my feet, but you know, I might become very sick. I might even have to stay in an elderly home. But if I stayed there, I would not take offence. No offence at all. I would not blame anyone. I am not afraid of death, I am not afraid of death. If it comes today, it is welcome.

For Ibrahim, frailty represented a departure from his former self. If he should need intensive hands-on care in the future, as was the case during his hospitalization, he said he wished to die as soon as possible so that his family would not see him in this vulnerable position. The ideal for him was to succumb to any frailty or sickness rapidly and in a dignified way. His

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[31] A male Turkish film actor who was featured mainly in action movies. He is well-known for death scenes where he dies on his feet after enduring many shootings.

memory of a very masculine actor strengthened how he considered any dependence as a threat to his masculinity. Rather than being dependent on others for his survival, he would embrace death as a solution.

For Hasan, deliberating about elderly care facilities in general is not a threat to his masculinity but an insult to his way of understanding being a modern man. After Hasan had praised the overall picture of elderly homes and home-help services in Sweden, I asked him what he thought about using these facilities. He told me:

> I don't want to think about it. I think it is primitive [traditional, unmodern]. The Swedish have a saying. The Swede gets up from his bed, Thank God, my feet move, my eyes see, my hands hold. He says I fill my mug, I drink my coffee. Thank God. He gives thanks for today, only for one day. I think the same way. I give thanks for this one day. Whether I will be old, whether I will be taken care of or not, when I will die, and whether I will be buried here or there, I don't think about these things.

Even though Hasan seemed to be more knowledgeable about elderly care facilities in Sweden than any other informant, he told me that he did not want to talk about these things with me nor with his family members. By invoking the Swedish and his mindset into his reasoning, he depicted himself as a man who thought only about today. In other words, thinking about frail old age and possible arrangements came to represent backward people, whereas his way of thinking aligns him with the Swedish.

Working out options

There are of course many other ways of thinking about care in old age. For first-generation Turkish immigrants in Sweden, the future is enigmatic in many respects. In the previous chapter, I delineated how their myth of return was reconsidered through medical encounters and emerging needs. When it comes to elderly care arrangements, they also work out different options, both in Turkey and in Sweden.

Fatma, as a veiled and religious woman, had suffered from the prejudice of others in the early years after she immigrated and she was also concerned about the invisible norms of Swedish institutions. When we began discussing about care homes in Sweden, she recalled an event that had deeply affected her. She and a friend were both veiled at the car factory in the early 1970s, and she recounted how someone pulled her friend's veil off during a lunch break to insult her in public. Then, even though the number of veiled women had increased and the prejudice about the veil had decreased over the last

decades, she thought she would not be fully accepted in Swedish care homes as a practicing religious Muslim woman. She juxtaposed this story with the emergence of elderly care homes in Turkey:

> In Turkey, in Kulu [a town in Konya], they established an elderly home. Old people go there from here. They also take their pension with them. They think, if I stay in an elderly home in Sweden, I don't speak Swedish so it [elderly home in Turkey] is more suitable for me, they say. I think the same way. If I find a very good elderly care home in Turkey, my pension is high, I can stay there. I don't want to stay in Sweden.
> Öncel: You don't want to stay.
> Fatma: I don't because my language, my religion, my food are all there. But in terms of care, Sweden is really good. [*short silence*] I don't know.

When I pushed with more questions about her unwillingness to stay in an elderly home in Sweden, she told me that many were reluctant because they did not speak Swedish well, but her own reluctance was due to concerns about fitting into the norms of the institution.

> I am not like them [other Turkish elderly], I can speak Swedish. But still I would choose my country, if there was a good institution, because we share the same feelings. Let me tell you this clearly; if I pray, if I read the Quran there [in a Swedish elderly home], it would be off-putting to the Swedish.

Although Fatma thought that elderly care is better organized and of a higher quality in Sweden than in Turkey, she was also worried that she would fail to belong to these institutions in terms of invisible norms. She knew that religious beliefs and practices were visible and respected in the Swedish institutions, but she had some reservations in the sense that she would not be able to share these "feelings" with others who felt the same way. Therefore, Fatma was considering moving to an elderly home in Turkey if she could find a good one.

Another concern for others was that members of the Turkish community in Sweden would reprove their adult children if they were institutionalized. Melahat, for example, thought that elderly care homes in Sweden did not come close to those in Turkey in terms of the quality of care, but she also believed that her two adult sons would strongly oppose this option since they would be considered by other Turkish people as ungrateful to their mother. Melahat did not want her children to face such disapproval. Rather, she anticipated that in frail old age, her sons would send her to her apartment in Turkey and hire a caregiver to take care of her. The rapid rise in the hiring of live-in caregivers among middle-class families in Turkey is well known (cf.

Akalin, 2007), and Melahat learned more about these arrangements during her stays in Turkey. A good friend of hers in Turkey had a live-in caregiver. For her, having a live-in caregiver in Turkey was better than staying in an elderly care home in Sweden since this solution would not only protect her from the coldness of institutions but, also, her frailty and her children's decision would be unknown to others in Sweden.

Beside these two options, there was a more commonly shared ideal that combines assumed Turkish and Islamic characteristics with the modern and high standard of care provided in Sweden: the establishment of a Turkish elderly care home in the city where they lived. Many had heard about a few examples of elderly care homes where special units were reserved for Turkish people with Turkish-speaking staff, especially in metropolitan areas. There were already many Turkish-speaking home-help assistants and care workers, thus recruiting would not be a difficulty. As the care team would consist of people who had studied and were working in Sweden, residents of the home would be offered a good quality of care. It was also believed that such an elderly home would create opportunities for Turkish associations and entrepreneurs to provide services such as food catering and activities for and with senior members of the community. As I described earlier, some of my informants were members of a small association that aimed to provide Turkish elderly with an elderly care home. They were also in contact with other migrant groups that had already established similar homes for their older members. Seda gave the reason for this demand and described the prospective elderly home as follows:

> Even people who come from Anatolia, from small villages, started to think differently. Their mothers don't live with them anymore. Children rent a small apartment nearby, and the old woman lives there. Previously, they used to live together but now mothers, grandmothers, and mothers-in law live separately. She has her own pension, and the state helps with the rent. They [children] sometimes drop by and clean their apartments. In fact, if this center works actively, it would be great. These women would not be lonely/stay alone. There would be no need for their children to visit them every day. There would be Turkish TV channels, Turkish care workers, Turkish food. We don't have it at the moment, but we will have it soon I guess, because there are many people who don't want their mothers with them. I personally know at least five or six older women who live alone. The son lives upstairs and his mother lives downstairs. [*short silence*] They are also right in their mind. Not everyone is the same. For instance, the daughter-in-law may not want it [to have her mother-in-law living with them]. I made a bequest; I don't want to stay with my children, never ever. (…) [*She names some of my other informants*] Our thinking is a little bit more modern than others'; please don't misunderstand my words, I don't mean to put them down. But as we are more educated than they [other older Turkish

immigrants] are, we don't want to be beholden to our children. For instance, someone from Konya says, "I raised my child and she has to care for me." We don't think like that. (...) Therefore, opening such an elderly home would be very good, especially for people like us.

Seda's description underlines changing patterns of care among Turkish families. According to Seda, co-residence is becoming less frequent, whereas adult children, mainly women of the family, living close to their older parents engage daily in caring activities. However, the main cleavage between these older people and people like Seda and her friends appears to be rooted in diaspora space, where some continue to be oriented to their adult children in terms of help and support at older ages, and others position themselves as "modern-thinking" people who are open to thinking and acting independently from their families.

This project of an elderly home was spoken about many times during my fieldwork. It was imagined to appeal to people who had come to this specific city in Sweden, lived together, and shared a collective history consisting of memories of the past and lived experiences as the first immigrants from Turkey. Therefore, the main emphasis is mostly on their shared collective history in the country of settlement rather than on rigid patterns, norms, and values that are attributed to Turkishness or Islam. On the other hand, they envision this home as a new home (Kontos, 1998), a co-housing community (Choi, 2004), a center (Myerhoff, 1979) where residents who had similar life experiences would live together and develop a sense of belonging. It was imagined more like a center organized around socialization and communality than an institution where only people in frail old age were expected to stay. This home/center would provide them with a sense of belonging and help them to combat solitude in general and specifically in *gurbet*.

However, this option also elucidates particular subject positions in diaspora space. As Seda suggested, this elderly home was endorsed more by Turkish people who "think like them," people who are as "modern" as the Swedish. They have an ambivalent attitude towards filial duty and family care as they seem to be against the idea of their adult children caring for them in old age. On the other hand, this center would suit them best, not because their children were willing to leave them, but because they would opt for this modern solution to care needs.

Conclusion

I started this chapter with a brief description of how my informants had come to use the expression "the Swedish" as a significant other to identify with, while at the same time keeping a distance in diaspora space. They are in a constant dialogic relationship with the image of the native who has successfully managed to be "modern" but has also fallen short of meaningful caring relations. "The Swedish" appears to be the epitome of an individualized and independent subject. My informants express their willingness to use formal care facilities to embrace the ideals, such as autonomy, individual decision-making, and independence, that they think form the criteria for being modern. They aspire to be modern in frail old age. Nonetheless, they also have concerns about completely alienating themselves from their families and other caring relations in which they have invested since their regrounding in Sweden. Presenting adult children as caring and disagreeing with formal care options and imagining a particular Turkish elderly care home where they would feel at ease are two main strategies in this objective.

In other words, some early-in-life immigrants affirm that they have become as modern as the Swedish, in tandem with their success stories of being well-integrated immigrants. However, they do not deny that their life stories have been marked by migration experience, a myriad of ways of inclusion and exclusion, belonging and difference. It is true that their continuous efforts to create sustainable caring relations in a new setting are always ruminated about through caring duties and responsibilities that are transnationally imagined and performed. However, these efforts have been also shaped by encounters with institutions, practices and social relations in Sweden. Having once been lonely and taken far from their caring relations paved the way for a diasporic consciousness where caring for each other became preponderant in *gurbet*.

To be caring is imagined by the migrants to be anchored in migrant family histories and in their identification with Turkishness and Islam, whereas formal care is perceived to be outside the moral economy of families. Therefore, discursively embracing formal care facilities reinforces their identification with the Swedish, through which they have come to make sense of their life stories as well-integrated and modern immigrants. Affirmation of these facilities creates some others who were unable to follow the same path so have not become "modern enough." Late-in-life immigrants or those with a rural background appear to be unsuccessful in integrating into Sweden, adapting to modernity, and thus they are confined to their family

and kinship relations. Vis-à-vis these others and aligning with "the Swedish," my informants manage to present themselves as "modern." This heterogeneity of positions taken by my informants towards other Turkish people with different backgrounds, the Swedish both as a modern actor and a *garip*, highlights once more how diaspora space is extremely meaningful in delineating older migrants' attitudes to formal care facilities.

The migrants' accounts about formal care options like home-help services and elderly care homes show that they feel empowered having an alternative to family care, and modern in the sense that they hope for better chances of independence for the sake of themselves and their children. However, at the same time, these arrangements bring about new ways of thinking about family and challenge the ways they identify themselves as Turkish. In the following chapter, the main focus will be on how families are constructed by the migrants as caring environments where particular emotions operate to affirm their difference from the Swedish.

7

Doing Turkish Family through Emotions

Introduction

Migration is not only about distant friends, lost networks, and nostalgia; it also creates new ties, new affinities, and new ways of socializing. The feeling of being abroad (*gurbet*) brings together people who would not even be acquaintances if they stayed in their mutual home country. Seda and Esra, with their incessant, friendly quarrels and teasing illustrate this diasporic intimacy very well. Even though they had different backgrounds and migration stories as well as completely divergent views about both Turkey and Sweden, they had become good friends, spending time together and helping each other. After a dinner at Seda's place where I first met Esra, we decided to prepare some *mantı*[32] at Esra's home the next time. Preparation of this special meal was a perfect occasion for people to come together and chat. I insisted that we all engage in preparing the food to make it easier for the host and more fun for us. Seda and I met in the city and got to Esra's place in the early afternoon. A young Turkish couple joined us there; they had stayed at Esra's place during their first years in Sweden.

Esra and Seda prepared the dough and we cut it into small pieces and filled them with minced meat; all the while, they kept disagreeing about almost everything. Everyone suggested a particular way of cutting and shaping the dough. Conviviality, festivity, joy, and the smells of food - everything was reminiscent of a family gathering, and we started discussing about family as everyone recalled the last time he or she had eaten *mantı*. Esra and Seda mentioned several times how special the Turkish family was.

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[32] *Mantı* is a Turkish dish, similar to ravioli, filled with sauced minced meat and, once cooked, served with yogurt. It has become a special meal where families and/or friends gather and spend time together.

CARING (IN) DIASPORA

When I asked what was so special about the Turkish family, I got no clear answers, but a lot of stories popped up. What was a Turkish family? How was it done and imagined in old age? Why and how was it different from the Swedish family? Seda's religious feelings, her large family with children and grandchildren who were settled in Sweden as well as her claim to be a modern, well-integrated immigrant made her more comfortable in assuming that the Turkish family would persevere in its authenticity while incorporating good traits of the Swedish. Turkish family was about re-organizing emotional relations *vefa* (loyalty) and *merhamet* (pity) in Seda's understanding, and that was enough to negotiate family responsibilities in Sweden. For Esra, a later-in-life immigrant who was from a secular background, there was a big difference between the Turkish family and the Swedish family, since the latter seemed to her to be completely devoid of *şefkat* (affection).

While we were discussing about families, *merhamet* (compassion, pity)*, vefa* (loyalty, faithfulness), and *şefkat* (concern, affection) came up as three specific emotions that set the Turkish family apart from others, especially from the Swedish family. After that afternoon, filled with of inspiration and joy, I went through my field notes and interviews to delineate this kaleidoscope of emotions in a more analytical way. These emotions were semiotically rich, illustrated with practices and stories, but above all, embodying desires, ideals, and frustrations that were deeply anchored in the experience of migration and transnational families. It is not to say that these emotions were invented in the host country and unknown in the Turkish context. On the contrary, these emotions are well known and pervasive in many domains, from politics to everyday life in contemporary Turkey. However, they gained significant subtleties in the migration and diaspora context, where conventional ways of claiming the Turkish family through love and respect, or through well-defined family roles and obligations, have been challenged by the host country's ideals, practices, and discourses. These protean emotions helped my informants to propound their difference as Turkish migrants and diasporics from the native without confining the question of difference(s) to rigid categories of culture, religion, or race/ethnicity.

This chapter, therefore, depicts how the Turkish family is defined, reinforced, and performed through emotions such as *merhamet, vefa,* and *şefkat*. These are multilayered emotions which may point to particular subject positions, family responsibilities, and care practices. Their polysemantic character can be used differently according to the effect people seek to create. Inspired by Sara Ahmed's approach (2004), I examine these emotions as

circulating and shaping collectives in order to claim and figure the Turkish family as different from the perceived Swedish family. "Emotions [are described] as processes in which individuals experience, shape and interpret the world around them, anticipate future action and shape their subjectivities" (Svasek, 2008: 218), and they suggest how collectives can be imagined and built. According to Ahmed (2004), "emotions define the contours of the multiple worlds that are inhabited by different subjects" (2004: 25) and "emotions *do things*, and work to align individuals with collectives" (2004: 26). Emotions overwhelmingly shape the experience of migration. *Vefa*, for instance, not only defines a particular migrancy that emphasizes loyalty to family and relations in the country of origin, but it also suggests a new collectivity in diaspora. An older Turkish immigrant, by invoking *vefa*, demonstrates that he is a genuine Turkish man who has not forgotten his roots, and he also redefines his family and community. In Ahmed's words (2004), these emotions tend to be "sticky" in order to form the collective, create the set of norms for the Turkish family as a collective in a migration context and align people with the rest of the Turkish community. Therefore, this is not confined to doing Turkish family but may also extend to a consideration of how caring (in) diaspora is imagined, which I discuss in the following chapter.

In this chapter I will analyze how these emotions, once articulated, come to shape and disseminate the ideal Turkish family, which positions and roles family members take in it, and what can be expected, demanded, and/or negotiated if and when care is needed in frail old age. These particular emotions come to be seen by the Turkish immigrants as a genuine way of adapting to the host country's perceived norms and ideals by recreating and endorsing their difference. In this sense, it is the quest for equilibrium between the assumed modern but uncaring Swedish family relations and the idealized caring Turkish family relations. While the former requires the praise and endorsement of independence, autonomy, and self-reliance of family members as individuals, the latter, in parallel with the discussion in the previous chapter, is a tribute to the Turkish family that they expect to reconsolidate as they get older. *Merhamet*, *vefa,* and *şefkat*, therefore attempt to recall subject positions for older parents and their descendants, as required by the caring relations of the ideal Turkish family, while eliminating some traits that might appear to be excessive, odd, and even misplaced in the Swedish context.

Merhamet (Compassion/pity)

The TV satellite dish was an indispensable item in every Turkish household I visited. A Turkish channel was on during one of my long visits to Ahmet and Birgül's home. Birgül was watching a well-known daytime program that brought single people together in the studio to see if they could marry each other. The large majority of bride or groom candidates in this reality show were older widows. Birgül, pointing to the older woman on the screen, commented that apparently this woman's children did not show mercy (*merhamet*) to her, and after her husband passed away she came to this show to find someone to end her misery and take care of her.

Merhamet was one of the emotions frequently invoked during my fieldwork. Broadly defined, it means pity, clemency, charity, compassion, grace, mercy, forgiveness, and altruism and it can be interpreted and used in different ways. It can be considered a virtue that one acquires in the course of time, but one has to be inclined to feel and express it in meaningful ways. In other words, it is both a moral and moralizing emotion. It is imagined to emerge and be shaped within interpersonal relations and it seeks to reproduce a moral environment. *Merhamet,* as charity and pity, not only defines a sense of altruism towards others, but it also crystallizes the imbalance of power positions in a relationship. The less vulnerable may be compassionate or feel pity towards the more vulnerable. If one feels pity for another, she can respond with kindness and support. *Merhamet* also invokes the absence of violence towards another who is in a powerless and vulnerable position. If one demonstrates *merhamet* towards another, it means that the latter is already in a pitiable situation, in need of mercy and protection against further harm. It is deeply anchored in Islamic tradition and has strong religious connotations. Like compassion in the Judeo-Christian tradition, the ultimate position of grace is God (*Allah*). Accordingly, subjects of God are encouraged to humbly appropriate God's benevolence in their lives. However, it is also a personality trait, clemency; some people are born and/or raised to be more *merhametli* than others. Some people are more naturally inclined to be so, but it is a question of socialization and education as well. It is mostly a predisposition, acquired by birth and developed throughout life through actions, consolidated with proper practices. This polysemitism obviously serves to define gendered ways of expressing it. For instance, while an adult son may be expected to be gracious, pity and not to abuse his elderly parents, adult daughters are summoned to show compassion and engage in hands-on care as well as deal with bodily suffering.

