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### The Problems with Care

*A Feminist Care Scholar Retrospective*

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Concept Paper

# The Problems with Care: A Feminist Care Scholar Retrospective

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**Abstract:** Seeking to support qualitative researchers in the artful development of feminist care scholarship, our goal here is to ‘look back’ on how we have conceptualized the problems of care and developed research that illuminates the social organization of care in distinct ways. As part of a ‘feminist care scholar retrospective’, we present five condensed ‘reverse research proposals’, which are retrospective accounts of past research or scholarly activity. From there, we discuss how each project begins with a particular problematic for investigation and a particular conception of care (e.g., as practices, as work, as a concept) to illuminate facets of the social organization of care shaping paid and unpaid care work and its interpretations. These approaches reveal multiple and overlapping ways that care is embodied, understood and organized, as well as ways care can be transformed.



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## 1. Introduction

There is a pressing need for change-oriented research on the care economy. As highlighted during the COVID-19 pandemic, many care providers and people who deserve to have their care needs met live within ageist, ableist, racist and sexist structures and contexts that devalue women and the work of care. Long-standing issues in the care economy include low pay, poor working conditions, worker exploitation, labour shortages or worker retention issues, as well as inadequate care levels, long wait lists and high violence, accident and injury rates [1,2]. Some also call attention to tensions or conflicts in a range of care settings, including in everyday care interactions in clinical or medical settings [3,4] At a broader level, the responsibilities and risks of care work are inequitably distributed globally and within nations. There is a need for social welfare reform and state initiatives to ensure adequate care provision; there is an incredible breadth of care scholarship to learn from.

Public discourse around care, care work and family caregiving is often urgent and apocalyptic in tone—frequently beginning and ending with questions of what is to be done in the face of this ‘care crisis’. Recognizing the urgency and seriousness of what we are dealing with, this article considers how we, as feminist scholars, have developed particular understandings of the ‘problems’ of care work and have engaged in research that both conceptualizes care and brings embodied social structures into view in different ways. We recognize that academic work often relies on a philosophical practice of problematization, which at its heart is concerned with turning the ‘givens’ of everyday life into a question [5]. To support other researchers, we reflect on the kinds of questions we have asked of care and the dimensions of the social we have brought into view. We are inspired in this regard

by Pat Armstrong's work with the Women and Health Care Reform, a group funded by the Canadian federal government to identify and fill gaps in research on gender and care, and (equally importantly) to translate research into policies and practices. As the chair of that group for more than a decade beginning in the 1990s and in collaboration with a small group of women from across Canada, Armstrong set about asking and seeking answers to four central questions: Why is care a women's issue? What are the issues for women? For which women? What can we together do about it?

Seeking to support researchers in the artful development of feminist care scholarship that responds to these aforementioned challenges, our goal here is to 'look back' on the development of our own past studies as part of a 'feminist care scholar retrospective'. In the art world, a retrospective can refer to an exhibition that displays or looks back on the work an artist produced over a period of time. In this article, we present retrospective accounts of past qualitative research conducted by us as care scholars at different stages in our careers. We begin this article by outlining the importance of looking at intersecting forms and relations of care and work together. From there, as part of this 'feminist care scholar retrospective', we will introduce five 'reverse research proposals'—covering, in turn: (1) a material semiotic and ethnographic study of dementia family care (Symonds-Brown, Ceci and Pols); (2) an interactional communication study of clinical care interactions (Cherba); (3) a narrative and interpretive analysis of meanings of care for older and dying people (Funk); (4) an ethnographic, feminist political economy study of nursing homes (Armstrong); and (5) a feminist sociological exploration of the limits of care (Klostermann). These studies were developed by scholars working in a range of disciplines (Communication, Nursing, Sociology) and using a range of approaches. They conceptualize and ask different questions of the problems of care and employ different conceptions of care to explicate dimensions of care's social organization.

#### *Context: Remembering for the Future, Confronting Problematics of Care*

The COVID-19 pandemic has revealed and increased reliance on unpaid care, which is primarily provided by women, including paid care workers and family/friend care providers [6]. Much of our own research is conducted in Canada, where family/friend carers of older adults, for example, provide a large part of \$70 billion in equivalent paid work [7]. In many social welfare states, state reliance on unpaid care has resulted in "decades of unreplenished energies and costs" especially for women shouldering the bulk of care labour [8]. The gendered valuation and division of unpaid care work has real stakes for low-income and minority groups who face more of such responsibilities and negative consequences [9,10] related to health or psychological well-being (e.g., [11–13]), social networks [14] and employment and labour force participation [15]. Care work is also often primarily performed by immigrant/racialized women, whether in people's homes or in long-term residential care facilities [16]. Notably, paid and unpaid care are linked; not only do many women often engage in both forms of care across their lives, but supporting unpaid carers often requires engaging formal services of paid care workers.

