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# **On the relational dynamics of caring: a psychotherapeutic approach to emotional and power dimensions of women's care work**

## ***Abstract***

Care is double-edged and paradoxical, inspiring a vast range of strong feelings in both care-givers and care-recipients. This paper draws on ideas about psychotherapeutic relationships to offer a theorisation of the complex emotional and power dynamics and imaginative geographies of care. Examining the humanistic approach developed by Carl Rogers as well as the psychoanalytic tradition, I advance an interpretation of psychotherapeutic practices that foregrounds the fundamental importance of the emotional and power-inflected relationship between practitioners and those with whom they work. I show how different traditions offer conceptualisations of the shape of therapeutic relationships that are highly relevant to consideration of the emotional and power dynamics of giving and receiving care. Against this background I discuss current debates about care, emotions and power, drawing especially on feminist and disability perspectives and arguing that psychotherapeutic approaches offer a powerful lens through which to understand the emotional and power dynamics of caring relationships. I conclude by emphasising how this theorisation helps to illuminate ubiquitous features of women's care work.

Key Words: Care, Emotions, Gender, Power, Psychotherapy, Relationships.

# **On the relational dynamics of caring: a psychotherapeutic approach to emotional and power dimensions of women's care work**

## **Introduction**

Care looks different and feels different from the perspectives of those delivering and receiving it. These different perspectives have been replicated in research about care, which has tended to focus either on care-givers or on care-receivers, but only rarely on both. One consequence of this is that the emotional dynamics of care relationships have received little attention in the context of geographical discussion of care and caring (Parr 2003). The aim of this paper is to provide a theoretical account of these dynamics. My approach draws on psychotherapeutic ideas, through which I seek to draw attention to emotional dimensions of women's care work, and to shed new light on conflicts between feminist analyses, which have focused primarily on women's experience of care-giving, and contributions to disability studies, which have focused primarily on disabled people's experiences of care-receiving (Watson *et al.*, 2004).

Feminist accounts of women's paid and unpaid caring work have noted how the gendering of care work is closely linked to the devaluation of care, which contributes in turn to the perpetuation of gender inequalities (England and Lawson 2005). As Hilary Graham (1983, 18) observed nearly a quarter of a century ago:

Caring is 'given' to women: it becomes the defining characteristic of their self-identity and their lifework. At the same time, caring is taken away from men: not caring becomes a defining characteristic of manhood.

Feminist commentators have also emphasised the ubiquity of care needs: none of us live our lives without relying on care provided by others (Sevenhuijsen 1998; Tronto 1993). Alongside the care needs we all experience in early life and which many of us also experience in later life, are numerous other more hidden examples of care required by supposedly independent, autonomous adults (Brown 2003). Feminists have also noted the associated centrality but invisibility of emotional dimensions of women's paid and unpaid care work (England 2005; Hochschild 1983, 2003).

In contrast to this focus on the gendered devaluation of care-giving, disability theorists (among others) have focused on the experiences of those on the receiving end of care, and have drawn attention to the ways in which care all too often contributes to the disempowerment of disabled people (Oliver 1990; Shakespeare 2000; also see Watson *et al.* 2004). In an oft-cited comment, Richard Wood (1991, 1999-200) protested:

Disabled people have never demanded or asked for care! We have sought independent living which means being able to achieve maximum independence and control over our own lives. The concept of care seems to many disabled people a tool through which others are able to dominate and manage our lives.

More generally, those whose care needs differ from or exceed those that are routinely hidden in relation to supposedly independent, autonomous adults are perceived and often denigrated as needy and dependent. This denigration and stigmatisation is frequently institutionalised within the organisation and delivery of care, which is experienced as actively disabling for the cared for, who are subject to paternalistic pity, demand for gratitude, abusive treatment, domination, control, confinement and marginalisation, all in the name of care (Shakespeare 2000; Wood 1991).

Care, it appears, has the potential to oppress both carers and cared for. Gaps and inadequacies in provision (for example McDowell *et al.* 2005), together with the (uncaring) organisation of care services (for example England *et al.* 2007), doubtless contribute to this oppressiveness. However, more important for my argument is that, for both care-givers and care-recipients, the oppressiveness of care is deeply *felt*. What care-givers give includes their emotional labour, the devaluation of which hurts or generates feelings of exploitation. Meanwhile, critical testimony from those on the receiving end of care also includes expressions of hurt, together with anger and outrage. And yet, in a wide range of contexts, at least some of the time, the giving and receiving of care is experienced as a deep and deeply rewarding expression of love, pleasure and vocation. Perhaps most widely cited is parental and especially maternal care (Ruddick 1989), but the positive virtues of care are also highlighted in numerous other, perhaps less expected, contexts and settings, including between those who give and receive care in institutions and workplaces (Sevenhuijsen 1998; Meagher 2006), and in the context of care provided by paid-workers in recipients' homes (Meintel *et al.* 2006).

