

W O R K

A N D

S O C I E T Y

Work and Society:

Places, Spaces and Identities

Edited by Paul Taylor and Paul Wagg

Issues in the Social Sciences

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**Work and Society:
Places, Spaces and Identities**

Edited by

Paul Taylor and Paul Wagg

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This book is dedicated to the memory of

Professor John Borland

Visiting Professor in the Faculty of Social Science

University of Chester

2007-2014

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CHAPTER 1

RECONCILING WORK, CARE AND SOCIAL JUSTICE: INFORMAL CARE, STATUS INCLUSION AND SELF- EMPOWERING DYNAMICS

Alessandro Pratesi

Some of the most important and complex challenges facing contemporary society and public policy are issues around intimacy, family, and care. While in the UK and elsewhere the official everyday discourse has tended to confine 'care' either within professional social care practices or within the private sphere of interpersonal relationships, care is a fundamental component of people's lives, survival and flourishing, with significant sociological, philosophical, political and moral implications (Barnes, 2012). Care also possesses important implications in terms of social justice, equality and citizenship. Despite the fact that several scholars have highlighted such connections, and tried to conceptualise care responsibilities as a public value and universal right (Tronto, 1994; Knijn & Kremer, 1997; White & Tronto, 2004), social care policies tend to define the notion of 'citizen-carers' in neutral terms (Barnes, 2012). All this has resulted in mounting care-related inequalities, based on gender, class, race/ethnicity, age, able-bodiedness and, more recently, sexual orientation. Such inequalities become more evident in a political and economic context increasingly forcing people to manage care needs in a self-sufficient way as governments and welfare systems struggle to cope with rising costs, changing demographics and what are too often conceptualised as unsustainable care burdens.

Whilst sociological, philosophical and political debates persist, everyday constructions and social representations of

care keep reproducing a collective imaginary of care characterised by myths of a better past (which was never there) and dystopian images of a deteriorating future (which, possibly, will never occur). The media and popular imagination are dominated by tales of social breakdown, of pathological and dysfunctional relationships between women and men or parents and children, producing individuals deprived of 'proper' love and care who instead may embrace the brutal intimacies of gangs, narcotics, and crime. Yet until recently, there has been a surprising lack of attention given to both the theory and experiences of care within family and non-family relationships. Moreover, both inside and outside the academic environment, family tales refer to deep-seated, prescriptive and heteronormative notions of what 'care' and 'family' should be. And yet, recent qualitative work suggests that beyond the structural changes involving family and care in contemporary Britain, the search for commitment and its moral contents are still central in people's lives (Roseneil & Budgeon, 2004; Duncan & Smith, 2006; Smart & Neale, 1999; Duncan & Phillips, 2008). The process of individualisation (Elias, 1985), if there is one, occurs within social bonds, not away from them. Rather than family ties breaking down, they appear as strong as ever, although sometimes in different forms, and such different forms also shape the different and changing experiences and meanings of care.

The meaning of 'care' cannot be taken for granted. It can have very different resonances in different cultural contexts and is frequently inflected by hierarchies of gender, race, religion and sexual orientation. Within UK and European Union social policies, for example, care is highly gendered, whereas 'work-family balance' policies tend to be framed in gender neutral terms, as it has been emphasised, among others, by Stratigaki (2004), Lewis (2006), Roth (2008) and

Kantola (2010). Moreover, while social scientists have frequently glossed care as a form of diffuse enduring solidarity (Weston, 1997; Barnes, 2012), this ignores the dynamic trajectories that care can take. The emotional tenor of a care relationship changes through time, and can encompass sentiments as diverse as affection, love, empathy, compassion, resentment, bitterness and hatred. To understand these sentiments we need to examine the full range of factors influencing the forms care relationships can take, the variations across different cultures and the difference between 'heteronormative' and 'non-normative' contexts.

The experience and interpretation of such complexity fulfil or prevent aspirations, forging new kinds of 'caring' (or uncaring) selves and 'cared-for' selves that go on to be social actors in a host of other situations. It is therefore crucial to understand the entire phenomenology of care, and the multiple factors that shape it: a major intellectual and moral development with significant interdisciplinary implications. A nuanced and in-depth understanding of what care might encompass in highly specific contexts enriches and revitalises important current debates within social sciences, but also in the field of social policy.

