THE UNPERSUADABLES:

WHY INTELLECTUAL DISABILITY TROUBLES CARE

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What expectations about the mind do people with intellectual disabilities depart from? A dominant argument maintains that their dependency troubles liberal relations premised upon a myth of autonomy. By analysing the centrality of persuasion in a home for adults with intellectual disabilities in the UK, I ask instead about the psychological assumptions made by relationships of care. Persuasion aims to cultivate, not their independence from care but rather, a recognition of their dependence upon it. Persuasive care’s repeated failure suggests an alternative answer to the question: people with intellectual disabilities are too independent-minded for this form of dependence.

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Media Teaser:People with intellectual disabilities trouble not just expectations about cognitive independence, but also assumptions about *how* one ought mentally to depend upon others in care.

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Intellectual disability[[1]](#endnote-1) refers to an early and enduring impairment of mental capacities essential to functioning in daily life. Those with more significant versions of this impairment rely on care throughout their lives. Despite significant precedents (Edgerton 1993; Langness and Levine 1988) and important ethnographic work in recent years (e.g. Kulick and Rydström 2015; Rapp and Ginsburg 2011), a full anthropological conversation about intellectual disability is in its infancy (McKearney and Zoanni 2018; Ginsburg and Rapp 2018). Its development will help us answer why adults with intellectual disabilities are marginalized from social life in many Euro-American societies, especially those such as the UK and the US that are importantly shaped by liberal values and institutions. In these contexts, becoming adult in years does not reliably result, for people with intellectual disabilities, in contact with the adult world of jobs, friendships, and romantic relationships. This cognitive condition has very real and very disabling consequences in these contexts.

Why? Tyler Zoanni and I (2018) argue that anthropology’s neglect of such individuals stems from assuming the equal distribution of a certain normative set of mental capacities. What assumptions about the mind might be operating in liberal societies that lead to an analogous marginalization? What expectations do their minds not “fit” with (Garland-Thomson 2011)? A dominant argument has it that liberalism assumes a degree of mental autonomy and self-reliance that people with intellectual disabilities do not, in fact, possess. This argument explains the marginalization these individuals face by the prevalence, in these countries, of relations premised upon such a conception of independence, over caring relations that can better accommodate mental dependence.

The dominance and intuitiveness of this narrative within and beyond conversations about intellectual disability means that there is not, currently, much of a conversation around it. With the aim of beginning one, I turn away from what threatens care from the outside to analyse how care operates in a group home for adults with intellectual disabilities in the UK. I focus, in particular, on the centrality of persuasion to care. By examining the assumptions about the mind embedded in this relationship of support, I argue that people with intellectual disabilities do not fit for the opposite reason that the dominant argument has it: they are too independent-minded for this form of dependence. This examination of the role of the mind in relations of care has implications for theories about the ethnographic and conceptual relationship between dependence and independence in Euro-American societies more broadly.

PERSUADING MARTHA

L’Arche UK is a charitable organization funded by government welfare payments to provide support to adults with intellectual disabilities. In 2013, I joined one of the group homes that L’Arche runs for five such adults in a large British town. There are always at least two carers on duty in this house; more, twice a day, to assist people with complex needs with bathing and eating. I worked there for over a year as a researcher and a full-time carer, on the understanding that I would prioritize my caring obligations but would be observing while doing so. I gained first-hand experience of the practical difficulties and ethical dilemmas involved in this labour through training, involvement in team meetings, practical discussions during work with other carers and managers, and extended interviews with them. All this served to triangulate my own experience of providing care, and enabled me to understand the interactional dynamics and structures of the care home.

One Saturday morning in October 2013, a few months into my year working there, I was assigned to spend a few hours supporting Martha, a 40-year-old woman who had lived in L’Arche for over 15 years. Martha has difficulty navigating, walking, and judging traffic. She is unable to read menus, understand transport routes, and handle money. So, Martha cannot very safely go out of the house on her own. But Martha’s family, friends, and carers all say that going out makes her less anxious, enables her to meet more people, and makes her more confident. I do not know if Martha agrees with these opinions, or whether this is how she reflects on her life. But Martha nevertheless “enacts” a preference: she visibly enjoys these trips when she is on them, and actively petitions carers to take her on new ones when she is inside the house (Pols 2005). Throughout the week leading up to that Saturday, Martha had been saying “pub” – her homonym for restaurant, café, and pub - to me with a hopeful and demanding look in her eyes while I supported her with different tasks around the home

For all Martha’s enthusiasm for going out, leaving is normally an emotionally complex affair that seems to induce defiance, anxiety, and shame all at once. I went into the sitting room to tell her that we could go to the pub. But she responded by looking down at the ground and saying “no” resolutely, almost as much to herself as to me. She looked up at me, as if torn by contrasting feelings. So, I followed what other carers had done before in trying to persuade Martha that *she* wanted to go out. “You know what?” I said, “I heard that Bob is going to a party at the pub. Do you know who else is coming?” A faint smile started to break out, as Martha looked at me excitedly. Slowly she raised her hand and exclaimed “and me!”

