REVISIONING CARE ETHICS AS A CRITICAL FRAMEWORK: INSIGHTS INTO PATERNALISM, POWER, AND RELATIONALITY

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ABSTRACT

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In this dissertation, I articulate and develop a particular account of feminist care ethics, which I offer as a critical orientation toward the world. I interpret the "care perspective" as a critical framework that contains various conceptual tools and resources for interpreting and interrogating practices of responsibility within our socio-political world. Although a positive association is often attached to the word "care", relations of care can nevertheless be manifestations of marginalization and oppression. If care ethics wishes to ground itself in human experience, it must be capable of recognizing when relations of care are problematic and of considering how they might be improved. Because of these commitments, I refer to my account of care ethics as a "non-idealized" approach to care. The care perspective I develop here does not provide transcendent guidance that informs someone "how to care". Nor does this approach contain a normative injunction to bring "more care" into the world – for better or for worse, care already permeates the world. What my approach does do is provide conceptual assistance for examining current facets of oppression and asking how arrangements of care both support them and could help mitigate them if arranged differently. Having a non-idealized approach to care ethics involves acknowledging that even when care is well intentioned it can express problematic understandings of our responsibilities towards others, which results in harm that is personal, social, political, or some combination thereof. One important concept that can help us comprehend how relations of care can be problematic in the above fashion is the concept of paternalism. Drawing on the resources that my critical care framework provides, I argue that

paternalism should be construed as a matter of exerting control over another through one's relationship with them. I then demonstrate the importance of having a sensible conception of paternalism, and reasons for care ethicists to be on guard against paternalism in relations of care, through discussing how cognitive behavioral therapy (CBT) works as a treatment for major depression. I emphasize the important potential that CBT as a practice of care has for treating depression. I also stress the importance of being able to appraise CBT from the perspective of care ethics, which I bring out through my discussion of how paternalism as I describe it can thwart the effectiveness of CBT. That my critical care framework can furnish and utilize a conception of paternalism that makes more sense than competing definitions of paternalism demonstrates the value of my critical care framework for evaluating relations of care.

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INTRODUCTION

I.1 Why We Should Care About Care

A few years ago, political theorist Fiona Robinson made the following insightful remark about the significance of care for human lives: "What is important about care is its *necessity* – it *must* be done; and its *ubiquity* – it *is always* being done".[1] Robinson's comment indicates concisely why matters of care should be on the radar of moral and political philosophers. The term "care giver" is often associated with a parent caring for their child, a healthcare worker nursing a patient back to health, or someone working in an assisted living facility. Such individuals are involved in practices of care that are important and worthy of moral attention, but they represent a fraction of the care that permeates human life. Human beings are both providers and receivers of care at various points throughout their lives and across various situations. Indeed, relations of care are among the most prominent, significant, and often underrecognized ways in which we interact with other people. While relations of care within close friendships and familial contexts have a special significance for one's sense of self, relations of care are threaded throughout various social and political institutions. Care is a crucial medium through which responsibilities within such institutions are delineated, carried out, and maintained.

Some feminist scholars who recognize the pertinence of care for matters of ethics work to formulate theories of morality that are based upon practices and values associated with care. The resulting body of literature, following Carol Gilligan's 1981 book *In a Different Voice*, develops

[1] Fiona Robinson, "Paternalistic Care and Transformative Recognition in International Politics", in *Recognition and Global Politics*, eds. Patrick Hayden and Kate Shick (Manchester, England: Manchester University Press, 2016), 171, DOI: 10.7765/9781526101037.00016.

what is variously referred to as "care ethics" or "the ethics of care".[2] While a number of theorists have made contributions to the literature on care ethics, care ethics remains something of an umbrella term. Care ethics encompasses a cluster of approaches, and although these approaches share some crucial characteristics that give them a sort of family resemblance, there exist non-trivial distinctions and incompatibilities between accounts, differences which include (but are not limited to) matters such as moral objectivity and moral epistemology. These differences between accounts of care ethics generate questions about how the relatively young body of literature should continue to be developed. Should care theorists, and those who wish to acknowledge care ethics, construe care ethics as a rival counterpart to moral theories in the philosophical literature such as Kantianism and utilitarianism? If care ethics is akin to those moral theories, does care ethics provide the means for deciphering what we morally ought to do in a given situation (in the case of care ethics, when and how one should provide care)? Or rather, should a candid appreciation of the various insights that care perspectives have provided include a rejection of traditional Western moral theories?

My contribution to the care ethics literature takes the latter route from the above options. In this dissertation, I articulate and develop a particular account of feminist care ethics, which I offer as a critical orientation toward the world. I interpret the "care perspective" as a critical framework that contains various conceptual tools and resources for interpreting and interrogating practices of responsibility within our socio-political world. It is vital that care ethics be capable of making sense of the ubiquitous relations of care within our lives and their socio-political impact. Although there is a positive association often attached to the word "care", relations of

[2] I typically prefer to use the term "care ethics", and that is the term that I typically use throughout this work. Nevertheless, I might occasionally use the term "ethics of care" for stylistic reasons, and when I do, I mean the same thing.

care can nevertheless be manifestations of marginalization and oppression. If care ethics wishes to ground itself in human experience, it must be capable of recognizing when relations of care are problematic and of considering how they might be improved. Because of these commitments, I refer to my account of care ethics as a "non-idealized" approach to care. The care perspective offered here will not provide transcendent guidance that informs someone "how to care". Nor does this approach contain a normative injunction to bring "more care" into the world – for better or for worse, care already permeates the world. It also does not attempt to provide a blueprint for what a "truly caring" society would look like. What my approach does do is provide conceptual assistance for examining current facets of oppression and asking how arrangements of care both support them and could help mitigate them if arranged differently.

Having a non-idealized approach to care ethics involves acknowledging that even when care is well intentioned it can express problematic understandings of our responsibilities towards others, which results in harm that is personal, social, political, or some combination thereof. One important concept that can help us comprehend how relations of care can be problematic in the above fashion is the concept of paternalism. Notions of paternalism are often based upon Gerald Dworkin's influential definition of paternalism as "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced".[3] While it is not uncommon for care ethicists to mention in passing that paternalism is something to be avoided, paternalism is not usually discussed in detail within care ethics. Some moral and political theorists have in fact suggested that perhaps care ethics should, at least in some circumstances, embrace paternalism. I believe that endorsements of paternalism from a care perspective stem from a failure to recognize that care

[3] Gerald Dworkin, "Paternalism", *The Monist* 56, no. 1 (1972): 65, DOI: 10.5840/monist197256119.

ethics, in rejecting aspects of liberal ideologies, should also reject certain *understandings* of paternalism that draw upon those ideologies. Drawing on the resources that my critical care framework provides, I argue that paternalism should not be construed as a matter of interference with some (disconnected) other for their benefit but rather as a matter of exerting control over another through one's relationship with them. When paternalism is understood in this fashion it becomes easier to see why care ethics should be disquieted by it.

I will demonstrate the importance of having a sensible conception of paternalism, and reasons for care ethicists to be on guard against paternalism in relations of care, through discussing an issue that care ethicists have (surprisingly) said little about: major depression. Major depression involves a significant existential shift in how one experiences the world's possibilities.[4] Such an existential shift has serious ramifications both for how one interprets one's capabilities to care and for the kind of care one believes they are capable of (even worthy of) receiving. Because depression is not a rare phenomenon, many people who have responsibilities of caring for others will struggle with depression at some point. Care ethicists might even wish to investigate whether some aspects and patterns of responsibility for care might increase a caregiver's vulnerability to depression. There is, of course, also the matter of what kinds of care are available for treating depression. Even when a person experiencing depression does not seek treatment for their depression, they are nevertheless liable to be receiving some kind of care from someone – to pick an example that should drive the point home to academics, from teachers and professors.[5] The impact of depression on both giving and receiving care and the difficulties that

[4] This understanding of depression draws upon Matthew Ratcliffe's remarkable book, *Experiences of Depression: A Study in Phenomenology*. Ratcliffe's account of depression will be explained in detail later on.
[5] To ignore professors as care providers, who cultivate care for our students through our various interactions with them as educators, guides, and sometimes pillars of support, would be an example of my earlier point that the presence of care in social and political contexts is often underrecognized.

can arise when working to treat individuals who experience depression are all reasons for care ethicists to concern themselves with depression. Through discussing how paternalistic care in particular is a barrier in treatment for depression, the critical care framework that I offer demonstrates the kinds of fruitful contribution that care ethics can make to discourse on depression when care is understood in a non-idealized fashion.

I.2 The Road We Shall Travel

My arguments in favor of construing care ethics as a critical framework and that demonstrate this framework's importance for thinking through issues of problematic care are spread across four main chapters and a short conclusion. In the first chapter, I review the literature on care ethics, and I situate my care ethics framework within that literature. This review of the literature will inform readers about care ethics' origins within academic conversations surrounding moral development and will enable those who are unfamiliar with care ethics to understand the basic commitments that are shared across differing accounts. My literature review also elucidates differing answers that can be found within the literature concerning how to understand the notion of "care" and showcases some differing responses as to whether or not care ethics should be construed as a moral theory. To conclude the first chapter, I consider the problem of paternalism for care ethics, and I review Uma Narayan's caution against care ethics developing in a manner that encourages paternalistic care.

In the second chapter, I explicate into my account of care ethics as a critical framework in detail, explaining its theoretical commitments and implications. I indicate why my account does not attempt to anchor ethical thought in some transcendental vantage point. Drawing on work from Margaret Walker, I present an alternative understanding of ethical thought as socially

grounded and collaboratively authoritative. I indicate what moral criticism looks like from this social, collaborative perspective, which involves investigating whether aspects of ethical thought "make sense" when understood transparently. I explain what is involved with questioning whether or not some aspect of ethical thought makes sense, and that we must be aware that ethical thought will make sense to an "us" which is historically situated and can be more or less representative. Returning to the subject of paternalistic care, I acknowledge the viewpoint that care ethics should not be opposed to paternalism. I suggest, in counterpoint, that we need to have a sensible conception of paternalism before we can make that claim.

Having explicated what underlies care ethics as a critical framework, in the third chapter I use the lens of my care framework to examine various definitions of paternalism. I review some different ways in which paternalism has been conceptualized, and I indicate some shortcomings with these accounts that are brought to the forefront when we appreciate what it means for people to be inherently relational beings. I proceed to offer an account of paternalism that is informed by the criticisms that I raise. On my account, paternalism is understood as an effort to exert a measure of control over another. In the fourth chapter, I present further arguments that support my account of paternalism, relating them to major depressive disorder and its treatment. I present an understanding of depression that draws on Matthew Ratcliffe's view of depression as a shift in existential feeling, and I discuss a prominent kind of psychotherapy for treating depression, which is cognitive behavioral therapy (CBT). I emphasize the important potential that CBT as a practice of care has for treating depression. Correspondingly, I stress the importance of being able to appraise CBT from the perspective of care ethics, which I bring out through my discussion of paternalism and CBT. My discussion demonstrates the merit of my critical care framework, furnishing as it does a conception of paternalism that makes more sense

than competing definitions for evaluating relations of care. The need for care ethics to being of help in assessing and appraising CBT will be further illuminated in the dissertation's conclusion. In the conclusion, I discuss why it is important to view CBT in connection with the social determinants of health, and I explain my belief that care ethics as a critical framework will be helpful for doing so.

It is remarkable how far care ethics has come in 40 years. But if care ethics is to continue to grow and we are to realize the radical potential of care ethics, we need to move beyond situating care ethics as a competitor to prescriptivist approaches to moral thinking like Kantianism and utilitarianism. We need a non-idealized approach that can contend with the potential for abuse, manipulation, and domination in intimate and socio-political relations. When care ethics does these things, it is an important complement for feminist thought and can make contributions to anti-oppression efforts that would otherwise be missed. Care ethics helps us to be cognizant of the crucial role that care has in various aspects of human life and of just how significant care is. Relations of care with particular others form part what makes our lives worth living. Practices of care and inequitable distributions of caring responsibilities can also reinforce oppression and contribute to making one's existence miserable. Feminists need to be capable of accounting for care. The conception of care ethics developed here is an important contribution to making that happen.

CHAPTER 1:

CHARTING HOW FAR CARE ETHICS HAS COME

1.1 The Genesis of Care Ethics: "Women's Voice" and Beyond

Care Ethics entered academic discourse in 1982 when Carol Gilligan published *In a Different Voice: Psychological Theory and Women's Development*. This groundbreaking book contributed to a growing body of feminist criticism of social scientific research and theorizing, and was spurred by the recognition that "theories formerly considered to be sexually neutral in their scientific objectivity are found instead to reflect a consistent observational and evaluative bias".[6] *In a Different Voice* offered critiques of accounts from male psychologists that described women as inferior compared to men in their moral development. While *In a Different Voice* discusses the work of various psychologists, such as Sigmund Freud and Jean Piaget, Gilligan's main criticisms were directed at Lawrence Kohlberg's stage theory of moral development. In particular, Gilligan aimed both to explore and validate the female perspectives that she argued had been discounted in Kohlberg's work. It was in the service of this project that Gilligan identified and described what she would alternatively refer to as the "care perspective", "the ethics of care", and "care ethics".

In this chapter, I provide a literature review that explains the circumstances under which care ethics emerged with Carol Gilligan's work. I describe how various philosophers and political theorists have continued to develop care ethics over the years, and I identify shortcomings that have been exposed as care ethics has continued to develop. In the chapter's first section, I explain Gilligan's thesis that Kohlberg's account of moral development

[6] Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development*, 2nd edition (Cambridge, MA: Harvard University Press, 1993), 6.

misconstrued the perspectives of his female research participants. Gilligan's research, by contrast, considered the merit of those perspectives. After describing Gilligan's account, I discuss a major criticism of her work, which is that her account of care ethics and moral reasoning embodies gender essentialism. While I find the relationship between Gilligan's work and gender essentialism to be somewhat ambiguous, I argue that gender essentialism is quite explicit in the work of fellow care ethics pioneer Nel Noddings and critique her gender essentialist view that care is distinctly feminine. I subsequently proceed to discuss Joan Tronto's book *Moral Boundaries.* Tronto's significant text helped discussions of care move to beyond gender essentialism, and it charted a future direction for care as a matter of political concern that many care theorists have followed.

Following the work of Gilligan, Noddings, and Tronto during the 80's and early 90's, care theorists have proposed and continued to refine various accounts that established an impressive literature on care ethics. In the chapter's second section, I highlight four components of care ethics that are shared amongst various care ethics accounts and provide an overview of these features. These four features can be seen as markers that unite various accounts under the term "care ethics". Nevertheless, there are crucial discrepancies between accounts of care ethics. Then, in the chapter's third section, I review some competing ways in which care ethicists have understood the notion of care. After discussing flaws with these attempts at defining care, I introduce my own understanding of care as something that should not be idealized.

1.1.1 The Kohlberg / Gilligan Debate on Moral Development

Carol Gilligan's book *In a Different Voice* contrasts two accounts of the development of moral reasoning. One of these accounts is Gilligan's own, which represents the "care" perspective. The

other is Lawrence Kohlberg's stage theory of moral development, which represents the "justice" perspective. Since Gilligan's work was a response to Kohlberg's, we shall review his account of moral development first.

Kohlberg's account of moral development describes six developmental stages. At each stage of development, one's moral reasoning is informed by different criteria: (1) avoidance of punishment, (2) promoting self-interest, (3) seeking interpersonal accord and conformity, (4) maintaining law and order, (5) upholding the social contract, and (6) invoking universal principles. Kohlberg's six stages are further organized into three categories of reasoning capability: stages 1 and 2 reflect pre-conventional reasoning, stages 3 and 4 reflect conventional reasoning, and stages 5 and 6 reflect post-conventional reasoning. According to Kohlberg's model, someone who reasons from a later stage exhibits a more equilibrated understanding of justice than someone who reasons at an earlier stage, and post-conventional reasoning reflects the highest level of moral development.[7]

Kohlberg based his account of moral development upon a series of longitudinal studies that tracked the moral reasoning that male subjects utilized in childhood, through adolescence, and into early adulthood. Kohlberg and his researchers measured the moral reasoning of their research participants through asking them to consider various moral conundrums, such as Heinz's dilemma. Heinz's dilemma is a hypothetical scenario in which a man (Heinz) cannot afford a drug that will save the life of his sick wife, and the druggist in possession of the drug refuses to lower the price of the drug to accommodate Heinz's circumstances. After researchers provided research participants with a description of the scenario, they prompted participants with the question, "Should Heinz steal the drug?", along with a series of follow-up questions. These

[7] Lawrence Kohlberg, "The Claim to Moral Adequacy of a Highest Stage of Moral Development", *The Journal of Philosophy* 70, no. 18 (1973): 631-632, https://www.jstor.org/stable/2025030.

follow-up questions were used to illuminate the moral reasoning behind the participant's answer as to whether Heinz should steal the drug.[8] Kohlberg measured how moral reasoning developed over time in his research participants by looking at the *kind* of reasoning they used to arrive at their conclusions, rather than the actual conclusions they arrived at.[9]

The conflict between Kohlberg and Gilligan emerged when Kohlberg later included female participants in subsequent iterations of his longitudinal studies. For Kohlberg's female participants, their moral development appeared to stall at the interpersonal concordance stage, where morality focuses on pleasing others.[10] Kohlberg thereby construed the females in his study as falling short of the post-conventional reasoning capabilities that were exhibited in the highest stages of his model. Gilligan criticized this interpretation and argued that to interpret those female participants as stalling in the development of their conception of justice misconstrues their reasoning. Such an interpretation fails to recognize these girls and adolescents were drawing upon a different moral orientation altogether, one that is focused on care and responsibility instead of justice and rights.

Gilligan made her case by reviewing the recorded responses in Kohlberg's studies from female participants to Heinz's Dilemma. While Kohlberg's female participants were interpreted as indecisive, evasive, and using undeveloped reasoning, Gilligan claimed that researchers failed to recognize their female participants were seeing and addressing within Heinz's dilemma a different moral problem altogether. Kohlberg's researchers were viewing Heinz's dilemma from the justice perspective, so they expected participants' answers to fall somewhere within that

[8] Anne Colby, Lawrence Kohlberg, John Gibbs, and Marcus Lieberman, "A Longitudinal Study of Moral Judgment", *Monographs of the Society for Research in Child Development* 48, no. 1/2 (1983): 9, DOI: 10.2307/1165935.
[9] Colby, Kohlberg, Gibbs, and Liberman, "A Longitudinal Study of Moral Judgment", 1.
[10] Gilligan, *In a Different Voice*, 18.

orientation. This occurred with male participants, who were also using a justice perspective, but not with female participants.[11] Because the female responses were not fitting into the researchers' understanding of the problem, the researchers did not accept their responses. They continued to repeat and press their questions, leading female participants to lose confidence in their answers and begin to waver in their responses. Thus, when interpreted through Kohlberg's stage theory of moral development, the female participants appeared as though they were unable to think as deeply or systematically as the male participants.[12] Gilligan, however, claimed that because females were viewing Heinz's dilemma from a different perspective than one focused around notions of justice, the researchers misdiagnosed the problem. At issue was not that female participants possessed an inferior understanding of Heinz's dilemma or how to answer it, but that they were answering a different question than the researchers understood themselves to be posing. Because the researchers did not consider whether the failure to understand was on *their part*, they reached the faulty conclusion that their female participants had an insufficient moral understanding of Heinz's Dilemma.[13]

Gilligan argued that instead of attempting to determine whose rights trump the other's in Heinz's dilemma, female participants were pushing for more collaborative solutions. They saw the conflict as arising not out of the druggist's assertion of his rights as a business owner, but as a result of his failure to respond to the needs of Heinz's wife.[14] Instead of reasoning with immature conceptions of justice, these girls and adolescents were viewing moral problems from an alternative perspective altogether, one that came up with contextual solutions as opposed to

[11] Gilligan, 25-39.
[12] Gilligan, 29-30.
[13] Gilligan, 30-31.
[14] Gilligan, 25-32, 54.

categorical ones.[15] Such contextual solutions focused on how to get moral agents, such as the druggist or other people Heinz could turn to for help, to be responsive to his wife's need and help him obtain the medicine.[16] Thus, Gilligan contended that while the interviewers were asking whether or not Heinz should act in his dilemma, where they had predetermined that the only available form of action was stealing the drug, the female respondents already assumed Heinz must take action in response to the need of his wife. Their concern was rather with *what form* that action should take.[17]

Gilligan's wanted to articulate this "different voice" of care ethics to demonstrate the importance of including female perspectives in conversations about ethics and psychological development. She expresses her view about the radical potential of female inclusion in the following statement: "A new psychological theory in which girls and women are seen and heard is an inevitable challenge to a patriarchal order that can remain in place only through the continuing eclipse of women's experience".[18] Gilligan's critique of Kohlberg highlighted a double bind for women: characteristics that marked them as "good" women, wives, mothers, and so on were simultaneously used to mark them as deficient in moral development. Gilligan's argument that the care perspective is a legitimate moral perspective and one that is not inferior to the justice perspective was her manner of addressing this double bind.

[15] Gilligan, 38.
[16] Gilligan, 28-30.
[17] Gilligan, 31.
[18] Gilligan, xxiv.

1.1.2 Criticisms of Gender Essentialism in Care Ethics

It is important to note that, while *In a Different Voice* draws upon the moral perspectives of girls and women to furnish an understanding of care ethics, Gilligan did not intend for the book to promote ideas of gender essentialism, as we can see in the introduction to her text:

> The different voice I describe is characterized not by gender but theme. Its association with women is an empirical observation, and it is primarily through women's voices that I trace its development. But this association is not absolute, and the contrasts between male and female voices are presented here… to focus a problem of interpretation rather than to represent a generalization about either sex.[19]

Of course, one can produce work that has implications they did not intend, and if Gilligan did not wish to encourage essentialist notions of gender, she was not as careful as she could have been when it came to her choice of language within her book. She refers to care ethics as "the different voice of women" rather than something akin to "an unrecognized voice found within some women's narratives". It is not difficult to get the impression that there are distinct differences between male and female modes of thinking from passages such as, "My research suggests that men and women may speak different languages that they assume are the same, using similar words to encode disparate experiences of self and social relationship".[20] Whether Gilligan's work is in fact essentialist or has just been misunderstood to be so, many who have read *In a Different Voice* have come away thinking that it presented essentialist ideas about how women do and should reason.

While Gilligan's *In a Different Voice* left many readers with an impression of gender essentialism, fellow care ethics pioneer Nel Noddings explicitly espoused gender essentialism in her 1984 book, *Caring: A Feminine Approach to Ethics & Moral Education*. In addition to the rather obvious inclusion of "feminine" in the title, Noddings' book contains claims like the

[19] Gilligan, 2.
[20] Gilligan, 173.

following: "An ethic built on caring is, I think, characteristically and essentially feminine".[21] While Noddings indicates that the care ethics perspective can be taken up and utilized by men, she nevertheless contends that the perspective arises out of women's experience.[22] Furthermore, in describing care as feminine, Noddings links the notion of caring to mothering. She frames the exclusion of the feminine perspective from philosophical theorizing as creating a situation where "The Mother's voice has been silent".[23] Noddings describes differences between male and female interpretations of scenarios such as God's injunction in *Genesis* that Abraham's must kill Isaac, and when doing so she identifies the perspective of women with the perspective of "the mother".[24]

One problem that follows from an essentialist link between women and care is preservation of a status quo that care ethics can and should challenge. When the concept of care is conceptually linked to feminine qualities and activities, the moral salience of the care perspective that Gilligan argues for can be accommodated within existing socio-political arrangements without transformative effects. A common response to Gilligan's work from theorists such as Lawrence Kohlberg and Jürgen Habermas has been to regard care as authoritative for relationships within the private sphere, while maintaining that notions of justice and rights take precedence for discussions in the public sphere. Insofar as care is associated with women and justice with men, a feminine conception of care ethics does not unsettle the notion that women's place is within the household. Indeed, on a view like Noddings', men could decide to adopt the care perspective exclusively within the private realm while still using their usual

[21] Nel Noddings, *Caring: A Feminine Approach to Ethics & Moral Education* (Berkeley, CA: University of California Press, 1984), 8.
[22] Noddings, *Caring*, 8.
[23] Noddings, 1.
[24] Noddings, 43.

(masculine) moral concepts within public and political debate. As the history of segregation within the United States has demonstrated, "separate but equal" gives preference to those who orchestrate and enforce the separation in the first place.

Further problems arise for care ethics when "woman" and "mother" or "feminine" and "mothering" are conflated. A strong identification between motherhood and woman can pathologize women who do not meet that mothering standard (e.g., there is "something off" about women who don't want to have children). Furthermore, mothering standards have tended to draw upon white, middle-class, and nuclear families when presenting ideals of motherhood and what being a mother entails. Patricia Hill Collins, for example, argues that white feminists of the 70s and 80s uplifted the experience of white mothers, combatting negative stereotypes about them and highlighting their value. At the same time, they ignored and left intact harmful ideas about black motherhood (e.g., stereotypes such as the "mammy" or "welfare mother").[25] The discussion of these feminists was not informed by experiences of black motherhood, and there was no acknowledgement of the tensions within African-American communities about how motherhood gets viewed.[26]

1.1.3 Care as Political, Not Just Personal

A number of care ethicists have, like me, considered gender essentialism to be something care ethics should avoid. Thus, several care ethicists of the 1990's and later rejected gender essentialism. Care theorists have also sought to make clear why care ethics is not just suited for "private life" but has important social and political ramifications. Joan Tronto's book *Moral*

[25] Patricia Hill Collins, "Black Women and Motherhood", in *Justice and Care: Essential Readings in Feminist Ethics*, ed. Virginia Held (Boulder, CO: Westview Press, 1995), 118.
[26] Collins, "Black Women and Motherhood", 120.

