Becoming-care: reframing care work as flesh work not body work.

Abstract

This paper highlights the central role of the flesh within care relationships and how this disrupts and progresses existing understandings of care work. It is argued here that care work is a connected and fluid assemblage of diverse and changeable factors and that this relationship is best understood as a form of flesh work. Seeing care work in this way allows the care relationship between the person being cared for and the carer/s to be seen as a process of becoming; framed here as becoming-care. To illustrate this, two examples of a care relationship taken from a previous project are presented and discussed from a deleuzoguattarian standpoint. In this way, care work is assessed and theorised at the ontological level, resulting in the formulation of an alternative way of seeing care work that perhaps better reflects its reality – where the flesh is vital.

Key words: care work, flesh work, flesh, becoming, deleuzoguattarian

Introduction

Care work is defined variously but generally comprises childcare, care of people with disabilities and chronic illness, care of the elderly, and often domestic work and health care too (Huxley et al 2007). This paper focuses on care work in relation to the care of adults with learning disabilities, however, the examples used and the theorisation drawn from them can be extrapolated to other forms of care work. Understanding care work and care relationships, moreover, is of vital importance owing to the increasing number of people that this work affects (Schilling 2011). Care work is a growing sector, particularly in countries with an ageing population (Wolkowitz 2002). In the UK, adult social care has been estimated to contribute £41.8 billion per year to the British economy (Skills for care 2017). In addition to this the number of adult social care jobs has increased by 19% since 2009 and it is estimated that the paid adult care workforce is 1.58 million strong (Skills for care 2017). While care work is a growing sector, it is also a sector that has been subject to much criticism addressing issues such: as low wages (Stacey 2005), employment rights (Shute 2012), inequality of care based on class position (Adamson et al 2003), and the capacity for patient/dependant abuse by carers (Cambridge 1999). Such issues increase the need for a better understanding of this form of work.

Care work has been researched in a number of disciplines including: sociology (eg, Twigg 2000), feminism (eg, Betcher 2010, Harrington Meyer 2000), organisation studies (eg Hebson et al 2015), and disability studies (eg Walmsley 1993), to name a few. Within this work topics such as: carer and care receiver experience (Aubeeluck and Buchanan 2006, Stacey 2005); the organisation of care work (Isaksen 2002); emotional labour (Stayt 2008); and issues of equality, particularly gender and ethnicity (Timonen and Doyle 2010) are well acknowledged. The argument presented here, however, focuses on our ontological understanding of care work and addresses two overlapping and problematic commonalities found within the conceptualisation of care work in existing research; namely that care work tends to be positioned as a dualistic relationship between carer and dependant, and that care work is body work. In doing this a re-theorisation of care work is provided based on the ontological framework provided by Deleuze and Guattari (1984 and 1987) in their work *Capitalism and Schizophrenia*.

The first problematic commonality to be addressed is the tendency to position the care relationship as a dichotomy; the carer and the person receiving care are typically constructed as different and sometimes opposing bodies. When talking about the role of the body in health and social care work, Twigg et al (2011 p.174) explicitly split the bodies involved in a care relationship, stating: 'body work requires co-presence. Workers and the bodies they work upon must be in the same place'. This understanding of care relationships is also common in empirical research addressing care work. Some studies look at one 'body' or the other. Sheehan et al (2018) for example consider the experiences of family carers caring for a family member with challenging behaviour. Likewise, McDougall et al (2018) explore the care relationship from the perspective of young carers, while Aldridge and Becker (1994) explore the same relationship from the perspective of the parent being cared for. While many studies consider the experiences of both carers and dependants (Gustafsson and Bootle 2013, Williams and Robinson 2002), the distinction between the two is generally implicit if not explicit. Williams and Robinson (2001) found this distinction to be mirrored in the talk of the majority of their participants with learning disabilities and their family carers in that their participants tended to construct themselves in terms of supportive (carer) and dependant (person being cared for) roles. Indeed, the co-presence of differing bodies working and existing together but as separate physical entities in a care relationship, comprises a generally accepted way of seeing care work.

The second problematic issue addressed here, and linked to the first issue, is the framing of care work as body work, in that it involves the work of bodies on other bodies (Twigg et al 2011 and Twigg 2000). While body work can include various professions and types of labour, Wolkowitz (2002 p.497) tells us that, common to all of these performances, body work 'takes the body as its immediate site of labour'. Similarly for Twigg et al (2011 p.171) body work is 'work that focuses directly on the bodies of others: assessing, diagnosing, handling, treating, manipulating and monitoring bodies that thus become the object of the worker's labour'.. Probing deeper into this sector of work, Wolkowitz (2002) outlines three dimensions of body work: definitions of the body, divisions of labour and workplace interactions. For Wolkowitz, commonly held definitions of the body impact on care workers' relationship to the bodies they care for. She also identifies a hierarchy within care work and suggests that understandings of the body vary throughout this hierarchy with those occupying higher status roles interacting with whole or bounded bodies, such as medical professionals and those in lower status roles interacting with less desirable bodies and the fluids that can spill out of them, such as residential care home workers. Regardless of status however, Wolkowitz's body work involves bodies interacting with each other in the act of work.