Attempts at persuasion like this regular feature in Martha’s life. They occur, for instance, most mornings. Martha rarely wants to go for a bath, but the managers of the care home think it a good idea for her to have one every day. And so, her carers try to convince her to get in the water. Quite what would best accomplish this was a subject of considerable debate at the regular team meetings I attended. One carer, Emma, held that remaining calm and quiet, perhaps mentioning bathing or simply staying silent, was the best way. Lotte, by contrast, held that joking, chatting, and even singing worked best to convince her. In the past, some had even attempted to lure her to bathe with the promise of raisins afterwards.

Raisins were only used, during my time in L’Arche, to induce Martha to leave the house, or along the way once she had left. Martha takes a great deal of time to walk to or from the day center. When she is having a hard time, she anxiously says “home” over and over again, pointing in the direction she believes the house is and trying to pull the carer in that direction. When she is in a good mood, she wants to stop every few steps to herald a cat or point to the birds in the trees. There are often reasons for carers to hurry. Their shift might be finishing, or they might need to get back to care for one of her housemates, and so they resort to a similar mixture of tactics: patiently waiting, joshing with Martha to get her to hurry up, distracting her, or offering her raisins.

In desperate situations, when Martha is what they call “stuck,” they may resort to phoning a manager or carer whom Martha is particularly fond of, whose voice is reassuring enough to encourage her on her way. But many of Martha’s carers also see problems with this, because it reinforces what they call Martha’s “attachment” to particular individuals when they believe it would be better if Martha could accept help from everyone. As Emma put it, “She loses her independence when she gets attached to someone… It’s like losing yourself.” An experienced carer, Peter, repeatedly told us newer carers that such attachment contributed to Martha’s refusal to have a bath on some days. She rarely chooses to bathe with the assistance of some of her carers, but will regularly do so with others. But, he told us, the staff she wants are not always available, and those she is less fond of must still try to persuade her. Indeed, he told me, it is better for her if she is able to be supported in bathing by all the staff – that way she will always be clean and healthy, regardless of who is working.

Carers do not always try to persuade Martha or her housemates. When the care-recipients’ desires are aligned with what the carer thinks is best for them, with that person’s typical desires, and with what the carer can deliver given limited time and resources, then carers generally do not speak to them in this way. But there are many occasions when this is not the case. Ruth and Bob, for instance, are resist bathing too. And Ruth and Rachel are often reluctant to take their medication. They often, also, do not eat the amount their carers think they should. Many times, these individuals do or want things that are not evidently deleterious, but nevertheless challenge carers’ attempts to to fulfil all their responsibilities. Rachel can spend a very long time taking her medication, even if she does not actually resist doing so. Ruth might want to go out of the house when there are not enough carers on duty for this to be possible. At other times, they desire things immediately that contradict what carers suspect are more deep-seated and long-term preferences: Rachel says she does not want to eat any of her food, but this includes her favourite scrambled eggs; Bob or Martha say they do not want to go to the pub, but they enjoy it when they are there.

In these moments, carers begin persuading in ways they think most effective for the individual. No-one ever jokes with Bob when he does not want to do something. But people josh with Ruth by rubbing her hair, making silly noises, and even locking fingers to pretend wrestle with her when she spits out her medication and is becoming annoyed by her carer’s insistence. They imitate Sarah’s distinctive vocalizations to get her to laugh. They try to talk in an authoritative and commanding tone to Rachel when she says she does not want to eat anything, since she largely ignores any other attempts to convince her.

In these ways, a kind of persuasion is a regular part of care in Martha’s home. Carers think constantly about what a person might be doing that is damaging to themselves, or what they could be doing that might be more fulfilling or important. They try to sense, all the time, the mood of the person they are supporting, and so how that person might react to caring interventions. On this basis, they persuade: they attempt to get the person to do the desirable action, or to cease from the undesirable, of their own accord. This is a constant and unremarkable feature of the way that carers interact with those they care for.

MENTAL DEPENDENCE AND CARE

Eva Feder Kittay is a political and moral philosopher who has contributed to a long tradition of feminist work on care that maintains that liberal societies value autonomy, individuality, and self-reliance in ways that deny, obfuscate, and stigmatize dependence. People in such societies buy, Kittay contends, into an individualistic myth of independence defined as complete self-reliance: not needing others at all, overcoming dependence, and resisting relationality. But she argues that this is a “fiction” because we are formed *through* care rather than in opposition to it. This fiction has pernicious implications: “The underside of a society that places supreme value on the fully functioning, independent adult worker is the stigmatized and infantilized disabled individual” (Kittay 2019: 147-8). Kittay (e.g. 1999, 2007, 2009, 2011) develops these claims into a distinctive argument about the marginalization of intellectual disability, by drawing out the exclusionary assumptions about the mind that are contained within an emphasis on independence.

