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Dependence, independence or inter-dependence? Revisiting the concepts of 'care' and 'dependency'

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ABSTRACT

Research and theory on 'dependency' and 'care-giving' have to date proceeded along largely separate lines, with little sense that they are exploring and explaining different aspects of the same phenomenon. Research on 'care', initially linked to feminism during the early 1980s, has revealed and exposed to public gaze what was hitherto assumed to be a 'natural' female activity. Conversely, disability activists and writers who have promoted a social model of disability have seen the language of and the policy focus upon 'care' as oppressive and objectifying. 'Dependency' is an equally contested concept: sociologists have scrutinised the social construction of dependency; politicians have ascribed negative connotations of passivity; while medical and social policy discourse employs the term in a positivist sense as a measure of physical need for professional intervention. Autonomy and independence, in contrast, are promoted as universal and largely unproblematic goals. These contrasting perspectives have led social theory, research and policies to separate and segregate the worlds of 'carers' from those for whom they 'care'. Drawing on the work of Kittay and others, this paper explores the ways in which sociological perspectives can develop new understanding of the social contexts of 'care' and 'dependence'.

KEY WORDS – care, dependency, independence, inter-dependence, disability, ageing.

> A climate of dependence can in time corrupt the human spirit. Everyone knows the sullen apathy of dependence and can compare it with the sheer delight of personal achievement (John Moore, UK Secretary of State for Social Security, 1987).
>
> We are by our very nature both individuals and dependent creatures, and any plausible account of 'the sheer delight of personal achievement' must make reference to that dependence (Mendus 1991: 23).

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Introduction

In the context of the needs for assistance that arise from physical or cognitive incapacities – the care which Parker (1981) termed 'tending' – it is often asserted that those who depend on care have interests, needs and perspectives that are radically different from the people who see themselves as responsible for providing it. As argued in this paper, this is because research and theory on dependency and care-giving have emerged from different theoretical paradigms and proceeded along largely separate lines, with little sense that they are exploring and explaining different aspects of the same phenomenon. Research on 'care' has exposed to public gaze and to policy what hitherto has been assumed to be an unproblematic and 'natural' female activity. Conversely, the disability activists and writers who have promoted a social model of disability have challenged the language of and the policy focus on 'care', as oppressive and objectifying: these perspectives have also recently begun to penetrate academic social gerontology (*e.g.* Oldman 2002). 'Dependency' is an equally contested and widely used concept. Although concepts of autonomy and independence have received critical attention, they are nevertheless commonly promoted as the antithesis of dependency and, moreover, as unproblematic and universally desirable goals.

But are 'care' and 'dependency' really distinct phenomena, and what is the relationship between them? Does the need for and provision of care entail a profoundly unequal relationship, characterised on the one hand by disproportionate power, and on the other by powerless dependency (Orme 2001)? Or are 'care' and 'dependency' both multi-faceted concepts which can accommodate a fine rebalancing of power through the recognition of interdependencies? Must a need for care necessarily be a cause of dependency; do the concepts of care and dependency need to be rescued?

These questions will be discussed in this paper with reference to the needs for help and support that can arise in old age, and to the 'care' which is provided by formal welfare services and, informally, by relatives and others. The paper draws on diverse theoretical and policy literature from Australia, Britain and the United States. The paper first outlines the origins of the discourse of 'care' in British feminist academic scholarship and in wider political debate, in order to make explicit the assumptions and meanings which have become attached to the term. It then discusses the complex and contested concept of 'dependency', and identifies some challenges to the conventional structuring of 'care' and 'dependency' as discrete, oppositional concepts, particularly those that arise from demographic changes and from social gerontology and disability writing.

Finally, by drawing on the work of Eva Kittay (1999) and others, some of the ways in which the tensions and conflicts between the languages of 'care' and 'dependency' might be reconciled are proposed. Kittay demonstrated the importance of power relations in the analysis of care. The paper argues that development of this approach holds considerable promise for future research and policy in this field.

Feminism and the discourse of 'care'

Research on 'care' emerged during the 1970s and 1980s from several concerns of feminist academics: to make visible the nature and extent of the unpaid work carried out by women in the private domains of the family and home; about the assumptions of both the economic and welfare states that this labour was somehow 'natural'; and about the implications for social justice. Theoretical writing and empirical research explored the position of women in relation to both the family and the state. The assumption that women provide extensive unpaid care for children and other able-bodied and disabled family members was made explicit and elaborated: '[Married] women acquire a set of domestic duties which include caring for their children, their elderly or sick relatives and, of course, their husbands' (Land 1978: 360).