Public policies and political rhetoric in Western societies define the kind of families which it is possible for public services to recognise and support while excluding the others. Conversely, responsive and responsible social policies and programmes for care can only develop when we openly acknowledge and understand the contributions of all social actors, be they young or old; married, single, cohabitant or living apart together (LAT); gay or non-gay; men or women. Adding a focus on different types of caregivers is important not only theoretically, to fill the gaps, but also strategically, to increase equality. Since the discrimination based on sex, sexual

orientation and marital status will most likely continue, bringing these different types of caregivers into the discourse on care and highlighting the value of diversity might be not only the most effective way to achieve more equality but also to shed light on the real meanings of care and its crucial role in people's life.

The questions then become: how do both state and citizens deal with this pluralism? To what extent do policymakers acknowledge that if we want to understand the role of care we need to empirically analyse and contextualise it in specific settings? What are the visible and less visible implications of care in different contexts? How does care intertwine private/emotional processes and public processes involving inequality, citizenship and status dimensions? How does it open new and unexplored possibilities for social change?

Emotions, Care and Inequality

Care environments are places where dynamics of inclusion and exclusion are constantly formed, often mechanically and unthinkingly. These dynamics are supported and/or hindered by the felt experience of care. In other words, emotions are key to show the grey areas connected with the concept of care and challenge conventional associations of care with ideas of burden, stress and social exclusion, which overlook the energising and empowering aspects of it. Care work may be connected with physical, emotional and psychological exhaustion but also with gratification, reward and self-empowerment. Care-givers experience both positive and negative emotional states in caring situations, and further studies on the rewarding and energising aspects of care may help us to broaden our understanding of how we can reduce the burdening aspects and increase the self-empowering ones.

The interactional dynamics of informal care have been central to an ethic of care as developed by many care theorists in the last 30 years (Gilligan, 1982; Noddings, 1984; Tronto, 1994; Held, 2006) and several approaches to the sociology of emotions have already inspired a rich research agenda, connecting micro (interactional) and macro (structural) levels of analysis (Kemper, 1990; Barbalet, 2001; Collins, 2004). The focus in this chapter is on the role emotions play in such interactions, and more specifically on those sociological approaches to emotions according to which social structures are based upon feelings of status inclusion/exclusion in groups or coalitions and constantly reproduced into situated interaction (Collins, 2004).

This chapter builds on the findings of empirical research on informal care – defined as unpaid, non-professional care of a physical, emotional, and social nature that is provided by partners, relatives, or friends – conducted in the USA between 2005 and 2007. The aims of the research were to construct a more inclusive phenomenology of informal care (focusing on different kinds of conventional and unconventional family contexts) and to understand its multiple implications when we look at care from a different standpoint: the felt experience of care. In doing so it aimed to grasp a 360 degree phenomenology of informal care, that is, an embodied understanding of care, which could be empirically grounded and situated into specific and ‘diverse’ contexts. I wanted to get insights into the role of emotions in connecting ‘micro-’ and ‘macro-’ levels of analysis and to challenge conventional assumptions connected to informal care.

The phenomenological analysis presented in this chapter sheds light onto the less visible and often unexplored aspects of care. One of these aspects concerns the energising and empowering effects of care responsibilities that clearly help

people not only to overcome the exhaustion connected with multi-task operations but also to balance their perceived status exclusion from other settings. Indeed, the crucial role of care in terms of status inclusion represents one of the unexpected and certainly still uncharted aspects of care. Such broader phenomenological analysis brings to the surface important and understudied elements, perhaps a blend of new and old elements, which acquire a completely new sense in light of the Interaction Ritual model (Collins, 2004) and with the inclusion of gay/lesbian and single carers.

Sample and Methods

Before starting to define the empirical and conceptual borders of 'care' and 'emotion' and their complex implications in terms of status inclusion and self-empowerment, it is necessary to say a few words about the research sample and methods. The purposive sample included 80 informal carers, 40 men and 40 women, involved in childcare or elderly care (or both). Forty-two caregivers defined themselves as gay/lesbian and 38 as heterosexual. Fifty-nine were partnered and 21 were single carers. Sixty-six carers had childcare responsibilities, nine were involved in elderly care and five both in childcare and elderly care. The discussion here presented, though, will mostly focus on some examples of gay/lesbian carers involved in childcare or critical (elderly) care. Elsewhere, other kinds of carers and implications of care are also addressed (Pratesi, 2011, 2012).