The foundations of her argument rest in her critique (2019, 2011, 2006, 2003) of what disability scholar Tom Shakespeare (2013: 11) terms the “strong social model” of disability. Kittay acknowledges that this movement’s call for independence, and its polemic against dependency, is more subtle than the myth of self-reliance. Dependency, to these scholars, is not so much about relying on others, but being under another’s paternalistic control – something people with disabilities experience in many relationships of support (Barton 1989; Oliver 2009). What these disability activists advocate is not freedom from care entirely, given that they push for government provision of support, but rather a different kind of independence: “a measure of control over their circumstances,” or the ability to “self-determine” *within* relations of care (Kittay 2019: 148). This type of autonomy is not self-sufficiency but rather governing one’s dependency within “the vast networks of assistance and provision that make modern life possible” for everyone, disabled or not (Davis in Kittay 2019: 149). “To us, independence does not mean doing things physically alone. It means being able to make independent decisions. It is a mind process not contingent upon a normal body” (Heumann in Kittay 2011: 50).

But Kittay points out that this move away from self-reliance to a subtler understanding of managing one’s dependence nevertheless continues to assume the capacity to carry out that “mind process” and thus a “normal” set of mental abilities. This ignores people with intellectual disabilities whose “impairments affect the capacity for self-determination” (Kittay 2019: 149) – those mental processes that enable people to manage their own lives (Kulick and Rydström 2015; Redley and Weinberg 2007). Even this subtler understanding of independence assumes that individuals are able to take decisions on their own, are the source of their own opinions, and can manage their affairs independently (Kittay 1999: 88–96). The ideology of independence embeds these assumptions about mental capacity so deeply into so many relations that the inevitable result is the exclusion of people with intellectual disabilities from social life. Their mental incapacity and resultant life-long dependence on others means that they will never fit these expectations about the self-reliant mind, and instead remain “marginal members of society” (Kittay 2019: 149).

The solution Kittay prescribes is to set aside the search for autonomy, even of subtler kinds, and turn instead to her model of care. This kind of care differs from paternalism in never taking the liberty to decide what is best for and impose it coercively upon the other person (Kittay 2007). Its legitimacy rests, instead, in its pursuit and respect of what the care-recipient themselves cares about, needs, and desires – in other words, on what is going on in the care-recipient’s mind (Kittay 2019: 208–213). But unlike relations of independence, this model of care does not need the care-recipient to be self-determining (Kittay 2019: 173, 211–213); when someone’s ability to manage their dependence is impaired, the carer takes up responsibility for pursuing that person’s flourishing on their behalf (Kittay 1999: 31).

This is particularly important in cases where the care-recipient’s desires are “self-defeating,” in that they do not “preserve (their) life, health, or other objective features of (their) well-being” (Kittay 2019: 207). In these cases, a carer will need to do more than respect their autonomy, for doing so will lead to neglect. Carers will, instead, reflect on what is best for the individual in a way that models of independence prohibit. Care thus avoids not only coercion but also the neglect that liberal logics of independence produce, and it does so by compensating for a person’s inability to pursue their needs and wants reliably and consistently.

Care’s attention to the mind makes no assumptions about cognitive equality, rationality, or capacity (Kittay 1999: 50). Care’s assumption of a relational and dependent self fosters a relationship in which there is nothing anomalous, problematic, or stigmatizing about people with intellectual disabilities and their incapacity to self-determine in this way (Kittay 2011). Rather than demanding the disabled mind fits with an ideal of autonomy, care fits around mental dependency. If such a logic of care was more widespread, then people with intellectual disabilities would neither be stigmatized for their dependence nor confined to the margins of social life as a result, but could instead be full and valued participants in it.

A similar argument about the deficiencies of independence and the importance of care characterizes contemporary writing on intellectual disability in anthropology, including an important article that discusses persuasion. Jeanette Pols, Brigitte Alhoff, and Els Bransen (2017) describe how carers in the Netherlands respond to people with intellectual disabilities who engage in substance abuse. The ideal of autonomy presumes that these people are able to “govern their own lives” (Pols, Althoff and Bransen 2017: 781) but carers think these individuals sometimes take choices that are “not good for their own well-being” (Pols, Althoff and Bransen 2017: 777). In these instances, the ideal of autonomy will only guide carers towards neglect. So carers engage, instead, in persuasion – attempting to lead care-recipients away from worse decisions towards better ones. Care assumes, unlike demanding ideals of independence, that minds are relational rather than self-sufficient, not closed systems but rather open to “influence” (Pols, Althoff and Bransen 2017: 781). Such care does what autonomy cannot do: accommodates the dependent features of these individuals’ minds.

