Reinventing caregiving around ageing
Developing new configurations of care and solidarity in collaborative housing

Lisa Buchter – EPA

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The division of care work—from childcare to caregiving for ill, disabled, and aging individuals—remains one of the major sources of gender and global inequalities today (Garrau 2020; Gerstel 2000; Hochschild 2003b; 2015; Oliker 2011; Schmidt-Sane et al. 2021; Tronto 2015). Caregiving is often devalued and done either for free or low pay, putting significant strain on formal and informal caregivers (Grigoryeva 2017; England 2005). The wellbeing of caregivers becomes even more crucial today, in the context of a "caregiver shortage," in which the population is aging and states have reduced their healthcare expenditures (Glass 2009, 283). Despite the increasing adoption of feminist ideals in many domestic spaces, women remain the main caregivers in households, as implicit rules reinforce their mental load, invisible work, and emotion labor in heterosexual couples (Haicault 1984; Halinski, Duxbury, and Stevenson 2020; Perray-Redslob and Younes 2021). At the same time, as more and more women enter the workforce and refuse to handle the devalued tasks of care, there is a broad trend toward outsourcing the care of vulnerable people, which reinforces global inequalities (Ehrenreich and Hochschild 2004; Hochschild 2003a) and the commodification of care, which can decrease its quality (Tronto 2013; Ungerson 1997; Schwiter and Steiner 2020).

In this article, I examine how members of collaborative houses— a term describing the "wide range of collectively self-organized and self-managed housing forms," including resident-led housing cooperatives, cohousing, and Community Land Trusts (Czischke and

Huisman 2018, 158)—have organized to question, at the collective level, the deeply-ingrained mechanisms of the unequal divisions of care labor. Often driven by an ideological desire to produce alternative forms of living, these forms of housing can be characterized by the establishment of mutual help and solidarity (Czischke 2018, 56) and the frequent questioning of gender inequalities (Jarvis 2013; 2017). While scholars have examined how these models may be beneficial for people needing care (Glass 2016; 2013; Rosenfelder 2017; Labit 2015a), to my knowledge there is no research specifically focused on how these housing arrangements affect the experiences of caregivers, and the transformation of care configurations. I show how the everyday practice of collectively and dialogically examining, questioning, and reinventing rules in collaborative housing helps to question current hegemonic and implicit organizations and divisions of care work. By favoring dialogue and space to re-organize care labor, members of collaborative houses prefigure new forms of solidarity that can challenge structural discrimination in the private sphere.

This article is based on two qualitative fieldworks. The first is focused on housing cooperatives in North America and involves a multi-sited ethnography of housing cooperatives in different cities, over 50 interviews, and archival work on the rules and political writing of different communities. The second fieldwork is based on a participatory action research project in France on how to promote autonomy through solidarity and collaborative housing for aging populations. This project involved half a dozen researchers, over forty activists and community members, and explored the question of reinventing care in a dozen of collectives in France, Belgium, and the United Kingdom. While it entailed more direct involvement of co-researchers who are not professional researchers, this second fieldwork relied on similar methods to the first: ethnography, interviews, textual and archives analysis, and focus groups.

Drawing on both fieldworks, I emphasize how enacting different caregiving arrangements, by collectively reflecting on the implicit rules of caregiving, questioning them, and reinventing them, helped prefigure new configurations of care through different means. First, these collectives decentered informal care from single-person, family-centered caregiving. Second, since caregiving was included in a broader community of non-relatives, I show how it was possible to set boundaries, question gendered assumptions, re-dispatch extra work, and prefigure new forms of caregiving. Third, these collective houses became fertile ground for insourcing and re-evaluating care work inside the household, breaking zero-sum visions of autonomy versus dependency by promoting small-steps vision of caregiving. As a result, some aspects of caregiving stopped being outsourced to third parties and instead became reintegrated and re-articulated in collectives through reinvented and shared roles. This gave rise to practices of re-insourcing care—reintegrating household care practices that have been increasingly outsourced in the past decades in Western countries (Halinski, Duxbury, and Stevenson 2020; Hochschild 2012)—mutualizing care (e.g., one parent handling the snack time of multiple children), re-assessing care (e.g., young parents being relieved of some chores when they just gave birth to a new child), and caring for the caregiver(s). Through describing how housing collaboratives organize bottom-up challenges to current divisions of care labor, this article answers the call by Organization Studies "to consider carefully and imaginatively how to create alternative conditions, which meet the social, cultural and political complexity of a superdiverse world" (OS workshop call for paper, p. 3). I believe that this reflexive and collective questioning of the unspoken rules of care labor act as a form of "dialogic organizing," understood as a way to "interconnect diverse life-worlds, to affirm the generation of inclusive and playful spaces (Hjorth 2005) that come with "affective solidarity" (Hemmings 2012)" (OS workshop call for paper, p. 3).

