# The Caring Phenomenon: A search for Absolute Good Caring

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## *Introduction*

*"We should know what we <u>are</u> talking about and what we <u>are not</u> talking about"Socrates*

There have been a lot of publications about caring attempting to define and clarify the concept of care, but the ideas about the phenomenon remain unclear. Caring may be dependent on different variables such as circumstances, environment and people involved (Brilowsky & Wendler, 2005).Noddings (1984) asserts that caring is a female attribute, a natural capacity to care and an innate moral concern with maintaining and enhancing caring.Care is most commonly understood as a benevolent act. It has been associated with women and their soft nature. Allmark (1995), Warelow (1996), Dyson (1997), Mackintosh (2000), Stockdale &Warelow (2000) suggested that caring is no doubt an admirable thing in itself (Paley, 2002). If a person is caring, it is presumed that it is because of their regular performance of caring acts that lie on moral sphere and have an aim that is praiseworthy (Edwards, 2000).In 1990, Morse, Solberg, Neander, Bortoff and Johnson defined caring as a human trait, a moral imperative, an affect or therapeutic intervention. Care connotes several meanings. Care may mean to be troubled or concerned about, to have regard or consideration for, to have a desire for, or to provide physical needs, help or comfort for (The Collin's Dictionary and Thesaurus, 1992). Care has also been defined in terms of its attributes. Some says itis compassion, competence, confidence, conscience or commitment. Brilowski and Wendler (2005) defined caring as a relationship, action, attitude, or acceptance. Caring means that persons, events, projects, and things matter to people (Benner and Wrubel, 1989 in Edwards, 2000).

Caring as a concept has therefore been universally generalized or commonly understood as "good". However, human civilization at different corners of the world has been developing and progressing in terms of language, beliefs, norms, cultures, knowledge/education, etc at dissimilar circumstances and pace. Hence, despite the universal understanding that caring is good, the "absolute goodness" of caring concept becomes questionable.
In literatures, care is not often argued as an act of or with malicious intention. It is also seldom discussed that care of/with good intention may be represented by undesirable acts. The relational disagreement between the "goodness or badness" of subjective mental act and the "badness or goodness" of observable actual act of care creates misconceptions. Because care isconsidered benevolent, it is expected that there must be sincerity or an agreement between the intent and the act of care; and perhaps, also when it comes to the effect of care to the recipient. Most literatures try to develop normative theories that delineate and suggest a "good" caring goal with "good" caring act and a "good" caring outcome. Although these theories emphasize the good nature of human beings, it tends to neglect the human imperfection in a complicated civilization that affects not only the caregiver, but also the care-recipient in the complicated inter-subjectivecontexts of care.

Care may be seen on two different perspectives; the ***caregiver's*** and the ***recipients'***. The first part of this essay will deal primarily on the caregiver's perspective. The interest will be to understand how caregivers think and how they can explain or justify their caring actions. To be able to do this, it is necessary to study how caregivers define and conceptualize care in their own perspective. Such perspective is believed to be prejudiced by the context of caregiver's particular circumstance. It will be influenced by age and maturity, gender, beliefs, culture, norms, education, etc.The latter part of this essay will deal on the care-recipient's perspective. It is meant to expose the consequences of a "caring" act on the part of the care-recipient. To find absolute good caring, it has to be studied as a complete entity wherein subjects involved (caregiver and care-recipient) and the objects, structures and processes within and surrounding the phenomenon are included.

In this paper, an **absolute good caring** would mean - a *conscious* form of care wherein the caregiver's intention and caring action *aims and envisage benefitingthe care-recipient* in helping them to meet their human needs.
Steven Edwards (2000) pointed out that one can care without having consciously decided to care. However, this paper will deal only with the ***conscious form of care*** where emotion, intention and choice of action are known to the caregiver.

## *Caring on the Caregiver's Perspective*

The literature shows that in defining care there are two main discourses: 1. the distinction between ontological and intentional care (Edwards, 2000), and 2. the incongruence between the two levels of intentional care which are the *subjective mental act of abstract intention*andthe*objective representation of such intention* which is otherwise called as the "caring acts" or "caring performance".Some authors have consensus on the ontological understanding of the meaning of care (Benner and Wrubel, 1989 in Edwards, 2001; Martine, 1993),while others explicate care on the intentional level (Edwards, 2001). Care in ontological sense is mentioned, but not treated in this essay because it is separate from the realm of conscious thought. Ontological care which is rooted in the "being" of human is severed from intentional care (Edwards, 2001). The ***intentional care*** is the dominion of conscious thought and the experience of emotion(Edwards, 2001).

