

Introduction to the Thematic Issue. Beyond the Ideal: Surveillance, Control, and the Complexities of Care¹

Zuzana Sekeráková Búriková² – Veronika Valkovičová³

Introduction to the Thematic Issue. Beyond the Ideal: Surveillance, Control, and the Complexities of Care.

This paper is a theoretical introduction to the special issue on care, control, and surveillance. Drawing upon feminist ethics of care, this paper introduces a conceptualization of care that enables us to examine surveillance practices occurring in care relationships. We argue that care ethics is inherently performative and the conceptualization of care as good or bad is negotiated through specific care practices. In this theoretical overview, we adopt a non-ideal approach to care. This framework allows us, on the one hand, to recognize that power asymmetry and even abuse can occur in caring relationships, while on the other hand it still enables us to reject harmful and abusive practices. We argue that, in order to understand surveillance in care, we need a non-dyadic, processual, and relational understanding of care, within which the particular nature of care is constantly negotiated. We believe that vulnerability and autonomy are crucial in the dynamics of care and surveillance. Furthermore, they play a crucial role in defining what can be considered good or bad care: good care acknowledges the inherent vulnerabilities in care and should enhance the dignity and autonomy of care receivers. We conclude the paper by discussing whether and when surveillance and control can be part of good care.

Sociológia 2024, Vol. 56 (No. 4: 285-301)

<https://doi.org/10.31577/sociologia.2024.56.4.10>



Key words: *Care; surveillance, control; vulnerability; autonomy; feminist ethics of care; good care*

Introduction

Research on care in various contexts reveals that carers often engage in numerous practices of surveilling, monitoring, or controlling people for whom they provide care: Parents monitor the online activities of their children in order to ensure the children's safety and healthy development (Baldry et al. 2019; Dungey, this issue; Livingstone – Blum-Ross 2020; Sikorska 2022; Taylor – Rooney 2016; Widmer – Albrechtslund 2021). Sons and daughters monitor their elderly parents to ensure their health and wellbeing (Mort et al. 2013; Khosravi – Ghapanchi 2016). Not only do individual carers engage in surveillance and monitoring; institutions prescribe regulations controlling their clients' movement within as well as to and from the institution (Campagna, this issue; Carboch – 2023; Synek et al. 2022). Also, welfare states monitor

¹ Acknowledgements: This text is the result of our work on the project "Power, control and vulnerability in intimate relationships – digital technologies and care" supported by grant VEGA 2/0063/23.

² Correspondence: Mgr. Zuzana Sekeráková Búriková, PhD., Institute for Sociology of Slovak Academy of Sciences, Bratislava, Slovakia. E-mail: zuzana.burikova@savba.sk

³ Correspondence: Mgr. Veronika Valkovičová, PhD., Institute for Sociology of Slovak Academy of Sciences, Bratislava, Slovakia. E-mail: veronika.valkovicova@savba.sk

whether carers (parents or institutions) are providing sufficient care (Murray – Tizzoni, this issue) and directly control citizens in order to assure the safety or health of the population (Lyon 1994; Miller 2024).

And yet, the role of surveillance (and control as one of its aspects) in care practices is relatively under-researched and social science has not found a consensus regarding the role of control in care. As Kirsten Stalker observes: “One popular image of carers is of committed selfless souls, while people who abuse individuals in their care may be portrayed as cruel monsters. Somewhere between these two extremes lies a hinterland which is seldom explored” (Stalker 2003a: 11). We believe the reason is that we tend to confuse the somewhat romantic ideals of care with actual practices of care. The ideals of care emphasize that care should not cause harm and that care receivers should benefit from care. Since we see surveillance and control as diminishing the autonomy of individuals or potentially harming them, we tend to dismiss practices containing aspects of control as non-care. Drawing upon Charles Mills’ differentiation between ideal and non-ideal theory (Mills 2005), Maurice Hamington calls the approach to care that ignores the complexity of life and the power imbalances inherent in care an ideal theory of care. He argues that care theory should be non-ideal, acknowledging that systems can fail and people can make mistakes (Hamington 2024: 8). Non-ideal theory aims to apply ideals while being cognizant of both barriers to their implementation and reluctance to their acceptance (Hamington 2024: 8; Mills 2005: 181).

This special issue adopts a non-ideal approach to care. Its aim is to examine the aspects of care involving control and surveillance through four empirical case studies. Within this introductory text, we identify aspects of care important for understanding the role of surveillance and control in both care practices and care ideals. Our thinking stems from literature dedicated to care and vulnerability, which constitutes a stream in a feminist care ethics (Tronto 1993; Noddings 1984; Kittay 1999). We consider feminist care ethics to be highly relevant for sociological research on control and care, because it views care as a relational and processual practice and recognizes the inequalities and vulnerabilities involved in care. At the same time, feminist care ethics approaches care as a political practice that should uphold some ideals (Hamington 2024; Tronto 1993).

First, we emphasize that care is a non-dyadic and relational practice embedded in power asymmetries and hierarchies. These characteristics of care are important, because while power asymmetries between carers and receivers of care can facilitate both harm and diminishment of agency, relationality makes the act of surveillance and control processual, dynamic, and fluid. We continue highlighting vulnerability and autonomy as crucial elements in both the dynamics of care and control as well as in defining ideals of care (i.e., in what can

be considered good or bad care). Next, we present ideals of care as defined by feminist ethics of care and suggest when surveillance can be part of good care. This helps us not to automatically dismiss all practices of surveillance as harmful or non-care, but to refocus our attention to autonomy as a key value of care.

