what it means to CARE

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In order to practice an ethic of care within the nursing profession, that is, in order to care for those for whom the nurse is responsible, caring for others needs to be distinguished from merely carrying out one's obligations by following rules. This article by using the method of philosophical analysis argues that caring is an emotion-like state fitting within a general explanation of the emotions as concern based construals and therefore as unified experiences of beliefs, desires and feelings. By clarifying the concept of care, it tries to lay a foundation for inculcating a culture of caring into the practitioners of the caring profession. Since caring involves care-specific beliefs and desires caring requires acquiring the appropriate beliefs and desires which constitute the experience of caring for others.

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Ten einde 'n versorgsetiek in die verpleging toe te pas, d.w.s ten einde te kan sorg vir diegene vir wie die verpleegster verantwoordelik is, moet versorging onderskei word van 'n blote uitvoering van pligte deur 'n nakoming van reels. Deur middel van die metode van filosofiese analise, voer hierdie artikel aan dat versorging 'n soort emosietoestand is wat pas binne 'n algemene verduideliking van emosies as bemoeienis-gebaseerde konstruele en dus as verenigende ervarings van oortuigings, begeertes en gevoelens. Deur 'n opheldering van die konsep "sorg", probeer dit 'n grondslag vir die inskerping van 'n versorgingskultuur by die beoefenaars van die versorgingsprofessie te bepaal. Aangesien versorging sorg-spesifieke oortuigings en begeertes behels, vereis versorging dat die toepaslike oortuigings en begeertes wat die ervaring van sorg aan ander konstitueer, verwerf word.

Philosophical discourse

When we talk of nursing as the "caring profession" we tend to assume that everyone understands what this means. Caring for one's patients, we think, obviously involves looking after those entrusted to one's keeping.

But the use of "care" in this context is not so clear when the notion of what it means to care is analysed. And if the aim is to shift from a scientifically slanted approach in medicine (which has tended increasingly to view patients not so much as persons but rather as the recipients of treatment) to a more humane one which takes the essential humanity of others as central, then nurses and others in like professions need to care in the fullest sense of the term.

Because this virtue must form part of the training of our nurses - especially new recruits - it is essential that those who do this training as well as those who are still undergoing it know how to care and this involves knowing what it means to care. It is at this fundamental point that a philosophical analysis of the concept of "care" can be useful by providing a framework for those responsible for the well-being of the sick to put into practice this crucial aspect of their profession.

The aim of this paper then is by using the methods of philosophical analysis to clarify the concept of care and thus to indicate some distinctions and some boundaries as well as remove some misperceptions in the hope that those whose job it is to care and to show others how they too can care might be made a little easier.

We use the terms "care" in its various grammatical forms in several situations such as taking care when driving, caring for one's elderly parents, caring about what happens in the future, being careful about one's appearance and so on. Given the present context of a discussion of care as it relates to the nursing profession and what is often seen as the need for nurses to care for their patients, obviously the relevant use here is caring in the sense of involving other persons for whose welfare one is responsible.

This brings in certain moral connotations which may be absent from other situations in which we care. Much debate about care has centred around the moral issues and, in philosophy, has largely concerned the merits of an ethic of care as opposed to the more traditional rule-governed ethic.[1]

The former can be said to involve our intimate concern for others; the latter can be seen as no more than the mere recognition of our obligations to them. Following an ethical rule such as Kant's categorical imperative which focuses on the motive for action and requires that we treat others as ends and not as means, or Mill's utilitarian Greatest Happiness Principle, involves adherence to formal principles (albeit of different kinds), and hence no commitment to any particular person.[2] In analysing the concept of care, I hope to be able to draw some important distinctions between just recognising obligations and behaving morally by following a principle, and caring.

I therefore want to show that there is a difference between just learning the rules and becoming part of a particular kind of relationship with another person. However, although I shall mention the ethical issues and what I say will have special significance for them, I shall not be concentrating on care as an ethical notion *per se* but rather on what it means to care for others at all.