At first, semantically and practically, body work seems a logical description of care work; the body of the person being cared for is cared for by the body of the carer/s whether this be taking someone to the cinema or assisting them with self-care. In this way, care work could plausibly be framed as body work. Still, and while the care relationship does of course include the carer and the person being cared for, and indeed sometimes they are separate or together in proximity, it is argued here that this relationship includes more than these essential components and also that no one factor in the multitude of factors that comprise care work should be prioritised as the body has been in previous conceptualisations.

Rather, it is argued that care work is better understood as a fluid and changeable relationship between a multiplicitous, and equally changeable, range of factors. These factors could include: objects such as equipment and sentimental items; emotions; environmental factors such as living accommodation, community centres, recreational facilities and outdoor spaces; cultural factors such as religious beliefs and traditions; bodies and the flesh of the carer and person being cared for as well as others such as family members, pets and friends; social factors such as the role of family, friends and pets; individual and shared norms and values; political and economic factors such as the wider political economy and access to benefits; and many other factors independent of different care relationships. The point to be made is that care relationships involve more than a dichotomy between two different bodies performing specific roles such as carer and dependant.

In this paper the care relationship is therefore positioned as an assemblage of fluid elements that are constantly in flux. While different bodies are of course part of this relationship, it is argued here that they are not central to it, rather the factors that the care relationship is composed of exist in a connected relationship with each other whereby no one factor is central. In order reformulate care work as flesh work, the problematisation of care work as body work is first discussed. This is then followed by the introduction of the flesh and the alternative ontology that this presents. It is here that the paper draws on the philosophical work of Deleuze and Guattari to reframe care work as flesh work.

What is a body/ what can a body do?

If care work is body work then we must first ask, what is a body or more crucially what can a body do? In asking this, however, a number of problems arise if care work is to be framed primarily as body work. Since the popularisation of postmodernism and post-structuralism, the body has received increasing sociological attention (Schilling 2012). Within the social sciences bodies have been positioned as various things: experiencing sentient body subjects, as in the phenomenological body (Merleau-Ponty 1964); pre-social material objects, as in the medical model of health predicated upon Descartes' cogito (Turner 2008); inscribed by power and discourse, as in the poststructuralist approach to the body (Butler 1993, Foucault 1989); and culturally constructed according to normalising standards that are organised patriarchally, as in feminist approaches to the body (Wendell 1996). There are, moreover, numerous ways in which to define a body or in which to approach social issues from the perspective of a body. Central to conceptions of the body, however, is the issue that, as Betcher (2010 p.108) highlights, 'the' body or 'a' body invokes an image of wholeness that can easily be formulated into the 'the logic of the one'. Indeed, Barad (2002 p.812) shows that while feminist, poststructuralism, and queer approaches to the body have sought to disentangle the body from the logic of the one, such approaches have failed to explain how bodies are produced, or essentially how matter matters.

The dominance of the mind/body dualism and the representationalism it is predicated upon perhaps goes some way towards explaining the dualistic approach to the bodies involved in care relationships found within much care work research. Descartes' *Cogito* (1640) separates the self from the body and is predicated on the acceptance that bodies exist before their representation discursively or culturally. For Descartes, the body functions mechanistically, independent of the self which is located in the mind or the soul. In this way the body is presented as a material object of secondary importance to the mind and knowledge is constructed as a reaction of the self to pre-existing external objects, including bodies (Edwards 1998). The mind/body dualism is found within both essentialist and social constructionist approaches to the body (Hughes and Paterson 1997) and has become a hegemonic part of Western thinking: accepted tacitly and uncritically (Barad 2002).

Framed as a whole, or as a thing or an essence, the bodies within care work, positioned as body work, are easily constructed as separate from each other despite the close relationship and co-presence that care requires. A further problem, if the body is constructed in such a way that it is amenable to the logic of the one, is the normalisation of the body as a whole functioning thing that can result. While feminist, phenomenological and poststructuralist approaches to the body refute the normalisation of the body, such approaches and social theories are often written with an implicit focus on the able, particularly the able minded (Shakespeare 2014, Wendell 1996). Carlson (2011) terms this cognitive ableism. Cognitive ableism is a product of accepted and unconscious ways of understanding the body (primarily as able bodied and able minded), characterised by the privilege of cognitive ability over all other characteristics.