The papers included were presented at a panel organized by the guest editors of this special issue at the Transforming Care Conference in Sheffield in 2023. All the papers use methods common in qualitative sociology and look at care relationally and processually. They also reveal how care is embedded in various institutions and driven by particular ideologies. In particular, the papers examine informal care provided within families (Claire Dungey); the relationship between state, family politics, and maternal care for young children (Marjorie Murray and Constanza Tizzoni); psychiatric care provided for people labelled socially dangerous in a Residence for the Execution of Security Measures (Amalia Campagna); and care provided to the survivors of domestic violence within the non-governmental sector (Angela Toffanin and Beatrice Busi).

Geographically, the case studies focus on Chile (Murray and Tizzoni), Germany (Claire Dungey), and Italy (Campagna; Toffanin and Busi). The authors focus specifically on ways how vulnerability is produced (Toffanin and Busi) and on contexts in which the actors are controlled or surveilled (Murray and Tizzoni), are exercising control and surveillance within their care practices (Dungey), or are trying to avoid using control as part of care (Campagna). The papers illustrate that the actors who exercise or experience control within care may vary: It can be the state exerting control over carers (i.e., mothers) who are expected to provide proper care (Murray and Tizzoni), or the providers of care (i.e., parents) exerting control over their children online (Dungey), activists providing care for vulnerable persons (such as survivors of domestic violence) (Toffanin and Busi), or medical professionals debating whether and how to control their clients' access to drugs (Campagna).

Care as a Relational and Processual Practice Embedded in Power Hierarchies and Asymmetries

We view care as a set of practices that help individuals fulfil their essential needs, develop, or keep their basic abilities while avoiding or minimizing harm, so that these individuals can thrive in the society (Engster 2007: 28). Care is a “species activity” (Barnes 2015: 34; Fisher – Tronto 1990): as a species, we are not able to survive without care from others, and from the instant of birth, every human being is involved in numerous care relationships (Hamington 2024). Feminist ethics of care understands care as essential to our everyday lives, since we are constantly engaged in activities, the objective of which is to take care of ourselves, others, and the environment (Tronto 2013).

Care does not flow unidirectionally; rather, the positions and identities of caregivers and care receivers are fluid (Barnes 2015: 34). We are providers of care in some relationships and contexts, and receivers of care in others. Even within a single relationship we sometimes give and other times receive care. Instead of being a private, exclusive relationship between two individuals, where one person gives care and the other receives it, care is a non-dyadic relational practice (Barnes 2015). Care can be given (and received) by groups, and even individual caregivers are supported by other people and institutions. The way care practices are executed is shaped not only by caregivers, but also by care receivers, states (e.g., through social policies or ideologies of care), communities, and institutions (such as market-based or non-profit organizations).

Since interdependency in care is multidirectional, and people involved in care relationships might have different positions, opinions, and interests; care is not a smooth practice bereft of power struggles. Joan Tronto (2013: 10) in particular argues that, since care belongs to key human activities, it is impossible to remove power from care practices. Relationships between people giving and receiving care are often deeply asymmetric (see Toffanin and Busi, this issue). Power asymmetries surface especially when those cared for have disabilities or have impaired cognitive functions, suffer from dementia, or are unable to speak (e.g., newborns and toddlers) (Kenner 2008; Mort et al. 2013). Power imbalances can be amplified when care is provided institutionally, since institutions can impact numerous aspects of the lives of care receivers – for example, an institution can determine or surveil their movement, food, or the organization of their day (Carboch 2023; Synek et al. 2022).

Power asymmetries surface especially in instances of bad care (Tronto 2013: 24), when carers, for example, use the justification of protection to follow different objectives that are detrimental to the ones they are supposed to protect. Tronto specifies two key “dangers of care”: the first danger is parochialism, where caregivers prioritize only the needs of the individual they are caring for and fail to recognize the care needs of others (including themselves); the second danger is paternalism/maternalism, where caregivers who possess more resources or competence than those they care for perceive themselves as better equipped than the care receivers themselves to decide how care should be provided (Tronto 1993: 170–172).

In the extreme, power asymmetry can result in abuse or violence against care receivers. While not conceptualized as part of care, domestic violence (Devaney et al. 2021), child abuse (Karkošková 2015; McCoy – Keen 2022), and abuse of elderly people (Välimäki et al. 2020) often take place within relationships of care. In such cases, the violence is committed by the very people who are supposed to provide care. Abuse in such relations can be also

conceptualized as failure of care, on top of being harm to an individual (Held 2010: 120).

Consequently, scholars of the ethics of care are adamant in positing that care should not be understood as a harmonious and conflict-less set of practices. Quite the contrary, they emphasize the need to theorize and study care practices as executed on the backdrop of power relations (Barnes et al. 2015; Tronto 1993). The aim of the ethics of care should not be the elimination of power in caring relationships, since that is not possible, but to acknowledge and understand differences between power and domination (Jeseková 2022: 68).

Power dynamics related to care are often ambiguous and multifaceted. In actual relationships, those who provide care are not necessarily those who are ultimately powerful, and those who receive care should also not be generally viewed as “powerless” (Tronto 2013; Stalker 2003b). Annemarie Mol, Ingunn Moser, and Jeannette Pols (2010) argue that if we view only those who receive care as being in vulnerable positions, we may overlook the ways in which both carers and care receivers exercise power in their daily experiences with care and shape care practices and relationships.

