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Chapter 12
Responsive Aging. An Existential View

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Old age can be considered a radicalization of the human condition. In this phase of life, its fundamental relationality is experienced in its extremes; in its dependency and loneliness as well as in the intensification of personal relationships of love and friendship. In dominant discourses of modernity, relationality competes with – or is at the most additional to – autonomy, understood as individual independence. By contrast, this chapter develops a *responsive* understanding of human life which comprises both individual agency and dependency in their dynamic interplay.

In advanced liberal societies, three discourses on old age can be distinguished (Baars 2010). Each provides a different approach to the relationality of growing older. The first one, the *political elderly discourse*, focuses on strategic policy decisions about societal consequences and economic effects of the demographic transition towards a "greyer" society. In this context, the older adult is regarded as a *homo politicus* and *animal sociale*. The emphasis is on participation in society. In late-modern society, policy aims to keep the elderly socially active and prevent them from isolation. In this discourse, the gerontological concept of "successful" or "active aging" is operationalized as a policy strategy (Rowe and Kahn 1997).

The second discourse, the *medical aging discourse*, concentrates on the physical and biomedical aspects of aging. Here, relationality is concerned with the decrease in mobility, the narrowing down of the social radius, and the reduction of social networks to close family members and near neighborhood. This discourse is informed by biomedical and empirical social scientific research and investigates how the decline in social needs in frail old age can be responded to in an adequate way. One example may be Lars Tornstam's empirical claim that in advanced old age, people turn away from the hustle of everyday life and the pressures of social expectations and redefine themselves more authentically by disengagement from conventions and superfluous contacts (Tornstam 2005).

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Finally, the *existential growing older discourse* is interested in the meaning of old age as a distinctive phase in the life course. What does it mean to grow older or to be surrounded by aging people throughout our lifespan? Whereas the elderly discourse and the aging discourse mainly consider old age from a third-person perspective, as a societal and medical concern, the growing older discourse focuses on the experience of aging in the first- and second-person perspective.

This chapter is written from this existential viewpoint (Cole 1992; de Lange 2010). The relationality of aging is taken as an essentially intra- and intersubjective affair: What does it mean for my relationship to life, to myself, to my body, and to others to grow old? However, it is important to note that questions of meaning cannot be isolated from social policy and health care arrangements, which also have their impact on the experience of meaning (Laceulle 2016, 27). Meaning permeates questions situated at macro-, meso-, as well as micro-levels. There is always a third party involved in the first and second person. The meaning of life for "you" and "I" often depends on conditions set by a distant "it."

12.1 An Existential Approach

The existential dimension of life relates to the basic human experience of "being-in-the-world." Existentialist philosophers like Kierkegaard, Heidegger, and Sartre depict our human condition as an experience of being "thrown" into a world without an inherently meaningful order, while at the same time having an insatiable yearning for experiencing life as making sense. Since there is no metaphysical order that provides coherence and meaning, we are destined to constantly search and create our own order.

Existential philosophy has a strong preference for phenomenology as its method. Following Edmund Husserl, phenomenology tries to get access to lived reality, leaving aside the objectification of reality by a disengaged Cartesian subject. By suspending our conceptual grip on the world, we give reality a chance to show itself. We then experience how our perceiving self is inextricably connected to the perceived world. Every perception is "given, apprehended, understood or interpreted *as something* i.e. endowed with a certain sense" (Waldenfels 2007, 72). We are connected to the world through a web of "intentional threads."

Husserl's student, Maurice Merleau-Ponty, took phenomenology a step further. In his analyses, he showed that our perception of the world is embodied and situated in time. Merleau-Ponty (1945) refrained from drawing far-reaching ontological conclusions about life's meaninglessness or – as existentialist philosophers like Albert Camus phrased it – its "absurdity" from his phenomenological analysis of our "being there" (*Daseinsanalyse*). His phenomenology of embodiment and temporality led him to recognize a fundamental ontological *ambiguity*: Human life is a tussle between light and darkness, sense and non-sense. According to Merleau-Ponty, meaninglessness is experienced when the embodied dialogue between ourselves and our surroundings is disturbed. There is nothing that "speaks" to us

anymore and makes an appeal to our apprehension. Expressed in a language of embodiment: We cannot find an appropriate *attitude* to the world anymore.

"Meaning" in a phenomenological sense is not a cognitive-reflexive concept but refers to the primordial experience that the world and I, we (still) somehow correspond. The challenge of existential aging then is about conquering meaning in the face of impending meaninglessness in old age, when our moral agency and social identity are under pressure. An existential ethics of aging inquires how a meaningful dialogue between frail and vulnerable human bodies and minds on the one hand and "the world" into which they are "thrown" on the other can be kept going as long as possible, until the very last breath.

12.2 Responsive Phenomenology (Bernhard Waldenfels)

Existential phenomenology re-acknowledged the inalienable relationality comprising the self and the world. At the same time, it still struggled to find an adequate conceptual vocabulary for the character and the dynamics of this relationship. Bernhard Waldenfels, a student of Merleau-Ponty, took up this challenge in what he calls a responsive phenomenology. With his work, the question "what does it mean to grow old" can be reformulated in terms of the threefold relationality of the self to life, to our body, and to others.