When it comes to responding to care crises and care deficits, we are heartened by recent public conversations about the care economy in North America (see [17,18]), as well as renewed efforts to shift conceptions and configurations of 'care work' towards interdependence, relationality, reciprocity and mutual support, to promote the rights of carers and people who need care, and orient to care as a socio-political or equity issue [19,20]. It is often difficult to see or monitor the impact of our collective research and we often work for years before it makes a difference. However, the devastation resulting from COVID-19 in a range of care settings demonstrates how important it is to do this kind of qualitative work. Indeed, even the Prime Minister of Canada has now recognized that the conditions of work are the conditions of care [21]. With that, we hope in a small way to contribute to shared projects of investigating and transforming the social organization of care, by elaborating how we conceptualized and undertook a breadth of scholarship that can support feminist goals of structural transformation. We also hope to support these efforts by engaging in

work that links paid and unpaid care more closely, that unpacks the social, material and conceptual relations shaping the lives of paid and unpaid carers alike, and that considers the organization and division of care as an indicator of equity.

## 2. Materials and Methods

As an interdisciplinary group of scholars at different stages in our careers, we wanted to support future work by reflecting on our own. While this article is not a wholly comprehensive overview of all possible approaches to care scholarship, and we are ourselves indebted to the work of other care scholars, we share our own conceptions of care and associated theoretical and methodological approaches and processes to support shared learning. We follow researchers who aim to support others with research design and knowledge production processes [22–24]. We are particularly inspired by Mason [25] who writes of the important ways that different methodological and substantive approaches to research inquiry can be engaged as ‘facets’ which reveal or produce ‘flashes of insight’ into a phenomenon, casting light in different contingent (angled) ways. We consider how creatively and strategically bringing different approaches together can produce new ideas and ways of seeing or thinking, while ‘troubling’ taken-for-granted and dominant assumptions about the phenomena.

After presenting the retrospective, we will come full circle to consider how studies with different starting points and problematics, along with different materialist or interpretive approaches (including conceptions of care) can generate distinct knowledges of the social organization of care. We also reflect on the value of integrating materialist and interpretive approaches to study care, raising questions about what responsibilities we have as researchers and knowledge producers. In making such a contribution, we contribute to scholarly conversations about how methods can be worldmaking and how doing “care-ful” research involves iteratively responding to concerns and crafting researchable questions [26–28]. We hope this article will be of particular use for students and researchers designing projects or preparing research proposals (such as for provincial or national grant applications). Similar to other applications, our condensed ‘reverse research proposals’ include details about “research objectives, context, theoretical framework, methods, and contribution” [24] (p. 312). Each proposal offers an example of how to ask questions of care, of how to develop methods or projects that respond to those questions and that illuminate different dimensions of social organization. They show different ways of aligning the research questions with the research design to respond to different problematics and to variously reveal “embodied social structure” [29].

## 3. Results: A Feminist Care Scholar Retrospective: Five Studies on the Social Organization of Care

Our five ‘reverse research proposals’ exemplify different projects as they: (1) conceptualize particular research questions and objectives; (2) engage different theoretical and methodological approaches, with different conceptions of care (e.g., as practices, as work, as a concept); (3) undertake different phases of research and study designs; (4) generate different findings or bring particular dimensions of care work and social relations into view; and (5) contribute in different ways to making change.

### 3.1. *A Material Semiotic, Ethnographic Study of Care as Practices—Holly Symonds-Brown, Christine Ceci and Jeanette Pols*

With a focus on the everyday care practices of families where one family member has a diagnosis of dementia, our research mobilizes a material semiotic and ethnographic lens to analyse how care is done within socio-material relationships. In Canada, as in most parts of the world, most people living with dementia are living at home. This situation has mainly been understood and investigated through measures of the ‘care burden’ on family or the effects of episodic and programmatic formal interventions such as day programs [30,31]. While such research has developed helpful knowledge to support families, the effect has often been to cleanse sites of caregiving of any evidence that there is anything beyond the

individuals themselves involved in the actual work of caregiving. That is to say, almost none of the whole gamut of practicalities, the multiplicity of material and organizational worlds that shape daily life are evident in the research literature. To counter these dominant approaches to knowledge and formal care practices, when we focus on people's practices of handling daily life in the context of dementia, we ask:

What do people do, how do materials mediate their actions, what ends do they strive for, and how do they account for what makes sense in particular interactions? What kinds of care practices are helpful to sustaining people and relations, including social and material arrangements that enable the distribution of the work, care and risks of everyday living for persons living with dementia and their families? What is at stake within these practices and for whom, and how do different values compete to enact what comes to matter most?