The interviewees were mostly recruited in Philadelphia urban and suburban areas, between winter 2005 and summer 2007. The sample was purposively diverse in terms of gender, sexual orientation, type of care (childcare and elderly care) and marital status, but relatively homogeneous in terms of social class. It included gay/lesbian carers not only because

they have been thus far excluded from the conceptual category of 'normal' carers and from 'normal' research on informal care, but also because from an epistemological point of view they were considered a key subject to visualise the less explored rationales of care and the crucial role of emotion in determining the outcomes of care activities in terms of status inclusion/exclusion and in terms of self-empowering or self-draining dynamics.

The research was based on a multi-method approach, including semi-structured in-depth interviews, participant observation, diaries, online discussion forums between members of parents' associations, ongoing conversations with the interviewees beyond the interview context, key-informants interviews, secondary sources on informal care and parenthood collected from adoption agencies and local associations, journal and newspaper articles, and the web. All this, in order to get an empirically grounded, situated and thorough understanding of informal care, analysed in a variety of contexts. But what do we know about care from the theoretical point of view? What are its conceptual and epistemological boundaries? Defining care and delimiting its theoretical borders is the purpose of the next section.

Defining 'Care'

The literature on care is gigantic, and trying to summarise even some of its main features would be beyond the scope of this chapter. Conceptually, the notions of formal and informal care refer to the conventional distinction between professional, paid care and other forms of qualified care, and everyday unpaid care for children, older/disabled people and other adults who need assistance carried out by family members, relatives or friends. In both spheres, care work potentially includes several tasks, ranging from activity to ethics, that is,

from 'caring for' in the sense of taking charge of others' physical well-being to 'caring about' in the sense of feeling concern for others' physical and psychological well-being (Graham, 1983; Noddings, 1984; Thomas 1993; Leira, 1994; Ruddick, 1998; Kittay, 1999; Kittay & Feder, 2002). It defines a particular kind of work, an activity directed to identify and meet the needs or well-being of certain others and it challenges binary thinking opposing head with heart and rationality with emotion (Waerness, 1984). It was Kari Waerness (1984) who almost 30 years ago described the 'rationality of care' as a form of rationality that encompasses both instrumental/practical tasks and affective/emotional relations, both caring for and caring about components; a form of rationality which implies connectedness, 'local' (empirically grounded) knowledge and interpersonal relationships.

Some of the early care theorists have tended to emphasise the emotional components of informal care, some describing care as meaningful and fulfilling to many women and viewing care as a model to be extended to larger social arenas (Gilligan, 1982; Ruddick, 1998), while others have highlighted instead the material and constraining components of care work describing it as an oppressive practice to women, forced into their role of carers by a variety of ideological forces (Finch & Groves, 1983).

More recent feminist research highlights how – whilst both the conceptual and empirical boundaries between formal and informal care are dissolving – this is happening in ways that still have strong gendered impacts. Yet the theoretical dispute on the dissolving boundaries between the two kinds of care still seems to be open (Graham, 1991; Thomas, 1993; Ungerson, 1995, 1997; Himmelweit, 1999). In addition, care theorists have further complicated the theoretical boundaries of care by arguing that care activities are different from, but

need to be integrated with, other activities in both the economic and political spheres (Tronto, 1994, 1987; Folbre & Nelson, 2000; Kittay & Feder, 2002; Hochschild, 2003, 2012; Hochschild & Ehrenreich, 2003; Zelizer, 2005; Barnes, 2012).

While the feminist debate on the ambivalent role of care in women's lives is still open, a growing number of care ethicists and scholars seems to agree that care cannot be envisioned as a unified theoretical category, but rather as an empirical one, to be analysed along its multiple and sometimes conflicting dimensions. According to such perspectives, examining care within specific historical and social contexts and looking for broader and empirically grounded definitions of care including affective/emotional and tangible/physical components is the most effective (if not the only) way to grasp a fuller understanding of its place and meaning in people's lives – rather than just in women's lives.

Why and How Emotions?

