Unyielding Selflessness:
Relational negotiations, dementia and care

Abstract

This article addresses how couples within care relationships engage in negotiations when mutual selflessness is the relational starting point. Evaluation of hypothetical dementia care scenarios offers insights into pressures upon joint decision-making. Strategic interaction models such as 'the prisoner's dilemma' focus on how a person's pursuit of self-interested preferences might be impeded by the self-interest of another person. Scrutiny of negotiations within care relationships demonstrates that selflessness can also present significant challenges, as combined strategies of altruistic intent mean that neither party is able to prioritise the other person successfully. Moreover, sociocultural pressures associated with illness and care mean that alternative strategic options are difficult to pursue. Care deliberations, predicated on mutual selflessness, can therefore present a static and unyielding interactional context for both parties to endure. The exploration of relational negotiations highlights the requirement to understand the complex breadth of factors that shape experience. This can accordingly enhance academic understandings of the relational basis of dementia and care, as well as informing the approaches of policymakers.

Keywords: care, dementia, interdependency, relational sociology, strategic interaction

Introduction

Dementia can generate significant practical and emotional difficulties with which people with the condition and their family members must contend. Not only is dementia a terminal condition, but its neurodegenerative basis impacts upon memory, communication and behaviour, and is also likely to generate intense pressures within relationships (Hughes 2011). This means that sensitive decisions on the nature of care and professional support will often need to be undertaken. Morally challenging deliberations on the most suitable site for care, such as a choice between informal care within the family home and professionalised formal care, might require demanding negotiations (Author 2015). This complex context presents dilemmas for policymakers and healthcare professionals with regard to how the decision-making of

people in care relationships can be facilitated. The aim of this article is to pursue an advanced theoretical apprehension of care relationships and the inevitable moral negotiations which are considered an essential and defining part of the delivery and receipt of good care. In particular we will explore the competing moral demands inherent in many care relationships of a) not wanting to be a burden and b) not wanting to abdicate the responsibility of caring.

In terms of societal discourses, people with severe chronic conditions are often positioned as passive and subordinate (Charmaz 1994). Additionally, as a consequence of its neurodegenerative basis, dementia presents distinctive challenges as an illness-state. Norms and values associated with mental competence provide a societal background against which people with dementia are judged negatively (Williams et al. 2012). This discursive constitution thus positions people with dementia as the *passive other*, who is dependent on care and support (Dean & Rogers 2004). A person with dementia is accordingly prone to being positioned as burdensome to family members (and society more widely) (Hughes et al. 2005). Under the societal imperative of staying active and independent, being dependent upon others is constructed as a highly defective state which those who consider themselves active citizens should seek to avoid at all costs (Author 2015).

Parallel to these discourses on illness, dementia and becoming a burden, those who provide care within family settings are judged with reference to principles of personal devotion and duty (Fine 2005). This mode of care can be understood through the 'commitment model' in which "we see responsibilities as commitments which are built up over time between specific individuals" (Finch 1995, p. 54). However, beyond

individual commitment the family also embodies rules about proper emotional behaviour (Svašek 2008) through which ideal care is positioned as a 'labour of love' (Kittay 1999), a designation that includes stereotypical images of women's work representing gendered patterns and cultures (Aboim 2010). Both family commitment and the emotional imperative favour a notion of altruistic care in which "the more the carer attends to the needs of others at the expense of her own, the better mother, wife, or daughter she will be in the eyes of others and possibly herself" (Pettersen 2012, p. 368). Ideal care within a couple or the family, as a consequence, is seen as a selfless act completely focusing on the other's needs (Pettersen 2012). Bahr and Bahr (2001) even criticise the negative connotation of *self-sacrifice* and argue that personal conduct within the family should eschew the primacy of individual freedom. Pettersen (2012) also warns, however, that such an altruistic understanding of care necessarily also requires an imbalanced personal perspective (i.e. a complete focus on the cared-for), which can be seen as equivalent to self-interest. It must therefore be recognised that there are complex intersections between one-sided self-interest and selflessness. The two orientations furthermore become interrelated when a person derives personal satisfaction from selfless actions (Ridley, 1997).

Linked to these attitudes and behaviours are physical and ideational settings within which the moral obligations and associations are expressed: the home as a site of care is contrasted with the institutional realm of paid work, professionalisation and bureaucracy (Meis et al 2007; Author 2015). The alignment of the home with natural values of love, affection and selflessness contrasts with the materialistic motivations related to the sphere of paid employment. Associated with these constructions, the traditional heterosexual family, and in particular marriage, is defined as the "supreme

caring relationship, rivalled perhaps only by the mother/infant bond" (Ungerson 1987, p.51). Formal contexts of care, in contrast, are constructed as impersonal, bureaucratic domains, which are shaped by instrumental principles.