A material semiotic approach assumes that entities, such as care, "take their form and acquire their attributes as a result of their relations to other entities" [32] (p. 3). This means we begin with an idea of 'care' that is not clearly defined in advance. So, in our research practices, care is intentionally maintained as a 'loose' or open concept [33], conceptualized as an ongoing social accomplishment achieved by multiple actors associated within webs of relations [34], but one whose content cannot be specified in advance. This stance is informed by a relational ontology and logic, in which 'care' is understood as fluid, with meanings and configurations that shift in different practices. We take the view that our research questions are most helpfully answered empirically, where we can show what care is through cases and examples. Our goal is to open up taken for granted ideas about what care is through creating thick descriptions of particular practices of care, how they travel, connect and interfere with other practices and how the politics of what comes to matter most gets worked out.

As an example of this approach to studying care practices, we undertook a study on at-home care for people living with dementia to learn more about how families were handling everyday life in the context of dementia. To learn about family care practices, the practicalities they handle and their relations with multiple social and material contexts, we used traditional ethnographic methods of observations, interviews and document analyses. These methods support understandings of people's situatedness in everyday practices, and within existing institutional and cultural situations. The centre of our study was fieldwork with four families, who were followed for periods of four months to one year. 'Following' a family meant going along with members of a family on visits to doctors' offices, day programs, caregiver support groups and social outings, as well as visiting their homes for informal conversation or to be present during visits from various health care providers. In concentrating on the arrangements that families made and how they enacted these, we considered what makes life at home possible or impossible, easier or more difficult, and then traced these elements beyond the specific site of home.

Our research highlights how every person 'does' dementia differently, and every family has to work out how, in their own singular and situated ways, to make things work. We also illustrate how formal care system processes often overlook the ongoing work of families, with practices in place that often do not recognize a family's care arrangements or the work done by people, ideas and materials to hold them together. This glaring absence in formal care policies and practices means that what is conceptualized as 'helpful' for families in dementia plans and programs is both limited and limiting, specifically limiting possibilities for action in terms of care [35,36]. In examining how the actualities of daily life with dementia articulate with ideological, practical and programmatic discourses and practices developed elsewhere (see also [37]), we found families' everyday lives were often, though not always, at odds with the kinds of practices and programs planned elsewhere, requiring them to adapt and adjust to priorities that are not necessarily their own.

### 3.2. *An Interactional Communication Approach to Studying Care in Conversation—Maria Cherba*

My work uses an interactional approach to explore communication in clinical care settings. Health care providers' communication and relational skills are essential to the provision of patient-centred care and have important implications for service utilization and health outcomes [38]. In turn, my goal is to contribute to applied research in health communication that aims to support service provision. I explore care through empirical studies of clinical care interactions, and in the context of lived experiences and stories told by patients, families and health care providers. My research responds to calls for studies focusing on concrete behaviours during medical care visits, through which interaction participants demonstrate their understandings of what is going on in a specific situation. With such an approach, the aim is to identify practices that shape the outcomes of clinical encounters, using such analyses to inform health care education and practice [39]. With a focus on interpersonal encounters and dialogue in patient–provider interactions, my research asks:

How are micro-level turns of talk and specific actions accomplished in conversations around health? How do participants mutually influence each other and jointly construct the interaction [39]? How can interactions between patients, families and service providers be transformed to improve support provision or access to care for different populations? What do these findings tell us about broader organizational processes and meanings of care [40]?

Centred on analysing patterns of interactions, an interactional communication approach brings into view specific practices accomplished in health care providers' everyday work, and highlights potential implications of certain ways of doing things for the course of a specific interaction, and ultimately for the provision of quality care. With a focus on localized practices and processes, a close analysis of routine interactions can help shed light on some of the gendered and intersectional barriers of access to clinical care. From this perspective, clinical care can be defined as accomplished through patient–provider and interprofessional interactions in a particular context.