Waldenfels depicts human beings as quintessentially responsive. Living a human life means responding to an appeal or demand of the Other. The otherness of this Other always involves something *fremd*, strange and unknown (Waldenfels 2006). In this context, "responding" should not be taken in the narrow linguistic sense but in its wider meaning of responding with all registers of our bodily experience.

> We respond by our senses, by our desire, by our memories and expectations, by our spatial orientation, by our speaking and acting, including diverse technical fittings. Besides, we can respond not only by words, but also by keeping silence; no answer is also an answer, as the proverb tells us. We respond by gazes and gestures, but also by acting and doing what the Other asks for (Waldenfels 2015, 423).

Our agency thus not starts in ourselves but outside us. Its origin lies elsewhere. "When responding, we are always incited, attracted, threatened, challenged, or appealed by a something or a somebody" (Waldenfels 2015, 424). The process of responding has to be taken as a basic trait, present in all our behavior toward things, towards ourselves, and towards others. Waldenfels calls this basic trait *responsivity*.

In everyday situations, our response is highly ritualized through conventions and habits. We have a repertoire of standard responses at our disposal: The little routines of getting up in the morning, clothing, shaving, making breakfast, reading the newspaper, taking the bus, going to work, etc. This is the small, seemingly well-structured world order we take for granted from day to day. The demands of our body, the world, and others on the one hand, and our response on the other, seem to interact playfully like a harmonious dancing couple. But there is an unknown strangeness

looming in the interaction. Suddenly, we may discover a weird blotch on our breast or develop a strange cough. In my oh-so familiar body, an unexpected otherness or alienness (*Fremdheit*) reveals itself and I do not know how to respond to it. There are many exceptional situations for which there is no script or standard scenario available, and to which we nevertheless have to respond the next moment: a refugee asking for shelter, a traffic accident, the sudden death of a partner, a terrorist attack. In every unexpected event that happens to you, there is a strangeness, a *heteron*, revealing itself, impossible to understand and control completely.

What distinguishes us as humans is our *logos*: the attempt to come to grips with the world on a symbolic level. It seems apt that "begreifen," "begrijpen," or "to grasp" (to understand in German, Dutch, and English) are etymologically related to "greifen," "grijpe," and "to grab." But this *logos*, on its part, originates in some sort of *pathos* (from *pathein*: to endure). Something overwhelms us and we spontaneously respond with amazement or fear. There is neither a once and for all predetermined metaphysical order to be discovered out there, nor a coherent, accomplished meaning to be constructed afterwards. Our experience is embedded in time: Up to the very end of our life, we have to respond to the newness and strangeness of what overcomes us, a *Fremdheit* hidden even in what appears familiar. Responsive phenomenology starts with the simple question: "'What are we struck by and what are we responding to while saying this or doing that?' Something surprises, overwhelms me or somebody addresses me by a request, a promise – or even an act of violence" (Waldenfels 2015, 424). The phenomenological keyword "intentionality" still may suggest a subject that is the origin of the meaning it creatively constructs by itself. By contrast, "responsivity" acknowledges that the world shows itself only in "events." The "intentional threads" which attach us to the world are always more or less severed or suspended by *das Fremde*.

> In sum, everything that appears [to us] as something has to be described not simply as something which receives a sense, but as something which provokes sense without being meaningful itself yet still as something *by which* we are touched, affected, stimulated, surprised and to some extent violated. I call this happening *pathos*, *Widerfahrnis* or af-fect, marked by a hyphen in order to suggest that something is done *to us* (Waldenfels 2007, 74).

This fundamental relationality of the human predicament, understood as responsivity, bears a strong ethical dimension. Nevertheless, it cannot be reduced to the sphere of morality and inter-human relationships. Though rigorously phenomenological, Waldenfels' philosophy reveals a theological touch by taking up the same strong appeal-response-character recognizable in the anthropology of the Hebrew bible (Chrétien 2004). Responsiveness refers to a fundamental ontological dimension of the human predicament. However, an ontology which understands being in terms of presence will be unable to express its character as an unpredictable and singular "event." There is an inalienable dimension of *temporality* in the act of responding.

> What appeals to us reaches us from a distance; it arises too early, compared with our own initiative, whereas our response is too late, compared with what happens to us. […] Thus, our speaking and acting are never totally up to date. Our responding is separated from what we are responding to by a hiatus (Waldenfels 2015, 429).

Waldenfels uses the ancient term *diastasis* to characterize this peculiar sort of time-lag, the *in-between* of a call and our response.

12.3 Towards a Responsive Anthropology of Old Age

Human beings are creatures that, as Helmuth Plessner already argued, are "naturally" indeterminate. This also applies to living up into advanced old age. Although we come closer chronologically and statistically to the inescapable moment of our death, there is a time horizon ahead of us until our very end. Every new day calls for an unpredictable response. The *inevitability* of responding is an important aspect of responsivity. We cannot *not* respond to the call of the Other. Even the refusal of or the incapacity to respond is a response. In advanced old age, our capabilities to live a good life may be severely reduced; however, even though our moral agency may be diminished and our personal identity damaged, we remain embodied beings until the moment of our death, responding to the Other in its strangeness, trying to keep going a meaningful dialogue between ourselves and the world.