It is not only carers who can abuse the power they have over care receivers. Even those who are providing care can be on the receiving end of violence. Care receivers can be violent either toward professional carers (Brophy et al. 2019) or toward relatives who are providing care for them informally (Isham et al. 2020). Power asymmetries do not involve only the carers and those cared for. Carers can feel powerless in relation to the management of care institutions (Campagna, this issue; Toffanin and Busi, this issue) or to the state (Murray and Tizzoni, this issue). For instance, research on paid domestic workers emphasizes the powerlessness, exploitation, and abuse that they face from their employers (Anderson 2000; Constable 2007). While research often focuses on the power imbalance between carer and care receiver, power asymmetries are created also by structural inequalities. For example, paid domestic workers’ ethnicity, migration status, gender, and living-in status (the fact that they reside in their employers’ households) make them particularly vulnerable to exploitation and abuse (Anderson 2000). Toffanin and Busi (this issue) illustrate how multiple vulnerabilities of survivors of domestic abuse affect care they receive, and Murray and Tizzoni (this issue) also reveal how both the overall neoliberal policies of the state and the social status of carers influence carers’ feelings of vulnerability toward state control.

The Role of Vulnerability and Autonomy in Defining Good Care

To fulfil our care needs, we depend on others. Care is often an intimate practice (Boris – Salazar Parreñas 2010). In both institutional and informal care settings, we are open to others who consequently can enter our private space. This

openness includes access to our bodies. Reliance on others for care can manifest as a form of dependency of care receivers on care providers (Scully 2014). The fact that care is rooted in power imbalances and hierarchies makes us particularly vulnerable. We argue that vulnerability and the approach to handling it are key factors in the dynamics of care and surveillance. Surveillance can serve both caring and abusive purposes. Similarly, we experience vulnerability in both care and harm contexts. This means that the way vulnerability is addressed determines whether care is seen as good or bad.

Vulnerability is a broad concept that refers to our state of “openness-to-others” (Cahill 2021: 191) – and consequently to our susceptibility to harm (Mackenzie et al. 2014). There are many sources of vulnerability, and one can encounter different forms of vulnerability in caring relationships. This encompasses inherent (or corporeal) vulnerability, which is a shared experience of humankind. According to Catriona Mackenzie, Wendy Rodgers, and Susan Dodds (2014: 7), we are all vulnerable to hunger, thirst, sleep deprivation, physical harm, or even isolation. One can also experience situational vulnerability, which is context specific (Mackenzie – Rodgers – Dodds 2014: 7) and can include physical vulnerability (Butler 2021) or vulnerability formed on the basis of social positioning (e.g., the status of a socially excluded group). Inherent and situational vulnerabilities are not categorically distinct. Situational vulnerability can also lead to so-called pathogenetic vulnerability. Pathogenetic vulnerability occurs when a person who is already in a vulnerable or disadvantaged position (e.g., a person with a disability, or a child) is also experiencing manifestations of “care” that are hurtful and abusive. For example, people with cognitive disabilities who experience vulnerability due to their care needs may also experience violence or abuse from their carers. Or the state who is supposed to provide care for marginalized people can instead reinforce inequalities (Mackenzie et al. 2014).

While vulnerability is a universal human experience – where everyone can be more or less vulnerable depending on specific circumstances – it is not an intrinsic quality of any individual. Though we do tend to speak of individuals and groups as marginalized or vulnerable (as if it was a personal characteristic), such perspectives are far from the reality of the human condition (Browne et al. 2021). Rather, vulnerability is a matter of interdependence:

Vulnerability as an ontological condition is always mediated, always a matter of the kinds of relations through which beings are connected: relations that are more or less exploitative, more or less egalitarian, more or less mutual, more or less sustaining or nourishing. (Gilson 2018: 231)

Being mediated and relational, vulnerability is not an isolated trait (Gilson 2021). Instead, it is shaped by social norms and occurs within our relationships with other individuals or institutions (Butler 2021: 39).

Gilson emphasizes that vulnerability as such should not be demonized, as it is not inherently detrimental to the vulnerable person. In care relationships, vulnerability is not a problem per se; rather, it is the exploitation of vulnerability that constitutes the problem (Gilson 2016). This perspective of the feminist ethics of care is relevant for sociologists, because it enables the examination of how vulnerability is created at both the micro-level of caring relationships – whether in formal care or within families – and the macro-level of state policies (Scully 2021: 165).

If we understand vulnerability as a state of “openness-to-others” (Cahill 2021: 191), we accept that such openness has an impact upon our agency. We often equate autonomy and agency with having full control over one’s body (Gilson 2016; Mackenzie 2014: 34). Erinn Gilson (2016) contends that industrial societies adhere to a particular perception of vulnerability, viewing it as synonymous with losing agency or becoming powerless, a state that is undoubtedly not something people readily admit to. Gilson challenges this viewpoint as a myth of autonomy, which incorrectly leads us to perceive vulnerability as the opposite of agency. On the contrary, vulnerability should not be equated with powerlessness. Gilson (2016) insists that we are neither self-interested, independent rational actors, nor do we have full control over our bodies. Agency is a matter of degree.

Autonomy is a relational capacity (Anderson 2014). Situated in particular care relations, the autonomy of an individual is constantly negotiated (Friedman 2004). Within this special issue, Campagna as well as Toffanin and Busi in particular disclose how autonomy is negotiated within formalized care provision settings. For example, the right of patients for a sexual life and intimacy can clash with the rules of a psychiatric institution, where what is and is not allowed is negotiated by both patients and staff (Campagna, this issue). Similarly, negotiations over the autonomy of survivors of domestic violence can be impacted by organizational requirements, such as reporting (Toffanin and Busi, this issue). Dungey (this issue) points out that, while parents may limit their children’s autonomy by monitoring their online activity, this practice can also grant children freedom of movement that might otherwise be unattainable.

To better conceptualize what constitutes good care, we need to examine how autonomy is addressed within caring relationships. Therefore, we should be looking at how both caregivers and those receiving care navigate care practices, negotiating their respective vulnerabilities and autonomy (Breachin et al. 2003: 161). Autonomy should be studied in terms of what it allows a person to

do, what resources it provides in specific contexts, or how it empowers and enables the individual (Anderson 2014).