In a recent study with colleagues at the University of Ottawa, we combined analyses of recorded clinical interactions with interview data to study the transformations of clinical practice in the context of telemedicine [41,42]. Specifically, we looked at collaboration between physicians and a nurse accompanying patients in a remote location, to understand how physical examinations are accomplished at a distance. In phase one, nurses, physicians, specialists in medical education, researchers and patient partners worked together to create a simulation scenario that would help address the challenges of patient–provider communication in this context. In phase two, we conducted and recorded ten simulated teleconsultations with surgeons and residents. After each simulation, physicians participated in an interview, where they watched their recordings and commented on what they did. We examined the simulation recordings to identify interaction patterns and distinct communication practices through which care is accomplished, and through which participants negotiate meanings and express what counts or what matters to them in a given situation [43]. The interview data helped identify specific nurse actions that were meaningful for physicians and that made possible the “sensory work” of diagnosis and decision-making [44] in a remote clinical consultation. Our analyses showed how the nurse's utterances and bodily movements played a role in interpreting sensory information and in establishing a trusting nurse–physician relationship.

Recognizing that gender bias persists in health care and that women can be more likely to face adverse health outcomes [45,46], the results of research such as this can help formulate concrete recommendations to inform clinical practice [40]. We found that inviting physicians to pay attention to and to reflect on their ways of interacting with patients during medical care can support them in identifying things they could do differently, including to facilitate their work with the nurse, to examine the patient remotely, and to establish a trusting relationship with them. An interactional communication approach can support

broader care mobilization efforts by examining how interaction participants develop a collective identity, how problems and solutions around care are negotiated, reinforced or challenged in conversations, how conflicts are managed and how decisions are made [47]. In addition, this approach can help understand how particular concerns can be silenced in clinical conversations (e.g., not responded to or expressed) and how routine interactions contribute to (or can help overcome) barriers to accessing care.

### 3.3. *An Interpretive Sociological Investigation of Care Work and Responsibilities—Laura Funk*

The broad objective of my program of research is to trace and critically explore meanings associated with care for older adults and dying persons, in various settings, contexts and relations of care. Across Canada, population aging and changing family dynamics, as well as social and political conditions, profoundly shape care relationships and responsibilities in a range of settings, including at home and in nursing homes. In dominant discourse, responsibilities for care still tend to be viewed as the private trouble of individual families, which is the implicit policy orientation in Canada [48]. As a sociologist of late life care, I work to understand meanings and discourses of care work and family responsibilities, through projects focused on paid and unpaid care for older adults and dying persons. I ask research questions such as:

How do paid and unpaid carers talk about their work and relationships, variously responding to and in relation to others? What broader narratives and ideas do they draw on and reinforce? How do carers interpret, negotiate and manage practical aspects of their roles, and meanings of responsibility, to set practical and emotional boundaries in the context of broader health care system constraints and cutbacks? What meanings circulate, manifest within and emerge from the practice of paid and unpaid care for older adults and dying persons?

To produce knowledge about the meanings associated with care, I typically draw on narrative approaches and interpretive inquiry [49], which integrates the social phenomenological study of identity and talk in interaction with Foucauldian-informed analyses of broader historical and cultural contexts. My goal is to learn about meanings and taken-for-granted assumptions surrounding care, as a way to contribute to shifts in structural and discursive forces that shape relationships of care and experiences of care work in various settings. Through my work, I have come to understand care as a highly gendered identity or subject position that is negotiated and constituted as people make meaning within localized encounters. Interpretive inquiry can illuminate interactions in 'localized' contexts, while elaborating broader discursive-material contexts or dynamics (such as neoliberalism, individualism or familialism).

A few examples from past projects in different 'sites' (different types of care, different settings and circumstances) serve here as helpful illustrations of my theoretical and methodological approach. In general, I design studies that recruit and engage carers in talk through research interview conversations about their daily lives, roles and responsibilities, analysing these interviews as situations of (albeit mediated) talk in interaction, in which carers strive to maintain valued identities and accounts of motivations to themselves, to generalized others and to the research interviewer. I examine functions of particular lines of talk in this regard as well as contextualizing particular lines of talk as grounded in and further reproducing broader socio-cultural and political-economic discourses.

