

Being a caring “presence”: caring for the care experience

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ABSTRACT

Before being a pedagogical and philosophical category, caring is a practice embodied in actions, looks, postures, words. Caring is “presence”: according to Heidegger, it is “being-in-the-world-with-the-others”. Caring endows situations experienced in healthcare contexts with unique qualities, e.g. when we accompany the dying, or when we allow people who live in existential distress to experiment different opportunities to be themselves. Being a caring presence “is at issue for it”: the practitioners live an inextricable and problematic intertwining between personal and professional dimensions. The article questions how to support this presence from a pedagogical point of view. Self-care, understood as an educational, professional and self-learning practice, could be considered as an answer that allows us to go beyond the individual empowerment. Indeed, self-caring could be an essential condition to take care of the whole existential experience in the healthcare contexts. The very understanding of how this process could work is a question open to further investigation.

Keywords: *Caring Presence – Care Experience– Authentic Care – Self-Care – Self-Learning*

Essere “presenza” curante: aver cura dell’esperienza della cura

Prima di essere una categoria pedagogica e filosofica, la cura è pratica incarnata in gesti, sguardi, posture, parole. La cura è “presenza”: heideggerianamente, “essere-nel-mondo-con-gli-altri”. La cura dona qualità uniche alle situazioni vissute in contesti sanitari o socio-educativi. Per esempio, nei luoghi in cui si accompagna qualcuno nel suo morire o in cui si consente a coloro che vivono situazioni di disagio esistenziale di sperimentare possibilità altre di essere se stessi. Nell’“essere presenza di cura” del professionista “ne va di sé”, in un intreccio indistricabile tra dimensioni personali e professionali. L’articolo si chiede come poter sostenere, dal punto di vista pedagogico, la presenza di chi cura e individua nell’aver cura di sé, intesa come pratica professionale formativa e autoformativa, una risposta in grado di andare oltre l’empowerment individuale. L’aver cura di sé può infatti divenire condizione essenziale per aver cura dell’esperienza esistenziale vissuta nei servizi sociali o sanitari: occorre però comprendere come.

Parole chiave: *Essere presenza di cura – Esperienza di cura – Cura autentica – Cura di sé – Autoformazione*

If we do not wish to reduce care to mere technical assistance, we need to view it from a phenomenological perspective (Iori, 2006). Indeed, something capable of stirring us deeply is required if we are to perceive those characteristics of care that tend to be obscured by routine. It is here that works of art can come to our aid.

Let us imagine that we are on a visit to the Villa of the Mysteries in Pompeii. We fall under the spell of a fresco, *The Mask of the Silene*. An elderly silene is holding out a cup to a young satyr. The satyr looks into the cup, expecting to see himself, and sees a mask, that of the silene. The mask is being held up, in an extraordinary architecture of bodies, by another youth. The young satyr is absorbed and does not notice the presence of the other young man. In the cup, he sees the reflected image of *who he may become*: a silene *like* the man seated beside him. This discovery excites him. He is captivated by the rite of initiation that is unfolding. What he is experiencing in this moment is taking him elsewhere: it is engaging him in a formative, a self-formative, process¹.

In care situations: authentic experience as a *possibility*

What does this fresco have in common with the many and varied scenes of daily life at social and healthcare services? On the face of it, we might answer nothing. Yet if we begin to reflect on the meaning of such scenes, we discover that this is not true.

Just as in the mystery rite, the recipient of care in a care situation may be *taken elsewhere*. Within the routine of a hospital or other care institution or service, it can happen that, at particular moments, while persons are being examined or treated, doing physiotherapy or other activities, they *may truly engage with what they are experiencing*. In certain situations – which admittedly can be rare – the carers’ actions enable patients – or “clients”, to use the conventional term² – to undertake a search for the meaning of their painful and unwanted condition. They comprehend what it means to *be in* that condition, and how the situation into which they have “been thrown” is related to their past, present and, most certainly, their future existence.

