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The Relationship of Care and Power in the Context of Feminist Care Ethics

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Feminist theories of care ethics point out that vulnerability and dependence are an inherent part of caring relationships, while also noting that these aspects and the sense of inequality that stems from them invariably enable the abuse of power. At the same time, Tronto (2013) argues that the best form of care is non-hegemonic democratic care. How can care be provided in a non-hegemonic and democratic way in situations where actors are characterized by their mutual inequality and their mutual dependence and vulnerability? The author argues that equality is not sufficient for sustainable non-hegemonic care and that inequality is not necessarily connected with the abuse of power in caring relations. The responsiveness, both at the individual and institutional levels, she considers as a necessary condition for democratic care based on inclusiveness.

Keywords: care – power – feminist care ethics – protection – vulnerability – responsiveness – non-hegemony

Introduction

Since its inception in the 1980s, the feminist ethic of care has been the subject of debate over the role it can play in achieving the key goals of feminist theory and practice, primarily the struggle against oppression and violence, and, by extension, against power in its various forms. The concept of an ethic of care has been questioned for its efforts to assert care and a caring attitude as a central value not only in interpersonal relationships but also in the public space, in public lives, and at all levels of social existence, including those of social and political relations. Given the situatedness of the notion of care in the dualistically and essentialistically constructed conceptual network of Western thought, it is not surprising that care represents an opposition to the forces of power, violence and conflict. In this conceptual map, care is perceived as being synonymous with love, universal understanding, harmony and peace, and thus, by extension, the principle of non-violence. According to such a conceptual scheme, care should have nothing in common with power. However, such an essentialist understanding of care has serious implications. Conceptualizing care as resistant or immune to power renders power and its use and abuse in the context of care itself invisible while also presenting care as being impotent in the face of power and its abuses, and therefore ineffective and unhelpful.

According to Held, we fundamentally misunderstand the ethics of care if we suggest that it presupposes something akin to harmony and the absence of violence:

> The ethic of care is not based on a mistaken notion of peace and tranquility. It can accurately grasp the extent of violence and conflict that exists within families, within societies, and between groups and states. It does not ignore the facts that parents sometimes kill their children, mothers not infrequently hit them, friends can argue to the death, and the world of human affairs is full of war and violence (Held 2015, 234).

While care is a fundamental human activity, power is an omnipresent factor in human existence and cannot be ignored, and the attempt to understand the ways in which power and its aspects affect the relationships and practices of care is thus a crucial field of inquiry within the context of the ethics of care. Understanding of these aspects could be useful also for understanding how particular caring practice and relations can create and maintain space for abusing power and even for different forms of violence.

Ruddick refutes the essentialist perception of care, seeing it instead as a social practice, and brings a processuality and relationality associated with situatedness and contextuality to the understanding of care (Ruddick 1980, 1989). In developing a feminist ethics of care grounded in a relational onto-epistemology, it thus makes little sense to think of care and power as strictly and rigidly separate essences and mutually exclusive opposites. Relational ontology of care perspective necessarily starts from relationship and looks at the ways in which needs are met in common (Tronto 2015, 264). So, caring persons / communities, and caring institutions must consider multiple factors, perspectives, and options, and need to consider the complexity of acting in the interconnected and so continually changing context. The current power structure of caring relations and acts is also necessarily the subject of their consideration. Power and its aspects, assumptions and possible consequences of its use are understood as part of the practice of care and not as some side or unintended consequences outside of the framework of care (Tronto 2015, 265). So, they need to reflect the fact of inequality in relations of care and the unequal distribution of power in the context of care practices (Tronto 1993, 143; Tronto 2013, 148) when humans or other beings or groups are not equally able to take care of themselves, and the likelihood of abuse of power, and therefore some form of violence, is increased.

So, how to achieve the goals of good care if we are mutually, but not equally interdependent, and so we are not equal? It might seem that the priority should be the search for strategies to achieve equality of actors, which is understood as a prerequisite or guarantee of eliminating the abuse of power, and therefore also various forms of violence. I argue that although equality of power, or rather the balance of power of actors of care, is desirable because it reduces the likelihood of abuse of power, equality cannot be considered a sufficient prerequisite or guarantee of eliminating the abuse of power. Without the cultivation of responsiveness, both at the individual and at the institutional, systemic and structural levels, any equality and balance of power in caring relations is only temporary and good or better care is unfeasible.