Considered together, my research has found that paid and unpaid carers (most often women), in both their actions and their narrative constructions, set boundaries on becoming fully implicated in the work of care, including by living apart from their partners [50], or by resisting formalization of the volunteer role in long-term residential care [51]. Moreover, my work shows how potentially stigmatizing narratives (about age, illness, disability, dementia, residential care and family responsibility, among others) and individualizing, biomedical and familialist (rather than collectivist, relational or politicized) narratives can be inadvertently reproduced through this process of coping and responding to care situations. This happens, for example, as paid companions (occupying a liminal role in

long-term residential care) strive to maintain caring identities and justify the need for their service [52]. Stigmatizing narratives can also be reproduced as resident care aides and/or nurses in long-term care settings strive to cope with aggression from patients and families [53], with the death of residents [54] and with feeling unable to effectively help clients/families in home care due in part to constrained resources [55]. Similar processes can occur among adult children struggling to maintain boundaries and cope with difficult emotions arising in their relationship with older parents requiring care [56]. Caregiving tends to be framed as a medical, rather than socio-political issue, with feminized carers at times reproducing commitments to social arrangements and understandings grounded in rarely-challenged familial ideologies (see also [57,58]).

My research reveals the complexities of meanings and identities circulating around care, while also examining how gendered and other inequities are maintained, reproduced and challenged in everyday talk and interactions about care (e.g., [59]). Interpretive analyses point to the need to promote reflexivity and critical reflection among practitioners, carers and the general public; to consider how we can promote carer well-being without reproducing potentially harmful discourses; and to identify spaces for shifting and challenging dominant narratives as well as shifting broader political and economic contexts that contribute to these processes. Thus, whereas some of my findings help in advocating to improve (and nuance the content and delivery of) supports for carers, they also highlight the need to invest in essential public services and mitigate gendered impacts of care work through collective and public action.

### 3.4. *A Feminist Political Economy Approach to Examining Social Organization of Care/Work—Pat Armstrong*

My interest in care grows out of my interest in gendered labour, which began with my MA thesis published as *The Double Ghetto: Canadian Women and Their Segregated Work*. Like others in the Canadian feminist political economy tradition (see [60–62]), my scholarship and research practice is informed by and contributes to strengthening my own personal activism around equity and social justice. My conceptualization of care has developed over time working with others on research and action. As part of my current program of research, I have led international, interdisciplinary projects that ask:

What approaches to care, to work organization, to accountability and to financing and ownership in long-term residential care offer the most promising practices for treating those who need and those who provide care with dignity and respect? In particular, what contexts, regulations, funding and working conditions allow residents and providers to flourish?

These questions are based on our understanding that care is a relationship, albeit often an inequitable one, and that care is a shared responsibility, leading us to investigate the privatization of care in all its forms [63]. Because we assume that contexts and populations matter, we also assume there are few single best practices and thus seek to identify promising ones. We are explicitly guided by feminist political economy, wherein the political economy “refers to the complex of institutions and relations that constitute not only what are conventionally referred to as the political and economic systems but also the social, physical, ideological and cultural systems” [64]. Feminist political economy particularly attends to paid and unpaid work, as it is organized or coordinated through the political economy. Like E.P. Thompson [65], we understand research as a dialogue between theory and evidence, constantly questioning both and understanding both as contingent. Theory, then, is always a work in progress. Our feminist political economy theory leads us to assume that:

1. Care is a relationship, one shaped by multiple intersecting social relations of inequality in terms of both material resources and power.
2. The conditions of work are the conditions of care, whether that care is paid or unpaid.



3. Contexts of care matter, and include the political economy at global, regional, national and local areas, which in turn includes values and ideas as well as material conditions, relations of power and both individual and collective actions.
4. Tensions and contradictions related to care matter.
5. There is seldom a single right way to care, especially when we recognize that care is about human individuals and their interaction. Evidence provides a guide rather than rules.
6. Time matters, including time for care, time of day and time of life.
7. Care skills are acquired and required—and acquired through multiple means.
8. Food, clothing, laundry, housekeeping, record keeping and advocacy must all be included in our understanding of care.

Funded through a SSHRC ‘Major Collaborative Research Initiatives’ grant, our international ‘Reimagining Long-term Care’ study of nursing homes allowed us to compare homes in countries aligning with each of Andersen’s [66] three kinds of welfare states. We developed an uncommon approach that involved team-based, rapid ethnography [4]. Our methods were feminist in at least five ways. First, the research process was collective as well as democratic, with data and ideas constantly shared and challenged not only within the team while we conducted research, but also through our everyday experiences, including as advocates. Second, we focused, as Smith [67] among others, advises, on listening to and observing those who live, work, manage and visit in nursing homes. Third, we took gender as it intersects with other social relations, as central to the analysis, recognizing inequities in power, and resources, as well as in bodies and histories. Fourth, we struggled to make the invisible visible, especially when it comes to women’s work and to the structural violence that prevents people from reaching their potential. Our approach meant attending to the unpaid work of families, volunteers and those otherwise paid to do the work. We attended to unpaid work’s relationship to paid labour and the skills involved in both, and attended to the structures that shape work and care experiences in inequitable ways. Finally, we made our research accessible to as many people as possible by speaking and writing in plain language and by using multiple means of communicating, practicing public sociology.