Pols and colleagues follow Kittay in placing the blame on the assumptions embedded in relations of independence and similarly suggest that the solution lies in more accommodating relations of care. Rayna Rapp and Faye Ginsburg (2011: 400), likewise, argue that the “American stress of “independence” poses deep challenges” to teenagers trying to become adults because it stigmatizes the support they need to realise this aim (beyond anthropology, see also Altermark 2018; Redley and Weinberg 2007; Welshman and Walmsley 2006). This condemnation of autonomy, and advocacy of a greater appreciation of dependence, is echoed outside of this specific conversation too, in contemporary work on care across anthropology (e.g. Mol 2008; Taylor 2008). Kittay’s clear and compelling philosophical argument is thus an articulation and elaboration of a more broadly held sociological position: that people with intellectual disabilities do not fit in liberal societies because of the prevalence of relations premised upon independence, and the mitigation of caring relations, in these contexts.

In challenging this, I question how well this argument helps us understand the presence and role of persuasion within Martha’s care.

PERSUASION BETWEEN COERCION AND NEGLECT

Autonomy is a central value of the social and policy context that shapes the care that Martha receives. Earlier in the twentieth century, many adults with intellectual disabilities in Britain were not given the rights of liberal subjects because they were imagined to be, like children, incapable of taking the kind of decisions about their own lives that would keep them and others safe. They were thus denied rights to self-determination (Welshman and Walmsley 2006). Many of the campaigns that changed this situation were inspired by the strong social model of disability’s advocacy of greater liberty and autonomy withincare. Legislation such as *Valuing People* (2001)and the *Mental Capacity Act* (2005) now mandates that standing in need of care should not deprive one of the kind of control granted to other adults in a liberal jurisdiction (Welshman and Walmsley 2006). Anything that carers do to support Martha should not be on the basis of what they think is best for her, but on the basis of what she herself decides. Carers should not take decisions about how to manage Martha’s care. She should be managing them.

In the caring relationships on which they focus, Pols and colleagues attribute persuasion’s presence in care to similar reforms in the Netherlands (see also Driessen 2018). They argue that the delicacy with which carers approach people with intellectual disabilities is a response to the reality of their autonomy: care-recipients can simply shut the door on their carers (Pols, Althoff and Bransen 2017: 776). This is similarly the context in which the case-workers in Paul Brodwin’s (2013) study try to persuade their clients with psychiatric conditions and drug addictions in the USA. In the many situations where case-workers have no formal power over their clients, their caring influence can only be exerted by trying to convince the clients themselves to take the decision that the care-giver has no authority to impose (2013: 58–9, 75, 153–4).

Kittay’s argument that independence is a central value does, in this way, help us explain why persuasion recurs in Martha’s care: it is an attempt to avoid coercion. Care’s legitimacy is constrained in these contexts by the care-recipient’s own desires. In this sense, acts of persuasion in care – and contexts such as advertising, political rhetoric, or irreverent critique – can be described as a quintessentially liberal practice (Asad 2009). In contexts where autonomy is less of a moral concern, carers need not be so delicate as to persuade but can resort to more coercive measures (e.g. Garcia 2015).

But Kittay leads us astray by arguing that respect for autonomy, in these instances and in liberal societies more generally, necessarily takes the form of the self-reliance she so opposes: that is, independence as opposition and resistance to care and relationality. Her argument cannot explain why, for instance, persuasion recurs with such frequency in caring relationships in such societies, but not in others that also value autonomy.

Francesca Mezzenzana (2019), for example, contrasts the interventionist nature of middle-class Euro-American parenting practices (such as Ochs and Izquierdo 2009) with those she studied among the Runa in the Pastaza region of the Ecuadorian Amazon. From infancy, Runa children are regarded as having individual wills (*munay*) that cannot and should not to be interfered with, to the point that people think “there is little an adult can do” to prevent children acting upon their will (Mezzenzana 2019: 5). This is so even when children have not developed the kind of careful thought (*yuyay*) that characterizes adulthood, and when their choices involve very real danger such as walking close to fast-moving rivers or climbing high trees (Mezzenzana 2019: 4). Persuasion is so alien to this form of parenting that even convincing babies to accept food, a routine in Euro-American parenting, is seen as problematic. When Mezzenzana suggests to one critic of this “mestizo” practice that the baby might not know what is best for it, the woman simply replies: “You can’t force a baby to eat, it is her will” (2019: 5).

The problematic nature of persuasion among the Runa extends to a more directly relevant comparison: caring interactions with adults. In personal communication, Mezzenzana described to me the case of an elderly woman who decided not to undergo the surgery recommended to relieve a horrendously painful liver calculus. When Mezzenzana suggested on the phone to the daughter that she could try to convince her mother otherwise, the daughter simply answered that her mother wanted to stay home. Trying to convince her mother was not an option, although it was Mezzenzana’s first thought. The child courting danger and the elder deciding against surgery are not imagined as being incapable of thought or independence because they take decisions that conflict with the carer-giver’s idea of what a rational person would choose. Rather they are taken to have an individual will that should be respected. Runa, as a result, hardly ever “attempt to change someone else’s mind” (Mezzenzana, 2019: 2).