The conscious intentional care has two different levels; the abstract or subjective level and the actual or objective one. The abstract is understood to be the intention of care, while the objective caring act is the observable instrument that displays the intended care. The relationship between the two creates conflict in understanding and accepting the concept as an absolute good. This is because the intention does not always justify the act, and the act does not always follow the true intention. Although in Aristotle's ethics, "the apparent good" is what seems good to a man, whether or not it is really good, it may seem unfair to judge the prudent disciplinary action of parents to their children, or the act of inflicting pain or implementing undesirable measures such as use of restraints or power to be able to treat, rehabilitate or protect a care-recipient from harm as "bad". Oppositely, the "good" caring act may be used as an instrument for malicious intent. Joseph Carver (2008), a clinical psychologist wrote that syndrome or the emotional "bonding" with offenders was a common story in psychology, and it was recognized for many years in studies of other hostage, prisoner, or abusive situations such as abused children, incest victims, battered/abused women, prisoners of war, concentration camp prisoners, cult members, criminal hostage situations, and controlling/intimidating relationships. This is because offenders somehow may have shown acts of caring or mercy to their victims.

Clearly, the subjective abstract intention and the objective act of care can be seen as separate entity. Caring is a particular emotional and behavioural response that draws on technical and interpersonal response (Brilowski&Wendler, 2005). This definition highlights the distinction between caring intention as a subjective /abstract goal, and caring act as an intended observable instrument to reach the said goal.

## *Two Levels of Intentional Care*

### *1.* Caregiver's Abstract/Subjective Caring Intention

German philosopher of psychology Franz Bertano introduced the doctrine that *"every mental act is intentional, that it is "of "or "about" an object that need not actually exist* (Encyclopaedia Britannica, 1988).Care in this sense is abstract and subjective, but the acts of care that are immediately accessible to our senses are mere objective representatives of suchidea of care, or perhaps an instrument to achieve the aim of intentional caring. At the outset, caringpresuppose a relationship between the carer and the cared for. Its goal should be to help another to meet their needs and achieve self-actualization(Brilowski and Wendler 2005). However, in a caring relationship, human emotions play an important role.

A creature without feelings according to Aristotle is non-human. For him, the good person will not only act righteously, but will also feel righteously in relation to the action(Vetlesen & Nortvedt, 1997).Emotion therefore has a moral significance in giving care. It was argued that people in caring professions such as nurses are required to empathize with their patients, and theyshould have the ability to engage emotionally in contrast to a cold and objectifying approach to patients (Vetlesen & Nortvedt, 1997).Emotion makes the caregiver interested and committedin the situation, at the same time it brings meaning to the caring experience (Martinsen, 1990).

However, feeling is fallible and it is possible that we may not develop sympathy to specific persons; or probably, the sympathy we feel is inappropriate to the situation; or maybe the sympathy that has been the basis of our

feelings and intention leads to immoral consequences (Vetlesen & Nortvedt, 1997). But feeling or emotion should not be understood as a non-cognitive phenomenon because feelings or emotions can be controlled and cultivated through human relationships (Vetlesen & Nortvedt, 1997).

Most philosophers consider human emotion inferior to human rationality. This is becauseemotion similar to senses may give us wrong information about reality (Descartes in Vetlesen & Nortvedt, 1997).
It is therefore advisable to control strong emotions such as aggressive feelings and strong passion so that it can impart appropriate and morally justifiable ramification, as it is delegated to theintellect (Vetlesen & Nortvedt, 1997).Emotion and behaviours are products of beliefs rather than direct responses to the environment (Abraham & Shanley, 1992).The view that feelings would be the most important factor in the growth and development of relationships is insufficient because feelings are affected by various human needs and social circumstances (Wright, 1985). Our feelings do not alone create relationships because relationships are influenced by personality, memory, experience, cognitive structures, personal needs, explanatory styles, and past relational experiences. People may therefore decide not to act on their own feelings. If we act according to our feelings, it may lead us to do discriminatory action, because the basis of such action is nothing but moral in nature (Vetlesen & Nortvedt, 1997). Emotions may also draw caring actions based on caregiver's personal moral beliefs without considering the care recipients'.As a caregiver, we need to be aware of our emotion and make use of them as strength rather than weakness to produce a good abstract intention in a caring situation. It isa sign of strength to have the feeling of commitment towards the duty associated to our roles in the society. It is for instance virtuous to act according to the caring intentions **pre-determined** by our professional roles. A virtuous act is one that a virtuous person would do, done for the *reasons*a virtuous person would do it (Appiah,2010). Foucault(1922) claimed that individuals establishes a relation to a rule and recognizes himself/herself as obligated to put it in practice (Faubion,2001).Caring persons perform regular caring acts that *aim* at benefiting care recipients (Edwards, 2000).