If applied to people with significant learning disabilities, for example, the phenomenological approach as an ontology is feasible. As something informing research practice, however, it runs into problems based on its implicit cognitive ableism (Edwards 1998, and Morgan 2008). For people with learning disabilities, the phenomenological language of perception and interpretation as ways of representing lived experiences as conceived of by able minded researchers is often not suitable (Morgan 2008). While people with learning disabilities are undoubtedly ‘experiencing’ bodies, just as those without learning disabilities are, access to the experiences of some people with learning disabilities is necessarily limited to the observations and interpretations of others. While this is not problematic morally (Cluley 2017), it does pose a challenge to the empirical application of a phenomenological approach. For those people with learning disabilities who cannot cognitively (verbally or otherwise) provide detail of their lived experience the premise of phenomenology is rendered cognitively exclusive. The point to be made is that bodies are heterogeneous and intersectional and that mind/body dualism is difficult to avoid if bodies are formulated in terms of the logic of the one, whether implicitly or explicitly (Barad 2002).

Although splitting the care relationship into a dichotomy of bodies is the norm, some researchers have highlighted the challenges this presents. Walmsley (1993 p.139), for example, presents the case that such an approach is in fact what she refers to as a ‘false dichotomy between care and dependence’ that obscures the commonalities between the person being cared for and the carer. Similarly, it is argued here that while research into care work is needed in that it serves to raise awareness about care work and the issues important to it, the typical construction of the care relationship in terms of body work that involves a relationship between dual, differing bodies does not adequately reflect the reality of this relationship.

In order to transcend the dominance of the mind/body dualism, Buchanan (1997) proposes that we should no longer ask what the body is but rather should focus on asking what a body can do. For Buchanan (1997), asking what a body can do opens the body to be seen as a fluid entity capable of change. In order to reveal the fleshiness of the body, and moreover care work itself, this paper also asks the question 'what can a body do?' and applies it to the bodies involved in the care relationship; viewing bodies in the deleuzoguattarian sensef, ie, without organs, in order to reframe care work ontologically. The argument presented here goes one step further than Walmsley's (1993) false dichotomy, in that it is argued that the care relationship involves more than commonalities; that it is an interconnected becoming and that this becoming can be understood through an appreciation of the flesh.

The fleshy body

While care work undoubtedly involves bodies, as outlined above, it also involves more than bodies; it fundamentally involves the flesh. Thought about in terms of its physical presence, flesh is everywhere and always present in a care relationship. Flesh is touched, hit, wiped, washed, moved, caressed and more. The flesh as a flexible, tangible and relational thing presents a way of seeing the fluidity and connectedness of life (Betcher 2010). Indeed, the flesh offers an alternative to the body that allows an escape from mind/body dualism and the and the problems it presents for understanding the care relationship.

The flesh/the fleshy body represents an alternative to body within the mind/body dualism. Shildrick (2018 p.167) tells us that the flesh and blood are 'not a passive surface, but the site of sensation, desire and experience which are in continuous interaction with discursive practices' For Shildrick an ontology of the flesh goes beyond the body and its connection to other bodies, incorporating myriad other elements that come together as embodiment. Similarly, for Betcher (2010 p.108) the flesh represents 'the dynamic and fluid physics of embodiment' and 'suggests that the capriciousness of life resembles a teacup cracked with ten thousand veins'. Thought about as Betcher advocates, flesh becomes omnipresent within care work. Common to these conceptualisations is the idea that the flesh problematizes hegemonic understandings of what a body is, allowing the body to be conceptualised as leaky, fluid and inter-relational (Shildrick 1997). The fleshy body seen through a deleuzoguattarian lens provides an alternative through which care work can be conceptualised.

As stated, the argument made in this paper is informed by the collective work of Deleuze and Guattari, specifically their two volume work, *Capitalism and Schizophrenia*. In *Capitalism and Schizophrenia* Deleuze and Guattari propose an alternative ontology based on the rejection of dualism in favour of multiplicity; their thought processes being influenced by thinkers such as Hume, Spinoza and Bergson. Divided into the two volumes, *Anti-Oedipus* (1984) and *A Thousand Plateaus* (1987), *Capitalism and Schizophrenia* aims to transcend the dominance of a logic predicated on essence by providing an on ontology based on fluidity, productivity and change (Fox 2002). In this way bodies are positioned not in terms of dualistic entities but in terms of functioning, creative machines that exist in a complex, intertwined and changing relationship with myriad other, changing elements.

