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Introducing the capacity to care

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CHAPTER 1. INTRODUCING THE CAPACITY TO CARE. 11042

Approaches to care

What is the capacity to care and why does it matter? How is it acquired? What are its origins in the early development of self and morality? Are women better at caring than men and, if so, is this likely to change with contemporary changes in parenting and gender relations? What would constitute a good enough family, as opposed to good enough mothering? How does the capacity to care inform the ethics of care debate about relationality and autonomy and their gender? How do people care across distance and difference? These are the questions that are addressed in this book. Through them I attempt to provide the current social discourses with an adequate psychology as a resource for understanding care, in the domains of theory, policy and practice.

During the week in which I finalised this manuscript, The Observer Sunday newspaper (26/03/06) had a two-page spread on women who are 'young successful, well-paid', asking 'are they killing feminism?'. It is based on a magazine article by a British academic, Alison Wolf, who argues that this manifestation of young womanhood 'has dire consequences for society', consequences that turn out to be that the pursuit of certain careers (a successful young woman investment banker is profiled) are turning women away from caring, both in the form of having children and entering the caring professions. According to Wolf, we are seeing 'the end of female altruism'.

In this and many similar ways, the principle theme of this book – the gender of the capacity to care and ethical subjectivity – is central to contemporary public debate. This debate, including the overdrawn claims and ill-conceived arguments is symptomatic of the profound anxieties that continue to accompany changes in gender relations in the new millennium. I hope that I succeed in my attempt to provide an analysis that is not hijacked by those anxieties – which can lead either to amplifying or denying the problems and potential of changing gender relations for care. ‘Society’ has indeed in many ways depended on women to care and on their ‘female altruism’ to motivate their ongoing capacity to care. As the realignment of caring is precipitated by the tectonic plate tremors of gender differences, it is a challenge to ensure that everyone has access to good enough care, not only infants, children, the old, sick and disadvantaged but also so-called independent adults and the carers themselves. Can both women and men access capacities to care freed up by the relaxation of rigid gender binaries? Through conceptualising some universal aspects of self – aspects that go beyond gender as well as those enabled and suppressed by particular gender regimes – I envisage ways that women and men can tap into the identificatory potential of every human being who relates with others through both their individuality and their intersubjectivity.

Why is it important to understand the capacity to care, as well as focussing on the resources and practices concerning care? When individuals fail to care for those they encounter, those others suffer. But that is just the start. The effect

is not just suffering (which ameliorates) but psychological trauma. If, as I argue, people are relational in the core of their being, then systematic and continuous failures of care have profound impact on a person's character and how they relate to others. This then creates a ripple effect in the social relations around each such person: care-less and hate-ful individuals are hard to care for and this has effects on the would-be carer as well as the person in need of care. When whole groups fail to care, cultures of hate, retribution and vengeance can be created that reproduce the traumatic conditions of their own making. There is less chance of the kind of citizenly care that provides a bulwark against political corruption, unbridled market forces or religious fundamentalism. Moreover, there is created an intergenerational dynamic that is harder to interrupt by social and political interventions when harmful individuals are drawn to reproduce the conditions of their own psychological damage. A convincing test of such an assertion is to look into the biography of any violent criminal, serial killer or psychopathic aggressor. They have invariably suffered deprivation, not necessarily of material resources but of relationships characterised by trust, safety, respect and love; that is enabled by the capacity to care of significant others around them.¹

A psycho-social inquiry does not therefore reduce to individual or interpersonal problems but underpins the big questions of society, politics, ethics and global environmental sustainability. Although I start my inquiry by asking how the capacity to care is first established in the intimate relations of

¹ It is worth qualifying this assertion by saying that the claim does not work in reverse: not all those who have suffered traumatic failures of care turn out to damage others. Some damage themselves. Some transcend their experiences through the creative use of internal resources that somehow survived the damage.

care between maternal figures and infants, by the end of the book I have broadened it out to explore how the capacity to care is implicated in institutional change and caring about strangers across difference and distance. Hardly a day goes by without these issues featuring in the news. In the same week as the newspaper feature about 'the end of female altruism', the Archbishop of Canterbury was interviewed on the morning radio news. He talked about the political failure to address global warming and its ethical implications, namely that because of western people's energy consumption, third world populations would be dramatically destabilised and billions would likely die. On the same evening, two television documentaries showed the particularity of people suffering through political and institutional failures to care; the first about African economic migrants trying to enter Europe illegally, the second about the underfunding of care for the elderly in the UK, told by the son of an old woman suffering from dementia, as he examined his conscience about putting her in a 'care home', rather than caring for her at home.

Many writers concerned with the state of the world, from philosophy to political and social theory, have converged on the question of living with difference (for example, Levinas 1999, Mouffe 2000, Connolly 2002, Arendt 1958). Ideal arrangements or attitudes are discussed in order to imagine ethical connections among people in the public sphere who are different from each other. However, few of these writers ask how – psychologically – respect for difference and care across difference are achieved. I am critical of any paradigm that does not appreciate how psychic structures and processes

transform and co-construct experience and culturally dominant forms of living. My aim is to supplement overly social and exclusively abstract paradigms of ethics, morality and care by providing a dynamic psychological account, situated in the relevant social contexts and anchored in life historical time. This produces an approach in which I ask, for example, how the capacity to care across difference is nurtured, from what starting points. The result is a rare focus on the effects of life histories of being cared for and caring; the vicissitudes of self development that are crucial in a person's later capacity for care across difference.

This is also an unpopular perspective: recent social science has rejected the paradigm of psychological development and focused on situating people in the present. It has also largely rejected the trope of the family, seeing it as a conservative sphere in which difference is defended against. My argument is that certain conditions which start early in life within families (families of all types) are usually decisive for later psychological capacities that produce caring (or hostile) relations to difference in others. These capacities may begin in families but they do not need to end there. Every person's life history is contained in their internal world and this internal world is active in shaping the ways they encounter current, everyday events and relationships, including the challenge of caring for familiars and strangers.

Care is a broad term which perhaps should be broken down into narrower categories, but the fact that the word has come to cover such a broad and varied remit is significant in itself and I shall try to work with the penumbra of

meanings to which it gives rise rather than shoehorn these into tidy categories. On care, there is a huge literature while there is a startling absence on the subject of capacity to care in theory, research and writing on care. The care literature mainly takes two forms. First there is a philosophical literature which includes a substantial body of work on ethics discussed at an abstract level. Second are the social work and social policy literatures, which tend to be directed towards advocacy for carers and working out the best arrangements, supports and resources to enable caring, paid and unpaid, to take place. More recently this has included an empirically focused literature with both theoretical and policy orientations. Williams (2004), reporting the conclusions of a large empirically-based research programme that brings together many of these strands, argues for an ethic of care that extends from private into political domains and recognises the importance of care ethics in people's lives and how these can be carried out in a diversity of living arrangements and family groups.