**2. *Caregiver's objective instrumental caring act***

Actions and behaviour affects each other (Vetlesen & Nortvedt, 1997). Acts of intentional caring are voluntary, deliberate actions that seem to lie on the moral sphere (Edwards, 2000).Aristotle distinguished two types of deeds/actions: the moral and the intellectual. *Sophia (theoretical) and Phronesis (practical)* are the intellectual deedsor deeds/actions based on learned ideas of intellect either through theories or practice/experience; while moral deeds are deeds/actions based on attitudes/behaviour and personal characteristics as they are affected by feelings, lust and desire. The latter have been discussed earlier, so we will now move on to the intellectual caring deeds, where knowledge plays an important role in giving care.

Knowledge and competence are essential elements of caring. Caring entails competence in the areas of knowledge acquisition, decision-making and execution of skills (Clayton et al, 1991, Clark & Wheeler, 1992, Halldorsdottir & Hamrin, 1997, Yam & Rossiter, 2000 in Finfgeld-Connett, 2006).Knowledge of a caregiver is a source of their power to influence the care recipient's situation. Caregivers in different areas of expertise such as nurses, medical doctors, psychologists, teachers, lawyers, social workers, etc puts effort in research to develop and improve principles in giving care. There are continuous endeavor to modify, improve or find better alternatives than undesirable or painful caring procedures. In short, there is a continuous search for a better form of caring through scientific research where knowledge produced can be applied to a wider or smaller population.

In contrast with emotion, knowledge provides reasons for actions of care, and this rationality provides alternatives for the caregiver's choices of action. Knowledge can regulate emotion, morals or human values in the context of actual caring situation/circumstance. Howell (1997) suggested that moralities may be served by focusing on the acting individual's process of reasoning, during which choices are made between alternative possible actions (Zigon, 2012).

Generalized knowledge that provide basis for "truth" (most acceptable truth at the time and space) in giving care to care-recipientsis objective and does not discriminate. This is because knowledge of generalized ethics and/or knowledge of signs and symptoms, diseases,treatment and rehabilitation are focused on the observable facts that will facilitate caring acts benefiting the care-recipient. The more generalized knowledge caregivers have, the more likely they are able to help the care recipient.However, generalized knowledge may require proper application, in order to meet the care-recipient's need for care.Generalized body of knowledge is a product of two complementary and non-contradictory scientific disciplines – realism and relativism.

### *Realism and Relativism*

*"The best way to know a thing is in the context of another discipline" - Leonard Bernstein*

The patterns of care commence from the unconscious thought that lies on the metaphysical nature of human beings (Martinsen 1996). In a **conscious** state however, the caregiver's intentionis construed. This will be manifested by their choice of actions as they are affected by dogma or their system of knowledge and beliefs, etc.Their perception of the care-recipient's need, may stipulate priority and focus of attention in caring. The consequences of caregiver's action are partly affected by the recipient's characteristics. This will be explained later.

In giving care, caregivers may view care recipients as human beings with the objective physical component and subjective emotional, psychological, spiritual components. In relation to this, scientific principles of two disciplines such as realism and relativism can be useful in understanding the dynamic caring relationship between the caregiver and the care-recipient. These principles as mentioned are not in conflict, but rather complementary. However, inappropriate use of these principles may result to faulty caring.