These dichotomous constructions place pressure upon family carers to ensure that support can be sustained within the loving locus of the home, with the need to access impersonal professional care minimised or avoided. At the same time, they can reinforce a moral imperative on the part of the care receiver to avoid relying too heavily on their own partner. The two moral demands, however, do not operate independently from each other. Bartlett and O'Connor (2010) argue that social scientific understandings of dementia should account for the interplay between personal experiences, interpersonal relationships and broader societal contexts. In the literature the feminist ethics of care approach (Tronto 1993) has made crucial contributions to an understanding of interdependency and "reciprocity between partners, exchanges between dependent actors over time, and the networking of these relations of dependence" (Fine & Glendinning 2005, p. 612). However, mutual reciprocity can be a challenge to attain within care relationships, particularly when a person has dementia (Kittay 2009).

While the concept of interdependency acknowledges concrete relations, the competing demands sketched above endure and still need to be negotiated. Likewise, the ideal of selflessness might supersede individualised notions of self-interested behaviour, but (as this article will explore) a relational 'starting point' of mutual selflessness can still generate collisions of intent that are very difficult to circumvent. Commitment and altruistic intentions can be understood as moral principles which,

however, need to be actively mobilised in negotiations about the 'proper thing to do' and the decisions being made (Finch & Mason 2000).

In order to disentangle the negotiation of moral demands and pressures we will utilise principles of strategic interaction, which offer a valuable lens through which we can obtain a richer sociological understanding of relational contexts defined by interdependency. This does not mean that interaction is being granted analytical sovereignty, but that it provides an invaluable starting point for scrutinising the breadth of elements that shape the experience of dementia and care. Analytical resources from strategic interaction (outlined below) provide a platform for the exploration of social scientific conceptualisations of dementia and relationships and how these should be contextualised. Analysis of decision-making via the key principles of strategic interaction will help to illuminate how such intersecting pressures might be articulated within relational settings.

Our analysis of deliberations on care start with an 'ideal type' model, under which it is assumed that remaining in the family home is preferable (whenever practicable) to accessing a formal care setting. This is in no way a criticism of formal care delivery, but merely reflects the cultural constructions discussed above. These sociocultural standards and pressures will influence decision-making within relational settings. With the nature of care relationships in mind, this article will consider how these are negotiated with reference to the interdependencies that underpin care relationships.

Analysis: From Strategic Interaction to Relational Negotiations

Strategic interaction (or game theory) is an approach to understanding the negotiation of combined decision-making (Goffman 1969). If an individual is making a decision on their own then this can be undertaken in a relatively straightforward manner with the goal and outcome clearly aligned. If the person is engaged in a negotiation with another individual, however, then the link between goal and outcome is rendered more complex.

A well-known approach to strategic interaction is provided by 'the prisoner's dilemma' model. Within the hypothetical setting of the prisoner's dilemma, two people are arrested for a crime and must negotiate with the authorities with regard to their sentence. These two people cannot communicate with one another or collude, but as part of a deal are offered the opportunity to stay silent (thus cooperating with their partner) or confess to the crime (thus defecting). The challenge is that the choices made by one prisoner intersect with the choices made by the other. Table 1 shows how the choices combine.

Table 1: Prisoner's dilemma - number of years in prison

	MELANIE (M)		
		Confess	Stay Silent
NATASHA (N)	Confess	M: 5 N: 5	M: 15 N: 0
	Stay Silent	M: 0 N: 15	M: 2 N: 2

This demonstrates that the optimal combined choice would be for Melanie and Natasha to stay silent as they then each serve only two years in prison. However, the best individual response, when considering how the other person might respond, is to confess. Melanie's best response to Natasha staying silent is to confess (as she would walk free rather than serving two years); and Melanie's best response to Natasha confessing is to confess also (as she serves 5 rather than 15 years).

The 'equilibrium' of this game (Binmore, 2005) is therefore for both parties to confess, despite the fact that both staying silent would be the optimal shared outcome. Under this game format, the best individual strategy (confessing) is incommensurate with the best combined decision (both players staying silent). Game theoretical principles thus demonstrate that combined decision-making, and its associated conflicts of interest, mean that two people will encounter impediments to achieving an ideal joint outcome.

