

7 Solo Living and Cancer in Denmark

Understanding Care Politics as the Architect of Human Vulnerabilities

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Introduction

What insights can people who suffer from cancer and who live alone provide about relations between vulnerability and care politics? This is the question that underlines the discussions raised in this chapter, as I set out to understand ongoing shifts in care politics as they emerge and transform in the context of welfare. The empirical material is drawn from Denmark and from ethnographic work among people suffering from cancer, but it speaks to much broader changes in the distribution and definition of care, and the rise in solo living that are taking place across Scandinavia and elsewhere (Vaittinen 2015). Also, ethnographic engagements with people who suffer from cancer while sustaining life in the context of solo living, allows me to explore what it means when we say that vulnerability is—at the same time—both fundamental to human existence and political, such as noted by Judith Butler (2020: 20–22).

In Denmark and more broadly in Scandinavia, since the 1960s onwards, the distribution of care resources have been organized around the guiding principles of a care politics that emphasizes state-supported social security and individual independence from the family. Anthropological literature on Scandinavia often names this an egalitarian care politics, emphasizing how Scandinavian welfare politics aim to promote equal distribution of care both within the families and within society, and how this involved a substantial professionalization and institutionalization of care. Ideally, women should no longer rely on kinship or marriage for survival or for living socially acceptable or sustainable lives, and the elderly, disabled or sick should not rely on their families for care and survival (Gullestad and Segalen 1997; Bendixsen et al. 2017).

The aging of the Scandinavian populations means, however, that not only is there a dramatic growth in care needs, but also a diminishing professional workforce, and the family and people's private homes are increasingly reconsidered relevant con-

texts of care (Vaittinen 2015; Mattingly et al. 2011). Since 2006 one in five beds in Danish hospitals have been removed (Skovgaard et al. 2022), and “same-day-treatments” of cancer patients have gone up by 40 percent. Also, home care services are increasingly targeted at the neediest persons. Fewer older people receive municipality services (cleaning, shopping, care) from 18 percent in 2008 to the present 11 percent of persons 65+ in 2019 (Hjelmar and Rostgaard 2020). This mix of capacity reductions and political attempts to move care closer to the home of the patient mean that sick individuals must increasingly navigate treatment and care from a wide range of professionals, kin, and services concurrently (Skovgaard et al. 2022). Anthropologists have described how the transfer of care responsibilities to families may both heighten existing tensions and conflicts and promote experiences of belonging (Sparre and Rytter 2021; Grøn and Meinert 2017; Lamb 2014). But we only have sparse knowledge on how people who live alone experience and manage changing possibilities of care, or how shifts in the distribution of care resources reconfigure intergenerational responsibilities and vulnerabilities for individuals who live alone.

According to Eric Klinenberg, an American sociologist, the prevalence of solo living was minimal in societies worldwide prior to the 1960s (2013: 2–4). However, the number of individuals living alone has now reached nearly 30 percent of all households in the United States. Additionally, several major European cities have witnessed a surpassing of the 50 percent mark in terms of one-person households (Klinenberg 2013). In Denmark, four out of ten adults live alone, with the percentage of one-person households among the elderly exceeding fifty percent (Danmarks Statistik 2023). This chapter makes its initial contribution by highlighting the increasing number of individuals living alone, and I propose that examining how people suffering from cancer sustain life in the context of solo living provide a way to begin to understand and theorize emerging shifts in the distribution of care resources that are taking place in Denmark and across Scandinavia.

Introducing in detail the biographies and lived circumstances of Lise and Michael, two interlocutors that I worked with from April 2020 until August 2021, and drawing on the understanding of humans as embodied and vulnerable (Butler 2020; Guenther 2016) and upon critical feminist writings on care (Fischer and Tronto 1990; Buch 2018), this chapter makes its second contribution by pointing out that access to care is increasingly dependent upon social negotiation, and studying care in the context of solo living is a means of theorizing fundamental dependency and ethical responsibility in the context of welfare. With Elana Buch (2018: 12) I think of care as “the messy, disparate forms of practice through which people work to make life happen”, and how these practices continually bring particular kinds of social relations, political economies, or vulnerabilities into being. Such a perspective on care reaches beyond the immediate, intimate context of care as practice, and it helps me acknowledge the polysemantic and shifting qualities of care and being

that emerges when care politics change (cf. Meinert 2021; Fischer and Tronto 1990). I suggest that attending to the productive dimensions of care politics and care practices helps to direct attention to what care produces (Buch 2018: 18)—including new kinds of vulnerabilities that are historically and socio-politically distinct. Before I turn to Lise and Michal let me share some more reflections on what I mean when I talk about vulnerability.