International comparisons allowed us to identify the different forces at work as well as the possibilities for change. For instance, we found that personal support workers in Canada were more than six times as likely as those in Nordic countries to say they face violence on a daily basis [68], and we determined that the main differences between countries was not in the resident population but rather in the better working conditions in Nordic countries. Similarly, our research illustrated the negative impact of privatization on quality and equity in care, highlighting the need for massive public investments and major changes in the social organization of long-term care [17]. Our research also explored how a Norwegian activist group was able to reverse some forms of privatization and how the US was able to use state tools to monitor staffing levels that are so critical to care. Through the research we were able to make visible the skills involved in care and to demonstrate the importance of oft-invisible laundry and housekeeping work for people’s dignity and respect [69].

### *3.5. A Feminist Sociological Approach to Reimagine Concepts and Configurations of Care—Janna Klostermann*

My research mobilizes the tools of feminist political economy, along with narrative and arts-based approaches to critically reflect on the limits of care from the standpoint of former carers—those who reached their limits and stepped back from paid or unpaid care responsibilities in Ontario’s care economy. In Ontario, long-standing public under-investments in care have exacerbated social inequities, care deficits and unmet care needs, as well as costs and consequences for women who shoulder the bulk of caring work. While much has been written about tensions in care or about the costs and consequences of caring for others, my research was distinct in its focus on the moral dimensions of withdrawing from care. Such a line of inquiry was motivated by my own experience reaching my limits

and resigning from care work. The study responded to calls to consider the perspectives of those opting out of or stepping back from care responsibilities [70]. It also aimed to push forward feminist theories of care, examining moral dilemmas that women negotiate, but which are lesser-represented in feminist theories exploring care ethics or the social organization of care [71,72]. With a focus on how women's lives are shaped both on and off the clock through paid and unpaid care work, I asked:

How do former carers frame their experiences of reaching their limits and stepping back from paid or unpaid care responsibilities? What exactly keeps women 'in' inequitable care relationships, and how do we get 'out'? What approaches to conceptualizing 'care work' are most promising for promoting equitable care relationships?

Guided by feminist research that understands care as central to social and political life [71], I mobilized a feminist sociological approach informed by theories of social practices, gender relations and the care economy. Such an approach assisted me in attending to people's embodied, situated practices, including their narrative or expressive practices. My goal was to explicate how those practices are co-ordered with the practices of others, with circulating conceptual narratives and with intimate and extended gender relations. I theorized how people's practices expand and produce new social realities and meanings [29,73]. Following feminist political economists, I conceptualized care as work that is central to social reproduction and involves a range of activities related to sustaining others such as providing direct care for a person, maintaining physical surroundings and fostering or maintaining relationships [74]. I also conceptualized care as a concept that is remade in relation—embedded in and brought about through "histories, networks, and narratives" [75] (p. 209). Such a framework helped me to examine how people's practices, including embodied and expressive practices, are shaped by and contribute to reshaping social relations and conceptual narratives.

'Care has limits' was the title of my dissertation [76]. In it, I used narrative research, arts-based autoethnography and the tools of feminist political economy to bring moral, gender relations and conditions in the care economy into view. In phase one, I recruited people who identified as 'former carers' with experiences in a range of paid and unpaid care contexts. In phase two, I conducted and transcribed 20 life history interviews with 12 people to explore how their practices were shaped. I also wrote about and analysed my own life experiences as live-in care worker at L'Arche, where I lived with and supported people with intellectual and developmental disabilities in the early 2010s. In phase three, I analysed all materials using an adapted "Listening Guide" that supported me in contextualizing participants' stories, while explicating how care is brought about through intimate and extended social relations. In phase four, I produced works of art and scholarship to express sociological truths in artistic forms and to invite alternative valuations and portrayals of care.

Making links to class, gender and conditions in the caring economy, I theorized women's stories of being coerced into care work, of negotiating contradictions at the limits of care, and of resisting or renegotiating expectations to care for others. I theorized care work as negotiated, and explicated moral, gender relations and conditions of care that not only shape women's involvement in care, but also shape our options for pursuing other paths. I found renegotiating responsibilities for care involves conceptual and rhetorical work to reorient to one's moral, gendered sense of self and to unpack moral, gendered ideals and expectations to care for others. These intrasubjective dynamics shape women's choices and shape the stories we tell about care and moral responsibilities. Taken together, the study contributed to a conceptual reimagining of care work, raising questions about whether "care as an ethic" should apply at the level of individual women's lives.