To explain this argument, the first part of the text will focus on the aims of care as outlined in the works of the most prominent theorists of care ethics, Ruddick, Kittay and Tronto, paying particular attention to the conceptualization of protection, autonomy, and human dignity as a part and goal of care. We will then move on to an exploration of the conceptualization of good care practice focusing on the distinction between hierarchical and non-hierarchical approaches. Finally, we will explore the possibilities for overcoming or preventing the potential abuses of power implicit within an ethics of care perspective, with an emphasis on understanding the concept of responsiveness.

I. Objectives of Care

Care as a practice is governed by certain values; it requires specific abilities, competences, and moral-psychological qualities (or virtues) from its actors and specific structural-systemic conditions at all levels of social reality to achieve its goals. An ethics of care formulates normative criteria of care based on the critical reflection on empirically evaluated experiences of practice and relations of care with the aim of identifying and distinguishing between various care practices in term of their suitability, quality and adequacy. This type of differentiation and evaluation is a prerequisite for improving the quality of specific care practices and eliminating the abuses of power and power structures.

Ruddick sees the goal of maternal care as that of sustaining life and fostering the growth of children, thereby helping them to develop into good people. Maternal thinking according to Ruddick grows out of a maternity practice that responds to a child's three basic needs: protection, growth, and social acceptance. Children are dependent and vulnerable, and maternal practice therefore begins with the recognition of this vulnerability as a relevant social factor and phenomenon that requires care and the acceptance that others need our attention, energy and commitment to act in a caring way. In providing maternal care, we accept our responsibility for such an action, our responsibility to make it happen. And although Ruddick associates the concept of maternal practice primarily with the act of caring for and nurturing a child, she also acknowledges that maternal thinking expresses "different ways of working with and caring for others" (Ruddick 1980, 346). In doing so, she draws attention to the possibility of understanding different kinds of social practices as practices of care, such as education, health care, social care, civic participation or environmental care. According to Ruddick children are vulnerable creatures and as such elicit either aggression or care (Ruddick 1995, 166). Ruddick not only reminds us that vulnerable beings require care, but also that our response to vulnerability can be hurtful. We are capable of hurting, that is, of using our power (in the sense of the ability to act) and harming, of causing pain, suffering, damage. Vulnerability, which Ruddick notices in children, concerns all human beings, not only when we are infants, infirm and frail in old age. We are care receivers, all, we have different needs all the time (Tronto 2013, 146). So, we all can be harmed. We can be exposed to pain, fear, anxiety, hungry, devastation, oppression, or different forms of violence. Tronto emphasizes that care presumes that people live in a world in which they cope all time with vulnerability (Tronto 2015, 267).

Thus, from a care perspective, all people are essentially vulnerable individuals who all have needs which must be met. The aim of care is to identify these needs and meet them where appropriate and in doing so promote a good life for everyone with an avoidance of harm. The key aspect of this task, however, is how we identify specific needs and threats which apply to everyone, how we determine what a good life means for all, and the tools, strategies, and approaches to achieve those goals in specific contexts and situations. In moral terms, this means the ways in which we determine our responsibilities for care in specific conditions and contexts. Everyone is different, with differing needs and ideas about what is the best means of care for their requirements and those of others, and therefore the possibility of providing adequate care for all might seem highly unrealistic. Tronto points out that the more powerful members of society define and determine the needs of others as a means of both demonstrating and preserving their power status (Tronto 2013, 148; Tronto 1993). Similarly, the situatedness and position in social structures also have an impact on how the threats and dangers are defined, more specifically who and what we perceive as a threat and how we should protect ourselves against them.

Thus, if we take as a starting point the assertion that we are all vulnerable beings (Tronto 2013, Mackenzie – Rogers – Dodds 2014) and that care is a specific human activity or set of activities (i.e., practices) that meets the needs of vulnerable persons, then we are all necessarily recipients of care; in essence, we are all in need of care, and we are therefore always necessarily dependent on care in some degree. As a result, then, we have a shared interest in defining the practices and approaches that best meet the needs of vulnerable people. How can we determine which care practices are most appropriate?