Vulnerability and care politics

Etymologically speaking, vulnerability means to be open to hurt. It comes from Latin *vulnerare*, to wound, hurt, injure, or maim. As a verb it specifies an action. That is probably why—in popular thinking and writing—vulnerability is often thought of as a state of being open to hurt from external risks (Vaittinen 2015: 104). A community can be susceptible to war, or a computer can be susceptible to damage. But as living, social organisms humans are also internally and persistently vulnerable to life itself; to the possibility of loss, destruction and to diseases such as cancer. There are no autonomous subjects without needs, “only degrees of embodied vulnerability” (Vaittinen 2015: 104) that elicits different care needs. In a similar fashion, Judith Butler (2020) says that vulnerability should not be understood as a static condition, but as a dynamic and relational process that unfolds in the context of social and historical relations. Humans are social bodies and therefore perpetually vulnerable to the loss of others, and to violence and disease. As humans we are “potentially undone by each-other” (Butler 2020: 23). Vulnerability, in this sense, is not a property of individual subjects, nor an external risk, but a product of social and political structures and processes. Vulnerability, Butler says, names “the porous and interdependent character of our bodily and social lives” (Butler and Yancy 2020: 483) and it invites discussions on how to live, how to face mortality and how best to make sense of the world (Butler and Worms 2023).

It is important to note that vulnerability to Butler, does not only gesture towards an existential condition. Instead, Butler advances vulnerability as an underlying aspect of human interdependence and coexistence, and one from which political principles emerge. Human vulnerability thus constitutes a repertoire of essentials that are subject to manipulation (for example through politics) and practice (such as care) for the purposes of producing what they call livable lives (Butler and Worms 2023: 27–28). Following this line of thought, I suggest that exploring solo living in the context of serious disease, testifies to the way in which care politics proposes itself as the architect of human vulnerabilities. I develop this argument by attending to what I consider to be emerging vulnerabilities in the context of solo living and changing care politics. The first being *relational vulnerabilities*, which refers to the increasing social and moral tensions that arise in negotiating access to care, and the second

being *vulnerabilities to the self*, which I with reference to Lisa Guenther's notion of unhinged (2016), define as the loss of abilities to engage in world-making activities.

Encounters with living alone

In this fieldwork, which I have done with my colleague Sara Marie Hebbsgaard Offersen, we have worked with ten key interlocutors, all aged 54–84, who lived alone and suffered from cancer. To understand how people sustain life with cancer, we invited interlocutors who were in long-term care, and who, to some extent, were living with the prospects of “a life with cancer”. Cancer is treacherous and unpredictable, though, and four of our interlocutors have passed away as I write.

The basic benefit of ethnographic fieldwork is its open-endedness (Rapp 1999). We conducted fieldwork from 2020–2021 (app. 14 months), but it did not work out as first planned. Our initial goal was to explore the social dynamics of care situations and to work with care workers and family caregivers as well as those in need of care. When the covid-19 pandemic broke out at the turn of the year 2019–20, enforced lockdowns challenged our presence at hospitals and other care institutions. Also, we were not able to visit with our interlocutors when home-care workers were present. We ended up spending many hours in the homes of our interlocutors, mostly being present when others were absent. Instead of witnessing the relational dynamics of care situations, we gained detailed insights into their life-histories, and through their experiences we learned about transformation in family- and gender values, intergenerational relations, and expectations to care; subjects of relevance to our understanding of care politics, and how it manifests in the minutiae of everyday life.