Boundaries: A Political Argument for an Ethic of Care was an influential step in that direction. One of Tronto's core claims in her book is "that we need to stop talking about 'women's morality' and instead start talking about a care ethic that includes the values traditionally associated with women".[27] She argues that strategies offering a "female perspective" to supplement or temper "male thinking" are ineffective at making a case for their inclusion within traditionally masculine spheres, such as politics within Western societies. Such strategies do not challenge the underlying conceptual boundaries and assumptions about ethics, politics, and gendered thinking that contributed to the exclusion of women in the first place. These conceptual boundaries and assumptions must be confronted if we are to understand the invisibilization of care work and the perceived irrelevance of concerns about care for politics.[28]

Tronto describes two prominent approaches to the relationship between morality, politics, and the boundaries between them within modern political theory that impede care ethics from entering into political discussion. The "morality first" view, which is embodied in the political liberalism of thinkers like John Rawls, focuses on first determining the moral principles that should structure societies (for example, using thought experiments like the original position), and then pressing the existing political world to conform to these principles.[29] When care ethics is disregarded as a moral perspective due to not producing abstract and generalizable moral principles, "morality first" views exclude care ethics from politics.[30] The "politics first" view, which is embodied in thinkers such as Niccolo Machiavelli, views morality as subsidiary and perhaps irrelevant altogether to the central concern of politics. Politics on this view is concerned

[27] Joan C. Tronto, *Moral Boundaries: A Political Argument for an Ethics of Care* (New York, NY: Routledge, 1993), 3.
[28] Tronto, *Moral Boundaries*, 6.
[29] Tronto, 7. I will discuss further in chapter 2 the "original position" that John Rawls proposes.
[30] Tronto, 10.

first and foremost with power struggles and control over resources, territories, etc. Hence, even if care ethics is recognized as a moral perspective, it gets excluded from politics due to the latter's amoral political orientation.[31]

In order for considerations of care ethics to be seen as salient within political discussions about the use of power, maintaining social order, and so forth, Tronto urges her readers to conceptualize the moral and political as related inquiries instead of viewing politics as an instrument for achieving what a "moral point of view" prescribes (e.g., politics as applied ethics) or viewing political and moral concern as having incompatible foci. A perspective that can simultaneously inform our conception of a flourishing moral individual and a flourishing social order demonstrates how moral and political questions intertwine.[32] Indeed, Tronto believes that is where the radical potential of care shows itself, for care ethics illustrates how moral and political questions can be concerned over the same thing: "the practice of care describes the qualities necessary for democratic citizens to live together in a pluralistic society, and that only in a just, pluralistic, democratic society can care flourish".[33] Thus, Tronto believes the radical potential of care consists in its demand for a shift in the terms that structure the boundaries of politics. We must regard questions of care as central to questions of politics if we are to counteract its devaluation, expose care's invisibilization within areas of public life, and deal with particular challenges for modern democracies.[34]

Since the 1993 publication of *Moral Boundaries*, several care ethicists have followed suit in arguing that the exclusion of care from political concerns is a problem with political

[31] Tronto, 8.
[32] Tronto, 9-10. Tronto makes clear that she does not want to regard moral and political questions and concerns as *identical*: "We would jeopardize the very basic of modern political life, and the possibilities for feminism and for freedom, if we were unable to separate any moral arguments from political ones…" (Tronto, 10).
[33] Tronto, 162.
[34] Tronto, 157.

assumptions, rather than with care as a candidate for political concern. For instance, Virginia Held contends that care is required for social and political goals such as educating citizens, mitigating violence, and achieving peace. She makes the bold claim that, "When its social and political implications are understood, [care ethics] is a radical ethic calling for a profound restructuring of society".[35] Selma Sevenhuijsen makes a case for the importance of situating and integrating ideas about care into conceptions of democratic citizenship and social justice.[36] Eva Kittay argues that the giving and receiving of care should be seen as matters of public concern,[37] while Fiona Robinson argues for the relevance of care ethics within the field of international relations, criticizing both the political liberal and political realist options that headline mainstream discussions.[38] The social and political promise that several feminist thinkers have seen within care ethics has resulted in continued development over the years, which has further furnished points of overlap as well as points of divergence between the proponents of care ethics.

1.2 Core Features Shared Among Different Strands of Care Ethics

The literature on care ethics has received an impressive amount of development in the forty odd years since Gilligan published *In a Different Voice*. Nevertheless, the literature is relatively young compared to more mainstream schools of ethical thought and there are a numerous aspects of care ethics that are still being worked out. In fact, while care ethicists often present themselves as writing in the care tradition or from the care perspective, care ethics has reached a point where

[35] Virginia Held, *The Ethics of Care: Personal, Political, Global* (New York, NY: Oxford University Press, 2006), 19.
[36] Selma Sevenhuijsen, *Citizenship and the Ethics of Care: Feminist Considerations on Justice, Morality, and Politics* (New York, NY: Routledge, 1998).
[37] Eva Feder Kittay, *Love's Labor: Essays on Women, Equality, and Dependency* (New York, NY: Routledge, 1999).
[38] Fiona Robinson, *Globalizing Care: Ethics, Feminist Theory, and International Relations* (Boulder, CO: Westview Press, 1999).

distinct strands of care theorizing have emerged, resulting in what I think is more accurately considered to be a cluster of related approaches rather than a singular one. In this section, I review four features that are shared among versions of care ethics that mark them as belonging to this "care cluster". These features are (I) regarding dependence upon others as typical of the human condition and not a characteristic of deviant or defective individuals, (II) a relational understanding of self-identity, (III) the importance of acknowledging particular others for moral reasoning, and (IV) the relevance of emotions for moral reasoning.

1.2.1 Dependence as Part of the Human Condition

While they might differ in other regards, all accounts of care ethics find significance in the fact that human beings are not self-sufficient creatures, where self-sufficiency is understood as reliance upon no one but oneself. Human beings enter the world unable to provide for their own survival needs, and require parental figures (or surrogates) for nourishment, protection, and emotional comfort. While most individuals can develop certain capabilities for self-care, which allows for increased levels of independence, such capabilities cannot be realized without themselves being nurtured. Although at some points of their lives human beings typically display increased levels of independence, it remains a species characteristic that to varying degrees we depend upon others for our survival and flourishing. For example, while someone might learn cooking skills, and thus not continue to depend upon another for the preparation of their meals, it is not typical for someone to grow all their own food and acquire on their own all of the tools and resources that are used in meal preparation.

Humans have variable and fluctuating health due to our various physical, emotional, and psychological vulnerabilities. Whether recovering from physical injury or illness, receiving

emotional support and encouragement, or overcoming something like depression, we depend upon the presence, support, skills, and resources of other individuals to a variable extent. As such, the difference between so-called "normal" individuals and those labeled as "disabled" is not a difference of kind but rather of degree. Positing a sharp demarcation between the two is often the result of a failure to recognize the vulnerabilities and dependencies that the so-called "normal" possess. The degree of dependency, and the source of one's dependency, might be more prominent at some points in one's life than others. But dependency is a pervasive feature of life nonetheless, although though its presence is not always recognized, which allows for the illusion of being a self-made person.

With dependence, vulnerability, and human need being pervasive within life, practices of care geared toward addressing them pervade as well. While care ethicists dispute how exactly care should be understood, they agree that care is something essential for the maintenance of living and the continuation of our species. Caring practices have various forms across various domains, and include activities with aims such as nourishing bodies, fulfilling emotional needs, and providing teaching and socialization. The social contract is purported to represent, either actually or hypothetically, humankind's point of transition out of an asocial "state of nature" in classical political philosophy. But people would not be able enter into social contracts with one another without (social) practices of care, which enable people to develop capabilities for self-care and social interaction, and which sustain individuals when their abilities to care for themselves are insufficient on their own.[39]

[39] Eva Kittay argues that John Rawls' original position, attempting as it does to modernize social contract theory, also invokes an idealization of a "fully functioning" cooperative member of society that ignores the fundamental human dependence upon care giving and receiving (Kittay, *Love's Labor*, 88).

That human need and dependence are pervasive, and that care is necessary for addressing them, supports the claim that care is a political concept. As noted earlier, Fiona Robinson emphasizes, "What is important about care is its *necessity* – it *must* be done; and its *ubiquity* – it *is always* being done. The political task is revealing and defending the ways and extent to which practices of care sustain life that is physically comfortable and emotionally secure". [40] Because there are important questions to be raised about who should perform care work, under what conditions, and so forth, how care is structured within society should be understood a pressing political issue that involves issues such as power dynamics and resource allocation. Whether and why care has additional moral and political significance is a separate matter that care ethicists disagree upon, which I will return to in this chapter's third section.

1.2.2 A Relational Conception of the Self

A second prominent feature of care ethics is a relational conception of one's self-identity. To some extent, one's sense of self is understood through one's connection with particular others, and one's wellbeing is entangled with the wellbeing of particular others. The relational conception of the self stands in opposition to what Michael Sandel refers to as the "unencumbered self", a view which he attributes to Immanuel Kant, John Rawls, and liberalism more generally. The unencumbered self is divorced from any particular interests, roles, and attachments.[41] According to a relational conception of the self, our identities are constituted in part through our social relationships and through the *importance* of those relationships to us. Care ethicists bring to the fore the insight that when one regards a particular other as unique and

[40] Robinson, "Paternalistic Care and Transformative Recognition in International Politics", 171.
[41] Michael J. Sandel, "The Procedural Republic and the Unencumbered Self", *Political Theory* 12, no. 1 (1984): 85-87, https://www.jstor.org/stable/191382. I will further discuss the unencumbered self in chapter 2.

irreplaceable, and values their connection to this special individual, the relationship has a significant impact upon one's conception of their own wellbeing. There are particular others that are so important to me that their ability or inability to flourish impacts my own, such that I become distraught when they are distraught. In at least some of cases, the reverse holds true as well. In certain situations, I would be more pained through not making a sacrifice to help one of these people and having them suffer than I am by the sacrifice I make. My own wellbeing is not identical to or subsumable under theirs, but insofar as I love them, I cannot entertain being unconcerned with their wellbeing altogether without challenging a sense of who I am or whether I do in fact love them. Insofar as someone has such attachments in their life, their wellbeing is entangled with the wellbeing of particular others.

1.2.3 The Pertinence of Particular Others

A third characteristic of care ethics, which pertains to moral reasoning, involves an orientation towards particular others as opposed to abstract persons. Virginia Held has summarized that orientation as "attending to and meeting the needs of others for whom we take responsibility", which has proven to be an influential formulation in spite of being rather vague.[42] Care ethics focuses on the needs of actual embodied beings instead of notions about what personhood requires or universal subjects are owed. When reasoning from a care perspective, we are not responding to someone as an individual abstracted from the contingent world (e.g., as a fellow member in a kingdom of ends), but as an embodied being with physical, mental, and social needs whom we have (or could have) some kind of relationship with. Because of the emphasis on concrete human beings instead of abstract personhood, the characteristic of attentiveness has an

[42] Held, *The Ethics of Care*, 10. Held's phrasing of "for whom we take responsibility" can make the responsibilities associated with care work sound voluntaristic in a social contract sort of way.

important role for discerning needs and providing care within various accounts of care ethics. Indeed, care ethicists often interpret attentiveness as a virtue. Joan Tronto captures the importance of attentiveness for caring when she states, "care requires the recognition of a need and that there is a need to be cared about… if we are not attentive to the needs of others, then we cannot possibly address those needs".[43]

1.2.4 The Relevance of Emotion for Moral Reasoning

A fourth feature common among accounts of care ethics, and the final one that I discuss here, is the relevance of emotion for moral reasoning. Unlike rationalist moral theories, which view emotion as being irrelevant for moral deliberation, and which often regard emotions as a bias to overcome, care ethicists think that at least some emotions have an important role in ethical deliberations. Exactly *what* relevance emotions are taken to have for moral reasoning can differ between accounts. For example, Michael Slote regards care ethics as a kind of moral sentimentalism,[44] while I do not. Nevertheless, that emotions have relevance is a common thread in the work of care ethicists. My own approach follows theorists such as Selma Sevenhuijsen in regarding reasoning abilities and emotional faculties as interconnected, and sees the dichotomization within rationalist theories between practical reasoning and emotion as misleading.

1.3 What Constitutes Care?

I have stated that while accounts of care ethics share all have the above features, they diverge on other crucial matters. I indicated one such divergence earlier when discussing how some

[43] Tronto, *Moral Boundaries*, 127.
[44] Michael Slote, *The Ethics of Care and Empathy* (New York, NY: Routledge, 2007), 5.

proponents of care ethics (like Nel Noddings) have seen it as a feminine approach while others find that stance to be problematic. There are two further divergences that I review here that can distinguish accounts within the "care cluster" from each other: (I) how the notion of "care" is understood, and (II) whether care ethics should be construed as a moral theory. In the remainder of this chapter, I will explore the first of these divergences, while the second divergence will be discussed in the next chapter.

Virginia Held explains that care ethicists, in their focus on care, are working to articulate something distinct from just affective attitudes, such as caring about someone or telling someone to "take care". Caring about indicates some measure of affective investment in or concern for another, while the phrase "take care" is the sort of thing one says to another because one cares about them.[45] Affective attitudes are relevant for the sort of care that care ethicists theorize about and attempt to elucidate. Caring about someone can be a powerful motivator to provide care for someone, and as we shall see later, Joan Tronto includes "caring about" as one of her four phases of care.[46] But care ethicists mean something more when talking about care, something that reflects care's active nature in creating and maintaining relationships with each other. As a result, there is typically agreement among those writing in care ethics that care at least refers to some kind of labor or practice. Where differences emerge is the matter of *how* to understand care as a practice, and whether care should also be understood as being something more, such as a normative good or a moral value.

[45] Held, *The Ethics of Care,* 30.
[46] Tronto, *Moral Boundaries*, 106.

1.3.1 Nel Noddings on Care

We will start our survey with the conception of care that Nel Noddings develops in her aforementioned book, *Caring*. Her book offers one of the earliest accounts of care in the care ethics literature, and she provides a more detailed conception of the notion of care itself than Gilligan does. Because her account in *Caring* is also one of the more restrictive notions of care, it serves as a good starting point, since most care theorists moving forward will regard care as encompassing more than Noddings does.

Noddings ascribes two characteristics to practices of care: care practices are spontaneous and care practices are driven by affection towards others.[47] Noddings believes the affection that motivates "natural caring" is the basis for a second sentiment, which motivates what she calls "ethical caring". This second sentiment is an emotional experience of "I must" that people feel in response to the perceived need of another. Noddings believes the experience of "I must" occurs because we remember the care that we have been given and received as a result of affection, which becomes conjoined with a desire to maintain or recapture such "tender" caring moments in our lives.[48] This feeling of "I must" leads into ethical caring if I respond with an instantaneous commitment to acting on behalf of the person in need. If I instead allow my thinking to move from "I must" to "something must be done", Noddings contends I have removed myself from the set of agents who are potentially responsible for meeting the need.[49] What allows "I must" to make a demand upon those who give care is the recognition that how they respond to the "I must" injunction will either enhance or diminish their attainment of an ethical ideal – that one is a caring person. Believing that having a "caring relation" is superior to other forms of

[47] Noddings, *Caring*, 24.
[48] Noddings, 79, 104.
[49] Noddings, 81.

relatedness, combined with the recognition that I could sustain or weaken caring relations between myself and another, allows one to feel the force of obligation.[50]

While I commend Noddings for helping to carve new territory, the account of care that she offers has serious limitations due to being simplistic and idealistic. Her account focuses on instances of care that are so wonderful that the mere remembrance of receiving that care purportedly compels people to feel that giving care is something they *must* do.[51] Whether receiving care is enjoyable will depend upon various factors, such as how another's care meets one's needs, which of one's needs another chooses to prioritize, and whether there is disagreement between oneself and others about what one needs. Caring for another can be a rewarding experience, but the reasons for why that is (when it is) are more complex and context dependent than what Noddings describes. I do not wish to discount the joy that can accompany the giving and receiving of care, but I believe that we must be cognizant of situations where caregivers are exploited and care recipients are harmed through care.

Additional problems arise from Noddings' stipulation that care is a spontaneous practice, such that pondering "something must be done" about a need forecloses possibilities for one to care. If taken as a guide for what people should do when faced with the needs of others, Noddings' view discourages care givers from considering whether the demands for care that are made of them are exploitive. The distributions of responsibility for care are often gendered, raced, and classed, among other things. But wondering whether certain caring demands are indeed one's responsibility, rather than being the responsibility of someone else, would impede

[50] Noddings, 83.

[51] Noddings does not make a compelling case that remembering care one has received would have the motivating effect she ascribes, as opposed to just compelling people to seek out others who will provide similar care for them (e.g., the husband who wants a wife that will cook, clean, and cater to him). Being socialized into giving certain kinds of care, having rewarding experiences with providing care (for example, a child who learns about giving care through having a pet), and realizing how care is *necessary* in order for certain social relations to exist, seem to be more relevant remembrances and realizations for motivating caring behavior.

someone from living up to their ideal of being caring person. Consequently, Noddings' understanding of what it means to care lacks the potential to radically inform how distributions of care could be re-arranged. Furthermore, her account presents care as dyadic – practices of care are spontaneously generated when one perceives another's need. Noddings' presentation of our alternatives as "I must do something" and "something must be done", obscures the option of "we must do something". Possibilities for group deliberation about how to care, discussions about the division of caring labor within a social group, and so on, have trouble finding a foothold in Noddings' account of care's affective and spontaneous drive.

1.3.2 Diemut Bubeck on Care

Our analysis of care now moves into the 1990's, beginning with Diemut Bubeck's book *Care, Gender, and Justice*. Bubeck departs from Noddings in thinking that caregiving must be affective and spontaneous, so she avoids having some of the limitations that Noddings' conception has. I will argue, however, that her conception of care is impoverished because of her view on the relationship between the providing of care and those needs that require care.

Bubeck believes that care requires face-to-face interactions between the giver and recipient of care and that the giver of care must be meeting a need that the recipient could not satisfy on their own.[52] At first glance, Bubeck's requirement that care requires face-to-face interaction appears to exclude actions that several people associate with care. Advances in technological capabilities facilitate connectedness even across geographical distances and have made it possible for long-distance activities to have the same aims as face-to-face interactions, such as the sending of "care packages" via mail in order to help reduce another's stress and

[52] Diemut Elisabet Bubeck, *Care, Gender, and Justice* (New York, NY: Oxford University Press, 1995), 129.

provide emotional comfort. However, Bubeck clarifies that her use of face-to-face encompasses "ear-to-ear" telephone conversations, "eye-to-eye" letter writing, and so forth. What is crucial according to Bubeck is that "that certain kinds of communication in themselves constitute care such as e.g. comforting, counseling, or even merely actively listening and constructively responding to someone's problems, worries, anger, and despair – whether such communication is immediate or mediate".[53] Having this communicative component be a crucial component of practices of care distinguishes caring activities from actions that meet generalized needs without having any particular people in mind, such as a baker who produces bread for anyone with the ability to purchase.

While Bubeck's requirement for "face-to-face" interaction is less restrictive than it appears to be at first, her stipulation that care must accomplish something that recipients could not achieve for themselves remains overly restrictive. Bubeck contends that if an adult is capable in principle of meeting their own need, then others who meet that need for them do not provide care but a service.[54] Her discussion translates the first component of care ethics, that we are dependent upon others, into the notion that we cannot receive care unless we are helpless in the relevant regard.[55] This move, however, strikes me as problematic. I can prepare a meal for myself if I am ill but not bed-ridden, or even when I am incredibly busy and feeling overwhelmed. But someone else might take care of food preparation for me in order to allow me to conserve energy for recovery or to reduce my stress level and provide me with more time to finish other pursuits. As someone who has carried out such tasks for ill or preoccupied loved ones, these strike me as different from providing a "mere service", as though this other person

[53] Bubeck, *Care, Gender, and Justice,* 131.
[54] Bubeck, 132.
[55] Bubeck's stipulation that receiving care requires helplessness also forecloses the possibility for self-care.

had ordered a pizza for delivery in order to avoid cooking and from the perspective of the delivery person nothing is distinguishable about this delivery from another. In such food preparation scenarios, there is an element corresponding to the third characteristic of care ethics discussed above (orientation towards particular others) when compared to "food delivery" services that one might purchase. There is also the further question of how what I am doing fits into the broader narrative about our relationship – whether it reflects friendship, protectiveness, exploitation of domestic labor, etcetera. Such things can be, although are not necessarily, absent from the purchase of services.

Finally, there can be overlap between providing a service and providing care. The two do not have to be not mutually exclusive, yet Bubeck does not make room for care services. That providing a service and providing care can co-describe actions aligns with the idea that one can purchase "care labor". Being able to conceptualize some relationships that involve monetary exchange as care labor is important. Otherwise, care ethicists risk overlooking important relationships due to thinking they are beyond the scope of their theories. Indeed, care ethicists have said little about an important kind of relationship that I will prominently discuss later in this dissertation – the relationship between therapist and client in cognitive behavioral therapy for depression.

1.3.3 Joan Tronto and Bernice Fischer on Care

I have already mentioned Joan Tronto's significant text *Moral Boundaries* earlier in this chapter. Even before *Moral Boundaries* was published, however, Tronto was collaborating with Bernice Fischer to develop an understanding of care. Tronto and Fischer's account of care is interestingly different from the two that we have reviewed so far. I have argued that Noddings and Bubeck

both provide understandings of care that are too restrictive. Tronto and Fischer, on the other hand, offer a much broader understanding of care that readily accommodates the notions of co-deliberative and purchasable care work, which is appropriate given *Moral Boundaries*' focus on the socio-political dimensions of care. Tronto and Fischer understand care in a teleological fashion, in the sense that at a general level they reference what care's end is rather than things like motivations or spontaneity. They describe caring as "a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible…"[56] Their use of the word "world" in their definition includes oneself, other individuals, objects (such as cars), and the environment as targets for care. Tronto further emphasizes that care is not limited to dyadic relationships and can permeate more complex social and political configurations.[57] While this definition of care covers a large range of human activities, Tronto emphasizes that care must have as its end the maintenance, continuation, and reparation of the "world" (as explained above).[58]

In addition to providing their above definition of care, Tronto and Fischer describe care as having four phases: caring about, taking care of, care-giving, and care-receiving. The first phase, caring about, involves "noting the existence of a need and making an assessment that this need should be met".[59] The second phase, taking care of, occurs when someone assumes responsibility for the identified need and determines how they will respond. The third phase, care-giving, involves the work that goes into the direct meeting of the need. The final phase,

[56] Bernice Fischer and Joan C. Tronto, "Towards a Feminist Theory of Care", in *Circles of Care: Work and Identity in Women's Lives*, eds. Emily K. Abel and Margaret K. Nelson (Albany, NY: State University of New York Press, 1990), 40.
[57] Tronto, *Moral Boundaries*, 103. While Tronto is the sole author of *Moral Boundaries*, she continues to refer to the phases of care discussed therein as her and Fischer's conception.
[58] Tronto, 104. Tronto believes requiring this particular end for practices of care does exclude certain activities from counting as care and thus prevents the concept from including so much as to be trivial.
[59] Tronto, 106.

care-receiving, involves the response of the care recipient, which Tronto contends is important for determining whether the need in question has been met.[60]

Tronto believes the four phases of care can be used to help us understand in what way particular activities are or are not caring. For example, she argues that giving money is not actual care-giving, and is rather one person providing another with resources that will enable them to do requisite care-giving. Giving money to a homeless person so they can purchase food is a matter of taking care of (one is assuming responsibility for helping to alleviate the homeless person's hunger and determining that giving money is how to respond) rather than care-giving that is a direct meeting of need, which giving food directly would be.[61]

Although Tronto and Fischer's four phases of care are supposed to shed light on practices of care, however, I nevertheless find ambiguities within their account. For example, it's not clear whether giving money is supposed to be inferior to directly giving food because the former operates at phase two while the latter operates at phase three. If giving money is inferior, does that mean care-giving is a form of care, while taking care of is not a form of care? Are neither "complete" care but just components of care, and if so, what is accomplished by pinpointing the giving of money as taking care of and not care-giving? Whether the existence of ambiguities such as these reflect a major problem depends in part on what we want our conception of care ethics to be accomplishing for us. In the final subsection of this chapter, after discussing Selma Sevenhuijsen's notion of care as involving "contested terrain", I will suggest that resolving these ambiguities is more paramount the more normative force that one wants to ascribe to the notion of care itself. This is why, as we shall see with our next author, Tronto and Fischer's account is considered to be too broad. In my own view, Tronto and Fischer's four phases of care provide

[60] Tronto, 106-108.
[61] Tronto, *Moral Boundaries*, 107

some helpful conceptual orientation, perhaps as a helpful heuristic for organizing how practices of care often unfold in particular settings, but we should not attempt to imbue them with normative guidance.

1.3.4 Virginia Held on Care

While Tronto and Fischer believe their four phases of caring help to delineate the boundaries of care as they define it, Virginia Held finds their definition of care to be too broad.[62] Held believes we must do more than consider the aim of activities (e.g., maintaining, continuing, and repairing our "world") in order to distinguish practices of care from non-care practices. She believes that some sort of positive affective investment is crucial to care practices, and she contends that care involves "a relation in which carer and cared-for share an interest in their mutual wellbeing".[63] In addition to care being a practice, however, she believes care is also a value. Held makes an analogy with justice to demonstrate her point: "We all agree that justice is a value. There are also practices of justice: law enforcement, court proceedings, and so on… A given actual practice of justice may only very inadequately incorporate within it the value of justice, and we need justice as a value to evaluate such a practice".[64] Held believes that we likewise need care as a guiding value in order to determine whether particular practices of care have the right characteristics.[65] Thus, she believes that care is both a practice and a value.[66]

To describe care as involving a shared interest in mutual wellbeing, as Held does, leaves out possibilities for caregivers to be exploited or coerced into providing care by individuals who

[62] Held, *The Ethics of Care*, 32.
[63] Held, 35.
[64] Held, 38.
[65] Held, 38.
[66] Held, 42.

do not in fact have the wellbeing of the caregiver as a central concern. Conceptualizing care in that fashion also leaves out possibilities for care to be forced upon people who do not reciprocate the feelings of the giver of care. It would seem that on Held's account, one cannot be exploited into providing care but rather into providing something else that merely takes care's name, a mockery of the actual thing. Held's contrast between relations of care and harmful relations comes into focus in the following passage: "Relations between persons can be criticized when they become dominating, exploitative, mistrustful, or hostile. Relations of care can be encouraged and maintained."[67] The value of care, which can be used to pick out caring practices within the world, thus excludes such negative characteristics from "true care" at the start, just as the value of justice is used to criticize certain proceedings that present themselves as justice as "sham justice".

I will argue at the end of the next chapter that accounts of care ethics that operate with an idealized notion of care are inadequate for recognizing and addressing an important particular challenge for care ethics, that of paternalism. An approach to care ethics that includes a non-idealized conception of care is needed to sensibly appreciate and deal with paternalistic relations of care. Before I present my non-idealized understanding of care in the next chapter, however, I will close this chapter with an explanation of why I do not attempt to define what care "really is" and instead conceive of care in a more open-ended and contestable fashion.

1.3.5 Care as Contested Terrain

Selma Sevenhuijsen's offers us a notion of care as "contested terrain" that I incorporate in my account of care ethics and build upon. Sevenhuijsen describes care "as a social practice, in which

[67] Held, 37.

different sorts of moral considerations and moral vocabularies can be expressed".[68] She contends that as a social practice, "care can be seen as a mode of acting in which participants perceive and interpret care needs and act upon those needs. How their interpretation and acting proceeds varies according to the situation and social and institutional contexts, and depends on a variety of factors, such as norms and rules about good caring…"[69] She contends we should recognize that ideas about what care "looks like" are open to contestation rather than fixed and monolithic, with the latter being what can result if one takes mothering as "the" paradigmatic case of care.[70] Care is not something "out there" that we can understand simply through coming up with a definition, and our ideas about care depend a great deal on how we come to "know" care through our lived experience.[71]

I think it is vital for us to remember that care practices exist in the world prior to our philosophical reflection upon them. Philosophy does not lead us to discover what care "actually" is, which enables us to pick out where in the world care does and does not exist. Instead, philosophy helps us refine our pre-existing ideas about care and care practices that we, as people who give and receive care, already have within the world. Indeed, I view philosophical discussion as one of the discursive practices that have a role in contesting what care looks like. The literature review provided here exemplifies that. Philosophical discussions, present piece included, propose pictures of what makes sense to think about as practices of care. In different times and places, different pictures might make more sense. For example, a literal face-to-face requirement for care makes more sense for an area without technological capacities for long-distance communication, for otherwise the orientation towards particular others fades from the

[68] Sevenhuijsen, *Citizenship and the Ethics of Care*, 19.
[69] Sevenhuijsen, 22.
[70] Sevenhuijsen, 22.
[71] Sevenhuijsen, 71.

picture. But technological changes prompt changes in the notion of what constitutes care for those with access to those changes, expanding the face-to-face requirement to include Bubeck's so called "eye-to-eye" and "ear-to-ear" variations, for example.[72] Rather than discovering the "true" nature of care, philosophy as a social practice has a role in helping to demarcate care's boundaries.