We cannot explain these stark contrasts between the centrality and acceptability of persuasion in and beyond care in Euro-America, and its difficulty and peripherality among the Runa, by recourse to Kittay’s argument that Euro-Americans value self-reliance. Mezzenzana argues that the Runa hold an “obstinate individualism” (Overing in Mezzenzana 2019: 2) that values strength (*sinchi*): the capacity to handle one’s emotions and one’s practical affairs without interference, instruction, or persuasion from others. It is precisely by *not* having one’s needs met by others that one develops. The commitment among middle-class Euro-Americans to responding to their children’s needs through relations of dependence suggests they hold, by contrast, a “soft individualism” (Kusserow in Mezzenzana 2019: 12) that sees learning to attach and rely upon others as way in which children grow into independent adults. Mezzenzana’s descriptions of the Runa suggests that we need to explain the presence of persuasion in care as a departure from, rather than a fulfilment of, the value of self-reliance.

We will do better by noticing that Euro-American societies like the US and the UK, however much they may recognise individuality and afford independence, have a way of conceptualising and responding to people’s wills foreign to the Runa. The extent of Martha’s dependence is established year by year in annual meetings where her social worker questions her carers about the activities she can do without support (getting dressed, going to the toilet), and those for which she must have help (bathing, cooking, arranging doctor’s appointments, thinking about her health). The more Martha is judged to be incapable, the more money the state gives her to pay for professional care. Martha has the physical ability to do all these tasks. What she is judged to lack is the mental capacity to know she needs to do them, how to do them, and how to get help with what she cannot do. Her dependence, in other words, is established not in relation to an ideal of total self-reliance but rather in contrast to the mental capacity to acknowledge, understand, and manage her dependence.

This judgment of dependency motivates forms of state support that give carers an obligation to avoid not only coercion but also neglect. The *Mental Capacity Act* protects people’s right to choose, but it also makes provision for individuals to be judged mentally incapable (particularly when their desires are judged to be “self-defeating” as Kittay puts it). Their right to self-determination may be overridden in the name of care. This can result in the imposition of Deprivation of Liberty Safeguards (2008), that legitimate, for example, confining a person within their own house. But carers must make these kinds of calls in much less official ways when, for instance, they walk with Martha down the street and stop her running into the road, or try to get her to have a bath even when she protests. The freedom that Martha is granted is constantly checked by considerations of care; it is conditional on whether or not she correctly governs her dependence.

Kittay’s argument, like that of Pols and colleagues, encourages us to see these checks on autonomy as occurring when the myth of independence meets the reality of actually providing care. But there is another way to frame this. Michel Foucault (e.g. 1975, 1995, 2009a) draws attention to analogous forms of intervention and to the way they generate new categories of dependency in order to legitimate interference. His arguments suggest that the logic of care proposed by Kittay as a subversive alternative to the norm in liberal societies is already deeply embedded in the way they govern dependence. This is not the same as claiming that the UK and the US are caring in the way Kittay would like them to be, nor a denial that autonomy is of high value in these countries. Foucault’s argument offers, instead, a different way to frame persuasion’s presence: not as the conflict between an unrealistic ideal and the grounded practice of care, but rather as the interaction of interventionist logics with liberal forms of government that place limits on such interference (Davis 2012: 193; Foucault 2008).

The resulting politics of that system are far from straightforward. The liberal ideal of self-care generates questions about who is able to manage their dependence and who is not that are central to contemporary political conflicts around care in shifting and ambivalent ways (Ferguson 2015; Fraser and Gordon 2003). It opens up the possibility for states to legitimate coercive interference, as in Brodwin’s (2013: 118) descriptions of a judgment that people are unable to take care of themselves mobilizing “more coercive tools” of the justice system that open up forms of caring power. It can also justify the withdrawal of welfare on the basis that people can and should be able to care for themselves. There has been a great deal of withdrawal in relation to Martha’s care. It has not been complete, and so when Martha is judged unable to govern her dependence, the state transfers to carers the authority and resources to do it on her behalf.

These complexities are quite different from the relative simplicity of the Runa case, in which those who have not yet developed the capacity to look after themselves sensibly are left alone to do so anyway, without interference, simply because they are taken to have a will. That unequivocal valuation of independence tidies up the enduring tensions around dependency that manifest in Euro-American societies in which independence, by contrast, is granted to those displaying the liberal capacity for self-care. This suggests that we ought not to describe Euro-American contests over care as a tussle between self-reliance and care (as Kittay would have it) precisely because the ideal of the subject who can care for themselves is part of the same system by which dependence is extensively measured, established, and responded to with care. This requires us to go beyond Kittay’s rhetorical contrasts and investigate what kind of independence is valued in Euro-American society, and whether it has a more intimate relationship to dependence than we have hitherto imagined.