Some visits were structured around life-history interviews, or on mapping and narrating the web of social relations that made up their lives. Other visits were dominated by informal conversations on experiences and notions related to “family”, “home” and “care”. Sometimes we would go for a walk, act as chauffeurs to the hospital, or go for a drive and visit significant places such as former homes and communities where they had once lived. Also, we talked about experiences with living alone, and we shared quiet moments together. Due to the risk of covid-19, three out of ten interlocutors were only engaged with through online platforms. While the online meetings tended to be shorter, and made “hanging out” difficult, they allowed for regularity (we met often with these informants), and it was possible to both do semi-structured interviews and engage in informal conversations. We also interviewed three family members, one friend and one volunteer. In total we conducted about eighty interviews.

Solo living in Denmark

Despite the moral dominance of the nuclear family and the detached house [parcel-huset] that developed during the 1960s and 1970s, the most dominant trend in living- and household arrangements in Denmark since the 1960s has been the rise in solo living (Klinenberg 2013). Today, there are 2.7 million homes in Denmark housing a population of 5.8 million people. In 1.3 million homes live only one adult (18+). People end up living alone for a variety of reasons and living alone is experienced and practiced differently. While research on Danish solo dwellers is very sparse Lynn Jamieson and Roona Simpson's research from Ireland (2013), as well as Eric Klinenberg's (2013) research from the US suggests that people who live on their own have different degrees of personal ties to kin, family, and friends. Some maintain relationships across households with partners, children, parents or friends, and others do not.

This diversity was also present in our material. Seven interlocutors lived alone because they had recently divorced, or their spouses had passed away, and three had lived alone most of their adult lives. Two of those had raised children on their own. None of them had actively chosen to live on their own, but that was "how life had turned out", as they would often say. There is thus an aspect of contingency and temporality to living alone. Some of our interlocutors had experienced it—at certain periods in their lives—as a source of freedom, while for others, and in other parts of life, it was associated with social isolation and hardship. None of our interlocutors, however, associated living alone with anything shameful, wrong, or dangerous (cf. Lamb 2022). Most of our interlocutors were middleclass, all lived in urban areas, and three, including Michael whom I will introduce in this chapter, lived lives that were burdened by poor economy and fragile relations.

In Denmark living alone is life-phase related and compared with other European societies such as France or Italy, inter-generational cohabitation is not very prevalent. Only three percent of all households in Denmark consists of three generations (Rytter et al. 2021). Living alone is considered part of conventional life-stages, and a source of "personal growth". Small children are trained to sleep on their own, to play in their own rooms, and young people are strongly encouraged to move out of their natal home to develop into a full person. Overall independency, which sometimes manifest as distance or self-reliance or living alone is considered a source of growth, and part of becoming a full person in Denmark.

In the 1970s one out of five elderly in Denmark, resided with the family of one of their children (Christoffersen 2004). Lise had, as the only one of the interlocutors that I worked with, lived with, and cared for her mother when her mother was aging. In 1972 Lise was in her mid-twenties, had a newborn daughter, and was going through a difficult divorce. She ended up moving in with her mother, who lived alone in a spacious flat. It was supposed to be a period of transition, but the three

generations of women ended up enjoying the mutual care and support of sharing the same household right up until Lise's mother passed away. Lise is now in her seventies, and her daughter has established her own home and nuclear family, while Lise is living on her own in the flat that she used to share with her mother. I asked her if she had ever considered moving in with her daughter now that she has fallen ill. She responded laughingly and said: "I would never ask my daughter to do the same. I am not her responsibility. She has her own family now." Lise always refers to her relationship with her daughter as "very close" [meget tæt]. But establishing the kind of connectivity and relatedness that Lise treasures includes "not asking for too much help", even though she is dependent upon elaborate care and attention from friends and family to sustain a meaningful life with colon cancer.