Because of women's historical association with caring, feminist literatures have been prolific and these have reflected the same two emphases, the first taking the shape of an extended debate about the ethics of care and its relation to gender and the second looking at caring as an activity. Managing the juggling act between paid employment and care is, understandably, a recurring theme in the latter. Both are often premised on understanding care in the light of women's subordination; often on the position that caring is associated with women's oppression and reproduces it.

These different tracks often reflect what has become quite a well-established conceptual distinction between caring about and caring for (Fisher and Tronto 1990, Sevenhuijsen 1998, Skeggs 1997):

Caring about which involves social dispositions that operate at a personal level and assume a relationship between the carer and cared for, and caring for which involves the actual practice of caring, involving specific tasks such as lifting, cleaning and cooking, and does not necessarily relate to caring about. (Skeggs 1997:67)

My interest in this book, because it is about the psychological capacities involved in care, emphasises caring about: the term capacity to care addresses questions to do with caring about. The disadvantage of the phrase 'capacity to care' is its connotations of a singular, static entity, whereas I address something dynamic, variable and situated, ideas perhaps better captured in 'caring about'. However, I wish to retain the connotation of relative consistency associated with the idea of core capacity as a result of its early roots which, while they can be modified, cannot be overridden by rational decision. Moreover, caring about and caring for are not as separable as Skeggs' neat definitions imply, because in my framework, the practices of care and their meanings are part of a series of mutually affecting dynamics that have an impact on caring about, which likewise affects practices. Caring about occurs in the context of practices and relations involving caring for. For Lynn Froggett, 'Both [caring for and caring about] are necessary but it is the latter that lifts caring out of the mire of condescension and abuse of power

with which it has sometimes been tainted' (2002: 125). I hope that I shall be able to convey what the qualities of caring about involve if they are to achieve this not inconsiderable feat.

Once I started reading the care literatures with a question in mind about the capacity to care, I noticed that they were often based on an unexamined assumption, namely that, given the appropriate resources and supports, people will care adequately. Of course given the long history of belief that women are natural carers, it is not surprising that the assumption continues that women want, and know how, to care. I hope that a sustained focus on the capacity to care can further expose the residues of this assumption, which remains despite the fact that the natural ability of women to care has been profoundly called into question, both ideologically and empirically. What is more, women's identities and roles are changing within changing gender relations. Where the care of children is concerned, the assumption of an unproblematic capacity to care now often includes fathers as well as mothers, as we can see in the shift to the term parenting where mothering used to be the common term. In describing and theorising the vicissitudes of acquiring the capacities involved in caring, I want first to problematise the assumption that the capacity to care is natural, which has led to it being taken for granted, and second to challenge the notion that it is simply social, the result of habit, training or practice.

Babies are not born with capacities to care and the acquisition of the morality that underpins good caring is a complex and conflictual process that is an

integral part of psychological development. Boys and girls experience the development of identity in very different ways because of the deeply entrenched meanings of gender everywhere around them. The meanings of care are gendered too and so the acquisition of the capacities associated with caring is never a gender neutral process. So, throughout this book my account keeps in mind the gendering of the capacity to care. It sets this question in the contemporary context of seismic changes in gender relations (in Western cultures in particular) in order to be able to explore what are likely to be their effects on women's and men's capacities to care.

I do not subscribe to assumptions about care being the natural capacity of women. However, social science has been afflicted by the kind of binary thinking that argues that if it is not natural it must be social. Post-structuralist feminist accounts have evolved out of the political imperative to challenge arguments based on women's biology and also out of a trenchant critique of views of subjectivity that assumed a pre-given, unitary and rational (masculine) subject. As a result, however, they commonly risk evacuating subjectivity and ending up with a socially determined subject. This applies even to the more sophisticated treatments of care as in positioning theory.

Beverley Skeggs (1997), for example, is interested in the way that the particular group of working class women that she studied in depth and over time came to construe themselves as caring in the context of the training that they were following. She draws on a Foucauldian idea of subject positions, for example when she inquires into 'the processes by which the caring self is

produced through the negotiation and performances of subject positions given by the organisation of the caring courses and caring curricula' (Skeggs 1997: 56). These courses were developed as part of a history of 'many attempts to induce women to enjoy their domestic labour and responsibilities, which Foucault identifies as a form of productive power whereby social regulation can be achieved willingly, even pleasurably, by the participants themselves' (op cit 41). Foucault's account of the production of selves within the circuits of power - knowledge - practice relations is frequently criticised for being deterministic, while being a powerful analysis of the social forces that frame, constrain and produce subjects. Skeggs positions her participants in the range of opportunities and discourses that are available and attempts to splice these together with more psychological considerations such as the importance of being recognised as 'respectable' in the wider social gaze or her claim that 'the caring subject is constructed by the conflation of caring for with caring about, in which the practices of caring become inseparable from the personal dispositions' (1997: 51). She does not inquire about these personal dispositions. In this book, these dispositions, their origins and trajectories are my primary focus.

Likewise in the more applied literatures, there is a sociological reductionism. Where there is breakdown of care, material and social factors are emphasised as causative: insufficient money and time, competing demands, the low status of caring work, inadequate training and safeguards, women competing with men in the world of work. Perhaps these have been adequate working assumptions. Capacities to care will certainly be put under greater strain if

resources and supports are lacking. Where policy is concerned, the greatest help can perhaps be delivered on this terrain (Williams 2004:73). The longer term, intergenerational influences on the development of a capacity to care that I shall be focusing on are more likely to elude policy interventions and do not happen within the length of a government's term of office. Uncared for children, growing into anti-social teenagers and perhaps incapable parents themselves, are widespread and the pattern does not straightforwardly reflect economic circumstances or changes in welfare provision. My question is therefore not just on what kind of adult, parental care is good enough to raise happy well adjusted children but how it will affect the care that they are capable of as adults and parents themselves, in families and beyond. The focus of this book is parenting and the care of children because I regard families (in whatever shape and form) as the crucible of subsequent caring relationships.

