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ORIGINAL ARTICLE

Relating through differences: disability, affective relationality, and the U.S. public healthcare assemblage

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Abstract Using affect theory and disability theory, this article theorizes relationality as it emerges between disabled people who require daily assistance and their paid care providers. In response to the question of how people relate when not only their social identities but also their embodied capacities are different, the concept of *affective relationality* is developed. Using the work of Deleuze and Guattari, Spinoza, as well as Harney and Moten, I describe how such relationality emerges based on the ontological, haptic connection of bodies that develops through recursive practices of a task co-conducted by and between those bodies, and is co-capacitative. As this study takes place in the U.S. neoliberal public healthcare assemblage—which involves mainly lower- or no-income disabled beneficiaries and their paid workers who are disproportionately lower-income, non/immigrant women of color—the concept of affective relationality is brought into the political arena by contemplating what the relationality does in such assemblage.

Keywords Relationality · Disability · Difference · Affect theory

Introduction

The exploration of ways to build solidarity among those who are different in terms of their socially constructed identities and related standpoints has long been a topic of feminist studies and activism (e.g., Hooks 2000; Smith 1998a, b; Yuval-Davis 1997). In this exploration, feminist scholars and activists have advocated for the differences among people to be considered a strength for the collective instead of

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putting such differences aside. In this paper I further delve into the topic by asking in which ways solidarity—or in this case, relationality—may be developed and nurtured when the differences among people are based on not only identities but also embodied differences in capacities. As this article stems from disability studies (and affect studies), by "differences in capacity" I am considering both constructed and embodied capacities to function in the given society as well as related needs for support from others to conduct everyday activities of living (Siebers 2008). As much as such capacity and debility are constructed socially, I also integrate the ontology of impairment or disability into my analysis—by foregrounding the reality of embodied continuation of capacity and debility which gives a rise to the care industries (*ibid.*; Puar 2009). I look into and theorize the process and nature of relationality forged between disabled people and their care providers by developing the concept of *affective relationality* in this article. Finally, I end with a contemplation of what such relationality does in the current neoliberal political economy, particularly as it manifests in U.S. public healthcare programs. For the development of the concept of affective relationality, I bring together affect studies—which has been incorporated and further developed by critical psychologists—and disability studies. Also, corresponding to the profoundly racialized nature of public healthcare and care industries in the U.S. (which is reflected in this study), concepts and theories developed by critical race theorists Moten and Harney (2013) are woven into this article.

This article emerged from a larger research project that investigates the influences of the neoliberal political economy on U.S. public healthcare programs and the ways in which (lower- or no-income and racialized) disabled people who require state supports to meet their care needs and their paid care providers (who are largely lower-income women of color and immigrant women) are treated under the healthcare structure. Captured and theorized here are the moments during which those care recipients and providers build and nurture supportive and caring relationality while they are managed and at times exploited by the public healthcare structure (Nishida 2015). Arguments developed in this paper are based on focus groups, individual interviews, and participant observations conducted for the above-mentioned larger study. The context as well as the structure of the research are further described below.

Affect theories and disability studies

In critical psychology and elsewhere, the affect turn has enriched the ways in which scholars understand human and non-human experiences and events (e.g., Blackman et al. 2008; Clough 2007). One of the fundamental contributions of affect studies I foreground here is the elimination of the conceptual boundary by which bodies—whether human or non-human—were previously bounded. In critical psychologist Blackman's (2010) words,

> The body is not bounded by the skin, where we understand the skin to be a kind of container for the self, but rather our bodies always extend and connect

> to other bodies … and to practices, techniques, technologies and objects which produce different kinds of bodies and, arguably, different ways of enacting what it means to be human and non-human. (p. 170)