A feminist ethics of care creates a normative framework for care performed in a non-abusive way. This normative framing defines ethical principles of good care, where good care (and respectively bad care) is an evaluative term reflecting the quality of certain care practices. It denotes effective care that adheres to the ideals of care. Rather than having a dyadic perspective of care as either bad or good, we should recognize that quality of care exists on a continuum (Hamington 2024: 9). Maurice Hamington insists that, even though perfect care may be unattainable, we should all strive to improve our methods, awareness, and actions of care (Hamington 2024: 24). For Hamington, ideal care practices “respectfully contribute to the well-being of others in a manner that maintains their dignity” (Hamington 2024: 7), and good care consists of humble inquiry, inclusive connection, and responsive action. Tronto (1993) introduces four ethical elements of good care: 1. Attentiveness; 2. Responsibility; 3. Competence; and 4. Responsiveness. In order to be attentive to others’ needs, carers need to suspend their own goals and ambitions. While attentiveness means orientation towards the needs of the other person, it also requires a recognition of one’s own needs. Carers are not selfless individuals; they also have needs that have to be fulfilled, so carers should not “sacrifice” themselves in order to provide care. Responsibility is linked to the recognition that one needs to take action in order to care for others, while competence assumes individuals need specific abilities and resources in order to perform care well. Lastly, responsiveness requires that we remain alert to the possibilities of abuse that arise with vulnerability. These principles offer a perspective within which it is possible to consider what constitutes “good care” (Barnes 2006).

The ethics of care is inherently performative, and what is seen as a good or bad care is negotiated through practice (Hamington 2024). The provision of care requires dealing with everyday dilemmas of choosing between different “goods” (Mol et al. 2010). For instance, parents of children in Germany worry about surveillance practices in the abstract, but realize that tracking apps can make the organization of family life easier, or can even enable their children to have more freedom of movement. Care receivers also actively enter these negotiations: the children themselves can have opinions about tracking and can either endorse it or boycott it (Dungey, this issue). Mol, Moser, and Polls (2010) describe such negotiations and choices as “practical tinkering and tailoring” (Mol et al. 2010), while Hamington even speaks of “process morality” (Hamington 2024: 7).

The performative character of care ethics is enhanced by the fact that the motives of carers do not necessarily correspond with the outcomes and quality of care (Hamington 2024: 7). Even if carers want to provide good care, they are

not necessarily tuned into the needs and feelings of the care receivers. Trying to understand how abuse happens from the perspective of carers, Ann Brechin, Rose Barton, and June Stein (2003: 164) posit that carers are often exhausted and even angry. Love and commitment can be interwoven with tiredness, frustration, and despair. Carers can be negatively affected also by organizational and monetary constraints (Toffanin and Busi, this issue). Moral dilemmas associated with caring are negotiated in messy interactions within a complex web of practices and relationships, and individuals “perform” ethics (of care) in their everyday lives (Barnes 2006: 122; Brechin et al. 2003). Practical negotiations of ethics are affected also by institutional contexts of caring (Barnes 2006: 122). For example, when carers respond to a situation in which a patient receives drugs smuggled in during a meeting with a family member, the health professionals in a Residence for the Execution of Security Measures studied by Campagna (this issue) have to negotiate their ideals of care. What they take into consideration are not only the rules of the institution that prohibit unmonitored drugs, but also the context of staff shortages in the institution. Thus, Mol, Moser, and Pols (2010: 12) do not ask what is good care, but what is “performed as good care.” And consequently, if not performed as a good care, then what is performed as bad care? Writing about the complex nature of such performative ethics, they demonstrate how the carers seek the compromise between “two goods,” which leads them to “attentive experimentation” (Mol et al. 2010).

Some scholars developed their theoretical perspectives of good care by expanding their understanding of vulnerability and autonomy within care relations. Hamington proposes that the assessing of care quality should involve considering the viewpoints of care recipients, thus recognizing their autonomy (Hamington 2024: 9). Tronto (1993: 163), for example, speaks of a paradox: While the need for care can stem from and cater to a particular dependency, the objective of care should be to alleviate this dependency, not to make it a permanent state. By recognizing that autonomy is relational just as vulnerability is, Mackenzie, Rodgers, and Dodds (2014: 9) insist that “the background aim of interventions triggered in response to vulnerability must be to enable or restore wherever possible and to the greatest extent possible the autonomy of the affected persons or groups.” When discussing why responses to vulnerability should be guided by autonomy, Mackenzie (2014) argues that such an approach not only counters the sense of powerlessness and loss of agency that tends to be associated with vulnerability, but also serves as a panacea to the risk of paternalism. Therefore, the specific handling of vulnerability and autonomy should be at the crux of deciding what is good or bad care.

Discussion: Can We Have Surveillance Within Good Care?

The usage of surveillance in care is complicated by power struggles and asymmetries, and by the vulnerability inherent in care relationships. In addition, given that care is a relational, situational, and processual practice, the perception of surveillance in care shifts depending on context. Actors interpret particular interactions situationally and relationally. The same practice may be assessed differently in relation to a child, or a partner, or an ageing parent. Correspondingly, the very same practices and situations can be experienced differently by caregivers and care receivers. For example, monitoring online activities or limiting access to mobile phones can be seen as care by parents, but as a controlling act by their teenage child (e.g., Madianou – Miller 2011).

