

THE AMBIVALENCE OF INTERGENERATIONAL RELATIONS THROUGH THE PRISM OF BODY WORK

Abstract. This article deals with the psychological ambivalence in intergenerational relations within the context of the care for the elderly. It starts with a brief presentation of a few key concepts that appear in the studies of family intergenerational relations (solidarity, conflict, ambivalence). Through the overview of several analysis that have studied family intergenerational relations it confirms the existence of the ambivalence experienced by the adult children and/or their ageing parents within their relations. Based on the conclusions gained in the research the text exposes the gendered nature of caring for the elderly 'at home' and the caregiver's stress or ambivalent feelings. In the continuation it focuses on the social and emotional complexity in intimate intergenerational caring in family life and exposes the fact that adult children remain important or even the most important providers of all forms of care for their ageing and frail parents. At the end the paper focuses on the specific tasks of care giving that carers may find aversive, disgusting or frightening and which may evoke mixed emotions and ambivalent experience from the 'child carers'.

Keywords: intergenerational ambivalence, care work, body work, gender

Introduction

Family ties are amongst the most important close relations of each individual. A number of researches have shown that they are a strong source of social support and that they importantly contribute towards the psychological well being throughout the entire life-cycle of an individual (see Rossi and Rossi, 1990; Filipovič Hrast in Hlebec, 2009: 208; Hlebec in Filipovič Hrast, 2009). In recent years researches from across the globe have become interested in the relations between the aging parents and their adult children as well as the informal family support mechanisms. This is mainly due to the

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new social problems that emerge from the social and demographic changes in post-industrial societies. The understanding of the factors that encourage or slow down children in their provision of support to their ageing parents and the conditions for compassion and solidarity in intergenerational relations are becoming increasingly socially relevant. Firstly, this is due to the ageing population (with which the number of the elderly is on the increase) and the decreasing role of the social state at ensuring formal long-term nursing care for the elderly. Secondly, it is due to the fall in the number of adult children – due to the high levels of divorces and the low levels of fertility – who usually provide informal support to the elderly family members. The research of intergenerational relations is especially important from the aspect of identifying social policies that could influence these relations.

Family relations and intergenerational ties on the family level can be conceptualised through the prism of solidarity that is expressed in the »behavioural and emotional dimensions of interaction, cohesion, sentiment, and support between parents and children, grandparents and grandchildren, over the course of long-term relationships« (Bengtson and Oyama, 2007: 9).

Bengtson and Robertson's (Bengtson and Roberts, 1991) theoretical model of intergenerational solidarity incorporates six independent dimensions: affectual solidarity, associational solidarity, consensual solidarity, functional solidarity, normative solidarity and structural solidarity. Affectual solidarity is a degree of positive emotions (for example, affection, love, emotional closeness, respect, trust, praise, acceptance) toward family members and a degree of reciprocity of these positive emotions. Associational solidarity encompasses various interaction patterns amongst the family members and includes the frequency of contacts. Consensual solidarity refers to the degree of agreement on values, attitudes, and beliefs among family members. Functional solidarity addresses the quantity of help and exchange that takes place between the family members. Normative solidarity refers to family commitment as understood by the family members. Finally, structural solidarity refers to the factors that enhance or reduce the opportunity for social interaction between parents and children. The expression 'solidarity' exposes the consensual aspects of family relations and thus overlooks their complexity. This is especially due to the high possibility of negative, conflicting interactions and relations that express ambivalence, which in turn leads to the idealisation of the family and intergenerational solidarity.

It is also important to take into account that all elements of intergenerational solidarity have the potential to create conditions for building-up burden, tension and conflicts between the various generations within the family. This can lead to ambivalence on the level of an individual psychological experience, i.e. mixed emotions as regards the relationship on the side of the children as well as parents. As stated by the author Szydlik (2008), financial

help is often an expression of the power relations between the generations or even a type of bribery, thus some receivers would prefer not to accept it if possible. Further, the cohabitation of parents and adult children in the same household does not always create merely pleasant experiences and positive emotions. Instrumental support, such as providing care for the elderly parents, can represent a rather heavy burden for the employed adult children, and regardless of the emotional closeness they feel towards their parents it can be accompanied by stress, tension and other unpleasant or negative feelings, even conflicts. On the other hand, research (George, 1986; Spitze and Gallant, 2004 in van Gaalen, Dykstra and Komter, 2009) shows that the elderly parents »might be caught between the wish to be autonomous, and the reality of being dependent on children«. Solidarity and conflict in intergenerational relations should therefore not be dealt with as opposites: the relations of solidarity are not marked by the lack of conflicts and the presence of conflicts between family generations does not necessarily indicate a lack of solidarity. Such a perspective demands for the positive and negative interactions not to be studied separately, but simultaneously within a single study (see Bengtson et al., 1996; Katz et al., 2004; Van Gaalen and Dykstra, 2006).