This is because our understanding of the term in a more fundamental way depends on how we understand what it means to care within the field of ethics and therefore on what is involved in an ethic of care. So in a sense what I plan to do is investigate the notion of care but with the hope that on the way I can make some contribution to the ethical debate as well and, in this way, also to the profession of nursing.

My concern is that little attention in the literature has been paid to unpacking what it means to care and a great deal on applying the unclarified concept in various areas. There does seem to be some implicit agreement though (even if not spelled out) that care is an emotion of some kind or is at least like an emotion (although this agreement seems to be based on intuition rather than sound philosophical principles).

...*ask* what a person is afraid of ...

However, the problem is that there is not much agreement on what an emotion itself is.

Not only does a simple exercise of trying to list all those mental states we call emotions in everyday contexts become extraordinarily complex when we consider every candidate from say, sorrow, love and grief to anxiety, depression and fear and then try to list what it is that makes them all fit under one label, but excursion into the philosophical literature reveals confusion rather than consensus.

Theories about the emotions vary from sensation, physiological, behavioural, evaluative to cognitive accounts, each emphasising one aspect above another.[3] It is not surprising then that Bach (1988: 362) for example, talks of the emotions as a "motley crew" and concludes that they "are a messy subject". What I want to do in a very short time is, because of the apparent similarities, to analyse the concept of care within what I take to be the correct account of the emotions (correct on the grounds of support from a range of examples plus analysis of the concept) with the aim of giving a sounder conceptual foundation to the idea of nursing as a caring profession.[4]

This of course cannot be seen in isolation from ethical implications.

First then, what is an emotion? As already indicated, even philosophers are not in agreement, varying in their explanation from identifying emotions with feelings (sensation accounts) to arguing that they are complex combinations of beliefs and desires (cognitive theories).

Given the wide variety of emotions that can be identified and their complexity, Bach's exasperation is only one expression of the difficulty experienced in trying to classify emotions

or even to draw the boundary around the general class of mental states we call emotions.

My own view which will become evident below, is that emotions are complex cognitive states and that although we do indeed feel emotions, it would be a mistake to assume that emotions *are* just feelings. Emotions, I shall argue, are also essentially cognitive although, because they are compounds of feelings, beliefs and desires (or desire-like states) - are not only cognitive.

It is because of their cognitive components, that is, the beliefs and desires included in them, that emotions are always directed at or about something external to them. Phrased differently, because emotions are always about something or someone, they are cognitive. The best demonstration of and support for this point is the use of examples.

For instance, when we are afraid there is always something which we fear, when we are happy we are happy about a particular state of affairs and when we are sad there is always something about which we are sad. Although fear and many other emotions may also be generalised in the sense that, we can be in a general state of fear, it always makes sense to ask what a person is afraid of or what they are happy or sad about and any state of happiness or fear requires that about which one is happy or of which one is afraid.

If we push the generalised case further it becomes evident that in most if not all cases the object of the fear has just not been identified and, in extreme situations, it might even take psycho-analysis for the person to recognise what it that is feared (or whatever the relevant emotion may be). The aboutness or directedness to what is external to them is what is known as their intentionality.[5)]

This notion, which I shall argue, in the case of emotions depends on the beliefs and desires contained in them, is also essential in understanding what it means to care.

Let us, however, first look at the implications of it for the emotions before seeing if the same analysis applies to caring and therefore before drawing any implications about caring. A sound method is to begin by analysing everyday examples.[6)]

Although emotions are intentional as described above, in being about something external to them, there are certain conceptual constraints on what any emotion can be about or directed at.

One is not afraid of or happy or sad about just anything. This suggests that there must be a conceptual relation between our emotions and what it is they are about. If we examine the components of any emotion we must further conclude that this, in turn, is because emotions necessarily involve beliefs and desires. Hence, as I shall try to demonstrate, these states are the intentional components of emotions and it is they which impose the conceptual restraints. I shall deal with each in turn by relying on examples.

Although there are a great number of things of which one may be afraid, about which we can be happy or sad, in the first place, that which one fears must be believed to be harmful, that about which we are happy must be an event or a state believed to be beneficial and that about which we are sad must in some way be believed to have been lost to us- in a broad sense.

