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Care and Control

Community Treatment Orders: Exploring the ethics and experiences of compulsory mental health care in the community

Laura Banks and Julia Stroud

School of Applied Social Science, University of Brighton

This paper would address the theme of tensions between concepts of care and control. It will draw on initial findings from a current National Institute for Health Research (NIHR) funded research study entitled "An Exploration of Service User and Practitioner Experiences of Community Treatment Orders" - a largely qualitative study based primarily on interviews with service users and practitioners across the Sussex Partnership NHS Foundation Trust area. The paper will give contextual information relating to the development of Supervised Community Treatment (SCT) and reflect critically on international perspectives on the potential effectiveness of CTOs and on social ethics around using coercive powers in 'care' (Rolfe, 2001; Campbell et al. 2005, Churchill et al., 2007). It will then focus on evidence from the research study around how compulsory powers are applied in the context of wider social care policies focussed on personalisation, choice and autonomy. It will also explore potential tensions around the application of SCT alongside provision of social supports and therapeutic interventions. In particular it will consider potential implications of compulsion upon the nature of relationships with those involved in providing care to someone on a CTO. Whilst the use of compulsion is not necessarily associated with an absence of therapeutic possibilities within relationships between mental health service users and workers, legal powers have been described as an 'intrusion' into such relationships (Caldicott, Conlan and Zigmond, 1999). On the introduction of CTOs in England and Wales (in the Mental Health Act 2007), concerns were thus raised around how the legislation may damage therapeutic relationships, through turning professionals into "Mental Health Act police officers" (MIND, 2007). The paper will therefore discuss the extent to which evidence from the research justifies those concerns. It will also refer to any examples of 'good practice' from the study where such an apparent conflict of roles was considered to be resolved or managed successfully.

Tronto's integrity of care as a framework to guide care by avoiding oppression.

Tula Brannelly

School of Health and Social Services, Massey University, Wellington, New Zealand

Forced treatment and detention have fundamental consequences for the lives of citizens. People who are subjected to control because of their mental health problems often describe practices of coercion and exclusion, and experiences of dehumanisation. Episodes of control have been told as more debilitating and distressing than the mental health problem that brought people into contact with services. On the other hand, some people welcome another taking control and experience care, such as in lifesaving interventions for depression. Engaging with the other to understand the crux of need and care is crucial to the experience of either coercion or care. When working alongside people in crisis, unpacking the messiness of all that has occurred to understand needs can also be difficult when trying to achieve care. An issue very specific to care and control is the question of responsiveness to intended care as an experience of unwanted control. An aim is that the

experience of dehumanisation is avoided when care is present and care may be present in a number of ways.

The principles of an ethics of care as described by Tronto (1993) are discussed here in relation to the experiences of detention and control, in an attempt to provide radical political possibilities (Sevenhuijsen, 2003) about practices of care in mental health. The care ethics principles can be used as a framework to guide practice or to reflect on practices that occur in terms of how outcomes are produced, or whether a person's needs are met over another's. Identifying a range of circumstances, events and situations that both sustain and interrupt care is useful to consider how care can be better achieved. This presentation draws on work from research that examined facilitated participation of older people with dementia and their families in care decisions around detention, and mental health survivors' acts of citizenship which aimed to make changes at an individual and systemic level in an attempt to improve services.

Physical restraint in residential child care: Using care ethics towards resolving ethical dilemmas in care and control

Laura Steckley

**Glasgow School of Social Work/ The Centre of Excellence for Looked after Children in Scotland,
Glasgow**

This paper explores the practice of physical restraint, one of the most acute manifestations of the tension between care and control, from a care ethics perspective. When carers must respond to behaviour which poses a serious, imminent danger, the response can sometime take the form of physical restraint. Physical restraint in human services has long been the subject of serious concern, and is one of the most complex, ethically fraught areas of practice. Negative effects can be severe and long lasting, not only on service users but also on the staff who carry them out. At best, the technical-rational approaches embodied in training techniques and organisational policy are inadequate in supporting practitioners to traverse this ethical minefield. At worst, they obfuscate a practical-moral approach to practice. This paper draws from a large-scale, Scottish study of young people's and practitioners' experiences of physical restraint in residential child care to offer an empirical enquiry into this complexity. The study found that practitioners struggle with considerable moral ambivalence about this area of their practice, as well as a distinct inarticulateness about its ethical dimensions. Young people were clearer in their views but shared a wide range experiences, from extremely negative to quite positive. The lens of care ethics is used to offer insight and clarity in making sense of the data, and more broadly of this difficult area of practice. Finally, the paper draws from Bion's therapeutic containment and Winnicott's holding environments, developmental theories which strongly resonate with the core principles of care ethics, to offer tangible ways of addressing the complex demands of meeting young people's needs. It argues that provision of therapeutically containing, holding environments can reduce the need for physical restraint and increase the likelihood that when it does occur, it is carried out ethically and is experienced as an integration of care and control.

Rescuing Ourselves from the Care Ethics Quagmire: Replacing “Care” with “Support”

Anna Stubblefield

Rutgers University-Newark

Disability studies scholars and disability rights activists have critiqued care ethics as demeaning to disabled people. They argue that care masks control: to see someone as a “care recipient” legitimizes subjecting that person to control in the name of protecting his welfare. As a disability studies scholar who is also a feminist philosopher and therefore drawn to care ethics as a welcome counter to overly masculinized ethical theories, and as someone who provides communication and life activities support for adults with significant impairments, I have long wrestled with the challenge of theorizing and applying care ethics in ways that neither denigrate disabled people nor undermine their civic equality.

Care ethicists have tried to shape their theories to cast recipients of care as subjects rather than objects. They have talked in terms of paying attention and the reciprocity of care. I argue that the problem perceived by disability studies scholars stems from care ethicists initially taking as their starting point the relationship between the parent and the young child. While it is understandable that this paradigm was selected as a relatively universal experience and one that has differentiated theorizing from masculine and feminine perspectives, the problem is that an infant or small child is dependent intellectually as well as physically. Thus, care ethics ended up being shaped by theorizing around intellectual dependency. And that led to constructing care as a relationship between those who are fundamentally unequal rather than as a relationship between peers. All the discussion in the world about interdependency cannot undo this “heart of darkness” of care ethics.

The people for whom I provide support represent a group of “care recipients” who challenge the fundamental inequality at the heart of care and thus provide a better starting point for thinking about care and whether “care” is even the best terminology. “Support”—which is empowering—is what people need, so what we should be talking about is “support ethics.” Constructing care as a relationship between people who are not peers works fine for infants and very young children, but it is less appropriate or useful as children approach adolescence and is never appropriate for adults. As I will argue, this is true even for adults who have been labeled as intellectually impaired. Thus, I argue that we should replace care ethics with support ethics, which would involve constructing the paradigmatic support relationship as that between adults who are understood as peers, regardless of intellectual disability labels and regardless of how much support is required, and then work from there to cases such as the parent-child relationship.

In this way, we can benefit from theorizing and implementing an ethic that emphasizes the value of paying attention to the specific needs of others and the skills required to meet those needs, without falling into regarding those with needs to be met as inferior to those who are able to assist.

Care and Technology

Connections between emerging technology learning theories and the political ethics of care

Vivienne Bozalek

University of the Western Cape

There is an increasing use of technology in higher education teaching and learning, and more recently technologies which use social networking tools have been used in pedagogy. The theories of learning which have been used to understand and analyse how technology may transform teaching and learning in higher education have been those which have emphasised the social aspects of learning including relationality and situatedness. More particularly, the theories of Vygotsky and other sociocultural theorists which maintain that learning happens first through the interaction with more knowledgeable others rather than being located in the individual mind, have been used to examine the potential of Web 2.0 technologies to provide opportunities for social learning. The Vygotskian notion that learning happens in relationships between more knowledgeable peers or teachers and learners rather than in the minds of individuals becomes much more of a possibility with Web 2.0 or social networking tools which offer endless opportunities of joint activities.

With regard to the political ethics of care, the notion that the world consists of independent, self-sufficient, equally placed humans, is challenged. Instead there is a recognition that we are all dependent at different times of our lives and dependents all need to be cared for. In addition, the political ethics of care foregrounds difference, particularity, otherness, plurality and context. From the ethics of care perspective, participation is seen as relational and connection-based rather than in terms of atomised individuals, in that care is dependent on a caregiver and a care receiver. Care is also seen as being located in the public and the private spheres. Additionally, Tronto has proposed that the four phases of care - caring about, caring for, caregiving and care receiving have moral values of attentiveness, responsibility, competence and responsiveness associated with each of these phases.

It thus appears that emerging technology learning theories and the political ethics of care have a great deal in common with regard to how human interaction is perceived and in relation to concepts such as relationality and situatedness. It is strange therefore that there have, to my knowledge, been no attempts to examine the similarities between such learning theories and the political ethic of care. This paper proposes that it would be fruitful to consider how the political ethics of care and sociocultural learning theories intersect with each other and also how they differ from each other in certain aspects. The paper further deliberates on how sociocultural learning theories and the ethics of care could be expanded or improved by incorporating a cross-pollination of ideas and concepts which are currently unique to those particular theories.

Care, technology and administration: an ethic of care analysis of the competing demands placed on ward nursing

Mary Darking, Steve Flowers and Flis Henwood

University of Brighton

Within public service professions, a tension is seen to exist between definitions of professional and administrative responsibilities. Where professional responsibilities include the direct care of patients or clients, as they do for social workers or clinicians, these tensions reflect a sense that core professional values are encroached upon by administrative requirements. Information technologies

are frequently implicated in the fulfilment of these requirements and typically add an associated training burden and complexity to administrative tasks. This paper attempts to explore the ways in which tensions around technology use, administration and professional responsibilities are expressed and how a particular group of public service workers – ward nurses – attempt to rationalise requirements placed upon them. Drawing on evidence generated by an evaluation of an ‘electronic patient record’ (EPR) system implementation within a specialist unit of a hospital trust, this paper considers the extent to which technologies used for administrative purposes are understood to enhance or detract from ward nurses’ ability to provide direct care to their patients. In the example reported on, ward nurses refused to implement the EPR system, despite its uptake in all other parts of the specialist unit, on the grounds that it would increase the amount of time they spend on administration and further reduce the time available to them for direct patient care. One of the interesting findings from this research is that ‘what counts as care’ in this context emerges an important arena of debate for nurses. Whilst administrative responsibilities are classed by some as ‘indirect care’ others regard them as ‘non-value added’ work that takes them away from the patient bedside. This research suggests that applying an ethic of care analysis to this area of debate may assist nurses, patients and carers to understand which elements of their administrative and/or technology-based interactions are of value and which pose problems. Through a focus on attentiveness, responsibility, trust, competence and responsiveness it is argued that new analytical considerations and opportunities for intervening in the constitution of technology use within professional carer roles are generated.

Ethical issues in the use of technology based social care

Andrew Eccles

School of Applied Social Sciences, University of Strathclyde, Glasgow

Assistive Technologies (AT) have become an increasingly important aspect of policy making in social care in the United Kingdom. Technological advances mean that these technologies are faster, more flexible and more sophisticated than before and are seen by governments as a crucial way of upholding a policy bias towards care in situ, rather than in institutional care, in a period of demographic change, escalating costs and inconsistent labour supply. This paper focuses on Telecare, currently the major strand of AT policy in the United Kingdom. It looks at three key ethical issues in relation to the Telecare agenda.

First, it considers the framing of the policy discourse around the perceived need for Telecare as a care policy strategy, and the way in which this discourse weaves together demographic change, dependency ratios and costs into a necessity for technological solutions to future care needs. Second, it critically reviews the ethical frameworks currently deployed in Telecare policy discussion and implementation. These frameworks are predominantly bio-medical, which may be better suited to acute or invasive medical procedures. As such, they lack the nuance for appreciating the complexities of long term social care. Here the paper argues that a more relational ethic would be appropriate, but notes the paradox that technological advances mean that actual relationships will increasingly be formed between service users and technological equipment (for example, through remote monitoring of health conditions, telecommunication prompts and reminders and recourse to call centres for assistance).

Third, the paper draws on interviews with front line professionals who are engaged in the assessment for, and deployment of, telecare technologies. Interviewees were drawn from the fields of social care, health and housing. Here there is an exploration of how these professionals view

some of the ethical dilemmas posed by telecare technologies and how they consider, more generally, an understanding of what might constitute good care in an increasingly technology-based world of care delivery.

The paper concludes that, while there is strong and wide-ranging evidence of benefit to be conferred from the use of some of these technologies, a greater range of ethical understanding ought to be deployed. This might make assessment for the use of technology-based care more complex, especially at a time when the trend toward greater inter-professional working carries the risk of minimising complexity in the quest for common professional understandings. But it ought at least to be employed in the wider conceptual discussion around the use of technology in care settings. A key element of this broader understanding would be engagement with an ethic of care, not least in how this approach might illuminate the altered relationships wrought by technology-based care and the remote monitoring of service users, in addition to it offering a depth of ethical understanding currently amiss in the widespread deployment of biomedical approaches to the complexities of social care.

Seeing Again. Monitoring technology and the visibility of care

Ike Kamphof

Department for Philosophy, Faculty of Arts and Social Sciences, Maastricht University

Homecare organizations currently experiment with the use of monitoring technology in the homes of vulnerable elderly people. Through motion sensors combined with information processing tools, this technology gathers data on clients' life patterns and provides evaluations of these data with respect to acute or long term health and safety risks. Monitoring gives care workers 'extra eyes' to observe their clients beyond the direct scope of care visits. This technology allegedly enables healthcare clients to continue living in their own homes longer and allows for more targeted and personalized as well as more cost-efficient care. In healthcare policy much is expected from the use of this technology in light of the managerial and financial challenges posed by an aging society. Monitoring technology is also subject to criticism as to its vast surveillance power. It is argued that it turns clients into objects of care interventions, which aim to manage their behavior instead of supporting them as persons. Care workers fear monitoring will replace empathic human care with cold mechanical observation. This paper addresses the use of monitoring technology as operating in a field of tension between control and person centered care.

A proper evaluation of monitoring technology cannot be based on speculation or fear, but needs to be supported by empirical research. On the basis of fieldwork with 2 homecare organizations in the Netherlands, combined with post-phenomenological analysis of human-technology relations, this paper articulates how the use of monitoring technology mediates care processes. Monitoring technology makes homecare clients visible in new ways. In order to support good care in an ethical sense, the 'seeing again' (re-specere) that this technology allows, has to combine careful perceptual attention with respect for individual clients. To function properly in this respect, it turns out, monitoring needs to be embedded in care relationships in which humans and technological systems actively work together to sustain these relationships. This puts demands on both the cared for and various caregivers, but also on the technological system involved.

