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# Infantilisation in Care, Community and Cognitive Disability

Thesis presented by

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## Introduction

This thesis presents a concept and theory of infantilisation, which can be summarized as follows:

Infantilisation involves conceiving of an adult as having the subjectivity or personhood of a child and treating them on that basis. This treatment has four distinguishing features: 'baby talk', infantilizing activities and environments, desexualisation, and stasis. Infantilised adults are presumed to have some level of cognitive impairment, denied personal autonomy, and experience limits on their liberty and mobility. These treatments stem from and are motivated by the conceptual root of infantilisation.

This project was undertaken in response to a gap in the philosophical literature. My original intention – to examine whether infantilisation is a form of dehumanization – had to be modified when I found that no existing concept or philosophical theory of infantilisation was available. The term 'infantilisation' has occasionally been used descriptively but otherwise left largely unexamined within philosophy. In other disciplines, where it has sporadically been the subject of some research for fifty years, the term has been used to refer primarily to linguistic phenomena (namely, 'baby talk'), although more recent work has uncovered a network of non-linguistic treatments and structures which are now seen as part of infantilisation (Dolinsky, 1984; Hepworth, 1996; Cassidy, 1997; Salari, 2006; Brady, et al., 2014; Capri & Swartz, 2017; Jongsma & Schweda, 2018). Additionally, research on attitudes towards disabled and elderly people has brought out the conceptual background to infantilisation (Dorozenko, et al., 2015; Robey, et al., 2006; Nario-Redmond, et al., 2019). Still, infantilisation has so far primarily been discussed and studied as a way of treating people. Its conceptual foundations have been essentially unexplored.

I dedicate Chapter 1 of this thesis to these conceptual foundations, focusing on how people are conceived of when they are infantilized. I argue that they are conceived of as being children in the bodies of adults: as adult bodies with the subjectivities or personhood of children. Understanding this conceptual basis is crucial in understanding the treatments which stem from it. It is also crucial in separating infantilisation from paternalism, especially as infantilisation seems to occur most often in situations where some level of paternalism may be appropriate. I argue that infantilisation is conceptually distinct from paternalism, and that clarity on this is necessary if the ensuing treatments are to be properly understood. The concept 'child' cannot be applied to an adult without conflict.

In Chapter 2 I develop a theory of infantilisation. I show how infantilisation is enacted. To do this, I draw on research from multiple disciplines and geographical regions. I use this research to show four distinguishing features of infantilisation: 'baby talk', infantilizing activities and environments, desexualisation, and stasis. These features result directly from the conceptual foundation of infantilisation just outlined, they are not found even in cases of severe paternalism, and they reflect the conflict which occurs when the concept 'child' is applied to an adult.

Methodologically, it is important to note the following two points:

- In developing a concept and theory of infantilisation, I have not imagined what it might consist in and then looked for evidence to support my claims. The concept and theory are developed from empirical research, the self-advocacy of infantilized adults, informal conversations with people affected, and personal experience. I have not attempted to invent a concept and theory and then apply it to the real world; I have observed a problem with how people are thought of and treated and aimed to both clarify the conceptual foundation

of the problem and provide a theory with accurate explanatory potential. The four features which I propose are distinct to infantilisation were found *in* the empirical research. In using these features to build a theory of infantilisation, and clarifying the conceptual root from which they stem, I have aimed to provide definition for a distinct phenomenon which I believe requires dedicated attention and intervention.

- In reviewing empirical research on infantilisation, I included any material which was available. I aimed to attain the broadest possible picture of the term in theoretical and practical use. This has included research in multiple disciplines and from multiple geographical regions (although I have been restricted to English language publications). In collating research from different regions and contexts, it has not been my intention to flatten or disregard cultural or geographical differences between them, but rather to include the widest possible range in a project of limited scale. Of course, differences in the practice and conceptual strength of infantilisation vary in different contexts, and these differences require further study. Given the range of contexts examined, however, it is notable that the four distinguishing features of infantilisation were vividly consistent throughout. That is why they are foundational to this theory.

It should be noted that my definition of infantilisation excludes some instances where the term has previously been applied. First, I am not concerned with self-infantilisation or performative infantilisation. Second, in Chapter 1, I note instances sometimes referred to as infantilisation: the treatment of women in some patriarchal contexts, and the treatment of some colonized populations and racialized groups by colonial powers and/or white supremacist authorities. I show that these cases are not, by my definition, examples of infantilisation. In order to pick out the specific wrongs and harms of a phenomenon, that phenomenon requires definition. The concept and theory I propose in this thesis is intended to accurately identify instances where adults are conceptually

infantilized and point to the specific pattern of harms which stem from this concept. It is therefore necessarily more narrowly defined than the word 'infantilisation' is in general use.

As noted, this is especially urgent as infantilisation seems to occur most often where people have additional support needs and in instances where some level of paternalism may be appropriate. With infantilisation, it is presumed that the target has some level of cognitive impairment or is cognitively disabled. With paternalism also, it is assumed that the target is, to some degree, cognitively incapable of making sensible decisions in their own best interest. Yet an adult can be assisted with decision making and day-to-day living needs without their being conceived of as a child. The infantilized adult is considered not only cognitively impaired in some specific respect; their subjectivity or personhood is understood globally as that of a child. In this thesis, I consider somewhat separately the infantilisation of elderly and physically disabled people (those with no marked cognitive impairment) and the infantilisation of cognitively disabled adults. I do this because I believe a common response to my argument will be that infantilisation is clearly wrong in the former case, but appropriate and justifiable in the latter. Therefore, I provide a brief history of mental age theory and demonstrate the sociohistorical contingency of diagnoses and psychological testing. I do not, however, argue that there are special reasons why cognitively disabled people should not be infantilized. They should not be infantilized for the same reasons that apply with everyone else: because infantilisation is demonstrably harmful to the health and well-being of the affected adult, disregards their life narrative, and erases their actual subjectivity.