Since our inherent vulnerability as human beings means that we are exposed to sources of potential harm, suffering, pain or disempowerment and various forms of oppression, violence or exploitation, our response to this vulnerability should be to protect ourselves from these possible threats. Mackenzie, Rogers and Dodds characterize this response as providing protection from harm, meeting the needs of others, providing care and preventing exploitation (Mackenzie – Rogers – Dodds 2014, 16). However, they also note that vulnerability is often associated with the conceptualization of vulnerable individuals as victims or as being incapable of defending or taking care of themselves. This perception often results in narratives and discursive practices around vulnerability and protection that lead to the labelling and stigmatization of individuals, groups or even entire communities and societies as vulnerable to the extent that they are incapable of acting and living autonomously, thereby engendering discrimination, stereotyping and unwarranted paternalistic interventions on the part of care providers (Mackenzie – Rogers – Dodds 2014, 16). They see the root of this problem as lying in an overemphasis on protection and a lack of focus on promoting autonomy and capability (Mackenzie – Rogers – Dodds 2014, 16). The question then becomes one of how we can provide care that protects without harming and limiting the autonomy of others and instead promote its development and growth.

According to Ruddick our response to vulnerability develops in mental habit or cognitive style that she calls scrutinizing. It can be described as a state when caring person or institution being aware of potential dangers but not letting them dominate one´s decision making, not letting fear of them reorient one´s priorities, not giving up and not diverting resources from the sustaining activities of daily life. This attention should be tempered by a humility concerning about what one can control to have potential dangers can´t become obsessive or intrusive (Ruddick 1989, 71 – 72). This humility she understands as an attitude that must be cultivated through reflective awareness emerging from a thoughtful engagement in practice of care. So, perfect protection of vulnerable is not possible and the effort for perfect or absolute control over all dangers can drive to power and dominance of carer and to failing of the protection as one of the basic objectives of good care. As interpreted by Cohn (2013), a reflective maternal practice will include acts of preservative love, nurturance, and training designed to equip the child with resources for avoiding dangers when possible and for otherwise dealing with the consequences of dangers that neither mother nor child will be able to perfectly control (Cohn 2013, 57). So, the reflectivity of good care allows one to understand the difference between protection and preservation and then act in practice in accordance with it. While the protection is close to dichotomic image of protector and protected, from Ruddick´s view vulnerability is not synonymous of victimhood or passivity as the agency of vulnerable humans is crucial (Cohn 2013, 64).

Within this context, Joan Tronto draws attention to the need for a critical reassessment of the concept of protection (Tronto 2013, 170), but this cannot be achieved unless we also change our thinking about the relationship between autonomy and dependency. Just as care is conceptualized dualistically and essentialistically as being in opposition to power, autonomy is generally understood in Western thought as being opposite to dependency. Since its inception, the ethics of care has emphasized a relational understanding of the self (Held 2015, 22 – 29), stressing the need to understand autonomy as the relationist, relationally grasped capacity to determine our own paths while remaining aware of our situatedness in our relationships and connections with others. Above all, we must come to see ourselves as interdependent. Tronto takes the position that dependence is a natural part of our humanity; all humans are born into a state of dependence as dependent beings, but we can learn to become autonomous beings (Tronto 1993, 163). Judgments about ourselves regarding our needs and desires do not cease when we are placed in a position in which we are dependent on the care of others, nor when we are actors in the process and practice of care (Tronto 1993, 163). Dependency in some moments or aspects of life does not automatically lead to dependency in all aspects of life. According to Tronto, one of the main aims of care is to end states of dependency, or at least to minimize them, rather than to make them a permanent condition (ibid). Thus, it can be said that good or better care is that which strengthens and promotes the autonomy of those for whom we care.