In the remainder of this chapter, I want to explore what a responsive anthropology might mean for three essential relationships in old age: How do I respond in advanced old age to the demands of (1) *life* in its finiteness, (2) my *body* in its frailty, and (3) of *others*, in needing to be cared of or giving care.

12.3.1 Responding to Life

As Chris Gilleard and Paul Higgs (2010) pointed out, deep old age functions as the metaphorical black hole of aging. In the social imaginary of the fourth age, an ideological divide is constructed between aging "successfully" and the deep, dark, and marginal – and hopefully short! – phase of frailty and infirmity, loss of agency, and dependence on care. Living without agency, reduced to the "otherness" of a diminished, suffering body, a will-less object delivered to the care of others: The fourth age counts as the "culmination" of old age and represents the abhorrent reality of real and deep old age.

Although the distinction between a young old age and an old old age does make a certain sense, the inevitable transition from vital seniority to care dependency in advanced old age mostly occurs gradually. There are very few who reach their nineties without experiencing a loss of health, relatives, and social status. Most elderly therefore perceive old age as a highly ambivalent stage of life where the experiences of meaning and meaninglessness compete for priority. An anthropology of old age, even if it takes sides with the struggle for meaning, should take this into account. *Loving later life* is a deeply ambiguous affair (de Lange 2015).

We did not ask for life. Even though we may experience its givenness (*datum*) as a gift (*donum*), it requires a response: We have to accept it as our life and make

something of it. The life given to me has to be lived, and nobody else but me can do this. In some way or another, I have to say "yes" to the strange call of life and make it my own as *my* life. My life is incommunicable, others cannot stand in for me. "Es muss 'mich' nicht geben" (Rendtorff 1990, 66) – "There does not have to be a 'me'."

Old age can be regarded as the intensification and radicalization of the human condition. In old age, the task of saying "yes" to life and relating positively to life may be even more pervasive than in earlier stages of life where well-defined social scripts (education, career) induce our response according to cultural routines and expectations. In retirement, we only have to play the "roleless role" (Burgess 1960) of an older person. A new chapter in the narrative of our life has to be written and there is no societal plot available yet. Existentially, the process of living into one's seventies and eighties can be experienced as entering into a no man's land, with death at its imminent horizon. The looming strangeness of life, present throughout the life course, becomes all the more palpable.

Why do I respond to the light of the new day every morning by getting out of bed? I do not need to live. I can refuse to and withdraw myself in an act of violence. Camus' assertion that suicide is the only really serious philosophical problem (*Le mythe de Sisyphe* 1942) seems to impose itself vehemently in old age, darkened by the losses and impairments one is subject to. Do I need to be there any longer? Why still love life when it hurts more and more? T. F. Powys (1875–1953) tells a story in which villagers are addressed in turn by a tree, the sea, and an abyss. The tree tells them: "Why do you not walk into the pond over there?" The sea: "Come on, just walk into the breaking waves till it gets deep." The abyss: "Wouldn't you just advance one tinier step ahead? Why not jump or let yourself fall?" (Powys, quoted by Mulder 2014, 26) Although it does not take much, some only lack the courage in advanced old age. The pull of death can be strongly felt.

Waldenfels refers to a scene taken from Herman Melville's short story *Bartleby the Scrivener* (1853). Bartleby is a clerk working as a law-copyist in the office of a lawyer in New York. After having completed his work assiduously for a long time, he suddenly refuses his service from one moment to the other, and he does so in a rather peculiar way. He simply answers to the lawyer's request to copy the documents as usual "with a rarely soft, fast voice": "I would prefer not to." He repeats his "no" again and again, and in that sense, a conversation continues. But at the same time, he denies that the dialogue makes any sense and inwardly withdraws from it. Waldenfels interprets this story as a case of "response refusal." Apparently, the clerk verbally already anticipates the suicide with which the story ends. "True, there is a dialogical remainder left, but it happens in the paradoxical form of a negative speech act such as: 'I am saying nothing'" (Waldenfels 2015, 428).

What makes some still joyfully say "yes" to the call of life in old age and others respond to its demand to continue the struggle for meaning with "I'd rather prefer not to"? There is no precept available. The response to the call of life always takes place after an unpredictable time interval, an *in-between* separating call and response. It is also possible that the seductive power of death is counterbalanced by the amazement that although I do not need to be there, I still am! Here I invoke the

testimony of Paul Ricœur (1913–2005). In the hot summer of 2003, when many elderly Parisians died of the heat, the 90-year old Ricœur became blind in one eye caused by a sudden rise in blood pressure. He experienced severe difficulties in reading and keeping his balance. He became depressed and had to give up writing. A pulmonary edema worsened his condition. Age took its toll on his body, his caregiving friend Catherine Goldenstein writes. Nonetheless, in spite of his – what he called – "lucid depression," Ricœur tried as long as possible to "be there, alive" through reading, following the news, receiving friends, listening to music. The philosopher celebrated his ninetieth birthday, fragile but strong of mind, telling his friends who gathered on that occasion: "There's the simple happiness of still being alive and, above all, the love of life, shared with those I love, so long as it is given to me to do so. Is not life the first, the inaugural gift?" (Ricœur 2009, 94)

