

## Chapter 2

# Informal Care in Context: An Expression of Social Relationships

### 2.1 Introduction

Care is the activity of looking after someone in need, and the act of providing such care is an expression of connectedness between individuals within families and communities. Informal care, therefore, is an expression of social relationships. In this chapter, we consider the social context of care, drawing on the concept of social capital and its key elements of the social bonds and bridges that provide the setting within which such care is provided. We focus, first, on the theory of social capital, and subsequently on its value in the broader policy context. We conclude the chapter with a brief discussion of some of the criticisms of the concept.

The growing importance of informal care and the recognition of a need for better policies to support informal caregivers implies we need a better appreciation of the experience of informal caregivers. As noted in the Introduction (p. xiv), formal and informal care are very much interdependent, but that interdependence tends to be downplayed when examining one or the other. Instead, much of the writing on caregiving tends to focus on either informal care or formal care. Many caregiving studies have also tended to limit the focus to the dyadic relationships between the family caregiver and the care-recipient, neglecting the broader context that may involve other informal and formal carers. Piercy (1998, p. 109) emphasizes, with regard to obtaining a full picture of care for older family members, there is a need to examine the roles played by ‘multiple and extended family members.’ Additionally, since much informal care is performed within the privacy of the home or between neighbours, it tends to be underappreciated, despite the growing scholarly and policy attention given to it. It is therefore critical to promote an understanding of the interconnectedness between the formal and informal care sectors, and what each contributes to the care needs of people with disability. In this respect, our purpose is similar to that of the already mentioned carers’ movements, inasmuch as it is oriented to giving voice to informal carers.

Informal care needs to be seen in its social context, and in the way the social networks involved in care are integrated (Timonen 2009). Such networks comprise

those of the cared-for person and their caregivers, the wider community context, and the health and social policy environments within which they are embedded. These policy environments reflect and inform specific cultures of caregiving and the allocation of care responsibilities, and they frame and structure the interactions between informal carers and the formal care sector.

A helpful way of grasping this context is through the notion of social capital. We do so in the way described by Woolcock (2010) in his overview of the ‘rise and routinisation’ of the concept:

Essentially contested concepts such as social capital do their work through the fruitful public debates they facilitate, not the clean, unambiguous, consensual path they chart (Woolcock 2010, p. 482).

The concept highlights several issues for fruitful debate. For example, it offers one way of explaining why people with the same level of impairment will go on to have varying levels of disability or other negative, or positive, outcomes. Disability as a construct is today seen as being closely linked with environmental and social factors. It does not inevitably arise from a specific impairment and people with identical conditions may have different outcomes, depending on the supports available to them. Variations of the maxim ‘it’s not what you know, it’s who you know’ are found in languages all over the world, and the notion of social capital provides a frame of reference for considering these issues across several planes. The social model of disability implicitly makes this connection, but in focusing on environmental supports, or the lack of them, has underemphasised the myriad supports provided by informal care, through mechanisms of family, friends and community.

While not without its critics, the social capital literature does provide some insight into the way communities are structured, the ‘bonds’ that link individuals within networks and the ‘bridges’ that link people across networks. It also draws attention to the nature of the relationship between caregiver and person with disability, and the specific resources in the form of care that are given and received. By drawing on the concept of social capital, we aim to recognise the impact of the broader societal and cultural environments on social networks within which care is provided. Some care policy regimes facilitate strong networks with the capacity to provide quality care through the formal sector, while others might be described as relying more on informal care. Giving attention to the policy context allows for the recognition of the different ways in which countries allocate and support such responsibility between families, the state and private markets for the delivery of care.

## 2.2 Informal Care in the Context of Social Relationships

Hands-on care almost always involves family members while support and instrumental activities are often undertaken, too, by neighbours and friends, and less socially close connections such as club or church connections. The underlying premise is that there are stable social ties, not necessarily longstanding as Peek and Lin (1999)

and van Tilburg (1998) suggest, but of goodwill and commitment. Members of such a network may be asked to increase their commitment either of instrumental or social and emotional support (van Groenou and van Tilburg 1997), and the extent and depth of that support can become designated as care, a set of actions which differ from the usual normative social relationships in everyday life (Walker et al. 1995).