The examples of 'specific care contexts' (and their ways of intertwining private/emotional and public/structural processes) illustrated in this chapter are analysed in light of the interaction ritual chains theory (Collins, 2004). Collins claims that the emotional dynamics underlying the social structures (such as inequality) are based upon feeling of membership or inclusion in groups or coalitions. In other words, the basic mechanisms defining both the individuals' positions in society and their interconnection possess an emotional nature rather than a merely economic, cultural, social or political one.

The theory is based on the assumption that situated actions and interactions constitute the micro-foundation of macro-structures. Every interaction generates different status and power effects according to the characteristics of the

interacting social actors and the ingredients of the interaction itself. In brief, if the interaction is successful, there will be an increase along the dimensions of status and power, if it is unsuccessful there will be a decrease. More specifically, a successful interaction produces a feeling of solidarity with a group: a sense of status membership or status inclusion, which is described in terms of Emotional Energy (EE). Collins describes the EE produced through a successful interaction as something conceptually close to the psychological notion of 'drive', but with a specific social orientation – EE is a long-lasting emotion that builds up across situations and makes individuals initiate or fail to instigate interactions, so it is simultaneously the (necessary) ingredient and the (potential) outcome of every interaction.

EE comes from various chains of interaction, and it ranges from the highest heights of enthusiasm, self-confidence and initiative – when the interaction between people is successful – to the deepest depths of apathy, depression and retreat from action – when the interaction is unsuccessful. Every successful interaction generates EE (initiative for action, enthusiasm, etc.), which becomes part of people's supply of emotional capital. It is a similar mechanism to earning money – successful transactions make people earn money and money increases their financial capital. The difference, here, is that we are dealing with 'emotions' and not money. People's choices, behaviours, and decisions regarding daily-life issues are based on their emotional outcomes and inputs; their chance to gain or lose emotional energy is strongly affected by the success of their interactions and by the supplies of EE accumulated through their ongoing chains of interactions.

Having explained the relationship of emotions with status and power dimensions and processes, we now need to describe the not-so-visible mechanisms through which

unexplored and unexpected outcomes in terms of status inclusion and self-empowerment can be produced while people care for and about their beloved ones or significant others.

Care and Reflexivity: Thinking and Feeling Care

My argument is that we can look at informal care in terms of chains of interactions. I am talking here about a particular kind of interaction, i.e. the ongoing internal dialogue between the 'subject carer' and a whole network of what Norbert Wiley (1994) calls 'permanent visitors', all those generalised others who are variably present in our thoughts and with whom we are in a constant internal conversation. During their constant internal dialogue with their permanent visitors the subject carers constantly verify (or disconfirm) their status inclusion to what I called the intangible community of successful carers.

Status inclusion (or status membership) – as we have seen in Collins' theoretical model (2004) – is the indicator defining every interaction as either successful or unsuccessful, with its consequences in terms of EE increase or decrease. It is precisely the internal processes of thinking and feeling care and the ongoing process of reflexivity that make a difference in terms of experiencing care as a source of emotional drain or, instead, as a source of status inclusion and self-empowerment. I therefore hypothesise that care activity is not only about tending to or caring for someone but also (if not mostly) about status membership and emotional energy production, which I suggest are its latent or less visible purposes. Without necessarily being aware of it, all carers participate in this invisible process of EE production through their care activities. The care experience thus becomes a crucial site to observe the unceasing reproduction of emotional stratification that is the

basis of social inequality and it is precisely the presence (or the absence) of care in people's life that makes a difference.

Rather than the difference – and therefore the inequality – resting on a distinction between 'different' types of carers (male or female, gay/lesbian or heterosexual, single or partnered), it becomes displaced on to a new distinction between those who do have and those who do not have care responsibilities. This argument, evidently, needs to be contextualised: it is not merely the presence of care that makes a difference in people's life, but also the presence and availability of a whole range of resources (financial resources, social/cultural/emotional capital, family/friend networks, and, above all, social services, including health and social care services). However, thus reformulated, the inequality connected to care highlights crucial and overlooked aspects of care. In fact, if the presence of care in people's lives can produce either draining or self-empowering dynamics, the total lack of care responsibilities from people's lives automatically excludes them from such possibility.

With this in mind, we can now turn to the examination of some of those less visible and unexplored aspects and implications of care. These unexplored aspects of care compel us to reframe the current discourse on care and to challenge certain assumptions, such as those describing care as a site in which gender-based dynamics of exclusion or emotionally draining experiences are often at stake. The following sections will navigate through some of these overlooked aspects of the phenomenology of care that, I claim, constitute instead its core nature.

