Solidarity and social esteem: the case of unpaid carers during COVID-19 in Northern Ireland

Lisa Smyth, l.smyth@qub.ac.uk
Queen’s University Belfast, UK

This article examines the connections between solidarity and social esteem for unpaid care. Focusing on the moral emotions experienced by unpaid carers during the UK’s COVID-19 pandemic, the implications for the social value accorded to care are considered. Analysis focuses on 32 qualitative interviews with 25 family carers in Northern Ireland during 2020 and 2021. Conceiving of solidarity as a norm whose strength and reach can be gauged through emotional experience, the article argues that unpaid carers’ perceptions of general indifference to caregiving indicate the weakness of democratic solidarity in this neoliberal context, with significant consequences for access to social esteem.

Keywords COVID-19 • unpaid carers • social esteem • solidarity

Introduction

The idea of solidarity appears to be undergoing a revival (Berrocal et al, 2021: 90, 95; Gawerc, 2021). Its value seems to have been amplified in the face of the ‘great collective shock’ (Durkheim, 1915: 244) of a deadly pandemic. The public health refrain during 2020 that ‘we’re all in this together’ (Guterres, 2020) offered solace to those living with too little or too much human contact during population lockdowns, isolated from each other yet living in very close proximity with household members. Evoking solidarity provided important political legitimacy for government restrictions on movement and physical contact (Browning et al, 2022).

The claim that care is central to democracy and citizenship has been well established (Daly, 2002; Tronto, 2013; 2017; Lynch, 2022). Unpaid family care in particular, often an invisible yet vital plank in care provision, has been defined as an urgent social justice issue (Cheshire-Allen and Calder, 2022). This article aims to extend Tronto’s (2013) argument that relations of solidarity are essential to social and political support for care. This is pursued through a focus on family carers’ experiences of COVID-19 lockdowns in Northern Ireland when most formal supports had been removed.
Tensions between carer expectations of solidarity promoted through public health campaigns (Department of Health, 2020b) and their experiences of esteem for caring during this crisis are the focus of attention.

The article begins with an outline of the social dimensions of unpaid caring, including the policy context shaping this role in Northern Ireland. Alternative conceptions of solidarity are then considered, and a normative approach is adopted. This treats solidarity not as an impersonal system that simply coordinates action but instead as an uneven attitude of shared fate, creating relations of mutual accountability and access to social esteem. Social esteem is then examined as a collective good shaping interaction and emotional experience, an indicator of the worth attached to specific practices, performances and roles. The emotional tone of interviews with family carers consequently provides the focus for exploring the dimensions of solidarity and esteem during COVID-19. What emotions like fear, gratitude, anger and indignation reveal about the strength of solidarity with those most physically vulnerable to COVID-19 and the social value of caring is examined. Finally, some policy implications are drawn in conclusion.

COVID-19 and unpaid care in Northern Ireland

What follows considers the question of solidarity in one UK region. Public spending across the UK is very low relative to other European welfare states and is expected to promote individual responsibility rather than equality and solidarity (Taylor-Gooby et al, 2018). During the COVID-19 pandemic, 40 per cent of all public spending (£147 billion) went to support businesses through the ‘furlough’ Pandemic Job Retention Scheme. By contrast, 24 per cent went to health and social care and 20 per cent to public services, and 16 per cent is officially described as supporting ‘individuals’ (Brien and Keep, 2022; National Audit Office, 2022). The UK provided no dedicated support for family carers (Carers Week, 2022).

Northern Ireland, the focus of analysis here, is a contested region of the UK and Ireland, emerging from decades of violent political conflict. It is also the most deprived area of the UK (Abel et al, 2016: 4). Welfare provision has been central to Northern Ireland’s politics. A ‘peace dividend’ of improved public services and quality of life, particularly for the most disadvantaged populations, has been closely linked to the promise of equality (Knox, 2016). Individualist norms are weaker in Northern Ireland relative to other regions of the UK, and traditionalist emphases on the family, religion and the nation are stronger (World Values Survey, 2020). Rates of vaccine hesitancy and resistance have been significantly higher here (at 49 per cent) compared to other regions of the UK (29–31 per cent), Europe (26 per cent) and the US (33 per cent) (Murphy et al, 2021: 4-5). This should perhaps not be surprising, given the association of vaccine hesitancy and refusal with economic deprivation, religious belief and authoritarian attitudes, all of which are high in Northern Ireland (World Values Survey, 2020; Murphy et al, 2021: 9). The question remains as to whether a broadly focused, democratic form of solidarity, which goes beyond ethno-nationalism, might shape social relations in a significant way in this region.