On this account, care is double-edged and deeply paradoxical. These paradoxes are embodied in emotional experiences of care and caring. Care oppresses and inspires; it hurts and it nurtures; it demeans and it fulfils, it enrages and it moves; it evokes love and it evokes hate. Sometimes caring relationships elicit similar feelings in both care-givers and care-receivers and sometimes they elicit very different feelings. Perhaps above all care connects people, whether they desire such connectedness or not, and imbues these connections with a wide range of emotions (Lawson 2007). Moreover, because care is inextricably bound up with human vulnerabilities and connections forged in and through these vulnerabilities, experiences of caring relationships, as well as being emotionally complex, these relationships are also always experiences of power dynamics (Brown 2003). Furthermore, by connecting people in these fragile and delicate ways, the relationships through which care is given and received produce imaginative and subjective geographies that help to give shape to people's experiences. These geographies are themselves paradoxical, for example when we feel very distant from someone who is physically close or experience as very close someone who is physically distant (Thien 2005).

The crucial importance of relationships in all kinds of care is widely recognised but generally under-theorised. For example, family doctors are well aware that qualities of their relationships with patients influence numerous dimensions of the care they provide from their patients' willingness to disclose crucial information to whether the patient will take medication as prescribed (Davidson 2007). Similarly, in informal care, people are well aware of the importance of relationships, often articulating issues about care in terms of the capacities of, and consequences for, kin relationships in the provision of care. Particularly poignant examples are provided by issues about the care of people who are seriously ill or approaching death, with intimate relationships variously enriched and strained by care, and care enhanced or depleted by qualities of the relationship between carer and cared for (Brown 2003; Morris and Thomas 2005).

In this paper I reflect on the paradoxical qualities of care, developing a theoretical account that focuses on the emotionally-laden, interpersonal relationships in which care is given and received. I offer an approach that foregrounds and seeks to illuminate the emotional and power dynamics of giving and receiving of care. My account draws on ideas about psychotherapeutic relationships to think about these dynamics. In so doing

my approach has some similarities with a small body of feminist work that uses psychoanalytic ideas to theorise emotional aspects of work and welfare (Aslaken 2002; Haylett 2003; Williams 2002; Wilton 2003). But my argument also differs from such studies in that it combines humanistic and psychoanalytic approaches to understanding human relationships (compare Oliver 2003). In so doing I illustrate how these different conceptualisations of therapeutic relationships offer resources for thinking about the emotional and power dynamics of giving and receiving care. I also draw attention to their distinctive spatial metaphors.

In the next section of the paper, I advance an interpretation of these practices that foregrounds the fundamental importance of the dynamic and power-inflected relationship between practitioners and those with whom they work. After briefly outlining the rise of psychotherapies, I discuss the humanistic approach developed by Carl Rogers, before turning to the psychoanalytic tradition, and to common ground shared by the two approaches. Throughout this discussion I suggest ways in which psychotherapeutic formulations are relevant to care relationships more generally. Against this background I return to current debates about care, emotions and power, drawing especially on feminist and disability perspectives and arguing that psychotherapeutic approaches offer a powerful lens through which to understand the emotional and power dynamics of caring relationships. I conclude by emphasising how this theorisation helps to illuminate ubiquitous features of women's care work.

## **Psychotherapeutic relationships and their relevance to other forms of care**

### ***The rise of psychotherapies: constituting a form of care***

Psychotherapy and its close relatives, for which I use the term psychotherapies and among which I include psychoanalysis, counselling, arts therapies, family therapy and couples therapy, have become increasingly widely used responses to a diverse array of issues and conditions from mental health problems, through work-related stress, to the impacts of ordinary life events such as bereavement and relationship difficulties (McLeod 2003; Nolan 1998; Rose 1990). The proliferation of contexts in which psychotherapies are recommended and offered suggests that they have become

influential ways of delivering care to those experiencing a variety of forms of distress or need. Wherever they are located and however their purpose is defined, psychotherapies work with and through the emotional experience of those seeking, or sent for, help.

Like many other forms of care work, practitioners of psychotherapies are numerically dominated by women (Coldridge and Mickleborough 2003; Pelling *et al.* 2006; Philipson 1993). Moreover, while in many jobs traditionally associated with women, emotion work is implicit rather than explicit (Hochschild 1983, 2003), psychotherapies constitute an arena in which emotion work is explicit and foregrounded. However, this has done little to disturb familiar gendered hierarchies: in psychotherapies as in many other occupations, a disproportionate number of men rise to positions of prominence and authority within the field whether as the authors of textbooks, senior professionals or the managers of organisations.

The rise of psychotherapies, their insinuation into a wide range of contexts, and their capacity to claim authority in relation to such a plethora of experiences and conditions from ordinary life events to diagnosed mental health problems, have prompted a variety of critical responses. Psychotherapies are often criticised for their individualising effects, fostering a preoccupation with autonomous selves at the expense of the relationships and communities in which people are embedded, and thereby contributing to self-orientated consumerism or a “me” culture (Lasch 1980), which would appear to run counter to the other-oriented values associated with care. Conversely, and in common with disabled people’s critique of care discussed above, some critics argue that the proliferation of psychotherapies has infantilising and disempowering effects, effectively cultivating vulnerability and thereby undermining people’s capacities for self-reliance (Furedi 2003; Masson 1989). Psychotherapies also stand accused of psychologising and emotionalising social problems by attributing distress to people’s psychological attributes and emotional responses to circumstances rather than recognising underlying socio-political sources of social malaise (Smail 1998). Indeed, psychotherapies are also criticised for actively recruiting people into forms of subjectivity that emphasise interior lives as key source of fulfilment (Rose 1990) as well as to the supposed emotionalisation of social life (Furedi 2003; Berlant 2004). Many of these criticisms interconnect via the idea that psychotherapies are de-politicising, encouraging people to conceptualise and address the difficulties they experience in terms of their own