It is necessary to specifically address the infantilisation of cognitively disabled adults in this thesis, but it is not my intention to present cognitively disabled people as a qualified exception or marginal case. I do not use the term 'cognitively disabled' as an ontological sortal. I use it to refer to people who have been classified as cognitively, intellectually, or developmentally impaired or disabled, fully

acknowledging that these classifications are historically and socially contingent and linguistically problematic. Likewise, and in counterpoint, I use the term 'statistically typical cognitive functioning' to refer to people who are not classified as cognitively disabled; fully recognizing that population statistics on intelligence and cognitive ability are historically bonded to eugenics and continue to be skewed by racialized discrimination and geographical privilege. The terms 'cognitively disabled' and 'statistically typical cognitive functioning' act as contingent (and no doubt imperfect) designators for how different people are classified according to perceived or actual cognitive functioning. Where adults are infantilized, they are assumed to have not only the cognitive capacities of children, but to actually *be* children in the bodies of adults. I argue that this assumption is rooted in discriminatory biases about disability and old age, not on unbiased, ahistorical or apolitical judgements about the actual cognitive abilities of the adult in question. Even if an objector *were* to argue that infantilisation is appropriate and justified with cognitively disabled people (but wrongful with those not so classified), that objector would need a clean, precise, a-contextual definition of what it means to be cognitively disabled. I am skeptical that any such definition could be produced.

Nonetheless, my short definition of infantilisation – *conceiving of an adult as having the subjectivity or personhood of a child and treating them on that basis* – is intentionally normatively neutral. This is a methodological choice intended to leave space for others to engage with this theory without its being normatively pre-determined. For my part, however, I argue that infantilisation is both conceptually wrongful and demonstrably harmful, and as such, should be urgently avoided. In Chapter 3, I examine this wrongfulness and harmfulness in detail, and assess where blame, if any, might lie. I propose a graded approach to blame, with strong epistemic conditions, which centers the infantilized adults who are wronged and harmed by infantilisation while maintaining a pointed consideration of the difficult and unjust working conditions of many carers. I conclude that the

infantilisation of adults – cognitively disabled or not – is both a social injustice and a conceptual failure.

Chapter 1

# A Concept of Infantilisation

## 1.1 **Chapter Outline**

Most existing discussion of infantilisation is focused on infantilisation in action, addressing the ways in which people are treated. A theory of infantilisation should explain how it is enacted, but it should also clarify what is going on conceptually in cases of infantilisation. People may be treated in similar ways for different reasons. Different concepts may motivate similar actions. How we think about or conceive of another person motivates how we behave towards them and interact with them. Infantilisation as a concept therefore stands somewhat prior to infantilisation as a way of treating others; to understand why people are subject to certain treatment or experiences, it is important to understand the concept motivating those actions. This chapter will clarify infantilisation as a concept (before discussing infantilisation in action in Chapter 2). In defining infantilisation as a concept, I will also distinguish it from paternalism. When looking at research on the infantilisation of elderly people, physically disabled or cognitively disabled people, and trying to explain the way these people are treated, paternalism may seem like a suitable concept. I will argue in this chapter that infantilisation is conceptually distinct from paternalism, and that infantilisation provides a better explanation for these cases.

## 1.2 **Defining Infantilisation**

Infantilisation, perhaps surprisingly, has received little philosophical attention. Where the word is occasionally used, its meaning seems assumed. In Licia Carlson's *The Faces of Intellectual Disability* (2010) she writes of "the infantilization of the feebleminded" (Carlson, 2010, p. 65). While she mentions ways in which cognitively disabled people have historically been equated with or treated

as children, the term 'infantilisation' receives no real definition. In feminist philosophy also, women are said to be infantilized without any explication on what this process really involves. The implied meaning in these cases seems to be that infantilisation is *treating non-children as though they were children*. This meaning comes closest to being defined by Jean-Michel Rabaté, who clarifies: "to infantilise someone, for instance treating an adult person as if they were a child" (Rabaté, 2011, p. 111). Interestingly, in a misreading of Rabaté's somewhat offhand definition, the Wikipedia entry on infantilisation specifies that it is "the prolonged treatment of one who has a mental capacity greater than a child as though they were a child", implying that infantilisation is irrelevant in many cases of cognitive disability. This implication will be explored fully later in this chapter.

This assumed meaning for infantilisation draws passively on research from other disciplines. Infantilisation has been discussed and researched in Gerontology, Social Care, Nursing Studies, Bioethics, Developmental Psychology, Healthcare, and related (primarily socio-medical) fields. The bulk of this work addresses the infantilisation of elderly people only. For some, infantilisation only occurs in this context: it is defined as "patronizing treatment towards older persons" (Salari, 2006) and "the tendency to treat older people as though they are dependent children" (Hepworth, 1996), a phenomenon stemming from or closely tied to viewing old age as a "second childhood… [or] a return to childhood" (Jongsma & Schweda, 2018). Yet while most available empirical research on infantilisation is based in elderly care, it is generally understood and defined as a phenomenon which occurs more broadly. Sometimes understood narrowly as a linguistic phenomenon "that consists of talking to an adult recipient as if he or she were a child" (Cassidy, 1997, pp. 7-8), it is increasingly understood to involve a network of linguistic and non-linguistic practices. It is pervasively defined as *a way of treating people*: broadly, "the act of treating an adult in the same way you would a child" (Brady, et al., 2014). Yet the root and precise relevance of this treatment is unexplored: Are they treated *like* children or *as* children, or merely in some specific child-

appropriate ways? I will explore these questions, and the distinct features of infantilisation as a way of treating others, at length in Chapter 2.