Initially, discussion focused on the sexual division of labour in the context of childcare and housework, but Finch and Groves (1980) extended this gender analysis to wider areas of public policy. They 'transformed' discussion and debate by cutting through 'the euphemistic language of "community" and "family" to argue that community care was essentially about the care provided by women; and discussed the effects of caring on women's life chances in terms of equality of opportunities with men' (Baldwin and Twigg 1991: 118).

A stream, then a torrent, of studies emerged over the next two decades. Feminist scholars argued that as the burden of caring in the home falls on women, community care policies needed to be understood as regressive and patriarchal, effectively transferring responsibility from the state to the family and, within the family, to women. Documentation of the extent of informal care-giving by women and of the personal, material and opportunity costs associated with it, which were not compensated by state support, were central to this approach (Finch and Groves 1980, 1983). Shaped by this paradigm, research focused on the so-called 'burden' of care, and documented various ill-effects that could result from caring for older relatives, including stress, limitations and emotional impacts (for example Nissel and Bonnerjea 1982; Wright 1986; Ungerson 1987; Lewis and

Meredith 1988; Glendinning 1989; Heron 1998). Because of the intellectual origins in feminist theory and feminist critiques of the welfare state, particular attention was paid to the circumstances of married women of working age (Brody 1981; Braithwaite 1989; Parker 1990; Watson and Mears 1995, 1999). Where male carers were included in such studies, accounts of their experiences were accompanied by evidence that many received more support from statutory welfare agencies than their female counterparts (Charlesworth, Wilkin and Durie 1984; Wright 1986; Arber, Gilbert and Evandrou 1988).

This burgeoning research was matched in the political arena by the emergence of carers' advocacy organisations, and by policy initiatives that responded directly to these concerns with various support programmes for carers. A significant and lasting consequence of these developments was the introduction of the terms 'carer' and, in the USA, 'care-giver' (Bytheway and Johnson 1998). The carers' movement appears to have emerged first in the UK where, from 1965, carers' organisations have consistently argued for compensation and improved support through the fiscal, social security, health and social welfare systems. In Australia, the term 'carer' was first used in relation to home-support of older people in a 1976 report, *Dedication* (Stephenson 1976). This was soon followed by a members' organisation that called for public recognition. Policy-makers' responses to these campaigns have been in part prompted by concerns about the actual and potential supply of people to care for older relatives, because the availability of unpaid care is thought to be particularly vulnerable to changes in labour market participation and family structures (Shaver and Fine 1996; Royal Commission on Long-Term Care 1998; Pickard *et al.* 2000).

An alternative strand of feminist analysis, with very different normative overtones, emerged in the USA. Rather than emphasising the negative ('burdensome') features of care, a discourse on the 'ethic of care' emphasised its socially positive and desirable features. In particular, this literature highlighted the relationships in which care is given: 'The ideal of care is thus an activity of relationships, of seeing and responding to need, taking care of the world by sustaining the web of connection so that no one is left alone' (Gilligan 1984: 73). Gilligan identified a distinctive set of moral principles linked to 'care' which need to be recognised alongside – distinctive from, but equal to – those of 'rights' and 'justice'. At one level this 'ethic of care', most evident among women, can be understood as the outcome of a process of moral growth, in contrast with the rule-based, impersonal justice often associated with masculine maturity. Gilligan argued, however, that this gender link is not inevitable: 'Development for both sexes would therefore seem to entail an integration of rights and

responsibilities through the discovery of the complementarity of these disparate views' (Gilligan 1984: 100).

Other writers on the ethics of care, such as Noddings (1984), Tronto (1993) and Sevenhuijsen (1993, 1998), have also sought to lift the concept from its taken-for-granted origins as a 'natural', highly personal and therefore essentially private activity undertaken primarily by women, and to locate it in a wider arena in which relationships, responsibilities and their practical execution are accorded social value. An important theme in Tronto's (1993) and Sevenhuijsen's (1998) work has been rejection of Gilligan's dichotomy between a (female) ethics based on 'care' and a (masculine) ethics based on 'justice'. They argued that care is a precondition for justice, and that the right to receive and to give care needs to be thought of as an issue of social justice. Because the relationships in which care is given and received are characterised by vulnerability and disempowerment, they argued that care needs to be subject to considerations of rights and justice, not differentiated from it. This approach has, in turn, been criticised from a post-modern perspective that challenges the search for an over-arching concept (or meta-narrative) of care (Bowden 1997). The argument is that because the ethical dimensions of the concept vary considerably in different contexts (such as motherhood, nursing, friendship, disability and old age), the attempt to elaborate a single set of principles is futile and possibly dangerous.