emotions, behaviours and attitudes rather than as manifestations of injustice, oppression and inequality (Cushman 1995; Lasch 1980; Nolan 1998). In this context, the fact that numerous people politicised by feminism and socialism have followed pathways into positions as psychotherapeutic practitioners is viewed by some critics with considerable dismay and concern, while for others it is evidence that psychotherapies offer much that is relevant to and consistent with feminist and leftist politics (Bondi and Burman 2001; Parker 2003).

While these various critiques contain important insights and challenges, they tend to downplay the extent to which psychotherapies mobilise inter-subjective, relational concepts, through which at least some of the dangers might be mitigated (Bondi 2003a, 2005; Prager 1998). It is not my purpose to mount a defence of psychotherapies in relation to these various criticisms but instead I draw out key features of an interpretation that emphasises inter-subjectivity and relationality.

### ***The person-centred approach: creating egalitarian spaces of connection***

As noted above, critics often argue that psychotherapies valorise individual self-determination over social connectedness. However, a core, unifying theme within psychotherapies is the centrality of the therapeutic relationship. Indeed one source of debate within the field revolves around whether the therapeutic relationship is one of the main factors, or the main factor, in therapeutic effectiveness (Ellis 1999; Howe 1999).

A highly influential humanistic approach to psychotherapy that emphasises the therapeutic relationship above all else is the person-centred tradition founded by Carl Rogers. In a seminal paper, Rogers (1957/1990, 221) set out six conditions, which he argued to be both necessary and sufficient to enable therapeutic change:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious, meaning that he/she is not able to be truly him/herself.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.

5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved.

[...]

The first condition specifies that a minimal relationship, a psychological contact, must exist. I am hypothesizing that significant positive personality [therapeutic] change does not occur except in a relationship.

For Rogers, therefore, effective therapeutic work depends primarily upon the capacity of therapists to bring into therapeutic relationships specific qualities.

Rogers' third condition stipulates that the therapist must be congruent or integrated within the therapeutic relationship, for which he also often uses the term "genuine", and which he describes (referring to a male therapist) as being "freely and deeply himself, with his actual experience accurately represented by his awareness of himself. It is the opposite of presenting a façade, either knowingly or unknowingly" (Rogers 1957/1990, 224). Congruence thus requires practitioners to be aware of, and to work constructively with, what might be thought of as their own uncaring feelings, such as irritation or impatience towards their clients. This is as relevant for people involved in care work of any kind as it is for psychotherapists, who are just as likely to experience "uncaring" feelings, which are liable to be suppressed, whereas Rogers suggests that they should instead be owned and thought about.

According to Rogers, therapists must also experience "unconditional positive regard" (condition 4), which he describes as a non-evaluative "prizing" of the client, and "caring for the client as a separate person, with permission to have his own feelings, his own experiences" (Rogers 1957/1990, 225). Complementing the inclusion of the full range of emotions in congruence, this demands that practitioners accept apparently unpleasant aspects of their clients, such as self-loathing, and contradictory dimensions of experience, such as both self-critical judgementalism and those attributes subject to such judgement, or outward self-confidence combined with inner turmoil. In non-psychotherapeutic contexts it might mean remembering that needing and receiving care can prompt an enormous range of complex feelings in those to whom care is offered.

The fifth condition requires therapists to understand their clients empathically. Rogers (1957/1990, 226) elaborates:

To sense the client's private world as if it were your own, but without ever losing the "as if" quality – this is empathy. [...] To sense the client's anger, fear or confusion as if it were your own, yet without your own anger, fear or confusion getting bound up in it, is the condition we are endeavouring to describe. When the client's world is this clear to the therapist, and he moves about in it freely, then he can both communicate his understanding of what is clearly known to the client and can also voice meanings in the client's experience of which the client is scarcely aware.

As this quotation illustrates, Rogers uses spatial metaphors to describe subjective experience and therapeutic relationships. The client's experience is described as a private world, potentially expansive, presumably troubled, into which the therapist comes and within which he or she "moves about [...] freely" by virtue of his or her capacity to retain an "as if" quality in sensing the client's feelings. Within Rogers' metaphors, this "as if" quality enables free movement because it means that the therapist is willing and able to face feelings such as dread or loathing that might otherwise prompt avoidance. Again, this framing is of considerable relevance in non-psychotherapeutic forms of care-giving, where the capacity to imaginatively enter the subjective world of the recipient of care, at least to some extent, can greatly increase emotional understanding, so long as awareness of the difference (and the potential for conflict) between care-giver's and care-receiver's experience is not lost (Bondi 2003b). In Rogers' conceptualisation, empathy is usefully thought of as an experience embodying a spatial paradox, in the sense of combining closeness and distance, similarity and difference.