My analysis is informed by the use of a psycho-social approach; a long-running theme in my work. Broadly it says that capacities to care are psycho-social in the sense that they develop as part of self development, which is intersubjective, and that the life histories of individuals during the course of this development are inextricably relational and derive their meaning also from their social setting (structures, cultures, practices and discourses). The experience of being cared for is essential in developing the capacity to care. However, one's ongoing experiences of care and its lack are profoundly mediated by internal psychological processes. My choice to focus on the capacity to care is a way of providing a psychological account of self to

address the absence of a theory of subjectivity in understanding care.

However, by taking a psycho-social perspective I avoid falling back into an individualistic account, even while challenging dominant forms of social constructionism.

I draw on a set of psychoanalytic principles that revolve around unconscious conflict in early relational dynamics, starting with mother-child relationships. Take as an example, the significance for new mothers of having their own mothers around. This should not be reduced to the principle that the mother provides practical child care support – though it will likely help if she does. Her mother is also central to the meaning of being a mother through that woman's experience of being her mother's child (Chodorow 2002). Her identifications with her mother's care (including its quality) will be expressed in her own mothering practices, which will continue her own course of moral development, particularised by her contemporary circumstances - her housing, employment, partner status, for example – whose meanings are all influenced by how she grew up and what home, her parents and their work meant to her. These are of course not a copy of her parents' meanings because of generational changes in her world (Brannen, Moss and Mooney 2004). As well as always including the social, the psychological capacity to care is also linked to biological characteristics. In my analysis I include the importance of the female, maternal body and the significance of the different reproductive capacities of women and men in early parenting and the effects of these on gendered capacities to care and their likely changes in the 21st century.

Because care practices and practising care are not in themselves guarantees of quality, the capacities or dispositions to care need to be addressed.

Consequently, this book enters the sensitive terrain of the quality of care.

What constitutes good enough care? There is not one single model for good quality care and there are probably as many different practices of care as there are contexts, relationships and meanings within which care is exercised.

But I shall take the view that there are universal ethical principles too (for example the principle of avoiding violence against others) and consider these alongside the specifics of contemporary western settings in the idea of capacities to care and how these are expressed in good quality care.

Family conflict and break up is widely agreed to be influential in children's development, but not all such families produce problem children and not all problem children have experienced conflict among and loss of primary parental figures. What makes the difference? Often, as feminism has regularly pointed out, mothers are blamed for how children turn out, and often they have been the lynchpin of childrearing. Can women's willingness and capacity to care (neither as automatic as the ideology would have us believe) survive changes in gender relations as they are currently manifesting in Britain and other western countries? The individualisation thesis that is central to current social theory debate argues that the individualisation of late modern societies tends towards self- rather than other-oriented motivations and practices. Is the individualising of women undermining their traditional caring capacities? The

newspaper article with which I began this introduction provided an example of this social science debate expressed in popular form.

Individualisation theory provides a literature about social changes impacting on the self that does not assume care to be natural and unalterable. On the contrary, the concept of individualisation refers to the complex processes of social transformation that increasingly produce individuals with a capacity for autonomy, freedom of choice and self reflection, and these processes are assumed to run counter to the affiliations and care obligations that are traditionally rooted in kinship and unequal gender relations in which women put the care of others before their own freedom of choice (Beck and Beck-Gernsheim 1983/2002). They may also run counter to the wishes and needs for dependency which survive in a conflictual form, jarring with the injunctions of autonomy (Hoggett, 2000). However, this sociological literature does not address changes in the capacity to care, in early or late modernity, perhaps because its exclusive focus on large-scale social transformations leads to an implicit assumption that selves result from these. In contrast, from a psycho-social perspective, I shall emphasise the recalcitrant aspects of selves that make them not so malleable and also render them vulnerable: the anxious, needy, desirous, controlling and above all relational features of self that underpin care. My emphasis on intergenerational transmission suggests that the account of social change in individualization theory (as in much of social theory) needs modification. Its account of how social change produces changed subjectivity assumes a rapid adjustment to new (individualising) social circumstances. Intergenerational transmission suggests that

identifications with an older generation (especially parents and back through them with former generations) act as a partial brake on those effects.

The socio-historical perspective of individualisation theory provides an important reminder that contemporary care is subject to a set of normative expectations and resultant pressures that did not exist in previous eras.² This is not to accept the view of the degradation of mothering (see Silva 1996 for a detailed critique) but rather to be mindful of its specific conditions and their effects on subjectivity. For example, I consider the ways that daughters and sons differentiate from mothers to be important in the kinds of caring capacities that they later manifest as parents (chapter 5). In the case of daughters, the 'need' to differentiate is situated within the late modern, feminist injunction to 'be a subject in one's own right', while at the same time being recognised as having consequences for the capacity to care in contemporary western cultures.

In search of subjectivity in the literature

I have said that there is a dearth of literatures on the capacity to care. What then are my theoretical starting points? Since Nancy Chodorow's ground breaking 1978 book, *The Reproduction of Mothering*,³ feminist interest in changing women's oppression has included a focus on mothering as a paradigm case of caring, including women's role as mothers in the

² Elisabeth Badinter (1981) furnished rich historical material that seemed to suggest that the many parents in late 18th century Paris who farmed out their infants for wet nursing did so without much solicitude.

³ See *Feminism and Psychology*, 12 (1) (2002) for an evaluation, nearly 25 years on.

reproduction of gendered caring in their daughters (see chapter 2). One branch of this interest has extended to consider the importance of men's care in parenting. The psychology of moral development has been hampered by its blinkered focus on moral reasoning, but has given rise to extensive debate through Carol Gilligan's (1982) gendered critique of Lawrence Kohlberg's earlier stage-based theory of moral reasoning (1976). Her argument for a care voice, predominantly heard in girls' and women's moral reasoning, in contrast to the justice voice privileged in Kohlberg's highest stage of moral development, created a central space in feminist theory for the idea of gendered differences in an ethics of care; theory that embraced the disciplines of philosophy, political science, social policy and sociology as well as psychology and psychoanalysis (see chapter 2).

Feminist philosophers and social theorists have been intent on pursuing a feminist ethics beyond the Kantian sphere of autonomy and justice and into the sphere of interdependence, relationality and care. This interest has extended beyond feminism. Emmanuel Levinas' philosophy (1961, 1974, 1985) takes the ethical relationship as central to subjectivity and responsibility for the Other. Following Michel Foucault's (1988) lead, interest has flourished in care of the self, albeit largely in the generalising way so characteristic of philosophical argument (see Roseneil 2007 for an exception). The political science angle on care ethics, notably Joan Tronto's (1993) and Selma Sevenhuijsen's (1998) work, has the strength of making links to large scale political issues such as the boundaries between the public and private

spheres and the question of how care ethics work beyond the intimate or at least interpersonal sphere, across social distance.