Care as Status Inclusion and/or Status Membership

The following examples offer an embodied understanding of care, thus helping to conceptualise its complex, ambivalent

and slippery notion by empirically grounding and situating it into specific contexts. Two of the recurring themes emerging from the majority of the interview accounts are that care activities (i) connect people who would have not have interacted otherwise or (ii) make people more efficient and increase their capacities to get more things done in a more focused way. It does not matter, for our purposes, whether these unanticipated outcomes of care are planned or unintended, or whether the carers are totally aware of them. The point is that the search for the meanings of care in the entire ecology of people's lives brings to the surface important and under-studied elements. One of these elements concerns the description of care as a 'gateway' for status inclusion or as a source of self-empowerment and emotional energy production, which clearly forces us to reframe and redefine the complex interrelationships between work, care, dynamics of inclusion/exclusion and social justice.

Interestingly enough, an example of the crucial role of care in terms of status inclusion is represented by gay/lesbian parenthood. Differently from what one might think, parenthood can become for gays and lesbians "an easy way to connect with people" as one of the interviewees says. It opens the doors to the (presumed) universal language of child rearing and creates an unprecedented link between gay/lesbian and heterosexual people, facilitating a dialogue which would probably never occur otherwise. The 'connecting' and status inclusive power of care is underlined for example by Stacey, who also highlights the pedagogical aspects of sharing similar experiences, as gay/lesbian parents, with heterosexual parents:

You have to wake up in the middle of the night and feed the kid and you have to change the diapers and you have to figure out what you're gonna do about day care or after-

school programs and all the tensions and all the issues for any family ... are the same regardless of whether the parents are opposite or same genders. And that's very, once again, it's very educational and enlightening to people, many of whom, probably, just it never occurred to them to think about before.

(Stacey)

Gay/lesbian parenthood and a family-oriented pathway can become an appealing, reassuring, and comforting option with unexpected consequences in terms of status inclusion or status membership. The following interviewee highlights an interesting contrast between a before, when, as a childless woman, she was just considered a career woman, and an after, when, as a mother, she started feeling "part of the mainstream":

having children is ... like an easy way to connect with people. And it's really ubiquitous. ... when I didn't have kids I wasn't part of the conversation. But as soon as you start to have kids - on a bus, in a training program with an executive, it doesn't matter - you can relate to so many people, you know, from this shared experience, this universally shared experience of having kids. So that is interesting, so I'm part of the mainstream [Laugh].

(Feona)

All of a sudden, the social identity of 'parent' seems to prevail over the 'sexual' identity, which previously defined these parents as gay, or lesbian. In other words, gay/lesbian parenthood redefines the conceptual categories of 'gay' and 'lesbian' in terms of social rather than sexual identities. The dynamics of status inclusion seem to be particularly evident in the following excerpt, where Kendrick, a single adoptive

father, vividly and clearly describes his parenthood as a gateway towards the 'club of heterosexual parents':

You have a different level of credibility with straight couples. ... I coached my son's baseball team, I was a baseball coach, you know. And ... I didn't come out and say I was gay or anything, I just did my job as a baseball coach. Most of the people in the urban setting are not stupid. I'm a white man with a black child, they're gonna figure out I'm probably gay. But I would have never had those relationships with those parents without a child ... And it's like you belong to their little club and you talk about the same things and you talk about struggles at school and your kid and oh, it's like being accepted into a totally different society.

(Kendrick)

This aspect, which is consistent with recent research on same-sex parenthood (Clarke, 2007, 2008; Nelson, 2007; Patterson & Riskind, 2010), is certainly one of the most interesting findings emerging from this analysis: the watershed around which dynamics of status inclusion/exclusion are played is not that between 'heterosexual parents' and 'same-sex parents', but rather that between 'parents' and 'non-parents'. This, quite obviously, possesses several implications also in terms of EE production and self-empowerment. Having or not having child-care responsibilities is what mostly determines the difference between the different social actors in terms of status dimensions and emotional capital.