The new theoretical and research approach enables both perspectives (normative, which Lüscher treats as cooperation, mutual support, and happiness within the family and those that the author treats as a source of conflicts and abuses) to be taken into account and analysis simultaneously (Lüscher, 2005: 96). By relying on the concept of ambivalence we also overcome the bias of the old model of intergenerational relations. Once ambivalence was qualified as a fact of social life, i.e. a totally normal phenomenon in human life¹, and once it was ascertained that the dynamics of family intergenerational relations revolve around sociological and psychological contradictions and their management in the daily family life, a new conceptualisation of family relations appeared in literature, the so-called intergenerational ambivalence model (Lowenstein, 2007). In the sociological research of intergenerational relations we talk about ambivalence when »polarized simultaneous emotions, thoughts, volitions, social relations and structures that are considered relevant for the constitution of individual or collective identities are (or can be) interpreted as temporarily or even permanently irreconcilable« (Lüscher, 2005: 100). The model of intergenerational ambivalence distinguishes between sociological (institutional) ambivalence that is applied to the normative expectations within a status or role and personal (psychological) ambivalence, which occurs on the subjective individual level and is applied

¹ Some authors state that ambivalence is a part of human nature and/or culture and is as such ontologically present in social relations. Others do not perceive ambivalence as universal, but merely as a reaction to the complex, quickly shifting human relations; therefore it is a feature or quality that should be empirically researched.

to the subjective closeness vs. distance. This article deals with the latter type of ambivalence, which involves contradictory motivations, emotions, and cognitions as regards a specific relationship or person and which appears in situational dependencies. But, do individuals truly experience ambivalent emotions? As Brehm and Miron (2006) suggest, it is difficult to know whether the affects are felt sequentially or simultaneously. Even though emotion theorists still lead debates on whether the simultaneous experience of opposing emotions truly occur (see for example Brehm and Miron, 2006: 15), numerous researches support the co-occurrence of positive and negative emotions (Schimmack, 2005; Larson, McGraw and Cacioppo, 2001).

As in all social relations individuals in family intergenerational relations encounter dichotomies (freedom and restrictions, the need for mutual co-dependency and the desire for autonomy, for instance the parents wish to preserve their independence, and not become a burden) that can raise complex, mixed emotions. Family ties often represent a mixture of love and affection (sympathy) and adverseness or resistance (antipathy). Lüscher (2005: 101) has ascertained that an important precondition for the ambivalence in the relations between the younger and older generation is the dependency which is typical for intergenerational relations. In intimate relations dependency is manifested in the need for support and care within the family. Parents and children experience a greater level of ambivalence in their reciprocal relations than in other social ties (Lüscher, 2005: 110–111). Throughout the family life cycle intergenerational relations are one of the most ambivalent social relations (Silverstein et al, 2010). The dependency between parents and children often switches around during the course of life, and when this switch takes place it is time to reorganise and restructure their relations. Later in life situations emerge in which the aging parents become dependent on the care and support of their adult children, who can experience great contradictions in the relations with their parents. The dependency between family members has different symbolic meanings – the dependency of (small) children on their parents is normal, expected, while the dependency of parents on their children is not – and when it occurs it demands greater adjustments and efforts from all involved.² The relations between two generations are probably more likely to be ambivalent when they are in regular contacts.

Does the need for and provision of personal care (from the child to the parent) appear to be a challenge to family life and one of the possible special sources of ambivalence in family intergenerational relations? Must the provision of demanding personal care – which includes help with basic life activities such as bathing, eating, dressing and using the toilet and is usually

² I would like to thank the reviewer Ph.D. Majda Pahor for this suggestion.

provided on a regular basis and more often is more intensive than for example practical household help – be a cause of negative emotions (for both members of the care dyad)? Physical care requires a close and direct intimate physical contact between the receiver of the care and the carer. Does dealing with ‘old bodies’ in the process of providing ‘body care’ cause the sense of confrontation, do ‘child carers’ feel threatened by them? These questions will be discussed in this paper with reference to the fact that adult children assist their ageing parents with various tasks that might increase emotional ambivalence, i.e. double emotional orientation. The paper surveys the literature in order to assess what conclusions can be drawn from the study of personal care services and how detrimental (or beneficial) can this type of care (direct personal and body care) be for the child carer.

At the beginning the paper outlines the previous research on the ambivalence of intergenerational relations and the so-called specialization hypothesis that argues that public care services relieve informal family carers from demanding and regular personal (physical) care, whereas adult children and other relatives are oriented towards providing less demanding, intense and burdening support. It then argues that although the support of the family is centred on sporadic help and assistance, adult children still provide strong personal care that is invaluable and important, especially in countries in which the service sector is poorly developed. Drawing on recent literature in the area of care work the paper discusses the concept of body work as ‘dirty work’ and identifies emotions that might be linked to this type of work. Finally, by drawing on the work of Julia Kristeva (1982) and others, it demonstrates the importance of considering emotion processes for fully understanding the social and emotional complexity of intergenerational dynamics between the ageing parents and their adult children.

Intergenerational relationships: solidarity, conflict and ambivalence

A number of researches have confirmed the existence of ambivalences as a compound of the everyday life and the normal experiences of the family members;³ one research has shown that »the intensity of dilemmas rose with

³ *Ambivalence can be characterized as a reflexive construct. Family members can be aware of the ambivalence in different relations; however, they might be unaware of them. Only a scientist looking from the outside can use a differentiated analysis in his diagnose. The following instruments have been developed:*

- *Assessment of relationships: People describe their perceptions of different relationships.*
- *Awareness of ambivalence: People tell us about their experienced ambivalence, or we compare utterances containing assessments of relationships with regard to ambivalences.*
- *Management: We asked people to tell us something about how they handle ambivalences (Lüscher and Lettke, 2000: 38).*

the frequency of mutual help« (see Lüscher, 2005: 108). A recent comparative study (Silverstein et al., 2010) carried out in 6 countries (England, Germany, Israel, Norway, Spain and the United States) indicated the presence of emotional ambivalence – affection and conflict exist simultaneously in all of the studied countries, and the intergenerational relations indicate ambivalence. The main source of tension in the relations between adult children and their parents are long-term interdependence and caretaking duties: more ambivalent relations with their children can be found amongst those parents who are dependent on them and receive help or care from them.