*a. Realism and objectivism* Realism is the conception that objects of sensory perception or of cognition in general are real in their own right, and exist independently on their being known or related to mind. Realism was stimulated by Auguste Comte's Positivist philosophy that excludes metaphysical speculations. Realists assert that classifications reflect distinctions inherent in the world. Realism has been extended by naturalism. Naturalism (late $19^{th}$ – early $20^{th}$ century) was an aesthetic movement inspired by adaptation of principles and methods of natural science. Naturalism denies the existence of truly supernatural realities and emphasizes accidental and physiological nature of man rather than their moral or rational qualities. They claim complete objectivity and presume that nature is in principle completely knowable. Naturalism originated in France and had its theoretical basis in the critical approach of Hippolyte Taine who was known for his speech introduction *"...there is a cause for ambition, for courage, for truth, as there is for digestion, for muscular movement, for animal heat..."*(Encyclopaedia Britannica, 1988). Hence, the interests of naturalists are objects of natural sciences such as human body parts. Doctors of medicine are for instance objective in giving care in the sense that their profession is a specific form of scientific endeavour, tracing human pain and suffering that is biological in nature (Paley, 2002). As a caregiver, doctors of medicine *tend* to prioritize on the patient's physical needs, and they *may*find it necessary and desirable to place a certain emotional distance between themselves and their patients (Paley, 2002). According to Paley(2002), medical objectivity is a good thing that has no moral connotations or has nothing to do with ethics. It is valued simply because it equips the doctor to battle with disease. Objectivity in itself has therefore the element of unquestionable good as part of an absolute good caring. However, if we will be talking about the complexity surrounding caring as a whole, realism may need supplementary knowledge that can be provided by relativism.

Inappropriate use of objectivity may lead to undesirable acts, even if the doctor's intention of caring through curing is good.Realism/naturalism may come short knowing that care-recipient as a human being has integrated objective and subjective aspects in life. Treating the care-recipients physically without considering their emotional, psychological, social/cultural and spiritual*being*may give them traumatic experience. Objectivity in a sense that we objectify persons is devastating (Stang, 1998).Objectification may connote lack of agency or an abuse of others (Keane, 2007). Objectifying means considering a person as an object or to be treated as an object by others. It happens when the person's thoughts, opinions, values, feelings or reactions have not been respected in a social relation, or when the person is deprived to express herself or decide for her/himself, and be oppressed (Stang, 1998). In health service, relativism is essential. This is especially because the relationship between the patients and the caring professionals can be described by the concept of *epistemic asymmetry*. Epistemic asymmetry means that care-giving professionals apply/manage knowledge and competencies that patients do not have, but do need them (Grimen, 2010). This implicates that the virtue of trust for the caregivers such as nurses and doctors become imperative in nature on the part of the patients. Such asymmetrical relationship demands that caregivers are trustworthy. Trust for the health-caregivers involve reliability, because patients are in a position of powerlessness, vulnerability and lack of (professional) knowledge (Grimen, 2010). To win the care recipient's trust, and to benefit the care-recipient fully, relativistic approachis necessary.

*b.* Relativism and subjectivism

Relativism is the view that what is right and good or good or bad is not absolute, but variable and relative depending on the person, circumstances, or social situation. And because what one thinks will vary with time and place, what is right will also vary accordingly. The view endures from ancient Greek Sophist, Protagoras (5th Century BC) up to the present, whilst it is used as a scientific approach for modern sociology and anthropology.
A caring person will avoid assumptions and seek to understand the meaning of a situation in the life of the person being cared for (Brilowski & Wendler (2005).A relativistic caregiver respects the personal experience of the care-recipient and will let the care-recipient interpret and define his/her situation in her/his own terms. Misunderstanding the care recipient's needs may result in unhelpful responses (Abraham &Shanley, 1992).Acaregiver with relativistic perspective endeavors to treat the care recipient as a human subject and respects the concerned persons thoughts, values, opinions and reactions.
In relativism, the caregiver focuses on the importance of the interpreter/caregiver's understanding the text as a necessary stage to *properlyinterpreting* it. In interacting with the recipients, we have to interpret their words, their body language or their moods (Edwards, 2000) *in terms of their own lived world and experiences*. Knowledge of relativism guides caregivers towards a successful and meaningful caring interaction. However, relativism may not suffice if we will talk about complications or dilemmas wherein standardize knowledge based on scientifically proven evidences are necessary.

A relativist caregiver faces challenges when their belief, values and knowledge is in conflict with that of the recipient's; or maybe if the care-recipient lack the ability to see what is best for her/him.Realism may then provide facts, sets of standards, rules, etc that may oblige the caregiver to give such kind of care that was proven to most likely benefit the care-recipient.