So why does *merhamet* break into the discussion again and again? What does it do? What subjectivities does it create and for whom? How do older Turkish immigrants understand and talk about this particular emotion? Anniko Rabo argues that "as citizens we learn to do family, just as we learn to talk family through a variety of social practices" (2008: 131). Those social practices were organized around two major emotions in the nation-building discourse, and a particular familial citizenship has been designed in Turkey (Sirman, 2005). Love (*sevgi*) and respect (*saygı*) are considered to be the essence of the Turkish family. Lundberg and Svanberg argue that "the Turkish concept of love for the young and respect for the elderly (*sevgi ve saygı*) places all initiative in the hands of the men" (1991: 33); even though this is a valid statement in terms of men's powerful positions in family life, it glosses over the significance of age in gendered ways of doing family. Older women of the family are also assigned to powerful positions within the family, especially towards the younger members of the family. In other words, family roles are not only imagined according to gender roles but also in relation to age. This also creates a particular intergenerational relationship where filial duty towards the elderly emerges as a moral duty. Love and respect are considered to be unchanging regardless of individual life and family stories and more ontological than practical, whereas *merhamet* is more flexible and open to interpretation and can be easily translated to care practices, based on changing family relations and care needs.

The recourse to *merhamet* instead of emphasizing love and respect is also a strategic way to articulate the migrants' difference from the native Swedish people. In other words, as it would be excessive and odd to describe Swedish people as lacking love and respect in their families, my informants refer to another emotion. Therefore, *merhamet* is articulated and talked about in diaspora space; the assumed emotional habitus of the Swedish is already present in this space to indicate different positions taken by Turkish migrants.

In order to answer the above questions in detail, I quote below a long discussion between Esma, Adnan, and me. We were discussing different elderly care arrangements when Esma broke in to say that Turkish people were self-damaging and thus more inclined to age early.

> Esma: Let me tell you this, Adnan, if we were like the Swedish, if we lived like them in Sweden, we would live until we are centenarians.
> Adnan: You would live, for sure.
> Esma: Because we have these thoughts, these feelings…
> Adnan: [*Interrupting*] Worries… Worries damage Turks.
> Esma: Of course, we have this joy of life, this willingness to live, but we can't be like them. Everything bothers us. Even with strangers [*yedi kat el*], we would sit and talk

about troubles, have heart-to-heart talks. We become sorry for them, we keep thinking about why such a bad thing happened, we are even sorry for the Swedish. God save this feeling inside us, only compassionate [*merhametli*] people have it probably. Does the Swede have it? I doubt it. He only cares about his own life. He does not care about his children nor his grandchildren. I would not like to live like that, though. Without any feelings.

Öncel: You had told me that your daughter would be very upset if you talked to her about an elderly home…

Esma: She would kill me, I swear.

Öncel: So, you mean, they [your children] also have this feeling? They look at things differently from the Swedish?

Esma: Yes, they would not be like them.

Adnan: Not yet, they are more compassionate [*merhametleri fazla*].

For Esma and Adnan, Turkish people appear to be more inclined to feel sorry for others than the Swedish are. Their altruism towards perfect strangers is overemphasized in order to implicitly refer to the extraordinary strength of caring relations within the Turkish family. This emotional responsiveness is imagined to "damage" them since it entails an ongoing readiness to feel for others. Meanwhile, they also adopt these feelings as characteristics that distinguish them from the native Swedish people. What is striking in this conversation is how adult children are positioned with respect to the Swedish: they are successfully acculturated into the Swedish culture and they have their own lives, but they are still emotionally attached to their families, especially to their aging parents. They are more compassionate and altruistic than their native peers who were raised by individualist, carefree Swedish parents. Obviously, this position attributed to the Turkish adult children stems from particular stereotypes, yet it invites adult children to be responsive to their older parents.

Moreover, *merhamet* seems to encompass the gendered family roles, highlight the existing power relations, and prescribe responsibilities and duties in family life accordingly. A compassionate father who has this quality will never treat family members harshly and protect his family from economic hard times. A mother is expected to be compassionate and affectionate towards family members, especially those who are in need of care. When *merhamet* is attributed to adult children, they are expected to feel compassion towards their parents at older ages, never abuse them when they are frail nor expose them to mistreatment, abandonment, or isolation. They are summoned to find a way to be caring. This evidently presupposes and may reinforce gendered roles and practices. While an adult son can be merciful by not consigning his parents to an elderly home and by hiring live-

in care workers, daughters are ideally expected to engage, at least partly, in caregiving. At first glance, this appears to be a typical example of a "traditional" patriarchal family with rigid rules. However, it also paves the way for setting out strict family obligations; one comes to care about and take care of another family member not simply because it is an obligation, but because one is a compassionate and altruistic person overall. It paves the way for new negotiations, practices, and meanings. An adult child can place her older mother in a public care home but still show *merhamet* by visiting her every day, by not leaving her alone. It is not a question of loving or respecting the older parents but a particular way of showing *merhamet* to them.

Therefore, this was also a response to the ideal of elderly care by family members in the Swedish context that was further challenged by the availability and variety of formal care facilities. The majority of my informants' adult children are employed in full-time jobs, and they have their own children, and therefore it would be difficult for them to provide hands-on care for their older parents. At the same time, the availability of formal care facilities puts more pressure on the assumed family obligations. These are challenges for many native Swedish families as well as for many families in Turkey. What is remarkable in this particular context is the fact that my informants take these as challenges to their identification with a Turkishness that they thought had not diminished from the time they migrated. Many preferred to present themselves as engaged in emotionally dense relations with their children and present their children as having successfully incarnated two ideals at the same time: caring but modern.

Even though adult children were considered to love and respect their elderly parents, it seemed unlikely that they would completely renounce formal care options in the near future. However, the ideal of the Turkish family prevents elderly parents from overtly assuming this challenge. On the one hand, *merhamet* is assumed to be what makes them different from the Swedish. On the other hand, it underlines once more my informants' ambivalence towards formal care options. When *merhamet* is continuously recalled, it balances this ambivalence: older Turkish parents seem to be ready to move to an elderly home or receive home help, but still their children, touched and shaped by *merhamet*, are expected to resist this solution, at least to some degree, and balance such a move by creating new practices of caring.

To take an example from my fieldwork, Selma is one of my informants who engaged in many transnational care visits. She travelled back to Turkey in order to take care of her family members, first her older brother, then her

mother. For her, care in old age is a family responsibility. However, she does not want her son or daughter-in-law to take care of her:

> We are compassionate [*biz merhametliyiz*], it is my duty to take care of my elders. All in all I did not become Swedish after more than 40 years. Of course there are many compassionate Swedes, but not all of them place importance on these kinds of family relations. My mother had cancer and I immediately went there [Turkey] and took care of everything with my sister. But I would not ask the same thing from my son. He has his own life. I know that he loves me but… I completely agree with the idea of an elderly home where he can come to visit me. If I return to Turkey, it would be even more difficult for them to arrange such visits.

Selma's understanding of *merhamet* is an attitude, a feeling to pass on to new generations, and it comes with a particular caring practice. This also appears to be nestled in her cultural identity, which is different from the mainstream cultural script in Sweden. By reminding me of the exceptions (compassionate Swedes), she identifies the main emotional norm as she perceives it. By telling this story to me, as a young person, and also by underlining the improbability of demanding the same thing from her own son, she knows the limits of such a demand. Her son loves her, but she does not take future family care for granted, the practice (caregiving) she juxtaposed with being *merhametli* can be challenged. If she moved to a formal care facility, it would not undermine her son's being *merhametli* and loving, he would find another way of expressing it (visiting regularly, for instance), and the relationship is expected to be the same. What changes is the practice of *merhamet,* whereas, as an emotion, it remains the same. The practice tends to be more likely to be contextual while *merhamet* as an emotion continues to align the individual (Turkish adult second-generation son) with the collective (the Turkish family and community).

Vefa (Loyalty/faithfulness)

Baldassar's work (2001, 2007) underlines emotional dimensions of long-distance relationships between parents left in Italy and their children who immigrated to Australia. She explores different patterns of "staying in touch" and argues that migrants and their families engage with not only practical and financial support, but also emotional support. I also noticed similar practices of providing economic, practical and emotional support to older parents and kin who stayed in Turkey. Being and staying loyal to family and friends in the homeland was a recurrent theme. *Vefa* is a double-edged emotion. It

defines the good Turkish migrant who did not forget her native country, nor friends and family left behind in that home country, while it also offers a significant way of doing Turkish family in diaspora space.

Vefa means loyalty, fidelity, faithfulness and consistency in love. Someone who feels *vefa* remembers the good old days, where one was genuinely loved, respected, and cared about. *Vefa* is therefore a question of memory and is rooted in the reminiscence of past emotional, financial, and practical help. It articulates the goodness and trust received in the past, and projects the hope for help and care in the future. It creates a dyadic relationship and a readiness to reciprocate. However, it does not impose any direct and immediate return of past kindnesses. *Vefa* can be deeply felt but it can be expressed at irregular intervals. For instance, visits to the country of origin, regardless of their motives and frequency, show that migrants did not renounce their roots, friends, and family members left behind. Visits based on special reasons embody the epitome of *vefa*.

There are also gendered ways of feeling loyal and being consistent in love. Not only do emotions have "ascribed meaning that tends to be gender-specific" (Peterson, 2005), but the same emotions are also embodied, experienced, and demonstrated differently. The feeling of culpability (Baldassar, 2008) is balanced with gendered practices and expressions of *vefa*. For instance, Selma was not expected to travel to Turkey when her mother was sick and needed care; Selma's sister was already there to take care of their mother. Nevertheless, Selma immediately went to Turkey to show her that even though she was away, she was emotionally attached to her and ready to care for her. During her stay, she provided hands-on care for her mother; this caring practice was a way to express her loyalty and love to her mother. Melahat, after her divorce, brought her mother to Sweden, and she cared for her in order to compensate for the years they had lived apart. A man, on the other hand, can remain loyal to his family by giving practical and financial support. Ibrahim went to Turkey to take care of the bureaucratic procedures related to his father's hospitalization but he was not involved in giving hands-on care. Samet regularly sent money to his family to show that his emigration had not uprooted him from his family. A disloyal (*vefasız*) migrant is expected to compensate for her past mistakes. Even though *vefa* is a familiar trope in Turkey, it is worth noting that it gains greater emphasis in the migration context as an emotional response to the anxiety, guilt, and shame of emigration (cf. Chamberlain and Leydersdof, 2004). Remittances, gifts, regular phone calls, being careful not to miss significant family events, such as weddings, funerals and periodic gatherings are significant ways to express and perform *vefa*. In other words, as emigrants, they are invited to a

subject position where they continuously have to justify their emigration and separation from the rest of the family, and prove that they still share the same feelings.

Vefa is also relevant in doing Turkish family in diaspora space. The assumption and stereotypical view of the Swedish family is that family members invest emotionally in their children until they are adults, whereas as the migrants saw themselves more engaged in mutual support and reciprocity in the family in order to overcome the difficulties of being in *gurbet*. Memnune put it this way:

> Memnune: We are very different from the Swedish families. When the Swedish are 18 years old, the family disintegrates. When one is 18 years old, he or she leaves the [family] home. Even if the child does not want to, parents encourage him or her to leave, to live with friends or partners. But we think that children should stay until they get married. We don't stop caring about them, in one way or another. They stop caring about their children when they are 18.
> Öncel: So, you mean that Turkish children continue to care about their parents?
> Memnune: They keep caring about us too.
> Öncel: How do you think they are attached to parents?
> Memnune: I think it is due to love they have seen in/from us, but I have never constricted my children. There are some very authoritative [Turkish] families, they say: "Where are you going my son?" "Don't go there" "Don't have a girlfriend." They oppress their children. I haven't.

Memnune refers to the Turkish family as a caring environment where children are loved and therefore they are inclined to show love to their parents in return. She positions the ideal Turkish family in between the carefree, less emotional Swedish family and the oppressive and backward Turkish family. A caring parent-children relationship is idealized and imagined to shape the children into a caring subjectivity.

Therefore*, vefa,* as consistency in love, places the family responsibilities and caring relations into a family history. *Vefa* creates a relationality where the shared family history gains primordial importance in future family relations and decision making. It refers to a common repertoire of norms (caring parents and loyal children who are consistent in their love) without neglecting the variability of practices and experiences depending on individual family histories. Many of my informants lived alone, but their adult children regularly visited and helped them with daily problems and activities. The elderly were aware that intensive family care in the future would not be a viable solution. By calling their adult children loyal, they invited them to return certain services and created a proper subject position

for both themselves and their children as Turkish people. *Vefa* bridges theory of reserves and theory of intergenerational solidarity (cf. Tufan, 2003). The former stipulates that the status of elderly people depends on the power positions that they hold due to their economic and social resources, skills, and knowledge, whereas the latter presupposes an unconditional solidarity between the elderly and their adult children. When the filial duty is understood on the basis of *vefa*, the intergenerational solidarity comes to be rooted in a caring environment. Therefore, deference to older parents' power positions and the rhetoric of unconditional love are translated to a particular family story that is shaped by emotional interdependence.

Emotionalizing family through *vefa* leads to two main understandings. First, family invokes once again the "old good days," when parents offered a new life to their children in a foreign country despite all of the difficulties involved, and now it is the adult children's turn to reciprocate in caring relations. *Vefa* appears to be a claim to authenticity by simultaneously keeping the possibility of being independent and autonomous individuals. Loyalty to the family wishfully invites adult children to assume their responsibilities for their elderly by pointing to their difference, as Turkish, from the rest of the society. Adnan, after a long account of how busy his son was, said:

> Our children are loyal [*vefalı*] (to us, the elderly of the family). They are born and raised here [in Sweden]. But they are like that, they would not feel comfortable letting us down.

Second, deploying *vefa* as a particular emotional discourse challenges the filial responsibilities and obligations that are considered to be traditional, backward, or at least too demanding. *Vefa* paves the way for demanding more than might deemed reasonable in the Swedish context. Even if they fail to provide hands-on care, by being *vefalı*, loyal to their elderly, the adult children can continue to care about and honor their parents, and do their difference from others who are not caring at all. As one of my informants put it:

> Even if they [children] put me in an elderly home, I know that that they wouldn't forget me there. They would visit me more often than others' children do.

One can demonstrate *vefa* by visiting parents in an elderly home, while another may voluntarily offer home help; but still being loyal to their shared past as family, they do not lose their identity as Turkish people. This rather becomes an understandable and modern way of shaping and appropriating family responsibilities, simultaneously doing Turkish family in the Swedish

context. *Vefa* therefore aligns both the older parents and their children with an idealized Turkishness by ensuring and endorsing the family responsibility for care, and at the same time it attempts to dispel criticisms about backward, patriarchal immigrants.

Let me finish this discussion with a story that Fatma told me during one of my visits. Fatma had recently visited a good friend who had been moved to a care home. She was upset to see her friend alone in an institution. According to Fatma, when her friend was in the early stages of dementia, her two adult children decided that they could not cope with this disease and thought that professional care would be better. However, the older woman could not speak Swedish, and her situation deteriorated after she was admitted to the care home. Fatma said that her friend's daughters regretted their decision but now it was too late since it had become more complicated to care for her at home. That is why they were visiting her every day, to show that they did not mean to be ungrateful (*vefasız*): they were there to compensate for their initial mistake.

Şefkat (Concern/affection)

Şefkat is a term currently used in Turkish and it literally expresses compassion, affection, concern, tender kindness, and solicitude. Its polysemantic character is differently interpreted and prescribes gendered family roles. As solicitude and affection, it is considered to be a maternal virtue. As compassion and protection, it is a paternal attitude and designates the forgiveness of the father. It mostly alludes to a mythical family where members are concerned about each other. It is worth noting that this emotion prescribes an idealized representation of the family rather than depicting the reality. Even though family care has also been criticized for its hidden inequalities, abuses, and mistreatments, my informants thought that "caring about" and "caring for" tended to be more easily integrated within the family than in formal facilities.

Ayşe was proud of how her adult children had carved out for themselves successful and independent lives in Sweden. Both her son and daughter had studied and got well-paid jobs. When we started to talk more about older age, she became less talkative. She was angry at the indifference of the Turkish community to any agenda concerning older members. As she had spent years organizing associational activities, she was quite pessimistic about the Turkish community. She argued that older Turkish people were and would be dependent on their adult children, and therefore they were reluctant to engage in associations working to establish a Turkish elderly home. Ayşe disagreed

with this idea of being dependent on her adult children in frail old age, and she was willing to move to an elderly home if she needed hands-on care. However, she was afraid of not finding *şefkat* in a care home. She told me:

> When you get old, when you cannot take care of yourself, God save you, it is difficult. Thank God, I manage very well at the moment. But sooner or later, we will all need something. You cannot expect your children to give you everything; they have their own lives. They cannot move to my place nor can I move to theirs. I can, I want to, move to an elderly home. Yet still, you don't know if you will find yourself in affectionate [*şefkatli*] hands there. There are good people, there are bad people [professional caregivers]. For sure, it won't be like family giving care. It will be like work for them, you cannot expect more from them, can you? I don't expect *şefkat* from them, it is enough if they do not do any harm.