The discourse of dependency

'Dependency' is also a widely used, strongly emotional, but essentially contested concept, especially in the context of elder care. But while 'care' is a heart-warming concept with a positive valance, dependency is cold and its connotations are almost entirely negative. Those identified as dependent are assumed actively to seek to reverse this status. There have been several academic analyses and critiques of the concept of 'dependency'. This section focuses on three aspects of the debate about dependency: its complex meanings and aetiology; its status as an intrinsic individual attribute or a social construct; and the appropriateness (or otherwise) of the negative connotations with which it is commonly endowed. In practice, however, at least some of the analyses and critiques range across these themes.

There is ambivalence about acknowledging that dependency is a normal, indeed necessary, social condition. In private life, 'dependency ties people together. A child who is unable to depend on adults for guidance would be a profoundly damaged human being, unable to learn and deeply

insecure. As adults, if we avoided people sicker, older, weaker than ourselves who needed help, we would at best have a circle of acquaintances, not friends' (Sennett 2003: 111). In the public realm, however, dependency has been made to appear shameful. Like the term 'care', dependency is an ideological as well as a social construct (Fraser and Gordon 1994). The ideological dimension suggests a broader use for the term than simply a descriptor. Fraser and Gordon (1994) identified four 'registers of meaning':

- Economic dependency;
- Socio-legal dependency;
- Political dependency; and
- Moral or psychological dependency.

Walker (1982) similarly differentiated several types, or causes, of dependency in old age: life-cycle dependency; physical and psychological dependency; political dependency; economic and financial dependency; and structural dependency. Gibson (1998) also proposed a typology that included economic, political, legal, psychological and emotional dependencies, each of which could be distinguished from dependency that arises from age-related ill health or frailty. The latter applications of the concept are particularly relevant to gerontological research, which has produced an extensive literature on the measurement of dependency. Each of these 'registers' of dependency has especial significance for older people. Moreover, they are not independent of each other: economic, political and physical/psychological dependency may be wholly expected and legitimated at particular stages of the lifecourse (Lloyd 2003). Furthermore, measures of one particular type (for example, physical or psychological dependency) may overlook other dimensions of dependency (such as economic and financial dependency) that interact with and exacerbate the effects of age-related disabilities (Wenger 1986).

This leads to the second area of debate, about the treatment of dependency as an individual attribute or a product of social relations. Arguments about the social construction of dependency in old age are well established. Townsend (1981) cited pensions policies and residential care to show how dependency is the result of intentional social and political actions. Both Townsend (1981) and Walker (1982) drew attention to the ways that the welfare state can create and legitimise dependency amongst older people, and to the compounding of their exclusion from waged employment through the institution of retirement by inadequate pensions and health-services support. In relation to the kinds of dependencies for which 'care' might be given in old age, Wenger (1986) and Wilkin (1987) both pointed to the ways in which conventional, medically-based measures of 'dependency' – the ability to perform a range of daily activities – are highly

influenced by an older person's wider social environment. Consequently, conventional approaches to measurement are confounded by the assumption that dependency is 'an individual attribute rather than a social relationship in which the behaviour and perceptions of all the actors contribute to the construction of the situation' (Wilkin 1987: 872). The next section returns to the social construction of dependency in the context of 'care-giving'.

The third dimension of the dependency debate examined here is the assumption that dependency is a negative state that should be alleviated wherever possible by public policy measures, treatments or other interventions. As Fraser and Gordon (1994) showed, in contrast to its historical acceptance, dependency is widely presumed today to be a negative attribute amongst adults, in which psychological and moral failings compound issues of legal, social or economic status. The goal of social, fiscal or other policies is therefore assumed to be the reduction or minimisation of this negative state. Negative connotations are also evident in demographic debates about dependency ratios and overall 'population ageing'.

Only rarely is dependency viewed more positively. Applying a typology of dependency to her psychological and social research with older people, Margret Baltes (1996) distinguished structural, behavioural and physical dependency. Although the immediate impact of each of these forms may be to deprive an older person of positive agency, each has a different aetiology and calls for different responses. Baltes argued that, while it may be desirable to adopt policies and interventions that eliminate structural and behavioural dimensions of dependency, this is not possible with physical dependency. Instead, she argued that to recognise dependency amongst those who need help as a result of age-related disability is a valuable 'optimising strategy in that it initiates and secures social contact' (Baltes 1996: v). She further argued that seeking and accepting the help of others should be a positive adaptation strategy which protects and maximises the use of scarce resources and capabilities in other areas of life that have particularly high personal value. In this respect, Baltes's rejection of a discourse that emphasises the negative aspects of dependency echoes the feminist writings on the ethic of care that emphasise care as involving the positive interweaving of a 'complex, life-sustaining web' of connectedness between people (Tronto 1993: 103).