I am not worried about having a more open-ended notion of care within my account, one whose parameters are open to contestation, because I am not seeking to articulate a notion of care that is a value or normative good. It is for theorists who construe care as a moral value or a normative good that having a less precise notion of care is a pressing issue. This can be seen when we consider Davina Cooper's following point on the "discursive slippage" in literature that discusses normative care:

> As a concept within feminist thinking care slides about. Even if we bracket the governmental register – 'taking care of' – care is variously used to identify relational decision-making, women's work, intimate, domestic or therapeutic labour, repairing the world, and committed attending to another. Obviously, there are connections between these different meanings – historically, conceptually and practically – but they are not the same. The trouble with normative versions of care is that the slippage between these meanings causes the object of valorization to become a blurred and changing target.[73]

We can spot these competing meanings in the various definitions of care reviewed above. The pressure to pick between these meanings – for example, Held's contention that Tronto's definition of care as "repairing the world" is too broad – becomes more paramount when care is supposed to be a value that shapes and guides practices of care, calls on people to provide care as a normative good, and so forth.

Whether or not care ethics should be understood as a moral theory that provides action

[72] Further technological changes since Bubeck's book, such as social media, might prompt us to further refine these notions, in case we think they would be stretched too thin.
[73] Davina Cooper, "'Well, You Go There to Get Off': Visiting Feminist Care Ethics Through a Women's Bathhouse", *Feminist Theory* 8, no. 3 (2007): 252, DOI: 10.1177/1464700107082364.

guidance is a crucial point on which care ethicists can diverge and which I regard as an important issue. For reasons that will be explored in the next chapter, I do not subscribe to the notion that care ethics should be construed as a moral theory. There is significant potential for care ethics to contribute to existent discourses, but the most profound contributions require us as care ethicists to "step beyond" moral theories and recognize care ethics as a different way of doing ethics altogether. I refer to this different way of approaching ethics as utilizing a critical framework. Explaining the metaethical commitments and the appeal of care ethics as a critical framework is what we turn to next.

CHAPTER 2:

CARE ETHICS AS A CRITICAL FRAMEWORK

2.1 The Importance of Care Ethics as a Critical Framework

Care ethics as a critical framework takes a non-idealized perspective on care. Both giving and receiving care can be a fulfilling and wonderful experience. Wonderful experiences do not, however, always accompany how care is carried out in the world. Care is an important and necessary feature of human life, so there will always be the possibility that care will be practiced problematically. To truly appreciate and fully comprehend how care can be problematic, we must be capable of situating relations of care within the social structural complexities that encompass how relations of care are formed and carried out. My critical care framework recognizes that recognizing and addressing problematic instances of care can necessitate looking beyond dyadic relationships. It is important to be cognizant of and attend to our surrounding social structures if we are to deal address problematic instances of care with more than "Band-Aid on bullet hole" solutions. Care ethics as a critical framework is more than *merely* capable of this. I believe care ethics is a valuable resource for feminist ethicists, political theorists, and social critics when understood in this way. Our understanding of various issues gets enriched by recognizing that practices of care permeate all sorts of life spheres. My account of care ethics can help us be vigilant about when, where, and how this permeation of care can be problematic. One such challenge, that of paternalistic relations of care, will be discussed in detail at the end of this chapter.

Care ethics must be taken up and developed as a critical framework if care ethics is to both address legitimate concerns that an emphasis on care can encourage paternalism and make

positive contributions to discussions on how to avoid paternalism. As a critical framework, care ethics can contribute to discussions on paternalism through informing our understanding of how and why paternalism is problematic even if liberal assumptions about atomism and autonomy are rejected. A sensible account of paternalism is crucial for understanding the grounds on which care ethics can oppose paternalism and for illuminating where and when social arrangements are indeed paternalistic. Explaining the metaethical underpinnings of my account will help to convey how this framework can inform our understandings of concepts like paternalism. These underpinnings include a conception of ethics and morality as social in origin, as opposed to asocial, eternal, and transcendent. Through explaining my account, I hope to make clear how care ethics as a critical framework can be helpful for feminists who wish to engage in social critique, whether they are addressing instances of paternalism or beyond.

My discussion in this chapter will proceed in the following manner. I begin with a review of some care ethics approaches that have been developed in the tradition of a moral theory. I explain how, by contrast, I interpret care ethics as a critical framework, and I discuss some other theorists who I see as working in this tradition and laying the groundwork that I build upon. Having explained this, I turn to discuss the metaethical underpinnings of my approach. I review the common position in Western moral theorizing that in order to properly engage in moral reasoning one needs to occupy or take on an "impartial perspective". I explain limitations that such a view has for socially embodied beings such as ourselves. We find significance in our social and emotional attachments that exist in the contingent (real) world, and we need to be morally accountable not just for but *to* each other. I proceed to explicate a notion of ethics as a social phenomenon that is expressed through our relations with one another, and I discuss how moral criticism is to be understood on such a picture. The critical care perspective is not

concerned with whether social arrangements and the moral concepts that serve as their justification embody or reflect transcendent moral standards (e.g., true caring) but with whether and how they "make sense". In the final segment of the chapter, I return to the issue of paternalism for care ethics. Care ethics as a critical framework can work to identify and address instances of paternalism, in no small part because it helps furnish a conception of paternalism that makes sense.

2.1.1 Care Ethics as a Moral Theory

Bernard Williams provides a helpful definition of a moral theory as "a theoretical account of what ethical thought and practice are, which… implies a general test for the correctness of basic ethical beliefs"[74] On this understanding, moral theories invoke some kind of uniform standard for determining whether moral beliefs like "action X is wrong" are correct. Examples of testing standards include whether an action violates a particular principle (such as the greatest happiness principle) or whether a justification for that action can be reached when following a particular procedure (like considering whether one's action could be universalized). Checking our beliefs against a standardized test is supposed to direct our actions in some manner. In the most extreme case, we are given a decision-procedure to follow in order to make sure our actions are morally right, such as calculating the differences in happiness caused between two courses of action and then proceeding with the action that is projected to generate more happiness.

We will now review some of the ways in which care ethics has been presented as being in the vein of a moral theory. Virginia Held is one example, regarding care ethics as a moral theory that serves as an alternative to "classical" moral theories such as Kantianism and utilitarianism.

[74] Bernard Williams, *Ethics and the Limits of Philosophy* (Cambridge, MA: Harvard University Press, 1985), 72.

Held does not directly state what decision-procedure care ethics utilizes, such as the categorical imperative for Kantianism and the greatest happiness principle for utilitarianism, but her discussions provide glimpses into what sorts of things care ethics might utilize. When Held contrasts care ethics with impartial moral theories and describes how the two can produce conflicting judgments about what one ought to do, she constructs a case to illustrate the differences between care ethics and utilitarianism. The case in question involves a schoolteacher who must choose between the alternatives of helping troubled children after school hours and spending afterschool time with his child. Held stipulates that on the utilitarian calculation, this person "ought to devote more time to his work, staying at his school after hours and so on, and letting his wife and others care for his own young child".[75] But she also stipulates that this person "thinks that from the perspective of care, he should build the relationship he has with his child, developing the trust and mutual consideration of which it is capable… the moral demands of care suggest to him that he should spend more time with his child".[76]

Within Held's example, the type of relationship that one has with others and more specifically the *role* one plays within their relationship with others seems to provide action guidance. Held's discussion insinuates that from the care perspective, being a father is more compelling and salient for one's moral reasoning than being a teacher. She also makes the somewhat curious remark that "there could be ways of interpreting the problem that would avoid a conflict between impartial moral rules and the pull of relationship between parent and child, but then the case would not be the one I am considering. The case I examine is one where the moral agent must choose whether impartiality or care should have priority".[77] It is not clear what

[75] Held, *The Ethics of Care*, 97.
[76] Held, 97-98.
[77] Held, 98.

implications Held takes that point to have. She might mean that one could attempt to dissolve the conflict through stipulating differently how much pleasure and pain will be experienced from everyone involved, so that the utilitarian would agree with the care perspective. She might even mean that if the situation were fleshed out more, the father could think that the perspective of care in fact requires him to spend time with his students rather than his child. However, there is a tendency within care ethics literature, perhaps because of a focus that some theorists give to mothering as an ideal, to talk about family considerations as though they automatically override other kinds of considerations within care ethics.

While accounts such as Held's seem to incorporate decision-procedures through invoking roles such as being a parent and attaching overriding responsibilities to those roles, other accounts such as Tove Pettersen's are more explicit in their explanation and inclusion of decision-procedures. Pettersen argues that care ethics can provide action-guidance about "what to do" in various scenarios, but that in order to provide this guidance care ethics must be founded on some "purely" evaluative premise that is distinct from information about the world that comes from lived experiences or the social sciences.[78] Pettersen identifies a moral principle that she believes underpins moral reasoning on the care perspective, which she refers to as the "expanded principle of not hurting". The expanded principle of not hurting prescribes two things: refraining from inflicting harm on others and intervening when intervention is required in order to prevent harm.[79] The intervention component of the expanded principle of not hurting is present because of emotional, psychological and physical harm that can stem from a failure to care within relationships (e.g., inaction).[80] Nevertheless, intervening to prevent harm cannot be an option if

[78] Tove Pettersen, *Comprehending Care: Problems and Possibilities in the Ethics of Care* (Lanham, MD: Lexington Book, 2008), 40. Pettersen accepts a sharp distinction between fact and value.
[79] Pettersen, *Comprehending Care*, 41-42.
[80] Pettersen, 159.

intervention requires harming someone else, because Pettersen stipulates that inflicting harm on someone for the (greater) good of others is *incompatible* with the ethics of care.[81] Hence, the expanded principle of not hurting entails a perfect duty to not cause harm that is universalizable and "held by all, owed to all".[82]

Pettersen purports that the expanded principle of not hurting guides rather than determines our decisions regarding care. We are required to be context sensitive and to have co-feeling and communication with others when determining what actions will cause or prevent harm.[83] However, although contextual information should be heeded to help determine which actions can prevent harm and which can cause harm, the overriding prohibition against causing harm that stems from the expanded principle of not hurting is demanded of each (and any) agent regardless of the situation that agent finds herself within. Thus, the expanded principle of not hurting is invoked in a more ambitious manner than some helpful heuristic device, and does appear to be a decision procedure in giving a test that actions can pass or fail (does the action violate the perfect duty to not cause harm?).

To provide one more example of how care ethics has been construed as a moral theory, Michael Slote regards care ethics as falling within the tradition of moral sentimentalism. He believes the emotional underpinnings of care ethics provide a totalizing account of moral motivation, evaluation, and reasoning. Whereas Gilligan regarded justice and care as distinct moral orientations, and others like Held have followed suit, Slote believes that care ethics in fact provides the foundation for our ideas about justice such as obligations to others. Properly understood, deontology is something that emerges from care ethics, rather than a contending

[81] Pettersen, 41.
[82] Pettersen, 42.
[83] Pettersen, 59, 102.

perspective. The ethics of care can be used to determine the scope of our obligations to care for others and to provide justification for such obligations, rather than being an account that contrasts with thinking about morality in terms of obligation altogether.[84] Thus, Slote takes a position similar to Pettersen in connecting ideas of obligation and duty to care ethics.

2.1.2 Care Ethics as a Critical Framework

While the above accounts differ in terms of *how* they construe care ethics as an ethical theory, all nonetheless construe care ethics *as* an ethical theory. Not all care ethicists, however, conceive of care ethicists as an ethical theory. There are some care ethicists who conceive of care ethics as being along the lines of what I refer to as a "critical framework". A critical framework provides what Amartya Sen refers to as an "informational focus", which calls attention to features of our world that are relevant for our assessment of social conditions.[85] That humans are dependent upon each other's care for survival and flourishing, and that humans are relational beings whose wellbeing is intertwined with those important to them, are examples of features that care ethics as a critical framework focuses attention upon. Critical frameworks thus bring to the forefront considerations that have normative relevance – for example, the relational self has implications for how debates about selfishness and altruism are understood.

While moral theories also provide an informational focus, such as utilitarianism's emphasis on sentient creatures feeling pleasure and pain, critical frameworks have crucial methodological differences from them. A critical framework contains conceptual tools and resources for interpreting and interrogating the ethical landscape brought under its informational focus. It does not prescribe "correct behavior" or "how to live". The approach to care ethics as a

[84] Slote, *The Ethics of Care and Empathy*, 5
[85] Amartya Sen, *The Idea of Justice* (Cambridge, MA: Harvard University Press 2009), 231.

critical framework is closer to Gilligan's original proposal of care ethics as a moral orientation towards the world, just as Gilligan discussed a justice orientation that was not itself a moral theory but a manner of conceiving a moral landscape. The orientations highlight considerations upon which others have sought to build moral theories, but those moral theories are nevertheless distinct from the orientations themselves.[86]

I consider Fiona Robinson's work to be in the vein of care ethics as a critical framework. Robinson's account eschews the robust sort of action-guidance that moral theories strive for: "Instead of prescribing 'right' or 'good' ethical behavior, its aim is to provide a framework for interrogating the patriarchal conditions under which values and practices associated with caring have developed".[87] Her approach does not posit "care" itself as a "normative good" that should be maximized.[88] Her account does not contain a decision-procedure to generate the right action for a given problem nor does it contain injunctions to bring about a "more caring" world. Using terminology that has been influential for my own understanding of "critical framework", Robinson conceives of her care ethics as a framework that contains critical tools for evaluating and criticizing the distribution of responsibilities to care and how our social (ethical) relations are constructed within a global political context.[89] She believes that through utilizing her care ethics framework, we can reveal new and improved possibilities of responsibilities for care to be arranged and carried out.[90]

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[86] While the understanding of care ethics as a critical framework draws inspiration from Gilligan's understanding of care ethics as a moral orientation, it does not necessarily follow Gilligan in regarding a focus on care as altogether separate from an orientation towards justice. Gilligan's articulation of the justice perspective as an alternative to the care perspective itself reflects ideas about justice (e.g., certain understandings of autonomy) that feminists might reject without also rejecting the importance of justice itself.
[87] Fiona Robinson, *The Ethics of Care: A Feminist Approach to Human Security* (Philadelphia, PA: Temple University Press, 2011), 32.
[88] Robinson, *The Ethics of Care*, 28.
[89] Robinson, 105.
[90] Robinson, 28.

I consider Selma Sevenhuijsen's approach to care ethics as a "moral vocabulary" that can be used to articulate moral problems and issues that need political judgment to be another example of work that coheres with the critical framework approach. Sevenhuijsen's account rejects recourse to transcendent and objective standards (in a rationalist or realist sense) that can be known via individual reasoning and invoked to determine decision-making in the face of moral and political disagreement.[91] However, she believes in the importance of moral and political dialogue for arriving at shared values and intersubjective standards that we regard as contingent but nevertheless authoritative.[92] Within such moral and political dialogues, the "moral vocabulary" of care ethics represents a collection of related concepts and insights that illuminate and bring to the fore crucial experiences and considerations that would otherwise be ignored.[93] Sevenhuijsen believes that care ethics, as a moral vocabulary to be invoked within particular political contexts and that works best when connected to a conception of democratic citizenship, should not attempt to displace the political concerns of "strategic action within the context of power relations and 'the art of government', with all its vicissitudes and unpredictabilities".[94] Rather than attempting to provide a picture of human relations that circumvents, ignores, or eliminates power within moral and political relations (as moral theories are prone to do), Sevenhuijsen believes care ethics should work with an understanding of power that "can capture both its restraining and enabling, creative, and generative dimensions, and which can also differentiate between power and domination".[95]

[91] Sevenhuijsen, *Citizenship and The Ethics of Care*, 64.
[92] Sevenhuijsen, 65.
[93] Sevenhuijsen, 34.
[94] Sevenhuijsen, 68.
[95] Sevenhuijsen, 66.

The work of Robinson and Sevenhuijsen have helped inspire the direction of my project. While my work builds upon their ideas that they have expressed in their accounts of care ethics, I develop an avenue for critical investigation and evaluation that goes beyond what they have expressed. In the next two sections, I will explore and unpack the metaethical commitments of my approach to care ethics as a critical framework. This will include explaining how social and moral criticism is understood on this approach, and how a central question is not whether certain moral statements are true according to some transcendent standard, but whether they make sense to "us" as socially embodied beings who are enmeshed in relations of dependency and care.

2.2 Metaethical Underpinnings of Care Ethics as a Critical Framework

Our approach to understanding morality is inescapably informed by our social-historical perspective. One's particular moral understanding is always a subset of their broader social understanding. Nevertheless, several philosophers nevertheless claim that by invoking the right method one's moral understanding can map onto something that transcends social reality, such as nonsocial and unchanging "moral facts" or moral principles that anyone is committed to acting upon if they are to act as a rational agent. Claiming transcendent moral authority for one's positions may sound appealing, but it is important to resist going down this route for moral justification. Conceiving of morality as social is crucial for orienting people's accountability *towards each other* and for viewing ethics as a collaborative project. An emphasis on sociality has particular importance for care ethics when it comes to conceptualizing and addressing challenges that arise through caring for others. As we will see, it will be crucial when working to avoid paternalism in one's interactions with others.

2.2.1 A Contrast with Problematical Impartiality

Conceptualizing morality as something that transcends our (or anyone's) socio-historical understanding relies upon a particular understanding of impartiality. To take an impartial stance in this context is to draw upon, invoke, or temporarily adopt an "absolute" perspective that is better positioned to judge moral matters than any more contingent perspective in virtue of lacking dependence upon more particular or localized features of our existence. We encountered such an understanding of impartiality in the previous chapter with Lawrence Kohlberg's stage theory of moral development that rated reasoning that invoked universal principles as more advanced than contextualized, care-based reasoning. How the so-called impartial perspective has been conceptualized varies between thinkers. Immanuel Kant proposed that one envision themselves as acting from the standpoint of a legislature within a kingdom of ends. In Kant's envisioned scenario, a moral agent selects laws that everyone (including oneself) must carry out. This moral agent uses reason to determine what maxims are capable of being universalized and acted upon. One acts from the duties that are necessitated by reason, and not desire or emotion.[96] Henry Sidgwick, in his treatise on the methodology of ethics, alludes to a universal perspective on the value of happiness and what is good as the point of view of the universe.[97] Meanwhile, in a more contemporary example, Thomas Nagel refers to the moral perspective that provides moral prescriptions and which can run into conflict with our own personal perspectives as "the view from nowhere".[98]

The impartial perspective can be drawn upon for more ambitious purposes than figuring out individual moral responsibilities. This perspective can be extended to considerations about

[96] Immanuel Kant, *Grounding for the Metaphysics of Morals: with On a Supposed Right to Lie Because of Philanthropic Concerns*, 3rd edition, trans. James W. Ellington (Indianapolis, IN: Hackett Publishing, 1993), 25-45.
[97] Henry Sidgwick, *The Methods of Ethics*, 7th Edition (Indianapolis, IN: Hackett Publishing, 1981), 113.
[98] Thomas Nagel, *The View from Nowhere* (New York, NY: Oxford University Press, 1986), 3, 61.

how societies should be structured and how given societal structures can be justified. John Rawls purportedly refrains from presenting a comprehensive moral doctrine in his political theorizing (i.e., a substantive account of the good or a full-blown moral theory), but he invokes an impartial perspective for the purpose of creating an overlapping consensus between people in liberal societies who otherwise have different moral doctrines. Rawls believes that a theory of justice workable within modern liberal societies must be anchored using what he calls "the original position", which is a thought experiment where individuals consider what societal rules and arrangements would be acceptable to themselves if they knew nothing about themselves in regard to their particular social positions, relationships, and values.[99]

Peter Singer contends that whatever we wish to call the impartial moral perspective, "Ethics requires us to go beyond 'I' and 'you' to the universal law, the universalisable [sic] judgment, the standpoint of the impartial spectator or ideal observer, or whatever we choose to call it..."[100] Notice how, in Singer's explanation, the step beyond "I" and "you" is not "we" but instead to something like a third-person impartial or ideal observer. The focus of ethics in such a picture involves attempting to emulate or be accountable to this envisioned (non-existent) authoritative spectator, as opposed to being accountable first and foremost to others within the world. Insofar as accountability to others is a concern, it is because the impartial perspective prescribes having that concern, making accountability to others a derivative concern.

[99] John Rawls, "Justice as Fairness: Political Not Metaphysical", *Philosophy & Public Affairs* 14, no. 3 (1985): 234-239, https://www.jstor.org/stable/2265349.
[100] Peter Singer, *Practical Ethics*, 2nd edition (New York, NY: Cambridge University Press, 1993), 12.

2.2.2 Encumbered and Unencumbered Selves

In addition to being regarded as "the" moral point of view, the impartial perspective is sometimes complimented by the notion that impartial normative reasoning reflects one's core identity, conceived in opposition to desires and emotions. To make decisions based on impartial reasoning is to exercise one's agency because one is self-determined (acting). By contrast, one is pushed around by the world by desire and emotion, because one being is determined by forces that are acting upon oneself (reacting). Immanuel Kant famously held such a view, describing action motivated by the categorical imperative and the moral law as autonomous and action motivated by emotion and desire as heteronomous.[101] Michael Sandel refers to perspectives that identify the self in this detachable manner as positing an unencumbered self that is "understood as prior to and independent of purposes and ends".[102] Although there are important distinctions between my stripe of care ethics and the kind of communitarianism that Sandel espouses, a relational self whose purposes and ends are connected to particular others will be very much be encumbered.

In response to critics such as Michael Sandel, John Rawls contends the aforementioned original position and the conception of justice as fairness that follows from the original position do not reflect any particular metaphysical notion of the person or personal identity.[103] Rather, the original position is said to be a device of representation.[104] Rawls does not therefore intend for the original position to describe us as we really are but to locate "some point of view, removed from and not distorted by the particular features and circumstances of the all-encompassing background framework, from which a fair agreement between free and equal persons can be

[101] Kant, *Grounding for the Metaphysics of Morals*, 39, 60.
[102] Sandel, "The Procedural Republic and the Unencumbered Self", 86.
[103] Rawls, "Justice as Fairness: Political Not Metaphysical", 223.
[104] Rawls, 236.

reached".[105] To accomplish this task, the original position abstracts from any contingencies of the social world, with a few select things being knowable to those considering what a fair arrangement would be.

In a contemporary take on Kantianism that is (purportedly) less metaphysical, Christine Korsgaard posits that one's self is constituted by "practical identities". Korsgaard defines a practical identity as "a description under which you value yourself, a description under which you find your life to be worth living and your actions to be worth undertaking".[106] While one has several practical identities, or multiple roles one is identified with, Korsgaard claims that moral identity is most fundamental. Of course, on her account, moral identity is understood in a Kantian fashion, either as having respect for humanity in the vein of the second formulation of the categorical imperative or as being a citizen of the Kingdom of Ends. Korsgaard denies that this Kantian moral identity is "all there is" to oneself and that one is just a moral agent and nothing more, but she nevertheless contends this moral identity is foundational. [107] The other "contingent" sources of one's identity, such as being a mother, a friend, a sister, and so on, are unable to provide one with reasons for action without this "necessary" moral identity standing behind them.[108] Thus, Korsgaard concludes, "moral identity exerts a kind of governing role over the other kinds. Practical conceptions of your identity which are fundamentally inconsistent with the value of humanity must be given up".[109]

When we consider how detachable from desires, emotions, and personal relationships the rational agent must be in order to achieve the so-called impartial point of view, there is a genuine

[105] Rawls, 235.
[106] Christine Korsgaard, *The Sources of Normativity* (New York, NY: Cambridge University Press, 1996), 101.
[107] Korsgaard, *The Sources of Normativity*, 125.
[108] Korsgaard, 129.
[109] Korsgaard, 130.

question whether such an idealized rational agent could be considered to be "me" in any real or meaningful sense. That is especially of concern for beings that understands themselves in relation to others. Even with thinkers like Rawls and Korsgaard who do not want to equate their conception of the rational agent with one's metaphysical identity, one is expected to have a certain detachment from one's commitments or other practical identities in order to set all those aside in favor of what is required by the original position or the Kantian moral identity.

Furthermore, the ethical resources one can draw upon from the so-called impartial point of view are much more barren than approaches such as mine, with much lived experience being excised in the name of impartiality. Bernard Williams argues that the kinds of impartial perspectives discussed above cannot compel allegiance without the help of thicker ethical concepts for which they leave no room. Thick ethical concepts cannot be mapped onto a clean distinction between "fact" and "value". Rather, thick ethical concepts involve an entanglement of descriptive and evaluative content. As a result, thicker concepts are more context sensitive, and contrast with conceptions like "good" and "bad", which can be stretched thin in their application. Williams explains that an agent's application of thick concepts are "guided by their experience". Thick concepts themselves figure into an agent's interpretation of situations and into their deliberations about what to do.[110] To provide a brief illustration of the difference between a thin and thick concept, consider the following phrases: "it was good to eat that sandwich" and "it was courageous to eat that sandwich". The first sentence is vague but nevertheless makes sense. But the second sentence sounds odd and does not really make sense unless we imagine additional context for the sentence (e.g., if the sandwich was considered by the present parties to be disgusting and someone would need to steel themselves in order to even try it). The grounded

[110] Bernard Williams, "Internal Reasons and the Obscurity of Blame", in *Making Sense of Humanity* (Cambridge, MA: Cambridge University Press, 1995), 37.

feature of thick ethical concepts makes them irreducible to each other. Consequently, there can be numerous thick ethical concepts that make sense within a given ethical community and which pertain to more significant situations than sandwich consumption.

I recognize that the pluralism that follows from grounding ethics within social life leaves a picture of ethical life that is messier. This picture contains possibilities for incompatible ethical demands that do not collapse in the face of each other, as there is no overarching principle to arbitrate between them. But that just makes the account more reflective of how messy life itself can be. Such a picture of ethical life correspondingly allows for greater nuance, richness, and relatability when it comes to how we understand our ethical relationships with others.

2.2.3 Ethics as a Socially Grounded and Collaborative Project

I have expressed concerns with attempts to locate normativity in some transcendental vantage point. Such a venture will not produce a good match for socially embodied beings who find significance in various personal relationships, emotional attachments, and meaningful projects. Margaret Walker provides a better alternative, which I take as my starting point, in her article "Moral Understandings: Alternative 'Epistemology' for Feminist Ethics". In her article, Walker introduces her expressive-collaborative model of morality, which she further develops in her book *Moral Understandings: A Feminist Study in Ethics.* Walker's expressive-collaborative approach provides a model for understanding morality as something that arises from interpersonal relationships as opposed consisting of eternal and transcendent truths about how to live. From the perspective of the expressive-collaborative model, an individual's "moral knowledge" inheres in the socially shared understandings that they express through assigning,

accepting, and deflecting responsibility.[111] The expressive-collaborative perspective is helpful for demonstrating there is not "the moral point of view" or "the moral law" but rather "our" moral understandings.