Another recent research (the previously mentioned van Gaalen et al, 2009) was carried out on adult children and parents who do not live together, but maintain frequent contacts. This research has shown that ambivalent relations and high quality relations appear in over 50% of frequent contact parent-child ties. It is highly likely for the daughters who are taking care of their parents and their ageing parents to experience negative ambivalence – this form of ambivalence is defined as »relatively low probability of support exchange and high probability for conflict and poor relationship quality« (2009: 16). These results were confirmed by the conclusions reached in a number of other researches, which state that middle aged women (in comparison to their brothers) represent the group with the most complicated position in the family since they experience the highest tension in their relationship as they provide care for the elderly parents who depend on their support, and this becomes increasingly difficult and less rewarding. Stress and ambivalence linked to the care for the aging parents are therefore gendered. As stated by van Gaalen et al (2009: 10), the analysis of the ambivalence of the other authors has shown »that daughters experience more ambivalence than do sons. Compared to men, women have fewer options not to act in accordance with normative obligations to care for family members (...). For example, female adult children of frail parents might feel obligated to support, and at the same time feel strained by such responsibility (...).«

The various researches on the ambivalence of intergenerational relations have discovered an important fact: the subjects do not perceive their subjective experience of ambivalence as negative per se. The level, intensity and context of these experiences are important when experiencing the ambivalence (Lüscher, 2005: 109). When and in what circumstances does an individual find the ambivalence aversive is therefore an empirical issue.⁴ As ascertained by Lorenz-Meyer (2001) distress is linked to the high levels of ambivalence, while moderate levels can revitalise the commitment to the relationship.

⁴ *Whether ambivalence represents a problem to the individual who experiences it is also linked with whether it is recognised.*

The conflict that appears alongside solidarity does not always have a priori negative consequences for the quality of the relationship. Dealing with ambivalence, with the presence of positive and negative perceptions of the relationship and the conflicting feelings is a challenge for the subjects and is in reality a necessary developmental task or achievement. According to van Gaalen et al (2009) ambivalence is not always linked to the poor quality of the relation, thus they propose a differentiation between positive and negative ambivalent ties. They have confirmed this idea with the research that has shown that »among the high contact ties, ambivalence is not always perceived negatively but is more often perceived as something positive. In positive ambivalent relationships, conflict has a normal (i.e., average) level. This finding confirms the idea that both solidarity (...) and conflict (...) are bonding elements within parent-child ties« (2009: 20–21).

Body work and old body – ‘a factory of filth’ or an encounter with the abject

These body fluids, this defilement, this shit are what life withstands, hardly and with difficulty, on the part of death. There, I am at the border of my condition as a living being.

– Julia Kristeva, Powers of Horror

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The care of the incontinent, demented or otherwise seriously ill elderly also includes help at performing basic life functions and the removal of bodily wastes. Physical care requires a close and direct intimate physical contact between the receiver of the care and the carer. Highly intense physical care, such as help with personal hygiene (washing) or activities involving eating and toilet visits, is intimate and consists of daily bodily activities. Care for the elderly thus involves their bodies and could be defined as a form of body work (Twigg, 2000: 389), at which the work is »performed on behalf of or directly on other people’s bodies« (Gimlin, 2007: 358). The body work concept has developed over recent years, mainly due to the wish to fulfil the lack of treatment of the body in the sociology of work. Body work that is performed by women in the domestic sphere as unpaid care work has attracted a lot of attention amongst feminist authors, and the concept also appears in the studies of paid care work (for an overview of literature see Gimlin, 2007: 358, 359).

Middle-aged women, who perform a great share of care work for the ageing parents (see for example Philp, 2001), are also most likely to perform the most intense tasks such as bathing, dressing and cooking. Taking into account the type of care women are more likely to provide personal care than men (see for instance Williams, 2004: 8; 79% versus 22%).

»Bodywork entails working on or through the bodies of others, handling, manipulating, appraising bodies which become the object of the worker's labour« (Twigg, 2004: 67). The forms of bodywork differ amongst each other as regards the character of the bodies upon which the body workers perform their work and the problems with which they deal. The most obvious forms of body work can be found in the fields of medicine, health care and beauty work. While the beauty industry, alternative medicine or spa treatments deal with nice, young, clean bodies, care work of the elderly deals with body negativities or defilement, such as faeces, vomit and sputum, which are aspects of an unbounded, open body. Body work with the elderly is marked by contradictions between the clean and dirty, liquid and solid, living and dead, private and public. Thus care work with the weak elderly, especially those who suffer from chronic diseases and incontinency is defined as dirty work.⁵ Body work with frail, physically disabled elderly mothers and fathers is a form of intimate 'dirty work', which includes dealing with bodily fluids and human wastes, and this can cause fears linked to 'being dirty' and thus 'untouchable' (frail old parents) or the ideas of danger and contamination (child carers).⁶ Bodily fluids, illness, the closeness of organic disintegration, death and the image of filth and contamination lead to the feeling of disgust that is linked to the body.

When defining the bodily dimensions of the care for the elderly as a specific care context that can create repulsion amongst the carers and with this emotional complexity and ambivalence in the intergenerational relations, we lean upon the concept of the rejected and abjected (as stated by Julia Kristeva in her work *Powers of Horror*). The abject refers to objects and experience that dismantle the identity, system and order; it does not respect the borders (Kristeva, 1982). The anthropologist Douglas (1966), who provided the base for Kristeva's work, states that everything that steps across the borders of the body is 'waste' that symbolises danger (contamination). The bodily waste products are an abject that is disgusting and horrifying, because it links the subject with the impure, animality, illness, decay and in the end with death; the subject that is confronted with bodily openings, bodily excrement and waste experiences fear, rejection and disgust. We reject the abject body, because it excretes bodily fluids and substances such as waste, and excreting bodies announce mortality. Excrements are therefore equivalent to decay, contamination; they denote danger for the body – human as well as symbolical.

