Embodying Moral Space: Exploring a Care Ethical Constellation Tool for Moral Deliberation

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Abstract
This paper explores whether and how moral space, as the unfolding of an expressive-collaborative process, can be fostered in a way that engages embodied, affective experiences in relational practices of responsibility. A care ethical constellation is a tool that aims to shed light on relational needs and responsibilities as experienced by participants in an institutional context. We present the theoretical backgrounds of this tool. Then the use of the tool in an eldercare organization is reflected on through a hermeneutical phenomenological analysis. We answer the following questions: (1) How are identities, relationships, and values in this organizational context experienced, as elucidated by the care ethical constellation? (2) Can this care ethical constellation be considered a suitable tool to foster moral space? Our findings show how this tool brought to the fore previously hidden experiences of distance and power struggles between several groups in the organization. It also sheds light on values at stake: a longing for connection and a shared sense of humanness. In the Discussion we look through a lens of “precariousness” to rethink the experience of power struggle, and to deepen our insight into the “political” of a political care ethics. There is a reflection on valuable features, challenges, and requirements concerning this tool for fostering a moral space that productively works with political care ethics in organizations. By inviting participants to share embodied experiences and paying attention to the political hegemonies at play, this approach highlights the embodied dimensions of political care ethics.

Keywords
care ethics, lived experience, moral space, caring institutions, power, precariousness, constellations

Introduction
Several national policies have been implemented in the last decade to improve the quality of eldercare in the Netherlands. For several years, eldercare organizations wrestled with increasing regulations, decreasing budgets, and a growing awareness of the large gap between systemic pressures and the residents’ lifeworlds. A rich variety of projects aim to close that gap (such as “Waardigheid en Trots” and “Kwaliteitselfportret”). At the core of these projects is the quest to find ways to honor the lived experiences of residents, families, and professionals in the context of systemic demands. One of these national programs is “The Good Conversation.” It aims to improve the quality of care by enhancing the quality of the conversations between professional caregivers and care receivers in residential settings. We were commissioned by one of the care organizations participating in the “The Good Conversation” program to explore through Participatory Action Research (PAR) what a “good conversation” actually means to the people who work and live in such an institutional setting and to gain insight into how to foster this particular kind of interaction. Halfway through this project it became clear that tensions and frictions between care professionals and management/policymakers in the organization needed more than mere conversations, as this dominant, verbally oriented approach had not succeeded in creating a moral space that could surface the full extent of the diverse perspectives and emotionally charged experiences.

A care ethical constellation is a new tool for moral deliberation through embodiment, first developed by Dutch care ethicists (Verkerk, 2004)—this tool will be elaborated on in

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more detail. We proposed the organization use this tool to jointly explore whether this would shed new light on the discordant relational dynamics. Through its embodied nature, we assumed, the constellation would transcend the level of calculated, smartly chosen words about how relationships in the organization “should” be, and show how these relationships actually are—or at least how they are experienced. The organization welcomed our use of this care ethical constellation for one of the meetings of the PAR study. As far as we know, this embodied care ethical tool to foster moral space in care organizations has not been systematically studied and evaluated yet. By studying the use of this care ethical constellation tool in practice, we aim to contribute new insights on moral deliberation that are not merely verbally oriented but primarily embodied and relational, as well as to create moral space in care organizations.

This article first describes the care ethical theoretical background of the care ethical constellation and presents in detail the practical steps the care ethical constellation tool consists of. Next, the actual use of the care ethical constellation in this particular care organization is presented (how did it take place, what happened during and after it), followed by a hermeneutical phenomenological analysis to answer the first part of our research question (How are identities, relationships, and values in this organizational context experienced, as elucidated by the care ethical constellation?). A critical discussion of the outcomes of our analysis in light of care ethical theory and an evaluation of the care ethical constellation led to answering the second part of our research question (Can this care ethical constellation be considered a suitable method to foster moral space?).

**Care Theoretical Backgrounds of a Care Ethical Constellation**

We position ourselves in the interdisciplinary field of care ethics (Leget et al., 2017). Care ethicists view care institutions as sites where morality is embedded in everyday social practices (Leget et al., 2017). Moral understanding is interwoven in dynamic and concrete routines and relationships among people who live and work in these institutions, as a “socially embodied medium of understanding and adjustment in which people account to each other for the identities, the relationships, and the values that define their responsibilities” (Walker, 2007[1998], p. 60 as cited in Verkerk, 2004). As a political theory, care ethics offers a critical perspective on top-down reforms in health care and the existence of moral boundaries that keep power imbalances in place in care practices (Tronto, 1993, 2013). When care institutions are seen as a myriad of complex processes, featuring pluralistic and conflicting needs and purposes from multiple perspectives (caregivers, care receivers, policymakers, and others), morality is a socio-political “doing” rather than abstract theoretical reasoning (Tronto, 2013, 2010; Verkerk, 2004; Walker, 2007[1998]).

This understanding of morality is what Margaret Urban Walker (2007[1998]) calls the collaborative-expressive model of morality (p. 57). According to Walker (2007[1998]), moral life is “a continuing negotiation among people, a practice of mutually allotting, assuming, or deflecting responsibilities of important kinds, and understanding the implications of doing so” (p. 67). This view of contrasts with the theoretical-juridical model, in which morality is based in “the logic of generalization and abstraction that guarantees uniform judgment on relevantly similar cases by subsuming them under covering principles” (Walker, 2007[1998], p. 70). This collaborative-expressive model of morality is central to the care theoretical perspective on caring practices as relational practices in which caring responsibilities are continuously being accepted or rejected by interdependent human beings who find themselves in diverse socio-political positions and who are always embedded in particular contextual situations (Gilligan, 1982; Held, 2006; Noddings, 1984; Tronto, 1993, 2013; Van Heijst, 2011; Van Nistelrooij, 2015; Van Nistelrooij & Visse, 2018). This expressive-collaborative view of care is relevant in this research context “as it creates space for the actual experiences and inclusion of people in thinking about morality in practice. (…) and the complex interweavings that constitute it: detailed, embodied, everyday life experiences, historically embedded” (Visse et al., 2015).