Becoming an informal caregiver places the caregiver in a context that, by definition, entails (an)other person(s). The study of caregiving, therefore, prompts us to think of the caregiver in relation to other individuals. This relationship begins with the care-recipient, but it generally extends to encompass a much wider constellation of other caregivers, formal and informal. Consequently, caregiving places the individual in an inherently 'social' context in relation to the care-recipient, other carers, and social contacts (where these are present), and as such expands the focus from the individual providing care towards the context in which they find themselves. Any attempt to understand caregiving, its antecedents, processes, and consequences, requires us to take into account the broader context that involves at least three separate layers, namely:

1. The care-recipient: his or her personality, life expectations, and reactions to the need for care;
2. The social and family network including formal carers where present: their expectations, level of involvement, and recognition of the contributions made by the primary caregiver;
3. The social care system: expectations, availability, and conditions attached to support; recognition and support of both informal and formal caregivers.

These systems of networks and care, based on close and formal bonds, become institutionalised as a 'network' in which the close social ties are its foundation and support (Keating et al. 2005).

Since informal care is given to single individuals who are connected in some way with the carer, this relationship is troubled from the outset by the fact that there are no boundaries on the potential response (Levinas 1989). Formal care, on the other hand, is society's response to the 'needs of strangers' (Ignatieff 1984) and it is constrained from the outset by utilitarian pressures in the direction of efficiency. Formal care is provided by a range of individuals, with a greater or lesser degree of training and skills from paid carers to health professionals. The degree of formality in the relationship varies considerably, but tends to occur within bureaucratic systems.

While informal care has a lower level of social recognition than paid or professional care, it tends to require a higher level of focus and responsibility across several domains. For example, the degree of responsibility carried by informal carers tends to be constant and without borders, whereas professionals have a more boundaried responsibility. Philosopher Elizabeth Wolgast (1992) used the expression 'artificial personhood,' to explain how membership of a professional organization tends to get in the way of clear acknowledgement of responsibility. It is not possible for informal carers to avoid responsibility in the same way. This is reflected in a temporal relationship that is sustained, whereas the response of the health

**Table 2.1** Dimensions of care and the degree of formality/informality of the relationship

		Temporality	Spatiality	Responsibility	Relationship
Degree of formality	Informal	Sustained ↓	Constrained ↓	Constant ↓	Thick ↓
	Formal paid carer	Episodic ↓	Permeable ↓	Intermittent ↓	Less Thick ↓
	Formal professional care	Occasional	Mobile	Boundaried	Thin

professional is often occasional. The quality of the relationships is obviously different and Margalit (2002) used the comparison of thick and thin to capture this distinction:

Thick relations are grounded in attributes such as parent, friend, lover... Thick relations are anchored in a shared past or moored in shared memory. Thin relations, on the other hand, are backed by the attribute of being human. Thin relations rely also on some aspects of being human, such as being a woman or being sick. Thick relations are in general our relations to the near and dear. Thin relations are in general our relations to the stranger and the remote (Margalit 2002, p. 197).

The differences in the temporal and spatial parameters of formal and informal care are compared in the above table. The table also identifies the implications of each form of care for the degree of responsibility that lies with the caregiver, and the implications for the relationship between the caregiver and the cared-for person (Table 2.1).

Informal and continuous caregiving usually depends on a relationship of love, affection, duty and, while other forms of caring exist, such as occasional, or irregular, informal help and social support, these basic components of caregiving create the fundamental ‘bond’ (Putnam 2000) for the provision of informal care, or ‘social care’ in Putnam’s terms. But informal care and support can extend beyond this intimate relationship to what Keating et al. (2005) have written from their study of social networks and informal care in Canada. They define social capital as potential support and cooperation for mutual benefit that is developed over time through the building of trust and through norms of reciprocity. The possession of social capital makes possible access to a wide range of resources, such as care and support, through contacts with competent others. If we are to understand informal care, we need to understand the nature of such connections and/or the access to them.