⁵ In literature (Hughes, 1958) the concept of dirty work is applicable to those tasks or professions, at which workers come into direct contact with concrete and material filth (apart from physical, also social and moral contamination of tasks and professions).

⁶ Professions that directly deal with the body and its waste are treated as professions with a low status and are considered to be on the border of pollution (Twigg, 2000).

In the Western cultural context the bodies of the elderly are considered as rejected. Old leaking bodies – in the event of urine or faecal incontinency, uncontrolled vomiting, etc. – are constructed, perceived and described as bodies that are lacking in self containment. Unbounded bodies show the fragility of the border between self and others or the erosion of the physical borders of the individual, which threatens with decay; old people thus have a ‘problem’ with defining and controlling the physical borders, they lack self-control, self-identity, and autonomy.

Kubie (1937: 391) defines as dirty everything that symbolically or in reality comes from the body, as well as anything that is polluted through a contact with the bodily opening. The body is an animated, mobile dirt factory that excretes dirt through every opening. The author reveals the basic assumption according to which the generally seen and protruding part of the body carries the image of cleanliness, while the hole or crack or cave in the body carries the image of filth. Filth provokes disgust, and this holds especially true for dirt that is applied to other people. McLaughlin (1971: 6) defined dirt as other people: »dirt ...is other people«, or as Twigg stated (2000: 395): »Our capacity for self-pollution is limited; and it is other people’s dirt that is of most concern.«

As stated by Isaksen Widding (2005: 115) some ethnographic studies from Sweden have shown that people perceive older human bodies as open, unlimited and unattractive bodies, and their descriptions often focused on open mouths, throats, phalluses, vaginas, and buttocks; they were linked to illnesses, danger and death.

Bodily waste of the elderly is believed to be dirtier than the waste of other age groups. The faeces of old people are believed to be ‘truly dirty’, people perceive the faeces of children as ‘less dirty’ than the faeces of the elderly and thus the latter need special professional help provided by specialists (nurses) (Van Der Geest, 1998: 8).

To a certain extent the feelings linked to excrement are defined by the nature of the relations between the carer and care-receiver: »(...) when hands-on care is given with genuine concern, respect, and affection for the receiver, the caregiver’s own sense of disgust need not be salient« (Isaksen Widding, 2000: 15). However faeces, vomit, wounds, disabled bodies, troubled minds, touching tabooed bodily products, cleaning intimate parts of the body and the disturbing, undesired presence of the dirty substances and odours that are emitted from the body can raise ‘lower’ emotions such as disgust, revulsion, repulsion, aversion, fear or contempt within the carer and thus create conflicting feelings.⁷ In the field of paid care work body work with the elderly

⁷ »Disgust is rooted in the fear of contamination, whether directly through oral incorporation or touch, or more remotely through visual images or moral pollution.« (Twigg, 2000: 395).

often leads to feelings of disgust, contempt or aversion amongst the so-called body workers (nurses), and these influence (transform) the relations between them and the patients (see for instance van Dongen, 2001).⁸ The paid carers also have a conflicting, often inconsistent relation towards their work and the elderly (Stacey, 2005). As ascertained by Twigg (2000), in the attempt to overcome their feelings of disgust, home care providers consciously reframe the elderly into innocent, sweet and vulnerable.

At the disgust raising abject old body we are dealing with the defence response of the carer to the danger that threatens the bodily integrity – the subject is made aware of his own vulnerability and mortality. The old body that ‘carries the traces of its debt to nature’ (Kristeva, 1982) or the most basic axioms of the bodily (organic decomposition, dying) reminds the individual of his own mortality: it appears as some sort of inner alien, as a carrier of something that does not belong into self, which is experienced as other, foreign, and at the same time felt as something that fatally marks the individual (all humans are alike as bodies). Abject is ‘nor a subject nor an object’, the function of disgust towards the abject is a form of protection from animality, contamination, filth and death. Or as Young (1990) stated: »I cannot deny that the old person will be myself, but that means my death, so I avert my gaze from the old person or treat her as a child, and want to leave her presence as soon as possible.«

The negative reactions that can lead to inner conflicts and ambivalent emotions are not only raised by the ‘leaking’, disintegrating old bodies and personal care work that consists of intimate daily bodily activities, but also the behaviour and emotions of the parents. Ungerson (1997) draws attention to the wrong idea as regards the relation between the ‘carer’ and the ‘cared for’, in which the care recipient is a powerless partner. With his convictions and responses the care recipient can influence the emotional well being of the carer – he also has the power to make the life of the carer unbearable. Additionally, due to the loss of self-control and physical dependency frail elderly persons suffer from the loss of self-respect and human dignity; they are unhappy, shamed, angry and irritable or desperate, depressed and numb. Their personalities change, and this increases the probability of »challenging behaviour« on their side, which in turn adds additional tension

⁸ *In the field of paid care ethnographic studies show that there is a gap between the conceptualisation of the body as a ‘living body’, with all ascribed positive meanings, based on warm, loving relations between the nurse and the patient on one side and the workers own understanding on the other hand. Body workers implicitly define their interactions with patients as ‘bed and body work’, and not as a relation with a living human being (Gimlin, 2007: 360). This is only partially true, for research has also ascertained that health professionals such as doctors, pathologists and nurses turn their dealings with dirt into a routine and give their work sense by seeing ‘beyond’ the impurity or the contaminated body. Lindahl (2008: 4) for instance ascertains that nurses experience impurity when they cannot save the patients from vulnerability and face obstacles I their provision of good care.*

and negativity. As shown in the family carers of older dependent people EUROFAMCARE (2005) research, which encompassed 6 European countries (Germany, Greece, Italy, Poland, Sweden and the UK), it is more likely for a carer who takes care of an elderly with behavioural problems to want to place an elderly person in a retirement home.