However, it is first important to get come conceptual clarity on infantilisation. I argue that it is not only a way of treating others; it is also a way of *conceiving of* others. Infantilising treatment is predicated on infantilizing attitudes. As people may be treated in the same ways for different reasons, it is important to understand the conceptual background to these actions.

Although I will argue that infantilisation is both wrongful and harmful, I do not want to build this assumption into my conceptual definition of infantilisation. Infantilisation has no prior definition within philosophy; incorporating wrongfulness into its conceptual definition would stack the deck in my favour. Gerard Dworkin writes that "as a matter of methodology it is preferable to see if some concept can be defined in non-normative terms and only if that fails to capture the relevant phenomena to accept a normative definition" (Dworkin, 2020). I have aimed here to follow that guidance.

I define the *conceptual* aspect of infantilisation as follows:

*Infantilisation involves conceiving of an adult as having the subjectivity or personhood of a child.*

Nothing wrongful is built into this definition of infantilisation. Although I will argue that infantilisation *is* wrongful, this definition allows for alternative interpretation. It could be argued (and has historically been assumed) that adults with certain cognitive disabilities do in fact have the

subjectivity or personhood of children. If this is the case, it cannot be wrongful to conceive of them in this way. I will explore this issue later in this chapter.

As in the examples given from existing research in the previous section, cross-disciplinary discussion of infantilisation refers primarily to 'child' and 'childhood', rather than referring to 'infant' or the specific developmental stage, 'infancy'. There are two reasons why this may be the case, and why I will maintain the use of 'child' and 'childhood', seen in other disciplines, throughout this thesis.

The first is that infantilisation is something which (primarily, or exclusively) happens to adults; through it, they are pushed back down a perceived linear developmental chain which runs from adulthood down through adolescence, through childhood and back to infancy. Thus, infantilisation pushes an adult *toward* infancy, though they may not, in the end, be perceived as infants; they may be conceived of and treated as older children, or even young adolescents. An infant, in most common definitions, is a very young child, but infancy is a stage of childhood nonetheless; one without a specific boundary.

'Infant' typically refers to a child before they can walk, and certainly refers to a child before they can talk. This is the second reason to maintain 'infantilisation' even while using the broader concept of 'child': the connection to infancy highlights the importance of speech as an indicator of rationality and personhood. If walking is developmentally important, talking is even more so; the development of speech is tied inextricably in both humanist and post-humanist discourse to the development of rationality, and rationality is – on most accounts – fundamental to being human. Above even physical development, "speech is an enactment of reason, and therefore of human identity" (St. Pierre, 2015). When adults are conceived of as being closer on the developmental scale to infancy

than to adulthood, where they lie on this scale is tied closely to their capacity for language use ('speech' is not necessarily verbal), as this is the key indicator of their cognitive capacities. Indeed, the Latin root of infant, *infans*, means "incapable of speech" or "speechless"; in civil law, 'infans' refers to "a child not having the ability to speak" (Merriam Webster, n.d.). Thus, the less an adult is perceived to have speech or language use, the closer they are to an infant stage. A greater capacity for speech may place them further along the developmental scale, as older children or even young adolescents.[1] However, even for fully verbal adults, once infantilized they are "left without a voice, unable to speak up against [their] treatment" (Brady, et al., 2014, p. 24). Their expressions of resistance – whether verbal or non-verbal – can be disregarded where their subjectivity is conceived of as that of a child. Infancy is a state of childhood characterized not only as pre-ambulatory and pre-verbal, but as a state of extreme vulnerability. The term 'infantilisation' is rooted in these meanings and the specificities of infancy as a childhood state; it nevertheless can be more fully understood using the broader concept, 'child'.

This leads to three questions: What is the concept 'child'? What are the repercussions when the concept 'child' is applied to an adult? Why does this happen?

### 1.3 **What is the concept 'child'?**

The popular conception of 'child' can be seen to include three main features: deficits, goods, and futurity. On the 'deficits model', the child is understood as a primitive or immature human, lacking in adult cognitive and moral qualities (which they acquire, given the right environment, in stages as they grow). The deficits model (and related 'stage theory') owes much to Piaget and Kohlberg but is reflected too in earlier philosophical literature (Matthews & Mullin, 2020). More recent work has

[1] This is solidified in 'mental age' theory, discussed at length in section 1.10.

highlighted the intrinsic goods of childhood; Alison Gopnik has argued that children "aren't just defective adults" (Gopnik, 2009, p. 9), and that childhood involves play, free time, innocence, and the absence of responsibility - features which are intrinsically good, not merely beneficial in the creation of adults.

While Gopnik's picture presents certain typical childhood features as intrinsically good, the deficits view of childhood includes perhaps the core feature in the popular and philosophical concept of 'child': that is, the importance of futurity. The child is a future adult. The modern concept of 'child' retains the broadly Aristotelian view that childhood is a state of potentiality. Until relatively recently, philosophical positions on childhood maintained that a child was morally significant only in their potentiality to become a rational adult (and thereby, a full moral agent). Arguably, the popular conception of the moral significance of children is closer to recent philosophical positions which argue that, beyond this potentiality, children are morally significant *qua* humans, or morally significant because of their relation to others (Kittay, 2005).