**Moral Space in Caring Institutions**

Political theorist Tronto (2010) argues, in line with Walker, that care institutions can be considered caring institutions only when moral space is created, as “an explicit locus for the needs-interpretation struggle” (p. 168). Through this moral space, the quality of care practices can be reflected upon and evaluated by all those involved. It enables a careful reflection on the needs of people in an organization and supports them in critically evaluating how responsibilities are (and should be) allocated in the organization. According to Tronto (2010, 2013), this is what is expected from institutions in a democratic society: to take into account the needs and perspectives of all those involved, even though this does not come without conflict, as there may be confusion on the interpretation of needs. Moral space is not to be mistaken for the equivalent of a specific communication platform. Rather, it is a symbolic space that exists when narratives of identity, relationships, and values are expressed and explored by those involved in particular contexts. It is an inherently political space too, since “people learn to understand each other this way and express their understandings through practices of responsibility in which they assign, accept, or deflect responsibilities for different things” (Walker, 2007[1998], p. 10). Hence moral space as we understand it is the unfolding of an expressive-collaborative process with a central focus on the socio-political dimension of the allocation of responsibilities. This process of unfolding can be fostered through care ethical moral case deliberation that
sheds light on the narratives of people (according to Walker’s theory) and engages participants in a dialogical learning process (Visse et al., 2015).

**Embodied and Relational Caring Practices**

Besides the attention for dialogue through the exchange of narratives, care theory argues that a more embodied and performative approach to moral inquiry can be a fruitful way to do justice to the embodied and relational nature of caring practices (Baur et al., 2017; Hamington, 2004; 2012; Tillman, 2013).

Caring does not take place through abstract principles, but in the way people with bodies interrelate to each other and the world around them: it is through our pre-reflective, embodied being-in-the-world that we understand ourselves and others, and give meaning to our experiences (Hamington, 2004; Merleau-Ponty, 1962[1945]; Tillman, 2013). The kind of knowledge that is needed to gain insight into what constitutes good care needs to include “a web of entangled feelings and subtle perceptions understood through the body” (Hamington, 2004, p. 45). A care ethical constellation may shed light on how relational practices of responsibility are formed and experienced by participants (Dartel, 2014). It takes into account the embodied and “felt” dimension of relational care practices, and as such may foster moral space as the unfolding of an expressive-collaborative process (Baur et al., 2017).

**Putting the Care Ethical Constellation Into Practice**

The development of a care ethical constellation by Dartel (2014) was drawn upon the argument of Walker (2007[1998]) that ethics consists of practices of responsibility and upon family constellations, which is a system therapeutic method (Hellinger, 2003). In a care ethical constellation, participants take a topographical position in the room that resonates with the way they experience their relationships with the client and other caregivers. The aim is to reveal in an embodied manner the practices of responsibility and the values and moral understandings these practices are embedded in. Hence a care ethical constellation can visualize the moral landscape of certain care practices (Dartel, 2014).

A care ethical constellation does not have psychotherapeutic intentions and is thus not meant as a therapeutic intervention to solve issues, yet may lead to the making of practical arrangements to improve situations after the constellation (Dartel, 2014, p. 185). The main focus of a care ethical constellation is to shed light on the actual division of responsibilities as it occurs and how it is experienced by those involved.

Dartel (2014) offered a general direction for the design to unfold, but no detailed information on how to practically design this specific (care ethical) interpretation and application of a constellation was available so far. Inspired by his work, we further developed a more detailed and practical design, based on theory on constellation work (Hellinger, 2003; Stam, 2016) and the care ethical theory on responsibilities as described above in the section on theoretical backgrounds. Table 1 presents the detailed step-by-step design of our care ethical constellation.

**Research Approach**

To conduct and study the care ethical constellation, we organized a meeting that took place in June 2017 with a group of 15 people from diverse functions in the organization. These people were involved in the overall PAR study thus far. We invited one of the care professionals at location one of the organization’s locations to compose the constellation. This was a deliberate choice, as the presence of managers and policymakers in the room could prevent persons in lower hierarchical positions (such as care professionals in this case) from voicing their experiences. This way, the constellation was formed from the perspective of a care professional.

Table 2 presents detailed information on the participants.

The data analyzed in this article consists of the various steps of the care ethical constellation. All participants were provided with information on the study and signed an informed consent form. The total duration of the meeting was 2 hours (first 30 minutes were used to provide information on data collection and the aim of the meeting; the session lasted 1.5 hours). Participants were given information on data collection and the aim of the care ethical constellation, including the voluntary nature of participation and the right to retreat at any time, and all gave verbal informed consent to document the constellation and to use these data for analysis and publication. The constellation (steps 2, 3, and 4; see Table 1) was videotaped and pictures were taken in order to document the positions people took. The reflective dialogue (step 5) was audiotaped and written out verbatim.