Fiona Williams has identified Joan Tronto and Selma Sevenhuijsen, feminist political scientists, as exemplifying a 'second wave' of work in the ethics of care (Williams 2001) with the first wave being triggered by Gilligan. The second wave is characterised by an attempt to 'resolve the tensions between an ethics of care and an ethic of justice rather than to understand them as a gendered binary' (ibid: 12). In the words of Sasha Roseneil:

[M]any feminists have expressed reservations about the whole-hearted embracing of an ethics of care, regarding it as over-reliant on a model of care developed from thinking about the fundamentally gendered care practices of mothers for their children, and fearing that it brings with it a diminution of concern about the ethics of justice and social equality. ... We should be wary that advocating an ethics of care might involve endorsing a model of self which is so fundamentally relational that any sense of individuality, separateness, and capacity to act autonomously is negated (Roseneil 2004:414).

Tronto and Sevenhuijsen are engaging with a tradition of theorising ethics within the polis, a public space that belonged to men and is even now usually defined in opposition to the home (the location of mothering and care). In political science discourse, the idea of distributive justice has dominated. Sevenhuijsen (1998) pursues its implications into the sphere of policy and

politics, demonstrating how care can be placed within conceptions of democratic citizenship. She argues that it is possible to transcend the binary of care and justice by going beyond the model of distributive justice with its 'abstract rationality, impartiality and sameness' (1998: 145) and instead focussing on practices in the context of power and domination.⁴ Once 'care' is not constricted by the motherhood paradigm, it can be seen, she claims, as structuring all human relationships, which includes political and public settings. Both these theorists emphasise care as a practice. Sevenhuijsen claims that 'the core idea of the ethic of care in my view is that care is a practice, and that it is crucial for developing a moral attitude – and thus also a moral vocabulary – of care by engaging in the practice of care. By doing so care can in fact grow into a disposition, a part of our everyday thinking and doing.' (2003: 18). Tronto follows in a long line of theorists, starting with Aristotle for whom 'a good polis was no guarantee that citizens would be ethical, but (...) it was almost impossible that good men could exist in a bad polis' (Tronto 1993:7).

But what understanding of subjectivity underlies these arguments? A Kantian model has dominated in political science discourse: autonomous, cognitive, rational; a model that feminist critics have identified as decidedly masculine. In this perspective, ethical practices are a product of correct reasoning.

Because of the influence of feminist critiques, political theory has become more aware of the weaknesses of proceeding according to abstract principles.

Andrew Dobson (2006), a political theorist of cosmopolitanism as well as an

⁴ Care writers in the feminist philosophy tradition such as Bowden (1997), Friedman (1993) and Card (1996) have addressed this binary, but they have not addressed the question of the model of self and self development that could transcend it.

environmentalist, raises a similar set of questions that result in him advancing a situated and embodied account of obligation and justice: 'thick cosmopolitanism'. He addresses cosmopolitanism's principle that the scope of political obligations is universal and diagnoses its weakness as being because it is based on a 'thin' definition of what connects people together in a common humanity. This leaves, in his view, a 'motivational vacuum' in explaining how people might meet universal political obligations, or in my terms, a lack of a theory of subjectivity which accounts for people's capacities to care (or not). This is in part due to the abstracted nature of political discourses of justice, as Dobson refers to when he comments that cosmopolitanism tends to construct 'human creatures as primordially thinking creatures' so that 'becoming a cosmopolitan is fundamentally an intellectual affair' (p19). He wants to 'thicken the ties that bind us to "strangers" ' (ibid) in a way that this fails to do and invokes an embodied subjectivity which would help causal responsibility to be conceived 'at-a-distance' (p21). I return to this question in chapter 6 in ways that I think help to transcend the residual dualism between care (embodied, specific, relational) and justice (abstract, rule-based, intellectual).

The absence of an alternative model of subjectivity also, in my view, compromises Tronto's application of care ethics to politics. I illustrate this by looking at her model of care. Tronto did not problematise the capacity to care. Her only reference to how people might be able to care is towards the end of her book when she says 'in order for these qualities [that is 'to care for those around one or in one's society'] to become a part of moral conduct, people must engage in both private and public practices that teach them, and

reinforce their sense of, these moral concerns' (1993:178). Sevenhuijsen's argument (above) that the practise of care leads to disposition to care takes this a little further into the domain of subjectivity but leaves it unclear if, how and when, such a process takes place. Tronto draws implicitly on a more simplistic model of social learning to account for moral conduct, reinforced with the idea that practice is a sufficient conveyor of moral values. In this, like many social and political theorists, she reduces subjectivity to an empty category filled by social products. The individual residue is therefore naturalised, as individual-society dualism dictates. As most moral philosophers do, she talks about individuals as members of a general category who show moral concern. Often she implies that if the political barriers to a care ethic were removed (by shifting moral boundaries that currently exist, for example between public and private) then people would naturally care ('from the perspective of care, individuals are presumed to be in a state of moral engagement' *ibid*: 164). This naturalisation of care is a blind spot in the literature about care ethics. If a 'good polis is no guarantee of ethical practices' what does create ethical citizens? In Fisher and Tronto's initial work (1990), five 'values of caring' defined caring: attentiveness, responsibility, nurturance, compassion and meeting the other's needs (also in Tronto 1993:3).⁵ I will discuss the three concepts that could potentially provide the conceptual resources for underpinning the capacity to care with a theorisation of subjectivity - meeting needs, attentiveness and compassion - and in the course of a brief critique, signal the ways that I develop these ideas in subsequent chapters.

⁵ Modified, these then formed part of a model of the 'elements' of care which, combined with the 'phases' of care, came out as: Caring about – attentiveness; Caring for – responsibility; Taking care of – competence and Care receiving – responsiveness.

Meeting needs, attentiveness and compassion

The idea that someone could desire to make themselves dependent on another's preparedness to meet their needs when this was objectively unnecessary is quite foreign to Tronto's way of thinking in *Moral Boundaries*. On one hand, she reflects upon the individualistic culture of the USA and its effects on making autonomy a possible and desirable aspiration. On the other, she believes that the possible and desirable state that care is always aimed towards is that of autonomy, when care is no longer needed. For example she subscribes to 'the reality that human beings ... manage to become autonomous' and that 'we can probably assert that one of the goals of care is to end dependence' (1993:163). Her critique of individualism and autonomy does not actually lead to a different conceptualisation of subjectivity despite her claim to adopt the principle of interdependence. For her, interdependence seems to mean that there will be different times of life when one will be able to extend care or need to receive care. At those times, she implies that the roles are fixed because they are related to physical needs which are ameliorable: at a given time, one is either caring or cared for.