PERSUASION’S FAILURE

Persuasion fails all the time. Martha and her housemates commonly carry on doing what they want to do, perhaps not understanding, perhaps simply ignoring, or perhaps actively undermining their carers’ attempts to convince them otherwise. Sometimes it fails more dramatically. Ruth, Rachel, Sarah, and Bob are known to erupt emotionally during acts of persuasion. Martha, too, seems often to resent attempts to convince her, most visibly expressing this by hitting carers when she is in the bath, leaving the house, or on the road.

Martha’s reactions sometimes change her carers’ minds about what is really best for her or worth pursuing, causing them to abandon an attempt at bathing or going out. But often carers remain convinced a certain course of action is necessary anyway. This may be because of the effect that providing care within organizational limitations has on carers’ perceptions of the legitimacy of people’s protests to institutional constraints imposed upon them (e.g. Johnson 1998). It may also be that the regulatory emphasis on avoiding neglect makes carers more accountable for failures to carry out tasks, such as bathing, to which they been assigned than for the imposition persistence involves (see also Kulick and Rydström 2015). Regardless of whether fulfilling those acts of care is what they are legally obliged to do, carers rarely have the confidence or the luxury of taking their own failures as indication that they should give up on particular caring tasks - either by using force to coerce Martha or by just leaving her alone. Rather they take their mandate as to continue caring. So, carers do not feel able to let Martha’s protests against bathing be the last word, but must keep going. And when Martha protests more violently, they keep doing what they think is best for her, and try to get her to have a bath, often at their own and Martha’s considerable personal expense.

Kittay’s arguments about carers’ obligations in the face of the care-recipient’s “self-defeating” or problematic desires reinforces this normative trajectory. If carers “remain convinced that the person would be better off” then they should “attempt to find ways around the obstacles” (Kittay 2019: 206). Kittay claims that this does not constitute paternalism because it still relies on consent of a “hypothetical” kind – that “if the cared-for could understand, then she would endorse” the care-giver’s actions as caring and would accept them “willingly” (2019: 205). The current desires of the care-recipient thus take a back seat to what they would desire were they to take the same decisions as the carer. The current self that does not want to be cared for has less authority than a hypothetical self that would. Kittay further suggests that, as long as the carer responds to “real” needs, the care-recipient has a duty to accept such care, no matter how much they understand it (Kittay 2019: 216–219). Martha, in other words, ought to be receptive and not lash out – doing so is to “refuse relationship” and frustrate the professional care-giver’s “duty and obligation” (Kittay 2019: 218).

The notion of “attachment” in L’Arche plays a similar role to Kittay’s philosophical arguments. It explains away Martha’s resistance to being bathed by some carers, and not others, as born of incapacity – she is emotionally overcome, and thus unable to be the self that would accept such care. The implication is that there is another self that would be content to be cared for by anyone, and it is Martha’s responsibility to become that self. Persuasion is, I contend, and turn her into that person by inculcating in her the virtues that Kittay commends: acknowledging dependence, managing how one relies upon others, and “graciously” receiving care (2019: 218). In this way, even Martha’s vigorous resistance is turned into another instance of dependency, another aspect of her mind that enjoins intervention and cultivation through persuasion. Like Kittay’s solution, this removes the conflict because it makes keeping on persuasively caring, once again, the right answer. The notion of “attachment,” just like the idea of a hypothetical self that endorses care, enables carers to square the circle otherwise posed by the misfit between their professional obligations and Martha’s desires, voice, and actions.

If Martha really is incapable of overcoming her reliance on care, then one can see why Kittay and carers in L’Arche go in this direction. This may be the best one can hope for: for her to feel like herself *within* caring relations, by accepting her need for support. Given that a certain conception of independence would condemn this subtle caring labour as paternalistic coercion, Kittay thus encourages us to interpret all this as further evidence of the inadequacy of demanding ideals of autonomy to articulate what care-recipients really need,.

I interpret this quite differently as evidence of the close connection between the liberal capacity to manage one’s dependence and the logic of care that Kittay describes. When compared to a strict kind of self-reliance, a liberal notion of self-determining independence has something in common with Kittay’s conception of care: they both involve the capacity to recognise our dependence. They require, we might say, a receptivity to care, an openness to the impulses and directives of caring authorities (Foucault 2009). In this sense, the virtue of acknowledging dependence that Kittay praises as the cornerstone of her logic of care is central also to this conception of independence (Kittay 2019: 163; see also MacIntyre 2009: 8). Could it be, therefore, that the independence liberal societies so prize is not the capacity to do without care, but rather the ability to depend in a particular way?