The care for the demented who are mainly cared for by adult children or spouses is especially stressful and emotionally hard as people with dementia show behavioural disturbances (aggression, resisting help with care). »For caregivers, these behavioural problems create mental problems of their own, including anger, grief and resentment« (DeKosky and Orgogozo, 2001, in Moise et al, 2004: 51). The research on the notion of dirty work and 'unbounded' bodies in the role of informal carers (Brittain and Shaw, 2007) shows that incontinence – which signifies a person who is lacking in self-control – generates feelings of anger and sadness, as well as embarrassment and depression. In the face of increased dependence and the inequality of power within the care relationship (see Fine and Glendinning, 2005) relations, communication and interactions between parents and children can change. Emotional closeness, commitment and positive cognition exist in a temporarily or permanently insoluble contradiction with dissociation and negative perceptions, amongst which the carer constantly oscillates, or the loving, warm relations become cold and the negative elements (distance, conflicts, abuses and violence) start dominating.

Social and emotional complexity in intimate intergenerational care

Care for the elderly includes a wide range of various tasks such as house-keeping, meal preparation, transportation, broad oversight or 'supervisory' care work, financial support, provision of psychological help (emotional support) and assistance with personal hygiene (e.g. bathing, dressing, etc). The various forms of personal care represent the central everyday reality of the care for the frail and dependent elderly, and can be ensured by formal paid carers (employed by the state or the private sector) or informal carers. Within the group of family carers we are interested in the 'children carers', who appear as that group of carers who often carry the major burden of the care for the elderly and is in literature described as 'a caring army' (see Bytheway and Johnson, 2008: 228).

Intimate hands-on care that is linked to the less attractive aspects of the body (of the other) is often neglected in studies on care (as ascertained by Isaksen Widding, 2000 and Twigg, 2000 & 2004). The research is often focused on the dimensions of 'care', i.e. emotional, social and reciprocal aspects of care. Due to their physical repulsion the bodily dimensions of caring are relegated to the realm of socially unseen/invisible and are thus not spoken about.

The carers for the elderly (informal as well as formal) do usually not speak about the negative feelings they experience during their intimate care work. In the context of care they are in opposition to the cultural rules of appropriate behaviour, and they also do not have appropriate words with which they could articulate their experience of taking bodily care for others.

When dealing with intergenerational ambivalence one needs to take into account a number of specific circumstances that could explain the emotional complexity in a long-term caring relationship. *Firstly*, in opposition to the formal paid care provided by care workers or professional providers (nurses, doctors, social carers, etc.) family-based informal care takes place within the existing relationship between the care providers and recipients. 'Child carers' decide to care for their ageing parents mainly due to their emotional bonds (love, affection), or due to the filial norms such as solidarity and patterns of reciprocity and obligation (sense of duty or personal sense of obligation) that have emerged over the long-term relationships. Accepting the responsibility for care is linked to the »question of life and death«, i.e. with issues that are of exceptional importance for the dependent frail parents. *Secondly*, Isaksen Widding (2005: 116) ascertained that the intimacy in the hands-on care - during which we realise our vulnerability as bodies - is mainly experienced in emotionally close relationships. *Thirdly*, 'child carers' are often poorly prepared for the tasks (they are unfamiliar with them and they do not understand them) they are confronted with during the care for the elderly and frail parents, especially when the needs of the parents/patients becomes progressively more demanding (for instance with the case of dementia). Furthermore, the concurrence of paid employment with caring duties and even parental duties seems to increase the strain of 'child carers' (and consequently their ambivalent sentiments) since it affects both - the work and private life of the carer.

In 2004 and 2006 the role of the family and other care providers to the oldest old, who are especially marked by physical frailty and consequentially depend on the help from others, was analysed within the frame of the European SHARE (Survey of Health, Ageing and Retirement) project. They ascertained that during the final year of life the most important source of help with the activities of daily living is represented by adult children and children-in-law, in particular daughters and daughters-in-law. Compared to the northern European countries and Western Europe adult children in Southern Europe have a greater role in the care for the elderly (Jürges and Hank, 2009: 77).⁹

⁹ In countries outside of Europe (e.g. Japan) the care for the frail elderly parents is primarily down to middle-aged adult children, especially daughters-in-law or daughters (Ogawa and Ermisch, 1996, in Moise et al, 2004: 34).

Brandt et al (2009) have ascertained that the adult children in Europe are three times more likely to offer their ageing parents help in housekeeping (i.e. a more distant form of caring) than regular physical care. Data shows that professional providers offer the medically demanding and regular physical care (crowding out of physical care), while family is more likely to provide the less demanding, spontaneous help (crowding in of help). In the familial welfare states in Southern Europe, where professional support is limited, children are more likely to provide physical care – whereas parents in the north are more likely to receive help from the children in the household or in dealing with the authorities. A greater inclusion of the family members into the care of the elderly (including direct personal and body care) in southern Europe (compared to northern Europe) cannot be (sentimentally) linked to greater humanity and greater caring or ‘goodness’ of the Italian or Greek family versus the ‘unloving’ or ‘uncaring’ Scandinavians. The difference Mediterranean – Central and Northern Europe can be explained by numerous facts, including the availability of nursing homes in various countries (i.e., the diffusion and quality of the networks of homes for the elderly), the average family income, as well as cultural differences regarding the perceptions of the (old) body, practices relating to the body and preferences as regards touch and interpersonal distance. How people understand and react to their and other’s bodies depends largely upon their culture. Touching is culturally conditioned – every culture has a clear regulation which bodies or parts of bodies can be touched. While some cultures have a more relaxed attitude to some fields of behaviour, others encourage higher levels of emotional and behavioural restraint. Several studies suggest differences between ‘high-contact’ and ‘non-contact’ (or ‘low-contact’) cultures, at which contact patterns spread into all aspects of everyday life and relationships. The meaning given to the body and the experience of body work will thus be different for a carer who belongs to a ‘contact’ culture than for a carer who belongs to a ‘non-contact’ culture. In a study that examined the effects of culture on the proxemic and haptic behaviour, the researchers (Remland et al, 1995) found that Greek and Italian dyads used touch during their interactions more than the English, French, and Dutch dyads which lead to the conclusion that Greece and Italy are contact cultures. Of course the question as to whether such cultural differences influence the readiness of the family members to perform bodily care for the elderly remains open, however it is a fact that physical care cannot be performed from a distance. Taking care always means body contact – it involves physical proximity as a reality that the carer and care recipient have to face and deal with in the care process. For the carers this means that they have to remain alongside the care receiver (in some cases for a longer period) and take care of him regardless of all obstacles and disturbing or unpleasant dimensions of direct care. However, personality or