Within Rogers' account, the first and sixth conditions make clear that, in addition to all that the therapist offers, it is also crucial for there to be sufficient contact and successful communication between client and therapist that the client is able to perceive at least something of the therapist's acceptance and empathy. Equally, in non-psychotherapeutic forms of care, at least some degree of person-to-person contact between care-giver and care-receiver is necessary if the relationship between the two is to impact on the care itself.

Carl Rogers' approach to psychotherapy portrays the relationship between therapist and client as containing within it all the resources that determine the effectiveness of therapeutic work. The therapeutic relationship is not merely a precondition for the application of therapeutic techniques and for the provision of care; it *is* the therapy and it *is* the provision of care. Qualities of specific therapeutic relationships constitute its value for the recipient (and the practitioner). According to this approach, who we are, how we feel about ourselves and how those feelings change, are all inherently relational and inter-subjective: our ways of being are necessarily constituted in relation to others and distress can be relieved or resolved through the experience of relating to another person. Rogers also emphasised the separateness or autonomy of the client from the therapist, but situated this separateness or autonomy relationally, converging with ideas developed in feminist philosophy about relational autonomy (for example Mackenzie and Stoljar 2000). While other forms of care often include tasks additional to the provision of a relationship, Rogers' approach contributes to a range of ideas that emphasise the centrality of human relationality and inter-subjectivity in all contexts, however task-focused.

Rogers' account of psychotherapy places great emphasis on egalitarian, non-hierarchical relationships between clients and practitioners, portraying the role of the practitioner as a guide or facilitator serving the client and not as a figure of authority. He wrote extensively on the subject of power (Rogers 1978). While his humanistic approach may be regarded as naïvely benign and optimistic regarding the possibility of egalitarian interpersonal encounters, and he has been criticised for his failure to acknowledge, let alone engage with, the institutionalised inequalities and oppressions associated with race, class and gender (Moodley *et al.* 2004; Waterhouse 1993), person-centred practice has since been developed in ways designed to overcome these limitations without abandoning core features of his approach (Kearney 1996; Natiello 2001). Affinities and conflicts between person-centred thinking and feminism have also been explored (Proctor and Napier 2004), with a view to developing more politically engaged versions of the person-centred approach (Proctor *et al.* 2006).

While Rogers' ideas have attracted numerous criticisms both within and beyond the field of psychotherapies (Masson 1989; May 1982; Moodley *et al.* 2004) they have also been highly influential, contributing indirectly if not directly to the shared emphasis on the

therapeutic relationship within the psychotherapeutic field (Kahn 1991). They have also been highly influential in the development of ideas in other professions, which have adopted and adapted the language of person-centred therapy in such contexts as patient-centred care, student-centred learning, child-centred pedagogy and so on. However, the translation of these ideas into practice has not necessarily followed, despite the extensive relevance to which I have drawn attention.

### ***Psychoanalytic perspectives: acknowledging unconscious entanglements***

The person-centred approach to psychotherapy developed in part as a reaction against the hierarchical authority relations that characterised American psychoanalysis in the early to mid-twentieth century. Carl Rogers' emphasis on key qualities of the therapeutic relationship as not merely necessary but also sufficient for therapeutic change challenged the entire edifice of psychoanalytic thinking, with its complex and arcane theories of psychological development and psychopathology, and the accompanying portrayal of patients or analysands as ignorant about themselves in comparison to highly knowledgeable and enlightened psychoanalysts. For Rogers, the investment of such power and authority in the psychoanalyst was counterproductive, hence his argument for a self-consciously egalitarian model.

The image of psychoanalysts as powerful figures with insight into what others do not know about themselves came under increasing challenge during the twentieth century within and beyond psychoanalysis itself. Statements from many psychoanalysts from the mid-twentieth century onwards are characterised more by modesty about the psychoanalysts' knowledge and expertise than by self-assured authority. This shift was related to changes in thinking about the therapeutic relationship.

That the relationship between psychoanalyst and patient might be the key to psychoanalytic treatment was recognised by Freud himself, perhaps most notably in his reflections on the celebrated case of Anna O., who was a patient of his colleague and mentor Josef Breuer (Freud and Breuer 1895/1955; Hughes 2004). Initially, the case prompted Freud to consider how the patient, in his or her ways of relating to the analyst, unconsciously conveyed and re-enacted core issues in relation to the analyst. Naming

this the transference, Freud went on to argue that psychoanalysis entails working through these core issues within the therapeutic relationship (Freud 1914/1958). He subsequently began to consider how the psychoanalyst brought his or her own unconscious issues and feelings into the therapeutic relationship too, hence the idea of the counter-transference (Freud 1912/1958). While Freud tended to regard the counter-transference (that is the subjective experience of the analyst in relation to the analysand) as an obstacle to psychoanalysis, which should be minimised through training analysis, subsequent psychoanalysts have come to regard the counter-transference as a crucial and positive resource through which to understand the patient's subjective experience (Heimann 1950; Hughes 2004). This development was connected to a shift from Freud's focus on the role of the father in psychic life to post-Freudian interest in the role of the mother, a shift associated partly but not exclusively with women's contributions to psychoanalytic theory and practice (Sayers 1991).