Across the UK, unpaid care is carried out by an estimated 10.6 million people, a rise from 16 to 20 per cent of the population since the pandemic began and valued at £135 billion annually. Carers provide essential support for family and friends who are unable to cope independently because of long-term physical or mental illness, disability or frailty.
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(Carers NI, 2021). The pandemic saw caring becoming more widespread and intense, as the numbers providing more than 20 hours a week of unpaid care across the UK increased by 42 per cent after early 2020 (Carers Week, 2022: 4). In Northern Ireland, 64 per cent of carers are women, often providing a high number of weekly care hours and sometimes combining this with childcare and paid employment (Carers NI, 2021).

Caring is a complex social practice, given that it tends to be caught up not only with familial and gender norms but also with state institutions, including health, welfare and the labour market (Daly and Lewis, 2000). The role of family carer tends not to be positively chosen but instead acquired by default in recognition of need, as well as of gender norms and the institutional demands of health and welfare services. While caring tends to be understood in moral terms, something a close family member, often a woman, is expected to take on as an expression of love, it does involve significant personal and social costs (Leira and Saraceno, 2002; Goldsteen et al, 2007). Carers tend to become excluded from full social participation (Tronto, 1993; Sevenhuijsen, 2000), experiencing ‘role captivity’, particularly when care is treated primarily as the responsibility of families (Aneshensel et al, 1993). Family carers tend to face health and disability issues themselves, as well as financial hardship, chronic stress, isolation, loneliness and anticipatory grief (Carers NI, 2019).

During public health crises, routines of caring can be severely disrupted as public places close and welfare supports, including visits from professional caregivers and access to day-care or respite facilities, are removed. The sense of carer responsibility for vulnerable family members is likely to be heightened when faced with an immediate threat to health and life, such as during pandemic lockdowns when ordinary routines and supports are removed (Carers Week, 2022). Northern Ireland’s initial public health response to COVID-19 in March 2020 involved discharging patients from hospital wherever possible, as well as closing all but the most essential day-care and related services. While it was officially recognised that this involved shifting the burden of care to families (Department of Health Northern Ireland, 2020a: 11), no targeted supports were provided. Carers in this study recounted being left without personal protective equipment, medical waste bins or direct access to essential food and medicines. It was not until June 2020, three months into the first lockdown, that carers were issued with identity cards for priority access to food shopping (Department of Health and Social Services Northern Ireland, 2020). The only other supports provided during 2020 were access to online mental health and stress control classes (Department of Health and Social Services Northern Ireland, nd). In February 2021, carers were given priority access to COVID-19 vaccination (Department of Health and Social Services Northern Ireland, 2021). A fund to support carers was established in April 2021 for voluntary sector projects (Community Foundation Northern Ireland, 2021).

While public health policy relied on unpaid and unsupported family caring in its pandemic response, the question remains as to whether solidarity shaped wider social relations during this era. Was there a shared sense of involvement in the fate of those most vulnerable to death from COVID-19? Did those providing care for family members during this crisis feel esteemed as a result?

**Solidarity and social esteem**

Solidarity is a central feature of modern democracies, where the rights and duties of each depend on the rights and duties of all, since ‘no one stands above the law’
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This, combined with the emergence of human rights, has generated the democratic idea of an ever-expanding political community of equals (Brunkhorst, 2005: 75–6). Democratic solidarity denotes not the obedience, loyalty and moral homogeneity associated with ethnic nationalism (Bauböck and Scholten, 2016) but instead an open, mutually involved and diverse society, whose citizens participate in creating the laws by which all are equally governed.

Democratic social institutions are expected to support equal involvement in public life, since any distinction between ruler and ruled is removed (Brunkhorst, 2005). The ideal democracy is shaped by relations of solidarity and equality. Democratic states promote solidarity by supporting social citizenship, making involvement in political and social life possible (Lindenberg, 2014: 42; Taylor-Gooby, 2016; ter Meulen, 2017). The provision of welfare support depends on solidaristic relations, where all feel involved in the fate of the least well-off (Laitinen and Pessi, 2014: 15).

The renewed interest in solidarity generally treats it as an expression of social bonds, a crucial mechanism that sustains social order and promotes coherent collective action (Karakayali, 2017). This article instead considers solidarity as a norm, that is, an expectation about appropriate action. From this perspective, solidarity conveys an attitude of shared fate. This attitude is adopted not by choice or for reasons of self-interest but because of a perception that ‘we’ are mutually interdependent, expecting that what happens to one of us will affect all of us (Laitinen and Pessi, 2014; ter Meulen, 2017). Understood in this way, solidarity involves ‘we thinking’ (Laitinen and Pessi, 2014: 2).