2.3 Bridges and Bonds

Social capital does provide a way of understanding aspects of relationships within social networks. With Turner’s (1974) reference to theory as a means for obtaining insight, we believe we can draw on these ideas as a way of obtaining a better

understanding of informal care within its broader context. The reference to bonds and bridges are one of these ideas. Putnam (2000) described bonding social capital as exclusive in nature, strengthening ties within homogenous, socially-similar groups and enhancing access to internal resources, whereas bridging social capital is inclusive, strengthening ties between heterogeneous, socially diverse groups and enhancing access to external resources. He has also theorised on the greater benefits of bridging social capital, contending that, while bonding social capital is a means to 'getting by', bridging social capital is a means to 'getting ahead'. It seems likely that both forms operate for carers. Bonding social capital describes the relationships that immediately support the person in need, whereas bridging social capital tends to describe the relationships that the carer forms with broader support networks. This resource of bridging social capital may not be available for all informal carers.

Bonding social capital is that which exists between people of equal standing or people in similar situations and similar backgrounds, such as family friends and close neighbours. It refers to intimate relationships within homogenous groups where the needs of members are known. In these networks there is an emotional intensity and the provision of reciprocal services, such as in families where there is a long history together and where there are strong normative obligations to care. Bonding social capital is best suited to providing the social and psychological support for its members to assist in their 'getting by' – or coping with day-to-day activities within their communities.

Bridging social capital refers to more complex, fluctuating social contacts between people from different, more heterogeneous social environments. Bridging social capital is useful in connecting people to external assets, offering access across social networks to other social opportunities or resources. Families alone are less likely to possess these network assets. They are more likely to be non-kin links to community supports. Bridging social capital is a concept that places the focus specifically on the ability to link across networks.

Bridging social capital is rapidly lost when the carer and disabled person are not able to invest in social networks. It is not simply a matter of higher incomes groups having greater access to bridging social capital. Bourdieu (1986) would say that the capacity to communicate in ways that enable bridging social capital is created through systems of training that are embedded deep in social structures. He coined the term *habitus* to describe the way that culture is transmitted through durable dispositions and practices that are developed in daily life. The *habitus* is therefore is a form of 'embodied capital' (Bourdieu 1986, p. 48) and it produces an ethos that regulates interactions and bodily practices. It is not a solitary practice, but rather a family, group and class phenomenon, where those who have faced common material conditions learn to act in according with those conditions.

Care networks, in terms of social capital language, are bonding networks. They help in coping with day-to-day life in terms of the performance of care tasks within the home or in the community setting. A strong informal care network assumes families are the basis for support, providing the most responsive, knowledgeable and nuanced care. Yet there are also concerns about their fragility as services are

increasingly rationed. Families' abilities to sustain high levels of care and gain access to formal services that might assist their caring are therefore increasingly important. Keating et al. (2005), though, ask whether this might mitigate against connecting to external resources. That is, does access to strong bonding social capital mitigate against connecting to formal care services? Wenger's (1991) suggestion that strong family networks tend to be less open to community-based networks is consistent with this view. This has implications for the types of services and policies that might strengthen bonding social capital and bridging social capital.

## 2.4 Macro and Micro Perspectives

Social capital theorists distinguish between macro and micro approaches. Macro approaches tend to be concerned with degrees of social integration at the community level and with degrees of civic involvement. Micro approaches focus instead on individual relationships within social networks. Both perspectives are relevant when considering informal care. The macro approach is associated with Putnam's work, which is described as a model of civic involvement and community support. Putnam (2000) focused almost exclusively on formalised civic involvement and maintains that it is possible to develop social capital by joining civic groups. There has been considerable exploration of how large scale investment may effectively mobilise social capital initiatives on the ground. The micro approach is associated with the work of Bourdieu (1986) and focuses on the investments required to activate or mobilise social capital on an individual level. Bourdieu pointed to the fundamental connection between capital and different forms of labour time investment.

Social capital at both the macro and micro level become expressed, or embodied, as care through efforts to produce lasting and useful relationships. The work of creating social capital requires investment of time, energy and competence, in similar ways to the investment of economic capital. While economic capital can give access to many goods and services, without any secondary cost, not all 'services' can be easily or blatantly bought, such as services and resources that fall under the rubric of love and duty, generosity and friendship. Such services and resources can only be obtained through social relationships (or social obligations). Until the moment of need, however, there is usually some degree of uncertainty about whether they can be effectively mobilised.