The body is an assemblage: "the particle aggregates belonging to that body in a given relation; these aggregates are part of each other depending on the composition of the relation that defines the individuated assemblage of the body" (Deleuze and Guattari 1980/1987, p. 256). In this line of thinking, the body is open-ended, composed by bits that constantly reconfigure their arrangements and relationships based on external and internal influences. The body is ever in formation (e.g., Clough 2008). This affective conceptualization of the body provides alternative ways to understand the encounter of multiple bodies and demands reconceptualization of relationality among bodies:

> Existing bodies do not encounter one another *in the order* in which their relations combine…. [E]xisting bodies, being themselves composed of extensive parts, meet *bit by bit*. So parts of one of the bodies may be determined to take on a new relation imposed by some law while losing that relation through which they belonged to the body. (Deleuze 1968/1990, p. 237, emphasis original)

Parts of bodies preconsciously connect, relate, and adapt to other bodies, their movements, and the larger milieu. This process involves haptic connection, to use Harney and Moten's (2013) words (that are further elaborated at this end of this article): "a way of feeling through others, for others to feel through you, for you to feel them feeling you…. its inherited caress, its skin talk, tongue touch, breath speech, hand laugh" (p. 98). It goes beyond cognitive connection and involves ontological connection at the encounter. Haraway (2008) describes that encountering bodies are.

> in the dance of relating…. [W]ho they are is in constant becoming in these rituals. Greeting rituals are flexible and dynamic, rearranging pace and elements within the repertoire that the partners already share or can cobble together…. [A] greeting ritual [i]s a kind of embodied communication, which takes place in entwined, semiotic, overlapping, somatic patterning over time, not as discrete, denotative signals emitted by individuals. An embodied communication is more like a dance than a word. (p. 126)

An encounter is a process of collective becoming, inheriting both capacitative and debilitative potential for the encountering bodies. This notion is deeply reflected in the field of critical psychology as well (e.g., Blackman et al. 2008). Frosh (2008), for example, suggests that "it is not what is *in* the message that is important, but what is *transmitted* by it" (p. 323, emphasis original). In other words, he foregrounds elements not captured in people's meaning-making process, yet which bring and connect them together. Bridging the perspectives of critical psychology and disability studies, Goodley et al. (2014) expand the notion of *post-human* to rethink the human subject and its subjectivity by inserting a disability studies perspective. As they describe, "One of the most significant contributions of critical

disability studies has been the dislodging and deconstruction of the fantasy of ableist human *one-ness*. Disability demands mutuality, support and interdependence" (p. 353, emphasis added). Foregrounding and valuing a state of dependence that is overtly associated with disabled people and thus stigmatized, this quote not only captures the disability studies principle of understanding human experiences by centering disability analysis but also connects affect studies (or critical psychology) and disability studies in terms of the ways in which the body is conceptualized as inherently open and constantly relating with other bodies as well as milieus.

Disability studies conceptualizes human differences and diversity as the norm, and centers such differences in the theorization of non/disabled people's experiences, while simultaneously analyzing the ways in which such differences come to be constructed and stigmatized across time and space. Thus, the field questions and challenges the notion of the independent, rational individual valued in general and particularly in this neoliberal era (Breckenridge and Vogler 2001; Goodley et al. 2014; Stephens et al. 2015). They assert, instead, that humans—regardless of disability status—are inherently dependent beings and maneuver the world in relation with their surroundings (Chandler 2012; Fritsch 2010; Gibson et al. 2012; Ruddick 2010). In the recent special issue of *Feminist Review* (2015), for example, the topic of debility is covered to address the ways in which a human's capacity (thus debility) is situated and co-affects those surrounding the person (e.g., Shildrick 2015). Chen (2012) also blurs the conceptual and actual boundaries of the human body by contesting the hierarchy developed among human and non-human matters and by highlighting the animation and affects of non-human matters. The notion of human bodies as shaped with and through their surroundings is further theorized with the concept of *assemblage* by disability studies scholars (e.g., Gibson et al. 2012; Stephens et al. 2015). Addressing geographers on the one hand, Ruddick and her colleagues suggest including the affects of material and built environments to understand the making of disability as well as the experiences of disabled people, as such affects shape the assemblage that can enhance or suppress disabled people's degree of social participation (Ruddick 2012; Stephens et al. 2015). On the other hand, Gibson and her colleagues situate their theorization in the field of rehabilitation studies by describing human relations—independence or interdependence, for example—as transient states enabled by a certain assemblage in which a (disabled) person is embedded. Therefore, they advocate for rehabilitation practitioners to support disabled people to learn ways to build their own support systems—or assemblages—that enable an interdependent state, instead of exclusively working toward the independence of disabled people. By building on these works on the making of debility in continuation with capacity and disabled people's experiences in relation to their surroundings, my focus is on the *process* through which affective relationality is built and nurtured. In particular, I pay close attention to the relationality between two groups of people, disabled people and their paid care workers, instead of diverting my attention to the materials and other bodies surrounding them as well.