Challenges to the discourses of 'care' and 'dependency'

Thus far we have outlined key features of the concepts of 'dependency' and 'care' and traced their development and use. Clearly there are strong

parallels, overlaps and causal inter-relationships between the two: caring may be a response to dependency; dependency is characterised by a need for assistance, which may be met through the provision of care; and care can itself create or deepen dependency. Yet the two remain distinct and dichotomised fields, with considerable potential for conflict. In the next section we identify two sets of pressures that require a more productive approach: the changing demographic profile of family care-givers; and younger disabled people's challenges to the dominant concepts and paradigms of dependency and care.

The demography of ageing and care-giving

The emergence of the academic study of 'care' from feminist scholarship on the roles ascribed to women in modern welfare societies may have obscured other dimensions of care-giving relationships. As Baldwin and Twigg (1991: 121) pointed out, 'Much of the feminist literature has been concerned with the unequal burdens of women in relation to the care of elderly people, of disabled offspring and other kin. This emphasis may have obscured important differences that obtain where the dependent person is one's spouse and where considerations of gender are less clearly dominant'.

Orme (2001) also argued that in feminist scholarship, men's role as carers has either been denied or been constructed as qualitatively different from that of women, although empirical evidence of the substantial contribution by men to informal care-giving has been available for some time. An analysis of the British 1980 *General Household Survey* (Arber and Gilbert 1989) showed that over one-third of co-resident carers of older people (those likely to be most intensively involved) were men. Longitudinal analyses have confirmed that it is not only working-age women who care for older relatives. Between 1991 and 1998, the number of men in the UK involved in co-resident and intensive caring for an older person increased absolutely and at a greater rate than for women in the same role. Most striking was the increase in men caring for a disabled spouse – by eight per cent per year, twice the rate of increase of women caring for a disabled spouse. By 1998, there were proportionally as many men as women providing care for a spouse (Hirst 2001). According to the 2001 UK Census, 14 per cent of men and 12 per cent of women aged between 65 and 84 years were carers, as were nine per cent of men and three per cent of women aged 85 or more years. More men than women aged 75 and over now provide between 20 and 49 hours a week of informal care, and more men than women aged 75 to 84 years provide 50 or more hours a week (Office of National Statistics 2003, Table T05).

Australian statistics also show that, although in the majority of cases women continue to take responsibility for informal care, approximately 30 per cent of 'primary carers' are male; and for those aged 65 or more years, a higher proportion of men than women report caring responsibilities (Australian Bureau of Statistics 1999). Older carers predominantly look after other older people (Milne 2001); indeed, in both Australia and the UK, the likelihood of becoming a carer increases with age among older people. Factors contributing to this shift include the increasing longevity of men and a decrease in multi-generational households into which older people have moved to live with their children.

Research on informal care networks (Kendig 1986; Wenger 1994) and other studies of the care of older people (Chappell, Penning and Behie 1996; Bytheway and Johnson 1998) have challenged the foundations on which the oppositional concepts of 'carer' and 'dependent' are constructed. Most significantly, for the purposes of this paper, the visibility of older people (particularly older men) as carers suggests that, in shaping patterns of care-giving, in this age group at least, gender is no longer the most influential factor. Moreover, in the case of older givers and receivers of care, it may also be increasingly inappropriate to distinguish a 'dependent' older person (with a range of personal, health, social and emotional needs) from a 'carer' (who meets those needs). It is likely that both will have some needs; indeed the extensiveness and severity of these may be finely balanced between the two. As one example, the role of dementia in creating needs for care in advanced old age is associated with high levels of stress and depression amongst carers (Melzer *et al.* 1994).

Current socio-demographic trends therefore call for a revision of earlier analyses which represented caring as a distinctively female activity, associated with 'intimate relations' in the 'private places' of the home and family (Graham 1983: 16) and marking the boundary between 'female' and 'male'. The relationships that provide an increasing amount of informal care for older people are clearly shaped both by patterns of reciprocity and obligation that have built up in long-term relationships and by gender. Research on the experiences of disability and care-giving in younger couples (Parker 1993), and the little that is known about care-giving relationships among older people (Milne 2001), confirm that a rethink of the feminist carer-dependent paradigm is appropriate. Moreover, Baltes's suggestion that the behaviours associated with dependency can be viewed as a positive adaptation also offers insights into the relationships between older people through which they manage their physical or mental limitations and negotiate care-giving and receiving.