The call of life is a deeply ambivalent appeal. Life – written with a capital L – has a Janus face. The affirmative surrender to life apparently is rooted in a choice, a decision, whether made consciously or not, to be constantly reconfirmed. The impetus and desire for life, the *connatus essendi*, as Spinoza calls it, driven by a mythical *élan vital*, only exists to the extent that its appeal is heard and affirmed. Saying "yes" to life is not a natural given. Life is a call to be answered by the personal will to go on writing one's personal biography, be it a next chapter or only the epilogue (Freeman 2011). In plants, animals, and young children, life is, apparently instinctively, fighting against death. Life then seems to be a matter of course. However, adults have to *want* to live, to survive, in order to go on living. You respond to the call of life by disregarding the eventually inevitable invitation of death as long as you can, by replying: "No, not yet, I'd rather prefer not to." Put in a theological vocabulary, one can say that the affirmation of the gratuity of life is an act of faith. Getting out of bed every morning at the age of 90 and greeting the day, as Paul Ricœur did, is a religious ritual, a daily confession.

A phenomenological study among elderly with an explicit death wish, conducted by Els van Wijngaarden, illustrates how ambivalent responding to the call of life can be at advanced old age. Van Wijngaarden interviewed 25 Dutch older adults over 75 who considered their lives to be completed. They were ready to terminate their lives at a self-directed moment. In her findings, van Wijngaarden concludes that their expressed death wish is only seemingly clear and univocal. "The liminality or 'in-betweenness' of intending and actually performing a self-directed death (or not) is characterized by ambivalent feelings of being torn, expressed in words like: 'dilemma,' 'doubt,' 'a difficult balancing act,' and 'a split position'" (van Wijngaarden 2016, 275).

In her interviews, the researcher also discerns how the expression "life is completed and no longer worth living," as used by her interlocutors, hides "a tangle of inability and unwillingness to connect to one's actual life." This "sense of disconnectedness," as she calls it, concerns these people's threatened self-esteem, their deteriorating bodies, the shrinking world around them from which they also withdraw themselves, and their stagnating sense of time (van Wijngaarden 2016, 241). "Frightening thoughts about the future and – in some cases – wistful thoughts about the past deprive the lust for life" (van Wijngaarden 2016, 275).

I suggest that what van Wijngaarden calls the experience of being "disconnected from life" and the loss of "lust for life" precisely reflects the stagnation in the older adults' responsive dialogue between self and world, effected by the vicissitudes of old age. It remains an open question whether we are witnessing a clear "responsive refusal" to the call of life or rather the powerless incapacity, the loss of being able to respond *tout court*. A death wish might also mask the desire to live a *different* life. The question can only be raised here whether the dynamic interplay between call and response can possibly be reopened and revitalized in some way or another.

12.3.2 Responding to our Body

It is in and through our bodies that we most immediately experience the difficulty of life in aging.[1] How do we maintain an affirmative relationship to our *body* when it becomes more and more unpredictable and painful as we grow older? With old age, in the words of *Ecclesiastes*, the "days of trouble" come (Ecclesiastes 12). Even if one escapes a life-threatening heart attack, cancer, a stroke, or Alzheimer's disease, advanced old age inevitably comes with increasing risks of heart failure, strokes, cancer, diabetes, arthritis, hip fractures, visual and hearing impairments, incontinence, dizziness, instability, and the risk of falls. Multiple co-morbidities are common, as are complications in symptoms. They negatively affect the functional ability to perform the activities of daily living. Geriatricians coined the term "geriatric giants" to refer to these major categories of chronic impairments that have a severe impact on the daily lives of older people (Staehelin 2005).

Phenomenology distinguishes between the body as *Körper,* a third-person object, and *Leib*, the first-person experience of being embodied. Nevertheless, it is precisely this first-person experience that teaches us how alien our own body may appear to us. Our body confronts us with a split self. Every time we listen to our recorded voice, watch ourselves on film, look at ourselves in the mirror, we are surprised. Is that me? Our oh-so familiar body reveals itself as a stranger. Even in our utmost *own* experience, our body is an event we did not initiate ourselves. As Waldenfels (2006, 73) writes, we have a *pathic* relationship to our own embodiment. In order to experience our body as *Leib*, we need a certain inner distance, a situation Plessner termed "eccentric positionality." We see – and see ourselves; we hear – and hear ourselves; we feel – and feel ourselves; we move – and move ourselves. Also, in the relationship to our own bodies, there is a *diastase*, an in-between, in which we respond bodily to what appeals to us in the experience of our body. Waldenfels speaks of an ecstatic alienness, an alterity in the broken relationship to ourselves. I am simultaneously "one in two and two in one" (Waldenfels 2006, 82).

The phenomenological tradition therefore rightly says that we are both at the same time, *Leib* and *Körper*, a *Leibkörper*. This inner polarity is the reason why I can be familiar with my body but also alienated from its/my (!) experience; that I

[1] See Dekkers, Chap. 5 in this volume.

can fall in love with my body but also regard it as my enemy. This becomes clear in pathological cases, as in the depersonalization of a patient who does not recognize her own hand and drops it on the table like a stone. Pathology is an extreme borderline case of our "normal" split self (Waldenfels 2006, 83).