The concept 'child', in common use, refers to a young member of the human species, who benefits from certain goods and freedoms by virtue of their child status, who is deficient in many cognitive capacities typical of adults, and who is expected to develop these capacities given the appropriate care and support. The concept child typically inspires care and protection. This nurturance is rooted in the assumed futurity of the child. Popular conceptions of the moral status of the child, and the care owed to them by adult members of the species while they are in their infancy, perhaps outstrip any connection to futurity; while children are unable to take care of themselves, they are owed care simply as members of the species. However, they are cared for and nurtured largely in the optimism of what they will become.

1.4 **What are the repercussions when the concept 'child' is applied to adults?**

There is an inevitable mismatch when the concept 'child' is applied to an adult. In some limited way, in so far as it may inspire a desire to care or protect, conceptualising an adult as a child may be contingently or temporarily beneficial. In a restricted and contingent sense, conceptualising the cognitive ability of a cognitively disabled person using the cognitive ability of a particular stage of childhood development may act as an approximately appropriate frame for interaction. However, applying the concept 'child' to adults, cognitively disabled or not, has several negative consequences. In conceiving of an adult as being at the life-stage of a child, the narrative of their life is erased. In using 'child' as a conceptual stand-in, their actual subjectivity is obscured. Prominently, it necessitates the complete desexualisation of the adult, placing them in the pre-sexual innocence of childhood[2]. And notably, when an adult is conceived of as a child, it is without the futurity and optimism intrinsic to the adult conception of actual children. When the concept 'child' is applied to an adult, that child is in stasis. The infantilised adult does not get to grow up. I will discuss these conceptual repercussions further later in this chapter, in the context of mental age theory. Their practical repercussions will be discussed in detail in Chapter 2.

1.5 **Why does this happen?**

Adults are conceived of as child-like, or equivalent to children, when they are assumed to have reduced or impaired cognitive ability as compared to statistically typical adults. Here I outline four reasons why this may happen: physical disability; old age; cognitive disability; race and gender bias.

[2] Their sexual agency, and agency regarding sexuality and gender, are denied, and their bodily maturity becomes a problem to be managed, as it conflicts with their assumed child-like subjectivity. They may, however, be sexually objectified; their child-like status does not protect them from sexual abuse and exploitation, any more than it does actual children. Desexualisation is discussed more fully in section 2.2 (iii).

- *Physical disability*

Where someone has a visible physical disability, non-disabled people may assume that their disability affects physical *and* cognitive function. This is referred to as 'disability spread': where someone is perceived to have a physical disability, the conception of their impairment 'spreads' to include all physical and cognitive function (Nario-Redmond, et al., 2019). If an adult is a wheelchair user, or has slow or slurred speech, or a markedly different gait and physical posture, it may be assumed that they also have reduced cognitive ability (Agmon, et al., 2016). Many adults with cerebral palsy, who may be visibly spasmodic and speak slowly and in a markedly slurred style, are assumed to be cognitively as well as physically disabled and treated accordingly. In one study, medical students were told in advance that their patients with cerebral palsy were physically disabled but had no cognitive impairment. The medical students nonetheless spoke to these patients as though they were addressing infants (Robey, et al., 2006). Conceiving of an adult as being child-like, or mentally equivalent to a child, is a common bias when non-disabled people relate to disabled adults. This is a discriminatory bias, based on a widespread lack of popular understanding of various forms of disability. It reflects deep cultural attitudes about disability and about disabled people as defective or incomplete persons. Physically disabled people are frequently assumed to be cognitively impaired and spoken to and treated like children. This infantilisation can persist, even where a person protests or demonstrates that they have the full cognitive functioning of a statistically typical non-disabled adult. (Nario-Redmond, et al., 2019; Agmon, et al., 2016)

- *Old age*

Elderly people, especially those in residential care settings, are susceptible to similar assumptions. They are often assumed to have an age-related decline in cognitive function. Long-standing tropes

about cognitive decline in old age – that it represents a second childhood or a return to childhood – contribute to blanket assumptions about the cognitive abilities of older people, especially in group settings (Jongsma & Schweda, 2018). Mobility and sensory impairments, which are increasingly common as people age, exacerbate this perception, with physical disability again taken to imply cognitive disability.

- *Cognitive disability*

In cases where a person is infantilized because they are assumed to be cognitively impaired, such as the cases of 'disability spread' or negative assumptions about old age outlined above, the infantilisation can be resisted by demonstrating that the person has the same cognitive ability as a typical adult. However, in the case of cognitive disability, the concept 'child' is applied in the absence of a proper alternative. The subjectivities and personhoods of cognitively disabled adults are poorly understood; they are different to non-disabled adults, but the nature of that difference has not yet been adequately conceptualized. The concept 'child' is the nearest available concept which seems to fit their cognitive abilities and modes of expression; thus 'child' acts as the "metaphoric grounding" (Hepworth, 1996, p. 425) of infantilisation. However, this concept can only ever be an approximate stand-in for cognitively disabled adults' actual subjectivities. As cognitively disabled people are typically unable to resist their infantilisation in the same way as non-disabled people (by asserting or demonstrating a statistically typical level of cognitive functioning) and as non-disabled people lack the conceptual resources to understand them correctly, the application of the concept 'child' becomes permanent and global. They are conceived of as children in ways that outstrip any connection to cognitive capacity. They are conceived of as *perpetual* children. Further, while cognitive disability is complex and extremely varied – with enormous differences in cognitive and communicative capacity even among those with the same condition – non-disabled people often assume near-total cognitive incapacity in any person with a perceptible cognitive disability. So, while

the assumption that a person has reduced cognitive capacity compared to a statistically typical adult norm may be correct, discriminatory attitudes influence the perception and treatment of the person similarly to the same effect in instances of physical disability or old age.

