

THE ROUTLEDGE COMPANION TO LITERATURES AND CRISIS

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CHAPTER 6

CARE CRISIS

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CARE CRISIS¹

Lisa Baraitser and Laura Salisbury

“Care crisis”

In June 1947, the first cover of *The Bulletin of the Atomic Scientists* showed a clock with its hands set at 7 minutes to midnight. The Doomsday clock was designed to visualise crisis: the imminent possibility of human time coming to an end in a nuclear apocalypse and the need for timely action to prevent the future’s annihilation. But there is a paradox in this static image of the clock, adjusted again and again following the twice-yearly deliberations of the group’s Science and Security Board, and still being used today (Bulletin, 2021). The image was designed to evoke an irresistible countdown to destruction in linear time if an intervention was not made; but it also precisely evokes the stuck time that remains when the end is both nigh and ungraspable (Bernard, 2023). Time in the shadow of nuclear destruction seemed hotly urgent in the 1940s but, as George Orwell predicted in the essay “You and the Atomic Bomb,” it also produced something more temporally suspended—a “permanent state of ‘cold war’” (1945). The Doomsday clock evokes a crisis in which there is no time to wait, and yet, then as now, there is little most people can do but wait.

Just as the post-war period entailed waiting in relation to an urgent yet seemingly frozen catastrophe, in the United Kingdom (UK) care for the present and the future required mobilising a collective capacity to wait. In July 1948, the National Health Service (NHS) was established as part of the development of a liberal welfare state designed to address the five great social “evils” of squalor, ignorance, want, idleness and disease (Beveridge, 1942). Centuries of unequal access to healthcare and specific privations caused by war had to be addressed, and social welfare aimed to provide a safety net to maintain citizens through their lives from “cradle to grave” (Beveridge, 1942). Yet because it was acknowledged that waiting was going to be one of the costs of universal care (Salisbury et al., 2023), initially, at least, it had a place as a collective practice within a shared, social project. Waiting could be organised collectively for the first time, so that those in urgent need could take priority over those whose need could wait for a while. Waiting could be represented and could even feel tolerable within the knowledge that individuals were now inside the giant waiting room of the NHS, rather than interminably shut out. However, under pressure from neoliberal health policy through the 1980s, the financial crash of 2008 and the rolling out of austerity measures post-2010, the narrative shifted from one of collective waiting to one of a “waiting crisis.” This sense of crisis, which only intensified during the pandemic years of the early

2020s (Dowling, 2021; Salisbury et al., 2023), can be understood as essentially a crisis in social reproduction linked with the systematic erosion of care infrastructures and the financialisation of all forms of care (whether social care, eldercare, childcare, chronic illness and disability care, or healthcare). The care crisis runs hand in hand, Nancy Fraser has argued, with the various crises brought about by the inherent contradictions of financialised capitalism (2016). Care and social reproduction, more generally, remain the necessary but repudiated, undervalued and often hidden activities that sustain capital accumulation. At the same time, unlimited accumulation, as it attempts to extract value from care, constantly undermines the processes and practices of social reproduction that are the ground from which all our interdependent futures grow.

One aspect of this contradiction is that the work of “making care” (Puig de la Bellacasa, 2017) does not align with that of production, progress or growth. Care is a time-based practice that requires engaging with the uncertain temporalities that reveal and sustain interdependence: waiting, staying, enduring, persisting, delaying and repeating, in order to maintain, sustain and repair social relations as they repeatedly and necessarily come undone (Baraitser, 2017). It involves being able, or being prepared, to return again and again to the scene where care is needed, even when this may appear futile or a “waste” of time. Care therefore has a distinctive relation to timeliness. No one should wait unduly when they need care; yet effective care recognises both the demand for a timely response and the vital importance of forms of what we could call “untimeliness”—allowing time to pass, sitting with and in stuck time and enduring the experience of nothing getting better. Healthcare practitioners know this well. They endure the extended time needed for therapy or medication to work; the watchful waiting before or after diagnosis; and the time that stretches out over remission, relapse, palliative and end-of-life care. At one end of the spectrum, in acute care, in the beat between the chest compressions that mimic the interval between heart beats during cardiac arrest, a tiny yet vital wait is inserted into care-making that can feel like a lifetime. At the other end, complex, long-term and often medically unexplained health conditions require ongoing sustained involvement with patients, often over years (Salisbury et al., 2023). Here, waiting *with* or simply continuing to be available becomes the key way of continuing to offer care (Salisbury and Baraitser, 2020; Baraitser and Brook, 2020).²