I will return to Lise later, but for now, suffice it to say that her biography reflects historical shifts in care politics and cohabitation patterns in Denmark. The reflections she shares with me about her relationship with her daughter also reproduce taken-for-granted visions of old age and illness as a time for naturally needing and deserving care from professional care workers. Care politics are contingent in the sense that they have emerged through historical struggle (Tronto 2013), and through (inter)subjective, situated, motivated and creative questioning (Meinert 2021; Buch 2018). Following this I understand care politics in broad terms, as the distribution and definition of care resources and responsibilities; not in a static sense, but as the ongoing consolidation of sense-making, meanings- and practices that is contingently re-established, but which comes to function as a generative matrix for further practice¹. We should, therefore, be careful to talk about care politics as something that axiomatically place care within the state or the family (Thelen and Alber 2018). But building upon Scandinavian care research, it is reasonable to say that care responsibilities within families have diminished due to the professionalization of care fostered within the context of the welfare state, and the structuring effects of an egalitarian care politics (Mikkelsen 2016; Ludvigsen 2017; Bendixsen et al. 2017: 5). As I will discuss further in the below, care, in the context of the family rather emerges into a relational ethics in the sense that it remains open to social and moral negotiation (cf. Andersen and Offersen 2022; Mikkelsen 2016). This perspective emphasizes the inherent vulnerabilities that are intertwined within the consolidating and generative effects of care politics, I suggest. In the following I introduce Michael and Lise, and I show how an increasing reliance on family and friends was—for some—a source of compromise and doubt, as well as of connectivity and relatedness; what I define as relational vulnerability. But for others, such as Michael, their homes were

1 I am inspired by Lisa Guenther's writings of quasi-transcendental structures in my definition of care politics. A full account of this concept and how it might relate to care politics is beyond the scope of this paper, but see Guenther (2021).

transformed into environments of unpredictability and instability. Difficulties in accessing care made Michael more vulnerable, and the enforced mobility between locations (in and out of hospital), imposed upon him a model of care, which he could not commit to and which—perhaps—ultimately contributed to his sense of abandonment and death; what I define as vulnerability of the self. Due to the complexity of Michael's case, I present his life and the conditions around his cancer care in greater length than Lise's.

Relational tensions

Lise is a former manager in the public sector, and today a highly active pensioner. She has gone through surgery, and she is in chemo to “fight a cancer in her stomach”, as she says. I visit her several times from spring 2020 until the early autumn 2021. I came to know her as a very warm and cheerful woman, with an extended and active network of friends and family. When I visit her in her large two-bedroom flat, we sit opposite each other in the large couches in her spacious living room. From where I sit, I can see her desk. It is loaded with papers signifying the mount of activities that Lise is engaged in as a volunteer in various associations [foreninger]. Her phone is always on the coffee-table that divides the space between us when we talk. The phone extends the sociality of the two of us to include her friends and the family-members that are calling to hear how she is. The text messages or the incoming calls function as invitations to share this and that story of a friend, or as a reminder for Lise to tell me who is acting as a chauffeur to the up-coming chemo-treatment. Lise's daughter, Ruth joins Lise for most hospital appointments, but chemo takes up a full day, and Lise's friend, Karen, whom she has recently met when she was volunteering in a local cancer support group, has “the chemo duty”. Often Lise is very tired after chemo, and she cannot drive her own car. “Chemo-duty” therefore not only includes driving back and forth from Lise's home to the hospital, but also in assisting Lise climbing the stairs to the second floor and prepare some food in the kitchen while Lise gets undressed in the bedroom. Karen brings the food into the bedroom when Lise is comfortably placed underneath her blankets and sometimes, she keeps Lise company while Lise eats. Karen leaves when Lise is ready to sleep for a few hours.

Due to chemo-treatments Lise is often tired, and she needs help shopping for groceries and washing her clothes. Sometimes a neighbor stops by with a liter of milk and some bread, and Ruth and her granddaughter helps her bring her clothes down the basement, where the washing machine is placed. Also, she has had to adopt to a life with an ostomy-bag. Lise is a large woman, and she cannot clean the tubes and the bag herself. Every morning a home care nurse comes by and help Lise clean the tubes and get dressed. Also, every two weeks a care worker come by for 45 minutes and cleans her house. “It is not enough to keep the house clean”, Lise says, and

she often hesitantly accepts Ruth's offer to wash the floor in the kitchen when she visits. To withstand the loss of bodily integrity, her sense of control and familiarity with her own body, that cancer has brought onto her life, Lise must—daily—engage in care situations with a wide range of friends, family, and professional caregivers. When friends come over, do the grocery shopping, or drive her to the hospital, Lise is reminded of “all the love that she has in her life”, as she says. Care in this sense, structurally supports her sense of self and her embodied capacities to engage in world-making activities (Buch 2018).