In the radicalization of the human condition in old age, this ambivalence in the relationship to our own body is experienced intensely. The tiredness in advancing old age is an apt example. Paul Valéry writes about it and observes in his *Cahiers*: "Par la fatigue le 'corps' devient chose étrangère" (quoted by Waldenfels 2006, 77). Our aging body becomes a strange Other, an alien I can no longer rely on. How can we maintain a meaningful relationship with a body turning into a stranger or even an enemy? Life calls upon me to go on loving my body or become friends with it again. What are my options?

Here, I would like to introduce several helpful ideas developed by Arthur W. Frank in his seminal book on body and illness. Frank describes a person's attitude towards his or her own body as an ethical choice: "[…] the body is, ultimately, a moral problem, perhaps *the* moral problem a person has to address" (Frank 1995, 29). We cannot choose our bodies or save them from decline, but in the course of a lifetime, we can choose the kind of relationship with the bodies we become.

Frank discerns several ideal typical ways of doing so. Thus, according to him, people first define themselves in terms of their body's capacity for control. A healthy body functions as expected. Health is experienced as a non-experience, *le silence des organes*, as the French surgeon René Leriche (1936) once famously defined it. Disease or permanent loss of functions (incontinence, memory loss, tremors, and seizures) can be experienced as overwhelming acts of violence or treason. The body loses its apparent predictability and becomes subject to random contingency.

One then can decide to dissociate from one's body and only view it as an instrument, a vehicle for survival. Thus, the philosopher Simone Weil talked patronizingly about her body as a donkey. She described how she had to keep her body down, just as you feed a donkey with sugar cubes and punish it with a whip (Weil 1998, 25). Weil died in 1943 at the age of 34 from exhaustion and undernourishment. After long periods of illness and radical medical treatments, people may also experience their body as an "it." "Ill bodies cease to love themselves," Frank (1995, 41) notes. They become objects of their "owners'" neglect, abjection, and shame. They then turn into what Frank calls a *monadic* body, isolated and withdrawn from any relationality. Although relationality is still "*there*," it is kept hidden. It is no longer on display to the eyes of others or to one's own eyes. The relationship to one's own body becomes a non-relationship. Touched by illness and impairments, older people may be inclined to withdraw from public view, ashamed of their deteriorated physical condition. One example is Michael Haneke's Oscar-winning movie *Amour* (2012), in which the octogenarian couple Georges and Anne entrench themselves behind the doors of their apartment after she suffers a stroke.

Yet, we can also respond by choosing to share the body, its sufferings included, with others. Frank calls this the *dyadic* body. "Dyadic bodies exist for each other" (Frank 1995, 37). Many old people dress in colorless and formless clothes, as though they want to become invisible. Being associated with one's body, however,

means developing an intimate relationship with it and still acknowledging it as a place of desire and delight for oneself and for others. The Dutch writer Josepha Mendels, with whom I became acquainted in the 1980s, told me this counter-story: As she used to go out and leave her Parisian apartment, far in her eighties and dressed flamboyantly and wearing red lipstick, her peers in the same house watched her in the lobby and asked her disapprovingly: "Ah, Madame, vous voulez plaire encore?" She made the ethical choice to stay visible to others. Having a dyadic body implies taking care for your body, feeding it, caressing, protecting, sheltering it – just like lovers do. And being fond of publicly showing it to others.

Responding affirmatively to your body reveals *self-love*. In a chapter about the biblical double-love commandment – love your neighbor as you love yourself –, philosopher Nicolas Wolterstorff (2011, 97) writes that maintaining caring relationships to the world and to others pre-supposes a loving relationship to oneself. "There is a duality in the self. Each of us is a Thou to himself or herself. […] We not only love and hate others; we love and sometimes hate ourselves. […] The I-Thou relationship is interior to the self" (Wolterstorff 2011, 98). In my book *Loving Later Life*, I suggest that the love commandment should therefore be read like this: "Love your neighbor as another self. And love yourself as another neighbor" (de Lange 2015).

Love has a variety of faces. "Wanting to promote somebody's good" (Wolterstorff's definition of love) sometimes implies being attached to someone (as to children) but also manifests itself by caring relationships (friends and relatives, or neighbors in the broad, biblical sense) or by being attracted to someone (as a lover). Old frail bodies often stop desiring and being desired in all these three forms, but not – as an agist prejudice seems to suggest – because it is somehow inherent to the nature of old age. Old people are just normal people, as depending on giving and receiving love as other human beings.

At a high age, this anthropological fact loses its naturalness. Frank cites Anatole Broyard, diagnosed with prostate cancer and exhausted due to his illness. The way he felt caused him – as he puts it – to fall "out of love with himself." He stopped cleaning his teeth and buying new shoes (Frank 1995, 39). In his behavior, he ceased to be desirable to himself and to others. However, there are also counter-stories, as we saw with Paul Ricœur, who, in his nineties, cheerfully communicated his fragile and vulnerable body with others on his birthday party.