Challenges and pitfalls of informal caregiving

Informal caregiving entails help provided by relatives, friends, or neighbors, can “include various tasks from helping with the household, to helping with dressing or bathing,” and is often associated with potential “high tolls to [primary caregivers] emotional and physical health” (Zwar, König, and Hajek 2020, 1; Camacho 2016, 691). Caregiving is multifaceted, involving “physical, cognitive, and emotional labor” (Randles 2021, 56). Scholars have compared forms of assistance with instrumental activities (e.g., transportation, household chores, meal preparation and delivery, cleaning the space) to assistance with personal care, such as using the bathroom, eating, and getting dressed (Sibalija et al. 2020, 771; Bertogg and Strauss 2020, 736). In this article, I propose to address together different forms of care labor, such as childcare, caring for a spouse or neighbor facing illness or disability, and caring for an aging person. While some of the underlying emotions are different (e.g., giving care to someone ill, suffering, or likely to pass away in the near future does not have the same emotional toll as caring for an infant in good health), these forms of care labor share commonalities, in particular a strong gendered division of labor and the global trend of increasingly being outsourced and commodified (Hochschild 2012; 2003a; Ehrenreich and Hochschild 2004; Hochschild 1989; Tronto 2013; Ungerson 1997). Feminist theories pointed to the invisible work involved in caregiving, such as “caregiver's mental and emotional responsibility for the care receiver” (Calasanti and Bowen 2006, 261). These various forms of caregiving also tend to compound, and scholars have described how taking into consideration care for elder parents would likely show how “the ‘second shift’ includes more ‘invisible’ work than has previously been suggested (Hochschild 1989)” (Grigoryeva 2017, 116). In this section, I review the literature on caregiving, to highlight different challenges currently explored in traditional caregiving configurations.

Sources of distress around informal caregiving

Because caregiving is often perceived as a labor of love, it obscures the potential challenges that being a caregiver can represent (England 2005; Finch and Groves 1983). Yet there are a significant number of challenges associated with caregiving, particularly when the primary caregiver is not supported through a broader network. Scholars have demonstrated how transitioning into caregiving for primary kin is often associated with an increase in depressive symptoms and psychological distress (Marks, Lambert, and Choi 2002, 657; Zwar, König, and Hajek 2020), and that these symptoms can outlast the caregiving role, even without bereavement or institutionalization (Uccheddu et al. 2019). Scholars have examined risk factors for "caregiver burden," such as "residing with the care recipients, financial stress and a lack of choice in being a caregiver" (Camacho 2016, 685). Caregivers can be exposed to primary (e.g., the cases of severe impairment) and secondary stressors (e.g., feeling captive) (Zwar, König, and Hajek 2020; Pearlin et al. 1990). Loneliness and isolation have detrimental effects on caregivers' health and well-being (Zwar, König, and Hajek 2020; Luo et al. 2012; Leigh-Hunt et al. 2017). Scholars have also highlighted the specific negative impacts of caregiving intensity (Liu and Lou 2019) and care recipients' "problem behavior and dependency" (Lin, Fee, and Wu 2012, 344).