From this perspective, “making care” depends on conditions that continue to produce elongated time in the suspended time of care’s formation. Kelechi Anucha calls this “fugitive care.” Drawing on the work of Fred Moten (2003), Saidiya Hartman (2007) and others, she proposes “fugitive care” to describe the ways in which care is “inventive, improvised and endlessly challenging, taking place in excess of sanctioned clinical and social pathways” (Anucha, 2023, p. 12). Fugitive care helps us understand the often-hidden strategies and alliances that emerge for resisting and negotiating structures of medical institutions and pathways through them. From this perspective, care must unfold without knowing the outcome of its improvisations. Care thus takes place under conditions of suspended “judgement.”

What does it mean, then, to speak of a “care crisis” when crisis depends on and mobilises the moment of judgement that care suspends? As developed in the Introduction to this volume, the term “crisis,” which is linked to the Greek *krinein*—to decide, to distinguish and to separate—describes a medical diagnosis in the Hippocratic corpus: the turning point in a disease when life and death hang in the balance. Koselleck and Richter (2006, p. 358) argue that the idea of crisis migrated from the medical into the sociopolitical sphere during the Enlightenment to describe the capacity of humans to act within a newly formed idea of historical time. In an era no longer predetermined by religious frames that produced apocalyptic narratives of redemption or deliverance, crisis called for a different kind of judgement: a diagnosis of events within history, a prognosis and a prescription for change in the present. Koselleck and Richter describe how this movement

towards prognosis produced an account of history that was inherently temporalised and that could be diagnosed and judged precisely because it contained moments of decision. With a sense of time produced in relation to human action, the future was figured as fundamentally open—something that could be shaped by decisions in a present that was distinguishable from the past. Perceptions of “epochal” change that arose in the late eighteenth century thus entangled history and the *telos* of progress itself with crisis (Koselleck and Richter, 2006, p. 358). It was from the “temporal” sphere of human history that a different future might emerge.

But in an historical moment when diagnosis and prognosis seem unable to produce a different future, a moment in which the present appears stuck and future narratives are themselves in crisis, lurching from crisis to crisis becomes the very condition of the contemporary (Baraitser, 2017). If the experience and framing imaginaries of crisis have become both chronic and acute—there is no time to wait but there is little to do but wait—perhaps the suspended temporalities of care that emerge in crisis’s shadow offer new paradigms for enduring the present and its relationship to the future. The conjunction of “care” and “crisis” could, in other words, signal not just an inherent contradiction in the structure of financialised capitalism, but a way to ask crisis to wait in order that it remains open to the possibilities of immanent care.

“Care crisis” is, after all, a crisis in and of time. It is not just that there is no longer enough time to care in cash-strapped public services in developed countries across the global north. It is that care is dependent on the suspension of time passing in linear and developmental ways for it to form *as* care, rather than neglect or even punishment. So, for example, the figure of the “frequent attender” in general practice—the person who presents in permanent crisis, returning again and again in an attempt to have their suffering alleviated—is often experienced and treated as a nuisance. As Davies and Moore have argued:

Usually figured as a woman, she embodies a recurrent predicament for a publicly funded healthcare system with an “open door” policy. On the one hand, her constant return appears proof of something working, of the NHS keeping its promise to be continuously “there” for those who need it, with an open-ended offer of time in which to care. On the other hand, frequent attendance has been used as evidence of what is wrong with universal healthcare—that by being too available it becomes vulnerable to misuse or overuse, to the point where (according to critics) only disciplinary measures or charges can “protect” this time.