Accepting that ethical understanding reflects a kind of shared social understanding, rather than a transcendental vantage point accessible through reason or intuition, results in a picture of morality that is significantly different from those dominant Western philosophical perspectives that treat morality as transcendent. Well-founded moral beliefs do not correspond to moral facts that are independent of human experience, nor are they grounded in some external anchor such as a conception of rational agency. Benchmarks for moral correctness, and by derivation conceptions of moral progress, are not "out there" for people to tap into. Our moral beliefs reflect a kind of contingence, not in the sense that they approximate to the best of our current abilities mind-independent and asocial moral truths, but because they express shared social understandings that have a particular socio-historical grounding.

While several philosophers have strived to transcend socio-historical perspectives in order to anchor morality in something absolute that imbues it with "indisputable" authority, I believe the contingent nature of our moral beliefs is something to be owned. Rather than pursue an elusive view from nowhere, we should search for moral grounding within, as Susan Wolf has put it, the "view from here".[112] Our reasons for shedding attempts to attain a view from nowhere are three-fold. First, we shed an unattainable ideal. Attempting to stand apart from, rather than broaden and inform, one's personal perspective and the socio-historical understanding that grounds it leads to deception within social settings. Walker makes the astute point that when

[111] Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics*, 2nd edition (New York, NY: Oxford University Press, 2007), 9-10.
[112] Susan Wolf, "Morality and the View from Here", *The Journal of Ethics* 3, no. 3 (1999): 219, DOI: 10.1023/A:1009833100856.

moral philosophers treat morality and the content of moral theory as something that transcends socially lived experience, and present their own moral understandings as "discoveries" about something transcendent rather than socially embodied, they provide a distorted picture of moral reality, as well as of the roles that their own institutionally sanctioned theorizing and teaching practices have in co-creating and sustaining particular moral understandings and practices.[113]

Second, owning the socio-historical contingency of our moral beliefs can be empowering, since this allows us to recognize that we are not worse off without the view from nowhere – that is, we are not left with the idea that we "have to settle" with something more contingent just because the absolute perspective is not available. We can instead develop confidence that we never needed the absolute perspective in the first place. Bernard Williams raises this issue in "Philosophy as a Humanistic Discipline":

> We are no less contingently formed than [our] outlook is, and the formation is significantly the same. We and our outlook are not simply in the same place at the same time. If we really understand that, deeply understand it, we can be free of what is indeed another scientistic illusion, that it is our job as a rational agent to search for, or at least move as best as we can towards, a system of political and ethical ideas which would be the best from an absolute point of view, a point of view that was free from contingent historical perspective.[114]

Now, it is important to be self-critical, reflexive, and work to recognize shortcomings of one's perspective, problematic features of how one was socialized, and so on. It is quite another thing altogether, however, to attempt leaving those things behind in toto. In addition to just being unfeasible, if ethics is to be something more than a theoretical exercise, it should relate to existent concerns that people have. While there are some existent concerns that we can be critical of (e.g., wanting to maintain white privilege), the impetus against those concerns comes from the

[113] Walker, *Moral Understandings*, 60-62.
[114] Bernard Williams, "Philosophy as a Humanistic Discipline", *Philosophy* 75, no. 4 (2000): 490-91, DOI: 10.1017/S0031819100000632.

world (e.g., oppressed peoples) rather than trying to leave behind perspectives grounded in the world altogether. One should not strive to transcend cultural perspectives altogether in order to find the "right" transcendent standpoint. It is better to seek out other (contingent, historical) perspectives that can help to broaden and inform one's own, a matter which brings me to the final point of this section.

Viewing ethics as part of a shared social project as opposed to it having an asocial and transcendent reality gives others a more prominent role in one's deliberations and the formation of one's ethical beliefs. When viewing ethics from what Walker refers to as the "theoretical-judicial mindset", if others have a role in one's deliberations then it is at best an auxiliary one. With proper reasoning (e.g., the right moral theory), one can determine appropriate courses of action, required moral changes, etc., without attending to the perspectives of others. Others can have a role in encouraging one to use the appropriate moral theory or to take account of the relevant considerations, but insofar as one has confidence in the project of moral theories, this comes off as non-essential. If one can tap into the absolute perspective for moral judgment, conversation with others is not necessary. Iris Young describes this effectively: "The impartial subject need acknowledge no other subjects whose perspective should be taken into account and with whom discussion might occur… one need not consult with any others, because the impartial point of view already takes into account all possible perspectives".[115]

Discerning solutions to all moral problems without need for interpersonal dialogue would be efficient, but such a picture has some serious problems from a *social* perspective. Bernard Williams illuminates the problem with such an ideal in *Shame and Necessity*, through his

[115] Iris Marion Young, "Impartiality and the Civic Public: Some Implications of Feminist Critiques of Moral and Political Theory", in *Iris Marion Young: Gender, Justice and the Politics of Difference*, eds. Michaele L. Ferguson and Andrew Valls (London, England: Routledge, 2021), 143, DOI: 10.4324/9780429023019-11.

discussion of Plato's famous thought experiment from *The Republic*, where we are presented with a just man who is not regarded as just by anyone, and thus receives no praise, honor, or recognition from anyone. Plato uses this thought experiment as the jumping off point for his ensuing discussion on whether a just life is valuable for its own sake, or just for the rewards that follow from it. Williams, however, offers this insight into the thought experiment in question: "A great deal is assumed in the formulation of this thought experiment. When we are presented with it, we are simply told that this man *is* just and that he is misunderstood by a perverse or wicked world. This is something we are supposed to understand from outside the imagined situation".[116] Following that commentary on Plato's thought experiment, Williams invites us to turn our thinking around:

> But suppose we decline to stand outside and to assume this man's justice. Suppose we change the terms of the solipsistic experiment and arrange it from the agent's perspective, rather than from ours or from Plato's… Then we should describe the situation in these terms: this is a man who thinks that he is just, but is treated by everyone else as though he were not. If given merely that description of himself, it is less clear how steady his motivations would prove. Moreover, it is less clear how steady we think they should prove. For given simply that description, there is nothing to show whether he is a solitary bearer of true justice or a deluded crank.[117]

Williams is making the astute point that when we praise people in such imagined situations as being morally upstanding or full of integrity, "we are assuming implicitly that they have some essential thing ethically in common with us".[118] This remark is insightful – when I considered the thought-experiment from *The Republic* as a philosophy undergrad, for example, I drew upon my own experiences, beliefs and values when trying to imagine the moral person in question. We should recognize that when Plato invites us to envision the scenario, one is not likely to imagine a figure whose moral beliefs and actions are contrary to one's own. From the perspective of the

[116] Bernard Williams, *Shame and Necessity* (Berkeley, CA: University of California Press, 1993), 99.
[117] Williams, *Shame and Necessity*, 99.
[118] Williams, 100.

imaginer, they would not be imagining a just person then. Any personal connection or sympathizing with the just person in the scenario will likely draw upon someone's own moral understandings, and these moral understandings, of course, were not themselves developed in isolation, but were and continue to be developed through dialogue with other people. And we should hope that individuals *will* be emotionally receptive and responsive to the expression of others on moral matters. Otherwise, as Williams puts the point, "the convictions of autonomous self-legislation may become hard to distinguish from an insensate degree of moral egoism".[119]

2.3 Making Sense from a Social-Collaborative Understanding

Understanding ethics as a shared and collaborative project bases ethical thought within our sociality. Talk of grounding ethics in the social world, however, rather than some transcendent standpoint, can raise a moral philosopher's hackles if they anticipate a form of cultural relativism that invalidates moral critique. My critical care perspective does not take moral criticism to be incoherent or unattainable. How we understand moral criticism and what we understand it to be accomplishing, however, differs from moral realist or rationalist accounts by forgoing the assumption that we have tapped into the transcendent moral truth of the matter while our interlocutors have not. There are a number of social things at which one might aim moral criticism, such as actions, patterns of action or behavior, social practices, configurations of responsibility, social institutions, and political and economic systems broadly speaking (e.g., democracy, capitalism). For brevity, I will use the Greek letter Phi (ϕ) as a placeholder for these various things throughout this section. When we do not attempt to place ethical justification in

[119] Williams, 100.

something transcendent, our question for social criticism becomes, does this way of doing things make sense to those involved when ϕ, its impact, and its justification are transparent?

When considering whether ϕ makes sense in a particular instance, we must draw upon lived experience and social reality in a manner that we do not when asking whether something is true according to some transcendent principle. There are a number of considerations that can go into answering whether ϕ makes sense – whether a particular part of lived experience is otherwise ignored, how adequately ϕ enables or contributes to social practices fulfilling (perceived) human needs, which thick ethical concepts are relevant and can be brought to bear on ϕ, whether standards that an individual or group professes to hold (e.g., equality) are consistent with ϕ, whether we can imagine alternative social and political possibilities that address salient shortcomings of current ways of doing things, and so on. Such considerations help inform reflection upon whether ϕ makes sense as something we can (and are willing to) stand behind with sincerity, and conversely, also helps us come to regard something as being arbitrary (at best) and perhaps outright problematic.

2.3.1 Accepting Value Pluralism

My understanding of what goes into determining whether something makes sense is pluralistic. There are a number of distinct and irreducible considerations that are brought to bear on the matter of whether ϕ makes sense. We might consider an analogy with determining who is a candidate for greatest guitar player of all time (GOAT). There are a number of considerations which might be brought to bear on the question – their influence on subsequent music, how original or unique their particular style is regarded, their (perceived) technical skill, the longevity of their career, the number of "hit songs" associated with their work, how exciting their live

performances are, and so on. Some of these considerations might strike people as more significant than others, and some might question whether certain considerations should be regarded as relevant at all (perhaps number of hit songs just boils down to popularity rather than merit). It might be difficult to settle definitively on the GOAT guitar player in discussion, but there are a number of candidates who could make sense based on the considerations above. Likewise, there are a number of candidates who it would not make sense to nominate based on the above criteria, e.g., a next-door neighbor who has a garage band. Such an individual might be someone's *favorite guitarist* for some particular reason, but to label them as the GOAT would seem capricious or unfounded – at the very least, a *very compelling case* would have to be made. When it comes to social criticism there can be similar and understandable divergence on what ϕ makes the most sense, and if there is an impetus to narrow our options, it might ultimately be for practical, pragmatic, or political purposes than because of what "morality demands". However, there will still be a number of ϕ that do not make sense from an ethical perspective, and in more nefarious cases, supporting ϕ that do not make sense from an ethical perspective will contribute to oppression and domination.[120]

2.3.2 Seeking Transparency

When we talk of something "making sense", we must remember that ϕ will always make sense to *someone* from *someplace,* both socially and historically. On the one hand, the social nature of ethical life means that we are not just asking the question of whether something makes sense to *me*. Recall the takeaway from our discussion of *The Republic* in the prior section; we should not be solipsistic when it comes to our moral epistemology. However, that something makes sense to

[120] If someone's or some group's goal is to subjugate and dominate, of course, then ϕ could make sense for achieving those purposes, even as it fails to make sense from an ethical point of view.

"us" should not be assumed unproblematically. Particular social groups and the individuals that comprise them have often been excluded from processes that lead to the portrayal and acceptance of practices and responsibilities within mainstream culture, social and political institutions, and socio-economic settings (e.g., workplaces). The applicability and value of existent practices, responsibilities, and ways of life more generally are often falsely assumed to be universally held, either among humanity as a whole or for all the members of a particular social group. False universalization even happens within counter-movements geared toward replacing existent practices and expectations with new ones that are supposed to better represent the interest of women, such as feminists who focus on the experiences of white middle class cis-women and exclude women of color, working-class women, LGBTQ+ women, and so on.[121]

The mere fact that exercises of power are involved in the formation of one's moral beliefs and dispositions do not make them questionable. There is not a problem with being socialized to participate in various practices of taking and delegating responsibility, learning justifications for said practices, being exposed to sanctions so that one learns that there are social consequences for actions, and being taught values. Our concern should be not *that* power is used, but *how* power is used (e.g., sanctions for not conforming to gender norms that are harmful for the benign expression and exploration of sexual identity). Our concern should be with identifying which parts of one's socialization into accepting ϕ are/were problematic (e.g., sexist), falsely representative of social reality, and so on. In order to appear legitimate, do specific assignments of responsibility, social positions, and relations of power depend upon (at least some) people

[121] Accounts of this happening in practice are well documented. Some well-known discussions include: bell hooks' *ain't I a Woman? black women and feminism* and Elizabeth Spellman's *Inessential Woman: Problem of Exclusions in Feminist Theory*. Mariana Ortega describes how this is not just an issue with second wave feminism of the past in her article, "Knowingly, Lovingly, Ignorant", *Hypatia* 21, no. 3 (2006): 56-74. DOI: 10.1111/j.1527-2001.2006.tb01113.x.

having a poor understanding of the relevant social practices and the underlying political or economic systems that enable or constrain our social possibilities? Do predominant ethical concepts, moral ideals, moral justifications, and values have their implications obscured, and do they (or their ascribed role, importance, etc.) misrepresent what is actually going on in shared ethical life? To answer these questions, we must consider whether, and to what extent, our existent moral understandings are transparent.

My use of the term "transparency" borrows from Bernard Williams, who uses the term to express the idea that "ethical institutions should not depend on members of the community misunderstanding how they work".[122] If a configuration of social and moral responsibilities only appears to make sense to someone when they do not grasp things as they are, this undermines the purported moral authority of such practices for them in particular and for "us" more generally. If another justification does not emerge that makes sense, we cannot expect current practices of responsibility, social obligations, etc., to maintain their previous moral status. If those social roles, moral responsibilities, etc., continue to be maintained through coercive power alone, we are looking at a form of social and political domination.

Coming to understand which justifications for social practices do and do not make sense should be construed as an ongoing, critical, and reflexive endeavor. We can have confidence that some particular ϕ is well-suited for our situation, circumstances, etc., without having to make an additional judgment as to whether ϕ would have been sensible at various points in the past, and without committing ourselves to the notion that for future persons (and perhaps even ourselves in the future) ϕ will forever be sensible. Critical reflection can reveal that changes in circumstance do not jibe with particular existent moral expectations, resulting in them no longer making sense

[122] Williams, *Ethics and the Limits of Philosophy*, 101.

or making less sense than alternatives. The effect that actions have can take on a new scope (e.g., globalization creating the potential for one's actions to impact others farther away). Particular social, political, and economic arrangements that were once deemed unfeasible might now appear to be actualizable candidates for how we conduct ourselves. It is important to emphasize, therefore, that seeking transparency is not a process that guarantees results. We do not go through the process once and come out having definitely seen things transparently and thus have settled the matter for all time. We should remain open to rethinking our moral expectations and revising how moral responsibilities are configured and carried out, in order to improve how we relate to each other and avoid perpetuating existent problems or failing to consider emergent ones.[123]

2.3.3 Using A Conceptual Toolbox

The conceptual tools within an ethical framework can reveal issues with existent practices and expectations, especially in light of changing circumstances, and the application of our ethical resources in a new and creative manner can lead to seeing issues in novel ways. Our ethical tools themselves should be open to revision, however, since there can be grounds for thinking that some of these tools are themselves no longer adequate and ill-suited for a changing social landscape. Alternatively, we might have failed to grasp earlier the social meaning and implications of the tools themselves, and perhaps that they were always inappropriate, resting upon misunderstanding, misapplication, or misrepresentation.

[123] For example, developments in communication technologies have given rise to new types of relationships (e.g., "online friends") whose demands on us might not sensibly be extended from previous kinds of relationships. Expedited interactions with existent relationships over long-distances create new possibilities for how care can be provided and received from great physical distance. The advent of the telephone created possibilities for emotional support that extended beyond letter writing, and additional communication methods such as email, texting, and social media have expanded that further (in addition to providing new ways to harm others and new expectations that can make people more vulnerable to the demands of others than letter writing).

Something helpful not just for evaluating practices but also our ethical resources themselves are genealogical accounts of how a particular ethical practice, belief, value, or conception came to be widespread. Mark Bevir succinctly describes a genealogy as "a historical narrative that explains an aspect of human life by showing how it came into being. The narratives may be more or less grounded in facts or more or less speculative, but they are always historical".[124] Genealogies aim to demonstrate contingence and particularity, answering *why* some group (often a "we") came to carry on as they do. Genealogical accounts can unsettle or vindicate ethical practices and values, depending upon the import those narratives have for understanding one's ethical inheritance. Does the explanation of how we came to have these practices, values, beliefs, etc., undermine the importance they were (previously) believed to have had? Or does the explanation provide an appreciation by demonstrating something that previously seemed mysterious now makes sense?[125] Either way, whether and to what extent a particular genealogy contributes to making some aspect of moral life transparent will depend on the plausibility of the genealogy in question.

We might believe that we have reasonably understood something in a transparent fashion until we encounter a new perspective that gives rise to doubts that we actually have a good grasp on how we've been carrying on, such as a new genealogical account, another's critical reflections, or someone sharing their personal experiences more generally. If someone has a shortcoming in their understanding, we should be wary of believing they will detect it without any kind of exposure to the ideas and experiences of others, for that very shortcoming could

[124] Mark Bevir, "What is Genealogy?", *Journal of the Philosophy of History* 2, no. 3 (2008): 263, DOI: 10.1163/187226308X335958.
[125] The most well-known example of genealogy as an exercise in deflation is probably Friedrich Nietzsche's *Genealogy of Morals*, with the work of Michel Foucault being another well-known example. Bernard Williams conducts genealogy as an exercise of vindication, in particular for the values of accuracy and sincerity, in *Truth and Truthfulness*.

influence any self-contained critical reflection that is supposed to locate shortcomings. Becoming aware of the social experiences of people who inhabit different walks of life can be a helpful check for those who do not experience certain social phenomena themselves, especially due to positions of privilege. Nevertheless, while reflection informed by interpersonal dialogue and listening to others is crucial, this is not a straightforward affair. It is particularly important to seek out the perspectives of people from socially disadvantaged groups, whether one has direct conversations with them or reads their written work, but one should not uncritically defer to another based solely on their social identity. There might be cases where deferral makes sense, especially interpersonal contexts where the content is personalized (i.e., believing a friend that a microaggression occurred even if you did not notice one). But stating that someone's perspective on some issue should be taken as definitive simply because that person belongs to a minority group fails to appreciate the diversity of perspectives within a given social group (minority or not). Treating any individual as though they speak "on behalf" of everyone in their social group is naïve and ultimately problematic.[126] The upshot is that we have a crucial but complicated task when comes to seeking out and considering other perspectives.

2.4 Care Ethics and the Danger of Paternalistic Care

While care ethics is typically labeled a "feminist" approach, having the label of "feminist" and being invoked to address various forms of women's oppression does not make care ethics and particular notions of care immune to being oppressive themselves. We should follow Michelle Murphy's caution against valorizing pro-social affections and attitudes within care scholarship,

[126] This stance is compatible with someone sifting through particular minority voices to find one who affirms what they already believe, and then point toward that voice as evidence that one's own beliefs are well-founded, essentially finding a "token minority" to use as back-up for their argument.

which often happens "without critically examining the ways positive feelings, sympathy, and other forms of attachment can work with and through the grain of hegemonic structures, rather than against them".[127] Depending on the social conceptions and moral understandings that someone draws upon when determining when and how to provide care, and who to provide care for, caregiving can reinforce problematic social roles and expose either the giver or receiver of care to domination. Fiona Robinson acknowledges the specter of paternalism as one of the greatest challenges for care ethics in that regard.[128] Paternalistic care perpetuates marginalization and powerlessness through placing or reinforcing limitations for participation and contestation upon the intended recipients of care, as the recipient's perspective is diminished if not outright disregarded when paternalism takes over.

Furthermore, a care ethic that perpetuates paternalism readily combines with prejudicial social conceptions to result in even more nefarious variations, such as "benevolent" colonialism. We can see examples of paternalistic care becoming colonial through looking at both historical examples and modern development efforts. Uma Narayan points out that while there were powerful economic motivations underlying colonialism, colonial projects "were made morally palatable by the rhetoric of responsibility and care for enslaved and colonized Others".[129] Narayan describes how projects of colonization were understood as being for the good of those people who were colonized. She highlights the notion of the "white man's burden" as demonstrating the moral impetus to control and dominate other people through paternalistic caring, which included "both a sense of obligation to confer the benefits of western civilization

[127] Michelle Murphy, "Unsettling Care: Troubling Transnational Itineraries of Care in Feminist Health Practices", *Social Studies of Science* 45, no. 4 (2015): 719, DOI: 10.1177/0306312715589136.
[128] Robinson, "Paternalistic Care and Transformative Recognition in International Politics", 160-161, 168-170.
[129] Uma Narayan, "Colonialism and Its Others: Considerations on Rights and Care Discourses", *Hypatia* 10, no. 2 (1995): 134, DOI: 10.1111/j.1527-2001.1995.tb01375.x.

on the colonized, and a sense of being burdened with the responsibility for doing so – an obligation and responsibility rooted in a sense of being agents who had a world-historic mission to bring the light of civilization and progress to others".[130]

Lack of awareness about the colonial application of historical care practices and about how they might be similar to contemporary care projects can perpetuate legacies of colonialism between so-called developed and developing countries. Parvati Raghuram, Clare Madge, and Pat Noxolo contend it can be misleading when we encourage people to care for "distant others", because in some cases we are in fact talking about others whose lives and modes of living are in fact proximate and still influenced by (neo)colonialism in its various forms. They argue that by failing to recognize our colonial connection to countries and dichotomizing between ourselves and distant others, "Western discourses around the global South, including development discourses, produce Africa, Asia, Latin America, the Caribbean in terms of absences, rather than presences, in terms of that which the North has that they do not".[131]

In a similar vein, Serene Khader discusses how a development practitioner's preconception of what they think other countries are lacking (e.g., the relevant absences of those countries compared to their own) can lead them to misconstrue their interlocutors and engage in what she dubs unjustified and unconscious paternalism within development ethics.[132] It would be a further mistake to think of colonial and imperialistic caring attitudes as just being directed outward towards other countries and not certain people within our own. We should be cognizant of the interconnected state of the world through material and informational economies, the

[130] Narayan, "Colonialism and Its Others", 135.
[131] Parvati Raghuram, Clare Madge, and Pat Noxolo, "Rethinking Care and Responsibility for a Postcolonial World", *Geoforum* 40, no. 1 (2009): 9, DOI: 10.1016/j.geoforum.2008.07.007.
[132] Serene Khader, "Beyond Inadvertent Ventriloquism: Caring Virtues for Anti-paternalist Development Practice", *Hypatia* 26, no. 4 (2011): 742-761, DOI: 10.1111/j.1527-2001.2011.01167.x.

mechanisms for migration and immigration, and (consequently) increased exposure to cultural diversity within the United States. Modern political projects both domestic and abroad that are intended to benefit a particular social group can reinforce marginalization, cultural imperialism, and economic domination without their paternalistic nature even being recognized.

Those who defend an idealized notion of care, where care comprises a normative good, might respond that we are able to find paternalistic and colonial practices problematic and thus criticize them *because* they do not in fact reflect actual care. There are, however, problems with such responses. First, such responses are liable to invoke ideas about attentiveness and its supposed absence in problematic circumstances in order to discount colonial or imperial practices as care. While I agree that attentiveness has a crucial role in providing care that another person will be receptive towards, if attentiveness is just construed as focusing on who others are and what others are doing and saying, it alone remains insufficient for caregivers to avoid participating in practices that dominate or marginalize others. One might be attentive to the identity of a particular other, what a particular other is expressing, and so on. Despite such attentiveness, factors such as distorted perception of a particular other can problematize ones' ability to interpret them, engage in mutually respectful dialogue with them, and develop actions that are adequate for meeting their needs while not perpetuating oppression.

Second, idealizing what constitutes "true care" does not sync with people's actual understandings of what they were doing in these situations, which seems to depart from the grounded, narrative context within which care ethics is supposed to operate. Trying to determine whether care is present or absent in a manner that is divorced from people's self-understandings of their own actions is prone to a top-down perfectionism that could exclude several kinds of activities in a non-ideal world from constituting caring activities. We should be wary of

disregarding the experience of people who do an imperfect job at meeting another's needs due to imperfect conditions but nevertheless consider themselves to be caring. Depending on the benchmark placed upon the ethical perfection required to provide actual care, we might wonder how often care shows up in the world at all.

Finally, resorting to idealization in order to prevent problematic instances of care from existing runs the risk of making care a more abstract and subsequently thinner ethical concept, contrasted with the world-guided features of their thick ethical counterparts. Davina Cooper highlights the dangers associated with vague notions of care, writing that "the lack of specificity in normative care writing enhances care's wider discursive power without being able to effectively anchor care to a progressive or feminist project".[133] Perhaps in response to such concerns defenders of idealized care could work to develop a more culturally elaborated (thicker) notion of what "true" caring practices look like – for example, that people who care for others perform X, and do not engage in practice Y. However, this move itself could support a kind of paternalism that encourages imperialism and colonial practices, where those whose cultural practices are too different are incapable of providing "true" care, and so we either need to "educate them" or be the ones to provide the care if these people are not to be deprived of their normative good.

The difficulty that care accounts with an idealized notion of care have with addressing paternalistic care help to demonstrate shortcomings of care ethics as a moral theory. Care ethics, understood as a critical framework that operates with a non-idealized conception of care, is much better equipped for recognizing and addressing the challenges that paternalism poses for relations of care. In the next chapter, I will further explore what contributions care ethics as a critical

[133] Cooper, "Well, You Go There to Get Off", 252.

framework can make to discussions on paternalism. By the end of that chapter, my critical care framework will elucidate a conception of paternalism that makes sense for socially embodied beings that are enmeshed in relations of care, and I will discuss how my critical care framework invokes that conception to characterize and mark as problematic those caring relationships where one party aims to benefit the other through exerting control over them.

CHAPTER 3:

MAKING SENSE OF PATERNALISM USING THE CRITICAL CARE FRAMEWORK

3.1 Making Sense of Paternalism

Because human beings require care from one another as part of the human condition, paternalism will always be a potential danger that we must be vigilant of. Care ethics is concerned with the relationships we have or could have with other people. In our socio-political world, and perhaps any socio-political world, such relationships will often involve power differentials. Sometimes one's social position and the privileges afforded by that position enables one to take advantage of care providers, such as immigrant laborers whose own social positionality makes them susceptible to exploitation and abuse. Other times, care providers have some measure of power over those whose needs their practices aim to address. Relationships involving parental figures, instructors, health care professionals, and caregivers illustrate examples of care providers who are socially or physically positioned in a manner that creates potential for some measure of control over their counterparts (children, students, patients, and elderly persons). Moreover, relationships are not always as simple as "care provider" and "care receiver" tout court, and care giving and receiving instead have a bidirectional flow. This can be the case, for example, when adult children grow up and start to take on responsibilities for their aging parents. So, individuals who are involved in particular shared relationships can be vulnerable to one another along different dimensions.