- *Race and gender bias*

Discriminatory assumptions about cognitive ability can be seen in other contexts. British imperial powers viewed their colonial subjects as having lower cognitive abilities. In patriarchal and sexist cultures women are assumed to have a lower cognitive capacity to men. In these contexts, some adults are considered less intelligent; less rational; less mature; less capable of education, conversation, and participation in civic life; less capable of making decisions in their own best interest. The assumption that they have inferior cognitive ability is based entirely on discriminatory sociocultural biases about gender and race. This assumption renders them child-like in some respects. Are these instances of infantilisation? I argue that they are not: they are instances of severe paternalism which do not have the distinctive features of infantilisation (which I outline below and discuss fully in Chapter 2). The features are different because the conceptual underpinnings of infantilisation and paternalism are different. In section 1.8, I will examine the features which are similar in paternalism and infantilisation and note the features which are distinct to infantilisation. This will show that while infantilized adults are conceived of as having the subjectivity or personhood of children, in cases of severe paternalism the targets are conceived of as being deficient or defective adults. This is the conceptual difference between infantilisation and paternalism.

## 1.6 **Paternalism**

Paternalism, broadly, involves "some kind of limitation on the freedom or autonomy of some agent [for] a particular class of reasons" (Dworkin, 2020). The justifiability of paternalism, in many forms, is thoroughly contested; from minimal 'nudging' of otherwise independent agents to behave certain ways, to severe paternalistic interventions controlling the choices and liberty of entire populations. The conceptual root of such interventions is that some person (or group of persons) is unable to make sensible decisions in their own best interest; therefore, some intervention affecting their autonomy is justified. Paternalism has been subjected to extensive debate and its boundaries are mobile and contested, but this attitude is central to the concept.

In many cases, it seems that even severe paternalism can be reasonable and justified. It is reasonable and justified for a parent to make decisions on behalf of their infant children, on the basis that infants do not yet have the cognitive ability or knowledge of the world to tend to their own wellbeing and welfare. As a child grows and develops, the paternal relationship should typically change to one encouraging of the developing person's independence and autonomy. Where a person is temporarily incapacitated by alcohol or drugs, it seems reasonable and justified for others to intervene to prevent them from harming themselves or others. Their ability to reason, judge, and calculate outcomes is inhibited; a paternalistic attitude is temporarily appropriate in their own best interest. Where a person is delirious or semi-conscious from illness or injury, the same conditions seem to apply. Where a person is unconscious or in a coma, paternalism seems reasonable and justified. In best practice, their prior wishes or instructions (if any) should be taken into consideration when making decisions on their care, but often no such instructions pertain. Family, friends, or medical professionals must adopt a paternalistic role, making important and potentially life-altering decisions on their behalf, without their involvement or consent. In such conditions, paternalism seems justified.

In these cases, paternalism is justified because the target of the paternalizing attitude is conceived of as being temporarily unable to make decisions in their own best interest. They are perceived, correctly, as temporarily having a lower level of cognitive ability to a statistically typical adult norm. However, there are also historical examples of severe paternalism which are not justified. In these cases, groups of people are incorrectly conceived of as having a lower level of cognitive ability, and therefore as being unable to make decisions in their own best interest. The British imperial attitude toward colonial populations was that such people were of a lower cognitive ability because of their ethnicity or nationality. Indian and Irish populations were thought of as cognitively incapable of democratic participation, higher education, and higher professional and social roles. Similarly, adult women in many patriarchal social/cultural contexts are considered to have a lesser cognitive capacity to adult men. They are and have been considered less rational, less intelligent, less capable of adult conversation or education, less able to understand politics, morality, or the economy, and overall, less able to properly understand the world around them or make sensible decisions within it.

In both examples, groups of people are conceived of as cognitively unable to make decisions in their own best interest, based only on their membership of a social kind. This results in a global loss of autonomy, restrictions on liberty, and a widespread denial of rights and opportunities. This wrongful conception of people is the result of discriminatory biases, and the resulting paternalism is unjustified. The outcome is that people are treated in ways which resemble the treatment of children. It may therefore seem appropriate to refer to these cases as instances of infantilisation.

### 1.7 **Infantilisation and Paternalism**

Severe paternalism seems similar to infantilisation in that some adults are conceived of as being cognitively less mature, rational or intelligent than those making decisions on their behalf. As they

are subsequently treated in some similar ways – treated, in many ways, as though they were children – cases of severe paternalism and of infantilisation might be conceptually indistinct. Paternalism at its most literal interpretation implies the adoption of a paternal or parental attitude toward another person or group of people. It rests on the assumption that these others are not capable of making decisions in their own best interest. Paternalism assumes this power relation – that one party is in the position of making decisions on behalf of the other, with or without their consent. If we imagine the most literal interpretation of paternalism – implying a metaphorical parent/child relationship - it seems reasonable to assume that the target is conceived of as a child or an infant. On this view, infantilisation may mark out something conceptually significant *within* paternalism, but it is part of the same concept. It could be considered a nested concept within paternalism, marking out its minimal extension or most literal interpretation. If paternalism is conceptually sufficient to explain what is going on in cases where adults are treated like children, and infantilisation merely points to the minimal metaphorical extension of paternalism, then a theory of infantilisation seems unnecessary.

However, people may be treated in similar ways on different bases. Different concepts can motivate similar treatment. While it seems descriptively appropriate to refer to the treatment of women and colonized populations as infantilizing, there are significant – and I argue distinctive – features of infantilisation which are not present in these cases.