The idea that good care should enhance the care recipient's ability to determine their own lives and make decisions about themselves due to their situatedness in relationships, the concept that care should shape and support their autonomy, is echoed by Ruddick (1980). Ruddick identifies degenerative and non-degenerative forms of maternal practice that correspond with degenerative and non-degenerative forms of maternal thinking, characterizing them through the typical attitudes, values and competencies of the actor of the respective maternal practice. Within this framework, the actor of a non-degenerative form of maternal practice is typically be characterized by attentive love, humility, understanding, respect for others, a sense of complexity and reality, the capacity to change as reality changes, the ability to explore, create and preserve on one's own values, and to see and identify existing forms of oppression and domination. Conversely, the actor of a degenerative form of maternal practice is characterized through a rigid and excessive control of others, self-rejection, the uncritical acceptance of the values of the dominant culture, or compliance, the sense of "unacceptable" in the eyes of mainstream society (Ruddick 1980, 354).

If the role or goal of care, and thus of the protection which forms a part of it, we will understood within the context of the full-fledged moral and political theory of care (Tronto 1987), then indeed, an excessive degree of dependency hinders civic participation, and without civic participation it is impossible to consider the fair distribution and allocation of responsibilities for care, a relationship which is supposed to lie at the heart of the political agenda of modern democracies (Tronto 2013). However, Tronto suggests that this by no means implies that care is incompatible with the democratic values of equality, freedom, and justice; on the contrary, it only underscores their urgency. "Only if caring takes place in the context of a democratic social order can human dependence be recognized as a necessity but also as a condition to overcome" (Tronto 1993, 163).

This would suggest that if caring represents both a moral and political value for us, we should take the task of caring more seriously and protect and promote the autonomy of those for whom we care. This approach would also allow us to carefully examine a crucial question: how can we determine whether a sufficient degree of attention is focused on protection and on the promotion and development of the autonomy of the individual or group? Protection would not therefore mean absolute isolation from all sources of danger and the imposition of absolute control over the person or group or community for whom we care. The importance of interdependence as a starting point for finding solutions in the above-mentioned issues will pose questions that need to be addressed from an interpersonal perspective. If we consider all citizens as equal from the outset, this may result in the displacement and marginalization of certain realities that might hinder true equality for all. If we see equality becomes a political goal, we will be motivated to examine why we are failing to achieve it and where the causes of inequality, such as the inequitable access to resources, lie.

II. Towards a Non-Hierarchical Practice of Care

Tronto makes an important distinction between care in the public sphere and in the private sphere. In the public sphere, citizens who find themselves in a situation in which they need help from other citizens or public institutions are considered as equals, and as such are expected to exercise autonomous judgements, decisions and actions. In the private sphere of the home, the family and interpersonal relationships of a personal nature, care recipients are typically perceived as being dependent individuals, in particular children, the disabled, the sick and infirm or the elderly, and are thus considered to be in an unequal position, deprived of the right to make autonomous judgements, decisions or actions (Tronto 2013, 75).

When we nurture the autonomy of care-recipients by fostering growth and acceptance, we are also nurturing a sense of equality between caregivers and care-receivers, and in doing so, we are also democratizing care relationships and care practices. Can the private sphere, the environments of our homes and families, truly be spaces in which non-hierarchical democratic care can be performed? While families and homes are typically the sites in which we experience the greatest love, they are paradoxically also foci of violence in its various forms and manifestations. In too many cases, protective care inflicts harm and injuries on the very people whom it is intended to protect. Sometimes it can even serve to mask mistreatment and the abuse of dependent care-receivers. Given this, is democratic, equality-promoting care even possible within a situation of mutual inequality? If so, under what conditions can it be achieved?

Tronto stresses that "if we wish to maintain some commitment to democratic values, then we need to explain how equality can emerge out of inequality" (Tronto 1993, 143). Her distinction between hegemonic and non-hegemonic forms of care may be useful in this context. Typical forms of hegemonic, such as unequal, hierarchical and thus undemocratic forms of care can be paternalistic or maternalistic and parochialistic. Paternalistic or maternalistic forms of care are characterized by care providers believing themselves to be better able to identify and assess the needs of their care recipients, even if that may not be the case. In such situations, the care-recipients are often children or adults who are treated in an infantilized manner, such as the elderly or socially deprived individuals and groups. Care providers, whether individuals or institutions, derive their power status or position of superiority in the hierarchy of relationships from a sense of their own importance in the care process or from a consciousness of the burden of duty associated with their chosen profession (Tronto 1993, 170); in the case of institutions, the source of this status is the expectations connected to the ascribed mission and the sense of importance from the idea that the state has a responsibility to take care of its citizens. In the case of the parochialist form of care, care actors perceive caring relationships in which they are personally involved as being the most important (Tronto 1993, 170).