So we can be afraid of the snake if we believe that it may harm us, happy about winning the lottery if we believe that it will change our lives for the better and sad that our cat has died if we believe that it has been lost to us forever. It is easy enough to test this claim by changing the belief in an emotion because when we do that we change the emotion itself - as any five-finger exercise on the emotions will demonstrate.

If, for instance, we do not believe that the snake will harm us it makes no sense to be afraid of it, or if we believe - as some people do - that winning the lottery will damage our personal relationships and so not change our lives for the better then we might regret having won - or at least be less likely to be happy. Furthermore, in cases where a specific belief is missing we tend to talk of moods rather than emotions.

This is why one can be in a sorrowful mood or a cheerful mood without being able to identify any object of our moods and when there is nothing particular our sadness or cheerfulness is about - although even here and debatably, general beliefs about the parlous state of affairs or one's ongoing good fortune do seem to be required.

I mentioned, however (and examples can show why), that desires or desire-like states are also aspects of emotions. If this is the case then the conceptual relation between an emotion and what it is about must also depend on this further necessary feature of them. In other words, the emotion we experience is both dependent on the beliefs that we have and on our desires.

When, for instance, Mary is sad that her cat has died she is not sad just because she believes her cat to have died and therefore to be lost to her forever, but also because she desires the cat to continue to be her companion and therefore not to be lost to her. If the cat had been a constant source of irritation to her because it messes her house, destroys her sweaters and keeps her awake at night, however, she might in fact be relieved that it has finally died because now she does not wish that it will continue to be her companion but on the contrary desires that it should never return. If Jack fears the snake he not only believes that it may harm him but also desires not to be harmed.

And although most of us are afraid of snakes there are those who are not - either because they do not believe that they will be harmed - snake handlers for instance - or even because there can conceivably be a person who decides to commit suicide by snakebite and so, instead of wishing that the snake should not harm him, in fact desires that its bite will be deadly. Here again if we change the desire we change the emotion and we can do another five-finger exercise to show that if there is no desire at all then there is no emotion.

Beliefs therefore by themselves can not be enough to constitute the cognitive component of an emotion.

The implication we must draw is that emotions have their specific objects (what they are about) because of the nature of the beliefs and desires they include. Many of these beliefs and desires can be about other persons and then our emotions are directed to a person and not a thing such as being angry with John because he did not keep his promise or distressed about Sally because of her continuing misfortune .

But because these beliefs and desires are not universal in the sense that not everyone will have the same beliefs and desires under similar circumstances since they depend on a network of further beliefs and desires that the subject has (for example, if I believe that today is Saturday then I must also have further beliefs about the days of the week), not all of us experience or will experience the same emotions in the same situations.

So although most of us fear snakes not all of us do and although most of us may be happy to win the lottery there are conceivably those for whom such a win might be a burden. This is why not all of us are afraid of mice, of heights or of the unknown and why although we are usually all happy about the same or similar events, there are also exceptions.

Once again, we can generalise this point over all of the emotions. The son, for example,whose beloved father dies will grieve but we do not rule out the possibility that on the other hand, a son who has been systematically beaten may be relieved that he will no longer be at the mercy of his abusive father and so instead of grief may experience relief, perhaps indifference or even regret if he believes further that there will now never be an opportunity for a loving relationship with his father and he wishes that there could have been.

Although, as cultural and social beings, we do share many beliefs and desires with our fellows, we are also individuals with our own histories and our own situations, meaning that if we do not all have the same beliefs and desires we will not all experience the same emotions in the same contexts. It follows that if we want people to change their emotions to those we might consider more appropriate, we try to get them to change their beliefs and desires.

So we do not as a rule tell Sally to stop being distressed and instead try to reassure her that the situation is not as bad as she believes it is and in this way by getting her to alter her belief so to alleviate or remove her distress. Psychotherapy works on this principle.

One of the complicating factors about emotions is that despite the essential requirement for a belief and a desire and therefore although they cannot therefore be identified with feelings, they *are* also essentially felt. When we experience sorrow or happiness or fear we not only have the appropriate beliefs and desires for these emotions, we also experience *feelings* of sorrow, happiness and fear.