No matter how severely paternalistic the attitude toward women or colonized groups may be, they are not spoken to in 'baby talk'; they are not addressed using childish language, higher pitched voices, and infant-appropriate tones. Their recreational activities are not limited to those suitable for infants. They are not placed in accommodation and environments decorated and designed for infants. They are expected to work and contribute to economies and societies (though their options

may be limited to domestic or manual labour). They are expected to marry and have children. They are permitted to have romantic and sexual lives and to maintain a household and a family. These differences in treatment (which will be explored more fully in Chapter 2) point to the different conceptual foundations of paternalism and infantilisation. In these most severe instances of unjustified paternalism, the paternalized other is conceived of as *an inferior kind of adult* but an adult all the same. They are perceived as less capable and less deserving of autonomy and independence because they are perceived as diminished persons. Their liberty, opportunity, rights, and autonomy may be restricted in ways that seem to mirror the restrictions placed on infants by their parents, but they retain many of the personal and interpersonal norms of adulthood. They are conceived of as being incapable of making decisions in their own best interest, based on discriminatory biases about their social kind, but they are not conceived of as adults with the subjectivities or personhood of children.

I propose that infantilisation is conceptually distinct from paternalism, and that it is necessary to identify and understand this distinction if the particular wrongs and harms of infantilisation are to be correctly identified and understood. Infantilisation and severe paternalism can be enacted in similar ways, resulting in people receiving seemingly alike treatment which nonetheless results from different conceptions. Without an understanding of the difference in the conceptual foundations, it is not always possible to identify what is going wrong with particular ways of treating and interacting with others. This is especially the case with cognitive disability, where some level of paternalism is often justified but, I will argue, infantilisation is always wrongful.

### 1.8 **Features of Infantilisation**

In addition to the features shared with cases of severe paternalism, infantilisation demonstrates four core features which point to the foundational difference between these concepts.

| | Paternalism | Infantilisation |
|---|---|---|
| Denial of autonomy | X | X |
| Limits on liberty and mobility | X | X |
| Presumed cognitive incapacity | X | X |
| Desexualisation | - | X |
| 'Baby talk' | - | X |
| Infantile environments/activities | - | X |
| Stasis | - | X |

These additional features are not seen in the cases of severe paternalism outlined in previous sections. They are seen in the conceptualization and treatment of elderly people, physically disabled people, and cognitively disabled people[3]. These additional features point to the foundational difference in these concepts, which can be understood as follows:

> **Paternalism**: conceiving of other person(s) as being unable to make sensible decisions in their own best interest.
>
> **Infantilisation**: conceiving of an adult as having the subjectivity or personhood of a child.

### 1.9 **Cases of Infantilisation**

[3] Based on the available empirical research, infantilisation is experienced by these groups specifically. This does not rule out its being experienced by other groups in other contexts.

These additional observable features indicate cases where infantilisation is operating conceptually. The person is not only considered unable to make sensible decisions in their own best interest; they are understood as being *a child in the body of an adult*. This leads others to engage with the infantilized adult as though they were a child. This wrongful and inapt conceptualization has harmful repercussions, as the concept 'child' cannot be applied to an adult without conflict.

Adults with visible physical disabilities - particularly conditions which affect speech, communication, and mobility - are particularly susceptible to infantilisation (Nario-Redmond, et al., 2019). As mentioned earlier in this chapter, this can be attributed to the idea of 'disability spread'; the phenomenon where non-disabled people perceive physical disability and assume the person's cognition is also affected. Elderly people, especially those in residential care, also frequently experience infantilizing treatment (Cassidy, 1997; Dolinsky, 1984). Often residential care facilities include residents with and without cognitive disability, and cognitive disability will be assumed in all residents (Salari, 2006); especially where a person has slow or slurred speech, mobility difficulties or incontinence. The conception of old age as a second childhood or a return to childhood is a long-standing trope, apparent from early philosophical literature to modern psychological theory: Erasmus points to old age as being "exactly what it means to become a child again" (quoted in Jongsma & Schweda, 2018, p.415), while contemporary views on dementia involve "the parallelization of disease stages and phases of childhood development" (Jongsma & Schweda, 2018, p. 416). There is extensive work on the conflation of childhood with old-age and how both life stages are marked by dependency; in their new dependency, elderly people are seen as becoming child-like again (Johnson, 1993; Dolinsky, 1984; Cassidy, 1997; Özen, 2019).

Elderly people and physically disabled people may be infantilized on the incorrect assumption that they are cognitively disabled. It is easy to see that the conception of these adults as equivalent to

children, or as having the 'inner' person of children, is conceptually wrong. These groups can attempt to resist or escape their infantilisation by asserting or demonstrating that they have a typical level of adult cognitive functioning and therefore should be conceived of and treated as adults, regardless of any additional care or support needs. So, while infantilisation might seem wrongful in these cases, it might seem appropriate in diagnosed cases of cognitive disability. It could be argued that, in such cases, there is nothing wrongful about infantilisation. It could be argued that it is proper and correct to conceive of a cognitively disabled adult as an infant or child, depending on the nature or severity of their condition. Where an adult has a mental age of six, isn't it adequate and appropriate to conceive of them and treat them as a child? If the conceptual aspect of infantilisation *just is* conceiving of an adult as having the subjectivity or personhood of a child, isn't this accurate and reasonable in cases of cognitive disability? In the next section, I will examine the concept of 'mental age' and how it is used in cases of cognitive disability. I will argue that mental age theory is conceptually deficient and wrongful. I will show how the use of mental age theory incorrectly and harmfully portrays cognitively disabled adults as perpetual children and acts as a barrier to their resisting or escaping their infantilisation.