Particularly interesting from an ethical perspective is the fact that monitoring technology does not just allow caregivers to observe their clients. It also makes care processes and caregivers visible (again), literally and metaphorically. Firstly, working with monitoring technology brings existing care

dilemmas to the surface again and places homecare workers for new dilemmas. The use of technology thus impels care givers to reflect on their care. Secondly, care activity is made visible by the technology in a literal way, especially when both family and professional caregivers have access to the sensor data. This too opens up space for debate about proper care. Thirdly, by making clients' needs explicitly visible, monitoring exposes care to its obligations to vulnerable people.

Self Care

Care through a queer lens

Sanja Milutinović Bojanić

Centre for Ethics, Law and Applied Philosophy, Belgrade, Serbia

Care is a concept burdened with uses and meanings. It is intimately tied to life, to care for oneself, as well as caring for another. The Latin verb *curare* and its noun *cura* are the carriers of a complementary duality which lies at the base of all thought on the Other. The other is cared for and supervised. The inseparable couple of Care and Surveillance need to be seen together as often as possible in their manifestations. These manifestations are brought about through a series of events, not necessarily causally linked. Philosophy, art, and religion have for centuries articulated the idea of care and its implementation. Each portion of human knowledge that aims at understanding and ordering either the intersubjective relationship or the life in the community has left its mark in the understanding of care. Based primarily on the polarization and the strict interdependence of the subject of care and the object of care in the reciprocal power struggle, a plethora of attempts that “pastoralized” care have missed their target. Care still remains oppressive and paternalistic. Far from preventive and preemptive strategies, the application of the principle of complementarity on the behavior that is described by the denominator *Curare* ought to abolish projections and prescriptions also eradicating the division into internalist and externalist obligations, and hierarchical classifications. The care that develops through a queer lens, surpasses the fear of the paranoid exposure before the other, such that the affirmation of life becomes unconditional. Liberating it from metaphysical and theological layers, especially from neoliberal utilitarian uses, and searching for its origin in Spinoza's *Ethics*, I will endeavor to examine the practice of care through the lens thematized by queer and trans* readings.

What is it, then, which determines the ethics of care that surpasses the subject/object dichotomy? How will it be possible to articulate the mutually contradictory motives of care in the cacophony of the de-theologized practices of care? What forms of care will reestablish the trust in those for whom this care is intended?

As its goal, the paper tries to renew within a framework of political-poetic analysis of the different manifestations of care the broken ties that “call” back to life (“call” in all meanings of the word calling/profession—of faith, of love, vocation and teaching), and back to its various, impermanent, and fluctuating modalities. The complementary way of fulfilling the reason for existence of the “ethics of care” is when it also becomes the “ethics of queer care.”

Self-care, citizenship and vulnerable populations.

Christine Ceci, Vera Caine, B. Cameron, H. Kohlen, and D. Sellman

University of Alberta

Policies and practices intended to convince people to care for and/or manage their own health and health needs have become increasingly prevalent as governments and health systems struggle to cope with rising costs, shifting demographics and what are often conceptualized as unsustainable care burdens. This is often described as a strategic shift to self-care or alternatively, the shift is implied through the growing emphasis on practices and technologies that require and/or enable people to take care of themselves – or both. From self monitoring of chronic illness indicators and an explosion of new self management tools and technologies intended to shift care to patients or families, to programs that encourage people to become ‘expert patients’ to enroll in ‘healthy living’, self-care is everywhere. Yet as a concept that represents a shift in thinking about the relationships between people and the care they may need, we find that self-care is not well theorized. Yet self-care, as a practice, an economic strategy and increasingly, as a cultural imperative, is driving much current policy, practice and research. While citizenship is at times called upon in the debate on self-care and responsibility we wonder about the political consequences of the link between self-care and citizenship. The central purpose of this paper is to examine the changing meanings and practices of self-care in health care for vulnerable people, and to explicate the ethical and political implications of the observed shift to self-care and the responsibility of others in health policies and practices.

Self-care as a relational practice: developing an ethic of care for ‘healthy living’

Roma Harris, Flis Henwood and Philippa Spoel

University of Western Ontario; University of Brighton and Laurentian University, Sudbury, Canada

Health care policy in Western countries increasingly emphasizes individual responsibility for health. For people who are coping with chronic disease, this may mean taking on complex self care duties that, in the past, were performed by paid health workers (see, for example, Oudshoorn, 2008). For the general public, the policy translates into the obligation to be informed about health matters, to avoid risky behaviours, and to practice ‘healthy living’, particularly with respect to food choices and exercise habits (see, for example, Ontario Ministry of Health Promotion, 2006).

In this paper, we report results from a study with older Canadian and UK adults who were interviewed about how they understand ‘personal responsibility for health’, ‘healthy eating’ and ‘active living’ and how they take up these ideas in their own lives. Our goal in the study was not to assess the respondents’ actual success in achieving ‘healthy living’, but to understand how people who are downstream from government policy engage with the ideas that shape what it means to be a ‘good’ citizen.

Our findings reveal a general willingness on the part of the respondents to accept the obligation to keep themselves healthy. Indeed, many of them described complex efforts and intricate routines by which they work to live up to this obligation. The respondents’ accounts also suggest, however, that attempting to practice healthy living is both isolating (because ‘it’s up to you, the individual’) and involves creating new connections (real or virtual) that are outside traditional supports from the formal health care system.

In this paper, we understand respondents' attempts to forge such new connections as reflections of their continued need for external support to stay motivated, i.e., to 'keep myself going', to find others who struggle with similar issues or share a similar world view, and/or to find new and dependable sources of information and care ('because the doctor's too busy, isn't he?'). These accounts suggest that policies that emphasize personal responsibility for health and self-care by off-loading health 'care-giving' to individual citizens or 'health consumers' do not eliminate the need for 'care by others' but rather oblige individuals to repopulate their care networks in new ways. We explore the significance of an ethic of care approach for developing an account of contemporary self-care practices that recognises their relational and interdependent character.

Teachers as Mothers in the Elementary Classroom: Negotiating the Needs of Self and Other

Jennifer Hauver James

Department of Elementary & Social Studies Education, College of Education, University of Georgia

Caring is essential to teaching. Students who experience caring presence with their teachers are more likely to develop the self-esteem and trust necessary to take risks and reach higher levels of academic achievement (Goldstein & Lake, 2003; Helm, 2007). Of course, teachers ought to care for their students. But how should teachers care? And how much?

In this presentation, I will draw on a year-long narrative inquiry of six women primary school teachers in the United States, asserting that teachers' constructs of caring often reflect a conflation of mothering and teaching. Particularly because these teachers worked with children who they believed lacked adequate care at home, they ascribe themselves a great deal of responsibility for students' social, emotional, physical and moral development. I will highlight literature that delineates the many ways such thinking is problematic for students. I will then make the case that the assumption of such responsibility is equally problematic for teachers.

The dominant notion of caring embedded in these women's constructs of teaching demanded that they give of themselves even when it meant not tending to their own emotional, social or physical well-being. When they resisted this notion, they were labeled "uncaring" and "selfish." Increasing resentment at their colleagues' judgment resulted in their alienation from peers and thus limited possibilities for social and professional engagement. Such consequences were particularly poignant for women teachers who chose not to, or could not become mothers themselves.

Findings from this study challenge the benevolence of traditional gendered notions of caring that emphasize selflessness and sacrifice (Noddings, 1992). Within the teacher-student relationship, as with the mother-child relationship, it is often expected that as teachers care for students they will be, in turn, rewarded by evidence that their caring has made a difference in students' lives. Women teachers (and mothers) will be further rewarded, it is assumed, by the increased sense of attachment that develops from engaging in caring relationships. Constructs of caring that reflect these assumptions, however, fall short of the "inclusive" solution described by Gilligan (1988) in which women, themselves, are recipients of care.

Despite increasing attention to a conflation of teaching and mothering in education literature (McBride & Grieshaber, 2001; Collins, 1998; Grumet, 1988; Fisher, 2001), the debate over the role of maternal thinking within the field of teaching remains largely theoretical. This aim of this presentation is to situate these more theoretical conversations within the lived experience of women teachers.

Reconceptualizing Care

Tove Pettersen

Department of Philosophy, Classics, History of Art & Ideas, University of Oslo

Care ethicists have contributed substantively to our understanding of care and its significant place in human life and society over the recent decades. However, despite an extensive discussion, there is no consensus on how to define care. Care can be construed in many ways; as a sense of concern, a practical task such as nursing the sick; it can be perceived as women's unpaid domestic work, an innate female disposition, a suppressed moral value capable of challenging patriarchy, a private or a civic virtue, a gender-neutral political concept, a citizenship issue, as the outcome of a welfare state or as paternalism in disguise, etc. Even if a full consensus never will be achieved, it is nevertheless crucial to continue the job of uncovering and scrutinizing different aspects of care, both in terms of practices and comprehensions. This is because our understanding of care, as Joan Tronto (1993,21) points out, is linked to structures of power and inequality. How care is conceived is clearly decisive to how situations involving care are perceived, acted on and evaluated, and how carework is distributed.

In this presentation I shall conceptualize and discuss some possible ways of understanding care with regard to the relation between care for ourselves and care for others. First, I want to articulate some of the difficulties arising from what will be termed altruistic care. Altruistic care is a comprehension where one holds that 'the interests of others, rather than one's own, ought to be prioritized'. As care work traditionally has been distributed unequally between gender, race and classes, altruistic care have had – and still have – significant social and political implications. However, in contemporary, western societies, there are also strong emphases on self-care, or what I will term egoistic care. Egoistic care can be understood as a comprehension where one holds that 'the interests of ourselves, rather than others, ought to be prioritized'.

Starting from the premise that in every society, some people (such as infants, elderly, sick, injured etc.) are dependent on the care of others, I shall discuss certain theoretical and practical problems with regard to both altruistic and egoistic care. Then I will argue in favor of a different concept, referred to as mature care. Mature care aims to highlight the relational aspect between persons involved in a caring relationship, as well as the wider web of relationships of which the carer and the cared for are a part. In particular, mature care intends to balance between caring for ourselves and caring for others. It emphasizes that care cannot be seen solely from the perspective of the carer, nor from the perspective of the one cared for. I will assert that mature care can serve as an ethical and political guideline when deliberating on how to distribute care between ourselves and others, a guideline aiming at eradicating structures of power and inequality when it comes to care.

Exploring self-care as self-in-relation to others

Lizzie Ward

School of Applied Social Science, University of Brighton

This paper examines self-care and the ways in which it is conceptualised and mobilised within policy discourses. It explores how an ethic of care perspective used critically can help us understand: the

implications of 'independence' and 'dependency' for self-care; issues of recognising our own needs for care; and the difficulties of accepting care. Using an ethic of care framework to critique dominant conceptualisations of self-care, it argues for a greater articulation of self-care as a way of recognising the universality of care needs and the relational nature of care. It goes on to explore this argument in relation to ageing and care using empirical research on older people and well-being. Finally it reflects on the implications for care practices in relation to older people's care needs.

There are at least three ways in which can think about self-care:

1. Self-care as the 'governance of self' – linked to rationalist policy objectives which aim to make citizens responsible for their own health and well-being. Evidenced within UK policy initiatives aimed at behaviour change, for example the Health Trainers programme, the Expert Patients programme, the 'Active Ageing' agenda.
2. Self-care as consumerism – the self, mind and body, as a site of consumption and encompassing a range of 'markets' aimed at self-improvement from 'pampering' and anti-ageing products; emotional personal development and well-being to physical fitness regimes.
3. Self-care as recognition of the universality of human care needs, part of the relational processes of care - both giving and receiving - and central to human interdependence. Self-care can only be fully expressed as self-in-relation to others.

Whilst the first and second understandings are part of the neo-liberal hegemony of Western political thought, the third from an ethic of care perspective, challenges the notion that we are autonomous, self-actualising individuals, seeking to maximise our own self-interest through rational choices. How does the autonomous / rational normative framework impact on our capacity to recognise our own needs for care, fuel our aspiration for independence and our disdain for dependency?

These questions will be explored by drawing on research findings that illustrate the difficulties older people experience in acknowledging care needs; asking for and accepting help; feeling that having help makes you 'a burden'; adjusting to care needs (both as a giver and receiver), role reversals in relationships and adapting to changes in identity – of moving from someone who has 'cared' to someone who needs care.

The ethic of care principle of attentiveness suggests that care-givers need to be aware of their own care needs (Tronto 1993) but this can also apply to those who are to receive care. This opens up the concept of self-care to one that encompasses self- in-relation to others, beyond meaning more literally 'caring for one's self'. Recognising and accepting care as we age is a difficult process for many people and one that has to be worked through and negotiated through caring processes and relationships. Greater awareness of this aspect of ageing could contribute to understanding care needs in old age and developing more appropriate care practices.

Family / Friends

Care beyond the 'sexual family'

Brunella Casalini

Faculty of Political Science, University of Florence

According to Katherine Franke and Mary Ann Case the way feminists deal with the topic of care labour hides a “repronormative” view –an emphasis on the value “of women’s reproductive labor such that maternalization of female identity remain intact” (Franke 2001, p. 184). It is true that when talking about the unequal division of care labour within the family feminist literature has focused heavily on heterosexual families with children. In *Justice, Gender and the family* (1989), Susan Moller Okin writes that the revolution yet to come is about an equal division of family responsibility and children care by both parents. Equally shared care labour between men and women might contribute to more just families, and, according to Okin, can have an another positive effect: “children of both sexes in gender-free families would have (as some already have) much more opportunity for selfdevelopment free from sex role expectations and sex-typed personalities than most do now” (Okin 1989, p. 184). Okin doesn’t challenge the fact that the family is founded upon heterosexual marriage; she assumes as given the institution of marriage. Thus, as Young points out: “[...] Okin writes as though the primary issue of gender justice is the distribution of household and child rearing tasks, and the distribution of paid work, between husband and wife” (Young 1997, p. 1). To answer effectively to Franke and Case’s critiques we have to rethink the family focusing not on marriage but on the value of informal caring and intimacy relationships and on the satisfaction of emotional needs. As Fineman (1995, 2004, 2009) suggests we need to go beyond the idealization of the sexual-nuclear family as the “sole institutional response to dependency”. A redefinition of the family that reflects the diversity of contemporary families appears today an important step to address the crisis in care. As some feminist authors suggest (cfr. Fineman, Minow, Polikoff, Woodhouse, Levy, Young, Metz, Williams), we need to extend formal legal recognition and public support to a variety of relationships such as “chosen family”, “fictive kin”, extended family and other forms of relationships involved in caregiving and mutual responsibility that fall into the category of “functional families” (MaClain 2006; Stacey 2003). A caring society must guarantee the material conditions to sustain such relationships and “take upon itself the primary responsibility of maintaining structures that will support the principle of care” (Kittay 1993). Expanding our idea of what counts as family is necessary to deal with the complex sociological reality of today diverse family forms (cfr. Roseneil and Budgeon 2004, Hines 2007) and with the demands and risks of intimate caregiving.