This would help explain why middle-class Euro-Americans persuade their children so much. Ochs and Izquierdo (2009) critique this parenting style for fostering dependency in children, and argue that the child-rearing techniques of, for instance, the Matsigenka of the Peruvian Amazon more reliably produce independent-minded, self-sufficient, and other-oriented individuals (see also Mezzenzana 2019: 8). Persuasion is an attempt to get another to care for themselves by getting them to accept one’s caring impulses as their own. Persuasion tries to develop independence out of dependency not by leaving a person alone but by encouraging them to be more docile. This logic makes no sense within an imagination of autonomy that pits independence and individuality against relationships and care. Being more open, or subjected, to the influence of another does not obviously help a person take their own decisions better. So what if Euro-American parents are trying not to get children to take their own decisions, but rather to internalize parental caring impulses? Persuasion makes a great deal of sense as part of an attempt to teach others to recognise their need for care, govern it, and perform it upon themselves – to become, that is, more receptive and malleable.

This is a distinctive way of enacting dependence, one that includes normative suppositions about the desirability of the mind’s openness to “influence” (Pols, Althoff and Bransen 2017: 781; see also Kittay 2019: 173). And the limitations of those assumptions mean that such care does not always work. Persuasion in child-rearing aims at its own cessation: when children have developed the capacity for self-care, parents can leave them alone. That end is not obviously in view for Martha. She has been classified as having an intellectual disability precisely because this socialization process did not produce its desired outcome, and the classification embodies stern doubts about whether similar socialization could ever change this in the future. Martha does not learn how to care for herself. It is more realistic to hope that she might one day learn to accept care. But even that is a ‘virtue’ that does not appear easy for Martha to cultivate, or others to cultivate in her. She remains resistant to many forms of caring. But influencing another’s mind remains a dominant model of care precisely because it holds out the promise simultaneously of avoiding coercion and neglect. And so Martha will likely continue to be subject to persuasion, regardless of how effective it is at achieving even its own very particular ends.

Those without obligation to provide Martha’s day to day care, and the legal accountability that comes with doing so, noticed the failure of persuasion more readily and thus offered other interpretations of Martha’s continued defiance. Martha’s sister, Sue, told me that she thinks it is good Martha is so vocal and determined about who she does not want to support her in the bath. It implies a healthy respect for her body and who becomes intimate with it. She told me that Martha “should be able to say, ‘I choose who touches me’” because such control over her own body is something that the rest of us would regard as an inviolable right. Sue suggests that here is a tragic conflict between Martha’s sense of self and the pragmatic realities of care in which Martha cannot always be supported by people she likes. Sue did not explain away, through a concept like “attachment” or a hypothetical self, Martha’s protests as evidence of incapacity, greater dependence, or the absence of the virtue of acknowledging her dependency. Rather, Sue implies that Martha’s resistance to care is a sign of agency and even virtue – even if it is one that carers, and Kittay’s ethics of care, are not inclined to treat as such because doing so would place significant obstacles in the path of their normative projects.

The resistance to care that Kittay rejects returns to the fore in Sue’s account. Sue does not interpret Martha’s protests about bathing as a mistake based on some illusion about her independence that needs to be broken. Rather, she articulates Martha’s resistance to care as a strength, an action, a decision, a response to a demanding relational situation. In much the same way that the Runa regard children as having a will to be respected regardless of how much they have developed thought, Sue sees Martha as still acting, even while Martha is unable to accept her dependence. She sees Martha as acting *in* refusing to accept her dependence. Martha’s resistance to care does not compromise a deeper, more relational selfhood but is another way of being a self (and, we might say, another way of being in relation). Put differently, on Sue’s account, care can compromise individuality, and resistance can strengthen it. But Sue has not bought into any of the fictions Kittay criticizes. She articulates this account of independence while recognizing Martha’s dependence upon others. She shows us that it is possible to value resistance to care even outside of dreams of total autonomy. Being more than the product of one’s relations is one way that we think about what it means to be independent.

In Martha’s care, then, we find a conflict. It is not the clash of an unattainable myth of independence and the realities of care, such that the outcome is foreordained, as in Kittay’s account. Rather it is the contest of two different conceptions of independence: acknowledging dependence and overcoming it, or internalizing care and resisting it. Martha has quite clear desires in the here and now. Were she among the Runa, these might be taken as evidence of the force of her will, selfhood, and independence, not least because they frequently involve attempting to free herself of reliance through resistance. Martha has plenty of desire, vivacity, and self-expression. Martha’s predicament is that this system of care does not recognise resistance as independence, reason to be left alone, or even meaningful action at all. Put differently, her carers must interfere with her not only because she is passive and incapable in the face of essential tasks, but also because she is not passive enough: because she is highly capable of doing things of her own accord which they think are not good for her.