Critical Care and Self-Empowering Dynamics

Now, one might think that this theoretical model – care as a source of status inclusion and supply of EE with self-empowering consequences – relates mostly (if not exclusively) to childcare, and that things may change dramatically when

elderly or critical care is involved. Conversely, my research findings show that such considerations also apply to elderly care and critical care. Greg (43) is a lawyer who narrated his sometimes painful but also extremely rewarding and significant care experience with his dying mother and his father affected by a curable cancer; a care experience described as a sort of 'exploration' vividly impacting on his life and changing it dramatically:

And towards the end of my mom's life she had a lot of pain management issues and I got involved with trying to seek out alternatives for her pain management issues. ... She was in a lot of pain and I started researching a lot ... [crying]

I: If you want, we can stop.

R: That's all right, I'm okay. But, I went to ... [crying]

I: I'm going to stop it here. [tape off]

[Pause]

R: I feel a lot, I think I feel a lot different about these issues than I would have, you know, seven years ago, if I wasn't, if I didn't go on this exploration.

(Interviewer & Greg)

Part of these changes concerns Greg's choice to prioritise care over career development. After his mother's death, he describes himself as strongly determined to take care of his father and even to organise and adjust his future career choices in order to be able to do that. Although the care experience with his dying mother was not an easy path, and maybe precisely because of this, such an experience radically changed his attitudes towards career and care, and towards life priorities in general:

And I think while my mom was sick the hardest thing was seeing her in pain. But I mean I know that if my dad's in a situation where he should be living with somebody, he's

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gonna live with me, I know that and I accept that. And it's not an imposition. ... I'm absolutely committed to taking care of him ...

One of my objectives in the future isn't to accumulate wealth. ... If you're asking me about how I feel about my career and things like that, I mean I do, within the context of care giving, I feel very strongly about looking after my dad and making that happen. ...

And I have thought about career choices within the context of taking care of my dad ... I'm more likely to think about career and kind of *factor in* what his needs will be in the future.

(Greg)

Interestingly enough, the positive, energising, empowering aspects of care, or what I have called the productivity of care (Pratesi, 2011) emerge quite clearly in this quotation, where Greg highlights one of the most obvious and still least supported arguments: that is, if you want productive employees, you need to provide them with responsive and responsible care policies:

And there are some progressive employers out there that understand that there's elder care issues involved with people. ... I do job search and there are employers out there that will provide you time for elder care, that they actually have arrangements, just like some employers deal with childcare, they have arrangements with elder care. ... And they realise, you know, that in order to have a productive employee, their elder care issues have to be taken care of.

(Greg)

Critical care can activate loops of automatisms by which people just keep going and develop strategies and practices focused on the necessity to deal with the emergency, to reconcile critical care with their daily working routines; all this

without losing their psychological and mental health. This is the example of Gill (39), a project manager who at the time of the interview was working for a large American company and had been caring for her dying father for more than two years. Gill's account also represents the paramount example of how care can become a source of emotional energy (EE) even in the most difficult situations. When I interviewed Gill, she had lost her father a few months earlier. However, although undeniably exhausting, care seems to become at the same time the cause of distress and its remedy; in other words, it somehow represents the source of emotional energy which helps people to keep going, even when the levels of stress can be very high:

It was hard. I did not go on vacation for the last two years; I did not do anything but work, play some sports locally and take care of my family. And, you know, I had a drink every night when I got home, I had a glass of wine as soon as I got home because that was the only thing that I could, like I needed to decompress for a half an hour by myself. Every day was a fight, was a struggle. I got up because, and I got out of bed and I went to work because I knew that I might have to take care of my father for the rest of his natural life, however long that was. ... I got up in the morning because my dad was around. That was what I did.

(Gill)

Gill's dramatic care history was further complicated by the fact that she had an idiosyncratic/problematic relationship with her mother and additional care responsibilities which involved one of her aunts (her father's sister). Gill had a younger brother and a mother who could have been more involved in the family care issues, but she was the primary caregiver. She took care of both her father and her aunt, as the principal carer. Why should she do all that? Why would she

not have delegated to someone else at least part of such difficult and challenging care work and responsibility? The answer to these questions lies in what I have described as latent and/or less visible purposes of care. In the following quote, Gill vividly exemplifies a sort of enduring care for her beloved father; a form of care which does not end even after her father's death:

He was my guy and I miss him. [Crying] I cry daily for my dad. I mean he's been gone for six months – he was the best guy in the world.