Surveillance within care can serve both as a tool of protection and a tool of control: “In surveillance studies, care and control have been described as two entangled interests driving practices of monitoring” (Peacock et al. 2023). Vita Peacock and coauthors emphasize an ambiguous position of surveillance in care, revealing that surveillance can be used or justified as serving the common good, for instance by stopping the spread of disease, but it can simultaneously serve as a means of data collection or monitoring of care receivers (Lyon 2021; Peacock et al. 2023). Surveillance practices can be also employed by perpetrators of abuse and violence (Henry et al. 2020; Lopez-Neira et al. 2019; Straw – Tanczer 2023; Yardley 2021).

This all makes the task of positioning surveillance on a scale within good or bad care very complex. Both carers and receivers of care are aware of this complexity and actively negotiate the use of surveillance in care. For instance, parents using apps tracking their children try not to interfere with what they see as their children’s privacy (Dungey, this issue); lower class mothers in Chile are aware that the care provided to them is rather supposed to monitor and control whether they are providing sufficient care for their children, and they consequently decide to avoid this control through silence (Murray and Tizzoni, this issue); activists checking shopping lists of domestic abuse survivors are aware of controlling nature of the act (Toffanin and Busi, this issue); and health care providers do not want to monitor their patients’ meetings with their relatives (Campagna, this issue).

While contemporary e-surveillance research looks at the practices of surveillance from the perspective of erosion of privacy and the totalitarian tendencies of the state, we should not by default understand all subjects as being surveilled against their will (Essén 2008). Some forms of surveillance can be “enabling,” and electronic care surveillance can actually allow individuals to live independently (Essén 2008: 129). For instance, smart homes and smart devices controlling the home’s internal environment (e.g., fire detection, gas

leakage detection, determining whether a door is open or closed) enable the elderly to stay in their homes and live on their own (Majumder et al. 2017; Pal et al. 2017; Van Hoof et al. 2016). Similarly, monitoring the movement and health functions of a person (e.g., wearable sensors for remote health monitoring) can lead to better healthcare outcomes and increase the wellbeing of people with diabetes (Shan et al. 2019) or Alzheimer's disease (Maresova et al. 2018).

We concur with authors who recognize that, while harm is not inherently part of care, harmful practices can occur within caring relationships (Held 2010; Jesenková 2016; Tronto 2013: 76). There is a need to both explore and explain care practices that have been experienced as oppressive, and to address abusive practices as problematic (Barnes et al. 2015: 14). We also need to acknowledge that some subjects are surveilled willingly and some types of surveillance can actually lead to their wellbeing and increased independence.

We believe that if we want to understand the role of surveillance in care practices, we have to examine surveillance in relation to the ideals of care introduced in this paper. The critical debate in this respect does not focus upon control and surveillance but deals with violence occurring in care. When abuse of power happens, one can speak of "bad care" from the perspective of the ideal (Jesenková 2016: 45). Virginia Held (2010) presents a key perspective: Carers, be they family members or professional staff, can be abusive. What she also makes clear is that such actions fail to fulfil values of care: "Care can be provided in ways that are domineering, oppressive, insensitive, and ineffective, but this is not good care" (2010: 121). Correspondingly, surveillance and control can happen in care practices. However, unlike violence, these practices can be part of good care if they align with the ideals of care. Good care should not involve using the other person to fulfil one's desires or needs (Jesenková 2016), and power in caring relationships should be primarily applied as an ability to respond to someone's needs (Held 2010). Ideally, good care would support the ability of individuals, social groups, and communities to co-decide about their lives (Jesenková 2022). If surveillance enhances this ability, meets the care needs of the care recipients, and leads to their greater autonomy, it can be considered part of good care.

But in everyday life, the realization of good care is not easy. Often, carers find their needs in contrast with what they must give to others (Tronto 1993: 109). This can thwart the autonomy of carers or those being cared for (Jesenková 2016), and even a practice that was originally intended for protection or care may ultimately serve to control or become an instrument of violence (Mackenzie et al. 2014). Good care requires a set of skills and abilities in order to be deployed in a non-harmful way (Jesenková 2016: 45; Tronto 2013). It also requires structural conditions and infrastructure (e.g., good

working conditions and organization of work in long term care or financial and personal support for informal carers) that enable carers to provide good care.

Conclusion

In this paper, we drew on a feminist ethics of care (Held 2010; Tronto 2013) to propose a conceptualization of care that enables us to examine both surveillance and control practices common in care relationships. We see this perspective as particularly useful when reading the studies in this special issue which is dedicated to care, control, and surveillance. Creating a relational and normative framework of what care is and what it should look like, feminist care ethics creates a valuable framework for both empirical research of care practices and for assessing the role played by surveillance in care while also enabling us to reject harmful or abusive practices. The proposed normative framework allows us to recognize this complicated dynamic. It is crucial to delegitimize abuse by asserting that abuse is morally wrong and should not be part of any relationships. Our aim here is not to downplay abuse and violence happening in care relationships; it is to recognize that deploying only one set of narratives – namely, that of the selfless and dedicated carer – does not allow us to see how power is being negotiated.

In this introduction we argued that, in order to understand surveillance in care, we need a non-dyadic, processual, and relational understanding of care, within which the particular nature of care is constantly negotiated in practice, situated within the web of relationships and institutions. Accordingly, the conceptualization of care as good or bad is negotiated through specific care practices, indicating that care ethics is inherently performative.

Our conceptualization of care, as well as the papers in this special issue, emphasize the importance of vulnerability and autonomy, which we view as relational and processual: we do not consider vulnerability a property of an individual or a quality residing in an individual; rather, it is produced situationally within relationships and practices. We believe that vulnerability and autonomy are crucial factors in the dynamics of care, surveillance, and control. Furthermore, they play a crucial role in defining what can be considered good or bad care: good care acknowledges the inherent vulnerabilities in care and should enhance the autonomy of care receivers.