The theories and arguments laid out below are built based on a larger research project of two years as described briefly above. In the project, narratives were collected through focus groups and individual interviews with 12 disabled people

who receive their long-term care[1] through New York State (NYS) Medicaid and 10 paid care providers who provide long-term care for disabled people under NYS Medicaid. 9 of 12 disabled care recipient participants are people of color (6 of them identified as black, 3 of them as Latino/a, and 3 of them as white) and predominantly physically disabled (10 out of 12; a few of them had multiple disabilities). 9 of 10 care provider participants were women of color (7 of them identified as black, 2 of them as Latina, and 1 of them as white), and 4 of them immigrated to the U.S (additional 2 people are children of immigrants). In addition to the focus groups and individual interviews, participant observation was conducted on care practices carried on by two pairs of disabled people and their paid care providers for a week. While narratives and field notes are used for the following theorization, they are not necessarily analyzed word by word, as is done in semiotic-focused discourse analysis. Instead, my intention was to read movements of those care providers and recipients through their narratives and my field notes on everyday care practices (Fox and Alldred 2013). I use the narrative and field note data as one manifestation of bodily experiences and the ways in which such experiences accumulate within individuals and collectives.

Affective relationality

Care recipients and providers' first encounters are not often neutral but already filled with various emotions and presumptions. As further contextualized later in this article, the roles of care providers and recipients as well as populations who (are pressured to) take such roles are constructed in the assemblage of U.S. public healthcare in relation to many elements including those of migration-, race-, gender-, class-, and disability-based social in/justices. Thus, innate differences among people's capacities to live independently in the given society and the need for others' support to do so are further amplified and solidified; thus, a clear division is created between the roles of care provider and care recipient. In addition, care recipients and providers of public healthcare (Medicaid in this case) are often extensively managed by care industries who coordinate and monitor their care practices. In other words, their practices of care are deeply influenced by guidelines and other structures enforced by care agencies, and that is no exception for care providers and recipient's first encounter.

> Supervisor gives you the case, but they don't tell you where you're going.… [T]ears coming to your eyes, because you don't know where you're going. You're scared to go. [Supervisor] don't tell you nothing about patient [*sic*]. So when you reach their house, patient gives you the attitude [for not knowing

[1] Receiving and providing *long-term care* means that care recipients and providers spend time together almost every day of the week to conduct the care-based tasks assigned by care agencies (e.g., assistance in bathing, dressing, cooking). Hours of care provision assigned to care providers and recipients I interviewed vary from 4 to 12 h a day, five to seven days a week. (In cases where a disabled person requires care every day, a few care providers rotate throughout a week.) Therefore, care providers and recipients of long-term care often spend most of their waking time together and co-experience daily events.