Based on these data, we followed a hermeneutical phenomenological approach in order to explicate the embodied, experiential meanings of the world (more specifically in this case, the care ethical constellation) as directly experienced (Finlay, 2012; Van Manen, 1997[1989]). In this hermeneutical phenomenological approach, a process of co-creation between researchers and participants unfolded. This co-creation happened in all phases of the data collection: during steps 2 to 4 the researchers were not distant observers of the constellation, but were engaged in an embodied and interpersonal search for meaning, together with the other participants (Finlay, 2005). The same happened in step 5, the dialogical reflection, in which the researchers engaged in a dialogical search for meaning, together with the other participants.

By reconstructing a narrative describing what participants experienced (textural description) during the care ethical constellation and the subsequent dialogue, and how they experienced it (structural description), the researchers aimed to provide a thick description of the data collected.
narrative was sent by email to the participants as a “member check,” asking whether they recognized this interpretation of the care ethical constellation and inviting them to make adjustments or add their different interpretations. Three participants responded, writing that they saw the report as an adequate representation and interpretation of how they had experienced the care ethical constellation. In informal conversations in the months after the exercise, the junior researcher (second author) also checked with the other participants whether the written document adequately reflected their experiences with the care ethical constellation. They all confirmed that it did.

The data were analyzed by means of hermeneutical phenomenological analysis, in order to answer the question of how identities, relationships, and values in this organizational context are experienced, as explicated by the care

### Table 1. Steps of the Care Ethical Constellation.

| Step 1 (10 minutes) |  |
|---------------------|------------------|
| • Introducing the general question that serves as a guideline for the care ethical constellation: How do those involved in care practices in this care organization experience and understand their relationships and caring responsibilities? |
| • Creating an overview of persons involved in the care practices at the particular location of this eldercare organization. Facilitator notes down participants’ input on a flip chart sheet. Purpose: gaining insight into who is involved in these care practices. |

| Step 2 (10 minutes) |  |
|---------------------|------------------|
| • Guided body awareness meditation. Participants stand in a circle and are guided through a few exercises in order to ground themselves and come into a present and awake state of embodied awareness. Body scan, bringing attention to the breath, directing awareness toward feet on the floor, shaking the body to release tension. |
| • Purpose: gaining access to embodied experiences in order to broaden the scope of rationalistic argumentation in moral deliberation. |

| Step 3 (45 minutes) |  |
|---------------------|------------------|
| • Constellation. One participant is invited to compose the constellation, and decides what functions (from the created overview) need to be positioned into the constellation, in what order, and represented by whom. The facilitator regularly checks what participants positioned into the constellation experience (bodily sensations, emotions). Whenever someone feels their position is not representative of the actual situation, changes are made by participants. |
| • Purpose: gaining insight into the allocation of responsibilities in the relational care practices. |

| Step 4 (45 minutes) |  |
|---------------------|------------------|
| • “Ideal” constellation. All participants are invited to position themselves in a manner that fits with how they ideally would want to see the situation. This can lead to a different constellation than the first one. |
| • Purpose: opening space for reflection on what values participants want to see reflected more in their joint care practices; gaining insight into what good care means to those involved. |

| Step 5 (30 minutes) |  |
|---------------------|------------------|
| • Reflective dialogue. Seated in a circle, participants reflect on their experiences during the physical constellation. The facilitator guides this reflection with questions: What struck you? What did you see? What new insights did this constellation bring about? How did the constellation affect you? Did this constellation offer a space for connecting to each other, and how/how not? |
| • Purpose: revealing the embodied experiences of participants in the constellation and dialogical deliberation. |

### Table 2. Participants of the Care Ethical Constellation.

| Function in organization | Role in care ethical constellation | Gender | Willingness to participate |
|--------------------------|-----------------------------------|--------|---------------------------|
| Residential caregiver    | Arranger (“Ilse”)                 | Female | Yes, all steps            |
| Director                 | Resident (“Mary”)                 | Female | Yes, all steps            |
| Policymaker              | Caretaker                         | Female | Yes, all steps            |
| Policymaker              | Residential caretaker              | Female | Yes, all steps            |
| Team supervisor          | Volunteer                         | Female | Yes, all steps            |
| Mental caregiver         | Family member                     | Female | Yes, all steps            |
| Residential caregiver    | Student                           | Female | Yes, all steps            |
| Student                  | Caretaker assistant               | Female | Yes, all steps            |
| Facility employee        | Team supervisor                   | Female | Yes, all steps            |
| Nurse                    | Residential caretaker              | Female | Yes, all steps            |
| Nursing home physician   | Specialized nurse                 | Female | Yes, all steps            |
| Nurse                    | Nursing home physician            | Female | Yes, all steps            |
| Residential caregiver    | Caretaker                         | Female | Yes, all steps            |
| Residential caregiver    | Participant in reflective dialogue (step 5) | Female | In step 5 |
| Chairman of client council | Participant in reflective dialogue (step 5) | Male   | In step 5 |
ethical constellation. Reading through the data, initial codes were written down. Based on these codes preliminary themes were formulated, which led to a moving back and forth between the details of the texts and the whole several times. During this process we practiced an open phenomenological attitude, bridling personal experiences and theoretical knowledge by identifying in the margins of the texts the interpretations that arose as well as critical and reflexive questions related to these interpretations.

This process led to the writing up of the themes that were found to describe how identities, relationships, and values were experienced during the care ethical constellation. These findings have been described in the research report for the organization too, and discussed in a reflection meeting at the end of the overall PAR study with the organization’s management team. During this meeting we presented the findings of the study and invited the attendees to reflect on them. All the members of the management team recognized the findings as an accurate reflection of the organizational dynamics.

In the next section we describe what happened during steps 3 and 4 of this constellation (see Table 1). Participants are pseudonymized.