Caregiving also often comes along with additional invisible domestic work. The boundaries between family caregiving and household labor can blur, especially when household members need informal care. When the person being cared for can no longer perform certain chores for the household, the spouse caregiver often must take on these new tasks and perform them as their own, adding to their workload (Calasanti and Bowen 2006). Scholars have described how "After retirement or other major life changes, couples might adjust the division of household tasks without reporting it explicitly as caregiving" (Bertogg and Strauss 2020, 736). Others have described the division of care for aging parents as paralleling known divisions of household labor (Henz 2010; Finley 1989). This additional work, on top of traditional household labor, also has consequences on the time available for employment, leisure, and contact outside the household. Scholars have studied how engagement in long-term, intense caregiving can prevent people from obtaining a job (Correll, Benard, and Paik 2007) or staying in a job, as caregiving duties can compel people to retire early (Dentinger and Clarkberg 2002). High-intensity care may make it necessary for adult children to drop out of the job market (Henz 2010). Employed caregivers faced with high demand for intense caregiving may therefore need to develop strategies to keep their employment, such as outsourcing care or sharing it with formal or informal sources of support (Bertogg and Strauss 2020, 739).

Family-centered and gendered norms around caregiving

Caregiving practices are also profoundly dependent on social norms (Craig and Mullan 2011), which dictate who should be engaged in caregiving, for what length of time, and to what degree of intensity. People often think first of informal caregiving as being the moral duty of direct family—spouse, parents, children (Marks, Lambert, and Choi 2002)—and these family-centered norms extend to blood lineage. For instance, scholars have studied how "care for the elderly tends to be distributed among blood kin" (Grigoryeva 2017, 118), leaving children-in-law with less care obligations. Research shows how "caregiving within the marital dyad today is still a popular and widely used option for dealing with declining health within a partnership" (Bertogg and Strauss 2020, 752). Researchers have noted that few scholars have focused on "non-kin, non-paid caregiving (e.g., Barker 2002) especially among older peers" (Glass 2009, 285), and previous research on gender and family labor has tended to focus on the primary caregiver only (Grigoryeva 2017), leaving aside broader networks of care. Yet recent research suggests examining these other care arrangements further, because solo-caregiving can have more deleterious consequences on caregivers' wellbeing and health (Wittenberg-Lyles et al. 2014). While caregiving can be done single-handedly by one caregiver, more people (relatives, neighbors, and home care services) can engage in sharing care-giving tasks (Bertogg and Strauss 2020, 736). Similarly, scholars have paid attention to copresence in childcare, defined as “caring for children together as a couple versus caring solo” (Craig and Mullan 2011, 838).

Scholars have demonstrated the significant role of gender in understanding the consequences of informal care (Zwar, König, and Hajek 2020), along with the role of health (Sibalija et al. 2020, 771; Liu and Lou 2019), class status (Bertogg and Strauss 2020; Randles 2021), and policy contexts (Hook 2006). Scholars have examined how the majority of people engaged in informal care are women (Zwar, König, and Hajek 2020; Pinquart and Sörensen 2006), who constitute “society’s main unpaid caregivers” (Oliker 2011, 968). The caregiving division of labor and gender inequality seems deeply intertwined (Oliker 2011) and gendered socialization plays a significant role in shaping how people adjust to the caregiver role (Bertogg and Strauss 2020; Russell 2007). Mothers tend to experience more stress and fatigue, and have less leisure time than fathers when engaged in caregiving (Hochschild 1989; Musick, Meier, and Flood 2016), seem overall more negatively affected by caregiving tasks, and face higher risk of lower-quality sleep (Burgard and Ailshire 2013). The division of family labor for giving care to aging parents also depends, not only on gender, but also the gender of siblings with whom caregiving is shared (Grigoryeva 2017). Scholars have described male caregivers as using a more “delegating or ‘managerial’ approach to organizing care” (Bertogg and Strauss 2020, 738), and noted that they are more likely to seek support when engaging in caregiving (Brown and Chen 2008; Feld et al. 2010) and to outsource care to professional workers (Gallo and Scrinzi 2016). They may also “resist some personal care tasks, such as bathing and dealing with incontinence, feeling that these should be performed by someone of the same sex” (Calasanti and Bowen 2006, 262). This gendered division of labor persists even when couples have egalitarian values, and often gets perpetuated without “efforts to reallocate labor or conflicts over who does what in their household” (Daminger 2020, 807). Scholars have explored how this gap between ideology and behaviors occurs through a de-gendering process, which assumes that the way in which chores are distributed is gender-neutral, and therefore glosses over the actual tradition division of labor (Daminger 2020). Others have studied how couples rationalize their unequal division of labor through a rhetoric of choice, which puts gender underground (Beagan et al. 2008). The impact of caregiving on employment is also gendered, and many scholars have pointed to the “motherhood penalty” on recruitment, earning, and career (Budig and Hodges 2014; England et al. 2016; Correll, Benard, and Paik 2007), while similar patterns have been shown for other forms of caregiving (Lee and Tang 2015). While there does seem to be some change in these patterns, especially when mothers contribute more to household earnings than fathers (Raley, Bianchi, and Wang 2012), these gendered inequalities remain blatant today.