In *Anti-Oedipus* (Deleuze and Guattari 1984) bodies are formulated as productive and desiring rather than lacking, as having the potential to resist the forces of capitalism. Owing to this potentiality, as Fox (2002 p.350) states 'it is possible for humans to be creative rather than reactive, to meet their (real) needs'. While this resistance is framed by Deleuze and Guattariin terms of capitalism, their conceptualisation of the body as a productive force is useful when considering care relationships. They conceptualise the body as without organs (the BwO), or in other words, without physicality or prior organisation. In this way the surface of the BwO is simultaneously 'smooth, slippery, opaque, taut' (Deleuze and Guattari 1984 p.10). The BwO is a consequence of multiple connections with other things. In this way it can become a body with organs, in that the dominance of medicalised discourse organises it to be such (Fox 2002). Deleuze and Guattari (1987 p.257) tell us:

> 'we know nothing about a body until we know what it can do, in other words, what its affects are, how they can or cannot enter into composition with other affects, with the effects of another body, either to destroy that body or to be destroyed by it, either to exchange actions and passions with it or to join with it in composing a more powerful body'.

It is this conceptualisation that prompted Buchanan (1997) to urge that we ask what a body can do rather than what a body is. In asking this, the idea that the care work is body work is problematized.

In *A Thousand Plateaus* Deleuze and Guattari (1987) outline a way of interpreting the world that runs counter to dichotomous and objective thought. The ontology developed is predicated on the idea that there is no one thing. Everything is multiple, everything is connected to other multiplicitous things, and everything is changeable. When seeking to understand ‘things’ they do not ask what a thing is but what a thing can do, what it connects with, how it is inserted into other multiplicities and how it is then changed. This echoes Buchanan’s (1997) question, what can a body do?

Deleuze and Guattari (1987) draw on nature, specifically rhizomatic growth, to show how phenomena - objects, experiences and bodies - exist as multiplicities that are connected to each other in a fluid relationship. They differentiate between the tree and the rhizome (think weeds, potatoes and orchids) in order to show how their thought process differs from normative, structural (tree like) ways of seeing the world. A tree is an example of hierarchical, structural approaches that dominate Western thought (Goodley 2007). Trees have points and positions within their structures, and tree like thinking organises social life in terms of dualisms (Goodley 2007). As already highlighted, the mind/body dualism is an example of tree like thought. Rhizomes by contrast are made up of connected nodes. Rhizomes start in the middle without a beginning or an end, they connect to other things, other rhizomes, and they progress in the face of change (Deleuze and Guattari 1987). When broken or fractured rhizomes are able to reconnect and pursue an alternative direction of growth. If you have ever grown Jerusalem artichokes, they are a great example of rhizomatic growth. No matter how well you think you have removed the plant and tubers after harvest, the next year you will almost certainly have Jerusalem artichokes growing again and likely in a different location to the previous year. It is important to note that this growth is not a case of the one becoming two. As Deleuze and Guattari (1987 p.23) state, ‘the rhizome is reducible neither to the One nor the multiple. It is not the one that becomes two or even directly 3, 4, 5 etc’.

Rhizomatic thinking, moreover, is non-dualistic, non-hierarchical, and multidirectional (Goodley 2007). Rhizomes progress in ‘asymmetrical, instantaneous, zig-zag movements’ (Deleuze and Guattari 1987, 291). Applied to the understanding of things, they do not exist because of an opposite and things are never things on their own. All things are connected in an assemblage of elements that in turn are linked and unlinked as things progress to other assemblages in a state of becoming. Deleuze and Guattari (1987 p.27) urge us ‘don’t be one or multiple be multiplicities’ and ‘make rhizomes not roots, never plant!’. The focus of such an approach is not being but becoming, for being pertains to the logic of the one and becoming pertains to the multiple.

The rhizomatic assemblage of the flesh comprises lines of segmentarity and lines of deterritorialisation or flight upon which the thing both assembles itself and reassembles itself in a constant state of becoming. Becoming is neither a flat nor a vertical ontology, rather it is a bumpy ontology without direction or destination. Thus, becoming is not a linear process with a beginning or an end, nor is there a teleological destination; rather it is rhizomatic in nature, it happens between things, it is a state of being in-between, and it produces only itself (Goodley 2007). As Youngblood (2007) states, the movement of becoming ‘creates something unique and particular within that would render the entire category imperceptible’. A becoming, moreover, is not an imitation of something else, nor is it a reciprocal relationship between things. For Deleuze and Guattari (1987) becoming is an involutionary process as opposed to an evolutionary process. Involution, they tell us, is creative rather than regressive or progressive. As they state, ‘becoming is a verb with a consistency all its own; it does not reduce to, or lead back to, appearing, being, equalling or reducing’ (1987 p.263).