What does *şefkat* imply other than love, *vefa* and *merhamet* in this account? What kinds of subject positions does it point to? As it appears in Ayse's account, *şefkat* appears to embody the difference between formal and family care, what can be expected from professional care workers and family members. The conceit of *şefkat* as solicitude and affection continues to reinforce the ambivalence towards the formal care institutions since it is mainly attributed to caring family environments. The general belief is that public care homes are modern, well equipped, and run by educated staff, yet they lack the solicitude of the family. The ideal elderly care is imagined to be given by "affectionate hands." Professional care workers can be compassionate (*merhametli*), but it is not sure if they can be genuinely affectionate as *şefkat* is perceived to be rooted in the family. Adult children can continue to be loyal and compassionate Turkish people who care about their parents, whereas *şefkat* requires work and engagement. In other words, *merhamet* and *vefa* can bring about different ways of "caring about," whereas *şefkat* refers more to "caring for" and is thus more apparently embodied.

This also alludes to the well-known discussion of feminist ethics of care. In the professionalization of care, there is an ongoing discussion about a transmutation of emotions from love labor to care work. While the former is imagined to be provided by primary care relations, such as family members, the latter is generally attributed to formal care facilities (cf. Lynch, 2007). Emotions such as trust, empathy, and respect are thought to be sustained, encouraged, and appreciated in formal care work, whereas compassion, love, and sympathy are seen as more problematic and difficult to realize in care work. *Şefkat* poses a similar difficulty; it is deeply anchored in how families see themselves as families, as emotionally tied collectives, and considered not to be totally acknowledged or performed in formal care facilities. In other

words, *şefkat* emerges as "part of a moral orientation of an embodied self" (Chattoo and Ahmad, 2008: 561) who is imagined to be anchored in a caring family. Therefore, it is deemed to lack in any caregiving activity outside the "genuinely," not professionally, caring environment.

Emotionalization of family

Skrbiš (2008) identifies five major areas of research concerning emotions and transnational families: emotional labor as a dimension of transnational family life, emotion and the experience of co-presence, emotions and longing, emotionalizing the national family, and emotional expressions in migrants' writings. The list is not exhaustive, but it underlines the major preoccupations. The aim in this chapter was to contribute to the literature concerning emotionalization of family by arguing that the set of emotions Turkish elderly deploy is a search for identity in diaspora space. This is a particular way of negotiating family responsibilities, ethnic identification, and different ideals of care. It is neither to argue for an "emotional" Turkish family as a haven versus an "unemotional" Swedish context nor to highlight an authentic Turkish family, but to underline how emotions bridge two differently conceived ideals of family and care. These emotions work to align the individual with the collective (Ahmed, 2004). They serve to create an ideal family environment where the first-generation Turkish immigrants and their offspring are positioned in between a Swedish family which is imagined to be modern but uncaring, and a Turkish family which is perceived to be traditional, demanding and oppressive. For instance, the ideal of autonomy of the elderly and adult children is not rejected; *şefkat* or *vefa* come to challenge and/or complement this ideal. The elderly do not want to be beholden to their adult children, and they wish to incorporate the characteristics of the ideal independent Swedish citizen, but these emotions point to an idealized caring subjectivity where it becomes less paradoxical to combine two ideals (autonomy and emotional interdependence).

Prioritizing, deploying, and reinforcing emotions contribute to doing Turkish family by constantly imagining it in relation to the Swedish society. As Bryceson and Vuorela argue:

> Families, ethnicities and nations can be seen as imagined communities. One may be born into a family and a nation, but the sense of membership can be a matter of choice and negotiation. One can alter one's nationality and citizenship just as one can alter one's family and its membership in everyday practice. The inclusion of dispersed members within the

family is confirmed and renewed through various exchanges and *points of contact*. (*my emphasis*, 2002: 10).

Merhamet, vefa, and *şefkat* are meant to create new points of contact for the older Turkish migrants, to give meaning to their identity, difference, and sense of continuity, and to provide a sense of belonging at older ages. Caring for and being cared for by family was a recurrent theme in their accounts, even though they knew that it would be less straightforward than they imagined. When an elderly man emphasizes how his children are loyal to the family, not only does he embrace a well-praised ideal of the Turkish family but also transmutes his desire (to be a respected father) and fear (of not being so) to his life in Sweden. Similarly, when an elderly woman recalls compassion, she builds her sense of self and family on emotional interdependence rather than concrete responsibilities and duties. Rather than imposing unchanging family obligations, she apparently opens space for further negotiations, which would oppose neither the norms of Turkish family where elderly care is imagined to be given by family members nor the ideal of embracing formal care. In a sense, she remains the genuine Turkish woman who has not suffered from the degeneration of long years of life abroad and simultaneously the good immigrant who has incorporated the norms of the host country.

The Turkish family to which elderly immigrants refer is not a monolithic institution, detached from the experience of being an immigrant in Sweden. Instead, it becomes a way of expressing their individual life stories by linking these to a diasporic repertoire of Turkishness. This repertoire does not derive from an unchanging Turkishness, it is anchored in an imagined and/or real dialogue with Swedish values, both of which can change over time. In other words, their myth of family is not a consequence of being Turkish, traditional, or different, but a continuous imagination and negotiation of Swedishness and Turkishness in diaspora space.

Conclusion

As White (1990) argues, "culturally defined emotions are embedded in complex understandings about identities and scenarios of action, especially concerning the sorts of event that evoke it, the relations it is appropriate to, and the responses expected to follow from it" (1990: 47). Even though the idealized Swedish family consisting of independent individuals emerges as a significant model for the older Turkish people, it is also rejected by the understanding of the Turkish family as a caring one. This paves the way for

emphasizing particular emotions in order to highlight how the Turkish family differs from other families, especially from the Swedish family.

The emotionalization of the family is one underlying discourse in diaspora communities (Skrbiš, 2008: 240) and this inevitably affects how older immigrants perceive their older ages and care needs. The concept of love for the young and respect for the elderly (*sevgi ve saygı*) has long been the *leitmotiv* of the ideal Turkish family, and this has contributed to the definition of roles in the family based on a hierarchical interdependence (cf. Liljeström and Özdalga, 2002). Kağıtçıbaşı's model of emotional interdependence (2002), which refers to decreasing independence in the material realm but increasing mutual dependence in the psychological sense is justified by my informants. However, it became clear that other, more protean emotions came to make sense of and regulate family responsibilities. To make sense of a Turkish family, rather than clearly defining and locating negotiations and responsibilities in family and close kinship, many referred to emotions such as *merhamet*, *vefa,* and *şefkat*. Finch and Mason highlight that "responsibilities between kin are not straightforward products of rules of obligation, they are (…) the products of negotiation" (1993: 60). In this case, these negotiations mostly derived from these protean emotions. Family is (re)constructed due to the deployment of these specific emotions, which my informants consider to be their cultural difference from native Swedish people, anchored in family, transmutable to the community. Following Lutz and Abu-Lughod (1990), these emotional discourses are pragmatic acts and communicative performances. They are pragmatic acts because they regulate the emotional economy as well as daily care practices, and they are communicative performances because they highlight the ways in which they create and present their difference as Turkish.

Deployment of these emotions also contributes to an understanding and configuration of community, responsibilities, and duties organized around a moral repertoire. It paves the way for a caring subjectivity that is not necessarily at odds with abstract and economic solidarity incorporated in the welfare regime. However, it highlights how divergences and singularities in claims and demands can be intelligible without being confined to well-protected boundaries of families and communities. *Merhamet*, *vefa* and *şefkat* are not the constitutive virtues of a homogeneous Turkish family and community; instead, they are claims to a sense of belonging organized around caring subjectivities, where the ideal elderly care lies for many Turkish immigrants.

8
From Family to Community: Emotions and "Caring About"

In the previous chapter, I have highlighted how compassion, loyalty, and affection (*merhamet*, *vefa,* and *şefkat*) have come to represent the Turkish family as different from other families and how they shape expectations, ideals, and responsibilities around care needs. *Merhamet* (compassion, mercy, altruism, forgiveness) regulates and sustains the relationship between older parents and their adult children. Accordingly, an offspring can pursue her life on a balanced appropriation of individual autonomy and family solidarity. The compassionate disposition that her parents attribute to her is expected to lead to a stronger responsiveness than perceived others –the imagined Swedish offspring– would show their own parents should they be in need of care. The offspring would not only show mercy to her vulnerable older parents, but also assume caring responsibilities. *Vefa* (loyalty, faithfulness, gratitude) refers to a family history shaped by the experience of migration and transnational relations. It is anchored in the moral economy of people who are engaged in a gift economy, not only with people they left in their native country, but also in the country of settlement. Loyalty is thought to regularize reciprocity on the grounds of emotions rather than direct exchange of services and goods. For an older parent, directly demanding a particular type of help or service is more difficult than ascribing loyalty to their adult children. *Şefkat* (affection/concern), on the other hand, appears to claim what cannot be given by professionals and generate the surplus of family care. It refers to the complexity of care where love is imagined to be provided by close people, mainly family members. The link between duties and emotions in terms of filial obligations to elderly parents has been well

discussed (see for instance a critical review by Stuifbergen and Van Delden, 2011). My contribution concerns the use and circulation of protean emotions to make sure that duties always come, consequentially, with appropriate emotions. In other words, these emotions are prescribed to generate particular moral subject positions from which it becomes difficult, if not impossible, to renounce filial duties.[33]

In this chapter, based on my informants' stories and accounts about how an older Turkish man, who had no family support in his frail old age, I underline how these emotions circulate among people who are not directly linked by family and kin relations, and consequently how a diasporic community is imagined. By "diasporic community", following the discussion about diasporization as a process, I am referring not to a well-established diasporic community with convergent ideas, collective actions, and rituals, but instead to an imagined community that is expected to incorporate these emotions. Therefore, this chapter will delineate how family and community are simultaneously imagined – and to some extent done – and how emotions are deployed to shape the collective around "caring about" each other abroad, in diaspora, in *gurbet*. The "homeland," collective memories of and myth of return to the country of origin, shape diasporic communities, and this has been of relevance in terms of understanding community-building processes in diaspora. However, there has been less attention to the complex and rich processes of communities that are imagined and constructed in new settings.[34] Here, I will attempt to underline how a particular Turkish community is imagined by three Turkish women through emotions. It is therefore a peripheral imagination around "caring about" each other, rather than strictly dwelling on presumed ethnic and cultural markers.

Circulating stories, moving emotions

Mehmet was one of my first contacts in the field. Mehmet was an early-in-life emigrant from a small province in Turkey and he immigrated to Sweden after short sojourns in several north European countries. He settled in Sweden just before restrictions were placed on immigration in 1973, and he spent the

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[33] Hoff Sommers (1986) in her famous article "Filial Morality" also argues that duty and feelings are not mutually exclusive. However, I disagree that duty comes first, and suggest that the active use of emotions, especially those like these polysemic emotions, pave the way for assuming duties.

[34] This point follows Abdelhadey's (2008) analysis of how those in the Lebanese diaspora construct their visions of "home" in their new settings. Similarly, I do not underestimate the role of community centers, Turkish associations, and many mainstream political activities around them.

rest of his life there. He was in his eighties when I went to visit him at an elderly care home to which he had been admitted nearly a decade ago, when he began to need intensive hands-on care. He was restricted in his movements and suffered from several chronic illnesses.

Mehmet's institutionalization and solitude in his frail old age, his lack of close friends, relatives, and especially family members, as well as his tormented family story appeared and reappeared in my informants' accounts. I did not interview Mehmet, nor did I meet his family and listen to their version of the story. Their family story must have been much more nuanced than the accounts I was hearing from outsiders, since families are known and done not only with their particular memories (Halbwachs, 1992) but also with their secrets (Kuhn, 1995). Here, I am not interested either in snooping nor revealing what kind of family story or secret Mehmet had, nor am I willing to repeat the cliché of disintegrated migrant families. Instead, I paid attention to the circulation of stories by my informants, who had come to know him in one way or another, and how they concocted stories and meanings that made them understand their own aging, future risk of dependence, family, and community relations. By the circulation of stories, I mean telling, talking about, passing along, and disseminating these stories among Turkish people who thereby come to apprehend their own migrant life stories as well as their caring relations. By doing so, I discovered how these stories were shaped by emotions. Stories are a particular medium for propagating emotions (cf. Kleres, 2011) and making them intelligible to a wider audience. Talking about Mehmet was also a way to project and reject a similar future. The circulation of stories about Mehmet was a way to make sense of being in frail old age and in need of care in *gurbet*. Compassion, loyalty, and affection were the main emotions that are evoked in these stories I was told.

The three women –Aylin, Seda, and Selma – that I will mention here were from of different ages and backgrounds and they took care of and cared about Mehmet by invoking and circulating this particular set of emotions in order to highlight the norms of a genuine Turkish family from which Mehmet had been alienated. Their actions also displayed an ethics of care which was anchored in gendered family roles but sought to go beyond them. The set of emotions that was doing the Turkish family was imagined to create a guideline for the Turkish community when the family was not there. This was a claim to moral subject positions in response to care needs, vulnerability, and interdependence in *gurbet*, rather than reinforcement of taken-for-granted family roles. Therefore, even though these emotions were anchored in gendered family roles, they also sought to transcend the boundaries of the family.

As discussed previously, these emotions (*merhamet, şefkat,* and *vefa*) are gendered and gendering. These women cared about and for this lonely older man not out of familial duties but due to their moral subjectivity that flourished from their experience as wives, mothers and daughters who were able to feel these emotions. In other words, they continue to define their activities as the outcome of their gendered experiences and practices, but they also imagine and wish to endorse a community where members ought to feel these emotions and care about each other regardless of their gender positions.

Caring about (and doing) community

Community has been a sharp-edged concept for feminist scholarship, and not without reason. Iris Marion Young, for instance, by referring to Derrida, argues that any ideal of community "denies the difference between subjects. The desire for community relies on the same desire for social wholeness and identification that underlines racism and ethnic chauvinism, on the one hand, and political sectarianism on the other hand" (1995: 234). In other words, any ideal of community is about inclusion as well as exclusion, and a feminist agenda should create a way of being-in-common without neglecting differences.

Like Young, Marilyn Friedman (1993) also points to the fact that traditional versions of community exclude and suppress outsiders but also that "the practices and traditions of numerous communities are exploitative and oppressive toward many of their own members" (1993: 240). Therefore, in order to warn feminists against straightforward acceptance of communitarianism, she proposes two different types of communities: communities of place/ origin versus communities of choice. The former are based on the idea that "the community is found, not entered; discovered, not created" (1993: 244) whereas the latter is where members share interests and concerns and can "provide new social and moral conditions out of which to forge a liberated future" (1993: 255). This schema, by opening a political space for those who suffer from the exploitative and oppressive aspects of communities of place, seems to underestimate the complexity of community-building dynamics in so-called communities of place. Hierarchies of domination and subordination within these communities should be seen as an ongoing negotiation of power positions.

Jean Bethke Elshtain, in contrast, sees "no way to create real communities out of an aggregate of 'freely' choosing adults" (1995: 259). Her main opposition to the hegemonic feminist views about community rests in the very denial of resistance or challenge stemming from within the existing

communities. She argues that "the presumptions that in order to have a revolutionary or feminist consciousness one must disconnect oneself from particular ties (…) are correctly perceived by members of working-class and traditional communities as destructive of their way of life" (1995: 264). Similarly, my three women informants who assume their gendered roles know that the emotions that they evoke have also been exploiting and oppressing them in many different ways. They have been inclined to feel more compassionate, loyal, and affectionate than men and thus engage in caring practices in the family. However, resignation and resistance to gendered subject positions can go hand in hand. My informants do not renounce the potential of these gendered experiences as they imagine a "new" community where members are invited to assume their emotions and moral roles. The emotions that they embodied constitute a rich resource that they willingly mobilize both inside and outside the confines of the family. A diasporic community should not make illegitimate claims on its members. Community members should not blame, despise or become hardened to the suffering of other members. Rather, they should endorse their moral subjectivities through these emotions.

The word "community" is also problematic in the sense that, in my informants' accounts, it refers to different groups and to "becoming" rather than "being." When they refer to "Turkish community" they are referring to different clusters of people as well as social ties. While for Selma community tends to mean the larger Muslim group, for Aylin it is mainly people of Turkish origin who came to know Mehmet, especially in the neighborhood where Turkish people have known each other and gone through similar difficulties for many years. For Seda, on the other hand, the community is less clearly defined; the idealization of Turkish and Islamic values is at the core of a future diasporic community.

There are three main repertoires of doing community in terms of caring about each other. The first is about moral duties as they appear in the Islamic tradition. Islam, like the Judeo-Christian tradition (Wuthnow, 1991), provides an ethical guideline for Muslim communities and emphasizes caring. Altruism has a central place in the Islamic worldview (Zokaei and Phillips, 2000). Caring responsibilities should be extended from families to the vulnerable in the society. Quranic verse explicitly highlights it:

> It is righteousness to…spend your substance out of love for him [God], for your kin, for orphans, for the needy, for the wayfarer, for those who ask, and for ransom of slaves; to be steadfast in prayers; and practice regular charity. (Quran, 92:177, cited in Zokaei and Phillips, 2000)

Accordingly, in order to be a good Muslim, one has to be responsive to others' needs for care. The idea of a global community of Muslims (*ümmet*) is appealing to many believers since it idealizes a space of commonality around the religious affiliation, but it also offers a readiness to act for those in need of help and support. When Selma and Seda as believers feel compassionate towards Mehmet, they can follow the moral script set out by their religion.

Second, being from the same country of origin affects the choice and mobilization of these particular emotions. The three women know how to create sticky, touching, easily circulating stories based on these emotions. When Mehmet was described as a migrant who was suffering due to others' disloyalty and mercilessness, it became possible to project his story onto similar life stories of other Turkish migrants.

The third common repertoire that all three women reiterate is the experience of being in *gurbet,* where reciprocity and mutual help and support gain significance. These emotions have also been used in the search for a sense of belonging to a community constructed *ad hoc*. The experience of being detached from caring others who stayed in Turkey has been compensated for by the creation of new affiliations in the new country. Many experienced alienation and solitude, and longed for emotionally dense caring relations after their settlement in Sweden. Mehmet's solitude in an elderly care home was reminiscent of these initial, emotionally difficult times of not feeling at home. It also mirrored fears of aging and being alone in *gurbet*.