(2023)

Yet instead of trying to get rid of the frequent attender, reduce her need for services or get her to look after herself, Davies and Moore invite us “think of her within the interruptible flow of everyday life,” where the experience of waiting with what is painful, repetitive and sometimes unbearable is fundamental to care in chronic situations. Unlike the Doomsday clock that statically holds in place the time of catastrophe just ahead of the time of the now, care time is a matter of “caring on,” insisting that the chronic time that is necessary for care inhabits crisis time and indeed holds within it the possibility for a response to crisis that could take us beyond what Janet Roitman calls “anti-crisis” (2016). For Roitman, we swing between crisis and anti-crisis but never arrive at a crisis-free future because crisis narratives themselves cannot produce alternative histories. Crisis is a form of critique or judgement turned back on history itself so that we ask, in a crisis, “what is going wrong in the present moment?” This is an anti-crisis strategy, but it does not in and of itself produce a different future. For a truly crisis-free future to exist, we would have to consider Roitman’s question: “How can we imagine that which fundamentally *excludes* our judgement, that *which calls for no decision?*” (Roitman, 2014, p. 90, our emphases). We offer care, understood as

a mode of waiting in the suspended time of its own formation, as that which has the potential to take us beyond the endless oscillation between crisis and anti-crisis.

Depressing time

Waiting with what is painful, repetitive and sometimes unbearable as a condition of care has an affective quality that is not always easy to sit with and may be better aligned with a different idea of “development” than that associated with teleological progress narratives. In a 1962 essay, the British psychoanalyst D. W. Winnicott wrote about adolescence as a developmental phase often experienced as a crisis (Catty, 2021). He begins by articulating the answer to the “problem” of the “long meanwhile” (2016b, p. 81) of adolescence in deceptively simple terms. The “cure for adolescence belongs to the passage of time” (2016b, p. 79), Winnicott writes; one must simply wait. Building on G. Stanley Hall’s path-breaking account of adolescence (Hall, 1904) as an “elongated hiatus between childhood and adulthood” (Waddell, 2018, p. 4), Winnicott asserts that the psychical process of adolescence “cannot be hurried or slowed up, though indeed it can be broken into and destroyed, or it can wither up from within, in psychiatric illness” (2016b, p. 79). Winnicott follows Freud in arguing that adolescence is a time when a young person attempts, once again, to resolve the psychic struggles of early childhood. And, although the “rapid alternation between defiant independence and regressive dependence” (Winnicott, 2016b, p. 81) produces something that often feels like a psychological crisis, alongside this, something else frequently emerges—a state Winnicott describes as “the doldrums.” Here, the young person feels “futile”: “They do not know what they are going to become. They do not know where they are and they are waiting. Because everything is in abeyance, they feel unreal” (2016b, p. 84). Although it seems as if nothing is happening, Winnicott suggests that the doldrums are a vital developmental phase. In them, the young person can use a period of waiting to try out personal identity formations, test their aggression against a society that will hopefully withstand their destructiveness and find a place for themselves that feels “real.”

“The doldrums” are not a purely psychic developmental phase, however. It is worth attending to the fact that Winnicott frames the “problem” of adolescence in relation to what it meant to grow up in an environment that was both post-war and lived as anxiously interwar. Following the “tick” of a Doomsday clock that has been set in motion, there was a sense of waiting for a “tock” that could mean the end of history, and perhaps even all human time (Kermode, 2000, p. 64). There is much to be said about the “pre-traumatic” stress of living in a world that anticipates annihilation (Saint-Amour, 2015; Pong, 2022, p. 264). Writing just after the Cuban Missile Crisis of 1961, Winnicott concentrates, however, not on the inevitability of a war to come, but the threat of a nuclear holocaust that, in his British context at least, seemed to stop the clock. Another war of the kind that had made historical time in the twentieth century could not come, he suggests, because there would be no living on beyond it. Winnicott, who had fought in the navy in the First World War and served as consultant paediatrician to the British children’s evacuation programme of the Second World War, writes:

The atom bomb affects the relationship between adult society and the adolescent tide, which seems to be for ever coming in. We have to carry on now on the basis that there is not going to be another war. Now it can be argued that there might be a war at any minute in some place in the world, but we know that we can no longer solve a social problem by organising for a new war.