Description of the Care Ethical Constellation

We are standing in a big circle in the light and spacious chapel area of the eldercare organization. We have just guided the participants through several meditative, embodied exercises. First a bit giggly and uncomfortable, the participants seem to be a bit more relaxed now. At the same time, there is a slight tension in the air: “What’s going to happen next?”, everyone seems to wonder.

“Resident” in the Center

We invite Ilse, one of the two participating care professionals, to compose the constellation. With slight hesitation and almost apologetically, Ilse agrees to do it. We ask her to step forward into the circle: “Who is the first person you want to position into the constellation?”. “The resident”, she states, now confidently. We ask Ilse who she thinks could be the resident’s representative. Without any hesitation now, Ilse approaches Mary, the general manager of the organization. Mary accepts this request to represent the position of resident’s representative.

“Everyone at Such Great Distance”

From that basic position, Ilse starts collecting other participants who represent other functions of this location. She guides them toward places in front of and on both sides of the resident so that an oval shape starts to become visible in the constellation. No one is standing behind the resident. The participants are quiet, their gaze searches, arms hanging alongside their bodies passively, sometimes folded over their chest. Mary, as role-play resident, is standing quietly with a wait-and-see attitude: arms alongside her body, her gaze passes by the other participants slowly. She seems to show a slight resignation, as if she has “checked out” somehow.

Now that everyone has been given a position, we check with Ilse whether she considers this constellation realistically represents the way people relate to each other at this location of the care organization. She confirms that it does. We sense a certain passive energy in the group, a feeling of resignation. We direct our question to the resident: “Resident, how do you feel at this particular position in the constellation?”, “Lonesome”, she answers. “Everyone is at such great distance.”

We check again with all participants how they experience their position in the constellation. They all experience distance and a disconnect from the resident.

Wanting to Move Closer to “Resident” and “Family”

Suddenly, the moment we ask the volunteer how she feels and what she experiences, the energy in the group shifts. “I feel like I don’t want to be here”, she says. “This position I have been put in, does not feel right to me.” We ask her whether she can feel what her impulse is, what direction she wishes to take. Without any hesitation she replies: “I want to move toward the resident and the family members.”

Before letting the participants change the constellation, we ask several more participants how they experience their position and whether this is an accurate representation of reality. They confirm that it is an accurate representation, and three more people experience that they want to start moving to a different position. We let them do that. They represent diverse specific functions that can be summarized as “professional caregivers”. Given the freedom to move in the constellation, they all reposition themselves closer to the resident, facing her.

Agitation and Anger

One of the persons representing a professional caregiver is still in her original position in the constellation, standing with arms folded over her chest. We approach her and ask what it is she wants to express. She addresses all other participants, speaking in an agitated tone: “Guys, we are all loners! That’s how it feels to me now. I do not feel any connection.”

Now we ask all participants to reflect upon the constellation as it stands right now. The person representing the volunteer, who was the first to state that her original position did not feel right, now speaks immediately: “Actually, I am feeling very angry! So much focus on the team of professionals. What about the resident? Are we focused only on each other? And how well we are doing here? As a volunteer, I
simply want to stand next to the resident, together with the family members. And you may all participate, at the right moment. And then simply get your act together. Right now, I really feel like ‘Come on! What is this all about?’”

After this outburst of the volunteer, another participant turns toward the resident and asks how she feels. The resident replies, with a passive attitude: “It still feels lonesome. So many people here, all with good intentions. That is all actually, but . . .” She has a disapproving look and slightly shrugs.

Shedding Light on the Position of Family and Volunteers

What follows is an emotional conversation amongst the participants, who are still standing in their (sometimes new) positions in the constellation. They wonder whether residents at this organization feel lonesome and left alone in real life. Some believe this is the case indeed. However, Ilse, who created the original constellation, states that in daily practice some people from the organization are closely involved with the residents. “There are so many functions and people indeed, and many of them are at great distance from the residents. But not all functions are at such distance from the residents.” Someone else points out that family members are still in a position that is quite distant from residents, whereas family members are supposed to play an important role in the organization.

Ilse seems to feel the urge to defend the way she created the constellation in the first place. We see how her various roles (as a professional caregiver and as arranger of the constellation) seem to mingle. Hands up in the air, as a gesture of powerlessness, and with slight frustration in her voice, she says: “Yes, but family never visits! For some of the residents, the department’s professional caregiver is closest to them.” Reflecting together on the involvement of family members, the participants conclude that situations can differ. For some residents, family members are close and come visit regularly. For others, family members are less involved and present. The participant who in real life is the team manager at one of the departments tells Ilse: “But it does show how easily we tend to forget things. It took quite a while before you placed volunteers and family members inside the constellation. It does show that it is not our primary focus, family members and volunteers.”

We now turn again toward the volunteer who had been feeling uncomfortable in the constellation. I ask her how she feels now. “Well, actually a bit . . . My anger is gone. But I feel a bit dispirited. Also now, I feel like it is all about us again, and the resident is still simply standing there . . .”

Creating Movement

“How do you feel?”, we ask the role-play resident. After a short silence, the resident answers: “Well, nothing much has changed. I do see people who do their best. But . . .” Awkward tension in the group. Then, one of the “professional caregivers” jumps forward, walks toward the resident and embraces her closely. She says: “That is the feeling I get now. And like, toward all of you, ‘Come on then, we are all in this together!’” [She gestures to the other participants, peddling her arms toward herself and the resident.] The resident adds: “Everyone is doing the best they can. But who really sees me? That’s the thing really.”