Frank's phenomenological analysis of the experience of illness and bodily impairments leads him to develop a normative view on the relationship between self and body. He thus helps us find an answer to the question how an old and impaired body can live a meaningful life as long as possible. In contradistinction to the isolated and hidden monadic body, but also to the dyadic body in danger of falling into narcissistic vanity, Frank discerns a *communicative body* that tries to come to terms with its sometimes violent enmity. Loving your later life also means offering friendship to an uncontrollable body literally becoming a *foreign body*. Alternatively to shame or admiration for one's body, a communicative body means trying to sustain a benevolent relationship with one's own body and with those witnessing it. I will present one example, just to show that this is not a theoretical construction. At the

age of 60, a close colleague of mine, a strong, forceful man with a radiating public presence, was diagnosed with a brain tumor that turned him into a severely paralyzed and handicapped person within one month. But he did not do what one might have expected: leave his job, withdraw from public life in order to prepare himself for death within the close circle of his family and friends. Instead, he continued to communicate, sharing his suffering and sorrows, hopes and joys, with as many as possible. He attended public events in his wheelchair, spoke with anyone who wanted to talk to him, and addressed audiences even when the tumor affected his ability to speak and express his thoughts clearly. I think his decision to continue to appear in public was also a strategy that helped him to respond to his own sick body in an affirmative way.

12.3.3 Care Responsibilities

The fundamental question in a responsive anthropology – what are we struck by and what are we responding to when saying this or doing that? – also applies to our relationship with others. The other affects me as an *alter ego*: a human being like me, but at the same time someone incomparably different. He or she may surprise me, overwhelm me with an act of violence, or simply address me with a request or a promise. We have a *pathic* relationship with others, as we have with our bodies. When other people are addressing me, they are making an appeal to me (Waldenfels refers to the German *Anspruch* in its double sense of appeal and claim) that does not already have a pre-determined meaning or follows a fixed rule, but asks at any moment for my new, previously unheard of response.

This fact of responsivity precedes the moral responsibilities we take or ascribe retrospectively (Waldenfels 2006, 57). A responsive ethics accounts for this fundamental phenomenon and thus proposes several corrections to the common understanding of responsibility (Waldenfels 2015, 425–427). The concept of responsibility originates in the juridical sphere and is dominated by two motives. First, it functions as a calling to account and as a giving account by means of arguments. Second, it refers to an imputation or ascription of actions. The dialogical process that is involved (response-ability) is well known from court proceedings, but the Judeo-Christian tradition broadened the concept to include the sphere of morality as well. The concept encompasses three essential traits: (1) One becomes responsible *for something* that one has said or done, whether of one's free will or by negligence (imputation, the ascription of acts); (2) one becomes responsible *to or before somebody*, whether a court or other instances; (3) one justifies *oneself* as a responsible person.

A responsive ethics will add certain qualifications to all the three aspects of the concept of responsibility. (1) It becomes clear that the juridical or moral ascription of responsibility is always an imputation *post festum*. The responsibility you accept or deny *in actu* precedes the existing order of rules and procedures. (2) The standards of responsibility are relative to circumstances. Every order whatsoever is contin-

gent. Responsibilities are always relative and subject to change. "Practical judgments are certainly based on reasons, but never on *sufficient* reasons, unless we are living in the best of all worlds" (Waldenfels 2015, 427). (3) Responsive ethics questions the assumption that a subject is always "master of his own house" (in Sigmund Freud's words). We might be affected by a *Fremdheit* in ourselves that makes that we *cannot* be held accountable or take responsibility for what we do. Being a responsible person presupposes the disposal of full moral agency, which might be damaged by one's physical or mental state. Here the ethical principle "ought implies can" is applicable. These caveats concerning the prevailing paradigm of responsibility suggest a certain modesty when it comes to judging and ascribing responsibilities, an ethical *epoché* (Husserl) in holding people accountable. As Waldenfels writes: "The singular demand, which I receive from the Other, differs from the universal claim to validity, which arises from everyone's assertion […]. Morality can no longer be taken for granted" (Waldenfels 2015, 425).

As the relationship between responsivity and responsibility has been clarified to some extent, we can now ask: How do we respond in our old age to the call of others who claim our care or whose care we need? Where does my responsibility end and where does the responsibility of others begin? In entering advanced old age, relationships with others change more or less radically. Our social network is getting smaller and centers on the circle of significant others: partners, peers, family, neighbors (Carstensen et al. 2003). A decrease in quantity of relationships occurs, but at the same time their importance and vulnerability increases: We are more dependent on fewer people.

Relationships in old age are generally characterized by care, physically, medically, emotionally, socially – the older one gets, the more so. Such care responsibilities have to be distributed among three parties: first, the older persons themselves, who have to take care for themselves and/or for others in their household, mostly their partners; second, those living close to them, partners, family, and, in particular, their adult children who provide informal care; and finally, society at large that is expected to deliver formal care (social security, medical care). Who is responsible for what, when, and where? Viewed from the perspective of responsive ethics, imputing and taking responsibility has to be contextual and subject to dialogue and negotiation. It is basically a political matter which has to be settled in a democratic process by considering one's health, moral agency, social network, socioeconomic position, and one's cultural traditions and conventions (Tronto 2013). Who should take care of whom and how depends on where, with whom, in which communities, and in what period one actually lives.

There is no "one-size-fit-all" theory for the distribution of care responsibilities in old age, nor an answer predetermined by nature. The conservative idea that adult children are the first ones responsible for taking care of their aged parent because it is the law of nature has to be dismissed as a naturalistic fallacy. Responsibility in old age is a matter of mutual assessment of all those concerned. It is the task of ethics as a discipline to set and supervise rules for a fair, dialogical, argumentative, nonviolent negotiation process without being able to claim some decisive knowledge or an external authority. Ethical knowledge is not knowledge of principles that are

waiting to be discovered in the moral domain but rather knowledge of principles of fairness within a cultural practice. In a contextual approach of responsibility, morality functions as a distributive code in the allocation of responsibilities, a code that has to be negotiated over and over again (Urban Walker 1998).