Ethics of family and care in healthcare 1

Janice McLaughlin and Marian Verkerk

PEALS, Newcastle University, Ethics of Family in Health and Social Care Research Consortium and Expertise Centre Ethics of Care, Groningen University, Ethics of Family in Health and Social Care Research Consortium

Ethics of care and relational ethics have done a great deal to challenge the centrality of the individual and their ability to act with autonomy to discussions of rights and the good life. Individuality has been decentred by placing people within the care relationships which inform both what they value and who they are. Family care relationships have always been an important part of the ethics of care debates; given the significance of family to the caring relationships which people are usually part of throughout their lives. There have nevertheless been tensions about how family should be conceptualised within such debates. Feminists have been nervous about any explicit or implicit sense of seeing ‘family’ as inherently better than other forms of relationship, particularly when this is associated with its roots in the private, nature and biology. This paper (and the ‘sister’ paper by Professor Marian Verkerk) will explore ways to recognise family within ethics in ways which acknowledge two important issues. 1) That families are spheres of power as well as care, meaning that not all actions or values within families are necessarily positive and nurturing. 2) Families are not always based in biology and can be made up from a variety of ties and senses of belonging that

bring with them notions of obligation and responsibility. Focusing on the context of health care, the paper will explore what kinds of familial patterns of care sustain people through ill-health by enabling them to feel part of care relationships within which they are nurtured; make decisions about their care and treatment which are respectful to who they are; and be recognised by themselves and others as valued human beings within and outside their family ties.

“I was the apple of his eye and he was the apple of mine”: informal care, status inclusion and self-empowering dynamics.

Alessandro Pratesi

Department of Social Studies and Counselling, Faculty of Social Science, University of Chester

Care work may be connected with emotional and psychological exhaustion but also gratification, reward and self-empowerment. Caregivers experience both positive and negative emotional states in caring situations, and further studies on the rewarding and energizing aspects of care may help us to broaden our understanding of how we can reduce the degree of burden while increasing the sense of satisfaction.

Broadening and intertwining the conceptual categories of care, gender and emotion, this paper discusses the dynamics of inclusion/exclusion and the consequent outcomes of inequality people produce while caring for others. It reports the findings of a micro-situated study of daily care activities among 80 American, upper-middle class caregivers, different in terms of gender, sexual orientation, and marital status. Although several examples of care situations taken from the sample of 80 caregivers will be discussed, this paper will mostly focus on few case studies. It will show how emotions represent a necessary step to show the ambivalences and the grey areas connected with the concept of care as well as to challenge the not fully explored assumption that care is often associated with burden and stress and viewed as a result of circumstances.

The theoretical framework draws on those approaches to the sociology of emotions that have already inspired a rich research agenda, establishing important connections between micro- and macro- levels of analysis and addressing the emotional mechanisms through which social structures are interactionally and situationally reproduced. In particular, the research here presented draws on Collins' theory of Interaction Ritual Chains (2004), according to which the emotional dynamics underlying the social structures are based upon feeling of status inclusion in groups or coalitions.

The phenomenological analysis of the 'meanings of care' presented in this paper 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 caregivers. One of these elements concerns the energizing 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. This paper sheds light into the less visible and often unexplored aspects of care, i.e. the interactional mechanisms through which the emotional dynamics revolving around care produce unexpected outcomes in terms of status inclusion and self-empowerment.

Care as Regulated and Care in the Obdurate World of Intimate Relations: Insights from Foster Care in Wales

Alyson Rees and Andrew Pithouse

School of Social Sciences, Cardiff University

This presentation first outlines care as a formal construct of a highly regulatory approach to being looked after in the setting of foster care. We then move on to consider foster care and its expression within the interdependencies and everyday moral “workings out” between people in caring relationships that cannot easily be reduced to some professionalised and contractual encounter. We show how these relationships are partly informed by exterior regulation, but also emerge predominantly from care as a daily human activity in which the self exists through and with others. Drawing from an extended in-depth qualitative study of ten foster families deemed to be good examples of successful care, we examine the moral texture of the foster family in regard to three areas of everyday domestic life that are often taken for granted and rarely researched as constitutive of care: food and its symbolism, issues of the body, and aspects of touch. In doing so, we position care and its ethical manifestation within the realm of identity (the fostered child as serial stranger), the relational (who are ‘family’?) and the motivational (fostering as ‘gift’). We conclude with a brief reprise of foster care understood as intimately contextual in contrast to its more formal construct as a professional and regulatory discipline.

Caring after death and embodied relationality

Jane Ribbens McCarthy and Raia Prokhovnik

Centre for Citizenship, Identities and Governance, Open University

This paper investigates and reassesses the key case study of the social and personal meaning of death to explore the light this throws on the significance of embodied relationality. The feminist ethic of care highlights as a political as well as moral issue the role of care throughout life, including on-going reciprocal caring for close others. However, the contested field of meanings around care and relationality can be further explored and analysed through the specific case of caring for a loved one after their death. Care after death graphically provides a means for rethinking and extending both the political and experiential character and value of feminist ethics of care work. It also raises key issues about the materiality of the body and the boundaries of the self.

The importance of developing a relational understanding of care after death derives in part from the continuing significance in Western societies accorded to a mind/body split. This binary can be seen as active in the social value given to biology as a pre-social bedrock, which operates as an obstacle to re-valuing the body as material, corporeal, enfolded. A focus on death brings the significance of bodies and embodied experience into sharp relief, in which relationality may be seen to be both deeply embodied while also transcending embodied experience. Yet the dominant social values around the death of a loved one lead directly to the underestimation of the significance of the physicality of grief and to the biologisation of the dead person. What is missing is the understanding that the embodied relationship with the dead person does not die with the person.

The outcome of the relational logic is to value more highly the materiality of the lived body, alongside the positive qualities associated with mind, and at the same time to value more highly the dead person as not wholly absent just because the physical biological body is gone. The lived person’s experience as a deeply embodied materiality as well as being in some sense free of their

body, is the source of their capacity to engage in relationality and relational care. Rethinking the lived reality of the material, corporeal, visceral, fleshy, seeping, affective embodiment of the person provides a basis for revaluing all that the now dead person brought to their relationality, much of which remains.

Drawing on diverse materials and ideas, from published and personal autobiographies to Wittgenstein's and Arendt's philosophical work, to cross-cultural evidence on the significance of continuing bonds in caring after death, we explore ideas of embodied relationality that cannot be easily contained within the dominant categories of liberal Western thinking.

Paradoxes of mothers care work after separation/divorce in (neo-liberal) Canada

Rachel Treloar

Department of Sociology and Anthropology, Simon Fraser University, Canada

This paper describes the collective impact of neoliberal discourses of 'choice' and 'responsibility' and familialistic policies and practices on the physical, psychological, and economic health and well-being of separated and divorced mothers. First, I examine the gendered nature of parenting after separation and divorce in Canada. Secondly, I draw on secondary data concerning mothers' primary care work of parenting after separation and divorce, and on examples from Canadian family policy. Recent policy decisions have been justified with reference to the principle of *family responsibility*; while at the same time promoting personal responsibility and independent choices. The concept of 'choices' minimizes women's difficulties in navigating the tensions between their productive and reproductive lives; promoting a limited and neo-liberal view of work that obscures the gendered dimensions, material costs, and health implications. I suggest that the ways in which mothers exercise choice with regard to self-care and familial caring roles are both shaped by, and rooted in, the socio-political context of neo-liberal reforms. In British Columbia, for example, the government has cut back funding to community agencies that support women and eliminated funding for most family law issues, while at the same time introducing reforms that involve reducing costs to government and a moral emphasis on parents' shared responsibility for their children. Carol Gilligan (1982), suggests that mature moral development for women involves balancing ones care for self with care for (and of) others. In other words, self-care is part of a relational field. However, a revamped BC Family Law Act requires that the best interests of children are the only consideration when making decisions concerning their care and residence. Finally, I conclude by raising potential questions for discussion: what would an ethic of care framework look like if applied to family law reform in this context (and how might we continue to build on the seminal work of Sevenhuijsen, Smart and Neale, and others in this area)? What are the paradoxes of self-care in this context? How might notions of responsibility and choice be reformulated to better support mothers to balance care for/about others and self-care in this context?

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Marian Verkerk and Janice McLaughlin

Expertise Centre Ethics of Care, Groningen University, Ethics of Family in Health and Social Care Research Consortium and PEALS, Newcastle University, Ethics of Family in Health and Social Care Research Consortium

The family has always been seen as the location in which most personal care is given and received. But families are diverse and not all close relationships are kin relationships. This presentation asks: can recent work on reviewing and rethinking families contribute to developing care ethics through understanding how care works in diverse intimate contexts?

In families, one is supposed to bear special responsibilities toward its members. Phrases such as 'it is family' or 'you look after your own' are common elements of public discourse. Still, it is not clear what justifies these special obligations or responsibilities. Also, there are many examples of close relationships that seem to bear this kind of special responsibility, but yet are not based on ties of biology or marriage. In various aspects of life the specific character of this kind of responsibility once scrutinized becomes less obvious. One area where we can see this is in the field of genetics. On the one hand, genetic counseling practices in cancer genetics imply individuals have special responsibilities (usually of disclosure) towards family members whom they have never met, simply because they share genetic inheritance. On the other hand, new developments in genetics and reproductive medicine seem to create new forms of altered kinship with its corresponding responsibilities.

Therefore, the simple fact that someone is biologically related to someone is not enough reason to have an obligation towards him or her. Although family relationships count, the history of that relationship and the particulars of the relationships and situation also count in determining the moral weight of responsibilities and obligations that we have towards each other. Assigning responsibilities are only intelligible within the background of existing practices and their normative expectations.

In short, it is not immediately clear what makes an intimate and close relationship special in terms of its responsibilities to care. At least two considerations should be taken into account: (1) in so far that a person is vulnerable to my actions (2) the history or narrative of my relationship with that person. Care in families also should be seen therefore as a contested practice, in which responsibilities are negotiated. This generates questions such as: Do we have a shared narrative that gives rise to responsibilities, or what makes you so special and vulnerable to my actions? These questions will be explored via drawing illustrative examples from the fields of palliative care and genetics.

Communities of Care: Exploring expressions of care in cultural communities

Nicki Ward

IASS, University of Birmingham

As indicated above, this paper bridges a number of the conference themes to consider the notion of communities of care.

Within a policy context the role of carer is usually defined either in relation to familial relationships or professional care. In the context of informal care one person is usually designated as the carer and one as the cared for and there is assumed to be an ongoing close personal relationship between the two. This paper moves away from that notion to consider the way that care is expressed and delivered between members of cultural communities. Building on Tronto's argument that care is a '*...species activity that includes everything we do to maintain, continue and repair our 'world' so that we can live in it as well as possible*' (Tronto and Fisher quoted in Tronto 1993:103) it will explore the care expressed by strangers and acquaintances in two contexts.

Drawing on examples relating to both Transgender and Pakistani communities, captured through personal narratives, this paper considers how the principles of an ethic of care are demonstrated in everyday life to develop an understanding of how care works in diverse communities. Participants will be invited to share their own examples of caring communities and alongside those of the presenter these will be used to consider the importance of the principles of care ethics to public life and explore care as a moral principle in civil society.

Care for Strangers

A critical ethic of care for the homeless

Kathleen Collins

Department of Social Work, University of Johannesburg

This paper presents dilemmas of service delivery for the homeless according to Tronto's ethic of care (1993). The empirical research for the application of the four moral attributes contained in the ethic, emerges from the work of an Anglican Church endeavour in Cape Town, South Africa, called U-Turn, which uplifts street people. U-Turn provides services for the homeless surrounding re-entry to society. Services are divided into three phases of relationship, rehabilitation and re-integration (www.homeless.org.za, accessed 17.01.12) involving professional and voluntary care. An ethnographic account of my role as a volunteer-participant in the soup kitchen, with social events and with networking for the homeless is given, as well as a quantitative account of trends of the process of homeless clients through the three re-entry phases over the past three years. The significance of the Christian base for care and the insecure progress through the phases, including the value of this kind of service to the sectoral community which accommodates the homeless are debated in the paper.

The numbers of homeless people living on the street in South Africa were estimated at several million of the population of 49 million people in 1998 (Olufemi, 1998). These numbers are growing as the unemployment rate rises, at present calculated at 30% of the population (Webster, 2010). Homelessness in South Africa is perceived as due mainly to socio-economic factors, unlike the situation in Europe and the United States, where the emphasis is placed on the infra-structure and quality of service delivery (Von Laere & Withers, 2008). The homeless in Western countries typically suffer from mental health problems and are marginalised from social and medical care (Schout et al., 2001). In South Africa, given the paucity of medical and social services, the homeless are not so much marginalised as help simply not being available. The state does not provide at all for the homeless as an identified group, instead, financial support extends to social grants for children up to 18 years from low income families, for disability and for the elderly, which usually exclude the homeless. With medical attention, the homeless take their place in the queues at public hospitals and clinics. Specialised services are left to voluntary organisations which supply care in the form of shelters for overnight accommodation, some of which are accompanied by social assistance. There are 52 such shelters in the greater Cape Town area of 5 million people, admittedly insufficient for the demand but also complicated by their lack of popularity amongst the homeless themselves.

Although political factors affect the situation of care of the homeless worldwide (Schout et al., 2011), in South Africa there are unique factors of the post-apartheid government policies stressing

the redress of inequality. These policies have given rise to expectations of care, especially amongst the black people as disadvantaged under apartheid, which have not been fulfilled (Ramphela, 2008; Jansen, 2009). A critical analysis of care for the homeless, representing the extreme end of poverty, is long overdue.

From Immersion to Process: The Empathic Turn in Pursuit of a Caring Ethic in International Development

Diego de Merich

London School of Economics

In the context of International Development, the language of rights and justice has been used – both within the Right to Development [RTD] Literature and as a grounding for the Millennium Development Goals [MDGs] – as a philosophical and discursive bridge between self and ‘distant other’. The idea, that all societies *and* each individual have a ‘right’ to development, universalizes the ‘why’ of the debate without ever fully interrogating the ‘what’ and the ‘how’. We are meant to understand that distant strangers have the right to Development without much serious regard for what Development means to that stranger or how it might best be achieved. As a result, the MDG project has sought to ‘fast-track’ an outcomes-based understanding of Development by piggy-backing on the rights discourse and institutions already employed within the United Nations framework. In so doing, the ‘stranger’ is made proximate by a series of tick-boxes which chart the economic and material ‘success’ of his or her ‘development’.