## *Types of Care*

### a. According to Congruence between the Caregiver's Subjective Abstract Intention and Objective Caring Act

There are two emerging types of intentional caring on a caregiver's perspective **according to congruence** between subjective abstract intention and objective caring act: *Benevolent care* and *Malevolent care*.
**Benevolent care** displays a good caring act emerging from good caring intention, where good means to benefit the care-recipient. It has an agreement between good subjective abstract intention and good objective caring act. Benevolent care can be genuine.It is the emotion that drives a mother to nurture a child, or a teacher to support a student (Noddings 2003 in Rose, 2008). It has an honest meaning and purpose on the part of the caregiver. It has an element of sincerity or truthfulness. It refers to honesty or self-awareness and about not pretending to be what one is not (Rose in Mason, 2008). However in cases where the imperfect human emotion becomes fallible, benevolent care may endure in a form of duty, where caregiver's caring abstract intention is pre-defined by such duty. Caring is not merely a moral ideal, but also a duty (Rose in Mason, et al, 2008). Moral maturity starts with an egocentric subjective perspective and obedience to authority, which is with an unquestioning acceptance of extant norms, duty and obligation (Sumner, 2001). Caring representing obedience to what is accepted as universally good is believed to subsequently produce an expected good caring actthat will benefit the care-recipient.Rational and moral justifications require objective obligations and natural laws (Shrewder, 1990). Rules, ethical codes, education and religious principles are "generally" accepted to basically have good intentions imposing good caring acts. Obeying them and doing one's obligation is therefore seen as benevolent in itself. Deontological theories suggest judgment of actions by their conformance to formal rules or principles. Some examples of benevolent care by duty or obligation are religious, ethical, legal, and educational obligation.Caring as a *religious obligation* rooted from the teachings of religious orders such as Christianity. The biblical teachings for example about providing for and/or disciplining children are concepts of care.

*The Bible strongly stresses the importance of discipline; it is something we must all have to be productive people and is much easier learned when we are younger. Children who aren't disciplined grow up rebellious, have no respect for authority, and as a result obviously won't be readily willing to obey and follow God. He uses discipline to correct us and lead us down the right path, and to encourage repentance for our actions (Psalm 94:12; Proverbs 1:7, 6:23, 12:1, 13:1, 15:5; Isaiah 38:16; Hebrews 12:9).*

http://www.gotquestions.org/disciplining-children.html

In Indian Buddhism, religious obligation has been a motivation for caring for the sick (Eriksson, 1989 in Vetlesen & Nortvedt, 1997). Many scriptures and church documents contain numbers of encouragements to take care of the weak, the needy, the poor and the outcasts. Some religions emphasize to include the strangers, and even enemies. It was argued that the motivation to care for the sick today is anchored in the historical religious view about human compassion (Nortvedt, 1997 in Vetlesen & Nortvedt, 1997). Caring as an e*thical obligation* has the intention tomeet the ethical requirements imposed by human codes of ethics. Such codes are meant to protect humans from possible neglect, abuse and exploitation. Caring asa *legal obligation* intends to abide the legal law.Law is a set of rules enforced by the controlling authority that makes people aware of their actions, duty, their potential susceptibility to liability in case they neglect their duties, and the judicial system(O'Keefe, 2001).Caring as an *educational obligation* is the act of care compelled by the caregiver's education. Education is designed to guide people in moulding behaviour, learning a distinct function, responsibility, culture, etc and guiding them towards existing and eventual role in the society.

**Malevolent care** is an act of good caring that benefits the care-recipient, but the caregiver has the abstract malicious intention to benefit oneself rather than the care recipient. Here, there is no congruence between the subjective abstract intention and the objective act of caring. Though most people agree that caring is something good;not all persons are caring. Some people are callous, cold and cruel (Edwards, 2000). Van Hooft (1987), Curzer (1993), Kuhse (1997) and Koehn (1998) meant that caring is not usually a virtue it is usually assumed to be (Paley, 2002). Caring encourages favouritism, creates injustice, provokes inefficiency, and tends to self-deception, infantilization and paternalism (Paley, 2002).Caring with malicious intent, appear to be a good deed on the shallow ground, but otherwise aims to benefit oneself for the cost of other. The Greek verb *phainesthai*means to seem or to appear does not indicate whether the thing perceived is other than what it appears to be (Encyclopaedia Britannica, 1988). Hollywood stars for instance have been subject for suspicions in adopting children from the third world countries. Some suspected that it is a form of publicity gimmick to gain more fans or to satisfy their own need for superiority and self – esteem. Although the consequences of caring actions are good, the intention of some good caring acts can be malicious. The distinction between good and bad has nothing to do with the consequences of actions, and it has nothing to do with the fact that these consequences have been useful to the beneficiary of a "good" action (Nietzche1966, in Paley, 2002). Malevolent care puts the care recipient in a position of being inferior, or probably an object for their selfish intention and personal satisfaction. However, because the abstract purpose/intention of the act is subjective and only known to the care-giver, we should take precautions in pre-judging or being cynical towards caregivers. We might have supposed that an act is good or bad before we have known whether the act was intended (Knobe in Appiah, 2010). In this imperfect world, it is important that caregivers should also be acknowledged as care-recipients.