### 1.10 **Mental Age theory**

The concept of 'mental age' was introduced by Alfred Binet in the early twentieth century, as part of his system of intelligence testing. A 'mental age' was assigned based on a person's test results when compared to average test scores for different age ranges in the general population (Martin & McFerran, 2017). Although intended to improve pedagogical approaches for children, Binet's system was adopted to categorize asylum inmates, "trapping [them] in a state of perpetual childhood" (Ilyes, 2020, p. 5), and reconfigured to work alongside concepts of intelligence and intelligence testing rooted in white supremacy (Stubblefield, 2010). It became a core tool of the eugenics movement, with people graded on their 'feeblemindedness' according to the Binetian test scores:

those assigned a ‘mental age’ of less than twelve were deemed unfit to reproduce, forcibly sterilized, and mainly confined to institutions. (Trent, 2017; Wilson, 2021)

These tests, and the designation of child-equivalent mental ages, grew from a conceptual background which already viewed cognitively disabled people as akin to infants; one which explained cognitive disability as a failure to develop beyond childhood. The shift from using the term ‘idiocy’ to the term ’feeblemindedness’ in the late nineteenth century was largely made on this basis. This change was argued for (most notably by Samuel Gridley Howe, superintendent of one institution) in the hope that it would result in better treatment: Howe “infantilized as an act of advocacy” (Ilyes, 2020, p. 5), apparently believing institutionalized adults would be less abused and better protected if they were understood as children rather than animals (Carlson, 2010). This *quantitative* understanding of cognitive disability ran alongside a *qualitative* one: where the qualitative understanding (tied to the term ‘idiot’) saw cognitively disabled people as a different kind of creature, more like an animal or plant than a human, the quantitative understanding (tied to the term ‘feeble-minded’) saw them as humans who failed to develop past an infant state. Their difference was in the quantity of human capacities they had developed, not in their ontological quality. This quantitative picture represents cognitive disability “according to a temporal scale or chronology, and thus the “idiot” becomes interpreted against the backdrop of childhood more generally” (Carlson, 2010, p. 30). From the late nineteenth century, ‘idiocy’ was largely replaced by ‘feeblemindedness’, a condition of human development “differing from others not in kind, but in degree only, - as merely having feeble mind… like that of little children” (Howe, qtd. in Carlson, 2010, p.30). On this view, “idiocy is akin to infancy, insofar as it is the lowest point of development of our human potential” (Carlson, 2010, p. 29).

The introduction of 'feeblemindedness' as a replacement for 'idiocy' was intended to assert this difference and was initially a dynamic – rather than static – representation of cognitive disability. In representing cognitively disabled people as children, the intention was to encourage the provision of education and support. Where previous conceptions of 'idiocy' saw it as a static, unchangeable condition, the 'feeble mind' could be encouraged to learn and develop, as a child might learn and develop. However, the development of mental age theory in the early twentieth century intersected with this prior understanding of cognitive disability, once again reshaping the picture of cognitive disability to one of stasis. Assigning a mental age to cognitively disabled adults not only designated their mental age at the time of testing; it placed a cap on their potential development in perpetuity. An adult assigned a mental age of six was assumed to remain at that mental age for life. Thus, mental age theory returned to a static picture of cognitive disability.

Although the testing and assessment process has since broadened to include cognitive, adaptive, emotional and communicative testing, these tests are today still scored against general population standards (Harris, 2010; Carlson, 2010), and these population standards remain foundationally shaped by racialized discrimination, gender, and class (Stubblefield, 2010). Specific mental ages continue to be formally and informally assigned to cognitively disabled people and mental age theory remains a significant feature in popular conceptions of cognitively disabled adults. I argue that the attribution of a mental age to cognitively disabled adults is conceptually deficient in its inaccuracy, assessment contingency, and its permanence.

Assigning a mental age to an adult is inaccurate for at least two reasons. First, the test assessments themselves can give only an estimate of a person's cognitive, communicative, or adaptive abilities. Test outcomes can be negatively influenced by the test environment and the style and pace of the assessment. Outcomes are distorted by assumptions made about the person being tested before the

assessment even begins: non-white people are more likely to be deemed cognitively impaired (Stubblefield, 2010) and females less likely to be diagnosed with some conditions, such as autism (Driver & Chester, 2021). Second, there is significant range within the age categories being assigned. Assigning a mental age of six appeals to a statistically average six-year-old; yet there is huge range in the communicative, cognitive, emotional, and physical abilities or styles of any given six-year-old (Gopnik, 2009). The assignation of mental age is similarly ambiguous. Averages for different ages or developmental stages can obscure the huge range and type of abilities among six-year-old children. Thus, assigning a 'mental age' can never provide an accurate framework.

Assessments of mental age, especially as regards cognitive disability, are profoundly shaped by the social and historical context of the assessment. Such assessments are contingent – that is, they are shaped by circumstance – in fundamentally significant ways; yet they are typically assumed to be objective assessments of the intrinsic abilities of the subject. The test outcome is taken to be an assessment of the "properties of decontextualized, singular brains" (Fein, 2020, p. 64), rather than reflections on the historical periods, political and social climates, and the environment and networks within which the assessed persons are situated.

Although assessments of cognitive capacity are assumed to provide an objective picture of an individual's intrinsic abilities and potential, there is ample evidence that they are fundamentally shaped by the extrinsic factors impacting on the person being assessed. As supports and attitudes have changed, so too have the assessment outcomes (Harris, 2010; Stubblefield, 2010; Wong, 2010; Trent, 2017). Michael Berburé writes: "in the 1920s we were told that people with Down syndrome were incapable of learning to speak; in the 1970s, we were told that people with Down syndrome were incapable of learning how to read…. Twenty years from now we'll be hearing ''sure, they get Woody Allen, but only his early comedies, they completely fail to appreciate the breakthrough of

*Interiors*" (Bérubé, 2009, p. 362). Down syndrome, as a genetic condition, has not changed; yet the potential of a person with Downs syndrome has expanded in line with the supports available. Where supports for cognitively disabled people are available, "early-intervention programs have made such dramatic differences in their lives over the past few decades that *we simply do not know what the range of functioning looks like*" (ibid.) [my emphasis]. The static picture of cognitive disability evident in mental age theory does not allow for such potentiality.