> basic information about them]. You have to calm them down saying that "you know what? I didn't know." (Care Provider)
>
> The agency are sending [care providers] sometimes three or four a week who [you] don't know.… You are admitting this person to your home.… They know everything about you, but you don't know anything about them which is [an] upsetting set up. (Care Recipient)
>
> With agency, you never know who's gonna come in your house. You have to go with the flow. Because if you don't, you're not gonna have the help for the day. (Care Recipient)

Depicting disabled care recipients and their paid care workers' first encounters, these sentiments illustrate how vulnerability heightens in both of their bodies at their first encounter. While it is the nature of care practices for individuals to experience vulnerability, such vulnerability is further induced by external factors including care industries who fail to provide necessary information about the newly formed care partners. Or it is not uncommon for the industries to send different care workers to disabled clients day after day, especially at the beginning of care arrangement. This consequently forces them to go through the first encounter over and over. Also, according to participants of the study, the most enforced guideline by the industry for these individuals is the ban on forming any sort of connection, such as friendship, between partners. With such enforcement, while individually experienced vulnerability at the beginning of the care practice is induced by external factors, it is often toward each care partners that the other's subsequent frustration is directed. Care practices begin with care providers and recipients being positioned antagonistically.

Despite the way their first encounter is shaped, care provider and recipient encounter, and in the case of care practices, their encounter is a *recursive* one. They co-conduct activities of daily living day after day. Disabled people and their care providers often spend most of their waking time together. Thus, regardless of how long lasting their care partnership would be, they work together every day and repeat the routines assigned by the care industries. These recursive practices of care routines bring some of the care providers and recipients closer. As critical psychologist Slife (2004) explains, "practices are the individual's main way of relating, with beliefs and values secondary to, and serving the relation we have, with others" (p. 158). The recursive encounters and practices slowly change the register of the bodies involved, allowing them to accumulate ontological knowledge about the other body. This accumulation of ontological knowledge or haptic learning[2] involves the adaptation toward each partner's particular body shapes, movements, capacities, needs, desires, and rhythms. The intensities of each body merge with one another, forming a bigger force together. The relationality is embodied: there is an "interpersonal sense of connectedness written into our bodies that can characterize such care" (McCarthy and Prokhovnik 2014, pp. 18–19). Affective relationality emerges; it is an ontological relation, connecting bodies haptically. Described in more details in the following section, such relationality is co-capacitative to the

[2] I use the term *learning* to emphasize its connotation to how the synchronization of bodies is gradually achieved through accumulated and repeated practices.

bodies involved. Affective relationality is a result of the recursive labor of those who are encountering, and it evolves through their differences.

> [The relationship with your personal care attendant] is the closest relationship you really have in the world.… It's one of the things where they can *sense* when you don't feel good. They can *sense* certain things no other person can sense. Because they are with you so much, in so many circumstances, so many environments, and so many places. (Care Recipient, emphasis added)

> When you're working with a person eight hours, nine hours, five days a week, seven days a week, you start to know what these people are. What their habits are, you know what their needs, you can almost *anticipate* what their needs are. (Care Recipient, emphasis added)

The second sentiment illustrates that it is not only care providers who adapt to their clients, but also disabled care recipients who haptically learn and come to adjust to their care providers. They feel each other and experience their surroundings through one another's body (Harney and Moten 2013).

> Just doing what she [her client] asked of me, no matter how many times she asked. And just doing it. She said that it takes a lot, a lot of patience.… Sometimes I did it a right way, but she'd say, "But I don't feel it right, so you've gotta do it all over again." … I really, really learned. (Care Provider)

It is the recursive practices of care that facilitate affective relationality. The labor of both providers and recipients of long-term care lets bits of their bodies reconfigure and slowly adapt to the other body and its shape, movement, rhythms, habits, and desires through repeating the same care tasks day after day. It takes the time and patience of both parties to build such a connection. Through this recursive collaborative dance of reconfiguration and adaptation, care partners begin moving their bodies to be in sync with other bodies in order to accomplish care tasks. Care practice, on paper, seems to be a rigid, clear-cut list of services that providers are assigned to perform for their clients. In reality, though, each task requires the collaboration of both bodies on multiple levels. A process which twirls both bodies beyond the boundaries of their skin.