Drawing upon principles of strategic interaction, examples of decision-making in relation to care arrangements will now be explored. In similar fashion to the 'ideal type' of interaction proposed under game theoretic principles, our approach does not try to detail all specific motivational influences upon decision-making (Binmore, 2005). The point is not to squeeze every aspect of life into the strategic interaction format, "but to create an idealized version of what happens when collective and individual interests are in conflict" (Ridley 1997, p.56). Exploration of the prisoner's dilemma model is valuable in the context of this article, as it broaches the matter of two self-interested people seeking the best outcome for themselves. This provides a platform for the consideration of interdependency within care relationships where the personal rewards for each player are essentially inverted with reference to the various combined outcomes. While the basis of strategic interaction is the combined decision-making of two self-interested parties, this article explores how an alternative dilemma might affect people in care relationships, with pressures to be selfless impacting upon available options. That is, how are dyadic relationships negotiated when both parties are presented with strong sociocultural pressures to place the other person's needs before their own?

To explore the pressures that shape decision-making a number of abstract scenarios involving this couple will be explored with broad reference to the principles of strategic interaction (or game theory). Crossley (2011) highlights that this approach is a useful way of subjecting the strategic interaction to detailed analysis. He also warns, however, against the abstractions of game theory and the fact it denies the resources and options that would be available in the social world.

Taking heed of Crossley's concerns, the goal of this article is not to advance a pure and asocial model of strategic interaction. The intention is to draw upon its underpinning principles to demonstrate the inherent challenges to negotiations within care relationships. While strategic interaction models valuably help to illuminate decision-making strategies when the intentions of both players are difficult to reconcile, we move beyond the narrow, discrete game theoretical approach in pursuit of a more sociological model. For example, we consider how different third party influences will shape decision-making. We also address how broader social and temporal contexts must shape settings of interaction and negotiation. To underscore this broader contextualisation, we define our own models as 'relational negotiations' rather than 'strategic interaction' (or 'game theory').

To explore the challenges that inhere within care relationships we will explore the interactions between a (hypothetical) couple, Alan and Barbara. This couple are married and live at home together within a 'care relationship' shaped by the experience of dementia. An evaluation of their combined decision-making, under three different scenarios, shows how care is allocated based upon negotiations when both parties are operating from a position of selfless intent.

Scenario one: The 'care deliberation'

The first scenario addresses a situation where both Alan and Barbara have dementia and therefore care for one another. To abstract the decision-making mechanisms for scrutiny, it is assumed that they both have the same level of mental capacity and scope to communicate effectively. Within this first hypothetical example, a professional has recommended that they require a break from supporting one another, as a

consequence of the practical and emotional challenges this is presenting to them both. It is proposed that a ten-day break utilising some format of formal care (such as respite care) would be beneficial. Whereas the prisoner's dilemma requires both parties to be kept apart to prevent collusion, under this care deliberation model Alan and Barbara are able to address this negotiation on a face-to-face basis.

There are different ways that the days in formal care can be allocated, depending on the combination of decisions:

- One member of the couple could spend all 10 days in a formal care setting, with the other person staying within the family home.

- The allocation could be divided equally between both members of the couple, with each of them spending five days at home sequentially (while the other person is in formal care for the corresponding period).

- If both members of the couple opt to stay in the family home then a compromise is agreed with the professional and they would both spend a shorter period in formal care (two days each).

Table 2 shows the different combination of possibilities.

Table 2: The Care Deliberation - days spent in formal care

	ALAN (A)		
		Formal care	Family home
BARBARA (B)	Formal care	A: 5 B: 5	A: 0 B: 10
	Family home	A: 10 B: 0	A: 2 B: 2

What is distinctive in settings pertaining to illness and informal care is the pressure to place the other person first. The prisoner's dilemma is based upon the premise that both parties will seek the shortest sentence possible for themselves. In this care-setting example, the pressure is likely to skew the decision-making in the opposite direction, with each person seeking to minimise the amount of time the other person spends within the formal setting.[1] This relates to the social constructions of illness, care and dependency addressed in the introduction: under this 'ideal type' model there will be pressure upon both parties to minimise the period of time the other person spends in formal care. Under the 'care deliberation', selflessness means that the best individual response is to select 'formal care' whatever the other person chooses.

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[1] The prisoner's dilemma merely provides insights into principles of strategic interaction. In no way are we suggesting that there is any similarity between prison and formal care settings.

- If Barbara chooses *formal care*, and Alan chooses *formal care* then Alan spends 5 days in formal care (rather than Alan spending 10 days in formal care if Barbara had chosen family home).

- If Barbara chooses *formal care*, and Alan chooses *family home* then Alan spends 0 days in formal care (rather than Alan spending 2 days in formal care if Barbara had chosen family home).