In many social and healthcare services, healing, in the sense of recovery from illness, is precluded. Being cared for may coincide with the – harsh and dramatic – experience of dying: *hospices* are the emblematic example of this (Cramer, McCorkle, Cherlin, Johnson-Hurzeler, Bradley, 2003).³ Or it may imply daily coping with chronic conditions or irremovable existential suffering, as in services for persons with disability or mental illness. However, even in such settings, *within* such experiences, another experience *may* unfold, that of the self in *this* situation; a situation that *may* be understood as the “bringing to completion” of one’s life, the apprehension of one’s “ownmost possibility of being” (Heidegger, 1976; Binswanger, 2001). Just as the young satyr, on seeing the mask of what he may become, is propelled towards his future existential possibilities, so patients or clients,

¹ I am indebted to Angelo Franza for this insightful pedagogical reading of the fresco and the rite (Franza, in Mottana, 1996, pp. 22-39).

² In adopting the term “client”, now widely used to refer to the users of a service, I am mindful of the risk it bears of reducing persons to their specific care requirements.

³ I take *hospices* as a key example here on the basis of my own experience in training healthcare professionals and volunteers who operate in these contexts; this particular experience, among others, informs my reflections throughout the paper.

through the experience made available by their carers, may gain insight into how to cope with what is ahead of them. They may feel that it is possible for them to engage with that situation in their own original – authentic – way. From the medical point of view, their fate is sealed: the dramatic nature of what they will have to go through is not denied. But the carers' presence can bear witness to the opening up of existential possibilities, even in situations marked by such an evident and terrible limit. And the context in which this happens can help the cared for to experience this in full and to elaborate it as best they can.

The care experience *may* be transformed into an existential event. This is not guaranteed to happen. For it to be “possible” (Bertin, Contini, 2004), we must care for the care experience of patients and carers. The carers' role, their *presence* in this experience, is key.

Being a caring presence, taking on its intrinsic problematic nature

In the mystery rite, the silene's presence has peculiar characteristics. He does not turn his gaze towards the youth: he is looking elsewhere, almost as though he were disinterested. Yet his whole body is engaged in an effort, that of holding the cup out to the young satyr, in coordination with the assistant who is displaying the mask. The silene allows the youth the time – and the space – to contemplate himself in the cup, to make his discovery for himself. The youth is *free* of the silene's gaze. In other words, the elderly satyr does not constrict the younger one within a relation based on judgement: he does not judge whether young satyr's seeing is good enough. And the youth does not feel judged, therefore he is able to see what he sees, from his own perspective and position within the strange postural architecture represented in the fresco. He is simultaneously *obliged to see* – because the layout of the setting leads him to do so – and *free to see*, because he is able to experience this seeing *without feeling obliged* to do so.

In this experience it is possible to identify aspects of that “anticipation of resoluteness” that constitutes “authentic care” (Heidegger, 1976, p. 158). The silene's apparent distraction, belied by his bodily engagement, represents attention to the context or the overall situation, while at the same time remaining concentrated on a gesture and posture that facilitates the other in having *his own* experience.

So what does it mean *to be a caring “presence”*? What does it mean in contexts that are particularly moving and difficult such as the social and healthcare services?

“Presence” is used here as a translation of Heidegger's *Dasein*: that “being-in-the-world-with-others”, characterized by both “affective tone” and “knowledge”, by being involved, and immediately concerned, in and by the world. According to Heidegger, being-in *is Care*: that structural intertwining of the factual and the possible on which he based his projection of the world and of the self (*ibidem*; Iori, 2006, p. 96). Therefore, as human beings, *our presence is automatically Care*: it expresses the way in which we are *who we are able to be*, given our limits, and the context, both material and relational, in which we live. In care, we live authentically when we discover our ownmost potential, facing up to the anguish associated with the possibility of choosing who we can be, each time as though it were the first. But, in care, we can also live inauthentically: when we follow the “one-does” or “one-says” and attempt to avoid the emptiness of anguish by occupying ourselves with meaningless activity.

Thus, as human beings, *we are all a caring presence*. Binswanger outlines the *ontic* modes of this presence. It is above all a “how”: it is expressed in the – unique and unrepeatable, because subjective – ways in which *we move and live in space, experience time, “our” time, are bodies, speak; in the way in which we are with others* (Binswanger, 2007).