One result of continuing to apply persuasion in these circumstances is that it often undermines Martha’s confidence in, and her ability to act upon, her current desires. In acts of persuasion, carers relate to her not as a coherent subject who can decide her own fate or who knows what she most deeply wants, but rather as a fragmented set of desires that need to be rearranged and redirected if she is to be kept alive and well. Persuasion deepens the sense that she is happiest and safest when she accedes to others’ decisions for her. Martha’s mother thinks that it is precisely this encouragement into dependency that Martha reacts so violently to: using aggression to assert what independence, individuality, and control is still hers in the face of a demanding and overwhelming sense of vulnerability.

CONCLUSION

Martha’s individuality in these moments of conflict – the strength, depth, and meaningfulness of her emotions - is often obscured to Euro-American analysts because, when it leads her to resist care, they are already on a well-worn track that frames her as incapable and dependent. This is the path that her carers are enjoined to travel down. Kittay’s argument that people with intellectual disabilities do not fit because they are too dependent only serves to mark this road’s boundaries more clearly, carrying us further towards the idea that such individuals cannot meaningfully act when they cannot care for themselves in these terms. My aim is not to undermine the idea that such individuals need care, nor to critique the care L’Arche offers as the deviation of some morally pure form of it. Rather, I want to draw attention to the consequences and the limits of the distinctive way care is justified in this context: by framing people with intellectual disabilities as incapable and as lacking agency.

This framing can neither explain nor avoid the repeated conflicts that care encounters, and the tension between neglect and coercion that plagues it. Persuasive care takes up this framing as it aims to resolve these fractures within care. But it rarely achieves that and often, instead, deepens them. Similarly, Kittay’s argument that people with intellectual disabilities are too dependent for liberal societies does nothing to articulate why the care that she proposes as the solution so often goes wrong, and why it is so emotionally fraught when it does. People with intellectual disabilities do not always want to act (or refrain from acting) in ways compatible with the kind of care she advocates. That may be the result of their intellectual impairment, as Kittay suggests. But it may also be because they do not add up to the kind of subjects that their system of care presupposes and requires. Instead, they regularly exceed its demands and expectations, and often appear to find the way that care surrounds every aspect of their life claustrophobic.

We need not claim there is an obvious solution to these problems, nor deny that such care is important, necessary, and deserving of better funding, in order to recognise this. But Kittay’s argument does not manage to do so because she advocates for dependence as the conceptual opposite of an independence she wholly rejects. In her zeal to resist the supposed dangers of autonomy, Kittay focuses questions about exclusion on logics of independence that are external to a more relational form of care that she claims is more accepting of dependence. She does not, as a result, ask whether there is anything limiting about the way she (and Euro-Americans more broadly) conceive of relations of dependence. Her argument places the responsibility for misfitting on the external factors that compromise care. But care may also be compromising.

It is not only logics of independence that make assumptions about how minds work. I have demonstrated how persuasive care appeals to a mind that canbe persuaded is predicated on a particular model of the mind that can both learn through care and be influenced by it. The reason caring relations break down is because they assume a receptiveness to caring attention and persuasion that people with intellectual disabilities do not necessarily possess. (We can continue to see Martha’s departure from this normative picture of the docile agent as an impairment. But when we take up my argument – that persuasion aims at the internalization of caring impulses – we might notice that this is the view of a caring ideology. This view obscures the fact that Martha is, in fact, highly agentive in that she does not always depend in the way her carers expect. Her vivacity thwarts a care premised upon receptivity and incapacity.)

This offers a quite different conclusion from Kittay’s claim that such individuals are too needy for a society built around relations of independence. People with intellectual disabilities ‘misfit’ in relations of care not because they are *too dependent* and incapable, but because they are *too* *independent* in the sense of being agentive, insubordinate, and unruly. They do not fit normative ideas of the self-caring individual and of how relationships of dependence ought to work. This misfit is not between a demanding ideal of autonomy and a deeply dependent subject, as Kittay would have it, but rather between a relationship of dependence that assumes recipients will be open to being cared for and an individuality that resists such interference.

To the extent that the dominant argument relies on the claim that care is accommodating of mental difference in a way that relationships of independence are unaccommodating, it will encounter difficulty in understanding the complex and variable ways in which certain minds do not always fit in caring relations. It will not help us make sense of the way such relations break down nor the role care itself (as the dominant mode of relationship in people with intellectual disabilites’ lives) plays in their marginalization. My argument is not that persuasive care is the only form that care takes in Euro-America. Rather my contention is that if we continue to lament only what prevents care, rather than investigating the different forms it actually takes (including what expectations of the mind it is premised upon) then we cannot investigate the role that caring relations play in the lives of those with minds that break expectations. If I have succeeded in demonstrating that a certain kind of persuasive care is part of the story of their misfitting, then it follows that it will take more than advocacy of more care to create a more fitting social world.

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1. This is the accepted academic term internationally, but is also referred to as ‘cognitive’, ‘developmental’, or ‘learning’ disability. [↑](#endnote-ref-1)