Crucially, from these combined responses based on selflessness, neither Barbara nor Alan is able to minimise the number of days the other will spend in formal care. The selfless desire to spend all 10 days in formal care while the other person remains at home will be gainsaid by the other person's selfless strategy. With reference to this standard, a 'selfless equilibrium' is the third-best outcome of four (with 5 days the outcome, rather than 2 days or 0 days).

Taking into account the pressures presented by these negotiations, Table 3 ascribes figures to the reward (or payoff) for each person depending on the combination of choices. These figures are based on the sense of value ascribed to each outcome based on selflessness and the individual's goal to spend more time in formal care than their partner. As per game theoretic principles, the exact numbers are not important. 'Ordinal payoffs' are allocated: these serve as a shorthand to rank the desirability of each outcome (Binmore 1994).

Table 3: Selflessness 'rewards'

		ALAN (A)	
		Formal care	Family home
BARBARA (B)	Formal care	A:+5 B:+5	A: -10 B:+10
	Family home	A:+10 B: -10	A: -2 B: -2

These reward values show how social standards of selflessness will place pressures on the interactional domain, and how rewards differ from those conferred under versions of games where self-interest is the starting point for negotiations. The rewards accordingly diverge from the rewards under the prisoner's dilemma, when the best individual outcome arises from a self-interested strategy. Whereas altruism can prove costly under the prisoner's dilemma, it is self-interest that proves costly under the formal care dilemma: within the care deliberation the greatest risk is placing one's own needs first when the other person chooses a selfless strategy.

If Alan chooses to stay at home but Barbara does not, then she will spend all 10 days in the formal care facility. Alan's decision has a negative impact upon Barbara and his self-interest is also contrasted with Barbara's selflessness. The perception that this would leave him open to judgement and social censure means that Alan is likely to seek to avoid the lowest reward. The same criteria apply to Barbara's decision-making.

If both parties choose to stay at home they could leave themselves open to negative social judgement. This strategy risked placing the other person within the formal care setting for 10 days (although the combined choice has prevented this from happening and does show a joint orientation within the couple). Nevertheless, Barbara choosing this option has still obstructed Alan from spending all 10 days in the family home (and vice versa). The professional's recommendation has also been eschewed by both members of the couple. This is therefore scored as a moderately negative position.

Both parties are therefore likely to select 'formal care' and this produces the highest combined reward. The fact that individual preferences (based on selflessness) form the highest joint reward implies that the interdependent negotiation, in this instance, leads to an efficient and positive outcome. As discussed above, however, this equilibrium prevents each player from achieving their strategy to put the other person first i.e. allowing the other person to obtain the maximum reward. It also presents challenges with regard to how interactional exchanges within the couple can develop. As noted above, the prisoner's dilemma requires decisions to be taken in isolation to render a joint strategy difficult to formulate. Alternatively, a collision of mutual selfless intent is likely to undergird the care deliberation, whether or not both parties are able to communicate directly with each other.

Scenario two: Third party influences upon the care deliberation

Under the prisoner's dilemma, two people must seek the best outcome between themselves without regard for any third party. The care deliberation, however, includes a recommendation being made by a professional. It is not just the thoughts and

feelings of the partner that must be considered, but also the professional who has made the recommendation. For example, if one or both members of the couple resisted the professional recommendation, then this could leave them open to perceived critical judgement from the professional and others. Nevertheless, it is also feasible that the couple could derive satisfaction from coping independently and eschewing 'expert' opinion. The perceived social judgement could therefore be more positive: the couple are able to manage privately in their family home and minimise their utilisation of professional (and possibly state-funded) resources. This outcome thereby meets cultural standards of independence, self-sufficiency and resourcefulness.

What could embed the selfless equilibrium further, however, is if the recommendation to utilise formal care was presented to the couple by a family member, particularly a younger family member such as a son or daughter. If the members of the couple feel that they are presenting a challenge to younger family members, then this is very likely to generate pressures that exceed the perceived impact on a professional. On one level this could be argued to have a genetic basis (i.e. kinship altruism) with parents seeking to optimise conditions for younger family members (Axelrod 1984). In addition, actions and beliefs are culturally influenced, and older people might feel that they will be judged negatively if they impede younger family members who are situated in 'productive adulthood' (Author 2018).