Innate and constructed differences of capacities and needs among people are a prerequisite for the establishment of care practices. Care providers and recipients are put together to work to complete care routines. They work with and through each other's differences via haptic, ontological connections. The individual differences are, in a way, the foundation from which affective relationality sprouts and develops. Affective relationality, or merging of two bodies, thus forms a bigger force than force of one body.

Becoming a bigger force together

> We call good, or evil, what is useful to, or harmful to, preserving our being … that is, what increases or diminishes, aids or restrains, our power of acting.

> Therefore … insofar as we perceive that a thing affects us with joy or sadness, we call it good or evil…. [T]he more a thing agrees with our nature, the more useful, or better, it is for us, and conversely, the more a thing is useful to us, the more it agrees with our nature (Spinoza 1677/1996, IV, 8. Dem – IV, P31, Cor).[3]

Affect theorists often go back to the seminal question of Spinoza, 'No one has yet determined what the body can do,' to explore body's capacity and define affect (Spinoza 1959/1987 as cited in Seigworth and Gregg 2010, p. 3). In the above block quote, Spinoza (1677/1996) addresses variability of bodily capacity at an encounter. Sad affect is the one that diminishes the encountering bodies' power to act, and a joyful one enhances this power to act. Not all care practices are joyful ones that automatically enhance the capacities of care providers and recipients. There is, in reality, an overwhelming number of cases where care is turned into abuse and workplace violence, thus destroying the bodies of care recipients and providers (e.g., Power and Oschwald, n.d.). As mentioned in the beginning of this article, the first encounter of care recipients and providers is often described as antagonistic. Vulnerability is induced in individual bodies by care agencies and subsequently projected by the care partners onto each other in the form of defensiveness. As affect is shaped by its milieu as well, many care providers and recipients are affected at the beginning of their care practices in a way that diminishes each person's capacity to act:

> The nature, *or* essence, of the affects cannot be explained through our essence, *or* nature, alone, but must be defined by the power, that is, by the nature of external causes compared with our own… that is why men [*sic*] are affected differently by one and the same object… [and] that is also why one and the same man [*sic*] is affected differently toward the same object, and to that extent is changeable, and so on (Spinoza 1677/1996, IV, P33, Dem, emphasis original).

Nevertheless, recursive practices as well as co-experiences of their daily lives slowly transform the feelings circulating between and beyond care partners, affecting both proprioceptively, and transforming the nature of their encounters as well.

> What [disabled care recipients are] going through is not easy. It takes a lot for people to ask somebody to wash them up. That's not something to get easily adjusted to do. That's a total stranger, somebody you don't know have to come into do everything for you, [though] you don't know [the person] yet. Your body is a temple, it's private.… It's a lot for them [care recipients] as well (Care Provider).

> [Care I received] was three days a week. And then, I asked for extra hour, because … I'm considerate of [my care providers]. That's not paying enough [for] them. So I said you know what, let me get an extra hour. [Care agency] wouldn't give me an extra hour, but they gave me an extra day. So, I said, you

[3] While Spinoza's notion of body entails "the *actual existence* of a human body and the *formal essence* of a human body," (Garrett 2009, p. 286) in this article I bring up his work to think about the actual existence of and ontology of human body.

> know what I'll take the extra day [while I told my aide to take the day off while getting paid] (Care Recipient).

In the process of recursive care practices, not only do some bodies slowly learn from and adapt haptically to one another, but also a sense of sympathy and intimacy begins to circulate between them. In the first narrative above, the vulnerable nature of the care arrangements that care recipients go through is acknowledged with sympathy by a care provider. Such sympathy and genuineness toward care partners is materialized in the second quote, as a care recipient recognizes and takes an action for the economic injustice her provider experiences. Their bodies and natures begin to transform and adapt to one another, thus composing a more powerful force. Spinoza (1677/1996) describes that when those whose natures agree—and their encounters thus bring joyful affects—are "joined to one another, they compose an individual *twice as powerful* as each one" (IV, P18, Schol, emphasis added).