Leaving aside the common objection to rights discourse within the context of International Development – what good is a right to someone who is unable to exercise it? – the purpose of this paper is to examine the possibility of a post-MDG framework which takes an ethic of care, rather than an ethic of rights as its starting point. Here the stranger is made proximate not by abstract right, but through a better articulated and purposefully implemented empathic processes. While Care Ethics literature has often vacillated between those who see care and justice as complementary and those who see care as simply an addendum or affective nuance, I seek to explore the transformative possibility implicit in the relational ontology of human interdependence. I suggest that while Michael Slote is correct in his assertion that empathy is the foundation of any transformative understanding of care, his implied focus on ‘affective response’ misses the nuanced cognitive-affective functioning of empathy. Between affect and cognition, self and other, empathy provides a hermeneutical device, best described by Louis Agosta, by which we might understand the ‘human potentialities’ of both self and other – potentialities which are at the heart of any transformative discussion of human development.

To bridge the divide between Development and Care, theory and practice, I examine the recent literature on ‘immersions’ – placing development workers within ‘host families’ – in comparison to the ‘empathy in action’ activities of the International Children’s Development Programme, or to Michael Morris’ democratic ‘process model of empathy’, to demonstrate the difference between a discrete empathic intervention and an empathic process. I argue that it is the latter which is both foundational to and instrumentally necessary for any future in which ‘caring’ Development is to be realized.

Abstract Caring Relations: Extending Care Beyond the Inner Circle

Rachel Fedock

CUNY Graduate Center, Brooklyn, New York

Since the ethics of care first arose as a reaction to traditional ethical theories that promote abstract, impartial, and universal principles, care ethicists have begun to fill in the gaping holes of morality at the very least and at most attempted to create a new and distinct ethic. The promotion of understanding concrete situations, partiality, and a flexible ethical outlook, accompanied by caring emotions is the backbone of this feminist ethic. However, some have come to criticize the ethics of care for the very tenets it promotes. For instance, some worry that partiality could lead to morally objectionable outcomes if left unchecked. Many care ethicists may be inclined to deny that wealthy parents who lavish their children with extravagant gifts and never donate time or money to those in need are indeed caring. But how is the care ethicist to value and promote partiality without ignoring the needs of others? In this paper, I will suggest first that we are engaged in concrete and abstract relations of care, and second that we can make sense of abstract relations when care is understood as involving caring emotions and practical doing, either actual or counterfactual. Finally, I will argue that creating and maintaining such abstract relations should be required by an ethic of care when one is able and has the means.

Concrete caring relations consist of those typically described by theories of care, such as the near and dear, but also those we have communicated with directly. Abstract caring relations extend towards distant others or even those not so distant with whom we have had no communication. Both kinds of relations involve caring emotions and practical doing, but they differ in that concrete caring relations require at least some *actual practical doing* whereas abstract caring relations may need only *counterfactual practical doing*.

For instance, the struggling Westerner who does not and will never have the means to visit X distant land, but feels the emotions of care (such as concern and sympathy) towards those in need in X, is motivated to help at least partly by such emotions, counterfactually would do the care work if she could, and alternatively donates money, is still caring and such caring would constitute an abstract caring relation on this account. Contrastingly, the wealthy CEO who feels no concern and sends money to charity for the purposes of good “public relations” is not caring and hence not in an abstract caring relationship. Alternatively, the CEO who sends money, feels sympathy, has the means to do the care work and plans to do it is caring and in an abstract caring relationship, soon to be realized as a concrete relation. Further possibilities of the complexities of concrete and abstract relations will be expounded in this paper. Lastly, I will argue that if we do not extend care to include such abstract relations, care may in the end fail to be a genuine ethic.

Critical Care and Medical Migration

Teodora Manea

**University of Medicine and Pharmacy, Romania, and Centre of Ethics and Health Policies,
University of Exeter**

In order to find a better approach for understanding ethical issues connected to medical migration (MM) I adopt an ethic of care perspective. The ethical dilemmas implied by medical migration from poor to rich countries is very hard to be solved in terms of traditional ethical theories. The main conflict that persists is that between *individual autonomy* and *social responsibility*. On the one hand, the individual should have the right to *leave* their own country to achieve a better life; on the other,

the *countries*, especially the poor ones, should have the moral right to *keep* the physicians, as an important social *resource* in whose formation they invested money and logistic. The key concepts of duty, responsibility, autonomy and free will seem to fail in solving the moral conflicts generated by medical migration. How could the *ethic of care* approach enrich the ethical discussion on MM? I place the individual and the countries in the context of care relationships, to give a more concrete form to duties, responsibilities and migration motives. With this purpose, I intend to analyze the following topics:

1. **Care for the next.** The physicians from poor countries have an immediate moral duty to *care* for their *families* in the first place. In many cases this is the first motive underpinning the decision to emigrate. The general philosophical premise structuring this argument is: “care for your *next!*”, which has more moral power than “care for society!” I will follow Rorty’s distinction between *final vocabulary* and *contingency* to justify this point.
2. **The dialectic: care giver – care taker.** The *inequalities* of relationships in care processes are real and *unavoidable*. They should be understood and theorized as they are. Every individual is at the same time in a complicated net of various relationships as *care-giver and care-taker*. The *care giver – care-taker* relationship is reversible and time related, so that every person will transform from care taker to care giver in different life phases. The physician is ipse facto a *care-giver*, but as a migrant in a new society this position will be more vulnerable and a *caring society* will be needed for them to provide medical care. (For this point I will comment on Noddings and Hoagland)
3. **Caring society.** I will extend the understanding of *care* from the individual level to *country* level. A caring society is a *pull factor* of MM, in contrast to a society perceived from its own citizens as a less caring one.

My theoretical investigation is completed by qualitative research consisting in interviews, participant observations and case studies medical migration between Romania and the United Kingdom.

Care, Place and Space

A relationship between the ethics of care and Māori worldview – the place of relationality and care in Maori mental health service provision.

Tula Brannelly, Amohia Boulton and Allie Te Hiini

School of Health and Social Services, Massey University, Wellington, New Zealand; Whakauae Research for Maori Health and Development, Whanganui, and Tui Oram, New Plymouth

Concepts that are central to Māori worldview are also central to the ethics of care and, in Māori mental health practice, are central to engagement with service users. Values such as *manaakitanga* (hospitality, kindness), *kaitiakitanga* (guardianship) and *whanaungatanga* (relationship, kinship, sense of connection) guide practices of relating and inclusion. Introduction in the relationship is stated through *whakapapa* (literally genealogy) which provides each of the participants with an indication of the others’ social standing. In addition, process for engagement is provided (*tikanga*) including access to elders (*kuia* and *kaumatua*) for support in difficult decisions.

This presentation draws on research which investigated practices of Māori mental health nurses. In a focus group, Māori mental health nurses discussed their dual responsibilities as Māori working in a Western context of mental health services, whether in mainstream services or kaupapa services, for Māori by Māori. The nurses focused on connection through relationships with service users and whānau (family) and the commitment to meet needs when working within communities with little resource. The nurses also discussed care for each other to share knowledge and prevent burnout, and the role of the different work environments as a source for sustaining care. Being a member of a particular community brought with it the responsibility to meet the needs of that community and resources and action was taken which blended work with community.

The effects of colonisation are far reaching in terms of the impacts that lost land and connection to the land have had on Māori. In Aotearoa New Zealand, Māori are overrepresented in mental health services and in poor housing, education and employment. One aspect that could be better understood is the way in which kaupapa services work within their indigenous communities to promote health and wellbeing. One way that this understanding can be reached is to analyse practices from an ethics of care perspective to examine the aspects of the integrity of care (Tronto 1993) and create a political space (Tronto 2010) to reflect on care practices.

Critical geographies of care: Regaining the politics of social reproduction

Rosie Cox and Kendra Strauss

Department of Geography, Environment and Development Studies, Birkbeck, University of London and School of Geographical and Earth Sciences, University of Glasgow.

This paper examines the possibilities for bringing together the concepts of ‘care’ and ‘social reproduction’ to extend the political valency of both. The concepts of ‘care’ and the ‘ethic of care’ have recently become popular within academic geography, at a time when the concept of social reproduction is perhaps less fashionable. ‘Care’ has been used widely by geographers, not just by those working on topics normally thought of as ‘care’, such as care for children or the elderly, but also by geographers working to understand and critique our relationship with the natural environment and with near and distant human and non-human ‘others’ (see Popke 2006 for an overview). Work on caring consumption and food production has been especially strong and Fisher and Tronto’s (1991) definition of care as a ‘species activity’ has been particularly useful to geographers seeking more just relationships between people and the natural environment. Notably it is geographical research in areas such as these, rather than that focused on care work directly, which has been at the forefront of celebrating the transformative potential of the ethic of care (Cox 2010). At the same time the concept of social reproduction is still used to great effect by some writers (see for example work by Cindi Katz and Strauss forthcoming) seeking to highlight systemic relations of inequality. Reflecting on this particular engagement with notions of care, this paper discusses the use that has been made of both concepts within the recent geographical literature and argues that they could be more productive if they were brought into dialogue with each other. We argue that the concept of ‘care’ has offered an optimistic philosophy which engages many people and highlights the humanity of caring interactions as well as attending to the non-human world. However, ‘care’ has been chaotically (and increasingly broadly) defined and conceptualised in some literature to encompass both attitudes or values and particular tasks – care as disposition and care as a form of work. This has resulted in a lack of clarity and an ontological uncertainty which reduces the purchase of the concept. At the same time the concept of social reproduction foregrounds the unequal relations inherent within caring and can reveal why regimes of care reproduce unequal relations within society. ‘Social reproduction’ is not a political goal in the same way as an ‘ethic of

care' but it is an analytical framework which inherently relates reproductive labour to productive labour and therefore to structures of inequality in society. A dialogue between the two concepts offers both the possibility of more coherent critique and a radical political vision which is greater than the sum of the parts.

Exploring an ethic of care in relation to place and the natural world.

Beatrice Gahagan

Age UK Brighton & Hove

Over the last few centuries, human beings have come to see themselves as separate to the natural environment and prior to other modes of nature. This is not only because, through processes of urbanisation, industrialisation and mechanisation, humans have come to live increasingly separately from nature. It is also a function of the huge changes in consciousness that have occurred during this material evolution. The enlightenment, Cartesian philosophy and Newtonian Science, and the conceptual frameworks within which most academic thought addresses nature are basically mechanistic, instrumental and anthropocentric. As Jung and other writers have expressed, the historical shift started by the scientific revolution has resulted in the repression of other forms of psychic participation in the world. The emergence of a secular scientific philosophy entailed a process of separation of consciousness, from being a like part of a given universe, expressed and articulated in terms shared with the universe into a separate tool working from the outside, without affinity or association to the objects from which it gains knowledge. Thus through the development of modern forms of thinking, and what have become the unquestioned dogmas of our scientific world view, certain states of consciousness that provide a means of relating to our environment have become somewhat buried. This inherent anthropocentrism is something that is difficult to fully appreciate and yet the task of understanding ourselves in relation to our environment makes detachment from this perceptive an essential problem to overcome.

An Ethic of Care philosophy offers us something helpful in this context. Ethic of Care principles imply processes that are interconnected and ongoing - a perpetual exchange between inner subjective states and the reality of others and otherness. Crucially, an ethic of care demands our psychic participation. It involves experiencing from within, the fabric of contexts, situations and the experiences of others with whom we are connected and using these to guide our own responses and actions. We can apply this psychic participation to our relationship with the places we inhabit and the natural world in which our own fabric is also interwoven. Rather than seeing ourselves as separate subjects in an inanimate world of objects we can open our consciousness to one of relationship and exchange with our environment. This is in contrast to viewing our world as basically inanimate and mechanistic and ourselves as the sole inhabitants of a private subjective life.

This paper explores how an ethic of care for space and place might offer us the experience of reciprocal interchange with other living beings and realities connected both in an interior subjective sense and exterior physical one. With its living principles of attentiveness, responsibility, competence, responsiveness and trust, we find a potential that can connect us to the natural world upon which we depend and the places which we inhabit and live our lives. Drawing on research into the consciousness of people in pre-modern cultures in which humans were implicated in a living dialogue with their surroundings, this paper argues that we can come to know our selves in relation to the places and natural world we live in so that our love for and care about them inhabits and nourishes our being and the being of the wider world upon which we so depend.

Starting in a Children's Home: The importance of everyday practices of care in developing a sense of belonging

Mark Smith

University of Edinburgh

The title of this presentation borrows from Nel Noddings' book *Starting at Home: Caring and Social Policy*. The book includes a chapter stressing the importance of Places, Homes and Objects in developing a sense of care. I take Noddings' ideas as a starting point to explore the relevance of a sense of place in developing a sense of belonging in the context of residential child care.

Residential child care has had a troubled past few decades, buffeted by ideological critiques of institutional care, abuse scandals and concern over poor outcomes for those leaving care, all of which have led to high, arguably excessive levels of public scrutiny and regulation. The consequence of this is that care has become a public rather than a private affair. Conceived of in largely administrative and instrumental terms, in which care planning is reduced to and understood as a series of tasks to be completed it has, some commentators argue, lost sight of any wider moral purpose.

The emergence of attachment theory as an increasingly popular theoretical model to inform residential child care policy and practice offers a welcome antidote to primarily instrumental conceptions, by stressing care's relational dimensions. I argue here, though, that attachment theory, while offering valuable insights, does not provide sufficient theoretical purchase on the nature of public care. Moreover, it represents the latest in a long list of attempts to 'psychologise' care. Specifically, it considers care as being located and understood within dyadic relationships. I argue here that care is enacted, not just through caring dispositions and relationships, important as these are, but also through particular practices of care. Together, these practices of care contribute to a sense of belonging to place. Belonging, according to De Certeau, is a sentiment that emerges and grows out of the activities of everyday life. This seems to offer a more inclusive and appropriate conceptualization of what a notion of care might involve in the context of residential child care than does attachment on its own.

In this presentation, I consider how particular variables such as patterns in the use of time, space and activity in a children's home can contribute to a sense of belonging and care. Central to my argument will be the importance of the everyday. In this respect I will draw upon Michel De Certeau's *The Practice of Everyday Life* to develop my arguments. Specifically, I will draw distinctions between what De Certeau might term the strategies of public policy in respect of care with the tactics of its everyday practice.

Going walkabout – spaces of care, learning to move in the landscapes of dementia

Naomi Smith

School of Applied Social Science, University of Brighton

Working from the experience of a recent pilot project on Dance and Dementia this paper will consider and examine a notion of the 'space of care' within the context of working with people with dementia. In looking at this I would initially suggest that there are three kinds of space or

landscapes in relation to working with people with dementia; the internal landscape of the individual with dementia, the external landscape that surrounds them and often contains them and the relational landscape of the space that exists between them and those they connect with and who connect with them.

We conceptualise space very often in concrete terms but in working with dance movement we are working within a space that whilst it may have concrete boundaries may look and feel very different as we move within it. I will explore what it was about the physical space we worked in on the project that helped to create a 'space of care'.

When the cognitive mind can no longer process individuals with dementia rely much more on physical and emotional memory which continue to be available to them for much longer. By working with the emotional and physical memory through dance movement we were able to encourage communication and reminiscence and create a space in which people could reconnect for a time with the people they were. It was a 'space' in which we could care about them and they could feel cared about.