Caregiving configurations and the mitigation of caregivers’ stressors

More nuance is necessary to understand the variations in the well-being of caregivers with regards to their gender, their role as primary or secondary caregiver, the significance of the caregiver burden, from occasional help to round-the-clock care (Zwar, König, and Hajek 2020; Brandt, Preisner, and Szydlik 2009), the frequency and length of caregiving over time, and whether other persons in the care recipient’s social network provide support (Marks, Lambert, and Choi 2002, 666). The voluntary dimension of care affects whether the experience is associated with positive or negative effects on a person’s well-being. For instance, one study showed how taking care of an in-law was often less difficult and more beneficial for a person’s development and well-being due to a lesser sense of “normative obligation,” and a greater voluntary dimension, which led the caregiving to be associated with “more autonomy, personal growth, purpose in life, and self-acceptance” (Marks, Lambert, and Choi 2002, 665). Similarly, whether an individual felt aligned with their caregiving role mattered in explaining their long-term wellbeing (Zwar, König, and Hajek 2020). Scholars have also pointed to the necessity for going beyond the "general stress model of caregiving" (Marks, Lambert, and Choi 2002, 665) initiated by Pearlin et al. (1990), and observed the potential positive impact of caregiving on caregivers' well-being, such as in the domains of "personal growth, purpose in life, autonomy, environmental mastery, positive relations with others, and self-acceptance" (Kramer 1997, 218).

The concept of "configurations of care" seems particularly relevant to understanding how structural changes can affect the experiences of caregivers (Lyon and Glucksmann 2008; Potter 2019; Raghuram 2012). Informal care is embedded within broader "configurations of care work," which enmesh formal and informal, paid and unpaid work, and is involved in processes of commodification, subsidy, and state provisions (Lyon and Glucksmann 2008, 101; Potter 2019). For instance, scholars have described how in Europe, professional providers tend to take over the "medically demanding and regular physical care," while family offers less demanding and more spontaneous types of help (Brandt, Preisner, and Szydlik 2009, 587). Yet resources to supplement informal caregiving depend on context and public policies (Hook 2006; Power and Bartlett 2019). Different care configurations have a different effect on the extent to which care recipients needs remain unmet (Potter 2019) and the risks associated with lower quality care (Wrigley and Dreby 2005), as well as the extent to which caregivers feel supported and comfortable in their role (Sibalija et al. 2020). In the context of systemic issues in care systems, caregivers can also take on important responsibilities without proper training and address pitfalls in care systems (Randles 2021), such as the lack of resources for providing care to patients who do not speak the countries' language (Camacho 2016).