**b. According to Caregiver's Focus and Priority**

Literature shows that Maslow has greatly influenced the view of human beings' need for care (Yura1986, Ashworth 198, Erikson, 1988 in Fagerstrom, et al, 1998).The caregiver has to determine what the recipient cares about, to be able to help the latter cope with the lived experience (Benner and Wrubel, 1989, in Edwards, 2000). A human need is an inner tension caused by a change in the human system (Yura in Fagerstrom et al, 1998), and the goal of care is to satisfy human needs and enable the person to achieve a higher degree of autonomy and well-being (Meleis 1985 in Fagerstrom et al, 1998). The human need for care can be understood in terms of human suffering which is commonly associated with illness and pain, anguish and agony (Eriksson, 1969-1992 in Fagerstrom et al, 1998).It is also related to fear, despair, hopelessness, and lack of strength (Lindholm& Eriksson, 1993 in Fagerstrom, et al, 1998). Younger (1995) suggests that separation, shame, stigma and alienation are part of experience of suffering (Fagerstrom, et al, 1998). It was also suggested that compassion within caring involves sharing in the world, and commitment includes devotion to the needs of others (Rose, 2008). In the process of caring, the focus is established by these existing needs and problems through objectivity and subjectivity. Natural sciences with objective approach help provide useful knowledge to meet human beings' need for physical care. On the other hand, relativistic sciences are useful to meet the emotional, psychological, social/cultural and spiritual needs of the care-recipient. *Physical care*is a care given to meet the physical needs of the care-recipient.This can be from meeting personal hygiene or meeting biological requirements such as nutritional needs or provision of sleep. This may also include clean environment that promote wellbeing and safety or prevention ofinjury; and help for the sick such as treatment and rehabilitations. *Emotional care*is the capacity to be sensitive to human sufferings, toempathize, and to develop the full-fledged virtue of compassion (Bloom, 2005). It is the care provided by the caregiver to meet the emotional need of the care recipient such as the need for love, empathy,

etc (Vetlesen & Nortvedt, 1997).It is a caregiver's response to the care recipient that should be guided by private norms of friendship and love (Cooper in Dyson, 1997). *Psychological care*is a care given to meet the psychological needs of the care-recipient. This starts from acceptance, respect, understanding, moral support, etc, to mental or behavioural therapy.Psychological care is care provided to help people affected by all types of health problems to face the psychological consequences that originate from such problems. As a therapy, it is directed towards helping the care recipients,by relieving the psychological burden they bear and improve the quality of their life.Human interactions and relationships promote psychological care by meeting people's need to feel loved, wanted or helped. *Social care*is the care given to meet care recipient's need for membership, the economical support, and so on.A person's self-image in a social world is only on loan to him/her from the society (Goffman, 1967). In this respect, relativism becomes necessary in a form of empowerment. Empowerment is a form of social care because it rejects alienation, sustain self-esteem and promote self-actualization (Stang, 1998). Alienation means that a person may feel strange among her/his environment, her life or herself/himself. It means that one is not in the position of controlling her/his own destiny because of other powerful influence such as people, organization, etc(Rotter in Stang 1998). If we are to understand about particular case, we need to understand the culture-specific aspect with a more universal aspect (Shweder, 1990). *Spiritual care*is the care given to meet care recipient's need for faith, hope or religious freedom. Hope is an aspect of caring that focus on the future possibilities. It was described by Swanson (1991) as "maintaining belief" in the person's capacity to face whatever the future holds (Brilowski and Wendler (2005).