Norms, as rough guides to appropriate action, are also tools of justification that allow us to ‘hold one another to account and … demand and expect things of one another’ (Brennan et al, 2013: 36). They exist in uneven and varying ways (Bicchieri, 2017). Their strength and reach depend on contextual conditions and actor recognitions (Laitinen and Pessi, 2014; Horne and Mollborn, 2020).

Norms, our ‘social grammar’ (Honneth, 1995), circulate in ways that are powerful but not determining, gaining and losing authority over time and place as they are affirmed, revised or replaced through interaction (Horne and Mollborn, 2020). From this point of view, norms are non-systematic, loosely formulated and potentially conflictual (Winter et al, 2012). Their power to guide, constrain, motivate and legitimise human action depends on being continuously recognised and interpreted in social interactions and institutional practices (McBride, 2013; Frega, 2015: 58–9). Without this sustained recognition, norms can lose force, both against other strong norms and in terms of levels of commitment to upholding them (Winter et al, 2012). As a norm, solidarity is necessarily uncertain and unstable (Salmela, 2014), particularly where expectations of competitive individualism are strong (Jaeggi, 2001; Morgan and Pulignano, 2020). This is compounded because ‘standing up beside’ others in solidarity (Jennings, 2018: 557) may involve significant commitments of time and energy, for instance, by providing help to alleviate need or defending against threats to collective life, perhaps by taking up arms against a common enemy (Salmela, 2014: 3).

Where solidarity is strong, social relations are characterised by equality, as ‘we’ are assumed to be equally involved in the fortunes of each other. This is very different from the exploitative and self-interested relations generated by contemporary capitalism (Brunkhorst, 2005: 84). When solidarity is absent, indifference to each other’s fate prevails (Emirbayer, 1996: 119; Jaeggi, 2001). Indifference blocks access to social esteem, an indicator of the worth ‘we’ attribute to specific practices or performances (Brennan and Pettit, 2004: 23).
Social esteem, a relatively scarce good, circulates in ways that indicate what ‘we’ value (Brennan et al, 2013: 157; McBride, 2013). Where an action or practice recognises a strong norm, it attracts attention and can be appraised as worthy of esteem. In the absence of a norm, the action loses meaning and so cannot attract the attention or evaluation necessary for esteem (Brennan and Pettit, 2004: 56–7). Such actions become invisible, lacking social value. Indifference can create inequality when essential roles and practices, such as caring, become invisible and excluded from the economy of esteem (Honneth and Margalit, 2001).

Where indifference prevails and esteem is unattainable, welfare arrangements are likely to be weak or non-existent, while motivation to cooperate, share or help those in need is missing. Solidary attitudes of trustworthiness and considerateness also become redundant, as actors do not see their fate as caught up with each other. Vulnerabilities and inequalities are instead treated as individual matters.

**Solidarity, esteem and emotions**

Emotions are central to the processes whereby esteem circulates and attaches to practices and actions (Smith, 2003). Esteem is emotionally felt as it is gained or lost (Brennan and Pettit, 2004: 16–22). Indifference is similarly felt, as the actor feels that their actions or practices are invisible, beyond attention and evaluation, worth nothing in the economy of esteem. Emotions provide crucial support for both the authority of norms and related struggles to earn esteem (Laidlaw, 2014). It is the emotional pressure we feel to affirm or recognise norms, in ways that are caught up with esteem, that sustains their force (Brennan et al, 2013: 3).

From this point of view, emotions also play a crucial role in actor evaluations of and responses to normative uncertainty and conflict. Emotions indicate to the actor their perception of where they stand in the economy of esteem, relative to others (Elster, 1989: 100; Smith, 2003: 15–16; Karakayali, 2017). Emotions are consequently key features of norm perception and response, allowing us to identify their presence and strength. Uncertainty about or the violation of norms, as well as the consequences for esteem, are emotionally registered (Thoits, 1989). For instance, shame indicates to the actor, in a deeply painful way, their perception that they have violated such a powerful norm that not only have they lost all esteem but their very place in society has also been forfeited. The only possible responses are either to disappear or to transform themselves (Lynd, 1958: 50–6; Scheff, 2000).