In this exploratory paper I will consider some of the challenges and issues that arose for me as a researcher in my first project working with people with dementia and which are informing how I am developing my understanding of the work I want to do. The ethic of care perspective provides a framework in which to review my practice. In particular exploring how the principles of attentiveness and responsiveness and the connection between the two can be seen in the different way that I began to work in this project.

'Going walkabout' can bring to mind 'right of passage' experiences. The phrase was offered to me by a colleague on the project as a way of understanding the internal landscape of a person with dementia. This idea helped me to frame the different ordering of events and memory that went with the individuals and to make what sometimes seemed like the disjointed shifts to follow where they were. In a real sense it also enabled me to go walkabout safely within the process of working with them and with their help to find another sense of myself as a researcher.

Embodied and Spatial Experiences of Closeness in Informal Care

Liina Sointu

Centre for Social Research University of Tampere, Finland

This paper explores everyday life of informal care from the perspective of those older persons who give care to their spouse at home. More specifically, the paper investigates experiences related to and emerging from the physical and emotional closeness of the carer and the caree. Practical and physical assistance, 'hands-on care', require physical proximity, sometimes conceptualized as co-presence. Often this significantly alters the daily life at home. Understanding these experiences as inherently embodied and spatial and using interviews as data, the paper seeks to answer *how is closeness manifested as embodied and spatial experiences in the daily lives of elderly carers.*

The empirical data consists of 23 interviews with 13 interviewees. In order to elicit talk about everyday spatiality in the interview situation, a method of photo elicitation was used with those interviewees (N6) willing to participate. The data is analyzed using thematic and interpretative analysis.

Theoretically the paper draws from two main ideas. Firstly, as suggested by previous theorizing of care, especially the ethics of care, care is understood as relational activity consisting of concrete practices as well as emotions and knowledge. Secondly, care and dwelling are understood as inherently embodied and spatial. Spaces and places are understood to be in close connection to our well-being (or lack of it), as our sense of self emerges in relation to different spaces: home, neighborhood and the wider community and even very distant places.

Understanding and conceptualizing experiences of the elderly is important, as ageing and receiving care at home has become a key political objective in the Western countries. Elderly spouses provide a significant amount of care, and their share of care is likely to increase as people with heavy care needs now live at home. Living at home with care often contain vulnerabilities in relation to the body and everyday spatiality. Recognizing these vulnerabilities and understanding society from this perspective is crucial in pursuing an ethics of care that ensures well-being for everyone.

Learning to Care: the meaning of care in a Cambodian Orphanage

Ruth Emond

School of Applied Social Science, University of Stirling

Caring in relation to children is most frequently constructed as a practice undertaken for and to children by adults (Cockburn, 2005:71). Indeed caring as experienced within the context of the family has '... come to act as the metaphor and standard for all forms of caring' (Tarlow, 1996:56). Approaching care and care giving from this position is embedded in broader ideologies about childhood, in that to be the 'cared for' is inextricably linked to being less powerful than the care giver. Children's status as 'objects of sentiment' (Zelizer, 1985:72) enhances this view of one directional care giving; from the adult to the child; from the strong to the weak; from the subject to the object. Caring is a much theorised concept which has come to mean far more than a set of actions undertaken on behalf of the self or others. It is imbued with notions of morality, of feelings and values.

Drawing on an ethnographic study of orphanage care, this paper seeks to present the types of caring activities that children in one Cambodian orphanage were involved in and to examine the meanings given to such activities. It argues that children's care- giving practices are manifest in their daily lives and that they provide and receive significant levels of care from each other. Such care giving and receiving requires and results from human interdependence, from conceptualising persons as relational rather than autonomous (Cockburn, 2005; Robinson, 1999). This paper argues that how children provide care to themselves and others contributes to the construction of their identities (in this case as 'mature'/ 'grown up'/moral). What they were and were not able to do in relation to care, defined and redefined their relationships with other children and adults, as well as contributing significantly to their moral sense of self.

In Western nations, the push toward smaller residential facilities as well as the arguably increasingly complex needs of those that they care for may be, in part, underpinned by an individualized approach to care (Berridge and Brodie, 1998; Kendrick, 2008). Concern to eradicate warehousing of children has led to the peer group as a resource for resilience building being ignored. Rather, peers are seen as a negative and destructive influence (Hudson, 1996). However, the capacity to make and sustain peer relationships, to access social supports and to make choices about actions and behaviours are all crucial in the development of resilience (Gilligan, 2001; Fraser, 1997). It may be

argued that the experiences of the children in this study suggest that opportunities to develop such capacities might also be located within the peer group.

Whilst the data generated by this small pilot project cannot be generalized to apply to all child care institutions, it is of note that it resonates with those few studies which have attempted to explore the complexities of peer relationships within such formal environments (see in particular Emond, 2003; Stokholm, 2005).

Interdependent caring relations, emotion work and participation in HIV-affected families and communities in Tanzania and Uganda

Ruth Evans and Agnes Atim

Department of Geography and Environmental Science, University of Reading

The principle of 'Greater Involvement of People Living with or Affected by HIV/AIDS' declared at the 1994 Paris AIDS Summit provided widespread international commitment to the participation of people living with HIV in tackling the epidemic at all levels. Organisations and networks of people living with HIV have grown rapidly in eastern and southern Africa in recent years in order to campaign for their rights to health and involvement in decision-making processes. Within many communities, people living with HIV are increasingly involved in delivering healthcare for family members and peers. The care and support of people living with HIV within families and communities, particularly the emotion work of caring, however, continues to be associated with women's and girls' assumed 'natural' nurturing roles and has been largely devalued and overlooked in HIV policy and practice to date. This paper draws on an ethics of care, emotional geographies and gender analysis to explore caring relations, emotion work and participation within families and communities affected by HIV in Tanzania and Uganda. We discuss the findings of two qualitative studies: the first was conducted with women living with HIV, children caring for them and NGO support workers in rural and urban areas of Tanzania; the second was conducted with men and women living with HIV participating in healthcare provision and with HIV policy and practice professionals in northern Uganda.

The research suggests that women living with HIV, who are usually constructed as 'care-recipients', play crucial roles in providing mutual emotional support, guidance and physical care for their children, family members and peers living with HIV. Care-giving and care-receiving often lead to close emotional ties and a high level of responsiveness, challenging binary assumptions about the identities and practices of 'care-givers' and 'care-receivers'. The research with families in Tanzania, however, suggests that the intensity of intimate caring relations, isolation and lack of access to adequate resources can cause tensions and contradictory feelings that may be difficult for both care-givers and care-receivers to manage. These conflicts can severely constrain care-givers' ability to provide the 'good care' that integrates the key ethical phases in Tronto's (1993) ideal of the caring process, resulting in diminished autonomy. The research from Uganda suggests that the participation of people living with HIV in healthcare provision, home-based care and peer support groups, however, can enhance 'relational autonomy' for both care-givers and care-recipients, although such initiatives often play out in highly gendered ways at local level. We reflect on the opportunities and challenges of the greater involvement of people living with HIV in healthcare and HIV support and highlight the need for an ethic of care that values emotion work and addresses the structural inequalities and gendered power imbalances that restrict women's and girls' participation.

Communities of Care: vulnerability and shared care-giving

Sheila Garrity

Child & Family Research Centre, National University of Ireland, Galway, Ireland

The development of the Irish early childhood education and care sector has had a very short history, with rapidly developing policies, services and funding modules beginning in the late 1990s economic boom, evolving exponentially over the past fifteen years. The Irish state has followed the UK path of relying primarily on the private sector, with provision found within community services to a lesser extent (Hayes & Bradley, 2006). Recent doctoral research carried out in the West of Ireland, within early years settings, set out to explore relationships between mothers and caregivers in a variety of care settings, seeking to understand the needs, values, demands and expectations of these actors.

This research was set within the ongoing debate concerning the universal need for care, be that for elder care, care of the young, the disabled, the infirmed or meeting other family care needs, best developed through the Ethic of Care, as a theoretical framework. As Ireland has relied heavily on the market place, and as the majority of care work is performed by women, is underpaid and undervalued, the debate about the role of the market in the provision of caring labour and services is a debate that mobilises feminist theorists with varied perspectives (Cox, 2010; Tronto, 2010; 2002; Gray, 2009; Hankivsky, 2004; Held, 2002; Nelson & England, 2002; Sevenhuijsen, 2000) and has informed this developing research project.

The ethic of care views us all as vulnerable care receivers at various times in our lives, in contrast to the privileged perspective of the independent worker, capable of contributing to the labour-market, unencumbered by caring needs or duties (Tronto, 2010; 1993; Engster, 2005; Hankivsky, 2004; Sevenhuijsen, 2000). Early data analysis from the recent research, suggestss that mothers are both vulnerable care-receivers, placing a child in caring settings, as well as workers, relying on these care settings so that they may engage in the labour market. Developing strong trusting relationships, underpinned by honest, open communication, allows these women to meet their responsibility to provide for their families economic needs, while the care-giving needs are met, by proxy, through service settings.

Early data analysis finds that once actors cross these thresholds, they find caring communities, in which members are valued, respected and supported, offer care and are cared for, extending beyond the immediate triad of the mother-practitioner-child. Observations have found complex multidirectional webs of care, where parents, children, practitioners demonstrate emotional investments in other children, other parents, other workers, within these institutions.

The early research findings will be presented within a government context demonstrating contradictory policy directions in regards to the ongoing development of the ECEC sector, promotion of a professionalised graduate-led workforce, within challenging funding regimes (DCYA, 2011; MES, 2011; OMC, 2009; Ireland, 2007).

'Women's morality' and the matriarchy of care in a context of hiv and aids

Anke Niehof

Wageningen University, The Netherlands

In southern Africa, women, as 'natural' caregivers, bear the brunt of caring for people living with AIDS. The work of Tronto and others has shown how the explanatory notion of women's morality constitutes a 'moral boundary' to a just and viable new ethic of care. In a context of high prevalence of HIV and AIDS such as in southern Africa, women not only perform most of the care labour for people living with AIDS but – in otherwise patriarchal societies – also derive authority and power from it. Care is no longer contained but has become a critical factor in communities where AIDS wreaks havoc on the social order.

At the same time, gender disparities in HIV prevalence rates are growing, with women becoming more often afflicted by AIDS than men. Research carried out by African women scholars as part of their PhD projects at Wageningen University as well as other studies have revealed both an emerging matriarchy of care and an ideological lag with regard to gender and care. While increasingly men are also called upon as caregivers, in particular for their spouses, the traditional constructions of masculine identity do not accommodate the care giving role. This causes the actual care work performed by men to be invisible, unacknowledged and underrated.

This paper investigates these emergent trends and their implications for an ethic of care in theory and practice, in a context of AIDS epidemics. In a situation where actual care demands exceeds by far the resources and capacity of formal institutions to provide the care that is needed, informal caregivers have become the primary actors in the evolving drama. How they can be best supported is both a practical and an ethical challenge that requires insight into care practice and ideology, both of which are gendered, subject to transition, and embedded in on-going social change.

Visual re-presentations of responsibility and response-ability for care for/by people with intellectual disabilities

Ann Fudge Schormans

School of Social Work, McMaster University, Hamilton, ON, Canada

'Care' is typically understood to be both a value and a practice. The practice of care – who is cared for, how, and by whom – are often reflective of societal values and the (de)valuation of particular groups of people. For many disability studies scholars, activists, and disabled persons care is predominately an oppressive concept, one involved in the creation and maintenance of 'disability' as a category and in the demarcation of just who is able to give care, and who is entitled only to receive it.

Speaking to the conference theme of care by and amongst service users, this paper will share the work done by a group of adults with intellectual disabilities with public photographic representations of 'care' of people so labeled. Rooted in a critical disability approach and a Levinasian ethics of responsibility, the project created space for people with intellectual disabilities to express their critique of public photographic representations of disability and care and to visually realize this critique through the use of photographic methods.

In their work with these images, the group members speak to the 'care' (and 'un-care') they see represented in the visual images and what this says about the place of people with intellectual disabilities in the world. Acknowledging their own need for care and the importance of 'good care' to their lives, they speak also to their own feelings of responsibility for the persons with intellectual disabilities they see in the images: seeing the human beyond the image, the 'real' person who lives outside the image's frame, they feel the need to provide care and to demonstrate this care visually.

Extending this to their own lives, they make plain how they not only receive care, but also give care to others – care that is often desired and appreciated and that should be acknowledged and not feared or rebuffed. But they also raise questions about their own response-ability; tethering this not to questions of intellectual capacity, but to social, economic, and attitudinal forces that make caring even for oneself often too difficult to manage.

I will present their work with three public photographic images – their critiques of what they read in the images, how they come to conceptualize 'care', and who is understood to be capable of caring. I will share, too, how they present these visually through the use of photography: in their re-imaging and re-imagining of these public representations of 'care' of people with intellectual disabilities (aided by Photoshop), in the creation new photographic images and, through the juxtaposition of the originals with the transformed and the new images, in ways that serve to disrupt that which we think we know about intellectual disability and the giving and receiving of care.

The Importance of Reciprocity and Mutuality: people with learning disabilities as carers

Nicki Ward

IASS, University of Birmingham

Like other binary divides, the division between care giver and care receiver tends to render invisible the realities of caring relationships and creates situations in which those traditionally seen as the service user can be subjected to paternalistic and oppressive practices whilst at the same time obscuring the care needs of the person deemed to be the 'carer'. People with learning disabilities are one group who have traditionally been seen as vulnerable and in need of care and support, whilst their parents and family carers have been seen as the carer.

This paper draws on examples from research with people with learning disabilities who are carers and uses an ethic of care as a framework to explore these experiences. It will consider what the experiences of learning disabled carers can tell us about the importance of mutuality and reciprocity in relationships of care and the impact of this on self esteem and citizenship.

Conclusions will be drawn about the implications for those in the caring relationship, for service providers whose role it is to organise and provide support for families and for policy makers.

Caring Institutions

Empowerment of the work floor in residential settings: The discovery of relations and connectedness

Tineke Abma, Linda Dauwerse, Wieke van der Borg and Petra Verdonk

VU University Medical Center, Emgo+ research institute for health and primary care research, Dept of Medical Humanities, Amsterdam, The Netherlands

Compassion and work satisfaction among caregivers is often thought to be a prerequisite for good care in residential settings. Training and development of care givers and facilitating leadership are mentioned to be characteristics of best practices in elderly care (www.myhomelife.org.uk). The relation between quality of work and quality of care has however not yet been systematically studied. What we do know is that work satisfaction is often under pressure due to the large case load. Care workers are part of a Tayloristic system. Many workers are female, a growing number is older and has a different ethnic background than the residents. Although the majority is working part time, the time to recover is often too short, and many run the risk of overburdening, and are going on sickness leave. In combination with low salaries and negative image of the sector many feel not recognized and disrespected.