Albeit formulated in a very different language from the person-centred approach, psychoanalytic approaches to psychotherapy have also come to view the therapeutic relationship as both the medium of, and the means through which, therapeutic work is done (also see Bondi 2005). Notwithstanding extensive engagement with the interior, intra-subjective experience of the patient, psychoanalytic theory and practice views processes of change as inherently inter-subjective as well as intra-subjective. Indeed psychoanalysis can be understood as a body of theory and practice that views the boundaries between interior and exterior, and therefore also between the intra-subjective and the inter-subjective, as porous, fragile and contingent. Unconscious dimensions of experience move to and fro across those boundaries and in so doing simultaneously unsettle and (re)produce them. While the person-centred approach argues that the very idea of the unconscious presumes that the practitioner may know things the patient cannot know (at least consciously), psychoanalytic approaches appeal less to the separateness and potential wholeness of persons within whom knowledge resides, and instead place more emphasis on unconscious interdependence among people (and between people and the non-human world). Through its emphasis on connections across porous, fragile and contingent boundaries, it suggests an alternative spatiality of inter-subjectivity. This is relevant to those involved in non-psychotherapeutic forms of care because it provides resources for thinking about what happens to people at an emotional level in a whole array of relationships. Giving and receiving care often

brings people into intimate personal and bodily contact with one another. From a psychoanalytic perspective, this is likely to evoke or touch upon feelings – often unconscious – deriving from infancy, when bodily contact is integral to the infant's relationship with care-givers. Such unconscious feelings may run counter to feelings of which the care-giver or care-receiver is aware and may disrupt conscious intent (Callard 2003). Psychoanalytic ideas are therefore sometimes especially helpful in circumstances where we find ourselves surprised, perplexed or disturbed by our own behaviour within care relationships.

The shift within psychoanalytic thinking from viewing the counter-transference as a problem to viewing it as a resource also had the effect of bringing the psychoanalyst down from some imagined pedestal to a position at the same level, or within the same field, as the patient. Freud's idea that the psychoanalyst could provide a truly blank screen onto which the patient's transference would be clearly projected implied that practitioners have the capacity for a high degree of detachment from unconscious relational dynamics. But if the relationship is as richly imbued with the psychoanalyst's counter-transference as with the patient's transference, the former is not detached from, but fully immersed in, unconscious relational dynamics. What the psychoanalyst offers from this messy situated position is someone with whom the patient can explore and make new meaning of his or her intra- and inter-subjective experience, including emotionally-laden experiences of oppression, victimisation, authority, subjection and many other dynamics of power. This conceptualisation does not mean that the patient will experience the psychoanalyst as an equal but instead it suggests that the experience of power dynamics – feelings about power – between the psychoanalytic dyad is available to be acknowledged, explored and thought about. Transferred to other kinds of settings in which care-givers and care-receivers interact, this approach acknowledges that what goes on in the negotiation of care is always more complex and multi-layered than participants can consciously apprehend. Psychoanalytic ideas are sometimes assumed to be of relevance primarily in understanding highly individualistic aspects of experience (Philo and Parr 2003), but this account suggests otherwise and emphasises their relational focus. While making sense of feelings may not be integral to other forms of caring, the intensity of feelings associated with unconscious as well as conscious experiences of power may nevertheless be helpful.

### ***The spatiality of care relationships: psychotherapeutic formulations***

Although generating very different theories of personhood and subjectivity, the two psychotherapeutic approaches represented by the person-centred approach and psychoanalysis hold in common a view of the central and profound importance of the therapeutic relationship between practitioner and recipient not merely as the medium through which care or treatment is delivered but as what actually constitutes the care or treatment. The primacy accorded to relationships between people echoes feminist accounts of the cultural and ethical orientation of women towards relationships (Gilligan 1982), and which tends to draw women more than men to this work (as well as to other forms of caring).

Both approaches demand of practitioners the capacity to bear, face and work creatively with a diverse and unpredictable range of feelings brought by their clients or patients and aroused in themselves. This emotion work often entails the apparently simple but arduous task of being available to be affected and being willing to stay with whatever feelings are aroused. Not infrequently the feelings in question are multiple and contradictory, combining, for example, hope and dread (Mitchell 1993), love and hate (Mann 2002), or envy and gratitude (Klein 1957) and the practitioner is called upon to hold the ambivalence implicit in such combinations of feeling. As noted in the introduction, the giving and receiving of many forms of care inspire equally multiple, contradictory and challenging emotional responses in care-givers and/or care-receivers. Among the simplest but potentially most powerful ways in which psychotherapeutic ideas may be more widely relevant to caring is in acknowledging the ordinariness of such mixed feelings and the challenges of managing them.

Via different trajectories the two psychotherapeutic traditions have also come to share a common view of the relative positions of patient or client and the practitioner in which the latter is more akin to a modest witness to the suffering of the former than an expert who can solve or explain his or her problems. For example, Adam Phillips (1995, 8, 32) describes the psychoanalyst as an expert on “the truths of uncertainty” and asserts that “analysts are often frightened of their patients”, while Arnar Arnason (2001, 299) has described bereavement counsellors as “experts in the ordinary”, and in a similar vein, I

have described counsellors as “experts in not being expert”, whose expertise resides “in their capacity to ‘invert’ or ‘negate’ conventional claims to, and relationships associated with, expert knowledge” (Bondi with Fewell 2003, 530).