Our more personally significant relationships are also characterized by a heightened level of vulnerability to one another. Erinn Gilson argues that vulnerability is "a basic kind of openness to being affected and affecting in both positive and negative ways, which can take

diverse forms in different social situations".[134] Vulnerability is a pervasive feature of the human condition, and Gilson contends that being vulnerable "makes it possible for us to suffer, to fall prey to violence and to be harmed, but also to fall in love, to learn, to take pleasure and find comfort in the presence of others, and to experience the simultaneity of these feelings".[135] Close personal relationships facilitate our potential for understanding one another, and this can lead to greater success in helping each other meet our needs on our terms. The closeness of personal relationships can also, however, embolden people to take certain presumptuous attitudes and actions. For example, if Raven believes she know Robin so well that she can grasp what's good for Robin better than Robin can, and subsequently acts in a manner that circumvents Robin's agency.

Conditions can be ripe for paternalistic care at societal, institutional, and interpersonal levels. Interpersonally, the vulnerability requisite for building trust and intimacy provides opportunities, and intimacy and affection can provide the motivation, for engaging in actions that circumvent another's wishes and wrest control away from them in some aspect. Circumventing one's control can result in a deeper emotional cut when the actor responsible is somebody one has a personal bond with, especially if the paternalized individual feels like the other person should have known better (or did know better) and their action is understood as a breach of trust or a betrayal. On institutional and societal levels, material and political advantages create conditions for the exertion and legitimation of force. Toward the end of the previous chapter, I mentioned the challenge that paternalism poses for care ethics. As Uma Narayan's work demonstrates, while intentions might be benevolent, paternalistic action elaborated upon by

[134] Erinn Gilson, "Vulnerability, Ignorance, and Oppression", *Hypatia* 26, no. 2 (2011): 310, DOI: 10.1111/j.1527-2001.2010.01158.x.
[135] Gilson, "Vulnerability, Ignorance, and Oppression", 310.

various kinds of social oppression can foster problematic social projects such as political domination and colonialism.[136]

While paternalism is a serious concern for care ethics, care theorizing about how to avoid paternalistic care has not received as much attention as it should. It is common to come across care theorists who express a passing concern with paternalism but do not dedicate much time to the issue, with Fiona Robinson being a notable exception.[137] In fact, some theorists with a positive view of care ethics believe that an ethic of care might indeed encourage paternalism and that this encouragement is not problematic. Michael Slote suggests that it is surprising when care ethicists, like the liberal theorists they critique, appear to find paternalism objectionable. Slote notes that the reasons behind this overlap in opposition to paternalism might not be the same. While liberals emphasize the importance of separateness from others, care ethicists might wish to ground objections to paternalism on the value of our connection to others, and concerns about how paternalism degrades that connection.[138] Yet Slote believes that empathetic concern can lead one to take paternalistic action, and contends that so long as one is practicing empathetic care, care ethicists can realize that paternalism is not inherently disrespectful towards others.[139] Care ethicists can thus "resist assuming that the value care places on connection forces it into ironic agreement with the general opposition to paternalism that liberalism defends in terms of the value of separateness".[140]

Michael Barnett similarly believes that empathizing with another is fully compatible with acting paternalistically towards them, and in fact, he takes that line of thought even further.

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[136] Review chapter 1 for a more in-depth discussion of this point.
[137] Especially in Fiona Robinson's "Paternalistic Care and Transformative Recognition in International Politics".
[138] Slote, *The Ethics of Care and Empathy*, 85.
[139] Slote, 57-8, 86.
[140] Slote, 86

Barnett defends paternalistic intervention in humanitarian affairs and human development projects by claiming that paternalism is latent in all relations of compassion.[141] On Barnett's view, our choices are between accepting some degree of paternalism towards other people, or refusing to act out of empathetic concern and affective consideration for one another. Barnett frames the matter in the following fashion: "It is easy to respect someone's autonomy and choices when you don't care about them. It is much more difficult to watch your loved ones make decisions that you do not believe are in their best interests. What is the greater sin, the occasional act of paternalism or the pledge of indifference?".[142]

I disagree with Slote and Barnett that the insights of care ethics reveal a tension between endorsing empathetic concern on the one hand and being averse to paternalism on the other. Whether or not a tension exists depends on our understanding of empathetic concern and the understanding of paternalism that we are operating with. A particular account of paternalism is needed in order to cast paternalism and indifference in a binary fashion. If someone claims to empathize with another but proceeds to act paternalistically towards them, then depending on our conception of paternalism we might doubt whether they are indeed being empathetic. Both Slote and Barnette draw upon a typical liberal notion of paternalism as involving something like "interference" with another (atomistic) individual for the purpose of benefitting them.[143] Their endorsements of paternalism from a care perspective stem from a failure to recognize that care ethics, in rejecting aspects of liberal ideologies, should also reject *understandings* of paternalism that draw upon those ideologies.

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[141] Michael Barnett, "International Paternalism and Humanitarian Governance", *Global Constitutionalism* 1, no. 3 (2012): 518, DOI: 10.1017/S2045381712000135.
[142] Barnett, "International Paternalism and Humanitarian Governance", 518.
[143] Slote, *The Ethics of Care and Empathy*, 6; Barnett, "International Paternalism and Humanitarian Governance", 492-3.

That we need a conception of paternalism that makes sense from a care perspective is the main theme of this chapter. The insights from my critical care framework will demonstrate why various liberal conceptions of paternalism are deficient. I will ultimately propose a conception of paternalism that, when seen in the light of our relational existence, makes more sense than those liberal conceptions. The notion of paternalism that I propose, in contrast with some of the accounts I will be reviewing, does not take paternalism to be something that has "good" and "bad" forms. Rather, paternalism is construed as a thick ethical concept, one which identifies certain actions, arrangements, and so on as exhibiting particular problems. My definition of paternalism will therefore be comparatively reined in so as to limit thin applications of the concept. It is important that charges of paternalism have clear ethical significance. Discussions on paternalism sometimes stretch the concept very thin. Paternalism is presented as something so widespread that its presence within relations of care becomes inevitable, which can then trivialize concerns about particular practices being paternalistic. Barnett's view that paternalism is present in all manifestations of compassion is one such example. We shall see one important application of having a thicker conception of paternalism in the next chapter when I discuss being able to recognize when paternalism is and is not occurring in cognitive behavioral therapy for depression.

There are a couple of quick points to make about my take on paternalism that I present in this chapter. While I limit the application of paternalism compared to thinner accounts that regard paternalism as more ubiquitous, I do not wish to suggest that things which other accounts might label paternalistic and that I contend are not paternalistic are therefore unproblematic. If I contend that a particular interaction within a social relationship should not be construed as paternalistic, that does not necessarily mean I think we should regard it as acceptable. It might be

rather mean that we need to be employing a richer vocabulary of thick concepts instead of trying to stretch paternalism to cover so many things.

Conversely, believing that paternalism is always problematic does not mean I think that paternalistic action can never be taken, since (as a value pluralist) I think it might be possible for paternalism to be the least problematic option that one is faced with in a moral dilemma. When paternalistic action is regarded as the best "all things considered" option among a range of unpalatable choices, though, we should not try to convince ourselves into thinking that we were practicing a "good form" or "good expression" of paternalism. Acknowledging there is an unethical component to our action has bearing on the question of where we go from there.

The discussion in this chapter will proceed in the following manner. The next section provides some more contextualization for how paternalism can be an issue within care. The following three subsections will then review different understandings of paternalism, indicating what weaknesses I see in those accounts, and which I wish to avoid in my own. The chapter's final section will then discuss my view of paternalism, which is the notion that paternalism involves exercising control over another.

3.2 Reviewing Definitions of Paternalism

Before we move onto our review of differing accounts of paternalism, there is a general point to consider, which informs how the ensuing discussion unfolds. Gerald Dworkin discusses various dimensions along which definitions of paternalism can differ. One such dimension is whether the presence of an appropriate motive is required for determining if an action is paternalistic. When it comes to accounts that regard one's motivation as pertinent for identifying paternalism, "whether an act is paternalistic or not cannot be determined without reference to the reasons for

which the [actor] acts. Two acts may have the same outcome, an improvement of B, yet only one counts as paternalistic".[144] Dworkin further explains how the requisite motive for paternalistic actions can be understood according to actualized or hypothetical criteria. According to the criteria for actual motive, an actor's action is paternalistic if their action is motivated by the relevant considerations. According to the hypothetical criteria, by contrast, an action counts as paternalistic *if it could* follow from a particular motive, even if an individual actor does not have that motive when performing the act.[145]

The definitions I review use actual motives as their criterion. Even for such cases, however, I believe considering possible or hypothetical motives can be worthwhile, insofar as someone suspects that another's stated motive is not their actual motive and has reason for thinking a hypothetical motive is as likely (or more likely) to be what drives them. My reasons for focusing on definitions that have these features will become clearer when I present my own account of paternalism.

3.2.1 Interfering with Another's Freedom for Their Own Good

While paternalism has been subject to numerous competing definitions, a useful starting point is found in Gerald Dworkin's seminal article "Paternalism". Dworkin demarcates paternalism into "pure" and "impure" cases. Pure paternalism consists in "the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced".[146] Examples include laws forbidding swimming at a public beach when no lifeguard is on duty, laws prohibiting dueling, laws regulating

[144] Gerald Dworkin, "Defining Paternalism", in *New Perspectives on Paternalism and Health Care*, ed. Thomas Schramme (Cham, Switzerland: Springer International Publishing, 2015), 18.
[145] Dworkin, "Defining Paternalism", 18.
[146] Dworkin, "Paternalism", 65.

personal drug use when such use does not lead to anti-social conduct, and laws making suicide a criminal offense.[147] With impure paternalism, by contrast, "in trying to protect the welfare of a class of persons we find that the only way to do so will involve restricting the freedom of other persons besides those who are benefited".[148] Examples include regulations on professional licensing or bans on the sales of particular commodities (e.g., cigarettes), where a practitioner or manufacturer is the target of interference, but a prospective client or consumer's welfare is the target of protection.[149]

Dworkin acknowledges that impure paternalism has a dubious status. It can be argued that, rather than needing a second kind of paternalism, the proscriptions of so-called impure paternalism are already covered under the idea of preventing someone from harming others. This is one reason that proposed definitions of paternalism often just map onto Dworkin's notion of pure paternalism. Dworkin responds that impure paternalism nevertheless captures something distinct, because in the case of impure paternalism, "the harm is of such a nature that it could be avoided by those individuals affected if they so chose".[150] With his reference to the individual's choice who is purportedly benefited in order to explain and legitimate the status of impure paternalism, however, the line between pure and impure paternalism starts to break down. Banning sale of high-risk commodities and prohibiting people from practicing without a license, where there is interference with individual freedom of choice about what purchases to make and who to seek services from, can be interpreted as instances of pure paternalism. If the notion impure paternalism is not to be regarded as superfluous and unnecessary, the concept needs a different justification from what Dworkin provides.

[147] Dworkin, pp. 65-66.
[148] Dworkin, p. 68.
[149] Dworkin, pp. 67-68.
[150] Dworkin, p. 68.

A broader definition for "pure" paternalism than Dworkin's is found in John Kleinig's *Paternalism*, in which he describes paternalism in the following manner: "X acts to diminish Y's freedom, to the end that Y's good may be secured".[151] Kleinig believes Dworkin's definition of paternalism is too restrictive in singling out freedom of action, contending that paternalism sometimes infringes on "other freedoms, such as freedom of thought and expression, and the freedom to be let alone".[152] Drawing upon an example from Bernard Gert and Charles Culver, he argues that lying to someone to shelter them from a psychologically distressing truth is paternalistic.[153] Kleinig consequently identifies paternalism with restriction on freedom simpliciter.[154] He leaves the notion of freedom within his definition vague in order to accommodate various potential liberal understandings of freedom and its corresponding infractions.[155] Kleinig further regards paternalistic restrictions on freedom as taking both active and passive forms. Active paternalism requires that someone perform an action for their own good (e.g., use safety equipment when operating a particular kind of vehicle), while passive paternalism requires that someone refrain from an action for their own good (e.g., prohibiting passage along a dangerous area).[156]

Kleinig's definition of paternalism contains minimalistic criteria for paternalistic action and is vague in how the conception of freedom is utilized. It consequently stretches paternalism to cover such a wide range of potential restrictions that we are left with a very thin conception. Kleinig's notion of paternalism casts a wide net, especially when coupled with the liberal notion of freedom as "freedom from interference". Isaiah Berlin famously articulates that notion of

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[151] John Kleinig, *Paternalism* (Totowa, NJ: Rowman & Allanheld, 1984), 18.
[152] Kleinig, *Paternalism,* 6.
[153] Kleinig, 6. Although Kleinig does not specifically state what kind of freedom is being violated in this example, I presume this is intended to correspond to an imposition on freedom of thought and expression.
[154] Kleinig, 7.
[155] Kleinig, 19. Kleinig is only concerned with liberal understandings of freedom.
[156] Kleinig, 6.

freedom in the following manner: "I am normally said to be free to the degree to which no man or body of men interferes with my activity… If I am prevented from doing what I could otherwise do, I am to that degree unfree".[157] If interfering with freedom includes such freedoms as "freedom to be left alone", then merely talking to someone about something one believes they should hear would be paternalistic if they would rather not have the conversation.

Kleinig's definition of paternalism is devoid of more concrete content, compared to how a thicker concept of paternalism would be, because Kleinig wants to avoid "moralizing" the notion of paternalism. He contends that despite the pejorative connotations that paternalism has, paternalism is akin to killing (where moral judgment is not built into the concept, even though matters of killing raise moral questions) rather than akin to murder (where moral condemnation is built into the concept).[158] Thus, Kleinig's definition is intended to be neutral and descriptive, as opposed to involving evaluation – he does not, he contends, "beg the question" against paternalism either way.[159] Despite positing that paternalism and killing are analogous in terms of their lack of an intrinsic moral status, Kleinig does not do more than stipulate their likeness before referring to the view that paternalism has negative features built into its definition as "the expedient of name-calling" in order to make his own position appear more reasonable and considerate in contrast.[160] We shall see later that there are important considerations in favor of having a thicker conception of paternalism, indicating the value of having a critical conception which has normative, action-guiding force.

Joel Feinberg, in his oft-cited book *Harm to Self*, accepts Kleinig's analogy between

[157] Isaiah Berlin, "Two Concepts of Liberty", in *Liberty*, ed. Henry Hardy (Oxford, England: Oxford University Press, 2002), 169.
[158] Kleinig, *Paternalism,* 4.
[159] Kleinig, 13.
[160] Kleinig, 4-5.

paternalism and killing. Feinberg believes that paternalism is not inherently unethical and so divides paternalism into two categories: "presumptively nonblamable paternalism" and "presumptively blamable paternalism". Feinberg describes paternalism that is presumptively nonblamable as "defending relatively helpless or vulnerable people from external dangers… when the protected parties have not voluntarily consented to the risk, and doing this in a manner analogous in its motivation and vigilance to that in which parents protect their children".[161] Feinberg references the legal doctrine of *parens patriae,* which is state protection of citizens unable to protect themselves, as an example of presumptively nonblamable paternalism.[162] Feinberg describes presumptively blamable paternalism, by contrast, as treating (capable) adults as though they were children by forcing them to act or refrain from acting in certain ways, regardless of their wishes in the matter, for "their own good".[163]

Feinberg incorporates consent into his definition of paternalism, and the nuance this addition provides is revealed through his discussion of how presumptively blamable paternalism has been interpreted in the literature as having two differing levels of strength: soft paternalism or hard paternalism. Hard paternalism holds there are possible cases where it is acceptable to protect competent adults from the harmful consequences of their actions even when those actions result from choices and undertakings that are voluntary. Soft paternalism, on the other hand, holds that the only acceptable reason for prohibiting conduct that could lead to self-harm is if that conduct is nonvoluntary in a substantial manner, or if temporary intervention is necessary to establish whether one's conduct is indeed voluntary. Such intervention involves determining that

[161] Joel Feinberg, *Harm to Self* (New York, NY: Oxford University Press, 1986), 5.
[162] Feinberg, *Harm to Self*, 6.
[163] Feinberg, 5. Feinberg technically classifies this as "benevolent paternalism" that is presumptively blamable. He also believes there is "nonbenevolent paternalism" that is presumptively blamable, which would be paternalism of the impure variety that Dworkin discusses (Feinberg, 5).

an individual is not suffering from a misinterpretation of facts, coercion, delusion, etc., in the absence of which they would make other choices in light of their own desires.

Despite the existent literature presenting soft paternalism as a more moderate approach to paternalism, Feinberg argues that soft paternalism should not be understood as paternalism at all. He argues the goal of the so-called soft paternalist is not to secure some good for an individual regardless of their wishes, but to help make sure that an individual can implement their "real choice(s)".[164] Feinberg in fact believes that "soft anti-paternalist" would be a more accurate name for the view that hard paternalism is unacceptable, and interference is permissible only in the absence of voluntariness or genuine consent. Nevertheless, he does not adopt that terminology within his own discussion, citing reasons of maintaining consistency with the existent literature.[165]

Including under the general heading of paternalism a position that is plausibly construed as being "soft anti-paternalist" is an example of the sort of conceptual move that contributes to paternalism being a thin concept. When perspectives with differing and incompatible aims are lumped under the same name, the charge of paternalism loses focus, and the negative import of the concept becomes less apparent. As the discourse evolves in this manner, it becomes more difficult for labeling something as paternalistic to serve a particular purpose in discussions, and invoking the label invites a "so what?" response more easily. Having a more focused notion of paternalism and more contiguous variations for that concept will be helpful for making it clear

[164] Feinberg, 12. Dworkin mentions coercion in his definition, and so at least incorporates consent into his definition insofar as coercion can undermine it, although this leaves room for soft paternalism to seem a viable concept if someone is interpreted as being coercive in order to detain another long enough to determine whether their actions are of their own accord. Because Kleinig believes there are cases of paternalism where coercion is not involved, he instead uses the notion of an imposition upon another (Kleinig, 7). His account does not flag soft paternalism as a peculiar notion because in soft paternalism there is an imposition involved, even if that imposition is to determine whether consent is present and genuine.

[165] Feinberg, 15.

what is at stake and why we should care when the charge of paternalism is raised.

We have seen Dworkin, Kleinig, and Feinberg all propose some variation of the notion that paternalism is interference with another's freedom. We turn next to someone who attempts to offer not just a different definition for the term but even a different name.

3.2.2 Parent-Like Interventions

John Kultgen takes up the matter of paternalism in his book *Autonomy and Intervention: Parentalism in the Caring Life*. As Kultgen's book title indicates, however, he opts for the term "parentalism" instead of "paternalism". Kultgen finds parentalism to be the more applicable word for actions or policies that get labeled as paternalistic, since the relevant comparison is with the paradigm of parenting rather than the narrower paradigm of fathering.[166] He writes that when we are concerned with how relationships between capable adults emulate how parents treat their children, it makes more sense to invoke parentalism as "a broad category that covers forms of care analogous to both fathering and mothering".[167] Furthermore, Kultgen utilizes a gender-neutral term in an attempt to "neutralize the assumption that the male is or should be the principal actor in the world and that the male role in the family is or should be the model for actions in the larger world".[168] Finally, he says that parentalism has a less pejorative tenor that paternalism, which will help prevent biased responses to parentalistic actions that are justified.[169]

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[166] John Kultgen, *Autonomy and Intervention: Parentalism in the Caring Life* (New York, NY: Oxford University Press, 1995), x. Kultgen adds that, "we might posit paternalism and maternalism as species under the genus of parentalism" (Kultgen, 48).
[167] Kultgen, *Autonomy and Intervention*, 48.
[168] Kultgen, 48.
[169] Kultgen believes that parentalism should retain some continuity with popular usages of paternalism to minimize conceptual confusion. Thus, parentalism "should retain some of the pejorative force of the word [paternalism] in everyday life" (Kultgen, 61). As with the previous authors we've reviewed, however, Kultgen asserts we should not incorporate a negative evaluation into its definition. An indictment of parentalism ("That's parentalistic!") indicates the need for a justification to be offered, but unless the justification is determined to be fallacious, the charge does not have further normative force (Kultgen, 61).

Because Kultgen employs a concept that is supposed to be analogous to both fathering and mothering, and because of his emphasis on parenting and "the caring life", I have selected his work as a relevant foil for my account of care ethics on that matter of paternalism / parentalism.

Kultgen offers a more detailed definition of parentalism than Dworkin, Kleinig, or Feinberg give for paternalism. On his view, "Action A is parentalistic if and only if (a) P believes that A is an intervention in S's life; (b) P decides to perform A independently of whether S authorizes A at the time of the performance; (c) P believes that A will contribute to S's welfare; and (d) P performs A for this reason."[170] Kultgen's definition appears to be more substantial than Kleinig's simple "X acts to diminish Y's freedom in order to secure Y's good". However, his longer description of paternalism does not necessarily result in a thicker or more useful concept. I argue that while Kultgen's definition of parentalism contains more criteria than our previously reviewed definitions of paternalism, his understanding of those criteria fashions a conception of paternalism that arguably provides the weakest critical power for demarcating paternalistic actions and policies from ones that should not be counted as paternalistic.

Kultgen relies upon an ideal of parenthood for identifying paternalism in spheres outside the household, which leads him to count actions as parentalistic when they resemble what parents do. According to this ideal, parents provide sustenance and protection for children, promote their children's mental health, and help develop their skills and talents. Kultgen thereby labels efforts from social organizations that similarly aim towards meeting those kinds of needs – such as providing welfare for the poor and unemployed, or employment benefits like health insurance for workers – as examples of parentalistic action.[171]

While Kultgen does not consider parentalism to be unacceptable, he still does believe

[170] Kultgen, 62.
[171] Kultgen, 51.

there is some prima facie moral objectionability to parentalism, which (while defeasible) should nevertheless be addressed when parentalistic action is suggested.[172] From a care perspective, however, it is a troubling thought that attempting to meet the needs of fellow adults would generate a prima facie moral objection, even if that objection is regarded as surmountable. Such a tentative predisposition against providing care for other adults provides fertile grounds for charges to be thrown around that any kind of social welfare brings us closer to a "nanny state" (note how that term itself draws on the image of a caregiver). The notion of the "nanny state" is often deployed as conceptual boogeyman, which serves the inflammatory purpose of shooting down social arrangements that are accepting of dependence upon other people.

Kultgen further claims that parentalism "is action taken independent of whether consent in any form is present".[173] He considers action independent of consent to be distinct from action without consent. Even if someone does consent to a particular action, that does not make the action non-paternalistic if their affirmation is irrelevant to the one deciding whether or not to perform the action (e.g., if the action would have been done regardless). Kultgen's view that parentalism is independent of consent is relatable to certain ideas about parenting, namely that sometimes a parent should be guided not by their child's preference but by other criteria.

There are some issues with Kultgen's conceptualization of parentalism (paternalism) as being "independent of consent" as opposed to "without consent". He contends that where paternalism is concerned, "while we are prone to think of cases in which she acts in the face of his objections or coerces him, there are others in which she acts on or for him without his knowledge or is determined to proceed regardless of what he wants".[174] Kultgen contends that

[172] Kultgen, ix.
[173] Kultgen, 69.
[174] Kultgen, 116.

while explicit current consent makes an intervention non-parentalistic, derivatives such as "that someone would consent if asked" do not. These instead have bearing on whether the parentalistic intervention is justified.[175] The problem with Kultgen's view is it covers courses of action which it seems dubious to count as parentalistic or as being especially characteristic of parent-child relations. For example, doing a favor for someone sometimes involves acting without their explicit and current consent, and determining the content of a surprise for someone always does. There are cases where individuals would obtain consent if they could, but they cannot, either because they cannot contact the other in time to ask for clarification regarding their intended favor or because it would compromise the surprise. Thus, they act independently of receiving explicit and current consent. Even if specific instances of favors and surprises can be parentalistic, we should regard these as instances where there is an overlap between paternalistic action and favors or surprises, and not regard favors and surprises as varieties of parentalism (the reasons why will become more apparent when we get to my account of paternalism).

Because Kultgen views parentalism as acting independent of consent, he even includes rational persuasion under the rubric of parentalism, casting attempts to rationally persuade another to alter their views as intruding upon their thoughts. He contends that while philosophers like to imagine abstract rational agents that are receptive to deliberating about their aims, "actual persons frequently do not welcome ones that dissuade them from a course on which they have set their mind… however reasonable the advice, the advice-giver is altering the other's choice-situation by forcing him to face facts".[176] So, engaging in rational deliberation with another is cast as an intervention in another's life of the parentalistic kind. When one's goal is persuasion, the decision to have a discussion with another is made independently of their consent (i.e., one

[175] Kultgen, 116.
[176] Kultgen, 71.

plans to bring up a topic independently of whether the other would like to discuss it).

There is something important to be found in what Kultgen is trying to articulate. We are reminded that rational deliberation with other people does not occur in a vacuum, and that real world sites of discussion often differ from the idealized settings that one might imagine. The intensity and level of persistence with which one attempts to convince another of a position might be make an interaction or series of interactions coercive. If someone appears to repeatedly enter into argumentation in order to eventually wear the other person down into accepting their reasoning, there might be a kind of pressure that could seem coercive. That pertains to how particular, on-going relations with another would be characterized over a period of time, however. The problem with presenting the mere altering of another's choice situation as a parentalistic intervention is that this basically casts us as asocial beings. It might not be easy to figure out when exactly repeated attempts at convincing, advice giving, and so on cross over into paternalistic / parentalistic action. What I will end up suggesting later is that a thick concept of paternalism could applied in certain situations to help us navigate whether certain relations seem to meet the criteria for paternalism.

3.2.3 Substitution of One's Judgment for Another's

The last account I review before moving onto my own is Seana Shiffrin's. Shiffrin's account has more similarities with my view compared to the earlier accounts, and her account therefore provides some helpful reference points for my own account. Nevertheless, there are some substantial disagreements between us on how to conceptualize paternalism.