individual carer characteristics can, as a factor of influence, importantly contribute to the perception of care, for completely different (high/low) 'caring orientations' can take place within the same family.

The image of the division of labour between the different care providers who are involved in direct personal and body care (home care service workers, volunteers and informal carers) is given in Lyon (2010: 177-180) who compares four European countries (Italy, The Netherlands, Sweden, and England).

In *England*, where the state financially supports the provision of personal care, a large share of the body work for the elderly is provided by the members from the household, especially spouses. In the case of elderly with personal care needs, who live alone, almost fifty percent of this form of help is performed by non-household relatives and friends/neighbours. Adult children are importantly involved in the personal care of this group, even though – in the opinion of the interviewees – the cultural norm defines that body care between adult children and their parents 'might be inappropriate'. Thus a high share of the care for the elderly is provided through the paid, formal form of care as well as through unpaid informal care – and both will continue to be on the increase.

Italy, a weak welfare state, has a high level of unpaid care work, joined by the high level of informal paid care work, which is »to a certain extent a substitute for the domestic labour of Italian women as wives, daughters or workers who, with the cash payments offered by the state that indirectly support the market solutions, sustains the continuity of family care as an ideal and a practice.« Lyon and Glucksmann (2008: 105) have ascertained that a large share of women aged between 25 and 49 years cannot find employment in the public sphere of paid work due to their care responsibilities. Families keep looking for migrant carers who are also prepared to take over the physical care for the elderly.

In *The Netherlands*, where there is a high level of informal unpaid care work (as well as a high level of paid and unpaid care work in the voluntary sector) the cultural expectations are such that the family members are not linked to providing direct body or household care for the elderly. Thus there are strict borders between paid care (such as body work) and informal care that is mediated in the form of practical help. In the event that body work is needed formal care prevails in The Netherlands. As stated by Lyon (2010: 179) other research shows that informal family carers rarely perform body work (help at maintaining personal hygiene), which is especially typical for the higher classes (the lower classes are more likely to provide direct care for their elderly parents).

In *Sweden* formal care for the elderly prevails in the form of paid employment within the public sector. Body work is in the domain of formal

care workers or public home help, family members merely perform more distant forms of caring (walks, washing the dishes, etc.).¹⁰ The elderly have reported that they do not want their children to take care of their personal hygiene (for different attitudes of older people in Greece see Triantafillou et al, 2006: 110). This holds especially true for women, who are paradoxically the group that receives the most personal care from their daughters and other kin.

In Slovenia the elderly are ensured help through formal (public and private expert services, voluntary organisations) and informal (family, friends, neighbours) social networks (see Filipovič Hrast in Hlebec, 2009: 202). Help at maintaining personal hygiene (washing, feeding, moving around, dressing or undressing) is performed by social carers within the frame of the social home help service. However, family members are still the most important source of help for the elderly; this holds especially true for adult children (Hlebec in Filipovič Hrast, 2009; for a review of literature see Filipovič Hrast in Hlebec, 2009: 208). Amongst them daughters dominate as family carers (Hlebec et al, 2003). Nursing and help at personal hygiene are not the most common types of care work provided by family carers (the most common are helping with financial matters and help in household tasks), but still 55% of all interviewed carers offer it, out of which 64% are adult children (Hvalič Touzery, 2004: 20). In Slovenia adult children, especially daughters, are also importantly involved into the care for parents with dementia (see Ljubej and Verdinek, 2006: 15).

In Europe family carers represent an indispensable part of the care network (Philp, 2001). The EUROFAMCARE research (2005: 6) has shown that amongst family carers (amongst which women prevail) nearly 50% are represented by adult children (the Swedish sample has a large share of partners). As regards the time spent on long-term care, most services within households are provided by informal care givers (family and friends), regardless of whether they receive any support from the publicly provided services or not. This holds true for all (European) countries, even for countries that are rather generous in their provision of public service, such as for instance Sweden (Huber, 2007: 1). Even though Sweden has been described as a country with a well developed service sector and the Swedish welfare state as universal, informal care plays an increasingly important role, at which, especially women are included also in the 'heavy end' of caring – i.e. providing personal care (Jegermalm, 2006). Such re-familialisation in the field of care for the elderly parents is in contradiction to the preferences of the elderly people – regardless of their class.

¹⁰ A different research (Jansson et. al. 1997) that took place in Sweden has shown that a large share of adult children are not willing to take care for their parents during the progression of the disease or ageing process.