To counter this problem a project was set up in four residential settings. This project was entitled "From armour to summer dress" and aimed to increase the productivity, work and client satisfaction. A quantitative evaluation study could not measure improvements. This was not in line with the experiences within the institutions, where improvement was perceived on face value. Therefore a qualitative evaluation has been started in three of the participating institutions. This project is carried out by a team composed of researchers with a background in (care) ethics (Dauwerse, Abma) and organizational psychology and work (Verdonk, Van der Borg).

Initial results from the qualitative evaluation show that for workers in residential settings relations matter, however, the quality of these relations is under pressure. The original goals of productivity, satisfaction and quality of care gain a different meaning in the context of practice. Care givers emphasize the importance of the relational quality of interactions between caregivers and the organization, among caregivers, and between caregivers and residents. Many however experience feelings of disconnectedness and powerlessness. Although workers experience the project as an attempt to restore broken relations between care givers, clients and the social context of clients, many are ambiguous about its results. Well-studied working conditions in health care such as high job demands and lack of control still form an obstacle to improve relations. Regulations and protocols aimed to improve quality of care seem to also restrict decision latitude for workers and clients and hence, diminish creativity and tailor-made health care in these settings.

Our study is grounded in an ethics of care in which good care is understood as a relational process between the older person in a vulnerable situation and the care givers who are in the situation to answer to the needs of older persons (Tronto, 1993; Holstein et al, 2011). This goes beyond a contractual relation, and always touches upon the needs and passions of care givers themselves. We expect that the ideas about relational quality developed in this project fit better with the gender socialisation of women than further rationalization of care.

Between care and justice: social work as 'ethics work'

Sarah Banks

School of Applied Social Sciences, Durham University

Negotiating the balance between personal engagement and professional accountability, between professional closeness and distance, between building relationships and measuring outcomes is a perennial challenge for social workers. This process of negotiation lies at the heart of the work of ethics in professional life. But in recent decades, the struggle to maintain personal engagement with service users and with the work (as a kind of vocation) has got harder as new accountability requirements (targets, standards, procedures and proformas) defined by governments and

employers increasingly dominate everyday practice. In so far as professional ethics is part of, and constructed by, everyday practice, this too is in danger of becoming managerialised and framed in terms of codes of conduct and regulatory frameworks. Whilst accountability (including operating in accordance with standards of justice as fairness) is an essential feature of professional social work, personal engagement (including the development of caring relationships) is equally essential. I will characterise the work that goes into holding this creative tension as 'ethics work' - which could be regarded as a sociological elaboration of Aristotle's concept of practical reasoning in ethics. It encompasses key elements that are important in the ethics of care (particularly attentiveness), as well as processes of reasoning (e.g. rational decision-making and justifying one's actions) that are important in the ethics of justice. Using case examples from social work practice, this presentation will elaborate upon and discuss the concept of 'ethics work' and the importance of a political ethics of care or situated ethics of social justice for social work .

Is support better than care? Exploring challenges of reintroducing care to social care practice

Marian Barnes, Lizzie Ward and Beatrice Gahagan

School of Applied Social Science, University of Brighton and Age UK Brighton & Hove

Current policy discourse within English social care is strongly influenced by neo-liberal ideas and emphasizes choice within care markets as the means by which service users can exercise control over the support they need. Care has become associated with oppressive, paternalistic ways of providing services and the term has been substantially excluded from official policy and practice literature (Barnes, 2011). How then, do we apply learning from research that draws substantially on an ethic of care framework to develop ethical practice? This is the challenge facing us as we work with older people and both statutory and voluntary sector practitioners to apply learning from participatory research exploring what well-being means to older people and how it can be generated.

This research drew on care ethics in two ways. Firstly, in sensitizing us to issues of importance in the way we worked with older people as co-researchers. We applied ethic of care principles to our research practice (Ward and Gahagan, 2010). Secondly, in developing a relational understanding of well-being from the analysis and interpretation of research data. Older members of the team had rejected a measurement tool to research well-being in part because of its exclusive focus on individual older people, rather than considering them in relation to others. Care was a key theme in interview responses and occupied an ambiguous, but central place in older people's accounts of well-being (Ward, Barnes and Gahagan, 2012).

Our aim in our current work is to apply learning both from the participatory practices we developed in carrying out the research, and insights from the research findings, to the development of practices to enable older people to shape and influence services, both individually and collectively. We are explicitly aiming to challenge the notion that choice is the 'best' means of 'empowering' older people, and to suggest that participatory practices based in a political and inter-personal understanding of care ethics can contribute to realising well-being. But we are doing this in a context in which, for many practitioners, the term care has been rejected in favour of 'support'. In this paper we explore the challenges of working within an ethic of care frame in the context of very different policy and practice discourses.

Client participation and 'care full policy making' in residential care homes

Vivianne Baur

VU University Medical Centre, Department of Medical Humanities, Amsterdam

In recent years, the collective participation of people who live in residential care homes has been subject of research projects in the Netherlands. In this paper we present the PARTNER intervention as an instrument for direct and collective participation of clients in practice improvements and policy making. Relational empowerment and partnership development are aimed for by the PARTNER intervention. This intervention is rooted in an ethic of care perspective, in which the interdependency and relationships between clients, volunteers and professionals in residential health care organizations are acknowledged as a pathway to collaboration and empowerment of all those involved.

The PARTNER intervention consists of five steps. Clients are brought together in an action group in which they set their own agenda for practice improvements (step 1). In this safe environment, clients find support and empowerment in the collectivity of the group. By regular meetings, the action group of clients develops a vision on practice improvements from the basis of shared experiences (negative and positive), dreams and hopes (step 2). Consequently, the action group of clients engages in deliberation with other groups in the residential care home (e.g. care workers, managers, volunteers) (step 3) to find shared values and to explore differences as a source of inspiration for new action ideas (step 4). On this deliberative basis, the action group and the other stakeholders develop a joint action agenda. The concrete actions that follow are brought in practice by the action group and the other groups collaboratively (step 5). By following these steps, clients and professionals who are involved in the PARTNER intervention develop a sense of partnership and relational empowerment.

In this paper we will explore the meaning of the PARTNER intervention for developing 'care full policy making' in residential care homes. We conducted several action research projects, evaluation studies and we brought together learning communities of managers, policymakers and facilitators of collective client participation. In this paper we will reflect on our data from these research activities with regards to client participation in residential care homes as partnership development.

What does it mean for professionals and policymakers to engage with clients in this new way, approaching them as equal partners instead of vulnerable and passive patients who need to be taken care of? How can deliberation and communicative action between clients and professionals be developed with a lasting effect, and what is needed for (elderly) care organizations to fully implement a culture change towards which partnership working between clients and professionals is central? The challenges and success factors related to this issue will shed light on a possible definition of 'care full policymaking' in terms of collaboration and relational empowerment between clients and professionals to improve practice and services in residential care homes.

'I try to develop a net around each patient': On the development of relationships in home care

Kristin Bjornsdottir

Faculty of Nursing, School of Health Sciences, University of Iceland

Home care services are provided at the intersection between the private world of patients and their relatives and the public world of institutions. Most home care clients, the frail elderly and those who

suffer from long-term conditions, need complex and flexible services that accommodate individual preferences and needs. Their care is shared among patients, relatives and health care workers and the boundaries of responsibility and expertise are fluid. This was clearly reflected in a recent ethnographic study of home care nursing in Iceland (Björnsdóttir, 2011). Flexibility was of key importance and the provision of care was continuously negotiated between the different actors. Based on these findings it was concluded that good care rests, among other things, on the development of working relationships between participants.

These findings raise important questions in relation to the development of home care. What ideals and understandings should guide the development of such relations? A number of studies, particularly among the elderly, have shown that care giving relationships can be demanding and difficult and are often fraught with all kinds of ethical issues and dilemmas. Studies that have explored every day activities in long term care have highlighted the mismatch between prominent ethical and policy discourses and the actualities of the care giving situation. In the Nordic countries the elderly are for example increasingly portrayed as consumer of services which has transformed the way in which relationships in home care services are understood (Vabø, 2006). Similarly, the emphasis on individualization and patient choice, which has become prominent in policy discourses in many countries, can easily become constraining (Ceci and Purkis, 2009; Mol, 2008; Pols, 2007).

My intent in this paper is to contribute to the conceptualization of what good home care might constitute by exploring the development of relationships between different actors. It is based on findings from an ethnographic study that I conducted of home care in Iceland. The nurses who participated in this study used the net as a metaphor to describe how they develop relations with patients, relatives, team members and different specialists. The development of such relations depended on opportunities for conversations around different issues related to care and to elaborate various options. These conversations seemed to be of key importance in developing ideals, values and objectives that guide practice. This is where Mouffe's (2005) elaboration of the political is helpful as well as Pols's (2007) development of empirical ethics in the care giving situation. The feminist literature on caring has been an important source of guidance and inspiration for different professional groups such as nurses working in home care. At the same time the caring theories have been critiqued for portraying an idealized and sanitized picture of care giving relationships and ignoring power imbalances. Cooper's (2007) re-evaluation of this literature is insightful and her findings are helpful in conceptualizing relationships in the practice of home care.

Elevating the Status of Care Giving

Andy Bradley and Kirsty Murray

Frameworks 4 Change

A political ethic of care focuses not only on intimate relationships, but on the contexts in which care is given and received. Care workers are often poorly paid and little attention is given to their needs for care. Is care possible if there is no evidence of it in the way work is organized, supported and remunerated? How can ethical practice be promoted within welfare organizations?

The challenge of giving every resident / patient a sense that they 'matter' is significant. In busy institutions with complex and at times competing needs and every day pressures individual preferences and differences can easily be overlooked. The pervasive culture in busy care homes and hospitals can leave older people feeling lonely, bored and unsafe, families feeling anxious and

worried, care and nursing staff feeling undervalued and unappreciated and managers feeling stressed and overwhelmed.

Placing compassion at the heart of the caring paradigm and including residents and their families and paid care givers in a drive to create consistently compassionate cultures offers hope that the resident care giver relationships can be transformed into one which is characterised by equality, deep care and respect.

The NHS constitution on compassion:-

'We respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care.'

When a care worker is stressed and under pressure will they retain their humanity and kindness? When a person is difficult to care for due to their own anxiety, pain or distress will the care workers and nurses continue to give comfort and relieve suffering? Do leaders work alongside care givers to appreciate what they do in order that a compassionate approach can be sustained?

What habits are required to create and sustain consistently compassionate domiciliary care?

Care environments are places where habits are formed, often unconsciously. These habits inevitably vary from place to place but there are some common unhelpful habits. These unhelpful habits can create the conditions for poor, mechanical care. The habits can leave workers feeling unappreciated and managers and leaders feeling stressed and overwhelmed. Families are left to worry and may feel guilt and a sense of powerlessness.

The creation of new habits offers a framework for changing these unhelpful and very common dynamics. The habits below lay the foundations for a more aware kind of care, in which care givers experience their role as a privilege and the people receiving care feel valued and appreciated; that they matter. The role of the positional leader is to embody and cultivate the habits; when the leader moves on, the habits remain.

Working directly with care giving teams in busy residential environments enables exploration and understanding of the care giver experience of suffering and their own need for kindness and understanding. To create and sustain consistently compassionate care we have learnt that the disciplined application of three habits is significant:-

Listening (with a quiet mind)

The routine giving and receiving of undivided attention results in us feeling that what we think and feel matters.

Asking (questions that matter)

Questions which invite us to reflect deeply on the kind of care we want to give and receive result in us finding new insights and perspectives on the gift of caring.

Thanking (from the heart)

Hearing that what we do and the way we do it matters to other people brings out the best in us.

Habit building programs which aim to create and sustain consistently compassionate care are now well underway in residential environments, domiciliary care and in the NHS.

The qualitative and quantitative evidence base is building to demonstrate improvements in well being for both recipients and providers of care when the habits are experienced, practiced and applied.

Exploring Meanings of Care in Older People's Care Homes.

Heather Dunn

Department of Psychology, Sociology & Politics ,Sheffield Hallam University

Despite a national increase in longevity and increasing dependency on later life care, little research in psychology has investigated the experience of living or working in older peoples' care homes in the United Kingdom. Concern over negative psychological health outcomes for residents (e.g., Barrowclough et al., 2002; Flick, Garms-Homolova & Rohnsch, 2010; Pierson, 1999; Stewart, 1995), poor care practice (Kenyon & Chapman, 2011), and financial mismanagement of older people's care institutions (e.g., winding up of Southern Cross Healthcare in 2011), demand more critical exploration and understanding of how nursing home care is constructed, and what barriers exist in relation to the delivery of appropriate care.

This paper builds on the findings of a qualitative study I conducted that explored Care Assistants' perceptions of residents' dining experiences in three UK nursing homes (Dunn & Moore, 2010; unpublished manuscript) that suggested Care Assistants' positive talk about older adults was juxtaposed against their accounts of caring, which were more aligned with the medical model than a psychosocial model, and served to de-legitimise residents' autonomy. In contrast, carer's empathic attitudes, cultural beliefs and the value of 'belonging' were important in the carer-resident relationship.

The present paper is a result of my doctoral research conducted in three private sector nursing homes in England. The research adopts a Critical Health Psychology approach; a constructionist and theoretically interpretive perspective, and uses ethnographic and reflexive methodology. The research is informed by a data-driven qualitative approach that aims to critically explore: what 'care' means to residents and staff; the psychosocial dynamics of the carer-resident relationship; and how carers/residents negotiate their relationship. The use of place and space in participating nursing homes is also explored. In keeping with a critical approach and constructionist perspective the methods employed include: visual ethnography (photography); researcher observations; photo voice/photo elicitation resident interviews; object/photo elicitation staff focus groups; staff work-along interviews; and manager graphic elicitation and participatory diagramming interviews.

Preliminary findings of visual ethnographic researcher observations in participating nursing homes will be presented. Discourse Analysis of data that is informed by Foucault's concept of 'power' (Foucault, 1982) suggests that 'care' in nursing homes is socially and historically constructed, medically driven, and imbued with inherent power structures. Such power structures serve to disempower older residents and are manifested through a process of institutionalisation, labelling, and infantilisation. Tensions observed in psychosocial relationships within participating nursing homes appear to be exacerbated by limited resources and hierarchical structures.

The research aims to develop recommendations that may challenge dominant discourses about the delivery of care in older people's care homes in order to improve quality of care and provide a voice for a burgeoning yet marginalised, under-represented, and vulnerable population.

Talking about care. Analyzing competing notions of public social care needs in an active welfare state

Ellen Grootegoed

Amsterdam Institute for Social Science Research Department of Sociology and Anthropology, University of Amsterdam

The concepts of care and justice - often considered mere oppositions - are connected by social scientists aiming for a de-gendered notion of citizenship (Tronto 1993; Knijn and Kremer, 1997). According to them, care responsibilities should be perceived as being applicable to all citizens, thereby conceiving it as a 'Public Value' (White and Tronto, 2004: 446). In the context of an economic crisis, social care policies aim for the activation of 'citizen-carers' (see Barnes, 2011) almost as if it constitutes this public, equally shared care labor division. Hence in practice, active solidarity might result in mounting gender and socioeconomic inequalities, as people tend to provide care for people in their own network rather than distant others (Trappenburg, 2009).