Shiffrin proposes that when considering a definition for paternalism, "it seems worthwhile to assess what is central in our normative reactions to paternalism and to employ a

conception of paternalism that complements and makes intelligible our sense of paternalism's normative significance".[177] In an effort to accomplish this, she offers an account of paternalism that has notable differences from understandings of paternalism as interfering with another's freedom in order to promote their good and from Kultgen's notion of parentalism. She provides the following definition of paternalism:

> Paternalism by A toward B may be characterized as behavior (whether through action or omission of action) (a) aimed to have (or to avoid) an effect on B or her sphere of legitimate agency (b) that involves substitution of A's judgment or agency for B's (c) directed at B's own interests or matters that legitimately lie under B's control (d) undertaken on the grounds that compared to B's judgment or agency with respect to those interests or other matters, A regards her judgment or agency to be (or as likely to be), in some respect, superior to B's.[178]

In Shiffrin's definition, as with the definitions reviewed above, the motive or reasoning behind actions and policies are essential for characterizing them as paternalistic. While Shiffrin's definition of paternalism still involves a kind of imposition upon another, she argues that paternalism involves one of (at least) two attitudinal stances which underlie that imposition. The first stance is that one regards their own judgment about how to handle another's affairs to be superior to the judgment of the person with legitimate jurisdiction over the matter. In order for certain positive effects to manifest themselves in that other's life, therefore, one privileges their own judgment and takes matters into their own hands. The second stance is that, while another is deemed to have acceptable judgment about their own interests, that person is regarded as nevertheless being in some sense incapable of acting to secure their properly perceived interests, and so one circumvents their possibility for action with their own.[179]

Shiffrin's account of paternalism is distinctive in that, while paternalism will in several

[177] Seana Valentine Shiffrin, "Paternalism, Unconscionability Doctrine, and Accommodation", *Philosophy & Public Affairs* 29, no. 3 (2000): 212, DOI: 10.1111/j.1088-4963.2000.00205.x.
[178] Shiffrin, "Paternalism, Unconscionability Doctrine, and Accommodation", 218.
[179] Shiffrin, 15.

cases involve limiting someone's freedom in some respect, doing so is not a necessary condition for engaging in paternalistic actions. She contends that paternalism can occur through omissions of action that do not diminish another's freedom. To illustrate her claim, Shiffrin proposes a scenario where an individual named Bob asks their acquaintance Alice (who possesses extensive carpentry skills) for help with building a set of shelves.[180] Alice, however, hesitates to help Bob because she thinks he relies upon her expertise too much and should learn how to build these things for himself. If Alice were to explain her reservations to Bob and through their ensuing discussion persuade him to construct the shelf without her aid, Shiffrin argues Alice would not act in a paternalist fashion. Alice would be engaging with Bob as a fellow agent and not attempting to supplant his agency.[181] However, if Alice merely declined to help Bob because of her reason stated above, then Shiffrin contends Alice would be acting paternalistically. By simply refusing to help Bob on account of her reasons, Alice substitutes her judgment for Bob's about what he should aim for and works around his agency to get him to act in a manner that she believes would be better for him.[182]

Shiffrin's account is further distinguished from the other accounts we've reviewed because she enlarges the motivation behind paternalism to include more than a concern for someone's good or welfare, writing that, "behavior may be paternalist if the motive behind it is

[180] Shiffrin just uses the designators "A" and "B" for her example, but I've replaced these with the names "Alice" and "Bob" for smoother readability.
[181] We can already see a contrast with Kultgen's position on rational persuasion and parentalism. One feature of this hypothetical situation that might be significant when it comes to the "history of conversation" is that while Alice is trying to persuade Bob, he is the one who initiated the conversation in the first place, and an attempt to persuade rather than ignore him is understood as an attempt to engage with him rather than circumvent him. Bob might not like hearing what Alice has to say, but that doesn't mean Alice is committing a foul for saying it.
[182] Shiffrin, 213. In addition to paternalism being able to result from omissions of action that do not diminish freedom, Shiffrin believes that certain scenarios can involve paternalism despite the target's freedom being increased. This would happen, for example, if "A creates opportunities or presents choices for B, with B's welfare in mind, that B has explicitly declared he would prefer not to have. B finds too much choice overwhelming or worries about yielding to temptation" (Shiffrin, 214).

simply that the (putative) paternalist knows better than the agent, or may better implement, what the agent has authority for doing herself".[183] Shiffrin invites us to imagine the following scenario to illustrate her claim: someone raises his hand at a talk, and starts presenting a particular line of thought in a halting manner. A sympathetic but impatient colleague believes she understands where his line of thinking is headed, so she cuts him off ("I think what he's trying to say…") and eloquently delivers the point he has been slow to convey. Shiffrin contends that taking over another's question because one believes they have superior command over the material another is trying to articulate is paternalistic, "even if her motive is really that she wanted to see the point formulated properly and not that she wanted in particular to help him formulate the point or to make his point understood".[184]

Through allowing paternalism to be concerned with more than an agent's wellbeing, Shiffrin creates room for "impure paternalism" in addition to the pure kind, offering a different explanation and justification for impure paternalism than Dworkin. To convey her ideas about impure paternalism, Shiffrin proposes another scenario: Betty is a duly appointed manager who intends to send out a policy memo to her workers. Unbeknownst to Betty, her co-worker Anna has substituted Betty's policy memo with one of her own. This subterfuge arises not from Anna's concern for Betty's welfare, but from her concern for the workers that Betty manages. Anna believes that her memo is clearer or establishes a better policy. Anna resorts to this indirect and (if successful) undetected method, however, because she does not wish to challenge the legitimacy of Betty's authority. She does not believe Betty is unfit to be manager or that Betty's

[183] Shiffrin, 216.
[184] Shiffrin, 217. Shiffrin adds, "If he has been stammering for some time or his point has been misunderstood through a few cycles of back and forth, the intervention may be proper, even welcome, and designed to move the conversation along, for the benefit of everyone. In the collective enterprise that talks represent, at some point, one loses legitimate, exclusive control of the floor. But if the intervention occurs, as initially described, quite early in the colloquy, the colleague's intervention seems paternalist" (Shiffrin, 217).

incompetence undermines her claim to legitimate authority over the workers.[185] Anna just acts from the motive that she could write a better memo than Betty and that this would create a better environment for the workers. Shiffrin believes that such a case indicates how someone can behaves paternalistically towards another even though that person is not the intended recipient who would benefit from one's actions.[186]

Dworkin describes impure paternalism as benefiting X through interfering with the freedom of people other than X. Because Shiffrin takes paternalism to be about substituting judgment instead of limiting freedom, she is actually defending a notion of paternalism that is similar to Dworkin's account of impure paternalism rather than endorsing his specific conception of impure paternalism. Nevertheless, she makes the same point that the target of paternalism's restrictions can be different from the intended beneficiary of that paternalism. While Dworkin's justification for impure paternalism in fact collapses into an explanation of how so-called impure paternalism interventions can be understood as pure paternalism, Shiffrin extends the considerations from pure paternalism outward: "Both cases seem to involve the same sort of intrusion into and insult to a person's range of agency… What concerns us about paternalism, narrowly construed, should spark the same concern about these closely related, similarly motivated cases. It seems arbitrary to single out paternalism, narrowly construed, as a special normative category".

Shiffrin's perspective on paternalism is valuable because she calls attention to *how* people are relating to one another. The earlier perspectives we reviewed too readily focus on the individual (e.g., "Am I being interfered with?") at the expense of disregarding the web of

[185] Shiffrin adds, "To be clear, if A were acting on the grounds that B had no real claim to authority at all, that would not, I think, be paternalist" (Shiffrin, 216).
[186] Shiffrin, 216.

relations they are necessarily enmeshed in. Shiffrin's account is more specific in its given criterion for the presence of paternalism. The comparative component of her view readily has bearing on the kind of relationship that exists between two people ("Is my judgment on this matter under their legitimate purview superior to theirs?" and "Can I do this task that they have jurisdiction over better than they can?). Even so, Shiffrin does not go far enough in considering how a purported paternalistic action configures into ongoing social relationships.

Let's return to the example of Alice declining to help Bob build a cabinet. Shiffrin indicates that if Alice refuses to help Bob without providing an explanation for refraining, she would be acting paternalistically. We might wonder, though, are circumstances such that Alice owes Bob an explanation for her decision? That matter can be more difficult to determine than it might seem at first. Assumptions like "friends owe each other explanations for their actions" might have heuristic value, but contextual information about the relationship between a given set of friends might alter our view on when that is indeed applicable. Real world friendships are not perfect, after all. Bob could be a rather demanding fellow, one who has displayed a tendency in the past to disrespect Alice when she has expressed concerns of her kind before, such that her giving a simple refusal along the lines of "I can't take on a project like that right now" or "I'm really busy at the moment" will be less likely to provoke an aggressive or verbally abusive response. Setting aside the matter of whether an explanation is owed, there might be other reasons for which Alice does not offer a reason for refusal that do not constitute an attempt to discretely manage another's judgment or agency. Perhaps Alice is mentally exhausted and just doesn't feel like getting into a big discussion with Bob. Perhaps Alice has severe social anxiety, and is worried about how such a conversation would turn out. That is not to say if one's decision for not engaging in conversation is not paternalistic, they could not be above reproach for other

reasons (e.g., perhaps one also has a good reason to be trying to work through their social anxiety on some issue). The point is that those other matters are what needs to be addressed, rather than someone exhibiting a paternalistic attitudinal stance.

3.3 Paternalism as a Measure of Control Over Another

The critical care framework, and its foregrounding of relationship, is helpful for developing a sensible conception of paternalism. Considerations from the critical care perspective have led me to believe that paternalism should be understood along the lines of attempting to exert control over another for their benefit. I propose we utilize the following loose definition of paternalism: *paternalism involves a relation where someone(s) exercise or attempt to exercise some measure of control over another, where said control is intended to benefit that other along some dimension that is determined to be salient by the paternalistic party.* I consider this conception of paternalism to be a fruitful starting point for continued discussion, as opposed to determining the essence of paternalism in a transcendental sense. It introduces some crucial ideas to focus our discussion of paternalism, even if further considerations lead to the revision or refinement of the definition in some manner.[187]

What is significant about an aspect of control where paternalism is concerned? When considering what merit paternalism has as a concept from the perspective of selves who are social beings, who are bound up to one another through relations of care, paternalism's merit as a concept is limited when construed in the traditional liberal manner. Having our application of

[187] For instance, some of the definitions that invoke criteria like interference or intervention will not regard something as paternalistic if another's autonomy is compromised in some sense (something that came up in the earlier discussion of "soft-anti paternalism"). Perhaps further discussion would reveal similar caveats to how the above definition is deployed as well. That is a matter beyond the present scope of this project and a topic for further exploration in future work.

paternalism be based upon interference as such presents our default state as an asocial one, feeding the unhelpful thought of folks like Slote and Barnett that empathy or sociality inevitably push us towards paternalism. Likewise, having our application of paternalism be guided by intervention casts us in an asocial light depending on how inclusive one's understanding of "intervention" is (e.g., if just interacting with another individual becomes an intervention in their otherwise asocial existence). Control as a concept is fully compatible with our social nature – indeed, control itself is a relational notion. Because control is something that unfolds over time, and involves powerful constraint upon how things unfold, it pertains to some kind of ongoing relationship between (at least) two parties. When making judgments about the presence or absence of control, as opposed to something like interference, we need to look at more than a one-off interaction between individuals pressed by one side. Some kind of narrative understanding is required. Is there, for example, a track record of action and/or behavior that coheres with effort to dictate some aspect of another's life, or else plausibly serves as a warning sign for the development of a controlling relationship? Control over another can have both benevolent and malevolent motivations, and the care perspective in particular highlights that when control comes from a benevolent motivation, it can sometimes involve a manner of care for another that delimits how an individual can provide care for themselves and how others can provide care for them as well.

The element of control needs to be understood in the context of some existent (or in the case of past tense, formerly existent) social relationship to be established. Furthermore, in order for a judgment about control to make sense, a controlling relationship needs to be parsed apart from relationships that are benevolent (perhaps even one-sided) that are not characterized by control. The upshot is that control is a thicker concept than interference or intervention. The

latter two concepts do not require us to know much beyond that one person acted on another. But we need much more information in order to accurately assess whether an interaction reflects one person exerting (or attempting to exert) control over another. Indeed, this is where hypothetical motives for paternalism can even have a role in our discussions, as I mentioned earlier. Because we cannot assume that someone who tries to control another will be straightforward about that, a plausible hypothetical motive that coheres with how matters have been unfolding might sensibly raise one's suspicions that an attempt to control another is afoot. Furthermore, because control involves being in another's power, control requires at least a vague understanding of power in order to be deployed. That is another reason why control as a concept pertains to the interactions of social beings.

When we consider relationships that are characterized by vast differences in power, considerations about paternalism must bear in mind differences between potential for control and actual control (whether exercised or attempted). This is helpfully seen when we consider parenting and ponder whether being parent should really be the template for what it means to be a paternalist. The claim that someone is a "controlling parent" is an intelligible one (as a quick internet search can reveal) and not redundant to the point of being confusing or vacuous. If exercises in control are important for guiding our applications of paternalism, being a controlling parent is paternalistic in a way that simply being a parent simpliciter is not.

To pursue this line of thinking, let us consider three "dinner time" scenarios: (1) a parent does not let their child eat ice cream after dinner, (2) a parent does not let their child eat ice cream after dinner unless they eat have eaten something healthy, and (3) a parent makes their child eat broccoli at dinner. Scenario #1 appears to map onto Kleinig's "passive paternalism". Scenario #3 appears to map onto Kleinig's "active paternalism". It is less clear where to place

scenario #2; this scenario seems to contain both passive and active components. The active component being conditional (you must X if you want Y) and the passive component being overridable if the conditional is met might cause some liberal thinkers to think scenario #2 is not paternalistic, although ice cream being "held hostage" might well be considered interference with or intervention that impacts a child's mission to have dessert. If all three scenarios are regarded as both controlling and appropriate on the part of parents, we can understand how the formation of the parental guide for identifying paternalism that informs the perspective of theorists like Kultgen occurs. In the interaction between parent and child though, should all three scenarios be seen as controlling, as they might be if they were to occur between two adult friends or acquaintances?

A relational perspective, and a foregrounding of care and care responsibilities, is helpful for thinking the matter through. A relationship between parent and child, when the parent is designated and understood to be the primary caregiver of the child, has distinctive qualities from a relationship between (for example) two adult friends. These qualities include things like a social expectation from others that the parent takes charge, and the fact that a child undergoes changes that will transform them into an adult and a potential parent themselves. A kind of asymmetry is built into the parent/child relationship – the insight in calling attention to the notion of a "controlling parent" is that it makes sense to look at an asymmetrical relationship on its own terms, rather than judging it by the standard of a (purported) symmetrical relationship. This kind of move makes sense for the contextual focus of care ethics as a critical framework.

Let's consider option #1 in more detail (that ice cream is not allowed after dinner). I suggested that conceptions of paternalism involving interference or intervention would probably construe the denial of ice cream after a given dinner session as paternalistic. If paternalism is

construed as being about control, denial of ice cream after dinner could sensibly be considered paternalistic if the parent never let their child have ice cream. But let's consider the opposite: what if a parent let their child have ice cream after every meal? Some might call that instilling and *enabling* a bad habit in a child – eating unhealthy food without regard to moderation. Unless we are to set up a dichotomy between being controlling and being enabling, it seems there should be room for more possibilities. A parent who sometimes lets their child have ice cream after dinner, but not always, would not on this understanding be inherently controlling (inherently paternalistic). What range is appropriate is not for me alone to figure, though having concepts like paternalistic can be helpful in figuring it out, since if a parent was charged with being paternalistic about their children's dessert activity, they might be pressed to reflect how their actions may or may not be controlling, and what adjustments they might make in light of that.

Scenario #3 (that one is made to eat broccoli at dinner), meanwhile, might readily fit with charges of paternalism. But if so, that probably has more to do with a track-record of controlling behavior that this particular interaction reflects. A parent could be seen as problematically controlling if, rather than working on ways to help a child be healthy that are satisfying or providing incentives to prompt the child to choose being healthy (as in scenario #2), the parent is apt to force a particular kind of food on their child. A child might not have the right to eat dessert whenever they want, and granting that request might be enable them in problematic ways. It does not however enable unhealthy habits if one does not force their child to eat broccoli. There are numerous alternatives for meeting a child's needs for nutrition, developing healthier habits, and so on, which include working *with* one's child to find satisfying ways for the child to obtain nutrients the parent prioritizes. The manner of meeting a child's nutritional needs, of building healthier habits, and so on can unfold in ways that are and are not problematic. It would be

valuable if a concept like paternalism could be applied to *parenting itself* to help us in working that out.

Attempts to control another can be more local (controlling specific actions) or more general (their life trajectory). Such attempts at control can take many forms, including dialogical ones. If we want to consider whether and when rational persuasion constitutes paternalism, we (unlike our thinkers from earlier in this chapter) will need to consider more than single interchanges of rational persuasion that are directed towards another on matters that concern their wellbeing. We will need to look at patterns of discussion, understanding where those discussions fit within a conception of that relationship. If person A has made their feelings clear on more than one occasion about some matter that pertains to their good, repeated attempts to get person A to change their mind might not just be insensitive but a kind of intellectual harassment, especially when their reasons have been made clear and there is no evidence that some change in circumstances have altered those reasons. Perhaps one hopes, at least in part, to wear person A down enough that they just give in. Such recurring dialogue could plausibly be interpreted as an effort to exert control over another through dialogical means.

I hope to have said enough about paternalism as involving control over another to convey, at least in an initial sense, why this is the conception of paternalism that the critical care framework supports. In the next chapter, I will further contextualize the concerns raised in this chapter through considering paternalism in relation to one of the prominent approaches for the treatment of depression, a kind of psychotherapy known as cognitive behavioral therapy, often abbreviated as CBT.[188] Discussions of paternalism in medical contexts typically focus on

[188] American Psychiatric Association, "How Do I Choose Between Medication and Therapy?", APA.org, American Psychiatric Association, Published July 2017, https://www.apa.org/ptsd-guideline/patients-and-families/medication-or-therapy

particular issues between physicians and patients, such as physicians withholding information, providing misleading information to get a patient to accept a particular treatment, or (in some cases) physicians forcing or denying particular treatments, all having the principle of beneficence as their motivation. The competing accounts of paternalism as interference, intervention, substitution of judgment, and control can all appear applicable for such situations. However, if we turn to a different kind of relationship, that which forms between therapist and client during particular psychotherapies, the issues with relationality that I discussed in the previous chapter are helpfully brought to the forefront.

CHAPTER 4:

PATERNALISM, COGNITIVE BEHAVIORAL THERAPY, AND DEPRESSION

4.1 The Significance of Depression for Care Ethics and Vice-Versa

Depression is a significant health concern because of its prevalence and its detrimental effects. The World Health Organization (WHO) estimates that 280 million people in the world experience depression,[189] and the Center for Disease Control (CDC) estimates that 4.7% of adults in the United States have depression.[190] There are various ways in which health professionals have recognized depression as interfering with a depressed individual's activities. The Beck Institute for Cognitive Behavioral Therapy, in their pamphlet "Coping with Depression", notes that people who have depression often report difficulty making decisions, sometimes even simple decisions about what to eat.[191] Severe cases of depression can be life ending, albeit not in the same manner as terminal illness - depression is the most common diagnosed mental health disorder in people who commit suicide.[192] The WHO acknowledges that depression may also be interrelated with physical diseases, either as a causal factor or as an outcome.[193] David L. Hare et al, for example, call attention to noticeable comorbidity between depression and cardiovascular disease.[194] The exact relationship between depression and health

[189] World Health Organization, "Depression", WHO.int, World Health Organization, September 2021, https://www.who.int/news-room/fact-sheets/detail/depression.
[190] Center for Disease Control, "Early Release of Selected Estimates Based on Data From the 2019 National Health Interview Survey", CDC.gov, Center for Disease Control, Accessed August 2, 2022, https://www.cdc.gov/nchs/data/nhis/earlyrelease/EarlyRelease202009-508.pdf
[191] Judith S. Beck and Francine Broder, "Coping with Depression", Beckinstitute.org, Beck Institute, August 2021, https://beckinstitute.org/wp-content/uploads/2021/08/Coping-with-Depression.pdf
[192] Keith Hawton, Carolina Casanas i Comabella, Camilla Haw, and Kate Saunders. "Risk Factors for Suicide in Individuals with Depression: A Systematic Review", *Journal of Affective Disorders* 147 (2013): 17-28, DOI: 10.1016/j.jad.2013.01.004.
[193] World Health Organization, "Depression".
[194] David L. Hare, Samia R. Toukhsati, Peter Johansson, and Tiny Jaarsma, "Depression and Cardiovascular Disease: A Clinical Review", *European Heart Journal* 35 (2014): 1365-1372, DOI: 10.1093/eurheartj/eht462.

issues such as cardiovascular disease might need further research, but the prospect that depression might contribute to the development of other dangerous health conditions is a disconcerting one.

Even setting aside the concern about health care costs for treating health issues associated with depression, care ethicists have numerous reasons to be concerned about depression. Because depression is not uncommon, there is a reasonable chance that people with caring responsibilities will struggle with depression at some point, will be expected to provide care for others who are struggling with depression, or some combination thereof. If someone finds it increasingly difficult to make decisions and act on them, this can impede their success in providing care that adequately meets both the needs of others and themselves. Experiencing increased difficulty with decision-making can also implicate how someone communicates their needs (i.e., which needs does one communicate, when, and to whom?). Difficulties with communicating needs, or even recognizing one's needs as valid, are further problematized when depression involves feelings such as hopelessness or worthlessness. These are all issues that arise from a general reflection on providing care when one is depressed and/or caring for those who are depressed before we even get to the question of care that targets treating depression specifically, which is accompanied with its own set of issues. The impact of depression on both giving and receiving care, and the challenges that can arise within the relationships that form when someone works to treat individuals who are experiencing depression, are all reasons for care ethicists to be concerned about depression.

Despite the seriousness of depression for matters of care and the potential severity of depressive symptoms, discussions of depression have been absent from the primary care ethics literature. A review of significant books from a variety of authors contain minimal references to

depression, if depression is mentioned at all.[195] I find it plausible that some care ethicists underestimate the seriousness of depression and its relevance for their views on care relations and responsibilities. Perhaps this could be attributed partly to their understanding of what depression is. Matthew Ratcliffe, who notes a similar literature gap in the phenomenology of depression, suggests that "Perhaps this neglect is due to the assumption that depression involves intensification or proliferation of commonplace feelings, emotions and moods, such as sadness, hopelessness, and guilt. So all one need do in order to appreciate the phenomenology of depression is imagine having unusually pronounced experiences of familiar kinds."[196] Although my present project serves as a starting effort toward filling in the gap in the care ethics literature on depression, the lack of a specific interlocutor from within the care ethics literature means my discussion will be more general.

Depression is disconcertingly prevalent, but something else that is prevalent is for people not to seek treatment for depression. In the U.S., for example, the National Survey on Drug Use and Health (NSDUH) conducted in 2005 and 2006 found that of 6,510 participants who reported a major depressive episode during the past 12 months, over a third of those participants (36.7%) reported not seeking mental health treatment for their depression.[197] A review examining NSDUHs conducted from 2005-2014 charted an increase in the prevalence of major depressive disorder amongst both adolescents and adults without a corresponding level of increase in mental

[195] Said texts include Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development*; Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education*; Joan C. Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care*; Eva Feder Kittay, *Love's Labor: Essays on Women, Equality and Dependency*; Fiona Robinson, *Globalizing Care: Ethics, Feminist Theory, and International Relations*; Selma Sevenhuijsen, *Citizenship and the Ethics of Care*; Virginia Held, *The Ethics of Care: Personal, Political, and Global*; Michael Slote, *The Ethics of Care and Empathy*; Tove Petterson, *Comprehending Care: Problems and Possibilities in the Ethics of Care*.

[196] Matthew Ratcliffe, *Experiences of Depression: A Study in Phenomenology* (New York, NY: Oxford University Press. 2015), 1.

[197] Ramin Mojtabai, "Unmet Need for Treatment of Major Depression in the United States", in *Psychiatric Services* 60, no. 3 (2009): 298, DOI: 10.1176/ps.2009.60.3.297.

health care contacts, leading the authors to conclude "The prevalence of depression in adolescents and young adults has increased in recent years. In the context of little change in mental health treatments, trends in prevalence translate into a growing number of young people with untreated depression".[198]

There are numerous reasons someone might choose not to seek mental health treatment for depression, and numerous barriers to receiving (adequate) treatment. The 2019 NSDUH indicated that the most reported reason by young adults (age 18-25) for opting not to seek treatment for major depressive disorder was financial cost (54.7%). Other prominent reasons that were reported included not knowing where to go for services (37.8%), thinking they could handle the problem without treatment (30.9%), and fear of being committed or having to take medicine (22.8%).[199] A thorough engagement between the critical care framework and the numerous structural barriers to seeking treatment, is a potential future project which is beyond the scope of this dissertation. For our purposes here, I want to discuss what might be deemed "personal reluctance" to seek treatment, exemplified for example by the fear of being committed or having to take medicine. Such fears seem to reflect a concern that a mental health professional will force someone to do things they don't want to or start to control their life. The thought that therapists dictate to their clients is a common enough concern that entering a Google search "do therapists tell you what to do" will generate numerous responses dedicated to countering that idea.

[198] Ramin Mojtabai, Mark Olfson, and Beth Han, "National Trends in the Prevalence and Treatment of Depression in Adolescents and Young Adults", *Pediatrics* 138, no. 6 (2016): e20161878. DOI: 10.1542/peds.2016-1878.
[199] Wenhua Lu, Melissa Bessaha, Miguel Muñoz-Laboy, "Examination of Young US Adults' Reasons for Not Seeking Mental Health Care for Depression, 2011-2019", *JAMA Network Open* 5, no. 5 (2022): e2211393, DOI: 10.1001/jamanetworkopen.2022.11393

Cognitive behavioral therapists use the term "therapeutic alliance" to refer to the working relationship between therapist and client. From the critical care perspective, we can understand the therapeutic alliance as a particular relation of care, and like other relations of care, it can take healthier forms and impoverished forms. Practitioners of cognitive behavioral therapy, or CBT for short, regard a strong therapeutic alliance as an important ingredient of successful CBT, for a strong therapeutic alliance is associated with better treatment outcomes.[200] The therapeutic alliance, as a condition for successful CBT, needs to be able to nurture the requisite trust for a client to approach a therapeutic relationship with openness.[201] Michelle M. Tran et al conducted a study which found people who knew others who had mental health problem and/or sought treatment for mental health problems were more likely to seek mental health treatment themselves. The authors themselves note that future research will be needed to investigate whether the association is a causal one, and if so, in which direction.[202] Nevertheless, if people feel comfortable and open to sharing their experiences with therapy or mental health issues (such as depression), this could be helpful for encouraging participation in mental health treatment. It could additionally be helpful in spotting mental health treatment that is deficient compared to what others have received.

Care ethics as a critical framework provides insightful perspectival framing, and situates thick ethical concepts, that can facilitate discussion and evaluation of cognitive behavioral

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[200] Stirling Moorey and Anna Lavender, "The Therapeutic Relationship in Cognitive Behavioral Therapy", in *The Therapeutic Relationship in Cognitive Behavioral Therapy*, eds. Stirling Moorey and Anna Lavender (Los Angeles, CA: Sage Publishing, 2019), 4.

[201] Judith S. Beck, *Cognitive Behavior Therapy: Basics and Beyond*, 2nd Edition (New York, NY: The Guilford Press, 2011), 7-8, 17.

[202] Michelle M. Tran, Robert A. Curland, and Yan Leykin, "Association Between Seeking Treatment and Personal Knowledge of Others with Emotional or Mental Problems", *Psychiatric Services* 71 no. 4 (2020): 395, DOI: 10.1176/appi.ps.201900190. For instance, the authors note the association might be explained by people receiving treatment coming into contact with others who are also seeking treatment or others who are more open in disclosing their mental health experiences.

therapy and their requisite therapeutic alliances. I suggested in the previous chapter that my conception of paternalism could helpfully be construed as a thicker ethical concept that, unlike its competitors, is not stretched too far in its applicability. Discussion concerning the treatment of depression in CBT, and the qualitative characteristics of a given therapeutic alliance, is one area where I believe that could be the case. People who share their successful experiences with therapy could have more intellectual resources for discussing why their experience was not paternalistic, and the concept of paternalism could be used as a helpful check both for people receiving therapy and for therapists themselves. For paternalism to be capable of serving a helpful discursive role, however, it needs to make sense. I argue accounts of paternalism which construe paternalistic action as interference, intervention, or substitution of judgment do not sufficiently discriminate between therapist/client interactions as such and *problematic* therapist/client interactions. Unlike the critical care framework's conception of paternalism, these competing definitions are not helpful for considering whether and when an instance of CBT might be paternalistic – and subsequently problematic for successful treatment – and when CBT reflects a sound therapeutic alliance.