A becoming is characterised by acts of territorialisation, deterritorialisation and reterritorialisation. By this Deleuze and Guattari are referring to the constant state of change that assemblages and bodies are subject to (Fox 2002). Assemblages can be deterritorialised meaning that they are capable of change according to their elements, their internal interaction and their interaction with other assemblages. Deleuze and Guattari (1987) outline three potential becomings, becoming- woman, becoming-child, and becoming- animal. Importantly there is no becoming man, because in a patriarchal society, 'man is majoritarian par excellence whereas becoming is minoritarian' (1987 p.320). For Deleuze and Guattari, the language of minority and majority pertains to status/power and is linked to the process of deterritorialisation. Being minoritarian, moreover, refers to a lack of power. Importantly, minoritarian status is not static, it can and likely will change through processes of deterritorialisation and becoming. The minoritarian 'thing' has the potential to become majoritarian.

Deleuze and Guattari (1987) use another example taken from nature to illustrate the process of becoming; the relationship between the wasp and the orchid. For reasons of procreation, the orchid's petals resemble a female wasp so that a male is attracted to the orchid and pollinates it so that the wasp and the orchid connect in a process of becoming, becoming-wasp and becoming-orchid. In a becoming, moreover, there are generally two displacements as with the wasp and the orchid, each brings about a change in the other, or as Deleuze and Guattari (1987 p.11) state 'each of these becomings brings about the deterritorialisation of one term and the reterritorisalisation of the other; the two becomings interlink and form relays in a circulation of intensities pushing the deterritorialisation ever further'. This double becoming, however, does not unite the two things, the orchid and the wasp for example, rather it 'passes between them, carrying them away in a shared proximity in which the discernibility of points disappears' (Deleuze and Guattari 1987 p.323). The two points of becoming/deterritorialisation, moreover, do not swap places. The wasp does not transform into an orchid and vice versa.

The positioning of bodies as separate but close things in the care relationship is an example of tree like thinking bound up in more tree like thinking in the form of the ever dominant mind/body dualism. It is this dominance that the argument presented here hopes to escape through a rhizomatic approach to understanding care work. For Deleuze and Guattari (1987), bodies are rhizomatic assemblages of fluid and heterogeneous multiplicities. In Western thought, the body, they argue, is organised structurally in terms of an organism composed of functioning organs (Thanem 2004). This organisation renders the body amenable to dichotomous thought such as rational/irrational, mind/body, able/disabled. If thought about in rhizomatic terms, however, the problems of dichotomous thought that the body encounters are overcome, in that the body is no longer a single thing, it is no longer a structural construct, rather it is a fluid and connected entity, it is without organs. Tree like thinking has been replaced by multiplicitous and fluid thinking. Positioning the body in this way allows bodies to be seen as part of each other, as existing fluidly together and with other things rather than separately but close.

It is here that Betcher's (2010) understanding of the flesh as 'the dynamic and fluid physics of embodiment' links nicely. Betcher's tea cup with many veins as a metaphor for the capriciousness of life/the flesh acts in the same way as a rhizome does, starting in the middle with no beginning, end or destination. In the same way a crack in a tea cup can follow different trajectories and link to other cracks, the flesh can be conceptualised as a fluid thing that can relate to other things in mutliplicitous ways and can facilitate infinite becomings, taking shape and direction based on its heterogeneous relationships. For Deleuze and Guattari (1987), approaching the body and, indeed, all things in this way allows the complexity and interconnectedness of things to be exposed and explored. In this way, body work can be seen to be an example of tree like thought where bodies are essentially organisms subject to the normalising discourse of the one. To illustrate, we use the term body work also to refer to a particular type of car maintenance and repair. It conjures an image of mechanistic processes, with a beginning and an end and an agent working on another agent. Flesh on the other hand is malleable, it is tangible and stretchy. In this way flesh is rhizomatic. To refer to care work and the care relationships involved as flesh work, moreover, allows a more open and accepting way of seeing care that highlights the various elements involved, their fluidity and their connected relationship. Flesh work opens the care relationship to be seen as a becoming.

Deleuze and Guattari (1987 p.323) tell us that 'a becoming is neither one nor two, nor the relation of the two; it is the in-between, the border or line of flight, or descent running perpendicular to both'. In this way becoming can be seen as a continuous process of change that does not imitate, replicate or indeed end. Understanding the interaction of bodies and the flesh in the care relationship as a becoming provides an alternative way of seeing care work. Viewed as a form of flesh work the care relationship is freed from its dualistic ties. The flesh allows the connectedness and fluidity of the care relationship to be exposed. If we are to transcend the body in this way in order to better understand care work, however, we must ask further ontological questions such as what can the flesh do?; how does it function in connection with other things?; and how does it change when it connects with other things? These questions are addressed using the examples provided below.

Real life care relationships.