Under this particular instance of an interdependent negotiation, it is not just a case of considering the impacts of decisions upon one another, but impacts upon other family members. The urge not to be a burden, and to place younger family members' needs

first will alter the rewards. Adopting a self-interested approach under such circumstances could present very intense challenges and could further embed the fixed decision-making equilibrium discussed above. Table 4 shows how the rewards are affected if the recommendation for formal care is prompted by a family member. Selfless decision-making is granted a higher figure and self-interested decision-making is ranked more negatively with, as a corollary, the contrast between the two strategies rendered more significant. Therefore, there is an even greater chance that 'formal care' will be chosen by both Alan and Barbara.

Table 4: Selflessness rewards (accounting for younger family member)

		ALAN (A)	
		Formal care	Family home
BARBARA (B)	Formal care	A:+10 B:+10	A: -20 B:+20
	Family home	A:+20 B: -20	A: -10 B: -10

Scenario three: the care deliberation when one member of the couple has dementia

The final interactional situation adjusts the status of the participants: in this example it is only Alan who has dementia. The interdependent negotiation thus relates to whether the person with dementia should spend a period in formal care due to the challenges being experienced by Alan and Barbara in the family home. In this example, it could be argued that the ultimate decision should reside with the person with dementia as

they will be most directly affected by the outcome. Within relationships, however, significant life decisions will be shared to some extent and there will be a joint element to such negotiations. The practical and emotional impacts of the outcome will also affect both parties, so the decision-making remains interdependent. The reward values in Table 5 show the potential impact of the choices and how they interrelate.

Table 5: Selflessness rewards when one person has dementia

		ALAN (A) (person with dementia)	
		Formal care	Family home
BARBARA (B) (carer)	Formal care	A:+5 B: -5	A: -2 B: -10
	Family home	A:+5 B:+2	A: -2 B:+2

Alan is presented with the pressure not to impose excessive challenges upon Barbara. If he remains at home then he risks compounding these challenges. His concern for her needs, allied to the risk of receiving negative social judgements for imposing these challenges, increases the likelihood that he will opt for formal care. Barbara, on the other hand, is presented with similar concerns for Alan's well-being and the requirements to offer him selfless and committed support so that he can stay at home.

Alan scores negatively if he opts to remain within the family home, adding to the pressure of Barbara's care role, but scores positively if he puts her needs first and

chooses formal care. The opposite applies to Barbara, who scores negatively if she chooses formal care, but scores positively if she prefers Alan to stay at home. The scores are asymmetric to show that the carer will experience greater perceived pressures in relation to their decisions. The moral pressure to put the other person first will impact most heavily on the individual within the relationship who does not have the condition. Barbara is also likely to fear being judged particularly negatively if she opts for formal care when Alan prefers to stay in the family home. Seeking to avoid the social stigma associated with this combination of preferences places further pressure on the carer to choose that the person with dementia should stay at home.

It has been highlighted that gender does not alter player strategies when game theory is abstracted from social pressures (Brañas-Garza 2006). Within a care relationship however, cultural and moral factors related to gender will strongly intersect with these rewards. For example, the cultural association of feminine values with *good care* (Ungerson 2000) could also mean that female carers could feel distinctive pressures when negotiating decisions. In addition, men with dementia might also encounter distinctive challenges related to masculinity and illness. For example, to demonstrate that they have the resilience to cope with their circumstances (and to avoid imposing upon others) men might feel pressured to accept external support (Author 2017a). Alternatively, male carers and women with dementia might also encounter certain social and cultural pressures associated with gender roles and expectations.

In terms of rewards aligned with the expressed statements by both parties there appears to be an equilibrium within this negotiation: Barbara and Alan both score positively if the former chooses 'family home' and the latter chooses 'formal care'. This

presents a tenuous situation, as it does not provide an implementable outcome: there is no consensus on the choice that should be made. If an iterated version of this deliberation needed to be followed until there is a resolution, eventually either Barbara or Alan would have to accept a negative score. A workable outcome would require someone adopting a 'selfish' position, thereby accepting a reduced reward and its associated emotional impacts.

Discussion: Understanding Care Deliberations

Conceptualising interaction

Building upon the examples of strategic interaction above, this discussion pursues a balanced and contextualised perspective of care relationships that inter alia draws upon concepts from relational sociology. Archer and Donati (2015) invoke concepts that address the various dimensions that inhere within relational settings. *Me-ness* relates to the actor setting out to satisfy their own preferences; *thee-ness* pertains to seeking to inhabit the other person's point of view and aspirations; while *we-ness* refers to an emergent (and processual) collective agreement. The rewards in the examples above show that, operating from an orientation of me-ness, Barbara will seek to position Alan's needs first. This is to obtain positive feelings associated with selflessness in a close relationship and also favourable social judgement. This is accordingly rooted in a sense of thee-ness, which is a contemplation of the preferences of Alan i.e. a desire to spend as little time as possible in formal care. There accordingly appears to be a functional and sustainable melding of me-ness and thee-ness, based upon selflessness and the personal rewards this confers. The challenge is that Alan is also adopting the same approach and is seeking the positive associations with selflessness and to place Barbara's needs first.