The notion of a citizen-carer may therefore represent different 'economies of worth' (see Boltanski and Thevenot, 2006). While care activation policy is legitimized by its civic virtues (social solidarity, social cohesion), caring work is for a large part performed by a small group of family or friends on basis of domestic virtues (proximity, tradition). Question is: how do both state and citizen deal with this moral pluralism? To what extent do policymakers recognize that, even though the call for active citizenship is universal, contextuality of care is undeniable? And do caregivers/receivers identify a universal morality in activation rhetoric, despite their relative powerlessness in setting moral boundaries?

In this article, we demonstrate how competing political and civic claims of care and justice are embodied in care 'needs-talk' (Fraser, 1989). We use a Dutch case study to identify the discursive powers at play in preserving care for 'those that really need it'. According to a new cesure, enacted in 2009-2010, people with a so-called 'mild' disability are no longer entitled to public long-term care, and are expected to find informal arrangements, as proposed in the Dutch Social Support Act (WMO, 2007) – an act which appeals to the 'citizen-carer'. This reform does not only apply to future applicants, but also discontinues the home care and daycare for 60,000 persons with a psychiatric, physical and/or cognitive need (and for even more care rights are partially reduced).

First, we use policy documents and interviews with key respondents (politicians, client and advocacy organizations) to examine how disabilities have become re-categorized as being 'mild' - as opposed to moderate and severe - and thereby an object of activation. Second, we analyze 120 formal complaint letters of affected clients and their relatives, to demonstrate how citizens contest their new disability status and delegitimize the appeal for advanced active solidarity with a reference to justice. We end with a reflection on the impact of activation policy rhetoric on societal conception of care needs, and argue that a contextual care needs-test is needed to overcome the public-private divide and recognize the different care ideals people cherish in giving and receiving 'just' care.

What does 'care' mean in shelters for abused women?

Roma Harris and Nadine Wathen

Faculty of Information & Media Studies, The University of Western Ontario, London, Canada

Publicly-supported shelters for women who are escaping intimate partner violence are often assessed by the government agencies that fund them on the basis of input-output indicators such as number of beds occupied, length of stay, and costs per person per night. These measures reveal little about the actual experience of living in and/or using shelter services or about the longer term impact of this experience on the lives of abused women. For the past two years, an interdisciplinary team of researchers and practitioners has been studying shelter services for abused women across the Canadian province of Ontario in order to develop a nuanced, context-sensitive method of understanding and evaluating the impact of shelter services. Through surveys and in-depth interviews with shelter directors, staff members and women who have lived in shelters and used shelter services we have been able to identify the intended goals of a broad range of shelter services and programs and to understand how they make a difference, from the point of view of the people who deliver and use them. As we have been analyzing data from the project, the profound impact of relational support, usually described by the participants as ‘caring’, has emerged as a persistent theme, regardless of the type of services or programs being discussed. In this paper, we will discuss the ways in which ‘care’ is manifest in shelters, how its presence (or absence) is interpreted by shelter workers and the women who use shelter services, and how it is linked to the processes through which women come to terms with and cope with the aftermath of intimate partner violence. We argue that shelters in which non-judgmental support is consistently demonstrated through exchanges that involve expressions of warmth, kindness and ‘taking time’ are able to go beyond providing the essentials of safety, accommodation and information-providing that are fundamental to all shelters, to build relationships of trust with and between the women they serve and, in turn, assist women to develop the confidence to advocate for themselves with systems and services outside the shelter. We argue further that neo-liberal-inspired public administration accountability systems in which efficiency and customer-service are the preferred indicators of success fail to take account of or provide evidence to support more valuable, if costly, care practices through which shelters can make a significant difference in the lives of abused women and their children.

Intersectionality and Care ethics

Olena Hankivsky

School of Public Policy, Simon Fraser University, Canada

This article explores the potential of intersectionality as an important theoretical resource to further develop and advance care ethics. It first provides an overview of care ethics, highlighting central critiques related to its conceptual inclusiveness and approaches to power and how this may limit the effectiveness of caring practices. It then discusses how the insights offered by intersectionality can address these limitations by de-centering care ethics¹ foci on gender and gendered power relations, allowing for the interacting and multi-level processes influencing experiences of inequity to be considered. A care ethics informed by an intersectionality paradigm can ensure its continuing relevance, applicability, and transformative potential in the context of complex and multidimensional political and empirical challenges.

‘Caring about’ the client: the challenges of being a social work student in South Africa

Neil Henderson

Department of Social Work, University of Western Cape

Fourth year social work students at the University of the Western Cape in South Africa are expected to identify an ethical dilemma in their fieldwork program in third year and to analyze this dilemma in relation to the ethic of care values and principles. This summative task is part of the Advanced Social Work Ethics Course (SCW412) presented in the first semester. This paper will explore student's unique responses to the question, reflecting on their own cultural backgrounds and identifying major social work challenges that are prevalent in South Africa. Students reflected on Tronto's (1993) four phases of the ethic of care, namely attentiveness, responsibility, competence and responsiveness. Themes that emerged are that social work students are attentive to the poverty that the majority of client's are grappling with but don't always feel confident about their competence and would refer cases to a more accomplished professional. Social work students are disempowered within agencies and would not easily report ethical issues to their supervisors, which could highlight challenges with responsibility towards the profession and their knowledge and application of the South African Code of Ethics. Clients are also not always able to be responsive to the care given due to inadequate follow-up by social workers in the field. Large case-loads continue to impact negatively on responsiveness. Bozalek et al (2007) highlights the plight of 'burnt out' social workers in the field in their study in the Western Cape. Confidentiality around disclosure of HIV/AIDS remains an ethical concern particularly when there is infidelity involved. Students recounted the importance of breaking confidentiality if there was risk of infection. Students did not always make the link between the four phases of the ethic of care or recognize the importance of the inter-connectedness to ensure that care is transparent and sustainable. Gender struggles within ethical dilemmas were under-reported which was disappointing as there is a strong focus on gender equality within the curriculum and gender-based violence continues to be a scourge in South African society. Other social divisions such as race and class were also glossed over, which highlights the tensions within South Africa on the intersection of these divisions on ethics and accountability despite a progressive Constitution. In conclusion, some social work students at UWC are needing care themselves as they are experiencing the same challenges that their client's experience. Unfortunately, within an academic environment these challenges are 'swept under the carpet' as through-put and subsidies take precedence over 'taking care' of our students.

Inform with care! Exploring the relationship between information and care in contemporary health and social care contexts

Flis Henwood

School of Applied Social Science, University of Brighton

This paper explores the relationship between information and care in range of contemporary contexts where care and information giving are practised. It is prompted by the concern that the current emphasis on information in recent health and social care policy and in related areas of practice may result in information becoming understood or experienced as a substitute for care.

The paper starts with a review of health and social care policy and analyses how the information-care relationship is articulated within policy documents. In particular, it traces the ways in which information, increasingly understood as best mediated by digital technologies, is positioned as the solution to the 'demand' and 'cost' problems in public care services- empowering patients to 'self-care', supporting 'care at a distance' and enhancing 'choice' to access care from the private as well as public sector. Such developments have variously been understood as the triumphing of a 'logic of choice' over a 'logic of care' (Mol, 2008) and of the increasing 'de-caring' of the welfare state (Schuyt, 1995, in Sevenhuijsen, 2003, no page).

This paper then explores a range of empirical contexts where information and care practices clearly intersect and yet where information and care paradigms, or 'logics', might be understood as interfering with one another, often leaving service users and patients unable either to access information that meets their situated and embodied needs, or to have their care needs fully met. Examples will include health information seeking in public libraries, self-care for 'healthy living', and GP consultations in the context of obesity.

The final part of the paper turns more explicitly to the ethic of care literature to reflect on where and how some of its fundamental principles- including relationality, interdependence (Tronto, 1993) and trust (Sevenhuijsen, 2003) might be used both to develop a more thorough-going critique of current information policy and practice and to set out some basic premises for an alternative practice: to 'inform with care'.

Social Investment & Ethics of Care: Complementary or Mutually exclusive paradigms? The case of childcare.

Margarita León

Institute of Governance and Public Policies (IGOP), Universitat Autònoma Barcelona

The social investment viewpoint presents social policies' enrichment of human capital as a cornerstone for a tentative new paradigm. Investment in issues such as childcare, education suited to the different life stages, improved combinations of active/protective labour market policies and social cohesion become key productive forces in present societies. Compared with neo-liberalism as the contrasting approach to the changing role of modern welfare states, social investment emphasizes the need to see childcare in productive, rather than in merely reproductive terms; the need to invest in the workforce of the future and also, the benefits of childcare availability for work/family conflicts. However, after decades of neo-liberal abuse of 'destructive-creativity', we should also be aware of the limits of permanent demands for tireless adaptive efforts. The works of Sennet, Tronto or Bourdieu, although addressing very different sociological dilemmas, have shown the importance of moments in our daily existence that rest more within the 'habit' rather than the 'creative' or 'productive' side of human action: our need for regularities and routines in everyday life and their troubled relationship with unrelenting change.

The increasing commodification of care work that has lead towards the formation of 'care markets' has evident implications for how social care is being re-placed or re-allocated in today's societies and the consequences that this reallocation has for the 'value' of care. In a moment where Europe seems to be drifting towards short-term reactive measures of the crudest neoliberal form, this paper aims at critically situating an 'ethics of care' perspective within the theoretical underpinnings of the social investment paradigm. How can an ethics of care influence public practice and welfare reform? Following Fiona William's work, what are the tensions between political commitments to the recognition of care and the values underpinning welfare reform? Or as Lister has argued, how is the location of the boundaries of responsibility between the public and the private critical to the construction of social citizenship? Relating to the 'caring institutions' theme of the conference, this paper addresses the above questions by looking at children's related policy formulations in European welfare states.

What happens to care when New Public Management and salutogenic theory join hands? Danish elderly care as example

Anne Liveng

Institute of Psychology and Educational Research, Roskilde University, Denmark

During the last decades Danish elderly care has been organized by principles and methods commonly spoken of as New Public Management. The aim of introducing NPM has been to rationalize and increase effectiveness of care work and thereby reduce the cost of the welfare services. Focus has been on the care providers; in general on the role and responsibilities of municipalities, and with the purchaser-provider model specific on the role and responsibilities of the employees in elderly care.

Today we see a shift in focus from the care providers onto the receivers of care. Large municipalities, such as the municipality of Copenhagen, develop politics for including and activating elderly citizens in taking care of own life and health. Active Ageing has become a buzzword; in policy documents the differences between groups of elderly are put forward and consequently the possibilities of still being able to make own choices, in order to live a meaningful and healthy life.

Where NPM originate in neoliberal thoughts and politics, the focus on the care receivers are inspired by Antonovsky's salutogenic theory and similar primarily individualistic understandings of health and health promotion. In the center of Antonovsky's theory stands the concept of meaningfulness. The paper examines some dilemmas this fusion of ideas is able to lead to, departing from empirical examples from Danish day centers for elderly people. Dilemmas can be found in the image of the elderly person created by the ideas, in the professionals understanding of their own role towards the elderly, and in the consequences for the responsibility of the municipality.

Shortly speaking: The elderly person is at the same time constructed as being able to make meaningful and healthy choices for own life and to need persuasion and guiding conversations in order to realize that he or she has to make these choices. The professional has at the same time to accept the choices of the elderly as being meaningful, and to try on the background of professional knowledge to convince him or her that the activities offered by the municipality are meaningful to take part in. The most fragile of the elderly, the professionals argue, are those who need the company and security of the day center most, are also those for whom it is often difficult to find the resources to come on their own hand. The responsibility of the municipality and thereby the welfare state becomes at one time to provide the possibilities for all citizens to live and carry out the activities they want to, and to secure that elderly citizens protect their own health and thereby reduces the costs of elderly care.

Finally the paper discusses where "care" – as concept and as practice – is left in this development. Which kinds of care are possible in a landscape governed by individualistic and rationalistic theories of human beings?

Exploring an ethics of care for adults with intellectual disability in residential facilities in South Africa

Judith McKenzie

Faculty of Health Sciences, University of Cape Town, South Africa

The ongoing care and support needs of adults with intellectual disability are not being adequately met in South Africa as in many other countries. In the absence of research evidence, it is assumed that most are being cared for in some type of family arrangement as in Western societies. However, family care is problematic when parents, for a range of different reasons, are unable to care for their intellectually disabled family members. In the context of HIV/AIDS, traditional caring roles of parents have been altered (Groce, 2004) and the grandparents and many families are turning to residential facilities to care for these family members.

This paper presents a preliminary review of a study of 40 residential facilities in the Western Cape Province of South Africa. It adopts a human rights, social model of disability. However, it stands in a position of critique of these approaches in that human rights remain an elusive goal for people with intellectual disability (Goodley, 2001; Mckenzie & Macleod, In press). The notion of social justice based on human rights needs to be complemented by models that incorporate care and protection of vulnerable individuals where there is a degree of inevitable dependence. This paper interprets quantitative and qualitative data within a feminist ethics of care framework to make visible the everyday relationships of care that occur within these facilities. The analysis highlights the relations of dependency care that are seen by Kittay (1999) to be central to a moral framework that places relationships at its centre. Thus the care needs for intellectually disabled people and their care workers fit within larger questions of care and this will be explored in this presentation.

Love's Labour Found; identification, reparation and reciprocity in therapeutic relationships.

Lindsey Nicholls

School Health Sciences and Social Care, Brunel University

Occupational therapists (OTs) that care for vulnerable clients in acute medical (i.e. clinical) settings need to use sound clinical reasoning and be emotionally sensitive to the client's anxiety about a change in their health status and/or grief over their loss of independence. Research into nursing termed this psychologically demanding relationship work as 'emotional labour' (e.g. Smith, 1992 and Theodosius, 2008).

This paper discusses an ethnographic research project, undertaken by an OT, which considered the relational work of OTs in an acute hospital ward environment. The project was inspired by the psychoanalytic organisational research undertaken by Menzies Lyth (1988), and was aimed at understanding the social defences that OTs may use to protect themselves from the emotionally distressing aspects of their work. These unconscious mechanisms may have protected OTs from the anxiety of working with vulnerable clients but could have thwarted therapists' fulfilment of deeper reparative desires.

The research was a psychoanalytically informed ethnographic study undertaken in two clinical occupational therapy departments in a first and third world country (the UK and South Africa respectively). Three linked data gathering methods were used; participant observation, free association narrative interviews and inquiry groups. The analysis of the data incorporated reflexive accounts by the researcher, including the researcher's and participants' dreams.