We ask the resident who she wants to have closest to her. Even before the resident can reply, the family member impulsively steps toward the resident and positions herself next to her, holding her in a warm embrace. People start laughing with a sense of relief. The resident responds: “Yes, this is my first wish. And even if I am not able to hold you, I can feel the warmth of your body. You are here.” Subsequently, the resident starts positioning everyone close to her—in front of her and next to her. People who started moving to a position behind her, are moved back by the resident to face her. She explains why: “I want to be able to see you. I do not need to feel the warmth of your body, as with my family, but I do want to see you.” The participant representing family members smiles relaxedly, adding: “Me too, I also love to see you all, so that I know where to find you if I need you.” Ultimately, the volunteer shares that her new position, next to family members and the resident, feels right for her now.

Completion

The atmosphere is relaxed now and the constellation seems to be complete. We conclude the constellation by having Ilse, who originally composed the constellation, thanking everyone and dismissing the representatives from their roles. All seated in a circle, we reflect dialogically on the physical constellation. This dialogue shed light on issues that had already been touched upon during the constellation, but which had not yet been expressed fully and in words.

After this dialogical reflection everyone gets back to work. But before they leave the room, I see Ilse and Mary embracing each other in a long hug. They are now standing closely together, face-to-face. I can see tears in their eyes, Mary holding one hand to her heart and the other hand placed on Ilse’s arm. I cannot hear what they say, but the emotional relief and close connection between the two is felt clearly.

Analysis

Our hermeneutical phenomenological analysis of the data was guided by the question: How are identities, relationships, and values in this organizational context experienced, as elucidated by the care ethical constellation? In this section we will present the three themes that emerged: (1) distance as status quo, (2) longing for connection, and (3) a shared sense of humanness.
Distance as Status Quo

The constellation rapidly showed the participants experienced a vast distance between the “resident” and the others involved in the organization, as well as a distance between those who work in the organization. Witnessing that distance was an uncomfortable and confronting experience for most. We observed this through the verbal and body language during the role plays and the wish to change positions to move closer to the resident. Whether residents also experienced a distance with the staff in real life might not be as relevant. As the participants concluded themselves: some residents may experience similar feelings, others may perceive things differently. In any case, what this constellation illustrates is how the experience of relational distance between various groups in the organization (between residents and staff, and between work floor and management functions) was represented in the constellation by their physicality. In the ensuing dialogue, some care workers interpreted the absence of the management team on the work floor as a sign of a lack of interest by the managers. One of them confronted the executive director: “You want to be close to the residents, but you place yourself at a distance instead?” This shed light on how different identities in the organization hold different power positions. It also became immediately evidenced at the start of the constellation, when the arranger of the constellation, care worker Ilse (lowest position in the organizational hierarchy) deliberately requested the director Mary (highest hierarchical position) to represent the resident in the constellation. In the dialogical reflection, the director expressed that she felt she was being “tested” by the care worker: “I felt like she put me over there in order for me to finally feel what it’s like, that practice of care.” The care worker confirmed this, and said jokingly: “Yes, like, if you don’t come over for coffee, then . . .”. The director responded fiercely: “I cannot . . . [drink coffee with the residents], five years ago I could still do this, with a lot of love . . . and I cannot do that anymore and I will not do that anymore. That is why I also get a bit angry and rebellious when I feel that you are pulling me. I then think ‘See me!’”

This seemed like a reversal of the power hierarchy as it was generally experienced in the organization: the care worker taking power over the director by putting her in a place where she thought the director had a lesson to learn. Also in the dialogical reflection phase, two of the care workers kept pushing their message forward toward the director, claiming that the director (and policymakers and other functions such as the care chaplain) should be present in residents’ living rooms in order to really see and experience what is going on there and to show that they really care. As such, the experienced status quo of distance between diverse positions in the organization was kept in place throughout most of the care ethical constellation (until the very last part of step 5, see next theme), while the participants played with reversing the hierarchical division of power.

Longing for Connection

Even though distance was present as a status quo that defined some of the core relationships in the organization (residents-employees; work floor-management), at the same time the care ethical constellation brought to the fore that all participants longed for connection. In step 3, the distance between the resident and staff roused a lot of emotions and feelings of discomfort in the participants: participants expressed their frustration and even anger concerning the distance that was evidenced in the constellation, and which clearly represented how relationships had been experienced in this residential setting in daily practice.

In step 4 of the constellation it became clear that underlying the frustrations about the status quo a strong desire for connection was present. Participants started to shift their distant positions, moving closer toward the resident and making sure that they were all able to see each other clearly.

In step 5, the dialogical reflection, this desire for connection was expressed when participants spoke about the care workers’ accusation against the director that she needed to visit residents’ living rooms for coffee in order to show that she cares. This interpretation was contested fiercely by the director, and an emotional conversation unfolded on the topic of “seeing one another.” The director responded very emotionally:

“This really gets to me. This is a very, very important topic. I do not feel seen by you, not at all. I notice that I even get emotional now when you put it like that [her voice shakes] . . . As if I can only be acknowledged by you when I show my love for people in exactly the same way as you do. What do you know about me? What do you know about my life history? What do you know about how much I love people? What do you know about what I do and what I contribute here? Could we maybe also respect each other, regardless of position? The message I feel from you is ‘if you do not come to my living room to drink coffee with my resident . . . ‘That’s how it feels, and it affects me deeply, very deeply. The residents, that is my motivation. It is like I am not seen as authentic in what I do, simply because I am not visibly present in the residents’ living rooms.”