This viewpoint contradicts the current political climate. Although there are relative differences in their policies, all Western European countries nowadays tend to regard care in old age primarily as a personal and private responsibility to be organized by individuals within their own social network. The state stimulates and mobilizes the financial independence and social self-reliance of its elderly citizens both on a national and local level. Formal care is regarded as a commodity regulated by the market. When you need to be looked after, pay for it (Timonen 2017). In this neoliberal outlook, the elderly are supposed to behave like active citizens and are held personally responsible for their own health. In consequence, living a meaningful life in old age is dependent on individual competence, physical activity, and self-reliance. The inevitable frailty of old age is no longer considered a matter of fate but an individual risk. The concept of "responsible aging" captures this viewpoint. It implies that older people should regard their past lives in terms of risks and choices they once made and for which they bear responsibility (Edmondson 2015, 30).

The promotion of individual responsibility, termed "responsibilization," is central to the rationality of neoliberalism (Rose 2007). Systemic health problems are reframed in terms of personal failure. Subjects are becoming responsibilized by addressing social risks such as illness, unemployment, poverty, etc., as problems of "self-care." Attention is shifted away from social, environmental, and structural factors causing health problems, and towards personal lifestyle (Bambra 2016). This responsibilization discourse involves a punitive conception of responsibility: Responsibility is individual accountability. "Rather than being concerned with taking responsibility, whether for ourselves or others, the final reason to embrace responsibility has to do with *thinking of others* as responsible" (Munk 2017, 23).

From this neoliberal perspective, "old age" stops being a common fate and turns into an individual risk. Elderly care, formerly considered a right in traditional welfare states, becomes the duty of active citizenship (Newman and Tonkens 2011, 145). This ideological idea of responsibility does not provide an honest and full account of the phenomenological reality of responsive aging. It denies that responsibility *in actu* should be born out of the concrete demands for care, that the standards of responsibility are contingent and should be reconsidered anew in every context, and that frail old people are not sovereign consumers but dependent individuals in the first place. Often, they are no longer "masters of their own house" and are lacking the autonomy and agency they are politically supposed to have (Davey 2002; Katz 2013).

As Newman and Tonkens (2011) write, care responsibilities cannot simply be understood as a zero-sum game. Citizens *are* responsible and are actually always already tied into networks of mutual responsibility, dependence, and care. According to these authors, the *responsibilization* thesis should therefore be treated with caution. "Its elaboration in critiques of the emergence of neo-liberal governmentalities of the self and personal lives tends to be at a high level of abstraction" (Newman

and Tonkens 2011, 185). Responsibilities are based in "pre-existing relationships, promises made, expectations or cultural assumptions about care and reciprocity in family life" (Newman and Tonkens 2011, 172). Responsibility has to be understood as a *relational* concept and not just as a political-juridical ascription (Newman and Tonkens 2011, 172, 182). Fulfilling responsibilities requires negotiating a range of practical, emotional, and moral dilemmas within the context of particular relationships and finding balances between various responsibilities for our self, those living close to us, and generalized others.

What does this mean in practice for the distribution of care responsibilities in old age? I think people, regardless of their age, have to take responsibility for their wellbeing as long as they dispose of their mental and moral agency. They also should take responsibility for the informal care for their partners in need, with whom they once decided to share a common biography, even if this implies a physical and mental burden which comes with real pain and suffering. However, no one can be held accountable if the burden of care becomes unbearable (for example, when a spouse suffers from dementia or is terminally ill), although the obligation may still be felt. Here the principle "ought implies can" also applies as a rule of thumb. For illustration, let me refer to data from a 2008 Dutch report which takes note that the proportion of older informal carers had increased in the previous years: Whereas 13% of care-givers were aged 65 years or older in 2001, this figure had risen to 20% in 2008. In 2008, more than 450,000 informal carers in the Netherlands aged 18 years and older said that the burden of providing care weighed heavily on them. They felt that too much responsibility for providing care was placed on their shoulders, that their independence was suffering and that the care-giving was affecting their health and producing conflicts at work or at home. The report directly relates these results "to the growing emphasis placed by government policy on citizens' own responsibility" (SCP 2010, 7, resp. 5).

The principle "ought implies can" is also valid when it concerns adult children caring for old parents. Neoliberal policy claims that those who live in proximity of the elderly have to take care of them. It appears that there is no communitarian or conservative rationale behind this claim, but that it is induced by pragmatic reasons: It legitimizes the idea that the state is *not* responsible. Then the primary responsibility falls to those who are physically close (in reality this is a deeply gendered issue: Mostly daughters and daughters-in-law are concerned). By declaring elderly care a matter of filial responsibility, late-modern societies seem to restore historical continuity with traditional, pre-modern societies. A responsive ethics, however, acknowledges the contingency of this seemingly universal standard of responsibility. The assumption that blood ties come with a special responsibility is highly questionable. With Robert E. Goodin, I opt for another view. Goodin's claim is that the special responsibility I have for others is not based on their physical and/or emotional proximity but on their *vulnerability* to specifically *my* agency. "Special responsibilities derive from the fact that other people are dependent on you and are particularly vulnerable to your actions and choices" (Goodin 1985, 33). The argument also holds true for situations where there is no physical or emotional proximity. The only thing that matters is that *you – only you* and no one else – can help this person in need. It is not the proximity but the dependency that is decisive.