(2016b, p. 83)

Winnicott argues that adult society must meet with mature understanding the aggression, sexual desires and social experimentation of adolescence that had previously been enacted and disciplined through war's social realities. Adolescent waywardness must be understood as structural to the waiting now required when the kind of activity that had constructed individual narratives of maturation, alongside the movement of historiography as a developmental process structured by global military crises, had been foreclosed. For the sake of an adolescence (or indeed of a developmental time) struggling to be born without a war outside that could be fought to produce historiographic and psychical staging posts in linear time, the doldrums had to be tolerated. Waiting might even need to be encouraged if the hasty enactment of aggression and violence at a social and national level was not to produce an end from which there could be no beginning again.

Foreshadowing his 1962 argument about the importance of an ordinary doldrums for adolescence, in 1955 Winnicott wrote about the individual and social value of depression, which has a specific meaning in Winnicott's lexicon. Freud (1917) makes a distinction between mourning and melancholia, with mourning associated with development and maturity, and melancholia with a repetitive form of misery brought on by the difficulties of acknowledging loss and moving on. But Winnicott turns to Melanie Klein's notion of the "depressive position" (Klein, 1946, p. 99), which is fundamentally linked to a form of waiting; it involves "the holding of an anxiety and a hope over a period of time" (Winnicott, 1964, p. 186) that produces a fundamental psychological capacity for guilt, ambivalence and ultimately for mourning. For both Klein and Winnicott, the depressive position is a psychic state that represents "an emotional achievement" (Winnicott, 1964, p. 185). It is the depression that enables loss to be faced through an acknowledgment that the things we love are also the things upon which we inflict violence. This brings with it the possibility of guilt, which becomes the ground for reparation that might take place over time. Winnicott goes on to suggest that a better name for the "depressive position" might in fact be "*the Stage of Concern*" (1964, p. 187), in which things come to matter through and over time and the possibility of care emerges (Baraitser, 2021, p. 46).

When faced with the reality of loss, however, a depressed, melancholic mood sometimes develops; indeed, Winnicott suggests that "where there is some degree of failure at the depressive position the result of loss is depression" (Winnicott, 1964, p. 198). But, for Winnicott, this mood, like the adolescent doldrums, also has some value. When someone is up against the dangerous and painful inner persecution associated with the loss of something loved, a depressive mood might emerge that attempts to retain some kind of equilibrium by dampening down the aggressive instincts and withdrawing from the external world to give time for psychical processing. Writing in 1955, Winnicott uses a military metaphor:

There is a danger situation, and the defensive mechanism of an overall deadening produces a mood of depression. The depression is a healing mechanism; it covers the battleground as with a mist, allowing for a sorting out at reduced rate, giving time for all possible defences to be brought into play, and for a working-through, so that eventually there can be a spontaneous recovery. Clinically, depression (of this sort) tends to lift.

(2016a, p. 199)

In a striking reworking of idea of the "fog of war," in which violence emerges as a response to uncertainty, Winnicott argues for the value of a blanketing mood as something that muffles the resounding urge for the immediacy of action. Instead of the action produced by crisis, a depressive mood instead makes time for waiting, for uncertainty to be tolerated and for understanding to

emerge. Although the depressive mood may be the result of a temporary failure of the depressive position, Winnicott insists that it also relies on there being something that endures sufficiently that it might ground an inclination towards a future. There is enough structure to the ego that it can understand itself as a “whole person,” or a “unit” (which in his later 1964 essay on depression invokes the sense of a military organisation of troops and armaments) in which different forces can be moved and mobilised, or blanketed, under a sense of overarching organisation (1964, p. 124). The temporary, protective depressive mood can thus be differentiated from more intense forms of depressive illness typically found in psychiatric settings and the sense of lasting futility and hopelessness they include. As Baraitser puts it, the time of depressive illness belongs “to the psychic time that lies outside the capacity for concern, a time before things come to matter to us” (2021, p. 46), whereas with depressive mood, there is “something” there that can feel depressed. If this “something” is intact, albeit inactive, then depression can come to have meaning and value.