### 2.4.1 *Micro Approaches*

The micro approach focuses on individuals and is concerned with the potential for benefits to accrue to individuals through their membership of and participation in social groups, through the deliberate construction of sociability for the purposes of creating such a resource. Informal care, performed by family members and members of the community, without payment or any binding agreement concerning the

provision of such care, is a fundamental resource in maintaining disabled and chronically sick people at home and in the community. This resource is given in the form of labour of the carer. The micro approach to social capital is clearest in the link made by Bourdieu (1986) between social capital and labour:

The universal equivalent, the measure of all equivalences, is nothing other than labor-time (in the widest sense); and the conservation of social energy through all its conversions is verified if, in each case, one takes into account both the labor-time accumulated in the form of capital and the labor-time needed to transform it from one type into another (p. 54).

From this perspective, social networks are not a natural given, but must be constructed through investment strategies that are oriented to the institutionalisation of group relations, and that become usable as a reliable source of other benefits (Portes 1998, p. 3). Bourdieu's approach implies a deliberate building by individuals of potentially useful relationships, investing one's time and energy to ensure future returns. Bourdieu (1986) defined the social resources that accumulate as:

the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition (p. 248).

He emphasised the interchangeable nature of different forms of capital and pointed to the fundamental connection between capital and different forms of labour time investment.

The volume of the social capital possessed by a given individual depends on the size of the network of connections he or she can effectively mobilize and on the volume of capital possessed in an individual's own right by each of those to whom that individual is connected. In conceptualising social capital in this way, Bourdieu helps us to see both the actual and the potential resources that may be used for action, and the dynamics that underpin how people access, or are denied access, to these network-based resources.

Ahn and Ostrom (2002) build on this approach and explain that social capital can be seen as a way of understanding the propensity of actors to cooperate through working together to reach particular goals. It is thus an explanation of the way collective action leads to the accumulation of resources. This method of understanding social capital sees it as the way working together in collaborative initiatives has the potential to build up the capacity of the collective.

Here, social capital is seen as 1) the product of the actors' motivations for forming an association (the values and aspirations that underpin the co-operative relationship); 2) their behaviour (types of association that define how actors co-operate); and 3) their perception of collective issues (cultural beliefs and influences, etc) (Franke 2005, p. 1).

### **2.4.2 Macro Approaches**

Macro, or ecological, approaches to social capital, typically associated with the work of Putnam (2000), tend to focus on themes of shared identity, interests and

trust within communities, and the resulting degree of community cooperation. Putnam (2000, p. 19) defined this as the ‘... connections among individual-social networks and the norms of reciprocity and trustworthiness that arise from them.’ He suggested that participation in social groups and activities generates access to social capital. Thus a community which is rich in social capital can be described as socially cohesive, cooperative and caring. In this perspective, social capital is seen as ‘both a glue that bonds society together and a lubricant that permits the smooth running of society’s interactions’ (Smith 1997, p. 170).

The macro approach to understanding social capital focuses on the significance of social integration and social cohesion. It refers to the ‘stock’ of resources built up over time which encourage mutual consideration and cooperation. It draws attention to the way a community’s social, political and cultural institutions express norms of trust and reciprocity, which lead to the conditions for social engagement, mutual support and collective benefit (Putnam 2000).

With regard to informal care, what matters is the way social capital at both the macro and micro level facilitates the generation of resources such as care and support (Portes 1998). It emerges from social ties and is then used by individuals and groups. It reflects the interdependence between individuals and groups within a community, and it has both individual benefits and group benefits (Franke 2005, p. 2).

### 2.4.3 *Social Networks and Social Capital*

We cannot, therefore, fully understand informal care without an appreciation of the way in which individuals are located within networks and the way networks are embedded within the broader collective. Another way of saying this is that we cannot understand informal care without an appreciation of the informal and formal institutions which structure the social network context. From a social capital perspective, these social networks are a resource that can be drawn upon for the purposes of securing support. In the Canadian Policy Research Initiative study (Keating et al. 2005, p. 3), social capital was defined as the ‘networks of social relations that provide access to needed resources and supports.’ Informal care, performed by family members, neighbours or others from within the community, without payment or any formal agreement concerning the provision of such care, is therefore a fundamental resource. In seeking to contextualise the experience of informal care, the concept of social capital as developed by Keating et al. (2005) offers this insight:

Viewing networks of social ties as a form of capital asset provides a lens for examining how these ties can be invested in and drawn upon in ways that complement other capital assets available to individuals and communities (p. 1).