The examples provided here aim to show the intricacies and diverse elements intrinsic to care relationships. They are anonymised realities taken from an empirical study, 'What does learning disability mean in the real world?'. This study used a combination of focus groups and photovoice to explore how different professional and lay groups make sense of and use the term 'learning disability'. The examples used here are taken from the photovoice findings. Photovoice is a participatory action research method that developed first in health promotion research (Wang and Burris 1997). The method involves including participants as co-researchers who take photographs of a negotiated subject matter, in this case everyday life. The photographs are then used to facilitate talk (usually group talk) about their content. Written and proxy consent was obtained for all participants. The study was granted ethical approval by the University of Nottingham and took place in England. Owing to this, the examples provided show the lives of people with learning disabilities accessing an English system of care. In England, unless the needs of a person with learning disabilities are considered to be predominantly medical, the local authority (a public organisation responsible for the commissioning and delivery of public services within a specified geographical boundary) provides social care based on their needs. This can range from nothing to the provision of 24/7 care in a purpose built care facility. It is also important to note that the term ‘learning disability’ is UK specific, in that it refers to people who internationally are considered to have intellectual disabilities (Cluley 2018).

Judy

Judy is 50 and has a learning disability with some support needs. She can do some things independently, such as going to the toilet, getting dressed, washing and making a simple meal such as a sandwich. However, Judy does not have the capacity to perform more involved tasks that an adult without learning disabilities might take for granted, such as: managing a budget; engaging in full time, unsupported employment; driving a car; and using public transport. She also has epilepsy and so wears a soft helmet to reduce the likelihood of injury during a seizure. Judy’s speech is very loud and often unclear. She has anxiety and also some sensory processing issues, meaning that she struggles to process sensory information. In Judy’s case, she starts to feel anxious in crowded and loud environments. This makes it hard for her to go out without a support worker or family member. Judy lives in supported living accommodation with other people with learning disabilities. This means that she has her own living spare but shares a kitchen. Judy’s accommodation is warden controlled, meaning that there is an accommodation manager who is facilitated by support workers. Her care and accommodation is paid for by the local authority and is delivered by a commissioned private provider. Judy’s carers support her to do everyday activities, such as attending interest groups, exercising, shopping, and cooking. Her carers also help her to wear her soft helmet correctly, help her to take her medication and act as interpreters when other people cannot understand what she is saying. Judy is visited every week by her sister and regularly has sleep overs at her sister's house. Judy enjoys going for walks with her sister and her dog.

James

James is 23, he was born with a profound learning disability and significant care needs. His care workers described James as 'having a lot of autism'. James cannot communicate verbally, cannot walk (although he can crawl) and he struggles to process sensory information which his carers said often results in challenging behaviour. Sometimes he hits out and sometimes he makes loud noises that are perceived as frustration. James lives in a group home where he receives 24/7 care provided by a team of care workers. Like Judy's care and accommodation, James' group home and the care provided here is paid for by the local authority and is delivered by a commissioned provider. While Judy is able to have more control over her self-care and day to day activities, James requires full support. James' carers use a hoist to get him in and out of bed and sometimes to help him into and out of his wheelchair. They also push his wheelchair to move him from place to place because James cannot do this for himself. They feed him, give him drinks, wash him and change him, put him to bed and get him out of bed, they administer medication, they brush his teeth and his hair, and they shave him. James has a keyworker who he is most familiar with, however, he also has different and multiple carers at different times of the day and week. James does not see his family very often because they live far away from the group home. While he has his own bedroom this is also a shared space in that he can only access it and use it with the help of carers. James' carers organise activities for him, he attends a weekly trampolining class and is taken on day trips and shopping excursions.

The care relationship in each of the examples provided involves a close relationship between the person being cared for and the carer/s in which their bodies and their flesh interact and connect in numerous ways. As well as the flesh and bodies of those involved (carer, person being cared for, family members, other residents, Judy's sister's dog) and their wider life experiences as inscribed upon and embodied within them, the care relationships depicted also include a wide variety of diverse and changeable elements such as: buildings and living environments; shared spaces; equipment such as wheelchairs, hoists and helmets; the political economy in terms of access to care provision; social norms in terms of social acceptance and stigma; cultural factors again pertaining to acceptance and care provided; gender issues; objects such as personal care items and equipment; transport facilities; and community support provision.

If thought about in terms of Deleuze and Guattari's logic of assemblage, all of these elements and more can be seen to exist in a fluid assemblage that is connected to other assemblages, such as the assemblage that comprises the organisation of social care and the assemblage that represents the political economy. The content of the assemblage of the care provided in each of the examples differs for James and for Judy. The process, however, is the same. Both examples viewed as rhizomatic assemblages will change over time as different elements enter and exit the assemblage as and when needs and circumstances change. The rhizomatic assemblage, however, will continue to exist, linking to other assemblages, travelling down lines of flight as things change and instigating becomings.