By the end of this chapter, I will have illuminated why the critical care framework's conception of paternalism as exerting a measure of control over another (or attempting to do so) allows the concept of paternalism to help capture particular breakdowns in the therapeutic alliance better than the competitor accounts that I reviewed. Our discussion for this chapter will proceed in the following manner. In this chapter's second section, I provide an overview of depression and how to understand it. My overview includes the DSM-V criteria for major depressive disorder, as well as some criticism of the DSM's approach. I will present Matthew Radcliffe's account of depression as involving a change in existential feeling, in how the world

appears to the depressed person. I connect depression to negative cognitive patterns about how one perceives oneself, others, and one's future. Having provided a brief overview of depression, I proceed in this chapter's third section to describe the workings of cognitive behavioral therapy. This includes an explanation of how CBT can be empowering for patients with depression, an overview of the focus of CBT's treatment and its rationale, and the methods that therapists practicing CBT employ. With a picture of depression and CBT in hand, I proceed in the final section to discuss the concept of paternalism in relation to CBT. I make the case that the conception of paternalism as an attempt to exert a measure of control over another is helpful for evaluating the therapeutic alliance in CBT in a manner that the competing conceptions of paternalism I have reviewed are not. The critical care framework, through showing how its conception of paternalism helps us to understand how paternalistic care problematizes treatment for depression, demonstrates the kinds of fruitful contribution that care ethics, when understood in a non-idealized fashion, can make to discourse on depression.

A couple of brief and final points before we move on to our overview of depression. First, although I recognize the value of cognitive behavioral therapy for treating depression, I do not want to suggest that CBT will be sufficient for everyone who is struggling with depression. As with other kinds of care, it is important to be open and attentive to what practices of care are and are not working to meet someone's needs, and reflexively proceed from there. Second, I am not proposing that CBT is a *solution* to depression being widespread. CBT can be helpful for moving persons out of a depressed existence, and it can help to build resilience from relapse into depression. But there are important questions about the *sources* and *determinants* of depression. It would be a mistake to cast all of these as individualized phenomena that are outside the scope of social criticism, such as having "poor genetics" (which would ignore epigenetics) or going

through traumatic experiences, as though encompassing social structures or agendas might not enable or facilitate these. We will return to this line of thinking in the dissertation's conclusion, where I bring up the social determinants of mental health and a future direction for the critical care framework to contribute to discussions on depression.

4.2 Conceptualizing Depression

Entire books have been written in an attempt to conceptualize and offer clarification on depression. While a mere portion of a dissertation chapter cannot deal with the question of "what is depression?" in a comprehensive manner, it is nevertheless important to provide some clarity on how I understand depression for the ensuing discussion. While there is widespread agreement among health care professionals that depression is a significant health concern, there is not unified consensus on how depression should be understood. Aaron Beck and Brad Alford note that one obstacle which muddies the waters is semantic in nature. The word "depressed" is sometimes used to refer to a particular feeling or mood, and sometimes used to refer to a particular kind of mental health condition:

> Not infrequently, normal people say they are depressed when they observe any lowering of their mood below their baseline level. A person experiencing a transient sadness or loneliness may state that he or she is depressed. Whether this normal mood is synonymous with, or even related to, the feeling experienced in the abnormal condition of depression is open to question. In any event, when a person complains of feeling inordinately dejected, hopeless, or unhappy, the term depressed is often used to label this subjective state.[203]

Even when the differing semantic uses for the word "depression" are recognized, Beck and Alford note disagreement among psychologists and psychiatrists regarding whether depression as

[203] Aaron T. Beck and Brad A. Alford, *Depression: Causes and Treatment*, 2nd edition (Philadelphia, PA: University of Pennsylvania Press, 2009), 8.

a mental health condition exists along a continuum with those mood swings where one "feels down", or whether depression involves a qualitatively distinct kind of experience.[204]

4.2.1 The DSM Criteria for Major Depression

We'll start with the account of depression found within the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, hereafter referred to as the DSM. The DSM is routinely consulted by mental health professionals within the United States. Additionally, DSM criteria for depression have been used for measuring depression rates in the United States by organizations such as the Center for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHS). The current iteration of the DSM is the fifth edition (DSM-V), which includes various categories for depression. My discussion will focus on "major depressive disorder" or "major depression", which according to the DSM-V, "represents the classic condition in this group of disorders".[205] According to the DSM-V, major depression is diagnosable when an individual exhibits five or more symptoms from a list of nine during a singular two-week period, with at least one of the symptoms either being "depressed mood" or "loss of interest or pleasure". The symptoms that the DSM-V uses to diagnose major depression are as follows:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note**: In children and adolescents, can be irritable mood).
2. Markedly diminished interest or pleasure in all, or almost all, activities most day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day. (**Note**: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.

[204] Beck and Alford, *Depression*, 9-11.
[205] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (Arlington, VA: American Psychiatric Association, 2013), 155.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear or dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.[206]

To indicate that a person is suffering from major depression, the 5+ symptoms that an individual displays must also cause "clinically significant" distress or impairment in social, occupational, or other important areas of functioning, and also cannot be attributed to the physiological effects of a substance or another medical condition.[207]

While the DSM-V is consulted as part of standard practice within the U.S. for depression diagnosis, the DSM nevertheless receives some criticism for its (re)presentation of major depression.[208] Kevin Aho and Charles Guignon are critical of the DSM for discussing depressive symptoms in a decontextualized manner, writing that "whereas psychoanalysis regarded an individual's behavior as a sign of inner processes or unconscious conflicts that need to be explained by psychoanalytic theory, the DSM-III and its successive editions, rejected all theory and instead focused strictly on identifying objectively discernable correlations between behavioral phenomena and diagnoses".[209] Aho and Guignon argue that consequently, a person with depression comes to be regarded as the locus for "decontextualized clusters of

[206] American Psychiatric Association, *Diagnostic and Statistical Manual for Mental Disorders*, 160-161.
[207] American Psychiatric Association, 161.
[208] A prominent critic of the DSM's criteria for depression, which I do not discuss here, is Jerome Wakefield, who argues that the DSM's criteria is overly permissive to the point that it conflates depression with "normal" experiences of sadness, such as grieving after the death of a loved one. I do not spend time talking about Wakefield in part because I do not want to get into his account of disease as "harmful dysfunction", which underlies his conceptualization of proportionately appropriate sadness and grief vs. depression.
[209] Kevin Aho and Charles Guignon, "Medicalized Psychiatry and the Talking Cure: A Hermeneutic Intervention". *Human Studies* 34, no. 3 (2011): 295, DOI: 10.1007/s10746-011-9192-y.

symptoms".[210] They claim that this results in an understanding of the person's psyche and of depression that is mechanistic.[211] Aho and Guignon further argue that if depression is regarded as analogous to physical diseases like diabetes or high cholesterol, we end up with an overly medicalized approach that regards depression as something whose symptoms are to be controlled through a lifetime of continued medication.[212] Just as chemical interventions as opposed to a "talking cure" (e.g., psychotherapy) are appropriate for diabetes and high cholesterol, so too can it appear sensible for pure medication be subscribed at the expense of psychotherapy.[213]

4.2.2 The Relationship Between Existential Feeling and Depression

In *Experiences of Depression: A Study in Phenomenology*, Matthew Ratcliffe critiques the DSM's presentation of depression on somewhat similar grounds as Aho and Guignon. Ratcliffe is critical of the DSM's mix and match approach for symptoms of major depression, noting that "one of two symptoms plus four of an additional seven allows for considerable variety".[214] Furthermore, he contends that these criteria themselves are rather cursory –identifying depression by "depressed mood", for example, is not particularly helpful when it is vague how that should be understood.[215] Ratcliffe further claims that the DSM describes some characteristics of depression in a manner that does not adequately reflect experiences of depression:

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[210] Aho and Guignon, "Medicalized Psychiatry and the Talking Cure", 296.
[211] Aho and Guignon., 298.
[212] Aho and Guignon, 296.
[213] Their point (and mine as well) is not anti-medication, but rather than medication can be a helpful supplement, and not sufficient for treating depression on its own.
[214] Ratcliffe, *Experiences of Depression,* 4.
[215] Ratcliffe, 4. While the DSM-V criteria included above mentions "e.g., feels sad, empty, hopeless", these are nevertheless distinct feelings, and feeling them together creates a distinct experience from feeling sad without also feeling empty, for example. The note that in children and adolescents the mood might be "irritable" rather than "depressed" further muddies the waters.

> Other symptoms are described in ways that are not just cursory but misleading. For instance, it is noted that 'even the smallest tasks seem to require substantial effort' (DSM-IV-TR, p.350; DSM-5, pp.163-4). This does not accommodate those cases where action seems not merely difficult but impossible, in a way that is not attributable solely to the amount of actual or perceived effort required. Impaired social function is briefly mentioned as an effect of depression, and thus – it would seem – as something caused by it rather than integral to it. Yet this is in tension with the insistence, in almost every first-person account, that changes in social and interpersonal relations are absolutely central to experiences of depression and their development, rather than by-products of depression.[216]

Ultimately, Ratcliffe contends that the DSM-V criteria present a picture of depression that is disjointed, and that consequently qualitatively distinct experiences can fit the DSM criteria for a "major depression" diagnosis.[217] In addition to the above heterogeneity, however, Ratcliffe contends the DSM does not recognize something that underlies most experiences of depression. Ratcliffe argues that depressive experiences involve what he calls to a shift in *existential feeling*: "seemingly different depression 'symptoms', such as bodily discomfort, altered experience of time, inability to act, estrangement from other people and deep despair are not mere accompaniments to each other but inseparable aspects of a unity shift in 'how one finds oneself in the world'".[218]

Ratcliffe, to explain the notion of 'how one finds oneself in the world', draws on the work of Edmund Husserl. When used in this phenomenological connection, "the world" does not refer to an object (e.g., the planet, the universe) that one's intentional thoughts can be directed toward, with propositions such as "the world is flat" or desires such as "a more just world". Rather, "the world" represents one's sense of reality, which frames how we relate to the various persons, places, and things that we might have intentional thoughts and feelings about. It underlies, for example, speculation that a particular state of affairs is the case, or hope that a

[216] Ratcliffe, 5.
[217] Ratcliffe, 6.
[218] Ratcliffe, 32.

particular state of affairs has transpired. The world is the psychological backdrop against which one forms individuated attitudes, beliefs, desires, and so on. and so on. Ratcliffe describes the world as the "phenomenological framework in the context of which perceiving, remembering, imagining, anticipating, doubting, believing, and so forth are intelligible possibilities for a person".[219] The world is furthermore experienced as shared with others – one has a sense of belonging in relation to various places, things, and other beings (including other persons). Whether we experience or think about another person in a personal or impersonal way, we have a background sense of residing in the same world as the one who occupies our awareness.[220]

Ratcliffe argues that the world, understood as our sense of reality which our intentional thoughts are situated within, is profoundly altered in depression:

> experiences of depression involve a change in the overall structure of experience, in terms of which a variety of symptoms – including despair, bodily discomfort, inability to act, guilt, worthlessness, anxiety, estrangement from other people – are to be understood. I refer to this as an 'existential change', by which I mean an all-enveloping shift in one's sense of 'belonging to a shared world', in something that all of one's thoughts, experiences, and activities more usually take for granted.[221]

The particular kind of existential change that Ratcliffe implicates in depression is a change in existential feeling, which is a pre-intentional way of "finding oneself in the world". It is important to underscore that the "feeling" in existential feeling is not an emotion such as "happy" or "sad', but a kind of orientation and openness towards the world, of seeing the world as "inviting" certain possibilities.[222] Whereas intentional emotions are directed at something

[219] Ratcliffe, 19.
[220] Ratcliffe, 17.
[221] Ratcliffe, 14-15.
[222] Ratcliffe mentions several examples of feeling in this way that are not emotions: "People sometimes talk of feeling alive, dead, distant, detached, dislodged, estranged, isolated, otherworldly, indifferent to everything, overwhelmed, suffocated, cut off, lost, disconnected, out of sorts, not oneself, out of touch with things, out of it, not quite with it, separate, in harmony with things, at peace with things or part of things. There are references to feelings of unreality heightened existence, surreality, familiarity, unfamiliarity, strangeness, isolation, emptiness, belonging, being at home in the world, being at one with things, significance, insignificance, and the list goes on". Matthew

(e.g., one is angry that X occurred), and some moods can be understood as generalized emotions that are not directed at a specific object (e.g., one is in a sour mood), existential feeling underlies the kinds of moods and intentional emotions, and their degrees of intensity, that one is capable of having.[223]

The relevance of existential feeling for depression is illustrated through Ratcliffe's discussion of hopelessness. To lose hope in regard to some project, goal, dream, etc., is to cease to have hope (as an intentional emotion) that X will occur. Someone can suffer simultaneous loss of several intentional hopes – as a result of some occurrence, one no longer hopes for X, Y, Z, and so on. A depression that feels hopeless is not, however, just a matter of losing however many intentional hopes – in other words, the fact that someone has lost a certain number of intentional hopes does not itself make someone depressed. Rather, such a depression involves a *diminished capacity of one's ability to hope at all*, of seeing the world as a place that offers hope. This is the difference between loss of hopes (intentional) and loss of hope (existential).[224] A diminished capacity for hope explains not entering into hopeful moods, and one's intentional hopes will be impacted. I think that in some cases, the collapse of a system of intentional hopes or of some hopes that are fundamental enough could trigger feedback that causes a shift in existential feeling towards hopelessness, something which fits with the view that stressful events often precede depression as a trigger.[225] But the loss of hope is not reducible to either one of those things.

Ratcliffe, *Feelings of Being: Phenomenology, Psychiatry, and the Sense of Reality* (New York, NY: Oxford University Press, 2008), 68.

[223] Ratcliffe, *Experiences of Depression*, 37.

[224] Ratcliffe, 105-110.

[225] Charles L. Raison, Lucile Capuron, and Andrew H. Miller, "Cytokines Sing the Blues: Inflammation and the Pathogenesis of Depression", *Trends in Immunology* 27, no. 1 (2006): 24-31. DOI: 10.1016/j.it.2005.11.006; Andrew H. Miller, Vladmir Maletic, and Charles L. Raison, "Inflammation and its Discontents: The Role of Cytokines in the Pathophysiology of Major Depression", *Biological Psychiatry* 65, no. 9 (2009): 732-741. DOI: 10.1016/j.biopsych.2008.11.029.

Ratcliffe's notion of existential feeling can helpfully situate features of depression experiences, so that people with depression do not just appear "decontextualized clusters of symptoms". For example, Ratcliffe's notion of existential feeling can helpfully situate three cognitive patterns that Aaron Beck and Brad Alford identify in people with depression. These cognitive patterns are interpreting one's interactions with their surroundings (including other people) in an overly negative way, viewing oneself in a negative way, and anticipating a negative future.[226] When interpreting the environment in a depressive manner, one "automatically makes a negative interpretation of a situation even though more obvious and plausible explanations exist".[227] Such interpretations include selective attention to negative experiences, regarding obstacles as insurmountable, and interpreting widespread deprecation towards them (e.g., interpreting a neutral remark as critical).[228] When viewing oneself in a negative way, depressed patients devalue themselves, often making sweeping generalizations about themselves based off localized actions and behavior, with these being regarded as deficiencies that dominate their conception of self. This can lead into self-rejection.[229] When it comes to negative expectations of the future, depressed patients ruminate about badness that the future will hold. Beck and Alford note that "their anticipations of the future are generally what they view as an extension of their present state. If they regard themselves as currently deprived, immobilized, or rejected, they visualize a future in which they are continually deprived, immobilized, or rejected".[230] The upshot is that since depressed persons consistently make negative conceptualizations about self,

[226] Beck and Alford, *Depression*, p. 226.
[227] Beck and Alford, 227.
[228] Beck and Alford, 227-229.
[229] Beck and Alford, 229-230.
[230] Beck and Alford, 230.

environment, and future, they end up having particular affective responses like negative moods and undergo alterations in motivation.[231]

It makes sense that if one's sense of reality is devoid of certain kinds of possibility, part of seeing reality that way will be accompanied with cognitive patterns. That one sees the world as a place with no possibility for redemption, for example, would be reflected in cognitions that one is unworthy of kindness, which can in turn lead to particular affections (intentional guilt as a result of an interaction) and so on. Additionally, the notion of existential feeling binds together the cognitive components of environment, self, and future. These are not additive components, but interrelate based on how one finds oneself in the world. Regarding an obstacle as insurmountable in a non-contingent manner (environment) has implications for how one regards one's self (one is incapable) and the future (one will never surmount it).

By situating one's cognitive distortions within the world that one inhabits, we can ask questions about the existential feeling that these distortions reflect. If having certain cognitions is connected in a non-piecemeal way to finding oneself in the world in a certain way, then challenging the very working of those cognitions (e.g., not just about item X, item Y, and so on) could have implications for how one finds oneself in the world, which would help validate the importance of psychotherapy. At the same time, an account of existential feeling might help us be patient toward the struggles some people have with overcoming their cognitive distortions or who end up relapsing, and not just wish to respond paternalistically to those who "won't help themselves". Additionally, if existential shifts are indeed *shifts*, questions arise about why these shifts occur, which can pave the way for a discussion of the social determinants of health. We

[231] Beck and Alford, 231, 234

can ask what social determinants might contribute to the occurrence of existential shifts such that the world appears hopeless, bleak, and so on.

While there is much more that could be said about the concept of depression, I have enough to formulate the working account I'll be using: depression involves a kind of orientation towards the world, which has implications for how one experiences oneself, one's environment, and one's future. Discussion about negative cognitions and affect (as depressive symptoms) can be helpfully situated within the kind of existential feeling that someone who is depressed experiences. Depression is not, therefore, just being inordinately sad.

4.3 Cognitive Behavioral Therapy as a Treatment for Depression

In the previous chapter, I reviewed and critiqued some different conceptions of paternalism that other thinkers have put forward. According to these accounts, when coupled with a motivation to secure or improve the wellbeing of another person, paternalism has been conceptualized as interference with their freedom, intervention in their life, or overruling their judgment with one's own.[232] I raised some objections to these accounts of paternalism, arguing these conceptions are not cohesive with the inherent relationality of human beings. Positing that interference constitutes paternalism, for example, presents the individual as isolated and atomistic, one who is unencumbered in their "default state". Various social restrictions and limitations individuals

[232] The fuller definitions for these conceptions were: "The interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced" (Gerald Dworkin); "X acts to diminish Y's freedom, to the end that Y's good may be secured" (John Kleinig); "Action A is parentalistic if and only if (a) P believes that A is an intervention in S's life; (b) P decides to perform A independently of whether S authorizes A at the time of the performance; (c) P believes that A will contribute to S's welfare; and (d) P performs A for this reason."(John Kultgen); "Paternalism by A toward B may be characterized as behavior (whether through action or omission of action) (a) aimed to have (or to avoid) an effect on B or her sphere of legitimate agency (b) that involves substitution of A's judgment or agency for B's (c) directed at B's own interests or matters that legitimately lie under B's control (d) undertaken on the grounds that compared to B's judgment or agency with respect to those interests or other matters, A regards her judgment or agency to be (or as likely to be), in some respect, superior to B's" (Seana Shiffrin).

experience are represented as consequent to this default state, and when these are for the individual's benefit, they are instances of (perhaps justified) paternalism. From the relational standpoint of care ethics, where the person's "default state" is someone who is bound up in relations with others, and whose identity is itself relational, such notions of paternalism have limited applicability at best and distort our understanding of how we relate to each other at worst. From a critical care perspective, part of understanding any relationship involves consideration of the limitations and boundaries that help to define that relationship. If we want to determine whether paternalism is afoot, we should not just check whether there are social limitations and boundaries at play, and conclude the presence of interference (and therefore paternalism) if they are found. Paternalism involves something more robust – exerting a measure of control over another in order to secure some benefit for that person.

With this account of paternalism, I will consider the psychotherapy known as cognitive behavioral therapy, often abbreviated as CBT.[233] I have a few reasons for selecting CBT and its treatment of depression as the context for our discussion of paternalism. CBT is one of the most prominent modes of treatment that has been helpful for people struggling with depression. My interest in examining CBT goes beyond this, however. Discussing the particular aims of CBT is especially helpful for bringing out the problems that I have with competing accounts of paternalism. Cognitive behavioral therapists aim to get their clients to both recover from depression and develop resilience against relapse. In short, they work to help their clients "become their own therapist" by empowering them in a particular manner, which helps them to curb cognitive distortions from gaining a foothold.[234] Although "empowerment" has various associated meanings in health care settings, which include "self-efficacy, self-management, self-

[233] American Psychiatric Association, "How Do I Choose Between Medication and Therapy?"
[234] Beck, *Cognitive Behavior Therapy*, 9.

care, patient participation, patient engagement, patient involvement, expert patient, shared decision-making, and health literacy",[235] a particularly relevant aspect of empowerment for our purposes is self-efficacy. Albert Bandura describes self-efficacy as an individual's belief about their capacity to execute the behaviors that are necessary for achieving certain outcomes.[236] Bandura writes that diminished self-efficacy can contribute to depression by leaving someone with unfulfilled aspirations, leading them to believe they cannot form or maintain the kind of social relations that will bring them satisfaction in life, or making their intrusive and ruminating thoughts seem inevitable.[237] Having unfulfilled aspirations or missing out on having a particular kind of relationship could make someone sad without also bringing about depression (e.g., a particular intentional hope that one has is frustrated, but the world does not appear devoid of hope). Nevertheless, we can still make sense of a connection between the world appearing to be without certain possibilities and these three things Bandura describes. Ratcliffe mentions how an existential shift that makes some possibilities feel closed off can include the sense that others can still achieve what one cannot: "it is there [in the world] for them but not for me".[238] For a depressed individual, empowering them by helping them to recognize that they are capable of realizing certain achievements will be bound up with altering their feeling of the world and its possibilities.

The methods that CBT uses aim to empower patients in their thinking and prompt them to shift out of the existential feeling underlying depression. Just because something has the aim

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[235] Paloma Garcimartín Cerezo, Maria-Eulália Juvé-Udina, and Pilar Delgado-Hito, "Concepts and Measures of Patient Empowerment: A Comprehensive Overview", *Rev Esc Enferm USP* 50, no. 4 (2016): 665, DOI: 10.1590/S0080-623420160000500018. In their literature review of articles whose titles contained one of the aforementioned words, Cerezo et al found 17 distinct definitions of patient empowerment.
[236] Albert Bandura, "Self-Efficacy: Toward a Unifying Theory of Behavioral Change", *Psychological Review* 84, no. 2 (1977): 193, DOI: 10.1037/0033-295X.84.2.191.
[237] Albert Bandura, "Self-Efficacy", in *The Corsini Encyclopedia of Psychology, Volume 4,* 4th edition, eds. Irving B. Weiner and W. Edward Craighead (Hoboken, NJ: John Wiley & Sons, 2010): 1535.
[238] Ratcliffe, *Experiences of Depression*, 52.

of empowerment does not mean that it cannot be controlling. We can see this in action when people are "empowered" in a particular way, toward specific ends, in specific ways. Isaiah Berlin was concerned with specious empowerment in his caution against "positive liberty" (e.g., Rosseau's infamous "forced to be free" remark). [239] Although I reject Berlin's solution that we restrict our theorizing and social agendas to working with "negative liberty", when that is conceptualized as freedom from interference, we can nonetheless appreciate his concerns. When CBT is practiced as intended, it does not consist in therapists dictating things to their patients. Their methods are collaborative and nuanced. Compared to the critical care framework's account of paternalism as involving control, the accounts of paternalism as involving interference, intervention, and substitution of judgment have difficulty appraising the methods of CBT. These accounts of paternalism do not appreciate when these methods are practiced in an empowering manner that will help clients overcome depression, and they struggle to anticipate when they enter into problematic territory that threatens the therapeutic alliance and stymies recovery from depression.

4.3.1 Cognitive Behavioral Therapy's Focus and Rationale

Cognitive behavioral therapy treats depression through targeting cognitive distortions in depressed patients. The targeted cognitions are referred to as "distortions" because people who manifest them form expectations and beliefs about themselves, their interactions, and their future that are unrealistic and maladaptive. I mentioned earlier some cognitive distortions when discussing Beck and Alford's cognitive triad of negative thoughts about environment, self, and future – these cognitive distortions included selective attention to the negative experiences,

[239] Berlin, "Two Concepts of Liberty", 194.

overgeneralization, and excessive rumination that renders one inert. Cognitive distortions are the focus of CBT because it operates on the premise that a person's thoughts (their interpretations of interactions, situations, and so on) have an influence on their emotions and behavior. Shedding distorted patterns of thinking can subsequently result in a corresponding improvement in mood and behavior.[240]

Cognitive distortions often involve automatic thoughts. A person exhibits distorted thinking without being aware that particular thought patterns are taking place. A therapist practicing CBT brings attention to these patterns of thought. Their clients are encouraged to "step back" and scrutinize their initial interpretation of themselves, of their situation, and so on when they recognize that distortive patterns of thinking are occurring. Georgia Panayitou provides a helpful overview of this aspect of CBT:

> The goal of the cognitive component of CBT is to increase awareness of the role of cognitions and interpretations on mood and behavior, to train the client to identify cognitive distortions, and to come about with more realistic interpretations of situations. The aim is *not* to attach silver linings to difficult situations, but to realize and mitigate the exaggeration, persistent self-blame, and stable, over-generalizations that often sustain negative thinking.[241]

A therapist who practices CBT works with depressed clients to challenge their acceptance of the automatic and deprecating thoughts that arise in their depression. Stirling Moorey explains that "CBT for depression is not about challenging all negative thoughts but about identifying which thoughts are realistic and which thoughts are distorted or unhelpful".[242] The task for a therapist in CBT involves getting the client to see when interpretations that follow from cognitive distortions are less plausible than alternative explanations. Following a situation where the client did not

[240] Beck, *Cognitive Behavior Therapy*, 3, 12.
[241] Georgia Panayitou, "Major Depression: A Cognitive-Behavioral Perspective to Pathology, Case Conceptualization, and Treatment", p. 115.
[242] Stirling Moorey, "Depression", in *The Therapeutic Relationship in Cognitive Behavioral Therapy*, eds. Stirling Moorey and Anna Lavender (Los Angeles, CA: Sage Publishing, 2019), 59.

successfully complete something they set out to do, a therapist might work on getting their client to challenge acceptance of their initial response that "I can't do anything right", which is an overgeneralization, with a more realistic assessment like "I struggle with this specific task". In addition to challenging the acceptance of cognitive distortions, CBT can also work to mitigate the generation of these thoughts, which is accomplished through engaging with the patient's core beliefs about themselves, the world, and other people. For instance, attempting to get a patient to have "I struggle with this specific task" as their first thought (rather than an overgeneralization) might involve addressing underlying beliefs about oneself and how one's actions reflect one's merit.[243]

CBT works not just to mitigate the occurrence of cognitive distortions, but to train clients to identify when cognitive distortions are occurring and to deal with them when they have arisen. As such, CBT is considered to have the educative goal of helping the client "become their own therapist".[244] We can see how becoming one's own therapist would improve self-efficacy among the third point that Albert Bandura mentions, that is, feeling unable to control intrusive or ruminating thoughts. Insofar as cognitive distortions interfere with the other two points Bandura mentions (fulfilling one's aspirations and forming/maintaining significant relationships), CBT can improve self-efficacy among those dimensions as well.