Relating to others, in existential terms, is *caring*. According to Heidegger, we can care for others in an authentic way, as we have seen, by enabling them to “become free” to care for themselves, or we can “put [ourselves] in [their] place in taking care”, that is to say in their prerogative to try out their own potential and limits, and to choose who they want to be and what they need in the various situations of daily life (*ivi*, p. 157). When we choose the latter option our care is “inauthentic”. This is a very common mode of providing care, and indeed it is inevitable when the person being cared for is particularly fragile and/or vulnerable. The problem arises, when throughout the entire existence of an individual, this is the *only* possible mode of giving or receiving care. Indeed Binswanger suggests that existential authenticity may only be attained when our “being-with-others” tends towards the “*modus amoris*” or “*amicitiae*”. That is to say, when in the encounter with the other we truly experience a “*communio*”, a “having a world in common” that goes beyond – albeit without denying – mutual difference and the asymmetries inherent in the situation in which the relationship arises (Binswanger, 2007, p. 135), as in the relationship between care professionals and those they care for.

Becoming a caring presence: designing and living one’s own “part” in the care experience

What does all this mean for a care professional?

If care is what structures human existence in general (Heidegger, 1976, pp. 227-231), it is not exclusive to those who choose it as a profession.

We might conclude that this awareness in some sense takes away from the caring professions: after all, we are all carers. However, if we consider that the healthcare professions exist in order to promote experiences of authentic care, our perspective changes: providing authentic care is neither spontaneous nor natural, but an opportunity that needs to be constructed and experienced with all its associated problems and difficulties. The challenge consists of first understanding *how* to give care so as to allow those receiving it to “be free to care for themselves” and then acting in consequence. This means training oneself to give care: modelling, exercising, and questioning one’s own mode of caring. Precisely because care is firstly an existential matter, when it takes on a professional dimension it becomes an extremely complex competence that is never wholly acquired or acquirable.

The question of “how to care”, at this point, does not only concern specialized technical competencies (Zannini, 2008). Rather, it has to do with the way in which such competencies are embodied and made useful, available and significant for those being cared for within an experience that enables them to become protagonists in their own care. It is about the way that care professionals *enact* care by *deciding* (or not) to be a caring presence, using their technical competencies *among others* to allow those they are taking care of to have an experience that can change their way of feeling, thinking and being, and even their attitude towards the care provided by others (Convington, 2003; Finfgeld-Connett, 2006).

All of this goes against one of the most widely held beliefs about the caring and helping professions: the contradistinction between the personal and professional spheres. An existential

phenomenological gaze reveals the carer's presence, which is *at once personal and professional*. Such a perspective sheds light on how professionals' individual interpretations of their caring role brings them face to face with their own limitations and resources, with what the other's fragility, illness, madness, disability, life story or way of dying says *to* and *about* – them. A professional's existence is revealed in his/her caring presence and actions, use of language, way of touching and looking at those in his/her care, of being with them day by day or of accompanying them to their death, and his/her way of being in the care context: how carers feel about the human condition represented by those in their care, and the existential meaning they attribute to that condition are manifested in their approach to care. The way in which professionals interpret their role tells us *who* they are as professionals *and* as persons who have learned to be-in-the-world and to care for others in *that* particular way.

Becoming a caring presence professionally therefore implies finding out how to transform one's existential and personal dimension into a resource that makes the care experience authentic, both for the carer and for the client. This is all the more important in those contexts, such as the social and healthcare services, that are more radically exposed to the vulnerability of human existence. In these cases strong emotional defences come into play, and safety is sought in situations and roles that reduce personal involvement (in any case always present to some degree) to a minimum (Iori, Augelli, Bruzzone & Musi, 2010). The associated risk is that the care experience will neither be effective nor significant. Not effective, because the pain of experiencing limits, difficulties, chronic conditions and death is not dealt with nor elaborated, given that it cannot be relieved by the sole use of pharmacological therapy or other recognized techniques. Not significant, because the experience does not support any process of understanding its existential meaning, in all its mystery. In other words, the care experience itself has not been cared for.

In one of his last research and educational works carried out at the then Educational Science Faculty of Milano Bicocca University, Riccardo Massa suggested that theatre is a metaphor that can show us how to overcome the role/person dichotomy in the formation of education professionals: how the professional's "part" and personal existence may mutually enrich one another when aimed at promoting authentic educational experience (Cappa & Antonacci, 2001). This metaphor can be of value for the caring professions in general, not only because they all include an implicit educational dimension (Zannini, 2001), but also because care, if existential, is intrinsically educational (Mortari, 2006; Palmieri, 2000).