By using two different using fieldwork sites the results highlighted how the therapists' personal (i.e. their biography) and contextual (i.e. social/political) history affected how the emotional work was managed and understood. The OTs, although busy 'doing' tasks with clients, were emotionally

sensitive to their communication and able to reflect on the reciprocal exchange (recognition) that occurred when working in intimate care situations.

The author extends the psychoanalytic notion of reparation to that of reciprocity in the care relationship. The work of a health care professional is essentially one of compassion, creativity and transformation; it is love's labour found.

Patient involvement and professional care: Contemporary tensions

Christina Sinding

School of Social Work and Department of Health, Aging & Society, McMaster University, Ontario

This presentation emerges from a study in Ontario, Canada. Informed by Institutional Ethnography as a method of inquiry and drawing on interviews with women diagnosed with breast cancer, I explore the work patients do to get (through) cancer care, and the implications of this work for ideas about care.

Considerable activity and effort is prompted for patients by the routine professional practice of outlining treatment options and encouraging patients to choose between them. I highlight patients' complex responses to this practice: their accepting, deflecting and reframing their positioning as decision makers, and their active negotiations of responsibility with professionals.

The literature on treatment decision making typically constitutes patients' reluctance to participate in decisions as a condition that requires remedy. Here I suggest that patients' ambivalent reflections on decision making can be read both for their critique of contemporary professional-patient relations, and for the vision of care they contain. I show in particular how research participants invoked health professionals who make their experience and intuitions available to patients and who can be counted on to direct patients to take beneficial treatments. Participants called on professionals to 'vote', to act on and make visible their stake in the patients' lives.

I then turn attention to additional aspects of care that women themselves wished for or actively sought to bring about. Experiences of unkindness and disrespect were often described as 'the worst thing that happened.' Yet in current discourse, the objects and outcomes of patient involvement are defined in very particular ways; efforts to elicit kinder or more respectful relations lack institutional sanction.

The presentation concludes with reflections on features of health systems that impede the vision of professional caring embedded in women's accounts, particularly contemporary initiatives in patient empowerment, and evidence-based medicine.

The Historical Implications of Measuring Caregiver Burden

Mary Ellen Purkis , Kristin Björnsdóttir, and Christine Ceci

School of Nursing, University of Victoria; Faculty of Nursing, University of Iceland; Faculty of Nursing, University of Alberta,

Ideas about the benefits of providing home-based care to ailing family members, primarily older family members, have been evident in the health care literature since immediately after the Second

World War. Over time, the impact of home-based caregiving on the carers themselves has been framed into the concept of “caregiver burden.” Since the 1970’s, that burden has been measured using increasingly complex techniques and calculations. Early research was motivated by an interest to “relieve or reduce” (Mohide et al., 1988) the burden, thus improving the quality of life of caregivers. Twenty years later, such ambitious aims are acknowledged as remaining unmet (e.g. Zarit & Femia, 2008), yet the research on refining measurements of burden continues. If the goal of relieving the burden from caregivers has failed, what are the implications of measuring the weight of the burden?

Our contention is that a calculation of the weight that family members will bear in relation to care of elderly relations has surpassed the earlier, practical interest in relieving that burden. The contemporary interest in calculating the weight of care borne by family members is underpinned by a largely unexamined shift in the epistemological basis informing these research activities. Early research focused on designing practical interventions aimed at supporting the work of caregiving. By contrast, contemporary research is characterized by interdisciplinary teams whose research reflects an increased concern with calculating the weight of the burden of caregiving, often linked with a discourse of social justice. These research reports demonstrate a tendency to advance a conception of caregivers that portrays them as unwitting dupes relying on the researchers’ calculations to support moral claims regarding the unacceptability of the weight of caregiving in the absence of any sort of practical assistance with their caregiving efforts.

An example of this sort can be seen in the work of Yantzi and Skinner (2009) who offer the unsubstantiated claim that “providers of care in the home are in jeopardy of not fulfilling their roles. They are being charged with greater responsibility for caregiving due to devolution, divestment and downloading in the health system” (p. 222). Yantzi and Skinner’s interests rest in inserting home-based caregiving into the formal care continuum so it will receive (economic) consideration as a legitimate component of the policy horizon of health care services. Their work illustrates a significant shift from the more practical – yet ultimately failed – efforts evident in earlier research that sought to relieve the burden of caregiving.

How can we understand and, more importantly, respond to such an evolution in the production of knowledge that claims an interest in improving the lives of home-based carers yet sets its sights in such tangential locations from the everyday work of those who manage the day-to-day conduct of the demented? We will explore this question by examining the ways in which research on caregiving demonstrates unexplicated assumptions about the epistemological privilege of the researchers who have shaped this important idea in the history of caring.

Mapping Relationships: Knowledge and Networks in the Organisation of Residential Care Services for Older People in Scotland

Catherine-Rose Stocks Rankin

Social Policy School of Social and Political Science University of Edinburgh

In Scotland, as in many other welfare states, the organisation of residential care services for older people takes place in a highly contested space where debates about demographics, limited financing and changing expectations of the state compete with questions about choice, rights, equality and types of care.

This organisation crosses the formal boundaries of the public and private sectors as well as the lines between public and private life. It traverses several policy spheres, including local governments, the devolved Scottish administration and the UK government and includes numerous organizational bodies, such as care home providers, the care regulator and the voluntary sector.

It incorporates ideas and experience from several professional groups such as law, accounting and social work and it reflects, at least in part, the needs and demands of service users, carers, government and private business. One of the central focal points of care services' organisation lies in the work of contracting. A contract for residential care services is both the bridge between the public and private sector and a formalized link between the individual and the institution. It is also an articulation of the, at times conflicting, needs of service users, government and business. The contract, as an artefact, links these spheres; the work of 'contracting' is the practice of translating and aligning the needs, demands, knowledge and experience of these different spheres. As such, it may have the potential to facilitate or negate care in the process of service organisation. Current Scottish guidance on the purchase, or procurement, and contracting of social care services suggests that a tension exists between the local government's duty of care and its duty to seek economic efficiency in the organisation of social services. This paper will explore this tension through an examination of experiences of actors involved in the commissioning, procurement and contracting processes. This project examines the ways in which knowledge and practice are created and consolidated in the networks that are tasked with the planning and delivery of residential care services. In so doing, it asks how these different, and at times competing, interests are negotiated and whether certain kinds of knowledge, practice or care might be privileged in this process. Through the use of in-depth interview data, this paper will give an account of the way knowledge moves within an organisation as well as the sites of negotiation which mediate this translation. As a result, this paper aims to reveal the lines of force which impact on the relationships amongst public sector employees as well those service users whom they aim to represent. In so doing, it seeks to show possible points of intervention and opportunities for change so that the organisation of care services might itself become more caring.

Care, context and autonomy: how does an understanding of autonomy as relational challenge the institutional contexts of clinical practice?

Mary Twomey

Faculty of Health and Social Care, Open University

The concept of relational autonomy is important in both care ethics and feminist ethics, and applying this concept in clinical practice has the potential to challenge both the institutional practices and the institutional power of medicine. This paper will draw on my work in breast cancer nursing to explore how the understanding of autonomy which is promoted in the ethics of care can change practice. I will explore how applying such an understanding in practice challenges the clinical context within which care takes place, and can also challenge the cultural understandings which are institutionally reinforced in clinical practice.

The principle of respect for autonomy is well recognised in current medical practice, and yet there is a danger of imposing a new orthodoxy of autonomy, which can be harmful to some of those involved as patients. In breast cancer care, as elsewhere, respecting autonomy is interpreted in practice as promoting information and choice, and obtaining consent. As Susan Dodds (2000) has argued, this focus places the clinical dimensions of care and the actions of clinicians at the centre of concerns, and uses the standpoint of clinicians as the starting point for conversations with patients.

An approach which emphasises relationships places the 'patient' at the centre of concerns and promotes both the exercise of autonomy and the capacity for autonomy. Further, by emphasising the relationships between those involved, the approach advocated by care ethics requires critical reflection by all those involved. The way in which this understanding of autonomy might play out in practice, and the implications for care workers, especially nurses, will be explored here.

A further dimension of working with the concept of relational autonomy relates to what Charles Taylor refers to as the 'shared meanings that underlie certain sorts of cultural practices'. Those who are seen as experts or specialists in practice might be used to test out the acceptability of certain decisions – what would you do; what do other women do? The cultural (institutional) practices which shape an understanding of femininity, for example, can be powerfully reinforced in such conversations. Making decisions about breast surgery requires thinking and reflecting on the meanings attached to how we look, and how the way in which we look shapes our view of who we are. Creating the conditions which allow critical reflection on such issues – what kind of person am I/do I want to be? – requires that those seeking to promote autonomy reflect critically on their own contribution to the shared meanings which shape practice. This in turn challenges the institutional contexts within which medicine is practised, a context which reinforces medicine's role as describing and sustaining cultural norms. Challenging such practice, I will argue, requires an understanding of the political as well as the personal contexts of practice.

Deliberating with Care

Now it is our turn! The power of altruistic action

Tineke Abma

VU University Medical Center, Emgo+ research institute for health and primary care research, Dept of Medical Humanities, Amsterdam

Participation of older people in designing and improving the care and services provided in residential care settings is limited. Traditional forms of democratic representation, such as client councils, and consumer models are management-driven. An alternative way of involving older people in the decisions over their lives was explored, grounded in notions of citizenship and deliberative democracy. In line with this tradition older people engage in collective action to enhance the control over their lives and those of others. Collective action is the joint and coordinated action by a group of clients based on their agenda. Often this entails 'life political' issues not dealt with in the system. Not seldom such life political issues are accompanied by a specific narrative and expressive way of communication which is functional to generate new ideas and to create strong bonds, but which also challenges professional frameworks.

Collective action is altruistic if it is grounded in feelings of solidarity and community engagement, and provided voluntarily. Such action requires a dissatisfaction, group identity and desired future. Not factual circumstances, but processes of meaning making and emotional recognition set collective action in motion. Only, if a situation is framed as being non-acceptable, powerful energies are freed. In our current individualized society this process starts with deep personal motivations and needs, but these can develop when experiences are shared and when emotional recognition leads to feelings of solidarity in a group. The experience that other people are living the same experiences is a joyful and encouraging discovery. Then, deeper personal motivations and interests

("I stories") may - via an interactive process of sense making - lead to a communal narrative ("We story"). It is this collective story that mobilizes people to political participation. The empowerment literature also demonstrates that people who experience a lack of influence and/or the burdening of stereotypes that marginalize their position in society, need the support of a collective to develop relationships and a new communal narrative around which they can also sustain changes in their own personal story. They find support with each other while they create new community narratives.

In this presentation the theoretical background of altruistic action is presented and illustrated by a case example of a group of women who changed the food policies within their residential home.

Caring in the context of activation: how clients and professionals deal with ambivalent return-to-work policies

Lineke van Hal

Department of Health, Ethics and Society, Maastricht University

The last decennium neo-liberal winds of change are blowing through social welfare systems in European countries. Regarding policies on 'work disability' in the Netherlands, attention has been shifted from income substitution to labour participation. In line with this paradigm shift, in 2004 a new disability act was constituted that explicitly values paid work above income compensation. The primary aim of this activation policy is to promote the return to work of employees with (temporary) health-related work restrictions. To support people with a work disability towards labour participation, vocational rehabilitation programmes were established. These programmes are in hands of private agencies. In the case of rehabilitation of work disabled people, the agencies get paid by the Dutch Social Insurance Institute. The duty of vocational rehabilitation agencies is to support people to sustainable employment in the quickest way possible. Usually, after a client is assigned the agency receives one part of the estimated programme costs, and only after the client has found sustainable paid work, the agency receives the rest of the budget: no cure, less pay. This financial structure easily contributes to programmes in which the final destination – sustainable paid work – is the guiding principle.

This focus on activation creates a paradoxical situation. The 'vitalistic' rhetoric of return-to-work policies makes illness, and other forms of human suffering, invisible. The strong focus on capabilities turns disability into a non-issue. This is problematic, especially in the case of vocational rehabilitation programmes that are developed to support people with a work disability. Illness is embodied, narrated, contextualized and practiced in the everyday lives of programmes' participants. Thus: illness is made irrelevant as well as relevant. This paradoxical starting point leads to an ambivalent system. Professionals and clients have to create ways to deal with this ambivalence in their daily vocational rehabilitation practices. How to care (for illness, suffering, clients' needs, etc.) in a context of activation?

With an analysis of various ways in which clients and professionals speak about vocational rehabilitation trajectories they participate(d) in, we illustrate how 'caring' enters the context of 'activation'. We base our analysis on narratives of clients and in-depth interviews with professionals. By articulating various ways in which caring is 'done' in vocational rehabilitation programmes, a new frame of reference will be created that may inspire policy makers in conceptualizing a differentiated notion of activation that leaves room for and values 'caring'.

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Barnes, Prof. Marian; Marian.barnes@brighton.ac.uk	p.37
Baur, Vivianne - v.baur@vumc.nl	p.38
Bjornsdottir, Prof. Kristin; kristbj@hi.is	p.38, p.48
Boulton, Amohia; amohia@wakauae.co.nz	p.26
Bozalek, Prof. Vivienne; vbozalek@uwc.ac.za	p.10
Bradley, Andy; enquiries@frameworks4change.co.uk	p.39
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Casalini, Brunella; casalini@studistato.unifi.it	p.17
Ceci, Christine; Christine.ceci@ualberta.ca	p.14, p.48
Collins, Kalthleen; Kathleen.collins39@gmail.com	p.23
Cox, Rosie; r.cox@bbk.ac.uk	p.27
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De-Merich, Diego; d.de-merich@lse.ac.uk	p.24
Dunn, Heather ; h.dunn@shu.ac.uk	p.41
Eccles, Andrew; andrew.eccles@strath.ac.uk	p.11
Emond, Dr Ruth; h.r.emond@stir.ac.uk ; hre1@stir.ac.uk	p.31
Evans, Dr. Ruth; r.evans@reading.ac.uk	p.32
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Henderson, Neil ; nhenderson@uwc.ac.za	p.43
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León, Dr Margarita; margarita.leon@uab.es ;	p.45
Liveng, Anne; aliveng@ruc.dk	p.46
McCarthy, Jane Ribbens; j.c.mccarthy@open.ac.uk	p.20
McKenzie, Dr. Judy; jmjudymckenzie2@gmail.com	p.46
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Murray, Kirsty; enquiries@frameworks4change.co.uk	p.39
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Niehof, Dr Anke; anke.niehof@wur.nl	p.33
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Stocks-Rankin, Catherine-Rose; s.stocks-ranking@sms.ed.ac.uk	p.49
Strauss, Kendra; Kendra.strauss@glasgow.ac.uk	p.27
Stroud, Dr. Julia; j.stroud@brighton.ac.uk	p.7
Stubblefield, Anna; chat4anna@gmail.com	p.9
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