For Winnicott, this depressive mood that emerges from the possibility of remaining in the depressive position, or in the doldrums, is valuable because it contains “*the germ of recovery*” (1964, p. 123). Counterposed to the escalation of conflict that might bring human time to an end through a secular apocalypse, a depressive mood withdraws from action in the name of making time for something else to unfurl, in its own more hesitant way. It is by being able to inhabit what Baraitser names “depressing time” (Salisbury and Baraitser, 2020; Baraitser, 2021), which is not aligned with the more assertively deadened repetitions of acute depressive illness but a more chronic suspension of the forward movement of linear time, that one might, over time, come to care about one’s own guilt (Baraitser and Brook, 2020). Depressing time, then, suggests the capacity to go on knowing about crisis without moving into anti-crisis—that is, without attempting forms of manic repair. Instead, the task might be to foster forms of connection that consist of holding together care and violence: waiting with, enduring with, staying with, staying alongside, through the continual capacity to suspend the judgement through which the time of crisis is structured. This is less the time of indecision than the time of *suspended* decision (Baraitser, 2021), an answer to Roitman’s “call for no decision.”

Flat time

What does it mean, then, to respond to a traumatic experience not with crisis-orientated judgements and affects, but with a flattened mood? And is there a possibility of care within this flat place, this depressing time? In her memoir, *A Flat place* (2023), Noreen Masud attends to flatness, both as an overlooked topographical feature in literature and nature writing and as a central part of her lived experience of complex post-traumatic stress disorder. Flatness is her psychical and embodied response to a childhood in which care was withheld over time—sometimes neglectfully and sometimes more violently—even though this experience is not quite narratable across a topography of extreme events or the peaks of crisis. Bringing the spatial and the temporal together, she notes that part of the difficulty in treating complex PTSD is that, “like a flat landscape—it didn’t offer a significant landmark, an event, that you could focus on and work with” (Masud, 2023, pp. 9–10). After leaving the Pakistan of her birth, personal trauma becomes folded into a more social trauma of living in a postcolonial Britain that persistently indicates to people of colour “that they shouldn’t think of themselves as real. Because if no one real was hurt, then no harm has been done” (p. 44). But Masud finds something in a flat landscape that matches her experience of dampened affect and the defence of derealisation and that somehow offers the possibility of feeling met, perhaps even met carefully. This experience of connecting with what has been overlooked, both

literally and figuratively, enables her to reconceptualise “what it means for something to ‘happen’ and to rethink what it means for something to ‘matter’” (p. 14).

A flat landscape and a flat life are experienced in spatial suspension, Masud suggests, and also within a form of depressing time. Flatness refuses the time of crisis, decision and action. But in holding carefully and closely to what emerges, minimally, within sites of flatness, Masud comes to understand something of what it means to dwell there. Towards the end of the book, she too turns to Winnicott and his idea “that living a good life after trauma means being able to be safely and absorbedly inside yourself [...] to simply *be*, rather than always responding to things in your environment” (Masud, 2023, p. 207, emphasis in the original). She is referring to both feeling “held” and being able to hold oneself, rather than feeling called on to act precipitately. Masud worries that such self-containment and having one’s borders clearly demarcated, shall we say, might mean an apolitical turning away from things that matter, including things that matter in temporal and spatial ways that don’t crest the usual horizons of visibility. “People think of flatness as numb and dead,” she writes, “[b]ut the flat place means being alive to things which are plausibly deniable: which happened just faintly or incidentally enough that most people feel able to ignore them” (p. 208). And this starts to connect laterally, across an overlooked landscape of intergenerational trauma and crisis. Before her own experience of complex trauma, Masud’s father had fought in the 13-day war in 1971 between Pakistan and Bangladesh in which around 3 million people were killed. This crisis bloodily sought to answer the questions of belonging that Partition from India in 1947 had left suspended. Masud’s father’s later response to this experience seemed, to her, unusually flat, although not talking about it mimed another form of overlooking that took place, and takes place, in political and cultural discourses where so much of the violence of colonisation and its aftermaths remains unspoken.