The challenge from younger disabled people

A rather different imperative for the reconceptualisation of the care/dependency dichotomy comes from younger disabled people. Like feminists, the disability rights activists have challenged both the language of, and policy focus on, 'care' and the conceptualisation of people who receive care as 'dependent'. Their approach is highly relevant for social gerontology theory and action (Oldman 2002). Younger disabled writers also point out that dichotomising 'care' and 'dependency' assumes an absence of 'caring' activities on the part of disabled people. In contrast, Morris (1991, 1993, 1994) drew attention to the care given *by* disabled women in their roles as parents and wives. Like other feminists, she argued that community care is predicated on the availability of unpaid domestic and familial labour in a way that exploits those women (and men) who provide it. Morrids argued that this degrades and disempowers the recipients of 'care'; she rebuked her feminist colleagues for treating caring as simply another form of unpaid domestic drudgery and its recipients as little more than a burden. In their concern to make visible the unrecognised and unpaid elements of women's work, feminists, it has been argued, have displaced yet further the voices of people receiving care (Keith and Morris 1995).

Disability writers have also addressed the concepts of 'independence' and 'autonomy'. Independence, they argue, needs to be understood not as being able to perform activities for oneself without assistance, but as being able to exercise control over whatever help is required in order to achieve chosen goals and objectives (Brisenden 1989). For older people, Collopy (1995) made a similar distinction between the process of making decisions ('decisional autonomy') and the ability to implement, operationalise and carry out those decisions ('executional autonomy'). Thus, someone may continue to exercise a substantial level of decisional autonomy, which maintains a sense of self and personhood intact, even though the execution of those decisions may involve others.

More recently, Shakespeare (2000*a*, 2000*b*) attempted to bridge the gulf between the 'discourse of care' and the 'discourse of burden'. He reminded us that the concept of 'dependency' too often connotes negative 'burdens' and deficiencies on the part of the person needing help, and argued that the voices of those needing help must be heard as clearly as those who provide it. Drawing on the feminist ethics of care, he argued that the 'individualizing and excluding' language of dependency should be replaced by a recognition of the basic social condition of 'interdependence' and caring solidarity (2000a: 63–4). The potential of the notion of interdependence for resolving some of the difficulties with 'care' and

'dependence' are discussed below. Although originating in the disability movement, his discussion is again highly relevant for thinking about dependency, care and ageing.

Promoting 'help' and 'interdependence'

Shakespeare (2000*a*, 2000*b*) called for the rejection of both 'care' and 'dependency'. He argued that these two negatively loaded concepts should be replaced by a recognition of human interdependency, and then suggested that the term 'care' should be replaced by that of 'help', because it suggests the possibility of alternative forms of social support and more informal, community networks and practices (Shakespeare 2000*b*: 71). These, moreover, can be underpinned by altruism and friendship – values that arguably give greater emphasis to choice and genuine moral and personal commitment, and which have the capacity actively to engage both recipients and care-givers.

Replacing the terms 'care' and 'dependency' with 'help' and 'interdependency' is an appealing linguistic solution to the difficult dilemmas we have considered. As Williams (2001) argued, friendship suggests a meaningful, mutual personal connection, something that should be a feature of any good relationship in which personal support is a feature. Similarly, the concept of interdependence has significant appeal as a social vision, and suggests a universal and positively valorised condition of humanity. The alternative notions of 'help' and 'interdependence' cannot, however, deal adequately with the problems of inequality and lack of personal capacity that still need to be addressed. Moreover, both terms pose the issue as inter-personal and effectively preclude the role of the state in managing risk and regulating resources and behaviours. If 'help' were willingly forthcoming from friends and the community, there would be no requirement for the state to intervene. Nor does an acknowledgement of generalised social interdependence legitimate claims from individuals with particular needs arising from advanced age to have access to the resources required to assist them. While the idea of mutual aid based on values of friendship suggests a pleasing and spontaneous willingness to provide assistance, there is no sense of the need for long-term commitments; nor a sense of urgency, need or priority in establishing claims for assistance. Nor does this approach offer a basis for providing help to those older people whose extreme isolation provides no opportunities for mutual aid (Lloyd 2003). This approach, therefore, while initially appealing, suggests a deeper unwillingness to confront the harder issues involved in making political, economic and moral claims for ongoing support.