My scholarship helps to examine how gendered divisions of labour are brought about. Historically, with the global division of labour, women and particularly racialized, Indigenous, immigrant and poor women, have been coerced and recruited into paid care work, while women in families provide the majority of unpaid care work [74]. I

understand the right (not) to care as a matter of gender and intersectional equity, with racial, class/income and citizenship differences shaping access to care, as well as who is tracked into direct care roles. Calls to recruit and retain workers into the sector, to date, outnumber calls to ensure care relationships are consensual or to support carers in exercising agency. With that, I ask questions about how people resist or about how people can have choices in the care they provide and receive.

#### 4. Discussion: Problems and Concepts of Care

The approaches above offer creative and reflexive orientations to research—conceptualizing and reconceptualizing the problems of care to reveal care’s social organization. These projects involved the political work of noticing and responding, as well as of interpreting findings, explicating tensions and contributing to alternative ways of understanding and relating. Here we elaborate how the approaches above embed different ways of (1) conceptualizing care; (2) identifying research problematics or starting points; (3) conducting research on care; and (4) strengthening mobilization towards structural transformation.

While by no means a comprehensive overview, the ‘reverse research proposals’ above illustrate different ways of conceptualizing care (e.g., as a loose concept, as a practice, as work). First, Symonds-Brown et al. narrow their empirical focus through ethnographic work, maintaining care as a ‘loose’ or open concept. Second, Cherba looks at ‘care’ as it is accomplished in localized contexts to elaborate situated, material relations. Third, Funk foregrounds meanings of care and brings into view broader discourses of care shaping people’s lives. Fourth, Armstrong examines care as work, identifying organizational, political and economic processes shaping conditions of work and care. Finally, informed by materialist and interpretive approaches, Klostermann orients to care as work that is central to social reproduction, and as a concept that is remade in practice, with the goal of bringing social and conceptual relations into view. With different lines and levels of analysis, these approaches focus on different settings and relations of care. They do not narrow in on care as an object in and of itself, but work to explicate social relations.

The proposals above engage different ways of writing about the problematics of care as the starting point for investigation, flagging contributions to scholarly understandings and to improving people’s lives. First, Symonds-Brown et al. highlight the need to contribute to descriptive/empirical understandings of care in practice. Second, Cherba highlights the need for extending research on health communication that aims to support service provision in clinical care settings. Third, Funk begins by calling attention to social and political relations, including population aging, changing family dynamics and discourses of family responsibility. Fourth, Armstrong takes the inequitable social organization of care as a starting point for her work. She begins with a critique of neoliberal privatization strategies that are shaped through political and economic relations. Finally, Klostermann references long-standing public under-investments in care that have led to care deficits and unmet care needs, as well as to costs and consequences for women who care. She also notes how her own experiences reaching her limits as a care worker motivated a scholarly investigation of how other women negotiate moral dilemmas at the limits of care.

As evident above, different theoretical and methodological approaches offer different ways of engaging in research. First, mobilizing a material semiotic approach and ethnographic research, Symonds-Brown et al.’s work attends to the practices of handling daily life as they are shaped through socio-material relationships and worlds. Through ethnographic research that involved ‘following’ families, they elaborated the workings of family care arrangements. Second, Cherba and colleagues applied an interactional communication approach, along with simulation methods to examine micro-level turns of talk and situated practices. Their close analysis of routine interactions can help shed light on some of the barriers to accessing to care. Third, with a narrative approach to interpretive inquiry, Funk brought meanings and broader discourses of care into view, considering how understandings of care or family responsibility shape people’s lives. Fourth, Armstrong used feminist political economy to explicate organizational, political and economic condi-

tions, and relations of gender, race and class, that shape people's everyday work and lives. Finally, through feminist sociological research using insights from feminist political economy, narrative research and arts-based autoethnography, Klostermann examined stories of leaving care, to learn about social and conceptual relations in the care economy. Looking at the examples above, we note differences in how researchers orient to participants, with some aiming to elicit people's accounts of their experiences, and others analysing people's everyday practices. Yet, with distinct ways to think and learn about social relations, each aims to move beyond identifying themes in qualitative data, to trace embodied social structures or modes of social organization.