Masud writes of the value of staying with the landscape in which she has found herself. She describes the possibility of making a life in a space and time where action at a grand scale is depressed—pressed out—and life and death feel coiled around one another. She anatomises the suspension of resolution that would gather things together into a landmark, but writes instead of

[k]nowing that it can be meaningful to focus on the “wrong” details. To make strange relationships with strange things. To allow a scene to blur out of vision, generously. At its best, that’s how the flat place feels to me. It doesn’t steer you or demand that you move in a particular direction. If it’s a place of terror and despair, pressed right up against the cold ground of something true, it’s also—and precisely because of that—a place where new kinds of connection might start, very furtively, to grow.

(p. 207)

In this final chapter of the book, Masud turns to the Black Lives Matter (BLM) movement to describe how something surfaced in 2020, breaking through cultural and political denial. Masud experienced it as a moment of sharing the space of trauma, laterally and across planes of difference, that enabled something to be known about racialised violence. Her emphasis on flatness within a broader movement for justice might even be read as adjacent to some of the protest strategies of the BLM movement that have also insisted on the value of staying low, in what might be called depressing time. Referring to activist strategies of staging “die-ins,” Elizabeth Freeman has suggested that “[m]iming death and temporal incapacity rather than seizing life and temporal capacity” is a way of repeating the social death that has cast people of African descent in the USA as “always-already dead” (2019, p. 86). But, Freeman writes, in “playing dead in the road over and over again, Black Lives Matter activists commit to an (a)social life within death even as they

fight for an end to the annihilation of blackness” (2019, p. 86). Through staying with a form of depressing time, forms of what Anucha names “fugitive care” are found.

Masud notes a lateral kinship, though importantly not an absolute identity, with the BLM movement and what we might mark as its strategies of flatness. As she describes it:

Areas of overlap were beginning to emerge, to be acknowledged, between my reality and those of other people. And I noticed that the flat place inside me didn’t vanish, or even really fade, during these moments of shared reality, or of expressing my own reality and seeing it accepted by those around me. But something about it warmed [...] I would always live in the flatland. But that might be alright. Because from time to time the wind stopped howling across it, leaving only the particular quiet spring warmth, against a grey sky, as flowers began to put their minds to uncurling. And I could stop looking at the sky, and simply trace my fingers through the loose soil on the surface.

(pp. 205–206)

Strategies of flatness can be shared and can provide points of solidarity, but they do not precipitate an exit from the flat place and its suspended time. Instead, Masud describes an acceptance of flatness and with it a slight shift in its mood, from the wind howling to the possibilities of warmth and a lateral unfurling—an opening out against a grey sky.

Conclusion

Masud brings her memoir to a close with an image and gesture, rather than an act, of quiet relationality and care—keeping low to the surface of the soil and paying attention to what is found there. We see a kinship between this “lowness” and Winnicott’s notion of “depression” that we have traced out here, in which there is a necessary withdrawal from the time of action and a willingness to remain in what he calls the doldrums, a waiting time, that allows something to unfurl. In response to Janet Roitman’s suggestion that we can only break open the oscillation between crisis and anti-crisis by imagining what calls for no decision (Roitman, 2014, p. 90), we have offered care, understood as a mode of “depressing time,” as one such imagining. Indeed, depression may turn out to be a more salient affect than anxiety for understanding the affective regime of late capitalism, both in its debilitating and in its reparative modes (Baraitser and Brook, 2020). As Masud writes:

[W]e think of ecology as a kind of harmony, but equilibrium is just as much about the balance of death as life. We can’t live in this world without damaging it or being damaged. The point is to be deliberate about which damage to give and take.

(p. 210)

In this sense, violence and care can never be disentangled, but we can, in depressing time, come to know something about the damage we have done and continue to do to what we care about and depend on; mobilise something like guilt; and attempt something like repair to go on maintaining and sustaining our world. The conjunction “care crisis” functions to draw our attention to how care’s suspension of time enables a vital suspension of the judgement inherent within the logic and structure of crisis. Relinquishing the desire for overcoming and indeed for cure, a minimal and reparative inclination towards a future is nevertheless maintained, in and as the time of care.

Notes

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