The strength of solidarity and its association with esteem can consequently be gauged by examining emotional reactions to its recognition or violation. Where solidarity is experienced unexpectedly, actors can feel surprised and grateful, as their actions are newly visible and meaningful, available for evaluation and the potential of esteem. Alternatively, frustration, resentment, anger and indignation can indicate a sense of betrayal at the weakness of what was expected to be a firm solidaristic response to need or crisis. Frustration indicates a sense of thwarted expectations, for instance, at the absence of practical cooperation, sharing or receiving help when in need. Resentment, anger and indignation, emotions of blame, may also be felt when it seems that the absence of expected mutuality has caused, or perhaps will cause, harm (Solomon, 2007: 20; Prinz, 2010: 527). During a crisis where lives are threatened, this can extend to intense fear, as actors find themselves isolated from ‘we thinking’ in their struggle for survival.
What follows examines the major emotions evident in interviews with family carers as they recounted their experiences of COVID-19 lockdowns. Of central interest is what these emotions reveal about the strength of solidarity and its association with esteem for those caring for some of the most vulnerable populations during a public health crisis. What can we learn about the quality of solidarity and the value attached to caring from emotional responses to this crisis?

**Solidarity and social esteem: carer emotions during COVID-19 lockdowns**

This article draws on 32 telephone interviews with 25 family carers living in rural and urban areas of Northern Ireland during the summer of 2020 and spring/early summer of 2021. These interviews gathered oral testimonials of family caring during the pandemic. Participants were caring for clinically vulnerable family members during lockdowns. They were recruited through gatekeeper carer support organisations and key individuals, including calls for participants on social media. Interviews included prompts for reflection on moral emotional experience, focused both on the self-evaluative emotions of anxiety, regret, shame and pride and on the other-evaluative emotions of anger, indignation, frustration and fear (Denzin, 2007; Prinz, 2010) (see Appendix 1).

This region recorded 4,845 COVID-19-related deaths during the 30 months from March 2020 to August 2022 (NISRA, 2022b). This contrasts with the 3,500 deaths from political violence during the 40 years from 1969 to 2010 (Rogers, 2010). Participants, aged from their late 30s to 70s, were typically involved in providing care for disabled or ill parents, spouses and children with clinical vulnerability or extreme clinical vulnerability to COVID-19. Care recipients ranged from six to 99 years old. The sample was composed of 21 females and four males.

This is a context where the most recent available data indicate that 20 per cent of the adult population provide care for a family member (Carers NI, 2022: 4). The gendered character of caring (Carers NI, 2021) is not surprising, given that ‘traditional’ values focused on religion, the nation and the family are strong in Northern Ireland, though this has seen some change in recent years (Inglehart and Welzel, 2005: 52; Basañez, 2016: 120–8). While increasingly socially liberal, the region is less tolerant of diversity and difference and more insistent on traditional gender roles and authoritarian political attitudes than either Britain or Ireland (World Values Survey, 2020; Michael, 2021). Minority ethnic groups make up approximately 3 per cent of the population, in contrast to 18 per cent in the Republic of Ireland and 19.5 per cent in Britain (Central Statistics Office, 2017; Gov.UK, 2018; NISRA, 2022a).

What follows examines the emotional tone of carer interviews through an analysis of other-evaluative emotions. This provides a route for exploring the strength of solidarity with and the esteem accorded to informal caregiving during this crisis.

**Gratitude**

When expectations of solidarity are low, experiencing support from strangers or acquaintances can provoke surprise and gratitude. There may even be a perception of new access to esteem for caring in this transformed context. Pam, for instance, recalled:
There’s a lady down the street, and … it was very surprising, you know, she left up some meals. And then there was another woman that, she used to live in the street, her parents still live beside Mum and Dad, and she left two bags of groceries at the front door. But Mummy hadn’t been talking to her in such a long time and it was never a friendship. It was, you know … your neighbour. (Aged 47, self-employed, caring for disabled elderly parents)

Indifference and invisibility were replaced here by the attention and practical help offered by distant neighbours, provoking surprise and gratitude. Patricia similarly recalled the unexpected help she and her sister received with caring for their very elderly mother when they both contracted COVID-19, commenting: ‘People are so good and so kind, they really are. I’m not like that; I’m going to have to step myself up afterwards. Seriously, I just haven’t come across this kindness before, and it’s wonderful’ (aged 68, retired, caring for severely disabled mother). Lockdown conditions appeared to change the quality of Patricia’s social relationships, as she experienced the attention and kindness of solidarity for the first time. She clearly valued this new experience and indicated her determination to reciprocate, something that would be likely to improve her access to esteem in the future (Brennan and Pettit, 2004: 22).