Social capital is therefore understood as being the aggregate of actual and potential resources from institutionalised relationships within social settings. To say such resources are institutionalised is a means of referring to how they become ‘set’ or



established as a set of social beliefs and practices. That is, an individual's relationships within families and communities are guided by established norms, rules and conventions that inform beliefs and behaviours around informal care. Norms are the shared, internalised prescriptions for behaving in a particular way, these being reinforced by members of a social network. Rules are the accepted directives that are mutually understood and applied (must, must not, may). Conventions refer to accepted ways of doing things. Those norms, rules (formal and informal) and conventions promote ideal social goals, such as the ideal family structure, and social roles and practices within social networks. To say they are institutionalised, in this interpretation, is to say they have become shared concepts, they are implicitly known rather than explicitly laid down.

This is what James (2000, quoted in Irving 2011, p. 24) is referring to when he explains the persistence of certain modes of thinking and being as part of the regular, habitual world:

an experience of a world seemingly 'shot through with regularities' and 'essentially bound up with the way in which one moment in our experience may lead us towards other moments.'

Such regularities are also evident in the linguistic and social conventions around family and informal care, and they structure different expressions for family and community care in different settings.

## **2.5 The Dynamics Between Claimant and Donor in Social Capital Exchanges**

The micro approach to social capital can usefully remind us of the dynamics between the carer (the donor), the person in need of care (the claimant) and the resources that are exchanged in the caregiving process. It enables us to distinguish between: (a) the possessors of social capital (those making the claim); (b) the sources of social capital (those agreeing to the claim); (c) the resources themselves. All too often the donor and claimant are viewed separately, and this can be like 'watching only a half court during a basketball game' (Bar-Tal et al. 1984). One of the strengths of the micro approach is the fact that it provides a single framework to gain a perspective on resources, donor and claimant. In a sense, it provides a form of triangulation, and a multi-faceted view of the care dynamic.

Focussing on the donor, the claimant, and the resources that are exchanged has the capacity to add a more nuanced perspective of caregiving. It enables us to avoid the tendency to see all social capital transactions as inherently positive, as it is often the case that donors are forced to take on responsibilities that exceed their capacity, leading, for example, to situations of carer burden. Feminist writers have long recognised the possibility of exploitation when resources are euphemised as 'natural', and they have been concerned about the power imbalance between donors and claimants, particularly in situations where claimants have the power. However, sometimes the power of the claimant rests not on their position in society, but on the

extent of their need. Kittay (1999) describes the responsive carer as ‘transparent’ to such needs, where she cannot walk away from an expression of dependency. The notion of such transparency is important to an understanding of how some of those with seemingly low levels of social capital can continue to access resources through their relationship with a competent and committed donor. This person is not self-interested or disinterested (as a participant in the Rawlsian original position), but rather the donor is passionately interested ‘but the interest is vested in the well-being of another’ (Kittay 1999, p. 51). But the extent of need of the claimant and their vulnerability if they are abandoned may be such that it is beyond the capacity of the donor to provide for it.

There is also the possibility that a potential donor may betray perfectly legitimate claims (Bourdieu 1986) and refuse the claimant what might have been expected in terms of reciprocity. The ambiguity of social capital is that, though it has economic capital at its base in the form of labour time, the subtle economy of time is always in danger of being misrecognised. This loss of social capital is partly alleviated by the concept of ‘closure’ (Coleman 1988, p. 899), which describes the existence of sufficient ties between a certain number of people to guarantee the observance of norms. Such ties are an investment strategy that requires an unceasing effort of sociability in order to affirm and reaffirm the recognition of exchanges. The situation of caregivers who become socially, financially and legally marginalised through giving (Schofield et al. 1998; Kittay 1999) is an indication of how fragile this ‘closure’ can be at a community and societal level. The power dynamics associated with a request, and the possibility of betrayal, makes it clear how tortuous the claimant’s task can be.

## 2.6 The Resources of Social Capital

In the policy discourse on social capital, informal care is frequently described as a ‘natural resource’. The premise is that disability services are funded and natural supports do not require any further support, because they are readily available and reasonably easy to access. However, we problematize the description of informal carer as a ‘natural resource’ because the dynamics associated with giving and receiving care can be anything but natural. Bourdieu (2001) recognised the capacity of some claimants to ensure that a particular social order or way of understanding social roles and responsibilities to be posited as natural. It describes, for example, the situation of an elite group which can demand care without even seeming to ask.