Mehmet: Scapegoat, object lesson or template?

Mehmet was the epitome of desolation and despair; he was a poster child for migration-afflicted Turkish families, an object lesson for the larger community, and pessimistically, a template for the future of other older Turkish immigrants. Whenever and wherever I mentioned my research to my informants, I was told Mehmet's name, I was told that Mehmet was what I was really looking for, a good case for the curiosity of an ethnographer. My key informant was his trustee. Seda and Aylin told me that they used to visit him regularly; Selma never visited him but always prayed for him. Mehmet's story from his admission to an elderly home until his funeral epitomized disloyalty (*vefasızlık*) and was an example for the community. Mehmet seemed to be the victim of loose family and community ties; he had the misfortune of being abroad with no one to care about him in his frail old age.

My key informant, as a man knowledgeable about the Swedish system, took care of Mehmet's legal and economic affairs. He encouraged me to visit

Mehmet because it was a telling case, but also discouraged me from doing so by saying that Mehmet was unconscious and in pain most of the time. I was ethically confused. I found neither any relevance in interviewing a suffering man nor a cogent link with my research purposes. I spent weeks thinking and reconfiguring where my research could go if I talked to him. Mehmet was therefore a deadlock, a significant turning point where I switched my focus from actual elderly care practices to how ideals and discourses of elderly care are concocted.

At this time, Aylin, a friend of mine who worked as a care worker, started to talk about Mehmet. She had worked part-time at the elderly care home where Mehmet lived. She worked a long time with him and she was emotionally attached to him since he was without relatives and friends (*kimsesiz, garip*) and because he reminded her of her father. After moving to another workplace she continued to visit him sporadically. She told me that she used to visit him more regularly but since he was unconscious most of the time, she had stopped going there. When I told her that I heard about Mehmet *Amca,*[35] she was happy to talk more about him and finally she invited me to visit him with her. It was emotionally very demanding for her these days to visit him alone since her own father's health was deteriorating, and along with her work and studies, she was also in charge of her father's daily care.

I met Aylin at the tram station very close to where she lived and we took a short walk in the suburban area. On our way, I asked Aylin if Mehmet needed anything and she told me that even though he could not eat a lot these days, he would be glad to have more mandarin oranges. The care home was surrounded by large apartment blocks and middle-class houses where many Turkish people live. Aylin, pointing to the residences where she knew that Turkish people lived, remarked that it was very sad for Mehmet not to have any visitors.

The entrance of the care home was silent, and we got to the third floor where the door to the ward was locked for reasons of security for residents with dementia. We rang the bell and a care worker welcomed us. Aylin exchanged a couple of words with her, and we walked the long corridor. We greeted people who were sitting in the lunch and coffee room and we headed to Mehmet's room. Aylin was very comfortable whereas I felt out of place, very awkward, not because I was unfamiliar with the place but because we had been told that Mehmet was suffering a lot these days. Mehmet's room was clean, spacious, and silent. He was sleeping when Aylin slowly

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[35] *Amca* means uncle in Turkish. Kinship terms are often used to create a sense of familiarity and closeness in the current usage of Turkish.

approached him. It took a while until he noticed that he had some visitors. He was happy to see us. He could not remember Aylin at first; he thought she was Seda, but then recognized Aylin right after. Aylin immediately noticed that he had a fever and was sweaty, and while complaining about her former colleagues, went into the bathroom, washed her hands, and changed Mehmet's t-shirt; then she washed her hands again, gave him some water, and tried to chat with him. Mehmet did not say anything; he was in pain. Aylin was quick in her movements. She was energetic, talkative and cheerful. I tried to help Aylin but she was quick and very efficient, and really needed no help. With no specific task to occupy me, I stood by and did not know what to do or say.

After a while, Mehmet fell asleep. We stayed there. Aylin's cheerfulness faded as she listened to Mehmet's spasmodic moaning, and the smile fell from her young face. She became still: there was nothing left to do. She said the obvious: he was in pain, and had no one to alleviate his pain. Aylin told me that Mehmet had everything he needed but *şefkat*. She said she was very sad for him not only because he was physically suffering, but because he was also suffering from abandonment, isolation, and lack of affection. The care workers were, of course, very professional and did give extra attention to Mehmet since he did not usually have any visitors, but she thought that an old man in his situation would need more affection. She said that Mehmet reminded her of her father and she would not leave her father's care to an elderly home. We sat there in silence for a while. Then, Aylin went to wash her hands again, explaining that it was a professional habit. She forced herself to smile and we left Mehmet. After this visit, I decided not to interview Mehmet but, surprisingly, I came to hear a lot more about him. He was talked about and thought about in a circle of older people. Similar to Aylin's concern, Mehmet's situation was an object lesson that prompted others to think about their own familial relations and community.

Selma prays for him

I came across two lines of story about why Mehmet was alone in an institution. The first was a medical story, therefore a brief one. Selma had never met Mehmet nor visited him. Selma's husband, Adnan, frequently went to the mosque for his daily prayers, and there he came to hear and know about Mehmet's lonely stay in an institution. Selma told me that Mehmet had severe illnesses and he was frail. His son was also suffering from a severe disease. When another health problem came into picture, there was so little to add. This was a tragedy, a misfortune, a trick of destiny (*kaderin oyunu*) for

the family. Both the frailty of Mehmet and the illness of his son therefore epitomized human vulnerability. For people who followed this story, there would be nothing or nobody to blame, it was an ordeal to assume with faith, a test of God in the human world. They eschewed clear-cut moral judgments. The prospect of ever being in a similar situation, in frail old age in isolation and with severely ill family members, was frightening. This fear was anchored in a particular understanding of fatality, the relationship between God and his subjects. A general popular belief among believing Muslims is that if a person disgraces, despises, or reproaches another because of an infliction given by God, such as a disease, misfortune, or deformity, God punishes that person with the same. Selma, who also had an only son, told this story with extreme caution, since she did not know what would happen to her and to her family in the future (*Bize ne olacağı belli mi?*). Mehmet was a tragic example of aging and having no family, and a frightening template on which she had come to think about her own aging and dependence on family relations. By expressing her compassion for Mehmet, Selma avoided judging his family for admitting him to an institution. Selma reminded me that many Turkish families, especially those affiliated with larger kin groups, were ashamed to move their aging parents into institutions. That is why she thought that the community should be more compassionate than judgmental and reproachful.

For Selma, adding her good wishes for Mehmet and his sick son to her daily prayer was what she could offer at the moment. She was mostly at home, taking care of her dear friend and neighbor Esma while Esma's son and daughter were at work. She was occupied and had neither the time nor the stamina to visit Mehmet. Her pity (*merhamet*) for Mehmet was a way to care about a suffering lonely man across a distance, whereas affection (*şefkat*) for Esma was about taking care of her close friends and family.

Seda's quest for community

> Parents give the offspring a whole vineyard, the offspring does not even offer a bunch of grapes (in return), it is this kind of story (Turkish saying, remembered by Seda.)

The second story was more critical of Mehmet's family and the Turkish community. Mehmet was there, agonizing in complete solitude because his family and the rest of the Turkish people who knew him did not care about him. Mehmet's admission to an elderly care home was a drastic rupture from the rest of the community. Not only did this relocation separate Mehmet temporally and territorially from the community, but it had also enabled

Mehmet's friends and family to relinquish their responsibilities (cf. Hazan, 2002).

In my second meeting with Seda, I told her that I had recently visited Mehmet and asked her if she knew him. She was happy to hear that I had visited him. When I told her that during my visit Mehmet had mistaken my friend for her, she was proud and touched by the fact that Mehmet remembered her. She regretted deeply that she could not visit him in his last days because she herself was unwell and unable to make the trip to the care home.

Seda recounted to me many times how she had met Mehmet. Seda had been visiting an acquaintance in the same elderly home where Mehmet was staying. This acquaintance stayed there temporarily when his wife went to Turkey and there was nobody to take care of him. Elderly people who were unable to travel themselves could stay in an elderly home while their actual caregiver was travelling. As Seda did not get along well with this man's wife, she was determined to see him as often as she could while his wife was in Turkey.

During one of these visits, a care worker – a Bosnian Muslim woman, insisted Seda – came to see Seda and asked if she spoke Turkish. She informed her about Mehmet, who had not had any visitors since his admission. Seda's eyes shone with joy when the story came to this point. "God bless her for what she did" (*Allah o kadından razı olsun!*), she repeated several times. When Seda entered his room for the first time, Mehmet was so happy that he burst into tears to have a visitor after three years alone in that room.

Seda was touched by this first encounter and by Mehmet's solitude. She started to visit him twice a week unless it was very cold or she was unwell. Seda spent one to two hours, sometimes more, with him. She read religious texts, sometimes the Quran, to Mehmet. He was a pious man and enjoyed these readings. He had his cassettes of prayers, and religious songs, and asked his caregivers to help him listen to them. When Seda continued these readings, he was quite pleased.

Mehmet was not particularly happy with the food he was served at the institution. Seda cooked and brought special Turkish food that Mehmet asked for. As he had diabetes, she was very careful about that and rearranged her cooking on the days she visited him. When she heard from the care workers that Mehmet did not want them to bathe him since it was *namahrem* (meaning religiously unsuitable for the other sex*)* for a man to be bathed by women, Seda solved the problem. She called a male acquaintance, who came every week with a friend to bathe Mehmet. Needless to say, bathing as an

important component of hands-on care is where bodily integrity, privacy, and gender roles are endlessly negotiated (Twigg, 2000). Mehmet was very satisfied with this arrangement. Seda also informed and encouraged her acquaintances and friends to visit Mehmet. She was particularly worried about Mehmet's solitude. She tried to increase the number of visits to Mehmet's room. She succeeded in having some company during some of her individual visits even though she was mostly alone on her way to the elderly home. However, more people came to know and talk about Mehmet.

Seda told me this story several times, adding new details about new people and incidents, every time she took it up. From their first meeting up until her last visit, she took every action with ease and the joy of care. She felt satisfied that she could feel this way and alleviate Mehmet's pain and solitude to some extent. First, for her, it was a religious call, a duty of a good Muslim to be compassionate and affectionate to the suffering and lonely. In this sense, it was a duty for a Muslim not to neglect human suffering. Second, as Mehmet was originally from Turkey, it was primarily a moral duty for someone from the Turkish community to care about a member who was in need of care. This was also anchored in the way many older immigrants understand their experience of being in *gurbet*. An elderly care home can offer a good-quality of care, but the absence of caring relations should be complemented by others who have similar life stories. This is not only because they share a cultural repertoire, including religious beliefs and the same language, but they also know the importance of caring relations as they had once experienced the solitude as migrants. As a small community, Turkish people would always need reciprocal help, and caring eyes and hands. Finally, it was a gendered way of knowing what can complement, adjust, and coexist with formal care practices. Seda was the mother of three children, and was very concerned about her close kin members. She took care of her family and cared for her mother when she was ill. Caring about others is linked to her moral subjectivity, which has been shaped by her migrant experience, religious beliefs, and family and community concerns.

Seda's story, both with its epic genre and emotional narration, is of course about how an ideal of caring subjectivity can be constructed among Turkish migrants. Compassion and loyalty are to be continuously felt and reflect social and care practices. However, these two main emotions (*merhamet* and *vefa*) and the moral subjectivities they invoke are not only rooted in her early-in-life immigration as a pioneer, as a woman whose first years in Sweden were marked by the absence of caring relations, but also in her story of empowerment through the language skills, knowledge, and respect that she successfully gained among Turkish immigrants. The gleam in her eyes when

she repeatedly reminded me of how she had mobilized a group of people to visit a lonely old man without family was a story of success, and empowerment. She could demonstrate how wise and respected she was as an older member of the community.

Unattended grave: End of life, proliferation of stories

Seda's epic story comes to an end with Mehmet's funeral. Even though his family was not at the funeral, Seda's emphasis was more on the number of people who were at the mosque on this holy day. His funeral prayer was performed by the Muslims who were there for their Friday prayer. The closure of the story was about people of good faith coming together for the last prayer, and also glosses over the absence of a large and emotionally supportive Turkish community at the funeral.

Aylin's story was different. One day, she called to tell me that something very strange had happened. When Aylin went to the cemetery on the 40th day after her father's death, she noticed a grave that was covered in weeds and grass. Curious, she went to look at it more closely, and she recognized Mehmet's name. She was devastated to think that nobody had visited this grave for a very long time. Nobody had taken care of the grass nor even watered it. In her view, in accordance with similar rituals of reverence to the deceased among the Turkish community, this was offensive and against good mores. She called this abandonment and unfaithfulness (*vefasızlık*), accusing both Mehmet's family and the Turkish community. She was so upset that she felt she had to take some action; she first went to the cemetery staff first, and then called the higher authorities, and she let me know about it. She insisted that people should be faithful to each other, and at least to the memory of the deceased. When I reminded her of Mehmet's loneliness, she was even more upset. No matter what, a person's grave should not be in this state: "He had not been cared about when he was alive, but it should be the case at least where he is resting. What a pity!" Unlike Seda's account, which gives Mehmet's story a happy ending, Mehmet remained a specter for others, examplifying the changes in emotional habitus and the ideals and practices that these emotions call for, even after death.

Discussion: A caring community?

Aylin, Seda, and Selma did not provide hands-on care for Mehmet. He was cared for by professionals until the end of his life. However, they attempted to complement the care he was given by their particular, peripheral, and

gendered imagination of an ideal of care in frail old age. Selma prayed for Mehmet and talked about his institutionalization not as something to be ashamed of, but a destiny to be assumed without reproach. Seda was affectionate and tried to attend to some important details to improve Mehmet's well-being, which would otherwise have gone unnoticed. She read religious texts which comforted Mehmet, arranged for people to bathe him according to his wishes, and cooked for him the Turkish food that he missed at the care home, but most importantly, she visited him and encouraged other Turkish migrants to do likewise. Aylin was also concerned about Mehmet's abandonment; she continued to visit him as often as she could as an expression of loyalty.

Prominent care theorists like Tronto and Sevenhuijsen leave unclear how different layers of care respond to, and are shaped by, different subject positions. In other words, they do not specify how people might "be able to care." Hollway (2006) discusses this question of how the capacity to care becomes possible, giving a detailed analysis of the intersubjective development of caring relations by harking back to psychoanalytic debates. Here, my emphasis has been on how caring relations and care practices are imagined and designed through particular subject positions in diaspora space and how these positions are understood through emotions. It is not to sentimentalize or romanticize the care work, but to show that ideals of care are evoked by emotions.

Emotions that I have discussed prescribe moral duties first to the family and then to the community, especially when family is not there. Accordingly, even when older people are institutionalized, they must be visited as often as possible, not only by close family members but also by people who define themselves as true and loyal members of the Turkish community. These stories are about Mehmet's frailty and solitude, but they also concern the Turkish migrants' desire to perseverate in connectivity. As Suad Joseph coins the term, connectivity consists of "relationships in which a person's boundaries are relatively fluid so that persons feel a part of significant others" (1993: 467). The connectivity among people who have been through similar experiences of migration appears as an important diasporic agenda. For Seda, Selma, and Aylin, Mehmet's solitude highlights the importance of and need for a collective consciousness towards the vulnerable of community members. Nevertheless, it is not a call for community care, as that is widely discussed and criticized (cf. Barnes, 1997). The care home was seen as a good place to be cared for; what my informants objected to was the loss of a particular emotional habitus among Turkish migrants, which led them to relinquish their responsibilities for each other in *gurbet*.

CARING (IN) DIASPORA

As many informants repeatedly mentioned, the people in Turkey would criticize the institutionalization of an elderly parent, and the reproach and stigma would be mainly on the family, more specifically on the person's children. Yet, as I tried to show in this case, there were three significant distinctions: First, there was neither direct opposition nor reproach to the family because Mehmet lived in an elderly home, but my informants' discontent stemmed from the abandonment of Mehmet. Not only was he otherized by his frail old age and institutionalization (Hazan, 2002), he was also detached from the rest of the Turkish community. Second, my informants, by harking back to their understanding and experience of caring and evoking emotions that are presumed to distinguish the Turkish from the Swedish, called Turkish migrants to develop a caring community around these emotions. The experience of having been uprooted from caring relations and the fear of ending up in solitude should motivate the Turkish community to be more engaged in caring about each other and in preserving the connectivity. Finally, in order to imagine this community, emotions are actively used and sought to construct caring subjectivities. This call for community does not derive from a need to identify with a collective to underline their cultural, religious, or ethnic differences, but it is a particular way of adapting to a society that is perceived to be highly modern but detached from caring relations, by preserving and revitalizing their emotions.

9
Conclusion

In 2011, I came across a report in a monthly magazine addressing the Turkish community in Sweden. The Turkish ambassador had been to an elderly care home in Stockholm and visited Turkish residents living there. After her visit, she made the following statement:

> When I listened to both the Turkish staff who worked here and the elderly who lived here, I had the impression that they were content and happy. They have nearly created a home environment here. Nevertheless, according to our customs and traditions, leaving parents to a care home is not acceptable. In my view, the longer we can keep our elders at our homes, the happier and more comfortable they will be. (…) There are six Turkish assistants who work here, they behave towards and care for [the older residents] as if they were their daughters. There are even Turkish TV channels. I was very moved and sorry. I can understand why someone who does not have any children, or whose husband had died at an early age, would stay here. However, leaving a mother who has five adult children to a home is unacceptable.[36]

The above statement is a typical and common discourse when it comes to Turkish people's needs for care in old age. A public elderly home, albeit with "Turkish" staff caring for older residents "as if they were their daughters," is imagined to be the last but not the best solution. According to Turkish "customs and traditions," it is not acceptable to leave parents to the care of institutions or "strangers." "We" should keep them at "our" homes so long as they can live happily in the care of their families.