Relief

While family carers in this study had tended to lead isolated and lonely lives prior to the pandemic, moving social life online with lockdown could help them reconnect with colleagues, groups and networks. Expressions of relief at this change were common, as carers felt newly involved in mutual social relations. Bernie explained: ‘In lockdown, everybody else was the same, and that was the first time we were not different from anybody else…. We were all in the same boat, and just for a while, we [carers] weren’t different from anybody else, and that was quite nice’ (aged 56, caring full-time for severely disabled son). Being ‘different’ because of caring, particularly in employment, was a source of disesteem. Working from home created significant ‘we thinking’, as ‘everyone was a carer now’. The reversal in relations of solidarity and esteem during lockdowns was consequently met with relief.

Carers who were in employment commented that they no longer felt that they stood out as ‘abnormal’, second-rate employees. Paula’s experience illustrates the emergence of solidarity with carers and the removal of disesteem from the role:

[With lockdown,] I am the same as everybody else, everybody else had caring issues…. Everybody had a different situation, and I didn’t stand out anymore. In the wider scheme of things, everybody was supportive and just really cared for [me], and actually, I am constantly cared for by my manager and supported by the team. It kind of put me on a more equal playing level. But now, I am worried we are coming out of it; it’s going to be me again [being a problem], you know? (Paula, aged 53, remote employment, caring for elderly disabled parents)

Paula’s anxiety about the temporary nature of the new normative landscape and the likely negative consequences for her access to social esteem after lockdown is not
unusual when the force of a norm, such as solidarity, is uncertain (Brennan et al., 2013: 172–4).

The switch to online social contact could create or reinvigorate a sense of social involvement and mutuality, which tended to be welcomed with relief as isolation and loneliness reduced. Again, Paula reflected on this experience, albeit in a way that was mixed with resentment at her more usual invisibility:

When everybody else had to go into lockdown and they were all complaining, I thought, ‘Well, welcome to my world!’ Then all these things presented themselves online and people were having communities, and I didn’t feel so lonely…. COVID, it has produced a lot online. I have been able to do yoga with my [distant] yoga teacher [beginning to cry]…. [J]ust to be able to connect with people I am familiar with online has really helped.

Solidaristic interactions could also recognise the relief from the fear of COVID-19 that carers experienced as vaccines became available. Susan, for instance, recalled:

I was standing in the vaccination centre, and I was in a queue. I just thought I was going to cry…. I had to fight the tears back. And when I sat down, there was a man, and we were just talking, and he said, ‘I see you are a carer’. He said, ‘It has been a long year’, and I told him I was standing in that queue fighting the tears back. He said, ‘There is a bit of light for you now’, and it does feel like that. (Aged 57, carer for two disabled daughters, one very highly dependent; part-time activist)

The solidarity Susan experienced with this stranger ‘standing up beside’ her (Jennings, 2019: 10), recognising her as a carer, acknowledging the strain she must have been under and offering some hope, allowed her to acknowledge her own relief from the constant fear she had been living with.

**Fear**

Fear was, unsurprisingly, a strong response to the pandemic among family carers, as well as wider publics (Wettergren et al., 2020). The object of fear tended to be the indifference of others, including those providing essential services, such as professional caregivers, as well as those encountered in pharmacies, shops and other public spaces. Expectations of solidarity, in the form of consideration and trustworthiness in following public health guidelines, appeared low. Instead, family carers tended to expect general indifference to COVID-19 vulnerability, gauged by their own sense of invisibility in the wider economy of esteem.

Fear of indifference or even hostility to public health measures was palpable in interviews. Janet, whose eight-year-old son is clinically extremely vulnerable and highly dependent, illustrated this: ‘The hospital staff have said that we can go out once a day for a walk as long as we don’t meet anybody. We tried that and we were so frightened we came back.’ Far from experiencing solidarity and esteem when walking in her local neighbourhood with her son, Janet was overwhelmed by fear at the indifference of others to the risk they posed by walking too close.
Bernie, who cares full-time for her severely disabled teenage son, similarly mentioned her intense fear at the easing of lockdown, as she became more exposed to general indifference:

It is terrifying, it’s easier for us to just close the door and say, ‘Right, this is what we do’ [in lockdown]. But now … because we live near the park, you can see that the whole world has relaxed. They are out playing football together and things and not exactly following the rules…. If we go out with a wheelchair, where do we go, will people stand back for us? The easing of lockdown is terrifying.

**Frustration, anger and indignation**

Other than fear, frustration, anger and indignation were hallmark emotional responses to pandemic lockdowns among participants in the study. Frustration is a response to unexpected and inflexible obstructions to intended action (Barbalet, 1998: 70–1). Anger instead indicates a claim to power (Rosenwein, 2020) in the face of a perceived injury or injustice (Barbalet, 1998: 132; Holmes, 2004).