> As Amy, a disabled person, and Patricia, her care provider, have worked together for years, it was obvious that they both embody a well-developed routine between them, allowing them to work in sync. They work in an egalitarian way, as they become assistants for each other. Amy assists Patricia by reading recipes in her newly learned Spanglish, to adjust to Patricia's language, and by picking stuff out of the fridge. Patricia assists Amy by doing most of the physical labor of baking a cake. As Patricia puts the cake into the oven, Amy automatically sets a timer. Without communicating verbally, they knew what each other needed and how each other worked. (Excerpts from my ethnographic notes, November 3rd, 2013)

Whether it is an increase in economic capacity, as in the above quote, or an increase of the collective capacity to bake a cake, through affective relationality, care providers' and recipients' capacities are enhanced to make their care practices smoother as much as the continuing co-conducting of care tasks strengthens their relationality. Thus, in this relationship, care providers attend to their care partners in ways beyond what they are assigned by their employer, the care industries. Similarly, care recipients also look after their care partners (e.g., by sharing food). In affective relationality, care becomes dialogical, and such relationality is a communal becoming, which contains the potential to increase the collective bodies' capacity or power to act (Curti and Moreno 2010).

The U.S. public healthcare assemblage

What does an affective relationality do in the U.S. neoliberal public healthcare assemblage? The assemblage draws women of the Global South into its circulation, migrating them to fill U.S. healthcare needs through ever-growing transnational care industries (Flores-Gonzáles, et al. 2013; Folbre 2006, 2012; Glenn 2010; Lowe 1997). Also sucked into the circulation are disproportionately lower-income women of color who are pushed to take any jobs as a result of welfare reform of 1996 (Glenn 2010). Also needed for the assemblage is disabled Medicaid beneficiaries who are

reconfigured with the implementation of managed care and whose legitimated needs for assistance bring revenues to care industries from the state (Bernstein 2014a, b, March 6; 2014, July 15; Polson 2013). In the U.S. neoliberal public healthcare assemblage, bodies are capacitated and debilitated alongside the flow of Medicaid funds, industry profits, labor capacities, and care needs; thus, care providers and recipients are created to be reduced to mere capacity and debility destined to be exploited within the assemblage (Nishida 2015). In that context, what does it mean that affective relationality is co-capacitative for care providers and recipients? What does the *more powerful whole*—born out of the affective relationality—do in the assemblage? A number of affect theory scholars are critical of the ways in which the capacitation and debilitation of bodies are manipulated and exploited under capitalism (e.g., Fritsch 2013; Puar 2012). Indeed, the care industries take advantage of the capacity that is born out of the care relationship. In reality, affective relationality—the bond—is part of what keeps care providers returning to exploitative care work and has them filling the gap between what care industries provide and what care recipients need. For example, even though care providers do not receive overtime pay,[4] they often stay at their care recipients' homes for extended hours, as unforeseen incidents and needs appear (e.g., a care recipient's last-minute bowel movement can take over half an hour to clean beyond the provider's work hours). Some care recipients also try to fill the gap between what care providers provide and what they are compensated for by their employer under their relationality. For example, forming of any kind of connection, including friendship, between care provider and recipient is strictly banned by the care industries, and breaking of the rule can result in sudden breakup and change of care partners. Regardless of the risk, as brought up in the form of quote above, a few disabled people mentioned that they deceivingly request extra days or hours of care of their care agencies, so that their care partners can get a day—or a few hours—off with pay. Acknowledgment of the ways in which care providers' further exploitation and care recipients' risk taking are facilitated by the emergence of affective relationality is crucial to avoiding the romanticization of care practices that are structured on the bedrock of various social injustices such as sexism, classism, racism, and ableism (Ehrenreisch and Hochschild 2004; Erevelles 2011; Flores-Gonzalez et al. 2013; Folbre 2012; Glenn 2010). While I foreground the care-based injustices care providers and recipients experience elsewhere (Nishida, under review), I further complicate the co-capacitative nature of affective relationality in the rest of this article.