Becoming-care

In order to view care work rhizomatically as flesh work, the initial questions of the role of the flesh in this relationship and what can the flesh do are revisited. As seen in the two examples, flesh is key to James and Judy's care relationships. Not only is their flesh physically present, in that it is touched, moved, fed, wiped, washed and so on by the flesh of others, their flesh is connected metaphysically to the flesh of their care workers and others in their care relationship in a process of becoming. As already outlined, for Deleuze and Guattari (1987) the body is not a set of functions bounded by the categorisation organism. The body is more than this; it is creative and productive, it has affects, is multiplicitous and links to and affects other multiplicities (Buchanan 1997). If thought about in terms of an assemblage, the flesh can be seen as a multiplicitous and connected thing that is composed of diverse and changeable elements. As such the flesh is an element in the assemblage that is the care relationship but the flesh itself can also be seen as an assemblage that is plugged into other assemblages such as the care relationship as and when needed.

The example of James attending a regular trampolining class, seen in figure 1, can be used to exemplify what is termed here, becoming-care.

'Figure 1 about here'

Figure 1. A photograph of James at his trampolining class.

The photograph was taken by his key worker because James enjoys the class. This is significant because the remit of the photovoice project was to photograph instances of everyday life. The trampolining class is a regular occurrence in James' life. In the photograph we can see James at the forefront. The trampoline and hoist can be seen behind James, as can a screen decorated in paint hand prints which shields a change station. James is strapped into his wheelchair and has been positioned for the photograph by his keyworker who is supporting James to take part in the research project. In just one image, many of the elements of James' care relationship can be seen; James himself, his wheelchair, the hoist needed to allow him access to and egress from the trampoline, the screened change station should James' incontinence wear need changing, the wheelchair of another resident who James attends the class with, the trampoline that he enjoys using and the photograph itself, taken by his keyworker.

Without this assemblage of elements, James could not attend the trampolining session and his keyworker would have a different work experience. It is in the coming together of these elements, the fluid connections between them, and their changeable nature that we can see becoming-care. It is not a case of one body working on another body, for becoming-care involves more than bodies and more than this transcends the body in acknowledging the flesh as a porous, connected and flexible substance. Within becoming-care the flesh is essential, although it is not prioritised. The connections between it and the other elements involved in this element of James' care is the priority. In this way, becoming-care is not a physical coming together of the flesh of two bodies, such as when James is manoeuvred out of his wheelchair into the hoist and his flesh and the care worker's flesh come into contact. Rather it is the imperceptible intersection of all of the elements involved with the flesh in the becoming-care relationship.

In the examples provided, if care work is thought about as flesh work, the flesh involved in the care relationships can be seen to be both productive and connected. For both Judy and James, the flesh of their carers and all that this entails and brings to the relationship is fundamental to their survival. When discussing anorexic bodies, Buchanan (1997) identified that food is necessary for the survival of a body and therefore must be considered to be part of the composition of a body, rather than an external factor as would be the case if the body was framed in terms of a bounded organism. In the same way, the flesh of others and all that this entails, i.e. the diverse elements that are part of its assemblage, is necessary for the survival of some people with significant care needs, as in the examples of Judy and James. Crudely put, without someone to get James a drink, to feed him and to wash and change him, James could not survive, his life would end. The same is true of Judy, who without the care of others would not manage and would likely not survive for long. Judy needs other people who are cognitively able to care for her and support her to access shelter and the means to procure food: without this Judy would struggle to live. In the same way that Buchanan (1997) identifies that food cannot be thought of as external to the body, nor can the role of the carer in the lives of many people with learning disabilities.

Conversely, the bodies and the flesh of those needing care provide a livelihood for the care workers that in turn impacts upon their wider life experiences and also serves to impact upon societal acceptance, or not as the case may be, of people with care needs. When talking to people with learning disabilities about the care they receive from family members, Walmsley (1996) found that the relationship between people with learning disabilities and their parents tends to be one of interdependency where both the parent and the person with learning disabilities care for each other in different ways. Williams and Robinson (2001) also report instances of mutual care between people with learning disabilities and their family members. One of their parent participants needed help getting out of the bath, this help was provided by her adult children with learning disabilities. Indeed, when Judy's sister spoke about Judy's sleepovers, there were no instances when she spoke about them in terms of a burden or Judy as a dependant. While of course there must have been challenges and times of frustration as there is in any human relationship, Judy's sister focused on the joy of having Judy to stay and the fun times they shared, indicating that Judy's visits were just as beneficial for her as they were for Judy. This acknowledgement of co-dependence rather than co-existence further contributes to the conceptualisation of care work as an interlinked/intersectional assemblage.