When anger becomes morally inflected, it can be reformulated as indignation (Jasper, 2014: 210). Indignation, an emotion indicating strong moral judgement (Solomon, 2007: 20), involves adopting what Pettit (2007: 174) describes as the stance of a creditor, to whom an apology is owed. If solidarity is understood as underpinning the distribution of welfare and justice, as well as a route to social esteem, it should be no surprise that perceived violations can provoke this sense of entitlement to an apology (Leach, 2008).

The tremendous frustration, anger and indignation evident in these interviews indicate that family carers believed that their ability to cope with lockdown and continue to provide care, sometimes in the most difficult of circumstances, was severely hampered by general indifference and invisibility, in ways that were often perceived as harmful. Frustration and anger were broadly directed, including at the government, broadcast media, the general public and even family members. This was evident in discussions about the absence of official supports, including priority access to food shopping in the early months and vaccination when it became available. The removal of respite cover, professional carer visits or day-care centre closures were also a focus of frustration. These tended to be perceived as violations of expected mutual cooperation and assistance for care in the context of a welfare state.

Indignation tended to focus more directly on the invisibility of family carers, who were not accorded social esteem despite the vital part they were playing on the domestic ‘front line’. This contrasted sharply with the high esteem conferred on health workers and formal caregivers, not least through weekly clapping rituals at front doors across the UK (Addley, 2020).

Solidarity often seemed to be missing in the way lockdown health and welfare systems were organised. For instance, carers could only be identified indirectly for vaccination, based on whether they received Carers Allowance or were undergoing a carers assessment, whether their general practitioner (GP) had added a ‘carers flag’ to their record, or even whether local carer organisations would vouch for them
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(NHS England, 2021). Laura, for instance, recalled the difficulty she encountered as she tried to get vaccinated without being able to prove that she was a carer:

> When I went down in January to get [vaccinated], I must have had to wait an hour. I was told to bring my [driver’s] licence, and when I went down, one of the nurses asked me for my wage slip. I said, ‘You can’t ask for that. What does that prove?’ It’s because there is no identification card for [informal] carers. (Aged 54, full-time carer for severely disabled adult daughter)

Some also experienced frustration when trying to secure agreement to work from home, a vital support for balancing employment with family care during a public health emergency. Nuala, for instance, a senior health service professional, recounted the frustrations she experienced when she tried to arrange this:

> When the whole country was shutting down, I was being told, ‘It’s business as usual’. [My manager] said I didn’t really have a problem; I had an office of my own, so she couldn’t see what the issue was…. The very first day I worked from home … [this manager] said not to ‘tell anybody that you are working from home – as a service, we are at our desks, we are working from our offices and we are not working from home’. I said, ‘Well, that’s in conflict with what the government is telling everybody, and it’s in conflict with the CEO [chief executive officer]’. She laughed and said ‘That does not apply to you … if you are telling me you have so little work that you can work from home, then I will redeploy you to ICU [intensive care unit]…. I said to her, ‘Can I just be very clear here? If I need to be redeployed, I will be redeployed, and there is no problem about it.’ I said to her, ‘Do you need me to work in the hospital? Because then I will just change my homeworking arrangements. I can’t care for my parents; I don’t know what is going to happen, but I can’t care for them.’ (Aged 60, carer for disabled elderly parents, employed)

The lack of attention to the needs of carers during the pandemic and the related disesteem she experienced for requesting an adjustment to her working conditions only served to move Nuala from frustration to anger:

> I feel extremely angry; I think I probably will do something. She has been a really good manager, and I try to say to myself she was stressed…. Yes, loads of our staff were redeployed into ICU, I get that. She was kind of telling me, ‘If I tell them you are working from home, I am warning you that you will be redeployed, and I am trying to protect you from that’. I couldn’t have worked in ICU anyway because I’m not a [registered] nurse anymore.

Indifference and disesteem led Nuala to later resign from her job.

Where solidarity is strong, social esteem tends to be evenly spread (Honneth, 1995: 128). This is because ‘we thinking’, including having a sense of a shared future, involves valuing diverse abilities, achievements and practices for the distinct contributions they make to collective life (Honneth, 1995: 128–9). Where solidarity is weak, competition and inequality can prevail and some social categories may become invisible, in the...
sense that they are not expected to seek or be accorded esteem. The anger and indignation characteristic of many interviews indicate a perception that carers and those they care for were socially marginal and invisible, despite the central role they played throughout the pandemic and beyond.