By both persons adopting the same stance, therefore, there is a collision of selflessness rather than a dovetailing of intentions. From a perspective of me-ness, both Barbara and Alan want to put the other person first: an *overt selflessness*. Thee-ness also means the time spent in formal care is not the only consideration; both parties will also be aware that the other person will also wish to adopt an overtly selfless strategy. Somewhat paradoxically, thee-ness would therefore require Barbara to put herself 'first' so that Alan's selfless strategy can be rewarded (and vice versa). It is accordingly the self-interested stance (choosing to stay at home) that becomes a *reoriented selflessness*.

This consequently presents a significant challenge: under these terms, if Barbara suppressed her own overt selfless needs (she allowed Alan to adopt an unimpeded selfless strategy) it could simply be viewed that Barbara has followed a self-interested strategy (minimising her own time in formal care). One member of the dyad adopting this reoriented selfless strategy could thus potentially have a negative emotional impact upon the other person (despite being employed with good intentions). In addition, if both Alan and Barbara both choose to suppress their own overt selfless needs respectively, then this could present challenges for both parties with regard to how they present a positive impression of the relationship. These pressures combine to ensure that selflessness continues to be oriented to minimising the other person's stay in formal care. The interactional and social challenges inherent in other modes of selflessness (i.e. enabling the other person's overt selfless strategy to predominate) thus render other strategies inaccessible.

The problem this generates is that interaction will be highly constrained. Game theory differentiates between the so-called 'one shot' prisoner's dilemma, where the deliberation takes place on just one occasion, and when the game is iterative (i.e. ongoing) for an unspecified number of games. While the equilibrium in a one-off game is to opt for a narrow self-interested strategy, under the iterated format more cooperative strategies evolve; for example, a 'tit-for-tat' format can become the equilibrium whereby the person responds to the other person's previous decision (Axelrod 1984). That is, if one person cooperated on the previous attempt then the person playing tit-for-tat would cooperate on the next occasion the game is played.

With this care deliberation it is difficult to envisage how an iterated version of the game would lead to an adjustment of strategy, as both players are actually commencing from a selfless position. The desire to be selfless and the fear of negative social judgement mean that the outcome of the one-off game is likely to be repeated. Commencing from a basis of self-interest leads to a dynamic non-zero-sum game whereby various interactional strategies can evolve. Selflessness as a starting point leads to a static game whereby one strategy is fixed and entrenched. This calls into question how 'cooperation' can be defined under this 'care deliberation'. Both people placing the other person's needs before their own does not constitute a joint strategy. When the aim in the first instance is selflessness, somewhat paradoxically it becomes harder to generate a collaborative sense of we-ness and a breadth of relational goods (Donati & Archer 2015). Whereas the self-interest of the prisoner's dilemma is predicated on a non-zero-sum situation, with an optimal joint outcome available, the selfless pressures of the care deliberation (and the associated problem of defining

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cooperation) mean that it actually becomes very difficult to apply zero-sum logic to the nature of the negotiations.

This demonstrates that relational negotiations undertaken within contexts of altruism and mutuality can still generate individualised outcomes. Conflicting individual intent could be particularly hard to unravel when selflessness underpins the context of negotiations: attributes such as trust, duty and empathy might moderate the narrow utilitarian calculations inherent in the payoffs of the prisoner's dilemma (Crossley 2011), but they actually undergird a recalcitrant *selfless* conflict of interest within the care deliberation. This is not to deny that these attributes are anything other than commendable at an individual level, but merely highlights that a deontological morality might not always be conducive to collaborative decision-making at a relational level. The 'care deliberation' not only means that selfless strategies are an unsuccessful means for putting the other person's needs first, but also generates a very challenging relational context. A relational context without scope for manoeuvre or development of interactional strategies could become strained and even toxic.

This recognition provides the platform for an evaluation of the current social scientific conceptualisations of dementia and care relationships. The importance of relationships in dementia care is highlighted by the concept of personhood, which asserts that the person's relational and social context can enhance the experience of the condition. Personhood is defined as "a standing or status that is bestowed upon one human being, by others, in the context of relationships and social being. It implies recognition, respect and trust" (Kitwood 1997, p.8). This approach to understanding the experience of dementia also highlights that negative behaviours expressed by

carers can generate a 'malignant social psychology' that is damaging to people with the condition.