One of the policymakers stated: “How can we see each other, without actually having to visit the other person and have coffee together? Because that [visiting for coffee, authors] is not what it’s about, I think.” It turned out that “seeing one another” actually meant “acknowledging the other” for their sincere intentions and contribution to the organization as well as being near the other physically. The dialogue shed light on the underlying desire of all participants to be seen and acknowledged for the good things they contribute to the organization, with the shared interest of caring for the older people who live in the organization. This desire to be seen and acknowledged, and thus to experience connection in their joint vision and goal, turned out to be present in all layers of the organization, from care workers to management team.
A Shared Sense of Humanness

After the status quo of distance in the organization and the longing for connection had become explicit, there was a turning point during the dialogical reflection (step 5), when emotions were expressed openly by the care worker and the director. The director pleaded to be seen as an individual human being with good intentions, and a shared sense of humanness was discovered. The conversation was no longer about differences but about a common need (being seen and acknowledged). When not only those in the lower ranks of the organization showed their emotions but also the director opened up, the barriers between the groups in this organization were broken down. The relief and sense of connection between the care worker and the director who hugged after their mutual expression of experiences, emotions, and needs, meant a breakthrough of the former status quo of distance—at least for that moment.

Discussion

The care ethical constellation led to an embodied and emotional exchange, showing how identities, relationships, and values in this organizational context were experienced by participants. Our analysis reveals that the participants experienced a distance between several groups in the organization who were positioned differently on the hierarchical ladder (residents-employees; work floor-management). This distance was experienced as a power struggle where power was seen as something that could only be allocated to one place/position at the same time. However, this uncomfortable and emotional confrontation with the status quo also provided insights on the values that were at stake. Participants expressed the value of seeing and acknowledging one another as human beings. This provided them with a sense of connection by sharing a joint goal: providing good care.

We will now reflect on the second question that is central to this article: Can this care ethical constellation be considered a suitable method to foster moral space? We will look through a lens of “precariousness,” as a critical care ethical perspective to rethink the power struggle that was revealed in the constellation. We will also reflect on valuable features, challenges, and requirements concerning the care ethical constellation as a method to foster moral space in a way that engages embodied and affective experiences in relational care practices.

Looking Through a Lens of Precariousness

At first glance, the power struggle in the organization showed a polarization of people who were part of different hierarchies. Participants interpreted this as the presence of two groups that did not sufficiently acknowledge each other for their respective contributions to the quality of care. When the participants became aware of shared values and needs, they realized this interpretation might not be the most accurate.

This could be observed when relational barriers dissolved during the dialogical reflection. However, participants still viewed power in terms of oppression. We deduce this from the back-and-forth power play between participants: the care worker inviting the director to represent the resident; the director trying to take back her power by confronting and defending; the care workers even momentarily taking over power by accusing the director of not knowing what happens on the work floor; the director trying to persuade the care workers into acknowledging her perspective.

Vosman and Niemeijer (2017) argue that the notion of power as oppression leads to “clear-cut categorizations of people as oppressors or as oppressed,” and that this “hinders us from seeing more complex and covert social positioning as they occur in caring practices in institutional settings, in late modernity” (p. 466). Instead, the concept of precariousness is introduced by these two care ethicists as a heuristic device, in order to rethink power in caring practices and lift the concept from the intersubjective level of relationships. Precariousness is defined as “ongoing insecurity of one’s own position in the ordering of the community” (Vosman & Niemeijer, 2017, p. 467). Vosman and Niemeijer (2017) claim that “marking out the positions of participants relative to each other in a field enables us to see the political character of the field” (p. 468). This allows a more ambiguous understanding of power: subjects can be viewed “as social actors and at the same time beings that are impacted by others, materiality, and time” (Vosman & Niemeijer, 2017). Thus, every actor in care practices also undergoes suffering as the late modern organizational reality (hyper pace, autonomy as a moral imperative) overshadows the care-based telos of the care organization (Vosman & Niemeijer, 2017).

Indeed, looking through the lens of precariousness at the eldercare organization where we conducted our research, we see that all actors (from care workers to the board of directors) suffered from the insecurity that characterizes our late modern times and institutional life. Our study took place in a period in which the organization was working hard to implement its vision on relational care in politically challenging times. The organization strived to create a shift from a patriarchal culture to increased autonomy for teams and care workers, which changes the way responsibilities are distributed in the organization. This kind of shift is exemplary for what Vosman and Niemeijer (2017) distinguish as the impact of late modernity on care organizations which leads to people being made vulnerable within the political order by imposed changes on their power positions. In this particular care organization we saw that policymakers and team managers were being removed from their formal positions due to reorganization. Many had to leave the organization, as they were being furloughed or fired. Care workers were not fired during this reorganization. However, feelings of insecurity were present as care workers had to make the shift to working more autonomously. This led to fear and insecurity for those who stayed behind.
This insecurity and precariousness was not only experienced by people lower in the hierarchical order, it also impacted the higher hierarchical positions, as these positions also need to be understood in a bigger societal context. Over the past years, Dutch care policy has focused on strict quality measures and cutbacks. This particular care organization handled these pressures by working hard to be innovative and to be considered a national forerunner in providing good care for older people. This led to even more pressure for those working in the organization, as staff who could or would not live up to the organization’s mission would be confronted with reprimands. What the concept of precariousness helps us see is that insecurity is not a secluded feeling of some people in the care organization, it has a social and political meaning that impacts all positions in the organization. This is not solely a formal, organizational practice that sees positions from a “vertical” perspective (hierarchy), but a socio-ontological practice, as precariousness also refers to our bodily and social insecurities and awareness. It impacts our ways of being with each other, because we are all focused on responding to our own bodily and social precariousness.