This study has been an invitation to think outside the ideological assumptions and/or common sense about ideals of care for older Turkish immigrants and how this distant and powerful position of "we" should be challenged. As is clear in the above statement, the tendency has been to

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[36] *Yeni Birlik*, 2011, Number 2. Latest access to the electronic version, on the 8th of November, 2013: http://issuu.com/e-dergim/docs/2011-1#embed

assume particular ideals, expectations, and patterns for the otherized elderly, whereas there has been scarce research and interest in how older people themselves understand their aging and care needs. On the eve of the celebrations of the 50th anniversary of Turkish immigration to Sweden, it will be an important challenge for both the Turkish community living in Sweden and the Swedish welfare state to face the fact that we should acknowledge the heterogeneity of the community of Turkey-born immigrants, which is marked by different ethnic and cultural backgrounds and diverse motivations and experiences of migration depending on their age on arriving in Sweden and their sense of belonging to Sweden. As I have shown in this dissertation, a significant group will consist of first-generation Turkish immigrants who have started to reach older ages and may need care in forms other than living "happily" and cared for "in their families."

I started this research with this preoccupation. I have attempted to explore how older Turkish immigrants make sense of their aging and caring experiences marked by migration, settlement, and long years of residence in Sweden and how they experience old age and imagine their care needs and arrangements in the future. I could identify that the experience of being a migrant, having once been uprooted from caring relations, being in *gurbet* as I have suggested, has affected their homing desires, their sense of belonging, and their ideals of care as much as their cultural and religious expectations have. Previous experiences of being cared for and about have been emotionally assessed in old age. Therefore, as I have shown, for understanding future expectations, it is crucial to give a genealogy of these emotions and consider these emotions, such as trust, confidence, feeling at home, compassion, and so forth as an important source of information when seeking to understand the future expectations and practices of care.

I have also argued that older Turkish migrants constitute a heterogeneous group with diverging understandings and expectations. This heterogeneity is based not only on their family stories, their transnational networks, and pre-migration frameworks but also on their positions in diaspora space vis-à-vis the native Swedish people and other Turkish immigrants. As I have advocated, this approach is more dynamic and significant than attributing particular needs and cultural expectations to migrant communities.

Caring (in) Diaspora is, therefore, at the crossroads of migration studies, including debates around transnationalism, diaspora, identity and home-making processes, and care studies, both ethics of care and elderly care. It also attempts to examine aging and care in a migration context, through the lens of emotions. Drawing upon accounts of a group of older Turkish immigrants in a Swedish context, it explores how cultural repertoires around

"caring about" and "caring for" are shaped in diaspora space, as well as which ideals, practices, and desires around care come into play as migrants work out of options at the threshold of old age. This study sought neither to problematize the "special needs" of elderly Turkish immigrants nor to find general solutions to already created ones. Rather, it speaks by questioning how older immigrants' lives have been marked by the experience of migration and repositioning in another land, how the impact of having once lost caring relations has reinforced aspirations to be "cared about" and "cared for," and how decisions and desires about care are discussed and understood in old age.

This study gives important insights about first-generation Turkish immigrants' understandings about care in older ages. Rather than generalizing and categorizing cultural, ethnic, or even religious expectations in the case of elderly care, it has sought to grasp the complexity of their ideals of care and caring relations by focusing on the condition of diaspora.

In the second chapter, I sought a framework to include both theories of care and diaspora. By suggesting caring (in) diaspora, I attempted to include the local and lived experiences of care in the conceptualization of diaspora. The experience of having distanced oneself from caring others in the context of migration can bring about a consideration of others as caring relations. How one hopes to be "cared for" is intricately related to how one feels "cared about" in society. While "caring diaspora" is a tautological statement since every community is imagined around differing degrees of caring responsibilities towards one another, "caring in diaspora" can envision the creation of a local, particular, caring attitude, practice, or disposition, one that derives from the remembered or actual hardships of being abroad, away from a (real or imagined) homeland. Ideals of good or good-enough care are partially distilled from previous experiences of being (or not being) cared about and for. By using "caring (in) diaspora," I have argued that the experience of having once distanced oneself and been away from caring relations in a migration context brings about an emotional and locally produced endeavor to embrace available others – institutions, other migrants, friends, and family members – as caring relations. To explore this, I focused on a specific term that is widely used by Turkish migrants for being abroad or away from home, *gurbet*. The term *gurbet* refers to a multifarious condition and not only affects the interpretation of present and future care needs but also shapes the contours of how certain ideals of care are imagined, expressed, and circulated among older Turkish people who live in Sweden.

In the third chapter, drawing from this theoretical discussion, I have presented important steps and methods of my research and discussed

ethnography as a caring relationship. I also discussed the limits and advantages of conducting research as a migrant researcher who was initiated to the field through a diasporic and caring relationship. The self-reflexivity of a migrant researcher transcends the confessional aspects of epistemology and creates pathways to an ontological stance where the researcher starts to understand his or her own experience as a migrant. I have also insisted on the importance of a narrative approach in order to understand caring relations and care practices.

In the fourth and fifth chapters, by focusing on medical care stories, I highlighted the importance of looking at previous experiences of being cared about and cared for in the deliberation of future care needs and expectations. Older Turkish people not only consider health care in Sweden to be good, but they also situate their relationship with medical institutions and teams in their lived experiences and senses of belonging. Medical encounters are replete with emotions, and how people come to feel and express these emotions is in constant dialogue with how they feel cared about by others, institutions and society. However, more attention should be paid to the variety of claims, experiences and wishes underlying these emotions. For instance, in the fourth chapter, I have discussed how my older informants came to trust Swedish health care by referring to their previous medical encounters. Trust can be named, and even longed for, as one of the dominant emotions that reveal a particular imagined relationship between citizens and the welfare institutions, a particular social imagination of formal care, not as customers, but as citizens, free from stigma and based on a balance of individual rights and social duties. A straightforward reading of older migrants' trust stories could obscure how dominant ways of imagining trust in institutionalized care come to be appropriated by people with different senses of belonging. A recently immigrated pregnant woman's attachment to a medical care team in the absence of caring family members and friends can be easily translated into a well-known discourse of the doctor-patient trust relationship, and as with every translation it loses some of the important traces of its creation. Or the experience of good care at a hospital can be translated as good-quality health care for citizens. It can be imagined as a citizenship right that is deserved after long years of labor participation, but, as is the case for some, it can also turn into a longing for belonging to the host society. Strong appreciation of medical care is rooted in the initial or continuing anxiety about not being cared about and in the gratitude for being cared for. Inconsistencies, divergences, and nuances can easily become unnoticeable and insignificant as soon as peripheral imaginations are contained by the dominant one. Looking after discursive and narrative traces of different understandings of care

among migrant people not only offers crucial hints about future misunderstandings, frustrations, and expectations, it also highlights the limitations of particular imaginations of care relations.

In the sixth chapter, by elucidating how Turkish elderly understand formal care facilities such as home-help services and elderly care homes, I underlined my informants' ambivalent attitude towards these options. This ambivalence was anchored in their ways of perceiving "the Swedish" as modern but uncaring as well as in their understanding of family members as caring others. The ideal of individuality and independence, at least from a family member in need of care, and the *imagined* presence of formal care options was where most of my informants consider themselves as having acquired the basic prerequisites of being modern. My informants, who presented themselves as having succeeded in their long story of inclusion in the Swedish system, as having gained rights and knowledge and been good modern parents with successful offspring, appeared to be more keen on having formal care in frail age. Other informants with similar dispositions but who are in close relationships with those who are considered less successful migrants are more cautious about the future. Of course, elderly people whom they may have encountered during their stays in Turkey were also seen as significant others, whose attitudes to family responsibilities, and to formal and informal care were criticized in order to reinforce the modern values that the immigrants had gained. On the other hand, my informants referred to this ideal of modern, independent, and individual family members as being detached, too individual and uncaring, and at odds with their understanding of caring relations. Meanwhile, the solitude and high individualism they perceive among the older Swedish people haunt their idealization and pave the way for the doing of an "emotional" Turkish family.

In the seventh chapter, I have shown how Turkish family is imagined and done through three emotions: *merhamet* (compassion/pity), *vefa* (loyalty/faithfulness), and *şefkat* (concern/affection). These protean emotions recall subject positions for older parents and their adult children, as required by their ideal of Turkish family consisting of close relations, while eliminating some traits that could appear at odds with their identity construction as well-integrated, modern Turkish migrants living in Sweden. In other words, this is a dynamic reconstruction of moral subjectivities in response to care and interdependence, rather than taken-for-granted family roles. Older immigrants' aspirations to shape family responsibilities around caring about each other have been made possible by assigning these specific emotions to particular subject positions, such as compassionate, loyal, and caring children. However, as I have argued, this emotionalization of the

family has not been about reinforcing, but about negotiating the filial duty towards older parents.

In the eighth chapter, I have highlighted how these emotions circulate inside and outside the family and how a caring diasporic community is imagined. To do so, I have examined three female informants' stories and accounts about a first-generation Turkish man who was in frail old age, lacked family members, and was moved to a public care home. Unlike the statement at the beginning of the chapter, which calls upon adult children to assume their filial duties, my aim has been to show that my female informants, based on their gender experiences, have stipulated the importance of reinforcing the ideal to caring about –not necessarily caring for– each other in *gurbet*. They made sense of this ideal through emotions that may be intelligible to many members of the community.

One salient contribution of this study has been to provide empirical material about how older Turkish immigrants in Sweden understand their aging and how they assess their future care needs and some options for meeting these needs. Even though the empirical material consists of the accounts and stories of a specific group of older Turkish immigrants, this study can also offer important insights about how people with a migration background in general understand their aging and caring experiences, not through cultural differences alone, but also through their experience of migration and settlement in another country.

Older migrants do not radically differ from native older Swedish people when it comes to concerns about their aging experience and care arangements in the near future. Many native Swedish people project their previous medical encounters on their future needs for care and they think about their sense of belonging, life stoires, needs for care, and options for meeting those needs at older ages. Many also have difficulty in keeping track of changes in procedures and policies around elderly care arrangements. What distinguishes the migrants from the natives is how these similar concerns about care are understood by the migrants in different ways, according to the positions the migrants take in diaspora space and how they make sense of their migratory life course. This study's contribution is that, in order to understand the possible expectations of older migrants when it comes to decisions about and needs for care, it is crucial to consider their experience of having lived and aged in diaspora space. Designing, deliberating on, and deconstructing particular ideals of care become possible only if we take these experiential, mnemonic, and relational meaning-making processes into account.

Older migrant populations are increasing in number in Europe and constitute very heterogeneous communities. This heterogeneity also stems from different migratory life courses and positions in diaspora space. The increasing cultural and ethnic diversity of older migrants in Sweden will pose new challenges for policy-makers, social workers, and social scientists, including gerontologists, sociologists and anthropologists. In order to better understand this diversity, an important agenda would be to include a critical approach about the heterogeneity of older migrants based on their life stories that have been marked by migration and positions in diaspora space rather than to presume cultural differences for ethnic and/or diasporic communities and create culturally competent care through fixed categories, such as standardized cultural and religious expectations and needs.

There is also greater interest in and increasing research about care needs, mobility, and transnational care networks of the older migrants. As I have claimed in this dissertation, it is equally significant to include the local and lived experiences of older migrants in diaspora space and their aspirations for a caring diaspora. This approach does not argue for a community-based care that is provided predominantly by the women of the community nor for delegating the whole responsibility to a diasporic community by excluding other options for meeting the needs for care. Rather, it offers a critical stance against the understanding of a diasporic community based only on shared ethnicity, culture, language, religion, or loyalty to an imagined and/or real homeland. A caring diaspora is a question rather than a solution to the migrants' longing for belonging to the host society.

I have also suggested that, in order to understand how a diasporic community is imagined by migrants around caring about each other, it is important to examine how and which emotions are deployed to align people with the collective. Diasporic communities are always imagined around feelings that have been supposedly shared by the members, such as loyalty to the homeland, nostalgia, culpability and so forth. I have shown that feeling and demonstrating particular emotions, such as *merhamet*, *vefa*, and *şefkat* in this case, not only provides moral guidelines about caring about and for each other, but they also position migrants as different from the native in diaspora space.

Further research should systematically include how different care cultures, practices, and facilities are experienced and understood by older migrant populations. This will pave the way for a better understanding of the present and future expectations and frustrations. On the other hand, the enigmatic nature of the future triggers new quests among older migrants when it comes to decisions about health and elderly care. As I have

emphasized in this study, working out new options, such as an elderly home for migrants in the country of origin or country of settlement, can be understood only if migratory and diasporic life stories and experiences are taken into account. New arrangements between countries concerning care provision are also continuously assessed by the migrants based on these stories and experiences. For instance, the slowly increasing number of care facilities in Turkey for older Turkish migrants and recent agreements about health care subsidizations and reimbursements as well as the portability of rights between Turkey and Sweden will shape older Turkish migrants' decisions and understandings. Further research should focus on these options, not only in terms of their legal and economic aspects, but also in terms of new understandings about care held by migrants who are navigating a variety of care policies and practices.

Sammanfattning (Summary in Swedish)

Genom en grupp första-generationens turkiska invandrare i Sverige undersöker denna avhandling hur kulturella repertoarer kring omvårdnad och vårdgivande tar form i ett diasporiskt rum (diaspora space), samt vilka ideal, praktiker och förväntningar på vård som framträder i alla de situationer av valmöjlighet som dessa personer ställs inför, då de blir gamla. Studien har inte försökt att problematisera äldre turkiska immigranters särskilda behov, och gör heller inte anspråk på att presentera lösningar på redan skapade problem. Jag vill snarare undersöka hur äldre immigranters liv har präglats av migration och (åter)etablering i ett "nytt" land. Vidare undersöks hur förlorade (vård)relationer förstärker immigranternas önskan och ambitioner om att bli "cared about" och "cared for", samt hur beslut och önskemål om omvårdnad och vård diskuteras på ålderns höst. Avhandlingen, *Caring (in) Diasporas,* befinner sig därför i korsningen mellan migrationsstudier och vårdstudier, då den både inkluderar frågor om transnationalism, diaspora, identitet och "home-making" processer, likväl som etiska frågor inom omvårdnad, vård och äldreomsorg. Avhandlingen syftar också till att belysa emotionernas roll i åldrande, omvårdnad och vård i en migrationskontext.

Avhandlingen utforskar första-generationens turkiska immigranters förståelse av vård i äldre ålder. Genom att fokusera på tillståndet hos diasporan, snarare än att använda sig av generella och kategoriska kulturella, etniska eller religiösa förklaringsmodeller gällande immigranternas förväntningar på äldrevård, eftersträvas en förståelse för komplexiteten i deras vårdideal och vårdrelationer.

Kapitel två behandlar avhandlingens teoretiska ramverk, som inkluderar både teorier om omvårdnad, vård och diaspora. Genom begreppet "caring (in) diaspora" (omvårdnad/vård i diasporan) har jag försökt att inkludera både det lokala och den levda erfarenheten av omvårdnad/vård i konceptualiseringen av diaspora. I en migrationskontext kan erfarenheten av att ha distanserat sig själv från vårdande andra leda till överväganden om andra som vårdande relationer. Hur en önskar att bli omvårdad (cared for) är intrikat relaterat till

hur en känner sig omhändertagen (cared about) i samhället. Om "caring diaspora" är något av en tautologi, då alla tänkta samhällen på något sätt inkluderar vårdansvar gentemot varandra på någon nivå, så kan "caring in diaspora" beteckna skapandet av en lokal, partikulär vårdattityd, praktiker eller position, som härrör från de hågkomna eller faktiska svårigheter som uppstår när en är i ett annat land, borta från sitt (verkliga eller imaginära) hemland. Ideal rörande bra eller tillräckligt bra omvårdnad/vård är delvis renodlade utifrån tidigare erfarenheter från att ha fått (eller inte fått) omsorg (being cared about). Genom att använda begreppet "caring (in) diaspora" argumenterar jag för att erfarenheten av att någon gång ha distanserat sig och ha varit borta från vårdande/nära relationer, till följd av migration, bidrar till en emotionellt och lokalt baserad strävan att hitta och tillägna sig andra som kan bry sig om en, eller som en skapar vårdande/nära relationer med. Dessa andra kan bestå i exempelvis institutioner, andra migranter, vänner eller familjemedlemmar. För att undersöka detta har jag använt mig av ett begrepp som ofta används av turkiska migranter – *gurbet* – vilket handlar om att vara utomlands eller att vara hemifrån. Begreppet gurbet hänvisar till ett brokigt tillstånd, och påverkar inte bara tolkningen av nutida och framtida omvårdnads- och vårdbehov utan formar även konturerna kring hur vårdideal uppkommer, uttrycks och cirkulerar bland äldre turkisk befolkning i Sverige.

Baserat på denna teoretiska presentation presenterar jag i tredje kapitlet avhandlingens metod, samt hur etnografi kan diskuteras som en slags vårdande relation. Avhandlingens empiriska material består till största del av observationer och semi-strukturerade djupintervjuer med 20 äldre turkiska migranter, 10 kvinnor och 10 män, som bor i olika stadsdelar i en gammal industristad. Alla mina informanter är över 60 år, men med en betydande variation i ålder. Kvinnorna är generellt yngre än männen, av vilka de flesta är över 70 år. Det vanligaste mönstret är att männen invandrade först, främst som arbetskraftsinvandrare, och att kvinnorna gifte sig innan de emigrerade och anslöt sig till sina makar. Alla informanter invandrade till Sverige under sent 1960-tal eller tidigt 1970-tal. Informanterna var svenska medborgare, pensionärer, hade kroniska sjukdomar och var bekanta med svenska hälso- och sjukvårdsinstitutioner. Jag träffade dem en och en, samt i grupper, med jämna mellanrum mellan 2012 och 2013. I detta kapitel diskuterar jag också begränsningarna och fördelarna med att bedriva forsking utifrån mina egna erfarenheter som invandrad forskare, som blev inbjuden till forskningsfältet genom diasporiska och vårdande relationer. Den självreflektion en migrerad forskare som jag själv behöver ägna mig åt överskrider de konfessionella aspekterna av epistemologi och banar väg för en ontologisk hållning i vilken forskaren börjar förstå sina egna erfarenheter som invandrare. Utifrån detta

har jag också framhållit vikten av ett narrativt förhållningssätt för att förstå (om)vårdande relationer och praxis.