Further contemplation

Spinoza conceptualizes power in two different modules: *potentia* and *potestas* (Spinoza 1677/1996). Potentia is the indwelling power of acting, inherent to one's existence, as he describes that '[B]eing able to exist is power' (Spinoza 1677/1996,

[4] The study this article is based on was conducted prior to the application of the Fair Labor Standards Act to domestic service under the U.S. Department of Labor (n.d.) which brings minimum wage and overtime protection among other labor protections.

I, P11, Alter). In contrast, potestas is externally induced and born out of friction with other bodies that entails domination of one over the other or one's interference with the other's potentia or power to act: 'Lack of power consists only in … that a man allows himself [*sic*] to do what the common constitution of external things demands, not what his own nature, considered in itself, demands' (Spinoza 1677/1996, IV, P37, Schol). This differentiation and complication of power (and capacity) is critical to further understand the co-capacitative nature of affective relationality. There is certainly a possibility for the capacity born out of affective relationality to be subsumed into potestas, as one's capacity is being exploited and diminished in the current public healthcare assemblage. Nonetheless, affective relationality is also a way to enhance care recipients' and providers' potentia: power to act. Indeed, it is the joyful encounter and collectivity that allow the enhancement of the collective's affects, or power to act (see more Spinoza 1677/1996, IV, P35, Schol). Tracing Spinoza's and then Negri's and Deleuze's work, Ruddick (2010) calls the forging of such collectivity "the task of freedom":

> The expansion of our capacity to act is at once relational, produced by mutually reinforcing collaborations, and the outcome of a complex interplay of affect and reason. It is through this interplay that we move from a passive experience of joy to an active understanding of the nature of the associations that empower (p. 26).

In the U.S. public healthcare assemblage, care recipients and providers are territorialized as they are individualized, ripped off by their agencies, and turned into rather passive bodies to be disciplined and controlled (Fox and Alldred 2013). It is through affective relationality that those who are made care providers and recipients deterritorialize: regaining their agency and potentia. Thus, such relationality is a line of flight, having the potential to interrupt the assemblage. With this relationality, for example, care providers and recipients shape their own ways to practice the care they need rather than simply following the guidelines of the care industries.

> [My aide and I] built a pretty good relationship. Like she fixes me food or anything. She'll probably take [food] for herself. Stuff like that. That's how we do things. I don't mind, as long as you don't take it for granted. Or I'll let her leave early, [when] she says "I have to leave early, because of another case." And I'm like, "Okay…. Can you come back later or can you finish that [task] next day?" (Care Recipient)

Forging their own mutually caring relationality against the industries' policy is an example of the way affective relationality disrupts the regulated flow of the assemblage. It is "the little mo(ve)ments," in Curit and Moreno's (2010) words, that go toward this disruption: "That is the embodied and shared micro-political moments as movements—that are the vital relational circuits through which negotiations, capacities for responsible and effective agency and change can most tangibly be grasped, explored, expressed and understood" (p. 414). Thus, the collective forged through affective relationality can be the foundation of larger resistive force. In their collaborative book, *The Undercommons: Fugitive Planning*

& Black Study, Harney and Moten (2013) conceptualize undercommon as an "underground, the downlow low down … where the work gets done, where the work gets subverted, where the revolution is still black, still strong" (p. 26). Or Halberstam (2013) interprets that the undercommon:

> cannot be satisfied with the recognition and acknowledgement generated by the very system that denies a) that anything was ever broken and b) that we deserved to be the broken part: so we refuse to ask for recognition and instead we want to take apart, dismantle, tear down the structure that, right now, limits our ability to find each other, to see beyond it and to access the places that we know lie outside its walls. (p. 6)