Although feelings, being first person subjective states, cannot have external criteria for an emotion's identification, it is enough for my purposes here that we can all tell the difference between our own feelings of anger, joy and sorrow and that in fact we identify our own emotions with reference to our feelings rather than to our beliefs and desires.

Personal experience also provides the evidence for the claim that when an emotion changes so the feelings change. Think here of being angry because another driver bumps your car. When you discover that the driver has in fact suffered a heart attack and has lost control of his car, your anger in all likelihood will change to compassion and the feeling of anger will be replaced by one that we associate with compassion.

But emotional feelings are also not mere adjuncts to the beliefs and desire which are the components of an emotion. They are in some way intertwined with those beliefs and desires into a single unified experience. A pang of remorse, for example, is very different from a non-emotive pang such as a pang of indigestion because in being an emotional feeling, the pang of remorse is not the outcome of a causal chain of events but is imbued with the beliefs and desires which together make up the remorse.

The fact that a person suffering from a pang of remorse, unlike the person suffering from a pang of indigestion, cannot be relieved by painkillers but only by undergoing counselling (which could vary from friendly and concerned questioning and advice to intensive psychological treatment), pays testimony to the difference.

Counselling, unlike drugs, does not rely on treating a chain of physical causes and effects but is aimed at getting the person to change their beliefs and desires until the remorse (or other emotion) disappears. This is why I claimed that this is how psychological therapy works. Remorse, like sadness or fear, being an emotional feeling, can therefore be said to be cognitively penetrable in the sense of being suffused with the beliefs and desires which together with the feeling make up the emotion.

In trying to capture this unity, Roberts has called this an *intentional feeling* which we have about or of *ourselves* (1988: 190).

One does not feel a pang of remorse unless one has with that pang remorse specific beliefs and desires and one does nothave an ache of sorrow unless one also has sorrow specific beliefs and desires. This unity of the experience can even be expressed linguistically and hence we can talk not only of feeling remorseful and of being remorseful but even of remorseful, sorrowful and fearful

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beliefs and, without too much strain, desires.

Although there are some differences, care seems to fit rather well into this brief sketch of the emotions. When we care we care about someone or something. And caring about a person or a thing includes having the appropriate beliefs and desires about what it is we care.

Depending on the beliefs and desires which we have, we can care for another person, a hobby, our possessions, our pets or about global warming. And when we do care about someone or something we believe the object of that care to be important and when that object is a person we desire that person's welfare or comfort. In other words, when the object of care is another human being, we desire the well-being of whom it is we care about.

... in caring for others we ourselves can grow emotionally and morally...

But the problem is that caring for someone is very like recognising that we have an obligation towards them because the same beliefs and desires can apply to both. The difference is that, as in the case of the emotions as described, when we care for someone these beliefs and desires are imbued with feeling. This is not the case when we simply recognise our obligations.

This is also where care seems to digress from what we would want to call a full-blown emotion - seeming rather to be an emotion-*like* state because it is difficult to identify what we would call a specific feeling of care. That we feel for the other person is not in doubt but this feeling seems to be more like concern than like an emotive feeling. Perhaps this is why it would be more accurate to say that care is "a distinct moral sentiment - an emotional attitude embedded in a relationship with another person" (Blum 1992, in Becker and Becker).

The "sentiment" is the emotive part and the "moral" here which only applies with difficulty to all emotions, refers, I think, to the fact that although care may not be the sentiment we *do* feel for others, it is the sentiment we *ought* to feel for others - especially in circumstances in which their welfare is our responsibility.

The specific "sentiment" since it is allied to an emotion I think refers to the fact that we *care* for the other as opposed to merely recognising an obligation to look after them.

The question that can now be asked is why recognising an obligation is not adequate in our relationship with others - especially within a nursing context and why we *ought* to care for others when after all what is important is what we do for others. The answer depends on the specific nature of what it means to care.

What makes caring different from many other emotions or emotion-like states is the special importance of what it is we care about. When we care for someone else and we are responsible for their welfare, we do not merely acknowledge that we have a duty to ensure that they are adequately looked after.