To argue against using the terms 'help' and 'interdependency' as replacements for 'care' and 'dependency' is not to reject the insights that these concepts offer. As Gibson (1998: 205) observed, few deny that members of ever more complex social systems will experience interdependence as a result of their location in multiple, overlapping networks of dependency. Indeed, this could be said to be a fundamental insight underlying the sociological analysis of modern social life. Emile Durkheim noted a century ago that in complex societies with extensive divisions of labour, 'social cohesion occurs because one person is always dependent upon another to achieve a feeling of completeness' (Durkheim 1984: 21–22, cited in Sennett 2003: 124).

From this perspective, interdependence can be seen as the result of reciprocity between partners, exchanges between dependent actors over time, and the networking of these relations of dependence. In other words, to recognise 'interdependence' is not to deny but to acknowledge relations of dependence. Kittay (1999: 67–8) spoke of 'nested-dependencies' that characterise 'exchange-based reciprocity'. Rather than there being an expectation of direct and immediate reciprocation between care-giver and care recipient, the exchange may take the form of a delayed reciprocity or transferred responsibility, with an expectation that the 'chain of obligations linking members of a community' will lead, if the need arises, to others who are in a position to respond. As one African-American woman said when asked to explain her commitment to caring for others, 'what goes round comes round' (Gerstel 1991: 20, cited in Kittay 1999: 68). Building on this idea, we suggest that rather than abandoning the terms 'care' and 'dependency', a more promising approach is to recognise their essentially contested nature, and to rethink and rehabilitate the meanings inherent in the terms. In doing so, it will be necessary to recognise and address the neglected issues of power that infuse both concepts, as Kittay (1999) has recently done.

Care, dependency work and power

Kittay placed considerations of power at the centre of her important recent re-analysis of the concepts of care and dependency. Dependency, for Kittay, is not an artificial or undesirable social condition, but a fundamental and commonplace aspect of the human lifecourse, an aspect of the human condition encountered in early childhood, illness, disability and frail old age. These are periods of 'inevitable dependencies' of the human lifecourse (Fineman 1995 cited in Kittay 1999: 29; see also Lloyd 2003). Cultural, social and moral conditions in different societies and at different

points in history shape both the way these dependencies are understood and the social responses to them (Kittay 1999: 29). One result of this, it can be argued, is that in advanced liberal democracies acknowledgement of the reality of dependency is denied though the promotion of an ideal of individual autonomy.

Providing care, the task of attending to dependants, is termed 'dependency work' by Kittay deliberately to emphasise that the 'care of dependants is work … traditionally engaged in by women' (Kittay 1999: 30). She identified those who directly provide such care (whether paid or unpaid) as 'dependency workers', while those whom they assist are termed a 'charge'. (We use this term, like that of dependency work, in accordance with Kittay's usage, but caution against its wider adoption). Kittay identified a paradigmatic form of dependency work in which daily, ongoing, personal assistance is required. Following Martin (1989, cited in Kittay 1999: 31), she defines this dependency work as labour that requires the three Cs: *care*, tending others in response to their vulnerability; *connection*, building intimacy and trust or sustaining ties between intimates; and *concern*, giving expression to the ties of affection that sustain the connection. The wellbeing of the 'charge' is the responsibility and primary focus of the dependency worker. While the worker has responsibility for the 'charge', the dependency relationship does not authorise the exercise of power unless it is for the charge's benefit.

To examine the nature of power within and surrounding the care relationship, Kittay made the useful distinction between inequality of power and the exercise of domination. Inequality of power, she noted, is prevalent in dependency relationships although it is not necessarily a one-way process, especially when care involves older people (Lloyd 2003). While the care recipient is vulnerable to the abuse of power by the care-giver, the reverse may also be the case; the charge may have power over the worker as a result of social position, wealth, control of employment, through forms of moral blackmail or through the worker's (over-) identification with the charge. These sources of unequal power do not necessarily mean that abuse is inherent in the relationship, as the relationship is, ideally at least, built on mutual trust and responsibility. Domination represents a breakdown of this mutual trust by either the worker or the charge. Kittay noted:

> Domination is an illegitimate exercise of power. It is inherently unjust. The moral character of a dependency relation and its nature as a caring or uncaring relation is determined, at least in part, by how the parties in the dependency relation respond to one another, both with respect to the vulnerabilities of the dependant *and* to the vulnerabilities created for the dependency worker. Inequality of power is compatible with both justice and caring, if the relation does not become one

of domination. That the relation be a caring one is largely the obligation of the dependency worker. That the relation not be one of domination is an obligation that equally befalls the dependency worker and the charge (Kittay 1999: 34, emphasis in original).