This set of rather covert assumptions in Tronto's treatment of care ethics ignores the existence of fundamental human needs that are relational like the needs for recognition and trust⁶ that exist throughout life, independently of the ebb and flow of our physical capacities to cater for our own needs. Ironically

⁶ Sevenhuijsen typically adds trust to the qualities of care that she drew from Tronto; trust that she sees as the 'oil in the wheel of care' (2003: 15).

Tronto remains on the territory of the enlightenment subject of moral rationality that was so influential, through Kant, in traditional moral and ethical theory, a perspective that she explicitly criticises. My analysis of intersubjectivity is very different from her interpersonal model that posits communication between two or more autonomous unitary rational individuals who occasionally need help from others.

A theory of subjectivity premised on the dynamic unconscious intersubjective flow of affect, identification and recognition between people means that care is the psychological equivalent to our need to breathe unpolluted air. We can survive, perhaps for a long time, in polluted air but it damages our vitality, we have to make do and adapt to less. Moreover, good enough care, like good enough air, is inside and outside us inevitably, all the time, whether in its presence or lack. This also means that participating in the daily flow of care, in private and public domains, with intimates and strangers, is not necessarily separate from pleasure and creativity, as Tronto claims (1993:104). In claiming this, she reproduces the common feminist conflict between caring for others versus self care or looking after one's own needs.⁷ Growing out of a primary opposition to women's subordination, feminism has often, understandably, equated women's caring with self-sacrifice. Conflicts between my needs and/or wants and those of someone else I care about exist as a frequent, continuous and inevitable part of life. However, to recognise this is not the same as conceptualising others and self as representing mutually

⁷ For example, see Bell 1993, Card 1996, Hoagland 1991.

opposed interests. It is simply a part of the experience of conflict between multiple possibilities which is the stuff of existence.

The idea of a primary or necessary opposition of interests between self and others not only derives from an individualistic ontology but it also renders invisible the profound pleasure of the kind of caring that is woven into the fabric of daily life. I don't want to restrict this claim to the performance of activities which can afford enjoyment to a carer (playing with a toddler, taking a convalescent on a day trip, reading a novel out loud to a blind person), nor simply pleasure in one's own altruism. From an intersubjective perspective, a virtuous circle of care can be established whereby a person can take pleasure in another's pleasure who also reciprocates. Someone who is being cared for, even if they are quite dependent, is potentially still capable of many forms of caring, perhaps psychological rather than physical, for example to elicit and pay attention to the state of mind of the carer, to share relevant experience, to express appreciation, thus recognising the other. Sevenhuijsen gives an example of a care worker with elderly people suffering from senile dementia who was quoted in a Dutch newspaper as saying that hearing a word for the first time from one old woman 'makes my morning worthwhile'. Among her characteristics of care – patience, empathy, attentiveness, intimacy - Sevenhuijsen therefore adds 'not least, the ability to draw satisfaction from fulfilling what may seem to be insignificant needs' (1998:1).

I agree with Sevenhuijsen, that needs are 'the quintessential object of care' (1998: 137) but they are rarely transparent and therefore demonstrate all the

complex ways in which caring for depends on qualities of caring about involving attentiveness and compassion. From a psychoanalytic perspective, needs are rarely fixed essential qualities that reasonably need meeting through care. Some needs will turn out to be more or less objective, such as when an old person can no longer reach their toenails to cut them, and the care response should be similarly clear cut. The needs of sick people come into this important category. But it is impossible to separate the practices of meeting needs from the psychological meanings, imported from many quarters, which even simple acts will carry. As I show throughout this book, any relationship carries with it the meanings that have built up through the life histories of both parties. These are held in their internal worlds and are transferred to some extent on to any new relationship.

Care relations are, of course, particularly subject to such dynamics, being key to the original foundation of intersubjectivity between infant and mother, or other primary carer. Thus physical needs that are the object of nursing care should not be separated from the whole relationship within which those needs and care are being expressed. For example, in paid care, 'the disclosure of nurses' embodied, emotional involvement ... enables connection with the patient's experience and well-being, and ... produces the refinements of physical ministrations that alleviate suffering, create the trust that subjectivity will not be betrayed' (Gadow 1990, cited in Bowden, 1997 p116).

To complicate matters further, the meeting of needs can be more harmful than helpful. For example, it is not unusual for the expression of needs for care to

contain an omnipotent wish to control the other and one's environment; a wish left over from infancy, where it was useful for survival. I discuss the role of omnipotence in thinking and development in Chapters 2 and 3. Such 'needs', if they are met, may grow without limit, so that we hear, for example, of adult men living with their elderly frail and poor mothers; men who still feel justified in making gross and unlimited demands on their maternal object (and here object is an accurate word). Meeting someone's needs uncritically can result in one's objectification. Omnipotent demands to have one's needs met stem from a failure to develop a capacity to care which involves seeing the other as a person in her own right.

For Tronto (1993: 121) 'if we are not attentive to the needs of others, then we cannot possibly address these needs'. The absence of attentiveness is therefore a moral failing. She draws from Simone Weil, who 'believed that the capacity for attention was crucial for any genuinely human interaction' (op cit: 127). Sarah Ruddick too regards this to be important, as in her emphasis on 'attentive love' (1989: 118). Selma Sevenhuijsen develops the idea of attention as a crucial feature in care as an ethical practice. She takes Tronto's starting point and develops the idea of caring about, as necessarily preceding caring for but marginalised from political discourse, without which the practices of care lack both 'a heart and a soul' (2002: 10). It is thus important how attentiveness is conceptualised. I agree with Tronto that it is a moral capacity but not one emanating from the will of an intentional rational subject ('the unwillingness of people to direct their attention to others' particular concerns' 1993: 130). We will not make progress in changing the conditions of

possibility for people's attentiveness. These I argue, reside in the evolving often unconscious intersubjective relations that surround someone and are available for identifications and internalisation. Of course these are expressed in practices and to this extent I share Tronto's and Sevenhuijsen's emphasis on practice, but without Tronto's rationalist and voluntaristic assumptions.

Recent psychoanalysis understands attention and more broadly 'thinking about' as developing relationally. An individual's developing capacity for realising and linking thoughts depends on them internalising a model of containment that makes the emotional content of thinking bearable. If they are unable to do so because the accompanying feelings are insufficiently contained to be bearable, then they will not be able to be attentive to whatever particular object is involved. Thoughts potentially pose threats to the thinker whether they are about people or not (see my account of Bion's theory of thinking, chapter 2), but given how closely our subjectivity is tied in with our relationships to others, it is particularly challenging to notice other people's states of mind and how these might implicate one's own conduct. The capacity to do so is not a natural given and so I provide a developmental account of how this is achieved (or fails to be achieved).