Regardless of the transfer of personal care to professional carers (especially in the north) adult children remain important providers in all forms of care for their parents, including personal care (for UK and New Zealand see Goodhead and McDonald, 2007: 20, 26; for Spain see Llacer et al., 2002; for Australia and the United States see Page et al., 2009: 6, 12–16, 70; for Canada see Rosenthal et al., 2007 and Williams, 2004; for Germany see Meyer et al., 2007 and Mnich, 2007: 107–108; for Greece see Triantafillou et al., 2006: 73, 102), especially if we take into account that the rates of institutionalization (of those in need of care) have dropped in almost all countries (Jacobzone, 2000 in Page et al., 2009: 65). At this one should take into account the fact that care remains important, vast and routinely carried out by family members (including adult children) also once the elderly are moved into an institution or residential care – care by family members encompasses all kind of tasks including physical care (feeding, changing clothes, trimming nails, etc.) (Milligan, 2004 in Goodhead and McDonald, 2007: 21; for Italy also see Lyon and Glucksmann, 2008: 106). Hospitals and other institutions shift a part of the burden for the care on to families, for instance practical help, social contacts and personal care, however due to the increasing costs even the reorganisation and new strategies of the health administration do not do anything to improve the cost-effectiveness (Wergeland, 2009: 22). From the aspect of evaluating the importance of the role of adult children in the care process one also has to take into account the ascertainment that the main responsibility for the daily care activities (dressing, bathing, eating, toileting etc.) of people with dementia (who in the intermediate stage of this illness usually live at home) are taken over by informal family carers, especially in countries with a strong tradition of extended families, such as Japan and Spain (Moise et al., 2004: 33).

And what sort of an influence do direct personal and body care have on child carers? The research of the bodily dimensions of caring (see Isaksen Widding, 2005: 115) performed by adult children in relation to their ageing parents (and also amongst homosexual and heterosexual partners and spouses, friends and neighbours) has shown that intimate, hands-on care, which includes touching, smelling and seeing unpleasant bodily products is an extremely difficult situation for all involved.¹¹ As ascertained in the 1993 Parker research and confirmed by the 2000 Isaksen Widding research (in Isaksen Widding, 2000; Isaksen's research took place in Norway)

¹¹ *The social and emotional complexity of the intergenerational relations in the context of the care for the elderly is additionally contributed to by the taboo of incest and the type of emotional work that the 'child' responsible for the dependent parent is forced to perform. Body work is performed in close connection to emotional work, at which carers manage their own and other people's mental states with the intention of creating a positive mental state of the elderly (Hochschild, 1983). Emotional work within the frame of the care work with the elderly includes constant cognition as regards the feelings of loss of identity as a human being on the side of the elderly, and its goal is to preserve the elderly from the feelings of humiliation and lack of dignity.*

intimate care for the parents causes the feeling of disgust amongst the carers and they become emotionally distant in the event that the care becomes a 'normal' situation, i.e. is no longer performed periodically, but they start dealing with tabooized bodily fluids on a daily basis. If the carers do not have help (this is usually the case with daughters), the loving family ties are easily transformed into cold relations that threaten family integration and solidarity.

In Greece, where the elderly are in most cases taken care of by family members who dedicate the highest number of hours each week for care amongst the 6 observed countries (research EUROFAMCARE), family carers evaluate their role as positive (for a great majority care giving is worthwhile, and they are good at handling the role of the carer - or at least this is the experience of the overwhelming majority of carers in all countries). However, over 50% of them feel that care giving is too demanding, and one third feel that care giving has a negative effect on their emotional well-being; the same percentage feel that they are trapped in their role as a caregiver. In comparison to family carers from other countries, especially Sweden and the UK, they show the highest levels of 'low' quality of life and the lowest levels of 'good' quality of life (Triantafillou, 2006: 83-85). Regardless of this a great majority is prepared to continue taking care of the elderly, even in the event that they would need more help over a shorter or longer time period; most of them also reject the possibility that they would place them into a care home; similar holds true for Italian and Polish family carers. A different situation can be found in Sweden, where a large majority of family carers would decide for a care home in the event that the elderly would experience a drastic disintegration in their health, while a fair share would opt for this option even in the event that the health of the dependent person would not change.

Even in Slovenia family carers are confronted with psychological or emotional strain that is expressed in various ways: »through a negative attitude to the older person (which may consciously or subconsciously lead to an abuse); the most frequent feelings are those of guilt, anger, sadness, fear, depression, helplessness and emotional exhaustion« (Hvalič Touzery, 2004: 29).¹² Carers who have strong emotional ties with the person for which they care for have ambivalent feelings (negative emotions, feelings of guilt) and experience various psychological pressures, while those who do not have strong emotional ties experience care mostly as a physical strain, which is reflected in their worsened health status, and they also feel negative emotions (anger and sadness). More than on the positive, the studies in Slovenia report on the negative aspects of care-giving: family carers are disturbed by

¹² *The most frequent abusers in domestic settings are adult children; one half of older people were abused by their children (Hvalič Touzery 2004: 31).*

the demanding and time consuming physical tasks of caring such as taking care for an immovable person, helping him walk to the bathroom, move around, problems with incontinence. Only slightly over one third of the carers feel capable of further performing the caretaking role for their elderly family member. In the event that there is a lack of external support the overload can be great, and this might lead to abuse. Abuse within the domestic setting is most often performed by adult children and in some cases these adult children are also family carers. Constant stress, overburdening and a lack of understanding are amongst the risk factors that lead to abuse (such as mental abuse and neglect) of the elderly (ibid: 29–31).