Ratcliffe's notion of existential feeling provides further elucidation on how CBT could be helpful for someone struggling with depression. It is understandable how automatic thoughts that portray oneself, one's interactions, and one's future in an unrealistically negative light will be generated when the world appears devoid of certain possibilities (such as hope, redemption, and so on). Challenging the plausibility of these automatic thoughts could have a reverberating effect

[243] Beck, *Cognitive Behavior Therapy*, 3.
[244] Beck, 9.

on one's sense of the world. Core beliefs about one's self-worth can be bound up with how one sees the world, being both supported by and supporting it. If the world has no chance of redemption, one's sense of self will be shaped by this (e.g., one is unworthy of praise or affection). Subsequent cognitions will then appear to offer confirming evidence, such as selective attention to and magnification of things that reflect negatively on oneself, cyclically reinforcing negative self-conceptions that are at home in the world being a particular way. Altering someone's self-conception has ramifications for how they find themselves in the world because the former is bound up with the latter.

4.3.2 Guided Discovery and Collaborative Empiricism

CBT employs various methods and techniques, but of particular importance for CBT in general and for our discussion in particular are *guided discovery* and *collaborative empiricism*. Guided discovery is a process that therapists use to help their clients identify distorted thoughts, distorted patterns of thought, and unrealistic core beliefs. In guided discovery, the therapist, rather than lecturing or debating, asks questions to help their client evaluate beliefs and eventually adopt more realistic attitudes.[245] To illustrate how guided discovery work, let us return to a prior example of overgeneralization – the thought that "I can't do anything right", which is liable to cascade into further thoughts such as "I am a loser". A therapist might ask "Let's suppose your sister did not complete the same task. Would you say that she cannot do anything right?" If the client answers "Well, no", the therapist can follow-up with "If your sister did not complete this same task, would you consider your sister to be a loser?" If this is followed again with "No", the therapist can pose a question like "If these thoughts aren't accurate for your sister, why should

[245] Beck, 10.

they be accurate for you?" Additional questioning might include "Do you think your sister thinks you can't do anything right?". An answer of "no" can be offered as a further strike against the overgeneralization, while an answer of "yes" could be unpacked through further questioning (e.g., "what makes you think your sister holds this view?").

Therapists, of course, need to learn about their patients in order to develop an understanding of the extent and severity of cognitive distortions. The impact of a strained relationship with one's sister would need to be considered differently than a relationship that (historically) has been harmonious. If the client has sound reasons for thinking that their sister regarded them as a loser, a therapist might explore why a client need not agree with their sister's assessment, an avenue they would not have to do otherwise. Judith Beck writes, "Therapists do not generally know in advance to what degree a patient's automatic thought is valid or invalid, but together they test the patient's thinking to develop more helpful and accurate responses."[246] This brings us to the second method, collaborative empiricism, where therapist and client form hypotheses about the client's cognitions. Continuing off the previous example, competing hypotheses might be "My sister believes I am a loser" and "You had a heated argument with your sister, and what she said reflects her frustration in that moment, rather than a deep-seated belief that she has about your worth". Therapist and client can work to develop ways to test these hypotheses, and the results can be further discussed.

The test component of collaborative empiricism often takes the form of homework for the client to do in-between sessions. Sometimes the hypotheses and any corresponding homework can be simpler than what I discussed in the previous example. Stirling Moorey writes that, "small success experiences, e.g., scheduling three activities you used to enjoy but have been avoiding,

[246] Beck, 10.

demonstrate that change is possible".[247] One's accomplishments in their homework assignments can contribute to the development of self-efficacy,[248] although sometimes a therapist might need to help someone with a negative selective bias see how something was successful (if the proposed hypothesis was "I am capable of scheduling three activities", then even if someone only ended up doing two activities that is a significant change over not doing any). Successful homework assignments and the possibility for change that they indicate can provide a wedge that helps dislodge the existential feeling supporting one's depression.

4.4 Paternalism, Guided Discovery, and Collaborative Empiricism

CBT can and should be understood as a particular kind of care that therapists provide to clients, which has significant ramifications not just for how the client lives in the world but how they perceive the world. If we want care ethics to make an informed contribution to encouraging people with depression to participate in CBT, it is important to be able to grasp the strengths of CBT and where the potential pitfalls for a therapeutic relationship lie. Our investigation between the merits/dangers of CBT on the one hand, and how paternalism should be conceptualized, is a dialogical one. When paternalism is construed in some ways rather than others, is it more helpful as an ethical concept for thinking about the therapist/client relationship? In turn, do some conceptions of paternalism make more sense for being better able to appreciate how the client/therapist relationship works in successful therapy? As I mentioned in the previous chapter, the motivation for paternalism tends to be constant across accounts – paternalistic actions, policies, and so on are performed to secure or promote the wellbeing of another. Where the accounts I reviewed in the previous chapter differ are the *what* of paternalism, not the *why*. The

[247] Moorey, "Depression", 53.
[248] Moorey, 54.

accounts of paternalism that I criticized understood this "what" as interference with someone's freedom, intervention in their life, or substituting one's judgment for theirs. I proposed, in contrast, that we understand paternalism as exerting a measure of control over another (or attempting to do so) for their benefit. I want to add now that understanding paternalism as being a matter of control coheres better with understanding healthy CBT practices than the competing accounts of paternalism that I reviewed.

Let us first consider the notion that paternalism constitutes interfering with another's freedom in order to improve their wellbeing. When paternalism is conceptualized as interfering with another's freedom to promote their wellbeing, there are issues with how applicable it can be to the therapeutic alliance in CBT. In particular, that conception of paternalism is unhelpful for illuminating situations where CBT falters because of a breakdown in the therapeutic alliance between therapist and client. If we were to assume that a therapist could not interfere with their client because their client voluntarily went to see them, charges of paternalism would be unable to find a foothold, but I do not think most who conceptualize paternalism as interference would go that route. The crux of the problem with paternalism as interference is rather that the definition is too broad for singling out and distinguishing problematic practices in CBT from good ones.

Let us recall John Kleinig's stance that the interference that constitutes paternalism includes interfering with someone's freedom to think what they do. When paternalism is understood in this fashion, it might appear helpful for tracking interactions between physician and patient where charges of paternalism could be raised, for example if a physician disrespects a patient's autonomy through inappropriately pressuring or manipulating their selection of treatment options. When we look outside that kind of scenario, however, we can see this

conception of paternalism does not apply to CBT in the same manner. Dialogue between care provider and patient is not a means to deciding upon a treatment but an integral component of treatment itself. When CBT is working well it is a prime example of not just doing what one thinks someone else needs without regard to their perspective. The critical care perspective can recognize that, thanks to its conception of paternalism as involving control. By contrast, if interfering with someone's freedom to think as they do is understood to be an example of paternalism, then the method of guided discovery appears to be inherently paternalistic, which is a problematic conclusion.

Remember that guided discovery involves a therapist working to illuminate particular discoveries for the client. The therapist's goal is for their client to cease having particular, distortive patterns of thought so that maladaptive thoughts do not dominate their mind. In some cases, therapists also aim to alter a client's distortive core beliefs when these are propagating and sustaining distortive patterns of thought. While concluding that guided discovery is inherently paternalistic would fit with what Michael Barnett has said about paternalism being manifest in relations of compassion,[249] I contend that such a conclusion fails to appreciate the particulars of the therapeutic alliance between therapist and client and fails to shed light on when CBT might be falling short of its potential in problematic ways. If guided questioning were to count as interference, and interference in those circumstances constituted paternalism because it was enacted for the client's wellbeing, then the method of guided questioning method (the method itself, not particular executions of it) would have the same categorical status as being manipulative or pushy for the sake of someone's wellbeing. Not only does this fail to consider the terms of the therapeutic relationship between patient and client, but it would stretch the label

[249] As discussed in chapter two.

of paternalism so thin that invoking it would accomplish little in discourse. It wouldn't really make sense, for example, to use the concept of paternalism to name and call attention to instances of pushiness in how a therapist is practicing guided questioning (would you be locating interference within interference?) If to avoid this conclusion, we attempt to reel back interference to not include influencing another's freedom of thought, it is unclear just how a charge of paternalism would find a foothold in CBT at all, given that CBT is all about thought.

John Kulgten's conception of paternalism (or parentalism) as intervention runs into a similar problem as the interference account, being either unable to find a foothold in CBT or having difficulty in discriminating practices. Remember that Kultgen's definition included the condition that one undertake action for the benefit of another "independent of their consent". Does agreeing to a therapy session mean the client has authorized any and all things a therapist will say or attempt during that session? Even if we bracket obvious abuses of power (e.g., sexual advances) this still runs into issues of disempowerment that go beyond just self-efficacy. Recall from our earlier discussion of empowerment and self-efficacy that although self-efficacy is an important component of empowerment there are other prosocial elements of "patient empowerment" such as patient participation, patient engagement, patient involvement, and shared decision-making. Self-efficacy is arguably not entirely separate from these explicitly prosocial elements as well. Being denied the capability to participate in a dialogue in a manner that one would like, especially a dialogue that is supposed to "help someone get better", is not liable to shift someone with depression into feeling like they are capable of having social interactions that are fulfilling.

Once we reject the blanket characterization that clients have consented to anything a therapist might say, we can see the difficulties with sorting out when the "independent of

consent" criterion would be satisfied within the context of CBT. Kultgen's view does gesture towards something crucial – therapists should ideally ask if someone wants to talk about something rather than forcing a discussion on that particular point. But some people might rather not be asked certain things in the first place, and it would be a peculiar demand if someone needed consent to ask for someone's consent (especially if this led to an infinite regress of needing to ask for consent). Additionally, given their goal of uncovering cognitive distortions, it might be important for a therapist to ask certain follow-up questions, even if a client indicates they are not interested in talking about something, such as "is there a reason that do you not want to talk about X"? It is important for our conception of paternalism to be able to distinguish asking questions and follow-up questions from forcing a conversation, and to be helpful for figuring out at what point the former (perhaps subtly) transitions into the latter. Parentalism as intervention is not adequate in this regard.

In some ways, Seana Shiffrin's conception of paternalism as substitution of judgment is more applicable to the therapist/client relationship than the previous two views. When compared to interference or intervention that is independent of consent, it is more readily apparent how substitution of judgment could crop up within a dialogue between therapist and client. Indeed, considering the therapist is not prone to accept or endorse certain views the client has (e.g., that their client is worthless), perhaps substitution of judgment would even seem to be one of the views that would cast CBT as inevitably paternalistic. On the contrary, however, Shiffrin's account still runs into some difficulties with being applicable to CBT, because her account stipulates that not just any substitution of judgment constitutes paternalism. To be paternalistic, substitution of judgment must be aimed at impacting someone's "sphere of legitimate agency" where that concerns "interests or matters that legitimately lie under their control". The puzzle in

a situation where someone seeks help from a therapist for treating depression is how to determine whether a therapist's judgment is being substituted for their client's over a sphere that "legitimately" lies under the client's jurisdiction. We might think that acting as though one knows another better than they know themselves is paternalistic. Is that what a therapist is doing in CBT? A therapist practicing CBT does not accept the patient's perspective that they are a worthless human being if the patient expresses that view, but it would seem curious to think that a therapist is being paternalistic on account of that.

How far does substitution of judgment in CBT need to go before it becomes paternalistic? While I think we ought to reject the notion that the relationship between therapist and client is inherently paternalistic simply because a therapist might consider something their client says reflect a cognitive distortion rather than a truth about themselves, we don't want to go too far in the other direction either. We might want grounds for raising the charge of paternalism if a therapist is seen as going too far. We wouldn't want to say the patient must just defer or be written off altogether simply because "they are depressed". As with my concern that I expressed about Kultgen' view, this would be rather disempowering for patients rather than empowering. Substitution of judgment gets us part of the way towards thinking about paternalism in CBT, but ultimately needs to be part of a bigger picture, one in which the therapist might be understood as *controlling*. Paternalism as control makes better sense of the therapeutic alliance between therapist and client while also being capable of capturing certain insights from its competitors (for example, cases where a physician can be understood as overriding patient autonomy). It is important for a critical care ethic to be capable of sorting out whether the work of a therapist is guiding and encouraging, or dictating and pressuring. A concept of paternalism as involving control is better equipped for doing that.

I want to discuss breakdowns in the therapeutic alliance further to bring out how paternalism as control for the benefit of another is a more helpful conceptualization of paternalism than its competitors. Judith Beck discusses important components for developing a successful therapeutic alliance with clients, which include sharing one's conceptualization and treatment plan, making collaborative decisions, and seeking feedback.[250] Beck describes the process of sharing one's conceptualizations with clients as follows:

> You will continuously share your conceptualization with patients and ask them whether it "rings true." For example, a patient may have just described a problem with her mother. You have questioned her to fill in the cognitive model. Then you conceptualize aloud, in summary form. "Okay, I want to make sure I understand. The situation was that your mother yelled at you on the phone for not calling your brother, and your automatic thought was, 'She doesn't realize how busy I am. She doesn't blame *him* for not calling *me*.' These thoughts led you to feel hurt and angry, but you didn't say anything back to her [behavior]. Did I get that right?" If your conceptualization is accurate, the patient invariably says, "Yes, I think that's right." If you are wrong, the patient usually says, "No, it's not exactly like that. It's more like..." Eliciting patients' feedback strengthens the alliance and allows you to more accurately conceptualize them and conduct effective treatment.[251]

Making collaborative decisions in a CBT session involves working with one's clients to set the agenda (e.g., what the client wishes to make sure is discussed in the session), seeking input on how to structure the session (e.g., whether to take a break in the discussion at some point), and co-constructing (rather than prescribing) homework assignments for collaborative empiricism. Seeking feedback involves both addressing issues that a therapist notices during therapy sessions, such as responding to a client appearing to become upset at something one said, and general solicitation at the end of sessions, such as checking whether the client felt misunderstood at any point or whether they would like to try something different next time.[252] Pondering whether a therapist might (even inadvertently) be attempting to control their client's recovery

[250] Beck, *Cognitive Behavior Therapy*, 18-20.
[251] Beck, 19.
[252] Beck, 19-20.

points us in the direction of the ingredients for good CBT that Judith Beck discusses more readily than notions of interference or intervention. A failure to co-collaborate is more about the control than it is about interference or intervention. When a problematic substitution of judgment occurs in a therapeutic relationship, such as a therapist failing to check whether their conceptualization of their client is accurate and just assuming it is, we should ask whether this reflects a symptom of control and look for specific patterns and at specific dynamics in the relationship (e.g., did the therapist just forget to check their conceptualization just this once, or is this a trend)?

Stirling Moorey, in his discussion of problems that can arise in therapeutics relationships, writes that "disagreements over tasks probably arise more often from poor therapist technique than anything else. Assigning homework tasks that are too difficult for the patient's level of depression, not relevant to the patient's goals and not clearly and collaboratively derived can mean the tasks are not completed and the working alliance put at risk."[253] Moorey recognizes that it is important for a therapist to be cognizant of concerns from their patients that the tasks involved in CBT are controlling and unfairly demanding. He offers some suggestions for how therapists can be responsive to those concerns. For example, a therapist might validate their client's feelings of being controlled and bullied in the past and assure their client that they do not want therapy to be that way. Therapists can also indicate to their client that if they feel misunderstood, demeaned, or fear their therapist cannot help, the two of them can work together in partnership to deal with these concerns.[254]

The discussion in this chapter has illustrated why it is important to construe paternalism as the exertion of control over another in order to secure some benefit for them. A conception of

[253] Moorey, "Depression", 54.
[254] Moorey, 57.

paternalism that helps to identify therapist's actions that can jeopardize the working therapeutic alliance with their client and prevent that relationship from helping their client recover from depression allows paternalism as a concept to serve as a regulatory red flag for both client and therapist. The threat of paternalism can and should invite reflection and dialogue concerning, for example, whether a therapist might be pressuring their patient to undertake particular experiments for the sake of collaborative empiricism and not respecting where their patient is at. As Beck has said, it is important to seek feedback from patients even when one believes the therapeutic alliance is not currently threatened, whether by paternalism or otherwise.

Beck's point above also helps to remind us of something important about care, which I have maintained throughout this dissertation, and which the critical care framework understands. Care is not an idealized, normative good. Care might meet some needs while failing to address others. In some cases, it will even create problems that give rise to their own needs. We should recognize CBT as a kind of caring relationship that can be of great help for depressed individuals, but which can be practiced in better and worse ways, and work to encourage anti-paternalistic practices. If we want care ethics to be helpful for people in determining whether and when CBT is right for them, we need to invoke a version of care ethics that helps furnish the conception of paternalism that we need. That is not all care ethics can or should contribute to discussions of depression, as we shall see in the conclusion. But it is an important start.

CONCLUSION

C.1 Future Research: Care as a Social Determinant of Health

In the preceding chapters I argued that care ethics must be vigilant about paternalism and that prescriptivist moral theories of care ethics do not have the necessary insight for recognizing how their prescriptions can perpetuate paternalistic care. For care ethics to fully realize its radical potential for social and political critique, it must contain resources for spotting, critiquing, and addressing paternalistic care. Care ethics as a critical framework not only has the needed conceptual resources for the task, but also helpfully informs our understanding of paternalism itself. Through demonstrating the lines along which paternalism must be understood if the concept is to make sense for relational beings, my account of care ethics can assist care theorists, and those who discursively draw on the language of care, in avoiding and critiquing problematic and unhelpful conclusions about the relationship between care and paternalism.

Through selecting a relational context in which to discuss the above points about paternalism, I brought our attention to another issue that care ethics needs to be able to grapple with. Depression, and the existential shift in feeling that underlies experiences of depression, is something that care ethics must be able to address. My care ethics framework can encourage people to be more open to receiving mental health treatment through legitimizing and addressing concerns they might have about being controlled. It recognizes that while therapies such as cognitive behavioral therapy can be paternalistic, they do not have to be, and that in fact when CBT is working well it is antithetical to paternalism. Of course, that is just one discussion among many potential and important ones that care ethics should be able to contribute to our thinking on depression. There is a lot more ground to explore between care ethics and depression than the

issues of paternalistic care that I have discussed. Of particular importance is the critical care ethics insight that our relationships occur within social-political contexts that can enable and constrain the possibilities for care in various ways. While the relationship between therapists and clients is important to consider, it is important for us to be able to contextualize that relationship, and the treatment of depression, within broader social settings and socio-political structures. Further work in this direction will continue to demonstrate the importance of the critical care framework. Indeed, I believe the critical care framework will prove to be a helpful resource for people who want to explore the relationship between depression and the social determinants of mental health.

When we account for the social determinants of health in our discussions on health, we are accounting for how a person's or population's life circumstances, which are shaped by social and political factors, impact their health outcomes. For our modest purposes here, we can utilize The World Health Organization's definition of the social determinants of health:

> The social determinants of health (SDH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.[255]

Various social determinants have negative mental health outcomes, including discrimination, low education, unemployment, homelessness, food insecurity, exposure to pollution, and climate change.[256] It is important for us to be cognizant of impacts the social determinants of mental

[255] World Health Organization, "Social Determinants of Health", WHO.int, World Health Organization, Accessed August 2, 2022, https://www.who.int/health-topics/social-determinants-of-health

[256] Ruth S. Shim and Michael T. Compton, "Social Injustice and the Social Determinants of Mental Health", in *Social (In)Justice and Mental Health*, eds. Ruth S. Shim and Sarah Y. Vinson (Washington, DC: American Psychiatric Association Publishing, 2021), 18-19. While the social determinants that impact mental health are more or less the same kinds of things as the social determinants of health in general, calling attention to the mental health impacts of social determinants is important because of the lack of attention that mental health treatment often receives. So, I use the phrase "social determinants of mental health" rather than just "social determinants of health" in order to highlight mental health impacts, but this phrasing is a matter of emphasis. To talk about the social

health have on the development of depression, and of the implications that the social determinants of health can have for depression treatment. When I discussed the methods of CBT in chapter 4, I mentioned that CBT works to help the client "become their own therapist", helping them to acquire mental tools and abilities for dealing with cognitive distortions that crop up in their thoughts. While a person can work to overcome cognitive distortions in their thinking, one cannot learn to master the social determinants of their depression in the same manner, and how one conceptualizes the relationship between their own negative thoughts and various social determinants can be encouraged in ways that make sense and in ways that are problematic. How CBT is practiced when one recognizes that there are social determinants and just not individual determinants at play in depression should be of important concern for care ethicists and cognitive behavioral therapists alike.

To address legitimate concerns that psychotherapies "overburden" patients with responsibility for their own mental health, it is important to develop a socially informed notion of empowerment.[257] I believe my critical care framework has the potential to be of enormous help for theorists and practitioners who undertake this project. An important avenue for future exploration is how my critical care framework could support a conceptualization of care not as a moral value, nor as a normative good, but as a social determinant of mental health itself. That is to say, the kind of care and quality of care that people receive or are capable of receiving, the kind of care and quality of care that people can provide or are capable of providing, and

determinants of mental health is not to posit a dualism between "bodily health" and "mental health", where these are not interrelated.

[257] Maria Orphanidou and Irini Kadianaki, "Addressing Individualisation in Depression: Towards a Socially Informed Empowerment", in *Conceptualization and Treatment: Dialogues from Psychodynamic and Cognitive Behavioral Perspectives*, eds. Christos Caris and Georgia Panayiotou (Cham, Switzerland: Springer International Publishing, 2021), 25-27.

expectations surrounding both of these things, are among the social determinants of their mental health.

To regard not just availability or access to mental health services like CBT as a social determinant of mental health, but CBT *itself* as being among the social determinants of mental health for a patient who receives CBT, socially situates client and therapist against a broader social and political backdrop.[258] Therapists who conceptualize not just the socio-economic access to psychotherapy, but the practices of care that are involved in psychotherapy themselves, as being among the social determinants of mental health can use that realization to encourage being socially conscientious of how their therapy could reinforce problematic social understandings and mental tolls. To consider a brief example, it is important to make sure that thoughts which are identified as distortions indeed make sense *as* cognitive distortions when a person's social context is considered. A negative thought that might be distortive for one individual might not be distortive for another individual who lives in the face of certain kinds of systemic oppression. Labeling thoughts that are formed in response to marginalization as distortions might (even when well intentioned) be inaccurate, unhelpful, and dismissive.[259] It is important to make sure CBT's collaborative empiricism considers broader social and political contexts and for a therapist to understand how their own work forms a part of their client's social context. The suggestion that care should be construed as a social determinant of mental health is just one line of thinking that points towards intellectual avenues that are worth pursuing, but it is a significant line of thinking

[258] Remember that, as I argued in chapter 4, CBT is a form of care. Consequently, practices of CBT would be included among potential social determinants of mental health.
[259] Sannisha Dale & Sherene Saunders, "Using Cognitive Behavioral Therapy Approaches in Assisting Individuals Coping with Marginalization, Oppression, and Discrimination", societyforpsychotherapy.org, Society for the Advancement of Psychotherapy, Published September 2018, https://societyforpsychotherapy.org/using-cognitive-behavioral-therapy-to-assist-individuals-facing-oppression/

whose pursuit could be a valuable asset for various thinkers whose work deals with the social determinants of mental health.

C.2 The End of the Road (For Now)

In this dissertation, I have shared my way of conceptualizing feminist care ethics, which I have referred as a critical care framework. I explained in chapter 1 that this critical framework, like other versions of care ethics, is premised upon four crucial insights. First, dependence on others is understood to be an inextricable part of the human condition. At various points in our lives, we will depend on others and others will depend upon us. Dependency *as such* is not a flaw with an individual to be avoided or overcome. Second, self-identity is construed in a relational sense. To some extent, one's sense of self involves a connection with particular others, and one's wellbeing is entangled with the wellbeing of particular others. Third, being concerned with the needs of particular others, like friends and family, is a proper avenue of moral concern. Furthermore, a care perspective does not respond to another as someone abstracted from the contingent world we share (e.g., as a member in the kingdom of ends), but as an embodied being with physical, mental, and social needs whom we have (or could have) some kind of relationship with. Fourth, emotional input is pertinent for moral deliberation. In particular, my account views our reasoning abilities and emotional faculties as interconnected.

My critical care framework shares some common ground with other accounts of care ethics, but as I explained in chapters 1 and 2, it has metaethical commitments that distinguish it from other prominent accounts. Our ethical understandings always reflect shared social understanding, rather than some transcendent vantage point accessible through faculties like reason or intuition. However, recognizing this social grounding of ethics does not mean

accepting a crass cultural relativism, where what is morally correct is relative to one's culture. My critical care framework partakes in moral criticism, though what I understand moral criticism to be differs from accounts that assume moral criticism is correct when we have tapped into the transcendent moral truth of the matter. My critical care framework engages in moral criticism through investigating "what makes sense", seeking answers in a pluralistic manner that draws upon various aspects of (shared) lived experience. Through determining what we think makes sense, we can gain or lose confidence in how we, a socially and historically situated group, are doing things. We gain or lose confidence that our ways of doing things, our institutions, etc., actually make sense when we examine the sources of their rationale, their implications (theoretical or in practice), and so on. The project of making sense is a reflexive and on-going critical endeavor. A new perspective might illuminate that we lacked a transparent understanding of our situation, and changing circumstances might mean something that made sense at one social and temporal point ceases to do so at another.

Care ethics, when construed as a critical framework and not a prescriptive moral theory, is better equipped to address the shortcomings of existent practices of care. It does not regard care itself as a moral value or a moral good, and this non-idealized approach can do better at problematizing relations of care. My account retains important insights from Carol Gilligan's pioneering work on care ethics while both moving beyond issues with Gilligan's original formulation and avoiding pitfalls that various accounts since Gilligan have struggled with. To demonstrate my approach's merit, I've shown how the critical care framework is better equipped for dealing with issues of paternalistic care, which present a serious obstacle for competing accounts of care ethics. Indeed, my critical care framework helps furnish a conception of paternalism that makes more sense than prominent understandings of the concept. These faulty

conceptions have often factored into discussions of paternalism and care, especially those that defend paternalistic care. The conception of paternalism that my account supports, where paternalism is understood as an attempt to exert some measure of control over another in order to secure some benefit for the one controlled, enables us to better understand the ways in which paternalism is problematic for relationships, and to better determine when paternalism is in fact occurring. This was brought into full force in chapter 4, that in the context of treatment for depression, we can see how this conception of paternalism makes more sense than competitors accounts.

Care ethics has come a long way in the 40 years since Carol Gilligan introduced it into the academic consciousness of psychologists and philosophers. But there are still important issues for care ethicists to sort out, both in refining how care ethics is best understood, and in realizing the various applications that care ethics can have. Care ethics as a critical framework, as I have developed here, is an important development in both regards.

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