What does theatre do? It "duplicates" life. It reproduces daily life through a series of "*mise-en-scènes*" that draw the spectators into what is happening on the stage, allowing them to view their own daily existence from other perspectives, to ask themselves questions, to initiate a search for meaning, to find their *own* meanings. Theatre offers spectators the opportunity to enjoy a – mediated and shared – experience of life and, at the same time, of their own relationship with it: something that life itself does not necessarily guarantee. The actors play a key part in bringing about this effect: they live life on stage, offering their own interpretations of it so that others may experience them. The actor is an integral component of the lived experience. If it is to be effective, he must interpret his part authentically: that is to say, he must "feel it", relate it to his own previous experience, constantly exercise empathy towards the character that he is playing, and become that character through being fully himself. His gratification will depend on the extent to which the final applause confirms that the experience did take place that an encounter really happened, that meaning was discovered and embodied.

Coming back to hospices or other social and healthcare services, at first sight such places would seem to primarily highlight the “thrownness” of existence: persons are received in these contexts on the basis of existential, social and relational difficulties that appear to consign them to a predetermined fate. Is it possible to duplicate life in places such as these? Maybe so, if being in a condition of disadvantage, disability, illness – whether chronic or terminal – is paradoxically understood as a situation in which *one may* attain awareness of living and of having lived. If the function of places of care, such as a hospices or other services, is also and above all to assist dying people (Kübler-Ross, 1976) and to look after suffering ones, providing residential care and helping them to re-learn how to face everyday life and to come to terms with mental illness (Brambilla, Palmieri, 2010), disability and social exclusion, it is possible to conclude that they provide (or you original choice “re-present”) a composite vision of the multifaceted, ambivalent, and complex aspects of life. It may be experienced *in another way*: it may be seen through other gazes, felt through other sensibilities, conceived of through other kinds of thinking. If these ways of looking, feeling and thinking are to be set off inside patients, the carers must play their part, in full: the part of the doctor, nurse, educator, and volunteer who make *their gaze, their way of feeling, their way of thinking* available so that the other can experience his/her own existence together with them, including and indeed above all in difficult conditions (*ibidem*). This means making their own subjectivity available: not unconditionally or spontaneously, but within a framework – the experiential and existential aims of the relationship and the material context in which it arises – that can help them as carers to discipline their own attitudes, feelings and thoughts and to embody them in an *authentically mediated* manner (Binswanger, 2007). This means that the carers must work on what they observe, what particularly strikes them, what they feel and think in a given situation, with a view to shaping their own actions. Shaping them in such a way as to bring the patients/clients to experience authentic care and to allow themselves as carers to share that experience and to seek out moment by moment the optimum balance between exposing, expressing and protecting the self.

To come back to the Villa of the Mysteries, the silene does not look away or hold out the cup by chance: his attitude produces given effects on both the context and the young satyr. What the silene thinks and feels is embodied in his part, which allows him both to express himself authentically and to protect himself. If this were not the case, this masterly architecture would collapse and the rite would be emptied of meaning.

Caring for the self: conditions and strategies for taking care of the care experience

Learning to live one’s own part means recognising self-care as a necessary pre-condition for taking care of others (Mortari, 2009; Iori, Augelli, Bruzzone, Musi, 2010).

What does it mean for care professionals to care for themselves?

In a contemporary scenario in which wellbeing has become an obsolete slogan, self-care is at risk of being misunderstood or interpreted in a reductive manner.

It is not a mere question of devoting time to oneself and getting away from everyday problems or the pressures applied by colleagues, patients, clients, and their relatives. It does involve finding time for the self but it cannot be reduced to individualistic and private enjoyment. It is not something to be experienced alone or when one has the opportunity to let off steam with somebody else, and neither does it consist of intellectual self-knowledge.