Shortly before the Christmas holidays, I call Lise to ask if I could come visit before the holidays begin, and she tells me—upset—that she has been through a very difficult period.

Signe [granddaughter] was in here washing my clothes again. I was just so tired, exhausted... you know. I just lied there. I was like a whale in my bed. I couldn't do anything. I was so tired. Ruth was of course busy at work, but we had to call her. And she came as soon as she could. We were afraid that I would lie there and just die in their hands. It was terrible. I did not want Signe to see me like this. And I was so dependent upon them. You know they cocked and took me to the bathroom. Things I had otherwise denied that they should do.

Lise ends up spending two days at the hospital because her lung had collapsed. “But now I'm home again”, she says. “It's lovely, and Mathilde [the care worker] now comes every morning and keeps an eye on me”. Lise actively engages in many different relationships, but it is important to her to reciprocate the generosity of others, and she is most comfortable when she has the strength to co-define the terms of her relationships. After the situation with the collapsed lung, she offers her daughter to go shopping clothes for Signe, and she is planning how to “spoil Karen” with a nice dinner when she has regained her strength.

To Lise, as well as to our other interlocutors, the necessity of asking for help was both a source of relatedness and connectivity, but sometimes it was also uncomfortable fact of life, producing social and moral tensions, or what I call relational vulnerabilities. To the elderly in Denmark, it is considered normal to be cared for by professional care workers, and our interlocutors felt their life balancing precariously at a juncture between “doing for themselves”—which included “getting by” relying on what many of them considered to be sparse professionally provided care and asking for help from family and friends. Statements such as “I always try to even out my needs, so one week I ask my daughter, and the next, maybe a friend”, or “I know my family would like to help me, but when? They have their own lives” were prevalent throughout our material. Lise's sense of self is inherently intertwined with her relationships and interactions with others, and care needs—in a sociopolitical context where care is often considered a condition of possibility (Guenter 2021) es-

tablished by the state—often become a source of relational strains or disturbance. As noted in the above, Lise often felt defined by “the virtue of the address” (Butler 2020: 46), in the sense that her care needs sometimes compromised her sense of self as a capable person, and her notions of what constitutes “a good friend” or “a good grandmother”.

In the context of solo living and cancer, embodied vulnerabilities are thus co-constituted by a repertoire of relational and meaning-making issues that must creatively be addressed to sustain life. Similar points have been raised by Buch (2018) and Grøn and Meinert (2017) in their work on care and relatedness, addressing the dark side of “kinship as a counterbalance to the recent illuminating preoccupation with kinship as belonging, relatedness and kinning” (Grøn and Meinert 2017: 583). Care is not only a “do-good-practice”. When in need of care, the ties we have with others are delineated (Butler 2020: 22), and relational vulnerabilities emerge as part of a relational ethics that is contingent on the centrality of defining and negotiating care responsibilities. In the following I describe the case of Michael and how a comparable situation involving unresolved care needs unfolds in another combination of solo living, care, and vulnerability.

A broken self

In early September 2020 Michael had a rectal cancer surgically removed. After a few days at the hospital, he was unwillingly returned to his home to recover. Every morning different home-care nurses visit him. They clean his surgical wounds, and the stoma-bag and tubes that has replaced parts of his intestines. But gradually Michael's wounds become infected, and he suffers from a pain that is brute and limiting, in the sense that he is confined to his bed, and it is difficult for him to move around in his home without assistance.

Michael is in his mid-fifties when I first meet him. We have talked on the phone a couple of times before I visit him one August-afternoon in the small, terraced house that he rents. Michael has worked on and off in casinos and had random chauffeur-jobs. For the past 15 years or so he has been “outside of the labour-market” [udenfor arbejdsmarkedet], living of social benefits. Before his life was interrupted by cancer and pains, he spent much time at the local library educating himself. Michael's curiosity and analytic interests in the world around him manifests in the ways in which he narrates and interweaves his own story with references to ongoing political debates on the state of the welfare society, lack of job-opportunities of political will to distribute resources more fairly. Michael is disappointed by the then sitting Sociodemocratic government, and he shares with me theories about the origins of what he calls “the flawed-well-fare-system” where well-educated managers and doc-

tors [djøffere og læger] earn a prosperous living, while people like himself are abandoned to a life in poverty.