This is how the managing director too found herself to be in a precarious position. When responding to the care worker who challenged her to come over to the living rooms to drink coffee, the director referred to the changes in tasks and responsibilities she had faced over the past 5 years. Looking through the precariousness lens, we not only understand the director’s wish to be seen and acknowledged as a person, but also as professional in a socio-political landscape. When expressing a need to be seen, the director is also asking to be acknowledged in her precariousness, as part of her own insecure position in the organization—as it were, positioned in-between national policy (and thus global trends of neoliberalism), the claims of others in the organization concerning good care, and her own precariousness as a human being. The managing director can be said to suffer from late modern pressure as much as the care workers who hold her responsible for the consequences of this pressure.

Especially the occurrence and expression of emotions turned out to create more space to discuss what really matters to those involved, their needs and perspectives. We argue that this was not because of the occurrence of emotion itself, but because of what was being expressed through these emotions: underlying frustrations and desires, everything that hadn’t been seen and fully acknowledged yet and had thus been living its own hidden life in the interactions between people. Could emotions be part of moral space in care organizations? Care ethical theory does acknowledge emotions as being relevant for the kind of moral reasoning that is not abstract universalistic but intrinsically interwoven with the relational, situated, embodied, and interdependent nature of caring practices (Baur et al., 2017; Pulcini, 2016; Tillman, 2013). Through pre-reflexivity and emotions people gain access to caring behavior as a natural tendency of human beings (Engster, 2015), and certain emotions, such as compassion, motivate care (Pulcini, 2016). Emotions can provide insight in what is really at stake or of value for those involved. For example, the emotion of anger can be a reaction to a situation in which certain values are compromised (Vanlaere & Burggraeve, 2013). Allowing the emotions of participants in the care ethical constellation to surface created room for reflection on the values that were at stake. As such, a valuable feature of this method turned out to be that it moves the conversation beyond words into the unspoken realms of what goes on in the contextual relationships of the people involved. Creating space for the expression and reflection on emotions thus contributes to moral space as an unfolding of an expressive-collaborative process in which identities, values, and relationships have a central place.

Another valuable feature of this method relates to its potential to transform conflict and differences between people to joint learning processes and transformation. This feature is closely related to the way a care ethical constellation creates space for emotional experiences and underlying values to be expressed. Needs, and the interpretation of these needs, can differ among people in different positions, which can lead to frictions (Tronto, 1993). Also, those who are in charge of determining how needs will be met through the organization of care can be at far distance from the actual care-giving and care-receiving (Tronto, 1993). The care ethical constellation clearly brought to light the needs of all those involved, in this way potentially contributing to attentiveness and responsiveness in this care organization.

Besides these valuable features of the constellation, it also comes with challenges. First of all, we see possible pitfalls when emotions are considered as pure, unmediated reflections of moral knowledge. Emotions can also be used and expressed deliberately in a manipulative way: participants may choose not to express certain emotions, or may amplify certain emotions in order to get their message across or to influence the situation. Working with a constellation method thus demands continuous reflection and open dialogue on the emotions at hand. Facilitators need to be extremely aware of...
body language and other subtle impressions that may reveal the risk of emotional manipulation. Also, they need to have good insight into the organizational context and power structures, and be able to relate and interpret the outcomes of the constellation to this bigger picture. We argue that, ideally, this reflective process is not the task of the facilitators exclusively but a joint task of all those involved.

Second, looking through the lens of precariousness shows that the representation of the field revealed by the care ethical constellation remains rather limited: it did not show the wider field, including national policy and global trends. It is this total field which forms dynamic positions and impacts people personally and professionally. At the time of our study this was still a blind spot for us as a research team. We therefore would recommend further developing the constellation method as care ethical reflection instrument, by taking into account the wider political context in which institutional care takes form and widening the field. It would likewise be helpful to reexamine the concept of “position” in care ethics, as this may refer to political as well as social and ontological dimensions in care.

We further argue that facilitators of a care ethical constellation should take into account and live up to some essential prerequisites and qualities that need to be in place for participants. Even though this constellation method is used for care ethical reflection, not as a therapeutic intervention, working with a constellation always affects those involved. Therefore, basic theoretical knowledge of the principles of constellation work is needed. Integrated experiential knowledge for facilitators is highly recommended when working with this method. The latter refers to being able to unconditionally hold space for whatever comes up in the constellation (emotions, unexpected turns, and resistance), which presupposes the facilitator’s ability to be aware of their own emotions, history, position, and triggers, and at the same time stay centered, open, present, and completely available for the participants—plus having an analytical and sensitive eye and “feel” for what is being shown by the constellation and what action (or non-action) is needed for optimizing the insightful potential of the constellation method. We reckon that permission and availability of participants is a vital prerequisite for using this method for care ethical reflection. Prior to the care ethical constellation, we explored which participants already had experience with constellation work. Three of them raised their hands. We explained the method and asked participants whether they agreed to participate in the constellation before starting it. All but two agreed. The two persons who did not want to participate sat down and watched the constellation take place. They did not partake in steps 1 to 4 of the care ethical constellation, but did join in the dialogical reflection of step 5 by sharing their interpretations and experiences.