Alongside this shared view of the position of therapist as modest witness, different traditions offer different conceptualisations of the power dynamics of psychotherapeutic and other care relationships, which are linked to the use of different spatial metaphors, or spatialities, of inter-subjectivity. The person-centred approach advocates egalitarianism in the context of conceptualising therapeutic work as taking place within the private, interior world of the client, into which the therapist comes with a view to offering genuine, accepting and empathic understanding. The two are viewed as relationally autonomous, and bounded albeit interdependent beings, with the therapist bearing responsibility for remaining clear about his or her separateness. Psychoanalytic psychotherapy in its various forms does not assume egalitarianism but conceptualises the subjective encounter between psychotherapist and patient as one in which both are unconsciously entangled. This encounter is understood as an exploratory arena within which power dynamics, in all their emotional richness and complexity, may be re-enacted and worked through. Boundaries between people are fluid and blurred and subject to unconscious reworking.

Increasingly offered in response to care needs, I have argued that psychotherapies conceptualise relationships between practitioners and those with whom they work as constituting the care provided and as embodying egalitarian or exploratory approaches to feelings, power and expertise. While in other contexts the content of care is very different, often entailing practical tasks, the giving and receiving of all forms of care also involves emotionally complex relationships. I have attempted to highlight some of the ways in which psychotherapeutic formulations offer resources for thinking about these relationships.

### **From psychotherapy to debates about care: rethinking emotions and power in relations of interdependence**

In this section of the paper I advance my discussion of the relevance of ideas about

psychotherapeutic relationships to understanding care and women's care work by returning to debates between feminist researchers, who have focused primarily on the perspectives of care-givers, and disability researchers who have focused primarily on the perspectives of care-recipients. While the former have argued for relational understandings of self and against the over-valuation of autonomy, the latter have argued for respect for self-sufficiency and against the cultivation of relations of dependency (Watson *et al.* 2004). As I have noted, psychotherapies have been criticised both for fostering self-centredness at the expense of relationships with others, hence the notion that the rise of psychotherapies has contributed to the erosion of family and community ties (Lasch 1980), and for fostering dependence and vulnerability, hence the notion that psychotherapies undermine people's ability to look after themselves and others (Furedi 2003). They might therefore seem an odd and unpromising place to look for resources to inform this debate. However, what I hope to show is how the notion of interdependence emerging from debates about care (Watson *et al.* 2004; Williams 2001) could be enriched by consideration of psychotherapeutic theories of relationships.

Feminist commentators have valorised, and sought greater recognition for, the emotion work of care-givers, arguing that it is integral to care work (Finch and Groves 1983; James 1991; Haylett 2003). They have also emphasised intimate connections and continuities between different sites and contexts in which caring occurs, especially between care within and beyond familial settings. In contrast to this, writers in disability studies have focused primarily on care provided by welfare services, and have viewed emotional dimensions of caring much more critically and suspiciously, in the light of care-recipients' negative experiences of depersonalising and patronising attitudes, disrespectful and sometimes humiliating behaviour, pressure to display gratitude and so on (see for example Thomas 2001). These criticisms have contributed to pressure from the disability rights movement to use market mechanisms to help separate instrumental from emotional dimensions of care. For example, disability activists have sought to replace care services with alternative ways of meeting needs, notably through direct payments to people who require assistance (rather than to carers), enabling them to purchase what they require on their own terms (Priestley 1999; Shakespeare 2000; Ungerson 1999). Advocates argue that such strategies restore control, choice and self-sufficiency to people who are disabled by normative assumptions that valorise particular kinds of persons and bodily performances.

Reliance on market mechanisms in the provision and delivery of care fits well with neoliberal welfare policies (Larner 2000). Indeed, we are all increasingly expected to take responsibility for decisions about how to meet our own care needs, whether we are apparently self-reliant and independent adults, or people living with disability, or patients with chronic illnesses, or the parents of dependent children. As commentaries on the carelessness of neoliberalization predict (Lawson 2007), these policies all too often fail to deliver activists' goals of empowering disabled people (Chouinard and Crooks 2005; Pedlar and Hutchinson 2000). However, in so far as these policy interventions signal a shift away from standardised, collective state provision, they point towards the possibility of creating more flexible and responsive services. They promise (even if they do not deliver on this promise) an escape from deeply unsatisfactory, oppressive and disabling forms of provision through increasing the choice and control of those needing and receiving care.

Replacing “care” with “personal assistance” and rendering more direct the contractual relationship between those with specific assistance needs and those selling their labour as providers of assistance, provided it is properly resourced and supported, appears to neutralise or exclude emotional dimensions associated with care. Enhancing the autonomy, control and choice of those seeking assistance with their care needs has thus gone hand-in-hand with liberating them from the unwanted emotional attention, demands and impacts of carers. However, while direct employer-employee contracts may have the potential to help to equalise the relationship between the recipients and providers of care or assistance, the activities involved in giving and receiving assistance rarely occur within wholly impersonal, neutral, detached relationships (Meagher 2006). There is, in other words, some emotional contact or interaction between those involved (Lawson 2007). This is true in many contexts in which people work and receive services, but many forms of care work involve unusually intimate and/or sustained contact between those involved. It is, therefore, not entirely surprising that research about the experiences of disabled people and personal assistants has found that the personal qualities of the latter matter at least as much as qualifications or training to their actual or potential employers (Glendinning *et al.* 2000; Shakespeare 2000; Ungerson 1999). These personal qualities include respectfulness, sensitivity and patience, which are less about task-related skills and more about emotional dispositions. What this suggests,

therefore, is that it is not possible to wholly separate instrumental and emotional dimensions of what takes place when people attempt to meet their own and others' needs. Thus, as feminists have argued, emotion work does indeed appear to be integral to effective care-giving.