To conclude, the presented special issue is not exhaustive, we need more relational and processual empirical studies of care, which do not romanticize care and do reveal the complex dynamics of power, control, and autonomy in care relationships and practices. Care is a constantly negotiated and changing process. When we recognize that power struggles inevitably occur within this process, it will enable us to examine and deal with power abuse, control, and harm happening within care relationships.

Zuzana Sekeráková Búriková, is a social anthropologist working as a senior researcher at the Institute for Sociology of the Slovak Academy of Sciences. Her research focuses on various aspects of paid and unpaid care. She is the principal investigator of the project "Power, Control, and Vulnerability in Intimate Relationships: Digital Technologies and Care."

Veronika Valkovičová, is a researcher at the Institute for Sociology of the Slovak Academy of Sciences. Her dissertation focused on public policies for eliminating violence against women in the Slovak context. At the Slovak Institute for Labour and Family Research, she was part of a research team that conducted the first nationwide study on sexual harassment among students at Slovak universities.

REFERENCES

- ANDERSON, B., 2000: *Doing the Dirty Work? The Global Politics of Domestic Labor*. Cham: Palgrave Macmillan.
- ANDERSON, J., 2014: Autonomy and Vulnerability Entwined. In: Mackenzie, C., Rodgers, W., Dodds, S. (eds.): *Vulnerability: New Essays in Ethics and Feminist Philosophy* (pp. 134–161). Oxford: Oxford University Press.
- BALDRY, A. C. – SORRENTINO, A. – FARRINGTON, D. P., 2019: Cyberbullying and Cybervictimization Versus Parental Supervision, Monitoring and Control of Adolescents' Online Activities. *Children and Youth Services Review* 96: 302–307. DOI: <https://doi.org/10.1016/j.childyouth.2018.11.058>
- BARNES, M., 2006: *Caring and Social Justice*. Cham: Palgrave Macmillan. ISBN 9781403921611.
- BARNES, M., 2015: Beyond the Dyad: Exploring the Multidimensionality of Care. In Barnes, M., Brannelly, T., Ward, L., Ward, N. (eds.) *Ethics of Care: Critical Advances in International Perspectives* (pp. 31–44). Bristol: Policy Press. ISBN 978-1-4473-1654-1.
- BARNES, M. – BRANNELLY, T. – WARD, L. – WARD, N., 2015: Introduction: The Critical Significance of Care. In Barnes, M., Brannelly, T., Ward, L., Ward, N. (eds.): *Ethics of Care: Critical Advances in International Perspectives* (pp. 3–20). Bristol: Policy Press. ISBN 978-1-4473-1654-1.
- BORIS, E. – SALAZAR PARREÑAS, R., 2010: *Intimate Labors: Cultures, Politics and Technologies of Care*. Palo Alto, CA: Stanford University Press.
- BRECHIN, A. – BARTON, R. – STEIN, J., 2003: Getting to Grips with Poor Care. In: Stalker, K. (ed.): *Reconceptualising Work with "Carers": New Directions for Policy and Practice* (pp. 160–167). London: Jessica Kingsley Publishers.
- BROPHY, J. – KEITH, M. – HURLEY, M., 2019: *Breaking Point: Violence Against Long-Term Care Staff*. New Solutions: A Journal of Environmental and

Occupational Health Policy 29(1): 10–35. DOI: <https://doi.org/10.1177/1048291118824872>

- BROWNE, V. – DANLEY, J. – ROSENOW, D., 2021: Vulnerability and the Politics of Care: Transdisciplinary Dialogues. In: Browne, V., Danley, J., Rosenow, D. (eds.): *Vulnerability and the Politics of Care: Transdisciplinary Dialogues* (pp.1–29). Oxford: Oxford University Press. DOI: <https://doi.org/10.5871/bacad/9780197266830.003.0001>
- BUTLER, J., 2021: Bodies Still Matter. In: Browne, V., Danley, J., Rosenow, D. (eds.): *Vulnerability and the Politics of Care: Transdisciplinary Dialogues* (pp. 33–59). Oxford: Oxford University Press. DOI: <https://doi.org/10.5871/bacad/9780197266830.003.0001>
- CAHILL, A. J., 2021: Disclosing an Experience of Sexual Assault: Ethics and the Role of the Confidant. In: Browne, V., Danley, J., Rosenow, D. (eds.): *Vulnerability and the Politics of Care: Transdisciplinary Dialogues* (pp. 188–202). Oxford: Oxford University Press.
- CARBOCH, R., 2023: Prahy Domova Z: Etnografie konektivity v pobytové sociální službě. *Sociológia* 55(3): (269–292). DOI: <https://doi.org/10.31577/sociologia.2023.55.3.10>
- CONSTABLE, N., 2007: *Maid to Order in Hong Kong: Stories of Migrant Workers*. Ithaca, NY: Cornell University Press.
- DEVANEY, J. – BRADBURY-JONES, C. – MACY, R. J. – ØVERLIEN, C. (eds.), 2021: *The Routledge International Handbook of Domestic Violence and Abuse*. London: Routledge.
- ENGSTER, D., 2007: *The Heart of Justice. Care Ethics and Political Theory*. Oxford: Oxford University Press.
- ESSÉN, A., 2008: The Two Facets of Electronic Care Surveillance: An Exploration of the Views of Older People Who Live with Monitoring Devices. *Social Science & Medicine* 67(1): 128–136. DOI: <https://doi.org/10.1016/j.socscimed.2008.03.005>.
- FISHER, B. – TRONTO, J., 1990: Toward a Feminist Theory of Caring. In: Abel, E. K., Nelson, M. K. (eds.), *Circles of Care: Work and Identity in Women's Lives* (pp. 35 – 62). Albany, NY: SUNY Press.
- FRIEDMAN, M., 2004: Autonomy and Male Dominance. *Soundings: An Interdisciplinary Journal* 87(1/2): 175–200.
- GILSON, E. C., 2016: Vulnerability and Victimization: Rethinking Key Concepts in Feminist Discourses on Sexual Violence. *Signs: Journal of Women in Culture and Society* 42(1): 71–98. DOI: <https://doi.org/10.1086/686753>.
- GILSON, E. C., 2018: Beyond Bounded Selves and Places: The Relational Making of Vulnerability and Security. *Journal of the British Society for Phenomenology* 49(3): 229–242. DOI: <https://doi.org/10.1080/00071773.2018.1434972>
- GILSON, E., 2021: The Problems and Potentials of Vulnerability. In: Browne, V., Danley, J., Rosenow, D. (eds.): *Vulnerability and the Politics of Care: Transdisciplinary Dialogues* (pp. 85–107). Oxford: Oxford University Press.