Like most social scientists, Tronto excludes a developmental perspective from her analysis. This has become a dominant feature of the social sciences since the 'turn to language' with its accompanying critique of developmental psychology (see in particular the 'new sociology of childhood', for example, Smart, Neale and Wade 2001). Although the critique was needed,

unfortunately the baby of development has been thrown out with the bathwater of developmentalism. This is compounded by a feminist reluctance to privilege the mother-child relationship as a paradigm of care, for example 'too often, care is described and defined as a necessary relationship between two individuals, most often a mother and child' (Tronto 1993:103). In contrast, I hope to show in this book how crucial the early primary relationship between mother and infant is for the capacity to care of both of these parties, a relationship which is not so much paradigmatic as ordinary. I hope also to show how care can and does extend from such beginnings to potentially all relationships, even across social distance. Of course its character changes in the process.

In Tronto's treatment, compassion figures in the context of other theorists' distinctions, which she wishes to transcend, between care and justice ethics where 'care draws out of compassion, justice out of rationality' (1993: 166). It is referred to only in a common sense way. In my view, compassionate caring about depends on accurate recognition. How this is achieved is addressed in the psychoanalytic concept of identification. Tronto has quite a lot to say about identification, but each time draws on a misleading critique that equates identification with what she refers to as 'overidentification'; that is, a dynamic where a carer loses the capacity to recognise the difference between their own needs and those of someone in need of their care. In contrast, I use the concept of identification in the psychoanalytic sense to describe the developmental processes that involve the internalisation of identifications with primary carers during the early years and which, when positive, can lay the

foundations of the self and for later care from the position of being a person in one's own right (chapter 3).

A focus on the capacity to care means that we ask how this relation to another person is achieved. The psychoanalytic concept of identification embraces processes that are conscious and unconscious, embodied, affective and cognitive, both primary (unthought) and secondary (thought) processes.

Without the psychological capacity to identify with others across the boundary that comes to define one individual from another, compassion and concern would be impossible. We can only know what another person is experiencing through empathy or 'fellow feeling'; that is through using ourselves as an instrument of understanding. The capacity for empathy goes far beyond cognitive-based understanding. It involves, for example, imaginatively flinching at the other's response to a cold hand or a sharp needle or an overhot drink and therefore being able to modify one's actions. It involves psychologically imagining oneself in another's position.

The capacity for accurate identification is constantly in danger of being compromised by the unwitting defences we are likely to mobilise in the face of painful feelings. Faced, for example, with a dying person who will not or cannot talk about death, how possible is it not to let one's own fear of dying get in the way of experiencing what they are going through? If they wish to finish their life quickly, how does a carer separate out their own wishes from those of the other – to keep the loved one for ever, to get rid of him or her to obliterate the obligation to care, or perhaps both at once? How does one

recognise and respect the difference between concluding, for example, 'if I were in their shoes, I would want to quit life now before my dignity was completely in shreds' (an example of what Tronto might call 'overidentification') and picking up the signals that, no, they might have thought that earlier but now they want to live every last day? Tronto's inadequate use of the concept of identification reflects a wider and enduring tension in the feminist literature between the idea that identification means feeling the same as (identity with) the other and acknowledging – and respecting – differences. She does this, for example, in her discussion of responsiveness where she claims that putting oneself into another's position presumes that 'the other is exactly like the self' (op cit:136). These need not be in contradiction if the concept of identification draws on the complexity that contemporary psychoanalysis provides (chapter 6).

Psycho-social subjectivity in care

I have concentrated my critique on Tronto, because of her importance in taking the care ethics debate away from the mother-child paradigm and into the public sphere, addressing justice. However, the 'second wave' of care ethics has a wider focus too, if it includes, as I think it should, the work of the group gathered within the University of Leeds CAVA project, directed by Fiona Williams. This work, with social policy issues at its core, is also committed to bringing care out of the private sphere, critically analysing the (gendered) power relations involved, factoring in the effects of changing family structures, gender relations and individualization and engaging with political movements

involving marginalised groups such as disability rights and self-help. I situate my work in this book at the psycho-social edge of this second wave.

Williams points out that from a social policy perspective, care is a powerful analytic concept in times of changing welfare regimes because they point to changes in the relations between state, family, market and voluntary sectors as care providers; tensions between cash and services modes of provision and who receives this, carer or cared for and broad changes in and demographic and gender relations in care work (2001: 2). She provides an example of how the British disability movement's questioning of relations between carer and cared-for challenges basic assumptions about 'the very notion of care' (ibid: 10). This arises out of a history of experience of paid and unpaid carers who have positioned them as dependent, 'at worst abused and stripped of their dignity, at best patronised and protected from exercising any agency over their lives' (2001:10). Clearly care has earned a bad name because it has been tainted by unequal power relations, expressed in a model of dependency. Disability activists are thus calling for independence and control over their own lives (ibid). As Froggett noted (above), this contestation points to the importance of considering caring about as well as caring for and addressing the quality of care in psychological, rather than just physical and social terms.

Roseneil, member of the CAVA group, argues that care in social policy needs re-imagining and uses 'the epistemological challenge offered by queer theory to propose a different gaze be cast on care which recognizes the practices of

care which take place outside normative heterosexual couples and families' (2004: 409). She has consequently used a model of friendship as a basis for her research into care relations (ibid). My approach, although informed by a similar critique, does not abandon the mother-child model because, as I hope to show, it reflects fundamental aspects of the way that caring selves develop; aspects that are modified to a greater or lesser extent in adult relationships but which nonetheless form the ground on which caring about is built and infuses practices. It should still be possible to transcend the binary between autonomy, independence and the ethic of justice on the one hand and relationality, empathy and the ethic of care on the other in understanding the capacity to care.

With the exception of psychoanalysis, most of the influential contributions to debates about care lack a psychology, notably a full, critically-based theorisation of the self, and its relational development on which the capacity to care is founded. Developmental psychoanalysis turns out to be the most theoretically fertile area for understanding the relational acquisition of capacities to care and also gets closest in subject matter, for example, through Klein's notion of reparation and Winnicott's understanding of concern. It is also insightful in theorising the effects of sexual and gender difference in the development of care. Psychoanalytic literatures, with the important exception of Winnicott, hardly use the word care. However, they do provide a detailed account of the qualities required by the primary carer in her relationship with the dependent baby if it is to thrive. They also theorise the way these qualities become part of the baby's potential, change with major

events in growing up - for example, the processes of establishing a gender identity - and how they mark the quality of relationships with others throughout life.