Caring essentially involves a *relationship* with the other because although the object of care is acknowledged to have worth in its own right, in order to care for them we need to understand the needs of the other and to respond to them appropriately. But relationships imply dual needs and responses. And although when we care, the needs of the other will guide what we do, the fulfilment of our own needs as moral beings in this relationship is also important.

If we really care we will be prepared to take risks in this relationship because although in the patient/nurse situation, the nurse takes the responsibility for the other's well-being, caring for the other will not rely solely on the dependence of the other. Taking risks can be seen in the light of what Frankfurt (1982: 260) has said of people who care and that is that they make themselves "vulnerable to the losses and susceptible to the benefits" because a person who cares "is as it were invested in" the one for whom she or he cares. If we are invested in those for whom we care it follows that our own well-being must be tied up with theirs and the implication is that in caring for others we ourselves can grow emotionally and morally.

This is what Meyeroff (1971: 1) says when he claims that caring is not to be confused with such meanings as wishing well, liking, comforting and maintaining, or simply having an interest in what happens to another. Also it is not an isolated feeling or a momentary relationship, nor is it simply a matter of wanting to care for some person.

Caring, as helping another to grow and actualize himself, is a process, a way of relating to someone that involves development, in the same way that friendship can only emerge in time through mutual trust and a deepening and qualitative transformation of the relationship.

He goes on to say that in this relationship although I, as the person who cares, do not care in order to actualise myself (this would of course be to have self-centered motives incompatible with caring which is essentially directed at the other), because in caring I *do* actualise myself, caring gives meaning to my life. Therefore those who care are also beneficiaries of that caring.

Although caring might involve a unique relationship with the person for whom we care, just as with emotions, the particular nature of the object of care and the special importance placed on it, will depend on the beliefs and desires that we have about the other.

And although there might be no unique feeling called a feeling of care, caring, as opposed to being under an obligation to look after another, is an experience imbued with feelings - several of them - especially a feeling of concern.

A parallel can be drawn here with guilt to fill out the point and to further illustrate why caring is different from mere obligation. A person can recognise that she is guilty of committing a crime and in that sense acknowledge her guilt and her obligation to change her behaviour - just as a person can recognise that he has an obligation to look after another and so acknowledge that it is his duty to fulfil that obligation.

The appropriate beliefs and desires are all that are required here. But in order to *feel* guilty in the sense of experiencing the emotion of guilt and so to truly *commit* herself to a life free of crime, being guilty must *matter* to her. And although she must take herself to be guilty in order to feel guilty she must also be concerned that she is guilty - in fact she must care about being guilty.

This is why Roberts calls emotions "concern based construals". In order to experience an emotion one must both take oneself to be in the emotive specific way by having the right beliefs and desires and this construal or taking must be of concern to one. This is why an emotive feeling, as Roberts has argued, is a feeling about or of oneself.

And caring, as we have seen, is not the mere acknowledgement of the other's importance, but because the other's welfare must matter to one, one must take oneself to be part of the caring relationship as explained above and furthermore, being part of that relationship must also matter to one. Mattering in other words must matter.

Taking oneself in this way is to experience a concern based construal of a special kind. If I am right, caring for others requires this condition in as intimate a way as feeling guilty, or feeling jealous or feeling anxious - if anxiety is indeed an emotion. And now the conditions under which "looking after the sick" becomes "*caring* for the sick" rather than just "comforting, maintaining or having an interest in what happens to another" become clearer.

Understanding what it means to care involves understanding that there are appropriate care-specific beliefs and desires and these can be inculcated or acquired.

Furthermore, since caring has moral connotations and consists in more than merely doing the right thing, caring for others seems to be desirable.

Given the inbuilt ought in what it means to care, it follows that caring must be worthwhile and that we should persuade those who do not care to become caring individuals - especially in contexts where the object of that care is another person whose well-being depends largely on one.

Persuading someone to care, like persuading someone to change any emotion, therefore involves inculcating care-specific beliefs and desires in those who do not have them.

But this in itself is not enough because caring is more than just having the essential beliefs and desires and just inculcating them may merely be to persuade such a person to recognise her obligations. This is because we can have these very beliefs and desires without actually experiencing the "moral sentiment" of care.