We acknowledge that our own scholarship aims to inform structural transformation in often more subtle and indirect ways than, for instance, approaches such as participatory action research or other anti-oppressive research, which are designed to achieve more direct transformation and to challenge the status quo through process and methods themselves (e.g., [77,78]). That said, our studies do have implications and openings for structural transformation, and for strengthening carer mobilization in this regard, whether through illuminating formal care systems' ignorance of how families accomplish dementia care (see Symonds-Brown, Ceci and Pols above); exposing interactional barriers with implications for inequitable access to clinical care (Cherba); tracing how stigmatizing and individualizing discourses can delimit carers' understandings of their work (Funk); identifying promising practices to promote quality, equitable care arrangements (Armstrong); or highlighting the importance of ensuring women have options to care (or not to care) across their lives (Klostermann). Taken together, the projects highlight the utility of orienting to people as expert practitioners of their lives [67] who have insights about how their lives are organized and about the meanings and identities that matter to them. Bringing these different approaches together may inform broader and more nuanced knowledges that help to strengthen community organizing and political action to shift things at an 'upstream' level such as by addressing modes of social organization shaping gendered inequities.

It is also important to note the possibilities and limits of the feminist studies above. Feminist research can center on "theorizing from the basis of embodied lived experience, on critiquing systemic and structural power relations, and on producing research geared toward social change" [79] (p. 85). Enacting such an approach, and aiming to reveal dimensions of social organization, the studies above primarily began by focusing on 'care in practice' or on people's everyday work experiences or stories. They examined situated happenings or everyday scenes of caregiving in localized contexts. With that, we recognize the need for transformative scholarship that uses arts-based or participatory approaches to engage participants as experts or theorists with insights to offer towards conceptualizing or remaking care. Relatedly, while the studies above primarily focused on paid and unpaid carers, there is a need for inquiry that develops understanding and facilitates coalition-building between people positioned differently in care relationships, such as family carers, workers, or people accessing care [80]. Such research may support "industry-level unionization efforts in care services, or, at the very least, stronger political coalitions to contest the devaluation of care provision" [81] (p. 185) (see also [80]). Further, while we highlighted a range of work in care scholarship, we also note that the work of social movement activists and of researchers in critical disability studies and critical aging studies have important insights to offer projects of investigating and transforming care [82,83].

## 5. Conclusions

Following recent efforts to support others with research design and knowledge production processes, our aim here was to elaborate how we asked questions of care and examined multiple dimensions of social organization. We opened this paper with questions about what is to be done in the face of the 'care crisis'. From there, thinking together about the work of noticing, responding to and conceptualizing the problems of care, we reflected on how we ourselves began with particular understandings of the 'problems' of

care work to engage in feminist care research that, in different ways, conceptualizes care and brings embodied social structures into view. We presented five condensed ‘reverse research proposals’ that variously oriented to the care economy as “embodied social structure” [29], attending to practices and meanings, as well as to structuring relations and circulating narratives.

The work of creating a ‘retrospective’ is political in that it involves re/scribing what are often taken for granted practices. Re/scription entails recognition that description is inherently political, as practices are re-written through the concepts one uses, and many stories can be told about the same situation [84]. This ‘opening up’ of the taken-for-granted allows for an evaluation of the research process and a deeper consideration of what values might be at stake and for whom. This work also helps to build a ‘vocabulary for care’, encouraging us to take account of, rather than shy away from, specificities, and to work at creating knowledge about particularities so that we might learn from, rather than ignore, differences [85].

To close, the COVID-19 pandemic presents new problematics for scholarly investigation. Not only have demands for paid and unpaid care been extremely high, but the pandemic has shone a light on interconnections between people’s work and family lives. Research is needed that begins with and responds to these problematics such as by focusing on intersecting social policies (e.g., childcare, parental leave, employment policies) or on how people’s working lives are intertwined with their caring lives. Moving forward, we would love to see similar reflexive engagements from other researchers and advocates, who may find it worthwhile to generate a ‘retrospective’ of their own. To craft the ‘reverse research proposal’, it may help to ask questions such as: What were questions driving your study? How did you conceptualize ‘care’ or your object of investigation? What theoretical or methodological steps were involved? What did your study bring into view? With the goals of deepening reflection and shared learning, such an exercise gives a way to acknowledge past contributions, legacies and work of scholars you are sharing a room with. Together we can reveal and transform embodied and structurally-mediated dimensions of our own and others’ shared lives. We can tend to, open up and remake circulating meanings or structuring organizational, political and economic relations that deeply shape care and caring.

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