(Gill)

What Gill probably missed was not only her father, but also her taking care of him – that chaotic, critical, and distressful period itself that produced so much pressure on her. What she was mourning was not only the absence of her father, but also the absence of care, the sudden emptiness created after such a dense and intense emotional period, when part of her feelings of self worth and empowerment were significantly depending on her father's need of care. Several scholars in the ethics of care tradition (Barnes, 2012; Noddings, 1984; Kittay & Feder, 2002; Kittay, Shoemaker, & Hill, 2007; Fisher & Tronto, 1990; Tronto, 1994) have suggested replacing both the concepts of care and dependency with the concept of interdependence (Dean, 2004; Weicht, 2010) which highlights aspects of mutuality and reciprocity between the subject carer and the person cared for, and problematises existing conceptualisations of the dependence-independence dichotomy informing current discourses on care in Western societies. Weicht (2010) suggests embracing dependency as both a political and interpersonal project aimed to overcome such "politically- and normatively-charged dichotomies" (p. 220). The specific case of Gill here illustrated presents us also with another

opportunity, that is, the necessity to rethink both the political and experiential character and value of feminist ethics of care within the contexts of the absence of care or of the continuing care for a loved one after their death. What is missing here, from current debates on care, is the understanding that the embodied relationship with the dead person does not die with the person.

Creating the Conditions for more Caring Societies: Concluding Thoughts

Understanding 'care' and its multiple meanings and implications represents one of the most important tasks facing contemporary society and public policy today. Past and current research on care too often focuses on the gendered costs of care and on its burdening or emotionally draining aspects. Less attention is paid to 'being excluded from care' or not being socially visible or fully acknowledged as a 'legitimate' carer on the basis of one's marital status or sexual orientation. The existing research gaps on the less visible implications of care prevent a thorough understanding of the circumstances under which care can become draining, burdensome and represent a source of social exclusion or, instead, can be enriching, empowering and represent a source of social inclusion.

The contribution presented in this chapter offers a more inclusive and thorough conceptualisation of what a notion of care might involve when analysed in highly specific and diverse care contexts, including male and female carers, married and single carers, gay/lesbian and heterosexual carers, child carers and elderly carers. Expanding the focus on different kinds of carers is not only theoretically important, to fill the gaps, but also strategically, to increase equality. A care ethic informed by inclusive approaches can facilitate its

theoretical relevance, empirical applicability and transformative potential in the context of growingly complex and multidimensional political challenges. The implications of more inclusive approaches to care are crucially important for current debates within social sciences, but also in terms of social policy.

The research here discussed has shown how care activities and responsibilities generate forms of group membership or status enhancement and consequent outcomes in terms of emotional energy production that alter people's emotional capital and emotional/social stratification. This in turn affects people's ability to successfully manage future interactions but also their ability to reconcile care work with work for the market. Reflexivity is the essential condition by which caregivers judge their care experiences as successful or unsuccessful. Without denying the importance of structural, economic and cultural factors in the reproduction of care-related inequality, this study claims that these factors need active mediation – the capacity and the willpower of individuals to act independently and to make their own choices – in order to be effective. Through their internal conversations, individuals reflect upon and mould their social and emotional situation in light of care-related tasks and concerns (Wiley, 1994; Archer, 2003, 2007). These inner dialogues govern caregivers' responses to social forces, their actual and potential patterns of social interaction, and whether they contribute to social inequality; an inequality that is based on the felt experience of care.

Acknowledging the intrinsic value of care and highlighting its potentially inclusive and self-empowering consequences does not mean giving voice to a romanticised view of the world or failing to recognise the draining aspects of care, but rather capitalising on care as a long-term

investment and a resource. If the majority of the carers in this study experience care in terms of status inclusion and self-empowering processes, some however experience feelings of disconnectedness and powerlessness. The capitalisation of care can only be accomplished by facilitating the conditions under which care can become a self-empowering and productive experience and by reducing those under which it becomes a constraining, excluding or emotional-energy draining experience.

Creating the conditions for more caring, more just and more inclusive societies and acknowledging the role of all different types of carers (single and partnered/married; heterosexual and homosexual; involved in childcare or elderly care, etc.) represents the first step towards these ends. In doing that, we can also reduce the inequality connected to this fundamental activity. But all this, quite obviously, cannot be left to the individuals alone and their personal/private responsibilities.

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