If we want to achieve the nonhegemonic and democratic care practice desired balance in the definition of care needs and in the distribution and allocation of care roles and responsibilities in society, the inclusion and participation of all actors involved in care decision-making processes is necessary. It requires that we listen to and understand situations from their perspective, thereby minimizing the evasion of care responsibilities and unequal burdens of care on the one hand but also avoiding exclusion resulting from decisions on the allocation of care responsibilities or the unequal benefits derived from care practices. If Tronto says that a democratic form of care is sustainable if it is linked to – among other assumptions – the balance between caregivers and care-receivers (Tronto 1993, 171), then we must think about the assumptions of this balance. She argues that this approach requires, above all, that we all think of ourselves as recipients of care, not just as providers of care. This self-image must become normal and natural to ensure that the sense of alienation in the perception of care-receivers can be overcome more easily. A wider awareness of our own vulnerability and dependence on care for our needs will increase the likelihood that we will not see those in need of care as "foreign objects" or as "others." However, this awareness is linked to a willingness to perceive this fact. Inclusion therefore requires the receptivity and sensitivity to the mutual interconnectedness and vulnerability of all care actors, and the subsequent willingness to consider otherness into one´s caring practices.

III. Responsiveness and Good Care

According to Kittay (2011) the model of ethical interaction striving for an ethics of inclusion should not put the autonomous individual at forefront and eclipse the importance of our dependence. The emphasis on independence extols an idealization that is a mere fiction, not only for people with disability, but for all of us. She suggests the focusing on the attention to other's needs, not reciprocal exchanges between equals as basement of inclusive ethical model. Kittay argues that the ability of a being to give and receive a care is a source of dignity for humans no less than the capacity for reason and she considers care as an expression of a person´s dignity (Kittay 2011, 51 – 52). When autonomy is the norm of all human interaction, the moral harm is identified with violation of the rights of equals and the only alternative to autonomy is paternalism. Without care we are then left in situation of absence of adequate moral resources to deal with genuine inequalities of power and situation. However, from the care ethics perspective moral harm is understood to be less a matter of the violation of rights, and more the failures in responsibility and responsiveness. If severing of valued connections, not the clash of interests, is that what in ethics of care matters, then the open responsiveness is essential to understanding what another requires and so responsiveness is crucial for good inclusive care based on cooperative, respectful and attentive relations (Kittay 2011, 55).

So, there are specific elements in the process of care, such as practices, abilities, dispositions or skills, that can help to achieve and maintain a balance between care actors and thereby foster a power-balanced, non-hierarchical democratic form and practice of care that can limit the abuse of power and act as a bulwark against excessive control and abuse in care relationships. From this point of view, responsiveness, the ability to react, to respond to the needs and vulnerabilities of others, emerges as an important factor in the process and practice of care. Responsiveness goes beyond mere duty or obligation and is based instead on a genuine commitment and attunement to care. Fisher and Tronto (1990) described the different phases of the practice of care that shape its integrity as follows:

1. the *caring about* phase, in which recognition of care needs through attention is key;
2. the *taking care* phase that requires action to be carried out and therefore requires the acceptance of concrete responsibility for satisfying the identified need;
3. the *care giving* phase, which is the provision and practice of the specific care, the key value of which is competence; and
4. the *care receiving* phase, in which the primary aspect is to be responsive and attentive to the ways in which initial care needs are or are not being met.

Tronto later added a fifth phase of *caring with* to the concept of integrity, which refers to the repetition of the caring process over time, during which habits and patterns of caring are formed and moral qualities of trust and solidarity are developed (Tronto 2013).