As a becoming, care work and care relationships are productive. They are capable of change and resistance. Lines of flight can access and exit the assemblage resulting in deterritorialisation or change. Becoming-care, moreover, is not static - it is always changing. As Fox (2002 p.354) tells us, 'people are the continual subjects of deterritorialisation and reterritorialisation as their BwOs are inscribed by the forces of the social'. In this way the bodies of the carer and the person being cared for are organised via social and cultural values, explaining the dominance of the tendency to construct care work as body work. The flesh, however, can provide a vantage point from which to view the everyday aspects of the care relationship and the connections and becomings this facilitates. Viewed as a rhizomatic assemblage, the assemblage of the flesh is plugged into the assemblage of the care relationship and vice versa. Within the care relationship, all of the elements involved act in connection with each other to produce a becoming among those involved. In the same way that the wasp and the orchid intersect, the line of becoming passes through the carer and the person being cared for. The molar (generally accepted) identities of the carer and the dependant as separate and physical bodies divided by a mind/body split are disrupted and deterritorialised. These two becomings are part of becoming-care.

Becoming-care is inclusive of becoming-carer and becoming-dependant in order to create an in-between. It is important to note, however, that rather than becoming each other or imitating each other, the line of becoming comes up through the middle of the care relationship. Rather than uniting the carer and the person being cared for in a co-dependant existence then, as Deleuze and Guattari (1987 p.323) state, the line of becoming acts by 'sweeping up the two distant or contiguous points, carrying one into the proximity of the other'. When talking about becoming-animal, Deleuze and Guattari (1987 p.302) stress that in this becoming, man does not transform into an animal, man becomes animal only when the particles of the molecule that is man enter what they term 'the zone of proximity' of the animal molecule. In the same way, becoming-care involves the flesh of the carer and the flesh of the person being cared for entering a zone of proximity among myriad other elements. The deterritorialisation that takes place does not involve the carer and the person being cared for changing places, James and his keyworker do not reverse roles, instead what is created, becoming-care, is indiscernible, or as Deleuze and Guattari (1987) frame it, imperceptible. Becoming-care, moreover, is not the united relationship between carer and the person being cared for, rather it is more than this, it is beyond this, it is the something in-between. It is the in-folding or holistic wholeness of the assemblage of the care relationship. Importantly, it is not a static or one size fits all relationship. It is fluid, heterogeneous and multiplicitous.

Conclusion

In positioning the practical examples of the care relationships provided as instances of flesh work and viewing this through a deleuzoguattarian lens, an alternative way of seeing care work has been formulated whereby care work is no longer framed in terms of dualisms or interdependencies, rather it is positioned as more than this, as a becoming. The molecules of the bodies and the flesh of those involved in the care relationship enter into each other's zone of proximity and form something that is imperceptible, something that is in-between, becoming-care. As argued, this becoming is not an imitation of something that previously existed, it is a new and changeable something that serves to highlight the connectedness of the flesh of those involved.

Viewing care work as flesh work, moreover, allows the intricacies and connectedness of care relationships that tend to be glossed over by approaches that frame the care relationship in terms of a dichotomy involving carers and dependants to be seen. Positioning flesh work as a rhizomatic assemblage allows the objects, environments, bodies, spaces and so on that are fundamental to Judy and James' care relationships to be accounted for without prioritisation and without pertaining to essence. Change can also be accommodated, in that the assemblage will adapt and progress as and when circumstances change. Viewing care work in this way, I argue, presents a better reflection of the reality of care relationships, in that the complexity and heterogeneity of these relationships are freed from the ties of dichotomous or tree like thinking.

It is not the case that viewing care work as flesh work requires a practical change in care relationships. Rather it is a basis for viewing this practical and, at surface level, tangible relationship more closely, in order to expose its porous connections, fluidity and potential for creativity and resistance. In other words, it better reflects the reality of care work as a diverse and changeable assemblage of heterogeneous factors. Becoming-care allows the molecular dimensions of the molar understanding of care work to be seen resulting in the problematisation of such dominant understandings of the body and care work as body work.

While the examples given in this paper are based on learning disability care work, becoming-care could be extrapolated to cover other forms of care work, in that becoming-care is based on the conceptualisation of care work as flesh work. Becoming-care could also be used in further research to explore how things happen or don’t happen in care work relationships and why this is.

In positioning care work as flesh work, this argument progresses care work research in that it moves away from the traditional confines of existing research that tend to frame care work dichotomously and/or as body work. Flesh work allows the transcendence of the body and the dualisms that are so easily applied to it. It allows the complexity and connectedness of the care relationship to be seen. As Buchanan (1997 p.86) states when referring to the body 'if we are to avoid falling back into the habit of saying what a body is, and are to nurture our new found practice of saying what it is becoming, then we must think in terms of what it can do'. As such, further research into care work should ask the same of the flesh, positioning care work as flesh work rather than body work.

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