These beliefs and desires must, as Blum has said, be "embedded", as Frankfurt has said must be "invested" in the person, and, if I am to care, according to Roberts, must be part of a concern based construal of myself that matters to me and this means that they must be part of a feeling that I have about or of *myself*.

Scruton (1987: 80) has tried to capture this difficult notion in the following way and, given the present context, we can now take the liberty of replacing his use of emotion which is what he is really talking about with that of care:

[Caring does] not involve thoughts and desires directed upon the object only, but also thoughts and desires concerning the subject. [It] is a kind of bridge between subject and object, and its direction onto the world is also a 'situating' of the subject... the self looms large as the bearer of sacred burdens...[and is]... susceptible to important transformations as we shift attention from the first person to the second person, and again to the third person point of view.

The self engaged is not the same as the self observed...

I think this is what is implicit in the so-called ethic of care and what nursing the sick in the morally right way implies - as opposed to merely practising a rule-governed ethic which has so often been assumed to be sufficient in our transactions with others.

But in order to grasp its full significance and, given the implicit ought in the notion of a moral sentiment, to find the right method of ensuring that those who do not, do come to care rather than just recognise that they have obligations, it is imperative that we understand what it means to care.[7]

Notes

1 An ethic of care is often taken to be a feminist ethic. The first systematic exposition of this type of ethic was by Carol Gilligan 1982. ***In a different voice: psychological theory and women's development***. I have also restricted my comparison of care within the area of philosophical ethics to what may almost be called its polar opposite, namely rule-centered ethics. This means that so-called virtue-centered ethical theories which may be able to accommodate the notion of caring, have not as such been included in my discussion. This is because feminists and others who endorse an ethic of care have specifically reacted to rule-centered accounts.

2 The aim of Kant's ***Critique of practical reason*** (1788) was to ascertain and explain the scope of moral reasoning and, taking motives as the foundation for an ethical principle, has become the example *par excellence* of a deontological ethic. Mill, on the other hand, who in ***Utilitarianism*** (1863), argued for the good on the basis of the consequences of action, namely that the greatest happiness should result, is taken as the prime advocate of teleological ethics.

3 Although Calhoun and Solomon (1984) call these the five main approaches, they demonstrate that there is further confusion by cutting across their own classification and dividing the articles in their volume into the various identified most intractable problems the emotions present.

4 See Wilkinson, ***Emotion and fiction*** (1992) for an extensive analysis of the emotions.

5 In reaction to the legacy of Descartes and in an attempt to distinguish mental from physical phenomena, Brentano (1874) tried to find a positive characteristic of mind and mental states. He took this to be intentionality. There are many problems associated with this notion and it has, as a result, received wide philosophical attention. This attention is often directed at trying to give a more detailed account of Brentano's original explanation and to overcome the problems inherent in it.

One such problem is the relation between the external (what the mental state is about) to the internal subject. See, for example Searle, J. 1984. ***Intentionality***. Cambridge: Cambridge University Press. Searle's argues that intentional mental states are representational and that representation can be explained in terms of more basic notions such as propositional content, direction of fit and conditions of satisfaction.

6 This method, also known as conceptual analysis, relies on examining the use of concepts in everyday contexts and uses ordinary language as the point of departure. Bertrand Russell was (arguably) the inspiration for it and it reached the height of its popularity in the mid-twentieth century after being perfected by Gilbert Ryle, *inter alia*, in the ***Concept of mind*** and JL Austin in, *inter alia*, ***Sense and sensibilia***.

Briefly, the rationale behind it is that ordinary language gives us all the distinctions we need and that since ordinary language can be both our best tool for dealing with reality and be deceptive, we need to examine and analyse how we use concepts in everyday contexts if we want to understand the meaning of concepts. It is also accepted that such understanding is a prerequisite for any sound theorising. Although now generally thought to be limited on its own, the method is also recognised for its contribution to clarity and rigour.

7 This article was first read at a symposium of the Unisa Honor Society of Nursing on "Caring" in August 1996.

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