Thus, responsiveness is the fourth phase of care practice, consisting of the care provider's response to the implementation and receipt of care from the side of the care-receiver. Since the situation of individuals who require care is one of vulnerability, responsiveness as a normative principle tells us that we should be receptive and alert to the potential for abuse of the power that arises in such situations (Tronto 1993, 135). Receptivity and sensitivity are crucial in determining and understanding how the received care is experienced and what it means for the person who receives it. The degree of reactivity as the ability to respond can therefore be evaluated based on the qualities of receptivity and sensitivity; in the absence of such factors, it is impossible to provide adequate levels of care. As a result, reactivity and its components are important in carrying out critical reflections and evaluations of the inequality between the caregiver and the care-recipient. As caregivers, we are not only vulnerable but are also capable of hurting and wounding, and we must therefore remain aware of these risks to ensure that we do not use power to achieve dominance and maintain submission but instead use it to meet the needs of care to an adequate degree.

Tronto emphasizes that responsiveness indicates a different way of understanding the needs of others than just perceiving the situation from their perspective. Instead, she suggests that we understand and think about the other's position as is discussed and expressed by the other themselves (i.e., the individual for whom we care). In this approach, we engage with the point of view of the other but without simply assuming that the other is exactly like us.

So, the inclusion requires to include the perspective of other's and so the risk of changing my own perspective, my own world. According to Tronto, the issues of the otherness and difference of others can be addressed more adequately through this perspective than through current moral frameworks in which individuals are assumed to be largely interchangeable (Tronto 1993, 136). This also corresponds to the urgent call for "caring listening" and "attentiveness" by other representatives of care ethics (for example, Noddings 1984, Sevenhuijsen 1998 and Bourgault 2020). Responsiveness requires an open and dynamic sensitivity and receptivity towards oneself and one's body and towards others and their bodies, but also towards the environment. It is associated with the perception of details that may not be immediately apparent and therefore requires listening, consideration, and reasoning skills in a process that goes beyond mere reaction. Reactivity then also requires a capacity for weighing and re-evaluating rather than a simple sensory reaction, integrating a complex of states, abilities and qualities.

The relational onto-epistemology of the ethics of care and the approaches that emerge from it are necessarily linked to a contextual approach that discourages us from perceiving people as being interchangeable. Every individual should be approached with due concern for the unique conditions and specifics of their situation. This requires a cultivated sensitivity and attention, and therefore a mindfulness of the needs of the care-recipient should be present throughout the care process. Only under such conditions can care-recipients actively participate in the determination, fulfilment and evaluation of care needs and the quality or adequacy of the care process, and it is through this approach alone that the practice of care can become less hierarchical and more balanced in terms of power relationships.

IV. Conclusion

If we understand that care is connected to power and accept the fact that power is aspect of care, then we also need to understand that just like formal equality (of power) of different actors of care practice and relations does not automatically guarantee the exclusion of abuse of power, not even the inequality does not lead automatically to its abusing in caring relations and practices. It means that the care theory as a set of normative concepts and theories that enforce standards of care and critically examines and evaluates specific care relations and practices, needs to be open to innovative and creative methods and critical examination of caring relations and practices. Contemporary forms of feminist ethics of care demonstrate examinations and analyses of processes and practices of care which focus only on the organization and implementation of care in society are somewhat insufficient.

We see that the responsiveness as the ability to respond to care needs is a complex phenomenon as it is an ability or quality which possesses a uniqueness associated with the individuality of each person but is also shaped by a specific context and environment in the process of socialization and enculturation. So, the responsiveness does not only relate to an individual responsibility for how we react or our degrees of sensitivity or receptiveness. Our institutionalized environment shapes, cultivates and develops our ability to respond adequately and carefully to our environment and to those who form a part of it, but it can also ignore, deform or degrade our capacity to react. The ways in which we respond to different forms of calling, how we deal with them, how we listen to (or disregard) them, how we misinterpret, form or transform them, are ultimately always conditional and dependent to some extent on the institutional nature of our environment. So, relevant careful researching should connect the systemic-structural socio-critical approach to the analysis of care processes and practices with alternative approaches which probe concrete lived experience to understand the possibility of better care and more caring world.

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