When you are not working, you are not a real human-being in this system, and it is the managers and doctors who decide if you can ever become a human being again.

The only family he has left is his sister, Susan. Susan lives in the Northern part of Jutland, which is a two-hour drive from Michael's home. According to Michael it is a troubled relationship, and he has a two-year old niece whom he has never seen. Besides from two male friends, who occasionally drop by for a chat and a beer, Michael spends most of his time on his own in the company of his cat, Muffy. Despite the painful absence of company and intimate relations, Michael's home is organized in ways that reflect traditional values of sociality in Denmark. A large barbeque is standing in the front of his house, and he can pull up extra kitchen chairs to make room for four or five people to share a meal in his kitchen.

Perhaps to establish meaningful, temporal connections between his past and his present, Michael often repeats how his father, who had worked as a manual worker himself, never encouraged him to pursue any kind education. "A society is always in need of strong men, who are willing to work hard", his father had reasoned. This strategy had failed Michael and he blames the difficulties with building long-term-relations on his poor economy and failed social status.

It is expensive to engage in friendships; to attend birthdays and eventually the birthdays of their children, participate in nights out—concerts and... so I guess that I gradually isolated myself.

Michael is eligible for public home care, which in Denmark is free of charge and provided by the municipalities. Every day he is brought a warm meal, and care workers clean his house every two weeks. Occasionally they will help him shower. Public care work is structured around tight work schedules, and care workers enter the homes of the elderly and sick with detailed, and temporally demarcated, task-lists. Elderly and sick people in need of home care on average receive 3.3 hours of care every week, and given the reduction in hospital-based care, they spend many hours on their own. Michael thinks "the homers" [hjemmerne] as he calls them—purposefully omitting "care"—are running in and out of his home, not really paying attention to him or his needs. Michael imagines that access to "proper care" [den rigtige hjælp] would repair the damage that cancer has done to his life, and that he, because he is living in a welfare society, is entitled to receive care from "the system" [systemet or det offentlige].

In Early December Michael estimates that he has lost 30 kg, and his skin is "hanging from his bones", as he phrases it. His surgical wounds are very sore, and he

suspects that they are infectious. Most days he is too weak to leave his bed. Simple maneuverings such as brushing his teeth or going to the kitchen for a cup of coffee previously neutralized through embodied knowledge and strength are now impossible. Michael feels abandoned, and his capacities and desires to engage in meaningful relations are diminishing. I know from a care worker that visits him, that he has been offered support by the palliative care team at the local hospital, and a male care worker, whom Michael trusts and talks about with kindness, takes charge of the situation. In December and January 2021 Michael is in and out of the hospital a few times. It turns out that his wounds were infected, and the infections have turned into a blood poisoning affecting Michael's rectal areas as well as the rod of his penis. At the hospital he is constantly worried that they will send him home too soon, and he also worries about transport. He succeeds, however, in persuading a nurse to grant him a flex-taxi. Flex-taxis are paid for by the state and provide a means for people who are not able to drive themselves to get a ride home. "They keep asking if I do not have someone who can pick me up. God dam it, I have told them SO many times, that I live on my own".

From Christmas onwards I only talk to Michael on the phone. He calls me two to three times a week. Sometimes he is joyful and wittingly asks how my managerial-life [djøf-liv] is going. His voice gives away the ambivalence that is so characteristic of the way that he relates to me and the care workers that come to his house. He is both angry and warm. Both dignified and very vocal about the neglect he suffers. He is dependent upon care workers for care, and on me for having someone to talk to. I ask if I can visit him, but he says: "My house is dirty, I am dirty, it would not be a dignified visit". I bring him food a few times, but I am not invited in.

In early spring 2021 Michael learns that his cancer has recurred. He is offered more surgery, mostly to relieve him of some of his pains. He refuses and tells me that he does not trust that they [the system] regard him "human enough" [de ser mig ikke som et menneske] to be granted the care that surgery requires. Michael eventually ends up at a hospice close to where his sister lives. He is there for a few weeks before he passes away. Eventually he is buried with his cat Muffy.