In my use of psychoanalysis, I draw on the work of Melanie Klein, Fred Alford, Jessica Benjamin, Donald Winnicott, Wilfred Bion, Thomas Ogden, Ron Britton, Juliet Mitchell, the British school of object relations and the American relational psychoanalysts. Attachment theory, which originated with John Bowlby's work, has also been highly influential in establishing as commonplace the significance to later psychological wellbeing of attachment relationship between babies and primary carer. In its later empirical manifestations (Ainsworth 1974, 1978, Main 1993) it has established these central claims and also refined its theoretical principles in the direction of an emphasis on intersubjectivity (Diamond and Marrone 2003). These literatures draw attention to the importance of relationships in understanding care, not just in the obvious sense – care is a relational term – but in the sense that the individual, caring (and careless) subject is constituted relationally, right through to the deepest most hidden parts of their subjectivity. The processes and the product are ethical in their very nature. I use the term unconscious intersubjectivity to refer to this idea. The foreword to Diamond and Marrone's book *Attachment and Intersubjectivity* begins by commenting that 'The term "intersubjectivity" has become contemporary shorthand for a variety of attempts to transcend an intrapsychic model of the mind' (2003:vii). Such attempts have become so common in the last fifty years that they amount to a transdisciplinary paradigm shift. The term has developed in three different

disciplinary areas: phenomenology, psychoanalysis and developmental psychology. I draw in particular on the last two. Many of the emphases of phenomenology are compatible with my emphasis, namely the view that 'existence is interpersonal from the first and always profoundly related to context' (Diamond and Marrone 2003: 13). A psychoanalytic perspective treats intersubjectivity as an unconscious flowing of states between people and modifying them. It thus raises questions about the psychological boundaries between people.

Events in the external world are not just mediated by language or discourse but, importantly, by people's states of mind. By this I do not refer to cognitive processes but to 'mental states' or 'internal worlds' where desire and anxiety act creatively on experience and transform it, so that its relation to reality can never be simply assumed. The idea of an internal world refers, in object relations theory, to a world of unconscious fantasy made up of the self and other internal objects such as people, things, ideas and values (Fakhry Davids 2002: 67). This world 'provides a template for our interactions with the outside world, is itself shaped by these, and is the wellspring of our psychic well-being and of creativity itself' (ibid). I use the term intersubjectivity in this sense.

Emmanuel Levinas' project to found philosophy on an ethics based on an interhuman order is part of the phenomenological tradition: 'a phenomenology of sociality' (Levinas 1999: 103). This has been influential in placing ethics at the heart of philosophy. Hayat, introducing Levinas' *Alterity and Transcendence* (1999) puts the point as follows: 'a philosophy of dialogue

cannot not be an ethics ... like Buber for whom the beginning of philosophy is not the cogito but the relation to the other' (1999:xxi). Likewise, an analysis of the capacity to care cannot not be a contribution to theorising ethical subjectivity.

My approach also emphasises the importance of life history to the capacity to care. In other words it is developmental. In thinking developmentally I aim to focus on the 'dynamics of becoming' (Loewald 1978:6). Development is not seen here in the way that developmentalism has been criticised, that is for viewing it as fixed, staged and normative (Burman 1994), but in the sense that people are a product of their pasts and that we cannot choose to leave behind how these have forged us, although changes continue. Ben Bradley (1989) shows that developmental visions of infancy tend to fall into two kinds: foundational or constructionist. Foundational accounts are based on the belief that babies have real limitations that change over time with experience. Constructionist accounts of infancy show the ways that different theories have been imposed on what is posited as a 'blank slate'. This is a dualism that I attempt to transcend in what I would call a critical realist approach to infant and child development: attempting to show how theories have constructed infancy and also to assess which ones best answer my underlying question 'can this theory give me any insight into the capacity to care?'.

The same critical realist approach characterises my treatment of mothering and here any version of realism is likely to run into political controversy linked to the value judgements that come with it; for example about the

compromised care that depressed mothers are likely to be able to provide for their babies. Certainly part of my project in this book is to go beyond the kind of relativism that recognises no real effects of development or mothering but treats solely discursive effects. At their most inadequate, these are the kinds of discourses which allow one to argue that oppressive discourses have kept mothers constrained entirely for patriarchal purposes and that the quality of maternal care has no actual effects on babies' wellbeing. My critical realism attempts to recognise the effects of such ideologies on women's subjectification and at the same time make some realist arguments about what kinds of care babies are likely to need. An example would be the way I make a distinction between the biological mother and 'maternal care' provided by others and also explore carefully what connections there may be between babies' experiences of the biological mother and other maternal figures and why.

My care ideal is that an adult can engage in four kinds of care. First, they will be capable of reciprocal interdependent care receiving and care giving.

Second they will be capable of providing the non-negotiable, asymmetrical demand for care that has always been required of mothers and is required of fathers and others who 'mother' babies and young children. Third they will be capable of self care. Fourth they will be capable of extending their care to both human and non-human objects (for example, the environment or non-human animals) outside their direct experience. Understanding how these are achieved entails understanding the vicissitudes of the development of mind, self and morality. It will become clear that there are many variations on

capacity to care and many conditions that risk the failure of good enough capacity to care.

Outline of the Book

Chapter one. Introducing the Capacity to Care. The current chapter has set the scene for my particular approach by discussing its contemporary relevance and situating the capacity to care briefly in existing literature. I identify a significant gap in addressing capacities to care and their acquisition psychologically. I make some initial links to the policy questions in which care is a central consideration. Tronto's widely cited account of the constituents of care was useful to introduce why and how a psycho-social perspective on subjectivity takes issue with dominant assumptions about how people care, to signal my different theoretical emphases and to introduce the core themes of my account. I have referred to ideas about people's capacity to care that are based on a radically different ontology from that which is dominant in Western culture and western social science, the latter being based on assumptions of a bounded autonomous individual. Feminist theory has been at the forefront of a critique of this ontology, notably through conceptualisations of care and care ethics.

Chapter two. Care, Ethics and Relational Subjectivity.