I det fjärde och femte kapitlet synliggörs, genom ett fokus på sjukvårdsberättelser, vikten av att leta efter spår av tidigare erfarenheter av att ha blivit omhändertagen (cared about) och omvårdad (cared for) i de övervägningar som görs gällande framtida vårdbehov och förväntningar. Äldre turkiska personer anser inte bara att sjukvården i Sverige är bra, de placerar även sina relationer med hälso- och sjukvårdsinstitutioner och grupper i dessa levda erfarenheter och känslor av sammanhang. Möten med hälso- och sjukvården är genomsyras av emotioner, och hur människor känner sig och uttrycker dessa emotioner hänger samman med i vilken grad de känner sig omhändertagna (cared about) av andra, institutioner och samhället. Mer uppmärksamhet bör dock ägnas åt den bredd av påståenden, erfarenheter och önskemål som ligger bakom dessa emotioner. I det fjärde kapitlet har jag därför till exempel diskuterat hur mina informanter började lita på svensk sjukvård genom att hänvisa till sina tidigare möten med hälso- och sjukvården. Tillit benämns som en av de mest framträdande emotionerna av informanterna, då vissa till och med längtar efter att känna tillit. Tillit avslöjar ett specifikt imaginärt förhållande mellan medborgare och välfärdsinstitutioner, en sorts social fantasi om formell omvårdnad/vård, i vilka immigranterna inte framträder som konsumenter utan som medborgare, fria från stigma, i balans mellan individuella rättigheter och sociala plikter. En simpel läsning av äldre migranters tillits-historier riskerar att fördunkla de olika sätt på vilka människor med olika känslor av tillhörighet anpassar doktor-patient relationen till sina specifika behov. Till exempel, så kan en nyligen invandrad gravid kvinnas anknytning till ett sjukvårdsteam, i brist på vårdande familjemedlemmar eller närstående, lätt översättas till en etablerad doktor-patient tillitsdiskurs och i den raka översättningen så riskerar viktiga nyanser att gå förlorade. På samma sätt så kan erfarenheter av god vård på ett sjukhus översättas till god kvalitetsvård för samhällsmedborgare. God vård kan liknas vid en medborgerlig rättighet som är välförtjänt efter flera år av förvärvsarbetande. Men god vård kan också, vilket är fallet för en del, bli en längtan efter tillhörighet till det värdland en befinner sig i. Immigrantens uppskattning av hälso- och sjukvård har i denna kontext sina rötter i en inledande och ständig oro över att inte blir omhändertagen eller ombesörjd och i tacksamheten för att bli omvårdad. Ett sökande efter diskursiva och narrativa spår av olika föreställningar av omvårdnad och vård hos immigranter medför inte bara viktiga fingervisningar om framtida missförstånd, frustrationer och förväntningar, det belyser också

begränsningarna med särskilda föreställningar om vårdrelationer (care relations).

Genom att i det sjätte kapitlet tydliggöra hur äldre turkiska personer förstår formella vårdinrättningar, så som hemtjänst och äldreboenden, understryker jag mina informanters ambivalenta inställning till dessa alternativ. Ambivalensen är förankrad i deras sätt att förstå ”svenskar” som ”moderna” men känslokalla, men också i deras förståelse av egna familjemedlemmar som vårdande andra (caring others). De flesta av mina informanter ansåg sig själva ha förvärvat de grundläggande förutsättningarna för att vara ”moderna,” då de med moderna åsyftade ett ideal om individualism och oberoende, åtminstone av familjemedlemmar i behov av vård, och den *föreställda* möjligheten till formell omvårdnad/vård. De informanter som presenterade sig som att ha lyckats i sin långa historia av integration i det svenska systemet och som att de vunnit rättigheter och kunskap, samt varit bra och moderna föräldrar med framgångsrika avkommor, verkade vara mer angelägna om formell omvårdnad/vård när de blivit äldre och bräckligare. Andra informanter med liknande dispositioner, men som befinner sig i relationer med personer som kan anses vara mindre framgångsrika migranter, är mer försiktiga i sina uttalanden om framtiden. Här kan även äldre personer som informanterna mött under sina vistelser i Turkiet också betraktas som signifikanta andra. Å andra sidan så betraktade mina informanter de ”svenska” idealen om moderna, oberoende och individuella familjemedlemmar som känslokalla ideal, alltför individcentrerande och icke-omhändertagande, och som varande i strid med deras förståelse av vårdande relationer. Här blir den ensamhet och höga grad av individualisering som de uppfattar hos äldre svenskar en paradox i deras idealisering av svenska familjer, en paradox som dock kan bana väg för skapandet eller görandet av en ”emotionell” turkisk familj.

I det sjunde kapitlet visar jag hur föreställningar om den turkiska familjen görs och formas genom tre emotioner: *merhamet* (medlidande/medömkan), *vefa* (lojalitet/trofasthet) och *şefkat* (omsorg/tillgivenhet). Dessa mångsidiga emotioner ger upphov till ett förstärkande av subjektspositioner för äldre föräldrar och deras barn, i linje med deras idealbild av en turkisk familj med nära relationer, samtidigt som de eliminerar vissa andra drag som kan vara i konflikt med hur de konstruerar sin identitet som välintegrerade, moderna turkiska immigranter som lever i Sverige. Med andra ord handlar detta om en rörlig förändring av moraliska subjektiviteter, som skapas i relation till vård och ömsesidigt beroende, snarare än föregivettagna familjeroller. Äldre immigranters ambition att forma familjeansvar kring omhändertagande om varandra (caring about each other) möjliggörs genom att tillskriva dessa

specifika emotioner till specifika subjektspositioner, så som medkännande, lojala och omtänksamma barn. Dock menar jag att denna emotionalisering (emotionalization) av familjen inte handlar om en förstärkning utan snarare om en förhandling om vilka plikter barnen har gentemot sina föräldrar.

I det åttonde kapitlet belyser jag hur dessa emotioner cirkulerar innanför och utanför familjen, samt undersöker hur föreställningar om det omhändertagande diasporiska samhället skapas. För att göra detta undersöker jag tre av mina kvinnliga informanters berättelser om en äldre förstagenerations invandrad turkisk man, som saknade familjemedlemmar och blev flyttad till ett äldreboende. Syftet med detta är att visa att mina kvinnliga informanter, utifrån sina könade upplevelser, anger att det är viktigt att förstärka *gurbet* som ideal gentemot varandra, det vill säga att förstärka idealet om att bry sig om och ta hand om, men inte nödvändigtvis att vårda varandra. Kvinnorna vänder sig här därför till en omhändertagande diaspora, snarare än kräver att mannens barn ska uppfylla sina plikter (*filial duties*). Kvinnornas meningsskapande av detta ideal sker således genom emotioner som kan förstås av flera medlemmar inom gruppen.

Avhandlingen bidrar med empiriskt material om hur äldre turkiska immigranter i Sverige förstår sitt åldrande och hur de bedömer sina framtida omvårdnads- och vårdbehov, samt de alternativ som anses behövas för att möta dessa behov. Även om det empiriska materialet består av berättelser och redogörelser från en specifik grupp turkiska invandrare, så kan studien också erbjuda viktiga insikter om hur människor med invandrarbakgrund i allmänhet förstår sitt åldrande och sina upplevelser av omsorg och omhändertagande, inte bara genom sina kulturella olikheter utan också genom sina erfarenheter av migration och bosättning i ett annat land.

Äldre invandrare skiljer sig inte radikalt från äldre infödda svenska när det handlar om frågor rörande egna erfarenheter av åldrande och planering av framtida vårdbehov. Många infödda svenskar projicerar tidigare erfarenheter av möten med hälso- och sjukvården på framtida behov av vård, och de har precis som mina informanter tankar om tillhörighet, livshistorier, vårdbehov och vilka alternativ som finns för att möta dessa behov i framtiden. Flera tycker att det är svårt att hänga med i alla politiska och organisatoriska förändringar rörande äldrevård. Vad som särskiljer immigranterna från infödda svenskar är hur dessa i grunden liknande spörsmål om omvårdnad och vård förstås på ett annat sätt av immigranterna, i enlighet med de positioner immigranterna tar i det diasporiska rummet och hur de skapar mening av sitt migrationspräglade liv. Avhandlingen bidrar här genom att visa hur en, för att förstå immigranternas möjliga förväntningar i frågor rörande beslut om och behov av vård, måste ta hänsyn till erfarenheten av att

ha levt och blivit gammal i ett diasporiskt rum. Skapande, förhandlingar och omskapande av specifika vårdideal möjliggörs bara om vi tar dessa erfarenhets, minnesbaserade och relationella meningsskapande processer i beaktande.

Populationen av äldre migranter ökar i Europa, men består av väldigt heterogena gemenskaper. Denna heterogenitet härstammar från olika typer av migrationslivshistorier och olika positioner i det diasporiska rummet. Den ökade kulturella och etniska mångfalden av äldre migranter i Sverige skapar nya utmaningar för politiker, socialarbetare och samhällsvetare, inklusive gerontologer, sociologer och antropologer. För att skapa bättre förståelse för denna mångfald, skulle en viktig fråga att driva kunna vara att inkludera ett kritiskt förhållningssätt till denna heterogenitet av äldre migranter utifrån deras livshistorier som har präglats av migration och positioner i det diasporiska rummet. Detta vore ett bättre förhållningssätt än att, som idag, förutsätta att det finns kulturella skillnader inom etniska och/eller diasporiska gemenskaper, och sedan låta dessa fördomar ligga till grund för kulturellt kompetent vård, i vilken en utgår från standardiserade föreställningar om kultur och religion.

Det finns ett ökat intresse för och en växande forskning om vårdbehov, rörlighet och transnationella vårdnätverk hos äldre immigranter. Som jag tidigare hävdat i denna avhandling så är det lika viktigt att inkludera lokala och levda erfarenheter av äldre migranter i det diasporiska rummet och deras strävan efter en omhändertagande diaspora. Detta innebär dock inte att jag argumeterar för en gemensamhetsbaserad vård som främst tillhandahålls av kvinnor i dessa gemenskaper, och inte heller för att vårdansvaret ska delegeras till de diasporiska gemenskaperna genom en uteslutning av andra alternativ för att tillgodose behoven av vård. Snarare erbjuder jag en kritisk hållning gentemot föreställningar om att diasporiska gemenskaper enbart utgörs av delad etnicitet, språk, religion eller lojalitet mot ett tänkt eller reellt hemland. En omhändertagande diaspora är en fråga om, snarare än ett svar på, migranternas längtan efter tillhörighet till värdlandet.

Jag har också föreslagit att för att förstå hur föreställningar om diasporiska gemenskaper och tankar om att ta hand om och bry sig om varandra skapas av migranterna, så är det viktigt att undersöka hur och vilka emotioner som används för att anpassa människor till kollektivet. Föreställningar om diasporiska gemenskaper är alltid knutna till känslor, så som lojalitet till hemlandet, nostalgi, skuld, som diasporans medlemmar förmodas dela. Jag har också visat att känslor och uppvisandet av specifika emotioner, till exempel *merhamet*, *vefa,* och *şefkat* i detta fall inte bara utgör

moraliska riktlinjer för hur en bör ta hand om och vårda varandra, utan de antas också positionera migranterna som annorlunda än infödda.

Framtida forskning bör systematiskt inkludera hur olika vårdkulturer, vårdpraktiker och vårdanläggningar upplevs och tolkas av äldre migranter. Detta banar väg för en bättre förståelse av nuvarande och framtida förväntningar och frustrationer. Å andra sidan så kan framtida utveckling och förändring ge upphov till nya utmaningar hos äldre migranter i frågor gällande val av omvårdnad, vård och äldreomsorg. Som jag har betonat i denna studie så kräver arbetet med att ta fram nya alternativ, exempelvis äldreboenden för migranter i ursprungslandet eller i det land en flyttat till, att en tar erfarenheter av migration och diasporiska livsberättelser i beaktande. Nya vårdarrangemang mellan länder bedöms kontinuerligt av migranterna utifrån deras livsberättelser och historia. Till exempel kommer de långsamt i antal ökande vårdinrättningarna i Turkiet för äldre turkiska migranter, och nya överenskommelser om subventionerad vård, ersättningar och överförandet av rättigheter mellan Turkiet och Sverige att prägla äldre turkiska migranters beslut och förståelse. Ytterligare och framtida forskning bör fokusera på dessa alternativ, inte bara utifrån dess legala och ekonomiska aspekter men också utifrån deras mångfaldigande av immigranternas förståelse av vård och omvårdnad när de navigerar mellan olika sorters vårdpolitik och vårdpraxis.

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Bibliography

Abadan-Unat, N. (2002) *Bitmeyen Göç: Konuk İşçilikten Ulus-Ötesi Yurttaşlığa* [*Unending Migration: From Guest Workers to Post-National Citizenship*]. Istanbul: Istanbul Bilgi Üniversitesi Yayınları.

Abdelhady, D. (2008) 'Representing the Homeland: Lebanese Diasporic Notions of Home and Return in a Global Context', *Cultural Dynamics,* 20: 53–72.

Adams, L. L. (1999) 'The mascot researcher: Identity, power, and knowledge in fieldwork', *Journal of Contemporary Ethnography*, 28 (4): 331–63.

Ahmed, S. (1994) 'Home and Away: Narratives of Migration and Estrangement', *International Journal of Cultural Studies,* 2 (3): 329–347.

Ahmed, S. (2000) *Strange Encounters- Embodied Others in Post-coloniality*. London: Routledge.

Ahmed, S. (2004) 'Collective Feelings: Or, the Impressions Left by Others', *Theory, Culture & Society*, 21 (2): 25–42.

Ahmed, S. (2004) *The Cultural Politics of Emotion*. Edinburgh: Edinburgh University Press.

Ahmed, S., Castañeda, C., Fortier, A.-M., and Sheller, M. (eds) (2003) *Uprootings/Regroundings: Questions of Home and Migration*. Oxford: Berg.

Ahmed, S. and Fortier A.-M. (2003) 'Re-imagining Communities', *International Journal of Cultural Studies*, 6 (3): 251–259.

Akalin, A. (2007) 'Hired as a Caregiver, Demanded as a Housewife: Becoming a Migrant Domestic Worker in Turkey', *European Journal of Women's Studies*, 14 (3): 209–225.

Akpinar, A. (1988) *Challenged Family and Kinship Ideals: Family Crisis and Social Networks among Turkish Immigrants*. Stockholm: Institutet för social forskning.

Akpinar, A. (1998) *Male's Honour and Female's Shame: Gender and Ethnic Identity Constructions among Turkish Divorcees in the Migration Context*. Stockholm: Elanders Gotab AB.

Albin, B. and Albertsson, M. (2005) 'Health and Consumption of Health Care and Social Service among Old Migrants in Sweden', *Primary Health Care Research and Development,* 6: 37–45.

Alpay, Ş. (1980) *Turkar i Stockholm. En Studie av Invandrare, Politik och Samhälle [Turks in Stockholm: A Study of Migrants, Politics and Society]*. Stockholm: Liber Förlag.

Alpay, S. and Sariaslan, H. (1984) *Effects of Emigration. The effects on the town of Kulu in central Turkey of emigration to Sweden*. Stockholm: Comission of Migration Research in Sweden: Swedish Government Printing.

Amit, V. (ed) (2002) *Realizing Community: Concepts, Social Relationships and Sentiments*. London and New York: Routledge.

Amit, V. (2004) 'Introduction: Constructing the Field', in Amit, V. (ed), *Constructing the Field: Ethnographic Fieldwork in the Contemporary World*. London: Routledge.

Anbäcken, E.-M. (2004) "Researching Home Help Services for the Elderly in Japan and Sweden: How Cultural Concepts Affect the Research Design", in Öberg, B.-M., Närvänen, A.-L., Näsman, E. and Olsson, E. (eds) *Changing Worlds and the Ageing Subject: Dimensions in the Study of Ageing and Later Life*. Aldershot: Ashgate, pp 96–114.

Anderson, B (1983) *Imagined Communities*. London: Verso.

Anthias, F. (1998) 'Evaluating "Diaspora": Beyond Ethnicity?', *Sociology*, 32 (3) : 557–580.

Antonsich, M. (2010) 'Searching for Belonging- An Analytical Framework', *Geography Compass*, 4 (6): 644–659.

Ålund, A. and Schierup, C.U. (1991) *Paradoxes of Multiculturalism: Essays on Swedish Society*. Aldershot: Avebury.

Baldassar, L. (2001) *Visits Home: Migration Experiences between Italy and Australia*. Melbourne: Melbourne University Press.

Baldassar, L. (2007) 'Transnational Families and Aged Care: The Mobility of Care and the Migrancy of Ageing', *Journal of Ethnic and Migration Studies,* 33 (2): 275–297.

Bambra, C. (2007) 'Defamilialisation and Welfare State Regimes: A Cluster Analysis', *International Journal of Social Welfare*, 16 (4): 326–338.

Barbalet, J.M. (1996) 'Social Emotions: Confidence, Trust and Loyalty', *International Journal of Sociology and Social Policy*, 16 (9/10): 75–96.

Barnes, M (1997) *Care, communities and citizens*. London, New York: Longman.

Basch, L., Glick Schiller, N. and Szanton Blanc, C. (1994) *Nations Unbound: Transnational Projects, Postcolonial Predicaments and Deterritorialized Nation-States*. Langhorne, PA: Gordon & Breach.

Becker, G. (2003) 'Meanings of Place and Displacement in Three Groups of Older Immigrants', *Journal of Aging Studies*, 17 (2): 129–149.

Ben-Rafael, E. (2013) 'Diaspora', *Current Sociology Review*, 0(0): 1–20.

Berger, J. (1975) *A Seventh Man: A Book of Images and Words about the Experience of Migrant Workers in Europe*. Baltimore, MD: Penguin.

Björklund, U. (1981) *North to Another Country*. Stockholm: Stockholm Studies in Social Anthropology.

Blackman, T. (2000) 'Defining Responsibility for Care: Approaches to the Care of Older People in Six European countries', *International Journal of Social Welfare*, 9: 181–190.

Blomberg, S., Edelbalk, P. G. and Petersson, J. (2000) 'The Withdrawal of the welfare state: elder care in Sweden in the 1990s', *European Journal of Social Work*, 3 (2): 151–163.