Geoff, for instance, whose disabled parent was resident in a care home, was furious about the deaths caused by state indifference to care home residents. An official policy in the spring of 2020 of discharging hospital patients to care homes without testing for COVID-19 (Spackman and Cooke, 2021) and removing regulations requiring regular care home inspections (Irish Legal News, 2020) led to a significant rise in death rates among care home residents: ‘Human rights have been breached, [care home residents’] dignity [has been violated]…. I believe it has been premeditated and I believe the powers that be wanted older people to die, and I will not mince my words. They wanted old people to die’ (aged 41, carer for disabled parent resident in care home, activist).

The official effort to frame what was at stake in hedonic terms as the lockdown went on, focusing on the general population’s access to pleasurable social activities, significantly downplayed the threat to life and health (Belfast City Council, 2020). As Geoff put it, ‘[Vulnerable people are being treated] like they are a burden on society … but they [public figures] don’t realise that could be their mother or father.’ The experience of becoming seriously ill and dying, often alone, without any family member present, seemed to be missing from public debate.

Sally, indignant at the general indifference or even opposition to infection control measures, illustrated the sense of invisibility and marginality evident from encounters with strangers in public places:

I was standing [in the pharmacy] one day, paying for something. This fella walked in, and the pharmacist called him back and asked him to put a mask on. He said he didn’t believe in COVID. She said, ‘If you don’t believe it, you will just have to go out and go into some other pharmacy then because you are not coming in here’. That was the best thing, and he had a look on him like thunder. A lot of people … say it doesn’t exist. I thought, ‘Well, why are so many people getting buried? Are the undertakers pretending there is people in these coffins?’, you know. It’s only when it happens to you that you realise that it does exist…. It’s people’s attitude, ‘Ok, it happened once before; it’s not going to happen to us again’; ‘it’s your imagination’; ‘I can’t wait to go on holiday’, blah, blah, blah.

Her perception here, underlined by her anger and resentment, is that solidarity was eclipsed by the strength of the hedonic norm, in ways which blocked access to esteem for those on the domestic ‘front lines’.

Susan’s comment on the absence of carers from media coverage is illustrative:

Whenever there is stuff in the media, and they are going on about professionals and all the different types of professionals that have stood up … and I always say … ‘And the people who have cared for those shielding?’ We are not mentioned, and we have skills. There are parents that I know administer and carry out nursing procedures. I have friends whose children are fed into their stomachs through tubes; the parents do that every day. I administer rescue
medication; we undertake a lot of the same tasks, but we are no better for it. (Aged 57, carer for two disabled daughters, activist).

### Pride

The palpable anger and indignation across these interviews indicate a violated expectation of solidarity, a crucial normative support for welfare, in the face of a collective health crisis. One effect of this anger was the pride in themselves that many carers expressed. This conveyed a positive moral evaluation of themselves as carers, focused on their ability to protect vulnerable family members from the virus, despite the absence of consideration or cooperation from the state, news media, family, friends or the public. As Jennifer put it, ‘This sounds really awful and very me, me, me, but I literally done everything possible physically and mentally to help [keep her alive]’ (aged 41, employed full-time, carer for partner with severe mental illness).

Participating in this study perhaps provided a rare opportunity to claim esteem for providing care during COVID-19. No participant expressed guilt or shame about themselves as carers. Instead, unmet expectations of solidarity supported a positive self-evaluation as individual carers struggled, often in isolation, to prevent vulnerable family members from becoming infected. Alice’s comment that, ‘Looking back, I don’t know how I did it all’, was not uncommon.

### Conclusion

Calls for solidarity during 2020 and 2021 were fundamental to official justifications for population lockdowns and other infection control measures. It did seem that the shock of this crisis might strengthen solidarity, particularly in democratic welfare states where this norm already supports equality measures. However, the emotional quality of informal family carer reflections on this pandemic in Northern Ireland indicates instead the uncertainty and unevenness of solidarity in everyday life. Despite the sense that ‘everyone is a carer now’ during lockdowns, family carers remained invisible. Rather than generating a new or strengthened attitude of shared fate across the population, the anger and indignation evident in carer interviews instead indicate a distinct sense of moral injury, as the effort to provide essential care in the most difficult of circumstances was largely ignored.