**c. According to Effects**

Caring on the care-recipient's perspective can either be constructive or destructive. Caring acts have corresponding consequences that will partly depend on the care recipient. The care recipient's characteristics/qualities play a crucial role whether or not the act of caring will produce a constructive or destructive effect. For instance, undesirable disciplinary action may have different effects on children.Teleological theories judge actions by their consequences, and neither on the intention nor the act.*Constructive care* is when the effect of the caregiver's caring act resulted to good positive outcome that benefits the care recipient, despite malevolent caring or inappropriate caring act.*Destructive care* is when the effect of caring act of the caregiver has resulted toharm the care recipient. Destructive effect of care may be avoided through knowledge of relativism, where the care recipient's reality or understanding of what is good for himself/herself is respected by the caregiver in a caring situation or circumstance. Recognition respect involves treating people in ways that give appropriate weight to some facts about them (Bloom, 2005).

## *Conclusion*

The journey to search for *absolute good caring* is challenging, ambitious and probably naive; and will remain to be an endeavor throughout a lifetime and beyond. There are many examples of partially good caring that I did not talk about. They may or may not be categorized under any of the suggested types of caring, proving the need for further studies on the subject matter. Examples that cannot be categorized among the identified types of caring could be dilemmas involving a third party, self-care, paternalism, mutuality in caring relationship between the caregiver and the care-recipient, allocation of resources between two or more care-recipients, socio-political issues, etc. Further studies should aim to identify, understand and minimize (if not eliminate) the objects and/or processes that hinder human beings to exercise/giveand/or receive absolute good caring through realism and relativism.Realism seeks and suggests the best/ideal possible good and may regulate the caregiver's subjective idea of "good" by obliging them to do what is scientifically proven to be good (benefiting care-recipient). It is especially helpful when the caregiver's belief of what is good is doubtful to benefit the care-recipient. Relativism respects the care-recipient's subjective idea of whatis good for him/her through empowerment; unless the care recipient is not mentally capable and/or the care-recipient's belief of what is good iscontradictory to what isalreadyuniversally/scientifically proven to benefit him/her as a human being in need. Obviously, countless examples aren't studied/proven yet to be trulygood/beneficial;and/because/therefore *we find clusters of civilization in a unique context somewhere in the process of dissimilar stage ofprogress anddevelopments*. Meanwhile, I hope that this paper may inspire and motivate potential caregivers (including care-recipients) towards an optimistic direction to discover a higher form of good (if not absolute), despite the imperfect world we were born and live in.

An absolute good caring is a *conscious* form of caring that has an abstract intention *to benefit* the care-recipient (either genuinely or pre-determined by obligation, therefore self-less);involves caring act that *benefits* the care-recipient (more examples of good caring acts that is in itself beneficial for the care-recipient should be identified through further studies); and has a*beneficial*(constructive) consequence. It is thecaregiver's intention and caring action that *aims and envisage benefitingthe care-recipient* in helping them to meet their human needs. Absolute good caring is a good object/process in itself, and is not necessarily dependent of caregiver's subjective qualities and circumstance. It is not conditioned by caregiver's emotion, culture, belief, etc, but israther dependent onproper identification and satisfaction of care-recipient's objective and/or subjective caring needs through appropriate use of realism and relativism.

This study shows that caring as a phenomenon should be treated/studied as a complete/whole entity from the onset of abstract intention to the objective act of the caregiver; and because it is relational in nature, we should also include studying its effects to the care recipient.

This study implies that "absolute good caring" involves *coherence between the good intention (to benefit the care recipient), good/desirable act and thereby good/constructive consequence.* Such coherence necessitates the proper use of realism/naturalism and relativism. Otherwise, caring will be considered either partly good, or probably not at all. The quest to discover and to put *absolute good caring* into reality - in a world full of complexity, seem to require understanding of the limitations/boundaries of human language, culture, beliefs, norms, knowledge, etc that dynamically interplay. And it is probably a good start by being aware of *"...what we are talking about and what we are not talking about"...* as our great-minded Socrates put it.It is also probably a good thing that we are in the process of finding absolute good caring through internationalization of education. Continuous education endeavors to discover the best possibilities for human beings today and in the future. Through international education (advocating research), we may find and/or construct(if not reconstruct or repair) a/the objective/real/common understanding and realization of absolute good caring that will truly benefit the subjective/relative nature of human beings.

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