Blomberg, S. and Peterson, J. (2007) "Elderly Care in Sweden as Part in the Formulation of a Social Citizenship: A Historical Perspective on Present Change", in Harryson, L. and Michael O'Brien (eds), *Social Welfare, Social Exclusion-A Life Course Frame*, Lund: Värpinge Ord & Text.

Björnberg, U. and Kollind, A. K. (2005) *Individualism and Families: Equality, Autonomy and Togetherness*. London: Routledge.

Bollini, P. and Siem, H. (1995) 'No real progress towards the equity: Health of migrants and ethnic minorities on the eve of the year 2000', *Soc. Sci. Med.*, 41 (6): 819–828.

Bolzman, C., Fibbi, R. and Vial, M. (2006) 'What to do after retirement? Elderly migrants and the question of return', *Journal of Ethnic and Migration Studies,* 32(8): 1359–1375.

Bowden, P. (1997) *Caring: Gender-Sensitive Ethics*. London: Routledge.

Brah, A. (1996) *Cartographies of Diaspora: Contesting Identities*. London: Routledge.

Braziel, J. E. and Mannur, A. (eds) (2003) *Theorizing Diaspora: A Reader.* Maiden, MA: Blackwell Publications.

Brodin, H. (2005) *Does Anybody Care? Public and Private Responsibilities in Swedish Eldercare 1940–2000*, Ph.D. Dissertation, Umeå: Umeå University.

Brubaker, R. (2004) *Ethnicity without Groups*. Cambridge, Massachusetts, and London: Harvard University Press.

Brubaker, R. (2005) 'The 'diaspora' diaspora', *Ethnic and Racial Studies*, 28 (1): 1–19.

Bryceson, D. and Vuorela, U. (2002) *The Transnational Family: Global European Networks and New Frontiers*. Oxford, New York: Berg.

Buonfino, A. and Thomson, L. (2007) *Belonging in Contemporary Britain.* London: Commission on Integration and Cohesion.

Burkitt, Ian (2002) "Complex Emotions: Relations, Feelings and Images in Emotional Experience" in Barbalet, J. (ed.) *Emotions and Sociology*, Oxford and Malden: Blackwell Publishing, pp 151–167.

Bäärnhielm, S. and Ekbald, S. (2000) 'Turkish Migrant Women Encountering Health Care in Stockholm: A Qualitative Study of Somatization and Illness Meaning', *Culture, Medicine and Psychiatry,* 24**:** 431–452.

Bäärnhielm, S. (2003) *Clinical Encounters with Different Illness Realities: Qualitative Studies of Illness Meaning and Restructuring of Illness Meaning among Two Cultural Groups of Female Patients in a Multicultural Area of Stockholm*. Karolinska Institutet: Stockholm.

Bäärnhielm, S., Ekbald, S., Ekberg, J. and Ginsburg, B.E. (2005) 'Historical Reflections on Mental Health Care in Sweden: The Welfare State and Cultural Diversity', *Transcultural Psychiatry,* 42: 394–419.

Castles, S., Booth, H. and Wallace, T. (1984) *Here for Good: Western Europe's new ethnic minorities.* London: Pluto.

Castoriadis, C. (1987) *The Imaginary Institution of Society*. London: Polity Press.

Castoriadis, C. (1994) 'Radical Imagination and the Social Instituting Imaginary', in Gilligan Robinson and John Rundell (eds) *Rethinking Imagination: Culture and Creativity*. London: Routledge, pp 136–154.

Cavarero, A. (2000) *Relating Narratives: Storytelling and Selfhood.* London: Routledge.

Chamberlain, M. and Leydesdorff, S. (2004) 'Transnational families: Memories and Narratives', *Global Networks*, 4 (3): 227–241.

Chattoo, S. and Ahmad, W.-I. U. (2008) 'The moral economy of selfhood and caring: negotiating boundaries of personal care as embodied moral practice', *Sociology of Health and Illness*, 30 (4): 550–564.

Choi, J. S. (2004) 'Evaluation of Community Planning and Life of Senior Cohousing Projects in Northern European Countries', *European Planning Studies*, 12 (8): 1189 –1216.

Clifford, J. (1986) "Introduction: Partial truths", in Clifford, J. and Marcus, G.E. (eds) *Writing Culture: the Poetics and Politics of Ethnography*, Berkeley, Los Angeles, London: University of California Press.

Clifford, J. (1994) 'Diasporas', *Cultural Anthropology*, 19 (3): 302–338.

Clifford, J. (1997) *Routes: Travel and Translation in the Late Twentieth Century*. Cambridge, Massachusetts: Harvard University Press.

Cohen, R. (1997) *Global Diasporas: An Introduction*, London: UCL Press.

Cristoforetti, A., Gennai, F. and Rodeschini, G. (2011) 'Home sweet home: The emotional construction of places', *Journal of Aging Studies*, 25 (3): 225–232.

Crowley, J. (1999) "The politics of belonging: some theoretical considerations", in Geddes, A. and Favell, A. (eds) *The Politics of Belonging: Migrants and Minorities in Contemporary Europe*. Aldershot: Ashgate, pp 15–41.

Dunér, A. and Nordström, M. (2007) 'The role and functions of the informal support networks of older people who receive formal support: A Swedish qualitative study', *Ageing and Society*, 27: 67–85.

Ehrenreich, B. and Hochschild, A. (eds) (2003) *Global women: nannies, maids and sex workers in the new economy*. London: Granta Books.

Elshtain, J.B. (1995) "Feminism, Family, and Community", in Friedman, M. and Weiss, P.A. (eds.) *Feminism and Community*. Philadelphia: Temple University Press, pp 259–272.

Estes, C. L. and Binney, E. A (1991) 'The Biomedicalization of Aging: Dangers and Dilemmas' , in Minkler, M. And Estes, C. L. (eds) *Critical Perspectives on Aging: The Political and Moral Economy of Growing Old.* Amityville, New York: Baywood Pub. Co.

Emami, A., Torres, S., Lipson, J.G., and Ekman, S.-L. (2000) 'An Ethnographic Study of a Day Care Center for Iranian Immigrant Seniors', *West Journal of Nursing Research*, 22 (2), 169–188.

Engelbrektsson, U.-B. (1978) *The Force of Tradition: Turkish Migrants at Home and Abroad*. Göteborg : Acta Universitatis Gothoburgensis

Engelbrektsson, U.-B. (1995) *Tales of Identity: Turkish Youth in Gothenburg*. Stockholm: Centrum för invandringsforskning (CEIFO).

Erder, S. (2006) *Refah Toplumunda Getto* [*Ghetto in the Welfare Society*]. Istanbul: Istanbul Bilgi Üniversitesi Yayınları.

Ergun, A. and Eydemir, A (2010) 'Negotiating Insider and Outsider Identities in the Field: "Insider" in a Foreign Land; "Outsider" in one's Own Land', *Field Methods*, 22 (1): 16–38.

Esping-Andersen, G. (1990) *The Three Worlds of Welfare Capitalism*. Cambridge: Polity Press.

Eyrumlu, R. (1992) *Turkar Möter Sverige. En Studie om Turkisktalande Elevers Skolgång i Göteborg [Turks Meet Sweden: A Study on Schooling of Turkish-speaking Students in Gothenburg]*. Stockholm: Carlssons.

Fereshteh, A. L. (2001) 'Gerotranscendence and Different Cultural Settings', *Ageing and Society,* 21**:** 395–415.

Ferrera, M. (2005) *The Boundaries of Welfare: European Integration and the New Spatial Politics of Social Protection.* Oxford: Oxford University Press.

Finch, J. and Groves, D. (eds) (1983) *A Labor of Love: Women, Work and Caring,* London: Routledge and Kegan Paul.

Finch, J. and Mason, J. (1993) *Negotiating Family Responsibilities*. London: Routledge.

Fine, M. D. (2007) *A Caring Society? Care and the Dilemmas of Human Service in the 21st Century.* Houndmills, Basingstoke, Hampshire and New York: Palgrave Macmillan.

Fisher, B. and J. Tronto (1990) "Towards a Feminist Theory of Care", in E. Abel and M. Nelson (eds) *Circles of Care: Work and Identity in Women's Lives*. Albany, NY: State University of New York Press.

Foner, N. (1997) 'The Immigrant Family: Cultural Legacies and Cultural Changes', *IMR*, 31 (4): 961–976.

Forsell, E. (2004) *Skyddandets förnuft. En studie om anhöriga till hjälpbehövande äldre som invadrat sent i livet* [*The Logic of Protection: A Study of Informal Caregiving to Older Family Members in Immigrant Families*], Ph.D. Dissertation, Stockholm University.

Forsell, E. and Torres, S. (2012) 'Social work, older people and migration: an overview of the situation in Sweden', *European Journal of Social Work*, 15 (1): 115–130.

Forsey, M. (2010) 'Ethnography as participant listening', *Ethnography* 11 (4): 558–572.

Fortier, A.M. (2000) *Migrant Belongings: Memory, Space, Identity.* Oxford: Berg.

Fortier, A.M (2003) 'Making Home: Queer migrations and Motions of Attachment', in S. Ahmed, C. Castaneda, A-M. Fortier, M. Sheller (eds) *Uprootings/Regroundings: questions of home and migration.* Oxford: Berg.

Fraser, N. and L. Gordon (1994) 'Dependency Demystified: Inscriptions of Power in a Keyword of the Welfare State', *International Studies in Gender, State and Society* 1 (1): 4–31.

Friedan, B. (1993) *The Fountain of Age*. London: Vintage.

Friedman, M. (1993) *What are friends for?* Ithaca, NY: Cornell University Press.

Froggett, L. (2002) *Love, Hate and Welfare: Psychosocial Approaches to Policy and Practice*. London: Policy Press.

Gambetta, D. (1988) *Trust: Making and Breaking Cooperative Relations*. Oxford: Basil Blackwell.

Ganga, D. and Scott, S. (2006) 'Cultural 'Insiders' and the Issue of Positionality in Qualitative Migration Research: Moving "Across" and Moving "Along" Researcher-Participant Divides', *Forum: Qualitative Research*, 7 (3).

Ganga, D. (2007) 'From Potential Returnees into Settlers: Nottingham's Older Italians', *Journal of Ethnic and Migration Studies*, 32 (8): 1395–1413.

Gardner, K. (2002) *Age, Narrative and Migration: The Life Course and Life Histories of Bengali Elders in London*. Oxford, New York: Berg.

Garrett P., Dickson H., Young L, and Whelan A., (2008) '"The Happy Migrant Effect": perceptions of negative experiences of healthcare by patients with little or no English: a qualitative study across seven language groups', *Qual Saf Health Care*, 17: 101–103.

Geertz, C. (1973) *The Interpretation of Cultures*. New York: Basic Books.

Gilligan, C. (1982), *In a Different Voice*. Cambridge, Ma: Harvard University Press.

Gilroy, P. (1993) *The Black Atlantic: Modernity and Double Consciousness*. London: Routledge.

Gilroy, P (2000) *Between Camps*. London: Allen Lane.

Graham, H. (2000) "Caring: A Labor of Love", in Finch, J. and Groves, D. (eds) *A Labor of Love: Women, Work and Caring*. London: Routledge and Kegan Paul.

Gray, B. (2008) 'Putting Emotion and Reflexivity to Work in Researching Migration', *Sociology*, 42 (5): 935–952.

Grillo, R. (ed) (2008) *The Family in Question: Immigrant and Ethnic Minorities in Multicultural Europe*. IMISCOE Research: Amsterdam University Press.

Gubrium, J. F. and J. A. Holstein, (2009) *Analyzing Narrative Reality*. Los Angeles: Sage.

Gunaratnam, Y. (2008) 'Care, Artistry and What Might Be', *Ethnicity and Inequalities in Health and Social Care*, 8 (1): 9–17.

Gupta, A. and Ferguson, J. (1992) 'Beyond "Culture": Space, Identity, and the Politics of Difference', *Cultural Anthropology*, 7 (1): 6–23.

Halbwachs, M. (1992) "The Collective Memory of the Family", in *On Collective Memory*. Chicago: The University of Chicago Press.

Hage, G. (2005) 'A Not so Multi-sited Ethnography of a Not so Imagined Community', *Anthropological Theory*, 5: 463-475.

Hammar, T. (1980) 'Immigration Research in Sweden', *International Migration Review*, 14 (1): 93–115.

Hammersley, M. and Atkinson, P. (2007) *Ethnography: Principles in Practice*. London, New York: Routledge.

Hammarström, G. and Torres, S. (2010) 'Being, Feeling and Acting: A Qualitative Study of Swedish Home-help Care Recipients' Understandings of Dependence and Independence', *Journal of Aging Studies*, 24: 75–87.

Hannerz, U. (1996) *Transnational Connections: Culture, People, Places*. London: Routledge.

Hastrup, K. (1992) "Writing Ethnography: State of the Art", in J. Okely and H. Callaway (eds) *Anthropology and Autobiography*, London: Routledge.

Hastrup, K. and Hervik, P. (eds) (1994) *Social Experience and Anthropological Knowledge*. London: Routledge.

Hastrup, K. (1995) *A Passage to Anthropology: Between Experience and Theory*. London: Routledge.

Hazan, H. (2002) 'The home over the hill: Towards a modern cosmology of institutionalization', *Journal of Aging Studies*, 16: 323–344.

Heikkilä, Kristiina (2004) *The Role of Ethnicity in Care of Elderly Finish Immigrants*. Stockholm: Karolinska Institutet.

Hernes, H. M. (1988) 'Scandinavian Citizenship', *Acta Sociologica*, 31 (3): 199–215.

Hjern, A., Haglund, B., Persson, G. and Rosén, M. (2001) 'Is there equity in access to health services for ethnic minorities in Sweden', *European Journal of Public Health*, 11: 147–152.

Hjälm, A. (2012) '"Because we know our limits:" Elderly parents' views on intergenerational proximity and intimacy', *Journal of Aging Studies*, 26: 296–308.

Hochschild, A. R. (2003) *The Commercialization of Intimate Life: Notes from Home and Work*. Berkeley, CA: University of California Press.

Hoff Sommers, C. (1986) 'Filial Morality', *The Journal of Philosophy,* 83: 439–456.

Hollway, W. (2006) *The Capacity to Care: Gender and Ethical Subjectivity*. London: Routledge.

Husain, F. and O'Brien, M. (2000) 'Muslim Communities in Europe: Reconstruction and Transformation', *Current Sociology*, 48 (4): 1–13.

Ilcan, S. (2002) *Longing for Belonging: The Cultural Politics of Settlement*. Westport, Connecticut, London: Prager.

Imamoglu, O. E. and Imamoglu, V. (1992) 'Life situations and attitudes of the Turkish elderly toward institutional living with across-culture perspective', *Journal of Gerontology Psychological Sciences*, 47 (2): 102 –108.

Isacsson, A. Hanson, B. S., Janzon, L. and Kugelberg, G. (1992) The epidemiology of sick leave in an urban population in Malmö, Sweden', *Scan. J. Soc. Med.* 20: 234.

Jamieson, A. (ed) (1991) *Home Care for Older People in Europe. A Comparison of Politics and Practices.* Oxford: Oxford University Press.

Johansson, L. (1991). *Caring for the Next of Kin. On Informal Care for Elderly in Sweden*. Ph.D. Dissertation. Uppsala: Uppsala University, Faculty of Medicine.

Johansson, L., Sundström, G. and Hassing, L. B. (2003) 'State provision down, offspring's up: The reverse substitution of old-age care in Sweden', *Ageing and Society*, 23: 269–280.

Joseph, S. (1993) 'Gender and Relationality among Arab Families in Lebanon', *Feminist Studies*, 19 (3): 465–486.

Jönsson, I., Daune-Richard, A.-M., Odena, S. and Ring, M. (2011) 'The Implementation of Elder-care in France and Sweden: A Macro and Micro Perspective', *Ageing & Society*, 31: 625–644.

Kagitcibasi, C. (2002) "Cross-cultural Perspectives on Family Change", in Liljeström, R. and Özdalga, E. (eds) *Autonomy and Dependence in the Family: Turkey and Sweden in Critical Perspective*, Istanbul: Swedish Research Institute.

Kao, A. C., Green, D.C., Zaslavsky A. M., Koplan, J. P., and Cleary, P. D. (1998) 'The relationship between method of physician payment and patient trust', *JAMA*, 280: 1708–1714.

Kaufman, Sharon R. (1986) *The Ageless Self: Sources of Meaning in Late Life.* Madison: University of Wisconsin Press.

Katz, S. (1996) *Disciplining Old Age: The Formation of Gerontological Knowledge*. London: University Press of Virginia.

Keith, C. (1995), 'Family Caregiving Systems: Models, Resources, and Values C', *Journal of Marriage and the Family*, 57 (1): 179–189.

Kertzer, D.I. and Keith, J. (eds) (1984) *Age & Anthropological Theory*. Ithaca, London: Cornell University Press.

Keyder, Ç,, Üstündağ, N., Ağartan, T. and Yoltar, Ç. (eds) (2007) *Avrupa'da ve Türkiye'de Sağlık Politikaları: Reformlar, Sorunlar, Tartışmalar* [*Health Politics in Europe and in Turkey: Reforms, Problems, Debates*]. İstanbul: İletişim Yayınları.

King, R., Warnes, T., and Williams, A. (2000) *Sunset Lives: British Retirement Migration to the Mediterranean*. Oxford, New York: Berg.

Kittay, E. F. (2001) 'A Feminist Public Ethic of Care Meets the New Communitarian Family Policy', *Ethics*, 111 (3): 523–547.

Kleres, J. (2011) 'Emotions and narrative analysis: a methodological approach', *Journal for the Theory of Social Behaviour*, 41 (2): 182–202.

Klinthäll, M. (2006) 'Retirement Return Migration from Sweden', *International Migration*, 44 (2): 153–180.

Knijn, T. and Kremer, M. (1997) 'Gender and the Caring Dimension of Welfare States: Toward Inclusive Citizenship', *Social Politics*, 4: 328–61.

Kontos, P. C. (1998) 'Resisting Institutionalization: Constructing old age and negotiating home', *Journal of Aging Studies*, 12 (2): 167–184.

Kuhn, A. (1995) *Family Secrets: Acts of Memory and Imagination*, New York, London: Verso.