In the last months of his life, Michael is in despair, and his unmet care needs filters into a breakdown of himself as well as his domestic space. As his body and his home breaks down, Michael loses his abilities to engage in meaningful relations or other world-making activities (Buch 2018), which again adds to his isolation and may be even to his death.

Engaging accusations of abandonment

Michael—more so than any other interlocutor that we worked with—struggled to access the kind of care that was necessary for him to sustain life (Butler and Worms

2023), and in the end—abandoned by the system and his family—he gave up. In such complex stories, with accusations of neglect it is important to consider different and potentially conflicting perspectives (cf. Meinert 2021). I primarily had access to Michael's version, but I also talked to one of Michael's care workers and to his sister, Susan, with whom he eventually re-connected in early spring 2021, just before he came to the hospice. According to Susan, Michael did not find peace at the hospice, but he "was calmer than when he had been at home", and he had shared with her stories of gratitude about some of the latter encounters that he had had with the hospital. A few weeks before Michael ended up at the hospice Susan went to see him several times a week. At first, he had refused to accept her presence and help, but eventually he gave in. Susan tried to negotiate more public home care, cleaned up his home a bit, and sat with him throughout the afternoons when he was tired and in pain; making sure that his most basic needs of water and food were met. Eventually she was on sick leave from her job. She was exhausted and together with a care worker, she made plans for Michael to go to the hospice.

I was constantly in a battle with myself. There was no way I could take care of Michael and my own family at the same time. Four hours in a car every time I went to see him. And feeling guilty, knowing that he was lying there, in pain all by himself when I left. What was I to do? I was glad when the hospice took him in, but also felt a bit guilty.

Michael and Susan's stories may be seen as everyday representations of an egalitarian care politics, as they both expect care responsibilities to primarily lie within the state. But their stories also exhibit the social negotiations and the porous connectivity that is fostered in the tension between Michael's care needs and Susan's insoluble situation, swaying between being able to help Michael, and being cut off, or not having the time and energy to care for him. The inevitability of Michael's care needs testifies to his basic, human vulnerabilities. The pain, his thirst, and immobility invite and demand resolution. Susan knew of this, and it haunted (Grøn and Meinert 2017: 582) her in profound ways. Like Michael she felt that they were let down "by the system", and she suffered from feelings of guilt and anger, because she was not able to support Michael in a way that she considered meaningful to him nor to herself.

I suggest that we see Susan's experiences with Michael as a testimony to the production of what I call vulnerabilities to the self. Lack of care made Michael's life and sense of self fall apart causing a profound unraveling of his life. He became unhinged (Guenther 2016) in the sense that he was unable to respond to any kinds of attention from professional care workers, from his sister and from me. He was increasingly disoriented and disconnected from the world, losing trust in the intentions of his sister and his other caregivers. Unhinged describes, according to Guenther, "what happens when the articulated joints of our embodied interrelational subjectivity are

broken apart" (2016: 12). In her work on solitary confinement, Guenther shows how physical punishment, exhaustion and isolation put intense pressure on the capacity of American prisoners to relate to other people and to their selves. Prolonged isolation cuts prisoners off from their network of social, cognitive perceptual and affective support, and "structurally undermine their capacities for meaning making. They become unhinged. They lose their embodied orientation in the world and their sense of self" (2016: 154). I do not mean to indicate that Michael's life is comparable to the life of supermax prisoners, but I suggest that his lack of access to care and the immense pains and what he experiences as a social abandonment result in him falling apart. In this sense lack of care can be seen as a form of violence that erases a subject's connections to others, and reduce them to a bare, isolated self, which can no longer sustain life.

The architect of human vulnerabilities

We are all given over to others and to life in ways that we cannot control (Butler 2020: 46). Cancer surely testifies to this. As attested by Lise and Michael, many embodied practices previously part of an everyday normal, such as taking a shower, cleaning the kitchen floor, or getting up and down stairs, are compromised, and in their attempts to sustain life they are forced to recognise and make visible to others "the basic vulnerable conditions of their embodiment" (Butler 2020: 26). For some, like Lise, asking for help, was a source of relatedness, but it was also a source of relational vulnerability, in the sense that access to care was contingent on inter-relational negotiations of care responsibilities. For Michael, social abandonment and lack of care transformed into a loss of self. He became unhinged (Guenther 2016) and lost his abilities to engage in meaningful world-making activities, suggesting that care resources may be distributed in ways that sustain or denies or erase certain forms of existence or subjectivity.