Conclusion

Care and support that the frail and ageing parents receive from their children appear as a challenge for family life and as one of the possible special sources of ambivalence in intergenerational relations. Adult child carers endeavour to preserve the wellbeing of the looked after parent. They might feel strong feelings of solidarity, love and compassion, however, over time their genuine care giving relationships might develop negative perceptions, attitudes and emotions (anger, disappointment, fear, disgust over disintegration). Working with their bodies ultimately involves emotions such as embarrassment, shame and disgust. An especially problematical aspect of the relationship between the carer and the receiver of care and a factor of increased emotional ambivalence is thus represented by the direct physical and personal care or the bodily dimensions of caring.

Care work can be identified and conceptualised as dirty work (in symbolic and concrete terms), for certain tasks carried out by carers (on the formal and informal familial) are perceived as distasteful. The type of dirt in the care work with the elderly is not limited to merely actual dirt (bodily excretions); on the cultural level it is an expression of vulnerability and ambiguity of the human body, which is connected to the life and death dimensions. This suggests the need to take into account the conclusion of Kristeva, who ascertained that excrements and corpses are like a theatre without make-up and masks that show us what we constantly pushing aside in order to survive. Thus carers can hold ambivalent or contradictory attitudes toward care giving as an activity or towards the parent as the care recipient. Because emotions and behaviour of each participant within the dyadic relationship influences the psychological level of the other, the mixed emotions experienced by children can stimulate ambivalent feelings also within parents. Intergenerational ambivalence, i.e. co-existing positive and negative feelings and experiences in the parent/children relationship can lead to psychological distress, at which both parties »may experience lower psychological

well-being because they care about the other party's feelings and desire a positive connection. Not knowing what to expect during each encounter (e.g. conflict or a positive interaction) may also engender stress« (Fingerman et al, 2008: 72).

We have ascertained that there is no universally shared caring experience and no universal patterns of opinion and behaviour. Discourses of culture, socio-economic class and gender give rise to different meanings and understandings of the body and body work involved in helping old people. On the other hand similar themes in family carers' experiences have been shown, and they touch the negative effects on their emotional well-being and destruction of good and close family relationships. The proximity, physical touching, coming into contact with unpleasant secretions and sight become a challenging experience of closeness and it could cause difficulties even among those who live within high-contact cultures.

One of the exits that enables the family members to be disburdened of the dirty work and for the carer and care receiver to avoid the negative ambivalence lies in the professionalization of this type of care – the transfer of direct care and body work onto outside formal carers. 'Crowding out of physical care' would disburden the intergenerational relations from the negative influences of this level of care. From the aspect of preserving social integration and qualitative family relations it would be sensible and useful for adult children to provide care limited to socialising, conversation or emotional support in which the elderly parents preserve their social status and dignity (they are not merely a 'dirty body'). Therefore it is important to organise and divide work efficiently and to disburden the family carer.

It has been ascertained that the need for body work performed by family carers is on the increase. This also holds true for the Nordic countries, where the increase of family care contradicts with the Nordic family legislation and policies of the care for the elderly, according to which the family needs to be disburdened – the municipality (and not children or other family members) is responsible for the care of the elderly. Because the refamilisation takes place also against the public opinion – most of the elderly wish to receive help from the public home care service, and not from their own children – this move towards 'forced informalisation of care' works as a potential stimulus that activates the negative and positive effects on both sides of the care dyad. For, as ascertained by Lagerspetz (2006) 'being forced to accept help from another person or being forced to help could be humiliating for both but it could also mean proximity and sharing, going together on the border of life' (in Lindal, 2008: 42).¹³

¹³ *When thinking about enforced care that can produce ambivalent reactions on the side of the carer*

Taking into account the fact that care for the elderly will continue to rely on adult children (at which they are not entirely unwilling to accept the responsibility), policies that will offer appropriate support need to be developed. The lack of access to sufficient funds, practical knowledge and support can cause tensions and emotions that are hard to manage; this lack can consequentially limit the carer's capability for ensuring the 'good care' that integrates the following key characteristics in Sevenhuijsen's (1998: 1) ideal of caring process: 'patience, empathy, attentiveness, intimacy, and last but not least, the ability to draw satisfaction from fulfilling what might seem to be insignificant needs.' Social help could offer citizens 'the power for help' (Pahor, 2003: 81) on various levels, from learning 'care techniques', the importance of psychosocial aspects to physical aspects (accessibility to aids, equipment, possibility to adapt the apartment, all of which can significantly disburden the carers and soften the discomfort or suffering of those who need the help).¹⁴

Because carers often represent an invisible group, it needs to be ensured that their work will be socially and politically visible as well as economically recognised. Due to the unattractiveness of body work and the emotional burdens that this type of care brings with it, channels need to be established through which it will be possible to communicate about body work and contradictory emotions (this would include counselling services). When facing the repulsiveness of old bodies, coping with other difficulties of elderly care – linked to ambivalence and aversion – and ensuring 'good care' family carers could learn from the professionals who provide care for leaking bodies and whose 'joys and sorrows ... are inseparably linked to their daily routine' (Sevenhuijsen, 1998: 3). Nurses who take care of old people and treat their bodies often attempt to see the whole person (and not only a nursing problem) in their patients, see beyond the dirty body parts, not feel disgust and provide consolation. In individual situations they think about the optimum solutions, define the goal and possible achievements and see the positive effects and the value of their endeavours. To patients who are defeated by their ill body, nurses can often provide merely services such as good company, a listening ear, and as much emotional and practical support as possible, so that the patient finds it easier to confront his daily life (Lindahl, 2008: 7; see also Sevenhuijsen, 1998: 1).

we cannot bypass the possibility that care recipients in high-contact cultures can call upon the moral imperatives to enforce their care expectations.

¹⁴ For this suggestion I would like to thank the reviewer Ph.D. Majda Pahor.

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