While solidarity is necessary in establishing social and political support for care, not least through the esteem it can deliver, its weakness in this context had significant consequences. The challenges faced by family carers during COVID-19 in Northern Ireland were treated as an individual rather than a collective issue. While esteem is an intangible good that, unlike material goods, cannot be traded and relies for its value on being unprompted and sincere, it is nevertheless embedded in systems of social power (Brennan and Pettit, 2004: 67). The conditions shaping access to esteem are, therefore, adjustable (Brennan and Pettit, 2004: 63). More specifically, the supply of attention can be modified to improve access to esteem for carers. This attention can go beyond providing the meagre Carers Allowance (Gulland, 2024) or access to competitive funding for voluntary sector carer organisations. Instead, where families, and especially women, are expected to carry a significant burden of care, this should be fully incorporated in the planning and delivery of services.
meeting the full costs of care for families, rather than treating informal care as a cost-free resource, would strengthen solidarity with carers, opening access to social esteem. This is particularly important in times of crisis, such as COVID-19, where families became a central strategic resource in planning to protect public health.

Despite the centrality of both solidarity and care to democracy and citizenship, the peripheral social position of family carers was deepened during the COVID-19 pandemic. The ongoing invisibility of family care during lockdowns indicates the weakness of democratic solidarity in this context, with consequences for welfare and equality for carers, often women. An open, diverse and caring democracy (Tronto, 2013) can only be realised when collective interdependence in the provision of care, whether formal or informal, is recognised.

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**Conflict of interest**
The author declares that there is no conflict of interest.

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### Appendix 1: Interview guides

<table>
<thead>
<tr>
<th>Wave 1, Summer 2020</th>
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<tbody>
<tr>
<td><strong>Context setting</strong></td>
</tr>
<tr>
<td>What family members do you care for?</td>
</tr>
<tr>
<td>What vulnerability do they have?</td>
</tr>
<tr>
<td>• What care do you provide?</td>
</tr>
<tr>
<td>• Do you have any help?</td>
</tr>
<tr>
<td>• Have they contracted the virus?</td>
</tr>
<tr>
<td>What has your living situation been under lockdown?</td>
</tr>
<tr>
<td>• (Who do you live with/not with and so on?)</td>
</tr>
<tr>
<td>• Any extra help?</td>
</tr>
<tr>
<td>• How is food and so on accessed?</td>
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<tr>
<td><strong>Emotions</strong></td>
</tr>
<tr>
<td>Prompts: - anxiety, resentment, regret, shame or pride, self-efficacy?</td>
</tr>
<tr>
<td>Have you felt able to cope with caring?</td>
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<tr>
<td>• What strategies do you rely on to support your family member?</td>
</tr>
<tr>
<td>How has your vulnerable family member seemed to be coping?</td>
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<tr>
<td>How do you feel about your caregiving role?</td>
</tr>
<tr>
<td>• Do you wish you could have done anything differently?</td>
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<tr>
<td>Do you have contact with others in similar circumstances? How do they seem to be coping (comparative)?</td>
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<tr>
<td><strong>Relational impact</strong></td>
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<tr>
<td>Has your relationship with your vulnerable family member changed with the lockdown?</td>
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<table>
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<tr>
<th>Wave 2, Spring 2021</th>
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<tr>
<td><strong>Change</strong></td>
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<tr>
<td>How have things changed since last March?</td>
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<tr>
<td>How has your family member been?</td>
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<tr>
<td>• Have they contracted the virus?</td>
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<tr>
<td>• Have they been vaccinated yet?</td>
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<tr>
<td>Have you felt able to cope with caring?</td>
</tr>
<tr>
<td>• Do you have any more help?</td>
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<tr>
<td><strong>Solidarity</strong></td>
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<tr>
<td>Do you feel forgotten or supported? Do you feel that “We’re all in this together”?</td>
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<tr>
<td>• More solidarity at the beginning or now? Has it gotten better or worse? (Caregiver stories silenced?)</td>
</tr>
<tr>
<td>• Do you think people should be free to choose whether to get vaccinated?</td>
</tr>
<tr>
<td><strong>Emotions</strong></td>
</tr>
<tr>
<td>How do you feel about your caregiving role?</td>
</tr>
<tr>
<td>• Regret: do you wish you could have done anything differently?</td>
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<tr>
<td>• Anger: are you angry about your situation?</td>
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<tr>
<td>Who do you blame?</td>
</tr>
<tr>
<td>• Anxiety: are you able to look to the future? Looking ahead, how do you feel about the future?</td>
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<tr>
<td>• Fear: do you fear? What of? Can you tell me a bit more about that?</td>
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<tr>
<td>• Positivity: some people say it is important to think positively. Do you agree/do you make an effort?</td>
</tr>
<tr>
<td><strong>Relational impact</strong></td>
</tr>
<tr>
<td>Has your relationship with your vulnerable family member changed with the lockdown?</td>
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