In this article, I use this notion of configuration of care to explore the local, micro-level implications, studying how caregivers can be embedded in different housing arrangements, support systems, and how this may affect their experience. There are many environmental factors that seem able to mitigate, or even reverse, the negative emotional consequences of caregiving. For instance, feeling like one has received affection and support, and engaged in positive social interactions, can profoundly increase caregivers' wellbeing (Sibalija et al. 2020). Scholars have pointed out that social activities are a way for caregivers to receive feedback and cope with identity change during the transition into informal care, decreasing the potentially harmful perceived mismatch "between caregivers' actions and their own internalized beliefs about how they should be behaving" (Sibalija et al. 2020, 771). The role of network size, and its impact on loneliness and the social isolation of caregivers is a prime concern (Zwar, König, and Hajek 2020). Social support and frequent feedback from peers can "reinforce positive self-concepts and decrease vulnerability to depressive symptoms" (Sibalija et al. 2020, 771). Recent studies have called for an investigation of how "kinship influences levels of social support and social participation for caregivers" and to explore "the role the community environment plays in facilitating social participation for caregivers" (Sibalija et al. 2020, 772; Lin, Fee, and Wu 2012). They have also pointed to the necessity for respite care for primary caregivers, in order to give people involved in intensive informal care a break (Sibalija et al. 2020). Having a network able to support caregivers "in coping with the emotional impact of caregiving" is important in helping to alleviate depressive symptoms (Zwar, König, and Hajek 2020, 6). Additionally, while there are often community resources to support family caregivers, research has shown that community resources are often underutilized (Brown and Chen 2008), in part because caregivers themselves are not always aware of these resources (Adelman et al. 2014). Scholars have also encouraged that more research be done on the "negotiations—relational work—that are involved in reaching, sustaining, or alternating the division of caregiving responsibilities" (Grigoryeva 2017, 138). This study of relational work (Zelizer 2010) could reveal who is involved in the conversations on providing care, and what pre-existing roles and expectations play in this process of negotiation (Grigoryeva 2017; Gerstel 2000). Research requires further "investigation of multiple role relationship contexts of caregiving" (Marks, Lambert, and Choi 2002, 666). For instance, scholars have described how there are normative expected roles for adult-children to assist with instrumental activities such as transportation, but not necessarily with personal care, such as going to the bathroom (Sibalija et al. 2020).

While alternative configurations of care and negotiations of care work can occur in different settings, I will further explore how collaborative housing can provide an interesting space for altering and questioning configurations of care and ensuring better support for caregivers. This next section provides a brief overview of housing collaboratives, and the existing research on this topic.

Collaborative housing as a space for reinventing care configuration

Collaborative housing are often designed to foster mutual help and share common interests around "environmental sustainability, mutual provision of care for children, senior citizens, and other people with special needs and, in some cases, a redefinition of gender roles in the household" (Czischke and Huisman 2018, 158; Lang, Carriou, and Czischke 2020). Collaborative houses can develop to cater to specific social groups, such as elderly people (Czischke 2018, 56), intergenerational groups (Beck 2020), and refugees (Czischke and Huisman 2018). Scholars examined how supportive relationship could build up over time, reducing loneliness and fostering mutual support (Hudson et al. 2021). They also analyzed how such forms of housing are often more than the living arrangement available in the current housing market (Tummers 2015), but favor the development of new lifestyle that can be based on "equality and neighborly cooperation" (Vestbro and Horelli 2012, 315) or can be articulated around a feminist vision of the domestic sphere, the repartition of domestic labor, and women emancipation (Vestbro 1997; Vestbro and Horelli 2012; Jarvis 2013). These housing have also been increasingly considered as an promising alternative to address the loneliness and precariousness of ageing women (Labit 2015b), in a context of ageing population overall (Labit and Chaland 2010).

Scholars have studies multiple benefits of collaborative housing for ageing population, such as the development of mutual supports to limit loneliness, insecurity, or even boredom (Pedersen 2015; Scanlon and Arrigoitia 2015; Glass 2013), the capacity to decide for oneself (Choi 2004; Andresen and Runge 2002). Such environment could promote better health (Andresen and Runge 2002; Choi 2004), increase life satisfaction (Choi 2004), and postpone the need for nursing care (Leenhardt 2017). Relying on principles of interdependence (Glass 2013), they seem to be reducing also the cost of care for the elderly (Borgloh and Westerheide 2012), and address "the growing demand from older people for autonomy and positive housing choices in later life" (Scanlon and Arrigoitia 2015, 2). Some elderly collaborative housing arrangements emerged from the recognition that "not all caregiving answers are going to come from families and corporations" (Glass 2009, 287). Yet—with few exception on parenting and childcare (Jarvis 2013; 2011; 2017)—there is limited analysis of how caregivers are affected by collaborative houses, and how collective living changes their position in a specific configuration of care.

[to be continued : background, methods, findings, conclusion]

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