Another topic of discussion is the transferability and scope of the constellation method in the organization. This took place in a deliberately created space (literally and figuratively speaking) that was safe, different than usual, and within closed doors. We reckon that this “special” character of the meeting contributed to the profound level of exchange that took place. However, the particularity of this setting could also hamper the transfer of insights into the daily routines of the organization and toward all those persons that were not present to participate in this meeting. To transfer the experiences and insights of the care ethical constellation to non-participants, we created and distributed a vlog (video logbook) on the organization’s intranet. Also, a short article was written on the care ethical constellation, for internal communication. Unfortunately, due to the scope of our study we have no insight into the actual reach of the content and impact of the care ethical constellation on the organization as a whole.

A final challenge is the importance of embodied awareness in the constellation. We invited participants to connect with their own bodily awareness to open themselves to the experience of the constellation and connect to their emotions. We noticed that a focus on body and emotions was not something people in this organization normally do during their job. For professional caregivers, policymakers, and managers in this organization focusing on their own embodied being felt a bit out of their comfort zone. By starting with a body awareness meditation we hoped to support participants to feel instead of think, reflect instead of talk. We only partially succeeded in fulfilling this intention. In the physical constellation we had to guide people explicitly to feel into their body what they experienced. It turned out that for some it was challenging to feel into the position of a representative and to let go of their personal experiences and opinions about the main question of the constellation. A phenomenological attitude of wonder may be helpful here: “the unwilling willingness to meet what is utterly strange in what is most familiar” (Van Manen, 2002). This may have been difficult because some participants were representing people from the same department where they themselves worked. It may be easier for participants to connect to their embodied experiences in the constellation when in real life they aren’t part of the exact same department of the organization the care ethical constellation is about.

Conclusion

We designed and facilitated a care ethical constellation method in a care organization where tensions between groups in different power positions had been latently present in a political context featured by top-down policy developments. Through this approach the lived experiences of participants’ identities, relationships, and values in relation to their relational care practice in the eldercare organization came to the fore. By engaging embodied and emotional experiences of participants, the care ethical constellation shed light on a status quo of distance that shaped the relational care practices, and on the joint longing for connection and a shared sense of humanness that the participants became aware of.
This process is in line with what Tronto (2010) considers a feature of caring institutions, as it sheds light on the needs and perspectives of all those involved in an organization. We propose a care ethical constellation as a suitable tool to enhance moral space in care organizations as it fosters the unfolding of an expressive-collaborative reflection on relational responsibilities. This is not a solely harmonious process; rather, frictions and conflict are brought into the open, where they can be reflected upon and become a learning vehicle. The care ethical constellation can be a valuable tool to practice institutional moral deliberation, respecting and actively seeking out insights in dispute and misunderstandings, and to work with these disputes productively in an experimental space.

**Theoretical Contributions and Implications for Further Research**

During a care ethical constellation the nature of democratic dispute is exposed, requiring further insight into the concept of the political, as care ethicists need practical ways to work with these hegemonic dimensions of practices. Dalmiya (2016) proposes an epistemological account which we deem relevant to deepening our work on the constellation, rooted in the care-ethical ontology of people as embodied, interdependent, vulnerable, and relational as presented in this article. However, the practical feasibility of such accounts had not been addressed yet. Our study shows how a political care ethics is *practiced*, bringing to the fore the “practices and institutions through which an order is created, organizing human coexistence in the context of conflictuality provided by the political” (Mouffe, 2005, p. 9). A care ethics constellation may function as a common symbolic space (Laclau & Mouffe, 2001[1985]) in which the fundamental disagreements that may occur are acknowledged and brought to our awareness instead of being covered up. Creating and entering this kind of symbolic space may prevent pseudo-participation and epistemic injustice along the way.

Care theory distinguishes several critical insights that are deemed essential for its specific approach to caring. These are continuously developing by dialectically connecting conceptual and empirical insights (Leget et al., 2017). Bodiliness is one of these critical insights of care theory (Hamington, 2012; Leget et al., 2017). Rooted in phenomenological and feminist approaches to the body, care theorists consider the knowledge of bodily experience the “groundwork for empathetic understanding of other embodied beings and is thus a basis for care” (Hamington, 2012, p. 62). Our analysis of the care ethical constellation confirms the value of visceral understanding for grasping the standpoint of the Other (Hamington, 2012, p. 62): participants demonstrated a strongly felt sense and embodied awareness about their own standpoints and those of others. For example, in the role play “family and volunteer felt the strong visceral urge to move closer to the resident.”

Our study contributes to the further development of the care ethical critical insight of bodiliness by broadening the scope of bodiliness from the dyadic caring relationship between caregiver and care receiver and the empathic quality of this relationship to the total web of relationships in the context of the care organization. We can thus argue that bodiliness can play an important role as a vehicle for both embodied and theoretical understanding of caring practices, in *dyadic caring relationships as well as in the web of caring relationships in the organizational context*. Our study sheds light on the political-ethical dimension of this web of relationships: the care ethical constellation can be a means to gain access—through visceral knowledge—to the unsayable dimensions of the care organization and to critically explore underlying needs, power inequities, and conflicts of trust and solidarity. This tool may offer an opening for participants’ embodied moral imagination, as their bodies’ felt sense points to ways to transform and improve the quality of the web of caring relationships in the organization.

Last, more insight is needed into the possibility that the care ethical constellation may have a ripple effect on the normative order of the organization where it is practiced. Further empirical research may focus on how a care ethical constellation may help gain insight into the quality of social relations in the institutional context, whether these are relatively open, and whether trust and solidarity—pillars of a caring democracy—can walk hand-in-hand with difference (Bos, 2016; Bos & Kal, 2016). We are aware of the study’s relatively small sample and recommend further experimentation and implementation of the care ethical constellation tool in other settings to continue studying promises and pitfalls of its conceptual structure, practicalities, and impact on care practices in the institutional context.

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