With this concept, Harney and Moten (2013) sharply critique how institutions are built on the bedrock of racial and other social injustices, while they also foreground the destructive work people engage in through interactions and hanging out (what they call *study*), which is always and already existing underneath the institutions, interrupting the system from within by forging the collective. Undercommons occupy undetermined space where people are embedded in violent institutions and simultaneously destructing them collectively and relationally. Considering that forging of affective relationality is in itself abiding of guideline enforced by care industries, the collective of care providers and recipients bonded through affective relationality is destroying the flow of the assemblage from within bit by bit, thwarting it from territorializing them into agency-less bodies of care providers and recipients: mere capacity to be taken up in the assemblage. As they change the flows, they deterritorialize themselves by actualizing interdependent, caring ways of living. Earlier in this article, haptic connection is described as a means through which to forge affective relationality. Bringing together the concepts of hapticality and the undercommon further amplifies the political potential of affective relationality:

> [Hapticality is] a way of feeling through others, for others to feel through you, for you to feel them feeling you…. This is modernity's insurgent feel, its inherited caress, its skin talk, tongue touch, breath speech, hand laugh. This is the feel that no individual can stand, and no state abide. (Harney and Moten 2013, p. 98)

Such haptic living is a reality of disabled people, alongside their care providers. Affective relationality born out of it is an undercommon of lower- (or no-) income disabled people and lower-income, non/immigrant women of color who are too often situated as care recipients and providers. It involves solidarity to acknowledge how such care partnership has been brought together in this global neoliberal political economy at the first place and who are made care workers and recipients in the U.S. public healthcare assemblage (Nishida 2015). Thus, such relationality fundamentally breaks the individualism entrenched in neoliberal society. Through the co-conducting of care tasks, these care recipients and providers embody interdependency—what many scholars fantasize and glorify as an antidote to neoliberalism (Butler 2004). As interdependence is increasingly acknowledged as important, the more crucial it is to pay attention to the process of how such interdependence is built and practiced. In this article, the process was traced in the

search to deepen our understanding of the ways in which people relate not despite their differences but through their differences. It is through affective relationality that an interdependent caring collective is forged; in other words, interdependence is a core component of affective relationality. Though the aspect of interdependence and affective relationality is not explicitly discussed by Harney and Moten (2013), the undercommon involving disabled people fundamentally entails an interdependent caring nature, as it is often the only way for many disabled people to participate in such collective resistance. Thus, the practice of interdependence should be woven into the undercommon and other acts of resistance, as it is a way to make such acts more inclusive to all, regardless of one's capacities or needs (for help from others), and to resist the individualism deeply rooted in the neoliberalism.

The development of affect theory and the turn within the social sciences equipped scholars with alternative ways to understand everyday reality and the ways in which im/material bodies are embedded in it and simultaneously affecting it (Massumi 2015). Usage of affect theory allows the theorization of relationality without relying exclusively on cognitive-based connection often employed through conversations to learn one another's interest or commonality. Instead, the theorization of relationality through theories of affect and disability foregrounds the potential of two different bodies coming together and relating ontologically. My focus was on people's innate and constructed differences in terms of capacities and needs (particularly to live in the given society) rather than exclusively on their differences in identity and standpoint. Bringing up cases of care practices between disabled people and their paid care providers (who are disproportionately lower-income, non/immigrant women of color) in the U.S. neoliberal public healthcare assemblage, I identify the recursive encounters and co-practicing of care tasks between them as key for relationality to emerge. In other words, forging such relationality entails the labor of all bodies involved. During care practices, these bodies—including their natures—begin to adapt to one another, becoming a more powerful force than when either one of them is alone. They connect ontologically and haptically through their differences, while they work in sync to complete care tasks. Finally, the collective forged through this affective relationality is an undercommon, destructing the neoliberal assemblage from within. Such deep connection enables and acknowledges the contribution of every body to form a fundamentally interdependent collective. In the neoliberal milieu, where individualization is accelerated and embodied (e.g., the normalization of individualized responsibility) and where other-ed bodies are automatically ostracized or otherwise commodified, ontologically formed affective relationality needs to be revalued as an infrastructure of resistance and transformative force to actualize a world where everyone participates *through* one another: a bigger collective enabled by relationality.

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