[T]he particularity of the dominant is that they are in a position to ensure that their particular way of being is recognised as universal (Bourdieu 2001, p. 62).

The sense of ‘naturalness’ associated with care can be understood as a privilege, and not necessarily available to those with low levels of social capital. The person who accesses care is effectively appropriating the labour time of this other. Good care or natural care will then become invisible and the labour of the carer can feel

as natural as using the limbs of one's own body. For the claimant, such natural care allows the 'dis-appearance' of the body (Leder 1990) so that the lived body can resume its career as the background of everyday tasks. This is an extraordinary gift on the part of the carer, but that gift is at risk of being subsumed under a cloak of invisibility created by the notion of 'naturalness.'

However, for claimants who do not have access to such high levels of social capital, asking for resources from an unwilling donor may be a source of deep shame. Care is anything but 'natural' in this situation. Those who can, tend to avoid asking for help, and develop adaptive preferences for doing less when they find themselves in a situation where resources do not match their need. This is defined as 'preferences persons form unconsciously that downgrade options that are inaccessible to them' (Elster 1987, p. 119). These preferences can also be made consciously as a way of 'coming to terms with adversity' (Sen 2002, p. 634) and they are the preferences expressed when people have adjusted to a second class status (Nussbaum 2006). Such dynamics are expressed when people refuse to ask for help because it undermines their sense of independence (Boneham and Sixsmith 2006) or makes them feel like a burden (Cousineau et al. 2003, p. 111 in McPherson et al. 2010).

In 1983, Gardner introduced the idea of multiple intelligences which included both interpersonal intelligence (the capacity to understand the intentions, motivations and desires of other people) and intrapersonal intelligence (the capacity to understand oneself, to appreciate one's feelings, fears and motivations). Emotional labour has generally come to be associated with paid employment, yet informal care can require intense practice of both interpersonal and intrapersonal intelligence. The specific competencies of carers were theorised by Ruddick (1989) based on an ethnographic and philosophic account of maternal practice. This was generalised to the work of carers of adults with brain injury by Butler (2010), and it can potentially be extended to describe the work of all carers. This describes care as the labour that goes into producing three specific outcomes: maintaining the substance of the person; fostering that person's growth; and enabling social acceptability.

These benefits of social capital operate at an individual level, but the practice of care also creates social capital within the wider societal context. It was not so long ago that societal expectations meant that the most obvious place for people with disability was within an institution. Families felt pressured into placing their relatives in an institution not only because they felt that the disabled person would get better care than they could give, but also because there were few examples of disabled people living successfully in the community, due to lack of effective supports and a philosophy focused on institutional care. Social capital can therefore describe the change in focus to empowerment within the community, with community support, and the dynamic where it has become not only acceptable, but expected, that families care for the disabled person in the community, as Wolfensberger (1972; Wolfensberger et al. 1996, 1998) insisted. The greater number of people practicing care in this way has led to the development of support groups and the development of channels for the diffusion of knowledge and information. Although individual carers may feel battered and isolated, as a group, carers have achieved considerable benefits for the disabled community. For example, it was the efforts of carers that

gradually created the case for integrated mainstream schooling. It has also been carers who have created a variety of work opportunities for severely disabled adults living in the community, from sheltered workshops to the more recent development of micro-enterprises.