The vulnerability of care recipients arises from their lack of physical or mental capacity. To counter this, moral opprobrium against their domination by the worker is strong, extending into legal sanctions and penalties that, although rare, may be enforced in either civil or criminal law. The vulnerability of the care-giver in turn arises from her social position, including the isolation of the domestic situation; from her readiness to assist; through her identification with the wellbeing of the charge; and from the moral or legal constraints on her ability to express annoyance or vent frustrations in interacting with the vulnerable charge in ways that are normally acceptable between equals. A special vulnerability of carers therefore arises from their dedication and sense of duty, and from the ties formed through the care recipient's dependence on their work (Kittay 1999: 34–35). As noted earlier, recognition of the vulnerability of dependency workers is a recent development, and the response in Britain and Australia (at least) has been to provide informal care-givers with information, counselling and access to limited financial support and support services such as respite care. Support for paid care-workers, as reflected in typical levels of pay and conditions of employment, remains equally limited.

The analysis of power in the dyadic relationship between dependency worker and 'charge' is thus central to Kittay's account, although it is only part of the picture. Equally important is the fact that dependency workers, whether paid or unpaid, 'have been made vulnerable to poverty, abuse and secondary status … and often suffer psychological, sexual and other physical abuse as well as economic exploitation' (Kittay 1999: 40–1). Expressions of these vulnerabilities resonate in the claims of carers' organisations for increased recognition and material support. Kittay explained this situation (which has not lessened with the increasing participation of women in the labour market) as one that involves a second level of dependency, one that might be described as socially constructed, in contrast with the primary, physical dependency of the charge. This second dependency arises from the fact that both the 'charge' and the dependency worker are sustained and protected by their reliance on a third party, whom Kittay called 'the provider'. In a familial situation, the worker, as wife or mother, may be dependent on a male provider, who assumes the position of breadwinner and head of the household. In an aged household in a welfare state, it is inappropriate to speak of a 'breadwinner' and the carer is likely to be

dependent on state old-age or welfare benefits or payments-for-care. Kittay noted:

> In the case of the dependency worker, the provider's control of resources combines with a general social devaluation of the work of dependency to thwart the possibility of a comparable autonomy for the dependency worker. To speak of this diminished autonomy is another way of speaking of the dependency worker's unequal relation to the provider (Kittay 1999: 45).

In this situation, as Ungerson (1997) has pointed out, both the recipients and the providers of care are at risk of impoverishment and vulnerable to exploitation. Kittay argued that if we lack the capability to care for ourselves and therefore need support, we should be able to receive it without those who provide the assistance being penalised. This too is similar to the arguments of both feminists and carers' lobby organisations for financial and other forms of support at a level that avoids impoverishment as a consequence of care-giving. Recognition of the increased risks of dependence in advanced old age, and of the need for care of those who are dependent, must involve an acknowledgment of human interdependencies. Such a concept is not an assertion of interdependency as an alternative nor a negation of dependency, but rather one based on the recognition of 'nested dependencies' that link those who need support with those who help them and which, in turn, link the helpers to a set of broader supports.

Kittay's analysis recognises the issues of power and dependency central to an understanding of care. Rather than avoiding the term 'dependency', Kittay shows it to be an important and effective conceptual tool for examining the intersections between those who require assistance and those who provide it. Recognising bodily dependency as the basis of claims for assistance, and identifying a second, socially-created level of dependency as an undesirable (and reversible) consequence of arrangements for the provision of care, does not preclude acknowledging the rights of both care recipients and care-givers to exercise independent decisions and to optimise control over their circumstances. Rather, it provides a sound foundation from which to justify claims for support. In this context, independence is perhaps best understood not as non-dependence – a structural notion that suggests the absence of practical, social or economic ties with another person – but as 'relational autonomy' (Mackenzie and Stoljar 2000). As Collopy argued, autonomy, which may be understood as the exercise of a sense of a complete self, is socially created and defined:

> … long-term care … must recognise self-determination that flows from an individual's affective metabolism, and expresses itself not in atomistic decision-making, but through intensive sharing and interchange with family members and

care providers. The principle of respect for autonomy … calls for recognising the complex ways in which individuals compose their autonomy from their relationships (Collopy 1995: 9).