In this way, it becomes more intelligible how responsibility works in long-term relationships between frail parents and adult children – people with a shared biography that has created mutual dependencies with regard to specific needs. In advanced old age, every role and status seem transient and obsolete, except the indelibility of parenthood (Urban Walker 1998, 91). Although strong blood ties may have their own evidence, responsibility is not based on biological proximity here but on a specific vulnerability caused by a common biography. Parents depend on the emotional support of their children, especially when their identities are threatened or damaged by the difficulties of old age. Children confirm and support their parents' narrative identity, through physical and affective intimacy, by telling and remembering stories of the past, by visiting meaningful places together, etc. (Goodin 1985, 83–85). The care provided this way not only expresses but also underscores the biographical relationship between parents and children.

What counts between parents and children is a *particular* vulnerability and a *specific* dependency. Other kinds of assistance (financial, administrative, technical, paramedical) should be provided by those who are specifically accountable for these needs because they – and *only they* – have the expertise required. Innovative medical technology contributes to the longevity of frail elderly who depend on specialized geriatric care for their quality of life. This means that care in old age is increasingly medicalized and professionalized. Thus, not only family and close community members but also state-financed formal care professionals are *special* in this respect and bear special responsibilities (Urban Walker 1998, 99). For these reasons, a mixed arrangement of responsibilities is preferable, one that considers the limits of available informal care for the elderly.

Understanding morality as a dynamic, cultural practice helps us avoid the so-called naturalistic fallacy in the allocation of responsibilities. Vulnerabilities and dependencies are not naturally given but are contingencies which can vary according to time and culture. "Rights and responsibilities in relation to the care of older people operate across a spectrum; with care being located firmly within the family and home at one end of the spectrum, and within the state and institutional settings at the other" (Milligan 2009, 58). In a changing landscape of care, care responsibilities must be constantly re-negotiated and traditional expectations may be challenged with good reasons.[2]

12.4 In Conclusion: Responsiveness as a Virtue

Responsive phenomenology starts with the simple question: "What are we struck by and what are we responding to while saying this or doing that?" (Waldenfels 2015, 424) What surprises and overwhelms us in advanced old age may be the fact *that we are being cared for.* Growing very old definitely means becoming a recipient of

[2] See Remmers, Chap. 13 in this volume.

care. How do we respond to this in such a way that it still contributes to living a meaningful life?

In her description of the process of care, care ethicist Joan Tronto distinguishes four analytically separated but interconnected phases. They are: caring about, taking care of, care-giving, and care-receiving. The first three phases are viewed exclusively from the perspective of the care-giver. They include (1) an assessment of a need and making the assessment that this need should be met; (2) assuming personal responsibility for the identified need of the other person and determining how to respond to it; and (3) the physical work required for the meeting of the needs. In the fourth phase, however, the viewpoint of the care recipient him- or herself is considered: How does he or she respond to the care he or she receives? Without an affirmative responsive behavior ("I accept the care offered to me, this is exactly the care I needed"), the circle of care cannot be completed and the care relationship cannot be continued in a fruitful way (Tronto 1993, 134–137). Tronto calls this moral moment in the care process "responsiveness" and presents it primarily as a moral competence of the attentive care-giver (Tronto 1993, 134–137). But should we not also regard it as an indispensable moral quality of the care-*receiver*?

In her design of a care ethics, Nel Noddings asserts that within the asymmetry of a caring relationship, a genuine reciprocity between the one caring and the one cared-for is implied. Otherwise, a caring relation cannot succeed. "Caring involves two parties: the one-caring and the cared-for. It is complete when it is fulfilled in both" (Noddings 1984, 68). The cared-for must somehow "receive" the caring, not by consciously expressing gratitude but by a spontaneous disclosure of oneself within the relationship.

Noddings mainly refers to parent/child, and teacher/student relationships as paradigmatic caretaking situations, but perhaps such an "ethics of being cared-for" should also be developed with aging adults becoming increasingly dependent on the support of others for their activities of daily living (ADLs) and their care-givers in mind. How to express recognition without feeling subservient? And how to be genuinely caring without demanding or expecting conscious acts of gratitude? Noddings' observations can serve as a point of departure: A caring relation "requires the recognition and spontaneous response of the cared-for" (Noddings 1984, 78). "The cared-for is free to be more fully himself in the caring relation. Indeed, this being himself, this willing and unselfconscious revealing of self, is his major contribution to the relation. This is his tribute to the one-caring, but is not delivered as a tribute" (Noddings 1984, 73).

Being able to receive care gratefully, without afterthoughts, and to incorporate this receptivity in one's self-understanding, is also a virtue in old age. It requires that, perhaps for the first time in adulthood, one overtly acknowledges one's own dependency and radical vulnerability. It thus involves an ability to accept a gift without feeling guilty or offended. Whether you are capable of doing so depends on whether you ever learned to thank for something that overwhelmed you.

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