Lager, D., Hoven, B. V., Meijering, L. (2012) 'Places that matter: Place attachment and wellbeing of older Antillean migrants in the Netherlands', *European Spatial Research and Policy*, 19 (1): 81–94.

Leavitt, J. (1996) 'Meaning and Feeling in the Anthropology of Emotions', *American Ethnologist*, 23 (3): 514–539.

Liljeström, R. and Özdalga, E. (eds) (2002) *Autonomy and Dependence in the Family: Turkey and Sweden in Critical Perspective*. Istanbul: Swedish Research Institute.

Lister, R. (1997) *Citizenship: Feminist Perspectives*. London: Macmillan.

Lloyd, L. (2000) 'Caring about Carers: Only Half the Picture?', *Critical Social Policy*, 20 (1): 136–50.

Lock, M. (1993) *Encounters with aging: Mythologies of Menapause in Japan and North America*. Berkeley, London: University of California Press.

Luhmann, N. (1979) *Trust and Power*. New York: John Wiley.

Lundberg, I and Svanberg, I. (1991) *Turkish Associations in Metropolitan Stockholm*. Uppsala: Uppsala Multiethnic Papers 23.

Lundberg, I. (1991) *Kulubor i Stockholm. En svensk historia [Kulu Migrants in Stockholm: A Swedish History]*. Invandraminnesarkivet Serie A. 4. Stockholm: Tumba.

Lutz, C. and Abu-Lughod, L. (1990) "Introduction: Emotion, Discourse and the Politics of Everyday life", in Lutz and Abu-Lughod (eds) *Language and the Politics of Emotion,* Cambridge: Cambridge University Press.

Lutz, H. (2011) *The New Maids: Transnational Women and the Care Economy*. London: Zed.

Lynch, K. (2007) 'Love labour as a distinct and non-commodifiable form of care labour", *The Sociological Review*, 55 (3): 550–570.

Marshall, T. H. and Bottomore, T. (1992) *Citizenship and Social Class*. London: Pluto Press.

Marte, L. (2007) 'Foodmaps: Tracing Boundaries of 'Home' Through Food Relations', *Food and Foodways*, 15 (3): 261–289.

Maule, A.J., Cliff, D.R. and Taylor, R. (1996), 'Early Retirement Decisions and How They Affect Later Quality of Life', *Ageing and Society*, 16: 177–204.

Mechanic, D. and Schlesinger, M. (1996) 'The impact of managed care on patients' trust in medical care and their physicians', *JAMA*, 275: 1693–1697.

McKie, L., S. Gregory and S. Bowlby (2002) 'Shadow Times: The Temporal and Spatial Frameworks and Experiences of Caring and Working', *Sociology* 36 (4): 897–924.

Milligan, C. (2009) *There's no Place Like Home: Place and Care in an Aging Society*. Burlington: Ashgate.

Mills, A. (2006) 'Boundaries of the Nation in the Space of the Urban: Landscape and Social Memory in Istanbul', *Cultural Geographies,* 13: 367–394.

Mishler, E. G. et al. (1981) *Social Contexts of Health, Illnes, and Patient Care*. Cambridge: Cambridge University Press.

Molinier, P. (2003). *L'énigme de la femme active: Egoïsme, sexe et compassion [Riddle of active women: Egoism, Sex and Compassion].* Paris: Editions Payot & Rivages.

Morgan, D. (1996) *Family Connections: An Introduction to Family Studies*. Cambridge: Polity Press.

Murat, S. (2000) 'Immigrant Turks and Their Socio-economic Structure in European Countries', *C. Ü. İktisadi ve İdari Bilimler Dergisi,* 2 (1): 25–46.

Myerhoff, B. (1979): *Number Our Days*. New York: EP Dutton.

Naldemirci, Ö. (2009) *Care and emotions: Gendering the experience of nurses in an oncology department*. Unpublished M.A. thesis. Istanbul: Bogazici University.

Noddings, N. (1984) *Caring: A Feminist Approach to Ethics and Moral Education*. Berkley, CA: University of California Press.

Okely, J. (1992) "Anthropology and Autobiography: Participatory Experience and Embodied Knowledge" in J. Okely and H. Callaway (eds) *Anthropology and Autobiography*. London: Routledge.

Olaison, A. (2009) *Negotiating Needs: Processing Older Persons as Home Help Care Recipients in Gerontological Social Work Practice*. Ph.D. Dissertation, Linköping: Linköping University.

Orbach, S. (1999) *Towards Emotional Literacy.* London: Virago Press.

Paerregard, K. (2002) 'The resonance of fieldwork. Ethnographers, informants and the creation of anthropological knowledge', *Social Anthropology*, 10 (3): 319–334.

Parreñas, R. S. and Lok C. D. Siu (2007) *Asian Diasporas: New Formations, New Conceptions.* Stanford, California: Stanford University Press.

Pateman, C. (1988) "The Patriarchal Welfare State", in Gutman, A. (ed) *Democracy and the Welfare State*. Princeton, N.J.: Princeton University Press, pp 231–60.

Percival, J. (2002) 'Domestic Spaces: Uses and Meanings in the Daily Lives of Older People', *Ageing and Society*, 22 (6): 729–749.

Peterson, A. (2005) *Engendering Emotions*. New York: Palgrave Macmillan.

Pearson S. and Raeke L. (2000) 'Patients' Trust in Physicians: Many Theories, Few Measures, and Little Data'. *J Gen Intern Med*, 15: 509 –513.

Phellas, C. (ed) (2013) *Aging in European Societies: Healthy Aging in Europe*. New York: Springer.

Portes, A., Guarnizo, L.E. and Landolt, P. (eds) (1999), 'Transnational Communities', *Ethnic and Racial Studies*, 22 (2): 217–37.

Probyn, E. (1996) *Outside Belongings.* New York: Routledge.

Qureshi, H. and Walker, A. (1989) *The Caring Relationship: Elderly People and Their Families.* London: Macmillan.

Rabo, A. (2008) ''Doing Family: Two Cases in Contemporary Syria', *Journal of Women of the Middle East and the Islamic World*, 6: 129–153.

Rapport, N. (2004) "Narrative as Fieldwork Technique", in Amit, V. (ed), *Constructing the Field: Ethnographic Fieldwork in the Contemporary World,* London: Routledge.

Rauch, D. (2007) 'Is there really a Scandinavian social service model? A comparison of Childcare and Elderly Care in six European Countries', *Acta Sociologica*, 50 (3): 249–69.

Ricoeur, P. (1984). *Time and narrative.* (Translated by McLaughlin, K. and Pellauer, D.). Chicago: The University of Chicago Press

Riessman, C. H. (1993) *Narrative Analysis*, Newbury Park, London, New Delhi: Sage Publications.

Sachs, L. (1983) *Evil Eye or Bacteria: Turkish Migrant Women and Swedish Health Care.* Stockholm: Studies in Social Anthropology.

Salzman, P. S. (2002) 'On Reflexivity', *American Anthropologist*, 104 (3): 805–813.

Safran, W. (1991) 'Diasporas in Modern Societies: Myths of Homeland and Return', *Diaspora*, 1 (1): 83–99.

Sankar, A. (1984) "'It's Just Old Age': Old Age as a diagnosis in American and Chinese Medicine", in Kertzer, D. I. and Keith, J. (1984) *Age & Anthropological Theory*. Ithaca, London: Cornell University Press.

San Juan, Jr., E. (2001) 'Interrogating Transmigrancy, Remapping Diaspora: The Globalization of Laboring Filipino/as', *Discourse*, 23 (3): 52–74.

Sayad, A. (2004) *The Suffering of the Immigrant*. Cambridge, Malden: Polity Press.

Sayad, A. (2001) 'La vacance comme pathologie de la condition d'immigré: Le cas de la retraite et de la pré-retraite [Vacancy/Vacation as pathology of the condition of the immigrant: The case of retirement and early retirement]' *Revue Européenne des Migrations Internationales*, 17 (1): 11–36.

Schierup, C.U., Hansen, P. and Castles, S (2006) *Migration, Citizenship and the European Dilemma.* Oxford: Oxford University Press.

Sciffauer, W. (2007) "From Exile to Diaspora: The Development of Transnational Islam in Europe", in Al-Azmeh, A. andFokas, E. (eds) *Islam in Europe: Diversity, Identity and Influence.* Cambridge: Cambridge University Press, pp 68–95.

Shenk, D., Kuwahara, K. and Zablotsky, D. (2004) 'Older women's attachment to their home and possessions', *Journal of Aging Studies*, 18: 157–169.

Sevenhuijsen S. (1998). *Citizenship and the Ethics of Care: Feminist Considerations on Justice, Morality, and Politics.* London; New York: Routledge.

Sevenhuijsen S. (2000) 'Caring in the Third way: The relation between Obligation, Responsibility and Care in the Third Way Discourse', *Critical Social Policy*, 20 (1): 5–37.

Sirman, N. (2005) 'The Making of Familial Citizenship in Turkey', in Keyman and İçduygu (eds) *Challenges to Citizenship in a Globalizing World: European Questions and Turkish Experiences,* London: Routledge.

Skeggs, B. (1997) *Formations of class and gender*. London: Sage.

Skrbiš, Z. and Svašek, M. (2007) 'Passions and Powers: Emotions and Globalization', *Identities: Global Studies in Culture and Power*, 14: 367–383.

Skrbiš, Z. (2008) Transnational Families: Theorizing Migration, Emotions and Belonging', *Journal of Intercultural Studies*, 29 (3): 231–246.

Skrbiš, Z., Baldassar, L. and Poynting, S. (2008) 'Introduction - Negotiating Belonging: Migration and Generations', *Journal of Intercultural Studies,* 28 (3): 261–269.

Soysal, L. (2003) 'Labor to Culture: Writing Turkish Migration to Europe', *The South Atlantic Quarterly*, 102 (2/3): 491–508.

Soysal, Y. N. (1994) *The Limits of Citizenship: Migrants and Postnational Citizenship in Europe.* Chicago, III: University of Chicago.

Soysal, Y. N. (2000) 'Citizenship and identity: living in diasporas in post-war Europe?', *Ethnic and Racial Studies*, 23 (1): 1–15.

Stewart, K. (1996) *A Place on the Side of the Road.* Princeton: Princeton University Press.

Strauss, A., Fagerhaugh, S., Suczek, B. and Wiener, C. (1982). 'Sentimental Work in the Technologized Hospital', *Sociology of Health and Illness*, 4: 255–78.

Stuifbergen, M.C. and Van Delden, J. J. M. (2011) 'Filial Obligations to Elderly Parents: A Duty to Care?', *Med Health care and Philos*, 14: 63–71.

Sundquist, J. (1995a) 'Ethnicity, social class and health. A population-based Study on the Influence of Social Factors on Self-reported Illness in 223 Latin American refugees, 33 Finish and 126 South European Labor Migrants and 841 Swedish Controls', *Soc Sci Med*, 40: 777–87.

Sundquist, J. (1995b) 'Living Conditions and Health: A Population-based Study of Labor Migrants and Latin American Refugees in Sweden and Those Who Were Repatriated', *Scan J Prim Health Care*, 13: 128–34.

Svašek, M. (2008) 'Who cares? Families and Feelings in Movement', *Journal of Intercultural Studies*, 29 (3): 213–230.

Svašek, M. (2010) 'On the Move: Emotions and Human Mobility', *Journal of Ethnic and Migration Studies,* 36 (6): 865–880.

Szebehely, M. (1998) "Changing divisions of Carework: Caring for Children and Frail Elderly People in Sweden", in Lewis, J. (ed) *Gender, Social Care and Welfare Restructuring in Europe*, Aldershot: Ashgate.

Szebehely, M. (2005) "Care as Employment and Welfare Provision- Child Care and Elder Care in Sweden at the Dawn of the 21st Century", in Dahl H.M and Tine Rask Eriksen (eds) *Dilemmas of Care in the Nordic Welfare State: Continuity and Change,* Aldershot: Ashgate.

Sztompka, P. (1999) *Trust: A Sociological Theory*. Cambridge: Cambridge University Press.

Söderberg, M. , Ståhl, A. and Emilsson, U. M. (2012) 'Family Members' Strategies When Their Elderly Relatives Consider Relocation to a Residential Home –Adapting, Representing and Avoiding', *Journal of Aging Studies*, 26 (4): 495–503.

Tanner, D. and Harris, J. (2007) *Working with Older People*. New York: Routledge.

Terzioglu, A. (1998) *Turkish Medical Doctors: Historical experience and self-narratives*. Unpublished M.A. Thesis. Istanbul: Bogazici University.

Thorslund, M., Wärneryd, B. & Östlin, P. (1992) 'The Work-relatedness of Disease: Workers' Own Assessment', *Sociology of Health & Illness*, 14 (1): 57–72.

Titmuss, R. M. (1968) *Commitment to welfare*. London: Allen & Unwin.

Torres, S. (2006) 'Elderly Immigrants in Sweden: 'Otherness' Under Construction', *Journal of Ethnic and Migration Studies,* 32 (8): 1341–1358.

Torres, S. (2008) 'L'ère des migrations: définition et importance pour la gerontology sociale en Europe' ['The age of migration: what does it mean and why should European social gerontologists in care'], *Retraite et Societé*, 55: 15–37.

Torres, S. (2012) "International Migration: patterns and implications for exclusion in old age", in T. Scharf and N. C. Keating (eds). Bristol: Policy Press, pp 33–49.

Torres, S. (2013) "Transnationalism and the Study of Aging and Old Age", in Phellas, C. (ed) *Aging in European Societies: Healthy Aging in Europe*. New York: Springer, pp 267–281.

Trigger, D., Forsey, M. And Meurk, C. (2012) 'Revelatory moments in fieldwork', *Qualitative Research*, 12 (5): 513 –527.

Tronto, J. (1993) *Moral Boundaries: A Political Argument for an Ethic of Care.* New York, London: Routledge.

Tronto, J. C. (1998) 'An Ethic of Care', *Generations* 22 (3): 15 –20.

Trydegård, G.-B. (2000) *Tradition, Change and Variation: Past and Present Trends in Public Old-Age Care*. Stockholm: Stockholm Studies of Social Work 16.

Trydegård, G.-B. and Thorslund, M. (2010) 'One uniform welfare state or a multitude of welfare municipalities? The evolution of local variation in Swedish elder care', *Social Policy and Administration*, 44 (4): 491–511.

Tufan, I. (2003) *Modernleşen Türkiye'de Yaşlılık ve Yaşlanmak* [*Aging and Old Age in Modernizing Turkey*]. Istanbul: Anahtar Kitaplar Yayinevi.

Twigg, J. (2000) *Bathing- the body and community care*. London: Routledge.

Twigg, J. (2006*) The body in health and social* care. Basingstoke: Palgrave Macmillan.

Tölölyan, K. (1991) 'The Nation-state and Its Others: In Lieu of a Preface', *Diaspora*, 1 (1): 3–7.

Ungerson, C. (1990) *Gender and Caring: Work and Welfare in Britain and Scandinavia*. London: Harvester Wheatsheaf.

Vertovec, S. (1999) 'Three Meanings of "Diaspora", Exemplified by South Asian Religions', *Diaspora*, 6 (3): 277–300.

Vertovec, S. (2000) *The Hindu Diaspora: Comparative Patterns*. London & New York: Routledge.

Vertovec, S. (2001) 'Transnationalism and Identity', *Journal of Ethnic and Migration Studies*, 27 (4): 573–582.

Waerness, K. (1984) "Caring as Women's Work in the Welfare State", in H. Holter (ed) *Patriarchy in a Welfare Society*, Oslo: Universitetsforlaget.

Waerness, K. (1987) "On the Rationality of Caring", in Sassoon, A.S. (ed), *Women and the State*. London: Hutchinson, pp 207–34.

Warnes, Anthony M.; Friedrich, K.; Kellaher, L and Sandra Torres (2004) 'The Diversity and Welfare of Older Migrants in Europe', *Ageing and Society,* 24: 307–326.

Warnes, A. M. (2006) "The life course, migration and old age", in. J. Vincent, C. Phillipson and M. Downs (eds) *The futures of old age*. London: Sage, pp 208–17.

Wax, R. H. (1971) *Doing Fieldwork: Warnings and Advice*. Chicago: Chicago University Press.

Westin, C. (2003) 'Young People of Migrant Origin in Sweden', *International Migration Review,* 37 (4): 987–1010.

White, G. M. (1990) "Moral Discourse and the Rhetoric of Emotions", in Lutz and Abu-Lughod (eds) *Language and the Politics of Emotion,* Cambridge: Cambridge University Press.

Williams, F. (2001) 'In and Beyond New Labor: Towards a New Political Ethics of Care', *Critical Social Policy*, 21 (4): 467–93.

Williams, F. (2004) *Rethinking Families*. London: Calouste Gulbenkian Foundation.

Wise, A. (2010) 'Sensuous Multiculturalism: Emotional Landscapes of Inter-Ethnic Living in Australian Suburbia', *Journal of Ethnic and Migration Studies,* 36 (6): 917–937.

Wuthnow, R. (1991) *Acts of Compassion: Caring for others and helping ourselves*. Princeton, NJ: Princeton University Press.

Young, I. M. (1995) "The Ideal of Community and the Politics of Difference", in Friedman, M. and Weiss, P.A. (eds) *Feminism and Community.* Philadelphia: Temple University Press, pp 233–257.

Yuval-Davis, N. (1997) 'Women, Citizenship and Difference', *Feminist Review*, 42: 4–27.

Yuval-Davis (2006) 'Belonging and the politics of belonging', *Patterns of Prejudice,* 40 (3): 197–214.

Zandy, J. (2004) *Hands: Physical Labor, Class, and Cultural Work*. New Brunswick, New Jersey, and London: Rutgers University Press.

Zechner, M. (2008) 'Care of older people in transnational settings', *Journal of Aging Studies,* 22 (1): 32–44.

Zeybekoğlu, E & Johansson, J. (eds) (2003) *Migration and Labor in Europe: Views from Turkey and Sweden.* Istanbul: Swedish National Institute for Working Life.

Zokaei, S. and Phillips, D. (2000) 'Altruism and Intergenerational Relations among Muslims in Britain', *Current Sociology*, 48(4): 45–58.

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