The literatures that could most be expected to address and understand the capacity to care in a moral and gendered framework are the feminist literatures, first on the ethic of care and second on the reproduction of caring

through the mother-daughter relationship. In this chapter I review these, aiming to specify their strengths, weaknesses, and blind spots. I draw on the developmental psychoanalytic emphasis on unconscious intersubjectivity through the concepts of identification, conflict, differentiation and recognition, to provide a modified account of gender differences in moral reasoning and the ethics of care and justice. My account foregrounds Fred Alford's concept of reparative reasoning (based on Melanie Klein's notion of reparation) and uses Wilfred Bion's work to go beyond the cognitive traditions of theorising thinking and attention. I demonstrate the need to transcend a gendered binary between separation/autonomy and connectedness/ relatedness, in recognition of the fluid, non-essential, character of gender subjectivity, particularly in the contemporary context of greater gender flexibility.

Chapter three. Intersubjectivity in self development.

Babies' potential to develop caring capacities lies in the intersubjectivity of their mental states and their absolute need for care from a familiar and dependable person. If and how they develop the capacity to care is fundamentally dependent on intersubjective processes and this chapter describes and theorises them in terms of babies' developing selves, unconscious intersubjective dynamics and how meaning is made of their experience, especially prior to language development. Central is how they develop the ability to imagine and identify with another's state of mind. I trace the developmental struggles through which moral subjectivity is achieved. My understanding of moral subjectivity is based on Kleinian and post-Kleinian, especially Winnicottian, concepts. I ground much of this in a brief and simple

example of a 2-year old boy, Carl, who makes a caring gesture to his harassed mother when her self control breaks down.

In this chapter I set up a related cluster of themes for elaboration in subsequent chapters. I ask how a child differentiates, or separates, from its mother or primary carer and how sex and gender affect these processes. I suggest that the carer's recognition of the baby's states of mind is important in how the baby learns recognition, with effects on subjectivity and capacity to care. I introduce Bion's concepts of the container and contained as a non-cognitive model for learning how to think and its implications for attentiveness. An illustration from a longitudinal baby observation provides the basis for inferring the internalisation of a parental good object and I consider how this is the basis for feelings of self worth and by extension the capacity for self care. In this argument, self care and care for others stem from the same source, rather than being in conflict. I discuss a question that is central to a psycho-social approach to subjectivity: the relation between the external reality that the baby meets and the inner psychic processes (for example splitting) that transform that reality and produce experience and meaning. Last but not least, I broaden out the focus on the mother-infant couple to introduce the role of dyadic and triangular structures in babies' development of 'mental space' and the role of siblings in the development of moral subjectivity.

Chapter four. Maternal subjectivity and the capacity to care

In this chapter I hold in balance the universal demands of being a mother, namely the non-negotiable character of the new infant's dependency, and the

situation of the woman who is never only a mother. I try to unsettle the binary of other- versus self-centredness in discourses that have characterised women's positions as mothers. I characterise the move into maternal subjectivity as a way of confronting, and potentially living up to, the challenges of caring for others in a dynamic way from the position of being a subject in her own right. Maternal subjectivity is forged out of the love, demands and responsibilities that help a baby move out of undifferentiation, omnipotence and narcissism - from a state of 'ruthlessness' (Winnicott) - to the capacity to feel realistic concern for, and therefore be able to care for, another person. The demands change continuously with the child's development, from one-way care to – ideally - a situation of mutual recognition and interdependency that characterises many other care scenarios. These dynamics of maternal development are not restricted to biological mothers.

Early mothering is a time that reemphasises, par excellence, the dynamic tension between intersubjectivity - on which condition in the mother the new baby relies for its psychological wellbeing – and differentiated subjectivity. I use Ogden's concept of the intersubjective third to explore this tension and how it can provide a way of understanding selves. I argue that the capacities born out of this dialectic can expand beyond being an actual mother or woman and provide the basis for ethical life. This is different from the valorisation of the feminine that characterised some 1980s feminisms in that it does not reserve these characteristics for women but explores how these capacities can be generalised through caring relationships, especially in the context of the unsettling of gender differences.

Chapter five. The gender of parenting, the gender of care

In this chapter I ask what might be specific to the position of a biological mother and if and how might this differ from the father's position in relation to the demands of young children. At the same time I address one political question that provides a backdrop to this book; namely 'what difference might it make if fathers rather than mothers were the primary carers for babies and children'? To this extent, this chapter focuses on men and boys and what, in their current development, may restrict their capacity to care. I take an intergenerational approach by keeping in mind the parenting conditions that are likely to affect the development of boys' gendered subjectivity and thus their later parental capacities to care. I ask what is particular about the (biological) mother's body, women's and men's bodies and their differences and how the infant and later child might experience these differences. For this purpose I draw on psychoanalytic work that theorises the importance of the earliest relations experienced in the mode of embodiment rather than thought or language, for later subjectivity, relationality and identificatory capacity. I conclude that the mother's and father's bodies cannot signify the same in the infant's early experience. Likewise the 'fantasy of the omnipotent mother' will not generalise to men's mothering without profound changes in its meaning and the child's experience.

Shifting focus from the sex and gender of the parents to that of the children, I draw on Jessica Benjamin's understanding of preoedipal as well as oedipal dynamics and in particular her distinction between the intersubjective

conditions that help a boy to renounce, as opposed to repudiate, his mother in the course of separation. From this, using the idea of cross-sex and cross-gender parental identifications, it is possible to understand how the defensively autonomous character structures typical of masculinity can be modified, affecting men's capacities to care. Finally I move beyond dyadic relationships using the emphasis in contemporary psychoanalysis on triangularity, the third term and the analytic third in order to complicate the question of what children need in order to develop the capacity to imagine themselves in the position of the other. I introduce sibling relationships into the family picture, showing their influence in the experiencing of love and hate, particularly on lateral relationships.

Chapter six. Difference and the capacity to care.

Throughout the book, the concept of identification has been central to theorising the capacity to care and here I try to untangle a common conflation between identification and sameness by discussing the conditions for identification with differences as well as similarities. I apply the psycho-social intersubjective model of the caring self that I have developed in this book to several scenarios that diverge from the face-to-face and familiar basis to unconscious intersubjectivity derived from the mother-infant couple. These cover friendship, institutional care and caring across social difference and across distance.

The chapter widens the focus to discuss the subject of ethics in the light of my theorisation of the capacity to care and its origins in the mother-infant

relationship. This takes two directions. In the light of the radically intersubjective ontology I have developed throughout the book, I further consider Levinas' similar ontology; also the friendship model of care as an alternative and complement to the mother-child model. To test how my approach extends from the intimacy of primary face-to-face relations, I ask if and how the capacity to care extends to apply to other settings, namely institutional care and charitable giving to third world countries. In this way I return to the question of justice and the role of motivations to care in political obligations. Once defensive autonomy and instrumental reasoning are distinguished clearly from justice reasoning, the care-justice dualism is further unsettled.