Kittay's analysis of care is as a relationship framed by power and sees its obverse, dependency, as manifesting the relative powerlessness of both carers and care-recipients. Despite her important and valuable distinction between power and domination, we suggest that this analysis of power remains underdeveloped. Further work is required to extend the analysis of care as a relationship framed by power, drawing on a contemporary notion of power as capability in which the underlying notion is not of force against resistance, but of power as a form of empowerment – 'power to' not 'power over' (Clegg 1989; Collopy 1995). Power, in this view, is more generally the ability to do or to affect something. As Giddens (1984: 14) argued, '[action] depends upon the capability of the individual to "make a difference" to a pre-existing state of affairs or course of events. An agent ceases to be such if he or she loses the capability to "make a difference", that is to exercise some sort of power'.

Such an approach, we believe, may lead to a more positive evaluation of care. It could help identify the ways in which both care-givers and recipients might develop their capabilities – to effect meaningful changes in their own lives, to manage the inevitable dependencies of life and to reduce or eliminate secondary, socially-imposed dependencies that deny their attainment of autonomy – in the systems of nested dependencies that constitute the broader system of relationships of care.

Conclusions

Along with the writers reviewed earlier in the paper, Kittay appears to see care as a one-directional activity, done by one person to another. At times she uses 'care' as a verb that denotes the work involved in providing ongoing personal support, supervision and monitoring; at others, it is used descriptively to denote special qualities. Both uses are acceptable, and both conform to Martin's criteria of the 'three Cs'. Kittay's cautious and somewhat ambivalent use of the term care is, however, suggestive of a deeper re-evaluation of the concept.

Recent studies of care suggest that qualities of reciprocal dependence underlie much of what is termed 'care'. Rather than being a unidirectional activity in which an active care-giver does something to a passive and dependent recipient, these accounts suggest that care is best understood as the product or outcome of the relationship between two or more people. As Baldock (1997: 82) pointed out, 'Social care is … produced and consumed

almost simultaneously. … In particular, the activities and response of the 'user' become part of the quality and success of the production'. From this perspective, both recipients and providers are intrinsically involved in the creation or 'production' of care (see also Finch and Mason 1993; Baldock and Ungerson 1996; Baldock 1997; Ungerson 2000).

Other recent analyses have also emphasised the agency of both care receivers and providers. Lloyd (2000: 148) argued that caring should be understood as a 'widespread activity in which we are all implicated', and that we need to 'balance the rights of both people in the caring relationship'. In calling for a rethink of care as a 'relationship-based' activity, Henderson and Forbat (2002) argued for the recognition in policy and research of the changing patterns of social relationships and care needs; and for open acknowledgement of the tensions that arise in care-related policy by incorporating the perspectives of care-receivers as well as caregivers. Bytheway and Johnson (1998: 252–53) took the argument further and asserted:

> … although for the individual, care implies active involvement in a number of one-to-one relationships (and this number may well be just one), these relationships are normally set in the context of 'ordinary' networks of personal relationships, networks which normally include a complexity and multiplicity of care needs. … The person with first hand experience will know that care relationships are often mutual, that most people who are involved in both receiving and providing care, albeit perhaps in very different ways.

This perspective, they argued, revives an earlier understanding of care, for example as articulated by Townsend (1963), as an ongoing and mutual activity undertaken by older people and their relatives in the context of family life. Recent biographical research on carers in Britain and Germany has similar elements (Chamberlayne and King 2000). A recent study that replicated the pioneering 1940s and 1950s investigations of the family and community networks of older people also confirmed the important contributions of family, local and wider social networks (Phillipson *et al.* 1998).

Thus, both recent empirical research and theoretical critiques have suggested that 'care' does not denote a narrow set of activities or tasks, undertaken without the active engagement of the supposed beneficiary (Rønning 2002). Instead, care is a complex concept that (with the exception of forms of self-care) cannot be undertaken by one person alone; it is both an ideal and a daily reality, a set of practices and ways of going about support that often falls well short of the ideal. It is a social concept that defies rigid definition, yet is helpful as both a normative, aspirational guide and a term for describing our behaviour. Both levels present possibilities for social analysis and create tensions between them.

Neither 'care' nor 'dependency' have simple, uncontested meanings. Both refer to a range of social phenomena that involve diverse characteristics that extend from physical activities, through the social relationships among individuals and groups and their positions in the transactions of care and dependency, to the mental states or dispositions involved in caring about someone or being dependent. Rather than calling for the terms 'care' or 'dependency' to be abandoned, there are good reasons to expect that both will continue to be used in policy discussions, research and elsewhere. But neither term should be regarded as having a fixed or rigid meaning. Instead, the range of meanings embedded in both concepts indicates important possibilities and ideals that create opportunities for the active development of practices of human recognition in response to lifecourse imperatives.

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