- HAMINGTON, M., 2024: *Revolutionary Care: Commitment and Ethos*. Taylor & Francis.
- HELD, V., 2010: Can the Ethics of Care Handle Violence? *Ethics and Social Welfare* 4(2): 115–129. DOI: <https://doi.org/10.1080/17496535.2010.484256>.
- HENRY, N. – FLYNN, A. – POWELL, A., 2020: Technology-Facilitated Domestic and Sexual Violence: A Review. *Violence Against Women* 26(15-16): 1828–1854. DOI: <https://doi.org/10.1177/1077801219875821>.
- ISHAM, L. – BRADBURY-JONES, C. – HEWISON, A., 2020: Female Family Carers' Experiences of Violent, Abusive or Harmful Behaviour by the Older Person for Whom they Care: A Case of Epistemic Injustice? *Sociology of Health & Illness* 42(1): 80–94. DOI: <https://doi.org/10.1111/1467-9566.12986>
- JESENKOVÁ, A., 2016: *Etika starostlivosti*. Univerzita Pavla Jozefa Šafárika v Košiciach Filozofická fakulta. ISBN 978-80-8152-472-1.
- JESENKOVÁ, A., 2022: *Občianstvo v kontexte etiky starostlivosti*. Univerzita Pavla Jozefa Šafárika v Košiciach Filozofická fakulta. ISBN 978-80-574-0216-9.
- KARKOŠKOVÁ, S. 2015: Sexuálne zneužívanie detí: Slabiny trestnoprávných postupov a návrhy k ich eliminácii. In Hullová, M. (ed.): *Zborník vedeckých štúdií a odborných článkov z medzinárodnej virtuálnej vedeckej konferencie na tému Mravnostná kriminalita ako spoločenský fenomén a možnosti jej kontroly*. Bratislava: Akadémia Policajného zboru (s. 105-118). ISBN 978-80-8054-646-5.
- KENNER, A. M., 2008: Securing the Elderly Body: Dementia, Surveillance, and the Politics of “Aging in Place.” *Surveillance & Society* 5(3): 252–269.
- KHOSRAVI, P. – GHAPANCHI, A. H., 2016: Investigating the Effectiveness of Technologies Applied to Assist Seniors: A Systematic Literature Review. *International Journal of Medical Informatics*, 85(1): 17–26. DOI: <https://doi.org/10.1016/j.ijmedinf.2015.05.014>
- KITTAY, E. F., 1999: *Love's labour: Essays on Women, Equality and Dependency*. London: Routledge.
- LIVINGSTONE, S. – BLUM-ROSS, A., 2020: *Parenting for a Digital Future: How Hopes and Fears About Technology Shape Children's Lives*. New York: Oxford University Press.
- LOPEZ-NEIRA, I. – PATEL, T. – PARKIN, S. – DANEZIS, G. – TANCZER, L., 2019: “Internet of Things”: How Abuse is Getting Smarter. *Safe – The Domestic Abuse Quarterly* (63): 22–26. <http://dx.doi.org/10.2139/ssrn.3350615>.
- LYON, D., 1994: *The Electronic Eye: The Rise of Surveillance Society*. Minneapolis, MN: University of Minnesota Press.
- LYON, D., 2021: *Pandemic Surveillance*. Cambridge: Polity Press.
- MACKENZIE, C., 2014: The Importance of Relational Autonomy and Capabilities for an Ethics of Vulnerability. In: Mackenzie, C., Rodgers, W., Dodds, S. (eds.): *Vulnerability: New Essays in Ethics and Feminist Philosophy* (pp. 33–59). Oxford: Oxford University Press. DOI: <https://doi.org/10.1093/acprof:oso/9780199316649.003.0002>