Kitwood's concept of personhood rejects a narrow individualised illness-centred perspective to recognise the importance of interaction between the person with the condition and other people. The concept has been critiqued, however, for understating the extent to which the person with dementia shapes their own relational circumstances. The notion of personhood as 'status bestowed' underplays the agential scope of the person with dementia and suggests that their experience is something imposed upon them by others (Higgs & Gilleard 2015). There is therefore a requirement to develop a more bi-directional interactive understanding within dementia studies (Bartlett & O'Connor 2010).

Evaluation that draws upon principles of strategic interaction contributes to this pursuit of a more balanced and bi-directional perspective of relationships. While it is of course vital to scrutinise individual behaviours within care environments, difficulties do not only arise from one person employing negative behaviours. Analysis of relational negotiations demonstrates that challenges within relationships could still emerge when both parties are committed, dutiful and selfless. Difficulties can arise from the complex nature of interdependency itself.

Academic endeavours have sought to build upon Kitwood's approach to personhood. For example, there is also a burgeoning strand of literature that promotes the concept of couplehood. Couplehood reinforces the relational basis of personhood, asserting that the importance of relationships means that the couple should be seen as the key

ontological unit (for those in spousal relationships). Related to the conceptual development of couplehood is the tendency to promote a unified and positive view of relationships. Positive language associated with unity and togetherness is associated with literature that draws upon the couplehood concept; for example being 'a team' (Hernandez et al. 2015), an 'us' identity (Davies 2011) and doing things together (Hellström et al. 2005). This rhetoric aligns with 'living well with dementia' policy discourses (e.g. Department of Health 2009).

Exploration of relational negotiations and care relationships endorses elements of the couplehood concept, as it highlights that relationships have emergent properties that cannot be reduced to an aggregation of individual intent. Decisions, choices and actions "are not purely individual acts, but are arrived at in relation to and with others" (Donati & Archer 2015, p.15). Nevertheless, this relational perspective is based upon recognition of the complex and emergent basis of interactions between individuals in the context of their relationship, rather than any reified sense that couplehood comprises a discrete ontological entity. The nature of the couplehood term (with its implication of a sovereign dyadic status) and the associated tendency to proffer a positive account of experience suggests that the couple represents a hermetic and unified whole.

Promoting a sense of togetherness and unity in the endeavour to counter negative perspectives on dementia risks misrepresenting the complex basis of care relationships and their intrinsic challenges. Analysis of relational negotiations has shown that an 'us' identity can be difficult to obtain even when the couple is operating from a basis of altruism and trust. While there are, of course, challenges to

relationships underpinned by discord and conflict, the nature of socially (and morally) framed interdependencies means that relationships present challenges even when they are positive and mutually supportive. In fact, counterintuitively, a clear sense of duty and togetherness could even compound some challenges related to reconciling individual and joint decision-making. Relational subjectivity is therefore not a pre-existing state of couplehood, but is an ongoing project (and challenge). "To maintain that the subject is relational means that he/she is part of a 'We' that is not a superordinate entity but is, instead, a relation" (Donati & Archer 2015).

Contextualising interaction

The utilitarian orientation of standard models of strategic interaction understate contextual factors. It is presumed that, as a central authority does not feature within the biological domain, regularised outcomes of relations must only be a bottom-up formulation, founded on kinship or reciprocity (Axelrod 1984). This can only be a partial account, as it does not capture how the interactional domain is also shaped in a top-down fashion by emergent social phenomena. To fully appreciate the challenges of care relationships, a deeper sociological appreciation of relational negotiations is therefore required.

Traditional approaches to strategic interaction tend to offer a 'presentism' that understates wider temporal dimensions that shape interaction. While there is a temporal dimension to iterative versions of strategic interaction, this is still only a linear sequence of games. An appropriate contextualisation of negotiations within care relationships must also take into account a history and future that frames an instance (or a sequence) of combined decision-making. That is, the decision-making is shaped

by the shared history of the relationship and how this influences each individual and the couple. The decision will also be shaped by projections of how actions and interactions will affect their interpersonal relations in the future. It is not therefore simply the case (as per iterative versions of strategic interaction) that repeated game formats are the only temporal dimension that shape relational negotiations. It has to be recognised that relationships always arise in context. "Given their pre-existence, structural and cultural emergents shape the social environment to be inhabited. These results of past actions are deposited in the form of current situations" (Archer 1995, p.201).