## 2.7 Critics

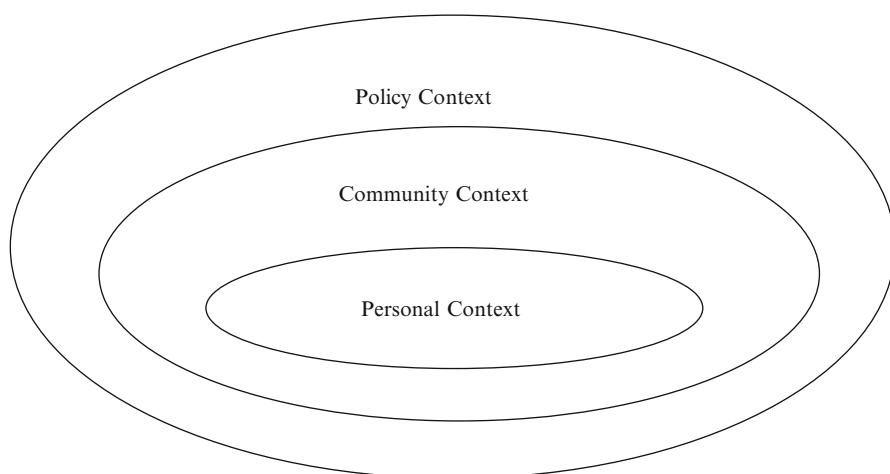
Theories of social capital are not without criticism. Edwards et al. (2003) for example, argues that social capital is an inadequate tool, both conceptually and empirically. They draw attention to potential problems that derive from the 'in-built static and formulaic ideas about the social fabric, which cannot capture the intricate dynamics of people's relationships within and between families' (Edwards et al. 2003, p. 267). They thus argue that social capital theory has important weaknesses in the way it explains the values that inform social interaction, the actual resources that people generate and acquire through social interaction, and how these might change in society over time. A more general concern is the way a focus on social capital has the potential to instrumentalise aspects of communal life (Scanlon 2003). That is, it can lead to a focus on social bonds in order to exploit them more effectively in the achievement of specific policy goals. The concern is that in doing so, the non-economic social connections between members of communities are seen simply as cost-benefit type market calculations that have the potential to assist a reluctant state to reduce its responsibility for social welfare. Social capitalists of this orientation therefore tend to see the benefits of a strong sense of mutual trust and reciprocity as being a basis for increasing economic efficiency in key areas of government policy. As Edwards et al. (2003) argue, such a view:

aids the shift in responsibility for 'social inclusion' from economy to society, and from government to individual, informing policies that focus on social behaviour. This reduces the cost to government, since ... social capital provides non-economic solutions to social problems (p. 9).

We do not dispute the criticism that to focus on social capital can be a way of providing support to arguments that governments should economise on social care by using the social ties of social capital. We accept the arguments of Wilkinson and Pickett (2009) who, in 'The Spirit Level', refer to the way there are higher levels of social capital in countries which have lower levels of economic disparity. The active reduction of social inequality, their argument implies, leads to higher levels of social capital, and larger income gaps lead to deteriorations in social capital. Further, economic approaches to the study of social capital tend to see it through political economy lenses. In so doing, they neglect the 'messiness, unpredictability and intricacies of social life' (Edwards et al. 2003, p. 10). In what follows, we do aim to take account of the intricacies, unpredictability and disarray which can be experienced in care receiving and caregiving. It does provide access to a perspective that takes account of the aggregate of actual and potential resources from 'institutionalised' relationships within social settings.

## 2.8 The Care Network, the Community and the Policy Contexts

The notion that care is nested within micro, meso and macro levels of influence implies different layers of influence. Keating et al. (2005) have identified these as the personal context, the community context, and the broader policy context. At the micro level, the cared-for person is located alongside and within their social, support and care networks, at the meso level, he or she is located within communities, and at the macro level within the broader policy settings of local, state, national or federal levels of government (Keating et al. 2005).



The personal context is the point at which support is provided to the individual. They suggest it can be seen as incorporating social networks, support networks and care networks. Social networks are comprised of the people known to those on need of care and with whom they have strong connections. It is the potential of these support networks to provide care which might be described as the degree of social capital. Social network capital refers to the number of members who are prepared to give assistance and the actual resources they can bring to bear on the situation. However, one of the axioms of social network study is that the 'mere presence of a tie between two people does not equate with the provision of support' (Walker et al. 1993, p. 72). Rather it is the ability to actualise the support potential.

Support networks, by contrast, consist of the actual members of a social network who provide everyday help and support those in need of care. These are the activities such as regular monitoring, emotional support, assistance with instrumental activities of daily living. Members of support networks are those with strong, stable ties with kin and friend relationships (Keating et al. 2004). When support network members are called upon to increase the amount of help and support to a person in need of care, be that instrumental or emotional support, they become members of

the care network. Care networks, according to Keating et al. (2005) 'are less diversified and more fragile with higher proportions of close kin than those without chronic health problems' (p. 3).

### **2.8.1 *The Broader Policy Context***

Policies are the more macro values and programs that influence the ways in which communities and networks relate to older adults. By virtue of these influences, the state has a central role in the construction of [care] through the allocation of scarce resources and the transmission of beliefs concerning family care and support. The policy environment itself is complex with public programs existing across levels of government and sectoral domains (Keating et al. 2005, p. 25).