When care politics change, so does both the conditions and experiences of living, and more profoundly of living alone. Consequently, solo living may be seen as a way of life made possible by care, and a way of life which is lived and experienced in the tension between relationality and care politics. Care and the structuring effects of care politics are, in this sense, what makes life livable (Butler and Worms 2023: 15–18). Understanding relations between solo living, care politics and vulnerability thus also testifies to another anthropological testimony essential to the solo living research, namely that living alone is not merely a reflection of an inherent, human thrift for autonomy or freedom (cf. Coleman 2014). Vulnerability understood as a generalized fact of life in many ways marks the limits of individualism (Butler 2020; Meinert 2021), emphasizing that solo living is a political and social accomplishment sustained by care. This argument is important since it (once again) shakes the mod-

ern delusion of the human as potentially autonomous and independent, and it is consequential for our understanding of the role of care in society (cf. Tronto 2013). Exploring solo living in the context of serious disease, I suggest, testifies to the way in which care politics proposes itself as the architect of our human vulnerabilities, and it reminds us that vulnerability is not inherently individual, but distributed by structures of power, privilege, and oppression (Vaittinen 2015). When I say that care politics proposes itself as the architecture of our human vulnerabilities, I mean to emphasise that the ongoing, creative distribution and definition of care resources is a process that is intrinsically also shaping, designing, and producing human vulnerabilities. In this chapter I show how changing care politics produce both relational vulnerabilities and vulnerabilities to the self. Care is in essence both a treatment and an enabler of human vulnerabilities.

Attention to care as productive to relatedness (Carsten 2007) and social inequality or vulnerability (Buch 2018; Meinert 2021) is not new to anthropology. Recently, Sarah Lamb (2014) and others (Meinert 2021) have described ongoing shifts in care responsibilities between states and families that are taking place around the world. In India, Lamb says, rural-to-urban labour migration intersects with drops in inter-generational cohabitation and negotiations of care responsibilities of the sick and elderly, and a law from 2007 stipulates that children may be fined and jailed if found guilty of neglecting their aged parents (Lamb 2014: 50). This law brings to light the belief that the family, rather than the state, is the proper agent of care and, perhaps, the fear that this obligation will not be honored. It also, however, bears witness to the difficulties and often devastating care-caps that develop due to the speed of social change, and it affirms that creating a society that generates sustainable lives for people of every ability and background means recognizing the ways in which care is deeply entangled with household-structures and changes in co-habitation patterns (Lamb 2022; Klinenberg 2013), as well as notions of intimacy, belonging and relatedness.

Historically the welfare state has played a significant role in enabling the possibility of living alone, and the rise in solo living has been facilitated by those same supportive care infrastructures that are currently undergoing transformation (Klinenberg 2013). The figure of the elderly solo dweller—I believe—in many ways embodies a shared notion of what a successful welfare state looks like. It is important for me to stress that I do not wish to contribute popular or academic narratives that represent solo dwellers as *per se* vulnerable or lonely, or which equals solo living with social disintegration (cf. Grøn 2016; Lamb 2014). I would argue that we see solo living as an emergent sociality (see also Coleman 2009; Klinenberg 2013), partly made possible by an egalitarian care politics. Lise confirms this when she laughingly litters my inquiry about the possibility of her moving in with her daughter. “No, I am not Signe’s responsibility”, she says, reflecting, how an egalitarian care politics have historically normalized and supported the distribution of particular care responsi-

bilities in Denmark. It is also important for me to emphasise that ongoing changes in the distribution of care, and the invention of private homes as contexts of care manifest in the everyday lives of sick people in a variety of ways (cf. Mikkelsen 2016; Andersen and Offersen 2023). But for all they set up the contours of a care politics in which the self, others and the home are brought into new forms of proximity, which may be a challenge for people who live alone. Solo living is, as noted in the above, regarded a normal way of life in Denmark. But it might in the future become a crucial site of political struggle and contestation, as current, intersecting conditions of care politics and embodied life are making solo living in Denmark both possible, yet increasingly difficult.

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