Moreover, dyads do not have an existence that is detached from wider social networks (Crossley 2011): other direct (and indirect) relationships will affect interactions. As has been discussed in the analysis above, Alan and Barbara's direct relationship with a key third party (i.e. professional or family member) will affect the basis of the couple's interactions with the situation thereby triadic rather than simply two-way (see also Quinn et al, 2013). The decision-making and actions of individuals (and couples) will also be strongly shaped by more diffuse sociocultural pressures. These pressures may be experienced as a mode of authority, even though they have not been inscribed with any formal status. It is not the case that causal influences arise only at the level of micro-interactions. Emergent social and cultural phenomena exert top-down influence upon situations of co-presence. For example, Mead's notion of the 'generalised other' (1967) draws attention to how people will engage with a diffuse social (and moral) collective when formulating their decisions and justifying their beliefs/actions. As noted in the introduction, an illness-related status might generate particular moral challenges related to passivity, dependency and selflessness. In addition, caring also relates to

matters of selflessness and coping independently. These can have a deleterious effect on those already encountering multiple challenges associated with the intensely disruptive impacts of a condition such as dementia.

The requirement for a more contextualised perspective of care environments has particular salience within dementia studies. Kitwood's model of personhood has been critiqued for proffering a narrow view of relationships that does not adequately account for wider sociocultural influences (Baldwin & Capstick, 2007; Author, 2017b). While terms such as 'personhood' and 'person-centred care' offer an appealing academic orientation, they also underpin an individualised needs-based lexicon (Bartlett & O'Connor 2010). Moreover, the emphasis on personhood as a *status bestowed* and the dyad as a bounded unit (as per the couplehood concept) further understates the breadth of factors that shape experience and relationships. Underplaying broader influences means that the interactional domain is the site wherein challenges are excessively situated. This narrow contextualisation accordingly lends itself to a model oriented to blame (Baldwin & Capstick 2007; Bartlett & O'Connor 2010), with 'healthy others' (Sabat et al. 2011) held accountable for bestowing malignant social conditions upon people with dementia (Davis 2004).

Conclusion

Scrutiny of relational negotiations in this article has valuably highlighted the challenge of reconciling personal and joint goals when both parties are seeking to prioritise the other person. Drawing upon principles of strategic interaction, this analytical process has demonstrated that, even in the context of respect and mutuality, the interactional domain can present impediments to personal (altruistic) intentions. This feature of care

relationships must be acknowledged if enhanced relational understandings of the experience of dementia are to be developed.

There is no such thing as an individual preference that can be neatly extracted from its relational context, and there are complexities within care relationships that mean personal and joint preferences will be particularly difficult to discern (and even define). There are accordingly inherent challenges within care relationships that must be addressed by professionals seeking to support people with dementia and their family members. People within care relationships require a mode of guidance and support that can help them navigate the various demands and moral pressures that render negotiations difficult. It cannot be assumed people operating within contexts defined by altruism, respect and duty will be able to negotiate combined decision-making situations successfully. As has been shown above, the input of third parties could even compound the collisions of pressures associated with mutual selflessness. People seeking to support those in care relationships are thus in a position whereby their well-meaning influence could exacerbate, rather than mitigate, the challenges of relational decision-making.

An associated challenge raised by the insights of relational negotiations is how to formulate appropriate policy responses to dementia and care, particularly within a liberal context where autonomous choice is paramount (Deneen, 2018). When decision-making processes are entangled within the complex interdependencies of a spousal relationship it proves problematic trying to discern an individual's best interests (and how these can be reconciled with another person's best interests). For example, when the person with dementia feels pressure not to be a 'burden' on others

(and will accordingly be accepting of external support) and the carer feels pressure to be a good carer (thus eschewing external assistance), in which direction should each person (or the couple) be 'nudged' (see Halpern, 2015) by policy initiatives? Policy must address individuals *and* relationships to help people sustain and generate relational goods.

The requirement for an enhanced theoretical approach to dementia and care relationships is not, therefore, simply an abstract and rarefied debate. As has been noted above, current conceptualisations of dementia care have been critiqued for being narrow and unidirectional, with agential emphasis on the carer. A considered sociological approach to strategic interaction helps to redress this balance, as it underscores that people's values and preferences are enmeshed within multi-directional and contextualised interdependencies of relationships. This recognition of the complexity of relationships can help to avoid binary categorisations; for example, the alignment of experience with either 'tragedy' or 'living well' discourses' (McParland et al, 2017). A model that takes relationality as its starting point can account for the emergent and fluid reality of relationship formations, but does not elide individual preferences and choices under an illegitimate unity associated with a 'living well' ethos. Appropriate conceptual tools can thus help to prompt a balanced, contextualised and reflexive grasp of experience and relationships.

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