Esping-Andersen's (1990) notion of a welfare state regime accommodates the way social norms inform family care practices, and therefore the way responsibility for care is allocated between the family, the market and the state. This is a way of capturing the broader context of families, social networks and policy settings. It implies the notion that informal care is nested within micro, meso and macro levels of influence. The notion of welfare state regime is an attempt to capture the policy contexts and the broad set of formal and informal structures and processes as they relate to the way different levels of government policy, or even nations, or groups of nations, protect vulnerable citizens and promote wellbeing. The idea of a welfare regime blends many different elements – moral values, social goals, institutional forms and social practices.

In Esping-Andersen's terms, welfare regimes are characterised by different patterns of state, market and family forms of care provision. According to Esping-Andersen (1999, pp. 34–35) a welfare regime is 'the combined, interdependent way in which welfare is produced and allocated between state, market and family.' Welfare regimes reinforce broad political, economic and social interests and ideas, and these tend to follow distinct paths of development. Policies have an ongoing effect in terms of their influence in the way they lead to the preservation of existing ways of doing things, which tend to reproduce or intensify the original care patterns. This happens when social policies for care result in pressure on families to conform to the accepted way of delivering care – the policies both reflecting and reinforcing patterns of care. Social pressures include the influences of policy which determine the allocation of care responsibilities and the types of care deemed to be acceptable. It includes the way formal care organisations are given certain caregiving roles, and the way norms around formal and informal care are developed and sustained through training and education processes.

## **2.9 Summary**

Informal care may be seen as an expression of social capital, this referring to the resources within social networks for mutual support and cooperation. The notion of social capital allows us to take account of the impact of individual strategies which

build the capacity of the broader collective, and of the stock of resources that are built up over time. Informal care is an expression of these resources. It is, therefore, fundamentally embedded within the networks of social relationships that give access to needed supports and help. Family members, neighbours and members of the wider community who provide care do so on the basis of the norms of reciprocity and mutual obligation built up within social networks. It is the bonds that exist within longstanding kin relationships and local neighbourhoods, and the bridges that connect people to resources and support across networks. Social networks occur within broader policy contexts, these both reflecting and reinforcing the norms about appropriate responsibility for the provision of care between the family, the community, the market and the state.

Locating informal care within the context of broader health and social policy contexts implies recognising informal and formal caregiving as overlapping domains. Such recognition implies approaching the examination of informal care, as we do in subsequent chapters, in a way that appreciates the following:

1. Care occurs along multiple dimensions (physical, psychological, social), by multiple providers (informal, formal), and in multiple spheres (home, community, institutions);
2. Experiences of caregiving are shaped by a personal context, including earlier life experiences (e.g. relationship quality before caregiving commenced, caregivers' background);
3. Caregiving involves distinct and important developmental experiences;
4. Caregiving experiences are shaped by specific characteristics of and processes in a wide range of inter-connected social settings (both proximal settings of everyday life and distal settings such as the state and its policies);
5. There will be differentiation in care-related experiences across cohort, sex, race and social class groups (see Settersten 2006, p. 4).

Most, if not all, questions that can frame our exploration of informal care can also apply to formal care. In addition to the above, Timonen (2009) proposes that we should understand caregiving as dynamic, something that is subject to change and transformation in the kind and sources of care over time. Our study of caregiving needs to incorporate the care-recipient, the caregiver(s) and their social context(s). She also recommends taking account of the micro and macro levels of social context (family, social network, society, social care, welfare state, political, and cultural levels). The significance of this is, as Timonen (2009, p. 324) states, the pressing need to understand better the way informal care is influenced by formal care in order to strengthen the design of policies and interventions 'to support both types of caregivers.'

## Discussion Questions

What are the beliefs in your family about who is the appropriate caregiver for a disabled child or frail elder? Are these beliefs universally shared? If not, then how do others view this situation?

'There are no boundaries on the potential response' in caregiving. Discuss this idea.

How do national health and social policies reinforce beliefs about who is responsible for providing care to family members?

Social capital has been described as both a goal of policy ('our goal is to build social capital') and a tool for policy. What is the difference between the two?

How is social capital related to the experience of informal caregivers? What type of social capital is likely to strengthen informal carers?

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