According to Gabrielle Meagher (2006, 48, emphasis in original), however, "it is neither realistic nor reasonable to expect a carer's *feelings* for those they care for to be the main underpinning of the caring motivations that themselves underpin a good caring relationship". Her account seeks to identify the normative resources necessary to support good practice in paid care as opposed to care provided in the context of familial bonds. For Meagher, love or filial piety provide normative underpinnings for care provided within family relationships, but cannot be presumed, even as an ideal, as a motivating force in other caring relationships. She argues instead for an approach to "good enough" care supported by a combination of contract, professional duty and compassion.

I want to suggest that psychotherapeutic approaches provide an alternative route through the complicated interconnections between power dynamics and emotions in the giving and receiving of care that is relevant both to paid care work, whether contracted directly by care recipients or commissioned by welfare services, and unpaid care work, whether provided by family members or other volunteers. Rather than demanding of care-givers specific kinds of feelings towards care recipients, such as love or filial piety, psychotherapeutic approaches call instead for the capacity and willingness to acknowledge and tolerate the full range of feelings caring and being cared for may stimulate, at the same time as maintaining an underlying respect for the care recipient, a respect expressed in part through bearing witness to their experience.

Whether care is primarily task-focussed or more emotion-focussed, the dynamic interplay entailed in giving and receiving care may be inflected with an enormous range of feelings including love, hate, compassion, disgust, tenderness, anger, resentment, pity, guilt, distaste, shame, pride, hope, dread, fear, anxiety, helplessness, desire and sadness, any or all of which may be felt by care-givers and/or care-recipients. While the purpose of psychotherapy might be to work with such feelings, in other care relationships where the focus is not on the emotional experience of the care-recipient,

psychotherapeutic approaches nevertheless offer resources for thinking about and perhaps responding to such feelings. Two interconnected themes are of particular importance in relation to the range of emotions care-giving and care-receiving may inspire, namely permission to feel *any* feelings, and consideration of the relational context of such feelings.

Apparently uncaring feelings – such as hate, disgust, distaste, anger, shame, resentment, pity, guilt, dread – may not appear to hold out much promise for compassionate, loving or tender care relationship, but they are also ordinary realities of interpersonal relationships. Psychotherapeutic approaches avoid associating such feelings uniquely with either care-givers or care-receivers: all of these feelings may be felt by either or both sets of people. In the preceding section I drew attention to Carl Rogers' (1957/1990) account of empathy, with its “as if” quality that enables the therapist to understand the subjective, emotional experience of the client and to retain a kind of freedom in relation to it, a freedom that allows the experience to be acknowledged. Empathic understanding is what enables care-givers in any kind of care relationship to imaginatively identify with care-recipients without confusing their own feelings with those they imagine to be felt by care-recipients. It is equally what enables care-recipients to imagine what it might be like for care-givers to do what they do. Where care-givers and care-receivers accurately empathise with each other, or where care-givers empathise accurately with those for whom they care and do not need reciprocation from them, good communication ensues. This communication is not necessarily cognitive, let alone verbal. It is primarily about emotional understanding, which may be communicated as much through touch, movement, facial expression, tone of voice, quality and pace of non-verbal utterances, what is not said and so on, as well as through declarative speech. Good communication does not guarantee good care but it does enable effective feedback about the match between needs and the care available, which may be sufficient to enhance the quality of care received. Where care-recipients accurately empathise with care-givers but not vice versa, those requiring care may succeed in ensuring at least some of their own needs are met by looking after the emotional needs of those who are deemed to be the care-givers.

In our relationships with others, we do not necessarily find it easy to hold on to the “as if” quality described by Rogers (1957/1990), or to the difference between what we imagine

another person to feel and how they actually feel. Care relationships are no exception. Consequently, empathic failures are likely to be recurrent. The psychoanalytic perspectives on psychotherapy I have described use the capacity to reflect on the counter-transference to think about the ensuing entanglements. Crucial to this approach is the idea that emotions are always relational so that what a practitioner feels does not belong uniquely to him or her but is understood to be inspired by the relational context in which the feelings are felt. Transferred to any care relationship, if someone to whom care is offered inspires in the care-giver a sense of not having the skills required to provide effective help, perhaps this is a signal of the intense helplessness felt by the person cared for. If someone to whom care is offered inspires in the care-giver feelings of disgust, the care-giver may find such feelings deeply troubling and seek to hide them, but perhaps he or she is tapping into painful and complex qualities of the care-recipient's feelings about his or her own need for care. In these examples, the tentative phraseology is essential: the care-giver cannot deduce this from how he or she feels, but the speculation might be of use in thinking about how to respond to the situation.