- MACKENZIE, C. – RODGERS, W. – DODDS, S., 2014: Introduction: What is Vulnerability, and Why Does It Matter for Moral Theory. In: Mackenzie, C., Rodgers, W., Dodds, S. (eds.): *Vulnerability: New Essays in Ethics and Feminist Philosophy* (pp. 1–29). Oxford: Oxford University Press.
- MADIANOU, M. – MILLER, D., 2011: Mobile Phone Parenting: Reconfiguring Relationships Between Filipina Migrant Mothers and Their Left-Behind Children. *New Media & Society*, 13(3), 457–470. DOI: <https://doi.org/10.1177/1461444810393903>.
- MAJUMDER, S. – AGHAYI, E. – NOFERSTI, M. – MEMARZADEH-TEHRAN, H. – MONDAL, T. – PANG, Z. – DEEN, M. J., 2017: Smart Homes for Elderly Healthcare—Recent Advances and Research Challenges. *Sensors* 17(11): 2496. DOI: <https://doi.org/10.3390/s17112496>
- MARESOVA, P. – TOMSONE, S. – LAMESKI, P., et al., 2018: Technological Solutions for Older People With Alzheimer’s Disease. *Current Alzheimer Research* 15(10): 975–983. DOI: <https://doi.org/10.2174/1567205015666180427124547>
- MCCOY, M. L. – KEEN, S. M., 2022: *Child Abuse and Neglect*. London: Routledge.
- MILLER, D., 2024: Care, Surveillance and the Good Citizens of Covid-19. In Robinson, J., Lamber, H., Abram, S. (eds.): *How to Live through a Pandemic*. ASA Monographs. London: Routledge.
- MILLS, C. W., 2005: “Ideal Theory” as Ideology. *Hypatia* 20(3): 165–183.
- MOL, A. – MOSER, I. – POLS, J., 2010: Care: Putting Practice into Theory. In: Mol., A., Moser I., Pols, J. (eds.): *Care in Practice: On Tinkering in Clinics, Homes and Farms* (pp. 7–27). New York: Columbia University Press.
- MORT, M. – ROBERTS, C. – CALLÉN, B., 2013: Ageing With Telecare: Care or Coercion in Austerity? *Sociology of Health & Illness* 35(6): 799–812. DOI: <https://doi.org/10.1111/j.1467-9566.2012.01530.x>
- NODDINGS, N., 1984: *Caring: A Feminine Approach to Ethics and Moral Education*. Berkeley, CA: University of California Press. ISBN 978-0520057470.
- PAL, D. – TRIYASON, T. – FUNIKUL, S., 2017: Smart Homes and Quality of Life for the Elderly: A Systematic Review. *IEEE International Symposium on Multimedia (ISM)*, Taichung, Taiwan (pp. 413–419). DOI: <https://doi.org/10.1109/ISM.2017.83>.
- PEACOCK, V. – BRUUN, M. K. – DUNGEY, C. E. – SHAPIRO, M., 2023: Surveillance. In Nieber, H. (ed.): *The Open Encyclopedia of Anthropology*. Online: DOI: <http://doi.org/10.29164/23surveillance>.
- SCULLY, J. L., 2014: Disability and Vulnerability: On Bodies, Dependence, and Power. In: Mackenzie, C., Rodgers, W., Dodds, S. (eds.): *Vulnerability: New Essays in Ethics and Feminist Philosophy* (pp. 204–221). Oxford: Oxford University Press.
- SCULLY, J. L., 2021: The Politics of Care: From Biomedical Transformation to Narrative Vulnerability. In: Browne, V., Danley, J., Rosenow, D. (eds.): *Vulnerability and the Politics of Care: Transdisciplinary Dialogues* (pp. 151–167). Oxford: Oxford University Press.

- SHAN, R. – SARKAR, S. – MARTIN, S. S., 2019: Digital Health Technology and Mobile Devices for the Management of Diabetes Mellitus: State of the art. *Diabetologia* 62: 877–887. DOI: <https://doi.org/10.1007/s00125-019-4864-7>.
- STALKER, K., 2003a: Introduction. In: Stalker, K. (ed.): *Reconceptualising Work with “Carers” – New Directions for Policy and Practice* (pp. 7–15). London: Jessica Kingsley Publishers.
- STALKER, K., 2003b: Carers: An Overview of Concepts and Debates. In: Stalker, K. (ed.): *Reconceptualising Work with “Carers” – New Directions for Policy and Practice* (pp. 15–36). London: Jessica Kingsley Publishers.
- STRAW, I. – TANCZER, L., 2023: Safeguarding Patients from Technology-Facilitated Abuse in Clinical Settings: A Narrative Review. *PLOS Digital Health* 2(1): e0000089. DOI: <https://doi.org/10.1371/journal.pdig.0000089>
- SYNEK, M. – HRADCOVÁ, D. – CARBOCH, R., 2022: “Všechno stejný, všechno zastavený”: Karanténa v “domově” pro lidi označené za postižené. *Sociologický Časopis* 58(5): 563–585. DOI: <https://doi.org/10.13060/csr.2022.029>
- SIKORSKA, M., 2022: “Addictive” for Children and “Helpful” to Parents: Electronic Devices as a Non-Human Actor in Family Relations. *Journal of Family Studies* 28(3): 841–857.
- TAYLOR, E. – ROONEY, T., 2016: *Surveillance Futures: Social and Ethical Implications of New Technologies for Children and Young People*. London: Routledge.
- TRONTO, J. C., 1993: *Moral Boundaries: A Political Argument for an Ethic of Care*. London: Routledge. ISBN 9781003070672.
- TRONTO, J. C., 2013: *Caring Democracy: Markets, Equality, and Justice*. New York: NewYorkUniversity Press. ISBN 978-0814782781.
- VÄLIMÄKI, T. – MÄKI-PETÄJÄ-LEINONEN, A. – VAISMORADI, M., 2020: Abuse in the Caregiving Relationship Between Older People with Memory Disorders and Family Caregivers: A Systematic Review. *Journal of Advanced Nursing* 76(8): 1977–1987. DOI: <https://doi.org/10.1111/jan.14397>
- VAN HOOFF, J. – DEMIRIS, G. – WOUTERS, E. J. M., 2016: *Handbook of Smart Homes, Health Care and Well-Being*. Springer.
- WIDMER, S. – ALBRECHTSLUND, A., 2021: The Ambiguities of Surveillance as Care and Control: Struggles in the Domestication of Location-Tracking Applications by Danish Parents. *Nordicom Review* 42(s4): 79–93. DOI: <https://doi.org/10.2478/nor-2021-0042>
- YARDLEY, E., 2021: Technology-Facilitated Domestic Abuse in Political Economy: A New Theoretical Framework. *Violence Against Women* 27(10): 1479–1498. DOI: <https://doi.org/10.1177/1077801220947172>