Rather it is a practice that needs to be exercised with discipline and dedication (Foucault, 2003; Mortari, 2009). It is a *critical* and *challenging* practice that does not immediately generate wellbeing, although it involves searching for a “good way to live” (Mortari, 2006). Caring for the self means taking a stance on one’s own existence: tasting its flavour, asking oneself what meanings it bears and what direction it is taking, and then deciding where to go. It is not a consolatory practice. Rather, it forces one to break away from the flow of habit and to accept and face up to “anguish” as a structural element of existence (Heidegger, 1976). Self-care emerges as a possibility when we succeed in remaining in those moments in which we feel alienated from our world and from what we ourselves are: when we feel that we could be different but we do not know in exactly what way, although we sense that we may only be authentic by trying to find out. Thus self-care is a practice aimed at “moulding the self”, “enabling one’s own humanity to flourish”, developing one’s existential potential (Mortari, 2006; Palmieri, 2000).

For those who provide professional care to others, practising self-care means learning how to allow all that which the relationship with the other, in his/her existential condition, moves within them to emerge freely: anguish, fear, anger, impotence, omnipotence, attraction, repulsion, boredom. It is not just a matter of feeling and living out emotions, but also of identifying the thoughts that accompany these emotions, and the meanings attributed to them, so that we can see how these thoughts and emotions are reflected in our actions and how our actions speak of us and of the care that we provide. The ultimate purpose of all of this is to bring about changes in professional behaviour, which embodies the way of feeling, thinking, relating and acting that expresses the existential uniqueness of the carer. The goal is to effect a double transformation, in the experience of both carers and the cared for, by working on the “part” enacted by the carers. On the one hand, this implies experiencing the relationship with the recipients of care in one’s own particular context in harmony with oneself; on the other hand, it means enabling those in one’s care to have an experience in which they can look for their own meaning, thereby promoting *their* self-care. In this way, self-care becomes a professional competence, not a solely personal or private affair that facilitates, sustains and enhances the care experience.

For self-care to be just that, a number of pre-conditions must be in place.

As a form of continuing self-education, self-care should be backed up by an adequate level of ongoing training (Iori, Augelli, Bruzzone, Musi, 2010), designed to develop and reinforce the types of key competence needed to establish an authentic care experience: observational, reflexive, relational and pragmatic. This means enabling healthcare professionals to mindfully experience their own way of being a caring presence; not only by enhancing their knowledge of theories of care, but also by creating situations in which they can analyse how they learnt how to give care, and maybe, use the theories to help them think and act differently. This is no small challenge, given that we learn how to care not only in formal educational contexts (e.g., medical school) but also from life: from how our relatives and friends took care of us, from shared cultural models of care (and “carers”) and from the models of care and care practices present in the workplace. Becoming aware of our own reactions to other people’s suffering and the educational histories driving these reactions is the starting point for working out how to develop other modes of care, potentially in concert with the other members of the professional team.

Thus, self-care is made up of a range of experiences that are simultaneously both personal and professional. It requires moments of solitude but also moments of sharing as well as a rhythm to connect these moments and make them functional to one another. Above all, self-care should be thought of as a dimension that takes concrete form in shared educational and self-educational practices: the intersubjective dimension is key to seeing, comprehending, elaborating and transforming individual approaches to care and to developing cultures and modes of care at the team level (Mortari, 2009).

All of this points up the importance of the environment in which professionals care for others and may care for themselves (Finfgeld-Connett, 2006).

It is critical to be aware that the material dimension of places of care can promote authentic care experiences: space and time can be managed in such a way as to allow carers and recipients of care to take stock of situations, ask questions of themselves and one another, seek out dialogue or solitude, implement potentially sensible actions. However, it is equally essential to explore whether or how the cultural framework implicit in current care practices encourages discussion, the search for meaning, or the elaboration of new cultures. This requires an appreciation of the symbolic – and not only the organizational or functional – function of objects, actions, procedures, labels, and diagnoses. It is critical to ask oneself what they lead to, what prospects they open up and what prospects they cut off, what kind of experience they facilitate, on the part of those, whether professional carers or recipients of care, who reside in this particular context. In pedagogical terms, it appears to be important to enquire as to *what* and *how* places of care allow carers and the cared for to learn from their lived experience (Zannini, 2011), where learning can mean to discover themselves in the experience or to acquire – even unconsciously - new ways of thinking, feeling and doing: of being present. But this in turn means enquiring as to whether and how such places care for the experience of care.

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