### **Conclusion: understanding the relational dynamics of women's care work**

The foregoing discussion of the emotions inspired by care-giving and care-receiving is indicative of the demanding and complex nature of the emotion work required of truly caring carers, who must be able to manage and withstand the diverse and often contradictory feelings stirred up in both themselves and those for whom they care. That this work falls primarily to women is no coincidence. The allocation of care work to women, described by Hilary Graham (1983) and many subsequent commentators, goes hand in hand with women's moral orientation to relationships (Gilligan 1982, Tronto 1993) and their association with emotion and emotion work (Hochschild 1983, 2003). The willingness and capacity to attend to the emotional dimensions of relationships I have described appears to be quintessentially women's work.

Joan Tronto (1993) has described care in terms of four phases that begin with the recognition that care is needed, followed by consideration of how to act to address the need, and proceeding to the direct giving and receiving of care. She observed that

It is important to include care-receiving as an element of the caring process

because it provides the only way of to know that caring needs have actually been met [...] But perceptions of needs can be wrong. Even if the perception of a need is correct, how the care-givers choose to meet the need can cause new problems (Tronto 1993, 108).

Tronto's account highlights the dynamic interplay between care-giving and care-receiving, which necessarily occurs within interpersonal relationships between those involved. Thus, however important practical actions or instrumental dimensions of care might be, unless those giving care make some kind of interpersonal contact with those for whom care is intended, it is impossible for them to know whether the care needed has actually been received. Tronto, however, does not elaborate the character of the dynamic interplay she describes as integral to care.

In this paper, it is this gap that I have sought to address, arguing that psychotherapeutic ideas provide useful resources for thinking about the shape of, and the emotional and power dynamics at play within, care relationships. I have suggested that these ideas also shed light on how qualities of care relationships might impede or enhance care. Although my account takes inspiration from the rise of psychotherapies as responses to care needs, I have not sought to describe particular kinds of care and care work. Rather I have argued that aspects of theories and debates in psychotherapy have a much wider relevance to the relationship dimensions of all kinds of care work. I have argued that different approaches to psychotherapy theorise the therapeutic relationship as constitutive of psychotherapeutic care and that different formulations of this key idea contain elements that are transferable and relevant to all care relationships, whatever the particular focus of the care work. In this context I am certainly not suggesting that more forms of care should be reconceptualised as psychotherapy. Rather, I have argued that because relationships are so central to all forms of care, certain psychotherapeutic ideas are transferable to other settings where they may be used to understand, value and work with what happens in care relationships.

Psychotherapeutic approaches suggest that, wherever interpersonal contact exists, the quality of care relationships is not dependent solely or even primarily upon the ability of the carer to deploy expert knowledge about care needs: the relationship itself is also vital because it is through this that needs and feedback about care are communicated. This communication is multi-faceted: it may be verbal, visual, tactile, intuitive, tacit,

unconscious and so on. It may be face-to-face or mediated by communication technologies. It is almost invariably emotionally-laden, whether or not it is also cognitive. Psychotherapeutic approaches do not prescribe particular kinds of emotions as being required of care-givers. Instead, they highlight the inevitability of troubling emotions and suggest ways of thinking creatively about feelings. In so doing they provide frameworks within which to understand the sometimes contradictory and paradoxical qualities of the emotions associated with giving and receiving care. Emphasising the mutual constitution of feelings and relationships, psychotherapeutic formulations enrich understandings of the gendering of care work as well as offering spatial metaphors within which to articulate subjective experiences of caring and being cared for.

Psychotherapeutic perspectives emphasise the importance of valuing and respecting the knowledge and feedback provided by the recipient of care, and of recognising the complexity, emotional richness, and importance of relationship skills – however ordinary – through which care is given and received. Expertise in specific caring tasks may be essential, but in many instances the capacity to bear witness to suffering and to view the recipients of care as experts of their own experience are also of great importance in the provision of care. This calls upon care-givers to consider their subjective positioning relative to the recipients of their care, including how this positioning might be perceived and how it might feel to those involved. The work of caring therefore requires sensitivity to imaginative geographies and, as I have shown, different approaches to psychotherapy offer a variety of descriptions of these subjective geographies.

By attempting to constitute something that simultaneously negates and claims expertise, psychotherapies risk criticism from opposite directions: for some they over-value autonomy; for other they cultivate dependence. But the combination of these apparently contradictory criticisms might also be understood as reflecting the multiple dangers of attempts – successful or not – to sustain the paradoxical qualities of therapeutic relationships. The emotional relationship dynamics on which psychotherapies focus presuppose interdependence as a feature of human life. Implicitly – through the centrality accorded to the relationship and all the feelings it inspires – psychotherapies mobilise relational understandings of self, arguing that selves are shaped and reshaped in relation to others. And yet, simultaneously, psychotherapies emphasise the autonomy of those seeking help, hence their emphasis on understanding, acceptance and respect.

They therefore provide conceptual and practical resources for thinking about interdependence, relational autonomy and the emotional dynamics of a diverse array of care relationships. In so doing they add an important dimensions to current debates about care, helping to resolve conflict between accounts that focus on care-givers and care-receivers experiences.

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