Clinical psychologist Elizabeth Fein, in her ethnographic research with young autistic adults and their families, finds a similar reflection of the impact of situation and environment on the supposedly neutral process of neuropsychological evaluation. She quotes one parent, referring to assessments of her autistic son, Allen, carried out a year apart. In that time, Allen had moved from a care environment which had caused him significant difficulty and distress, to one where he felt comfortable. Fein quotes his mother, saying; "I could show you a neuropsych [neuropsychological evaluation] from before he went there... and from after… and you would think you were reading two different child's descriptions." (Fein, 2020, p. 62) It is worth including Fein's full explanation of these assessments here, to understand why the extreme difference in the two assessments on the same person seems surprising. Fein writes that:

> "a neuropsychological evaluation consists largely in a series of tests, usually alongside an interview with the test subject and perhaps with their family members. The subject's performance on these tests guides inferences about their underlying brain function and, in particular, the potential presence of brain illness or injury. Developed after the First World War created a generation of battle survivors who suffered from lingering damage to localised brain areas, neuropsychological evaluations are now commonly given to assess cognitive changes in the elderly as well as learning disabilities in children… They assess a range of traits that characterize a subject's approach to the world: perception, learning,

> memory, attention, cognition. However, the concept of the brain lesion still metaphorically organizes the representation of the phenomena that have replaced it as objects of investigation. Although what is being investigated is now understood as a systemic phenomenon… - whole-brain regions and the connections between them – the underlying model persists… *The goal is still to infer the presence of some discrete problem in the brain that manifests through differences from the norm in task performance*… [all of] these characteristics are assumed to be inherent to the individual being evaluated*. The presupposition is that the tests locate bodily pathologies in the individual test subject*. Thus, the change in Allen's neuropsychological profile, between who he was in a stressful environment and who he was in a welcoming one, is remarkable… the same kid is not supposed to have two such different reports." (Fein, 2020, p. 63) [my emphasis throughout]

Neuropsychological assessments and assignations of mental age are inaccurate and profoundly context dependent. They remain in clinical use: perhaps more importantly, the concept of 'mental age' remains a core element in public perceptions of cognitively disabled people. Mental age theory is a significant element in the construction of the perpetual child. As mentioned earlier in this chapter, applying the concept 'child' to an adult results in a conceptual mismatch, so that the conceptualisation of the infantilised adult differs in significant ways from the conceptualisation of an actual child. One glaring difference, as previously stated, is that the infantilised adult does not get to grow up. This reflects the static (rather than dynamic) view of cognitive disability, where cognitively disabled people are understood to be permanently stuck at a particular developmental stage without the capacity to change and learn and develop. The application of a specific mental age severely exacerbates this stasis, with the assigned mental age often treated as a ceiling (Safta-Zecheria, 2018). Once assigned a specific mental age, a person is assumed to remain at this age indefinitely. Further, a reliance on mental age to conceptualise cognitively disabled adults creates a

looping effect; in assuming a limit on their development, they are treated as children, which in turn results in cognitive decline or lack of development. Disability activist Ivanova Smith writes: “A lot of my friends with intellectual disabilities have been misled by mental age theory. They feel they will never gain independence or get married because they have been told they are children and treated like children for their entire lives.” (Smith, 2017) I will explore this looping effect further in Chapter 3.

As with the phenomenon of ‘disability spread’, there is a kind of ‘mental age spread’ apparent in cases of cognitive disability. Once a mental age is assigned, it spreads to all areas of the person’s identity and subjectivity. Beyond any specific range of functioning, once assigned a mental age of six, their personhood and subjectivity are conceived of globally as that of a six-year-old child. Their interests, desires and needs are assumed to be those of a six-year-old child. Ivanova Smith writes, “Difficulty doing specific tasks isn’t the same thing as being an actual child… I [am] not mentally 12. I am mentally 28. I just have an intellectual disability.” (Smith, 2017)

Once they are understood to be context dependent and approximate, periodic or regular assessments of cognitive, adaptive and communicative abilities can form an important part of any care and support system for cognitively disabled adults. However, assigning a mental age based on the outcome of those assessments is conceptually bankrupt and demonstrably harmful. Mental age theory is often assumed to be an imperfect but functionally acceptable means of conceptualising and subsequently interacting with cognitively disabled adults. Yet it creates an inaccurate picture of their abilities, erases their life experience and personal narratives, and spreads into all areas of their identities – contributing to, exacerbating, and cementing their total infantilisation.

As with “chronological age, people use “mental age” as a shortcut to judge the maturity and competency of others” (Silverman, 2018), and as with other ‘shortcuts’ it is dependent on previously held biases about cognitively disabled people, their capacities and their identities. Neither assessments of mental age nor the conceptual infantilisation of cognitively disabled people are based on clean, clinical, ahistorical, and non-contextual facts about their neurological or intellectual reality. As with physically disabled people and elderly people, cognitively disabled people are infantilised based largely on biases and assumptions about *people like them*.

### 1.11 **Cognitive Disability & Infantilisation**

It is a conceptual failure to conceive of an elderly person or a physically disabled person as having the subjectivity or personhood of a child. The failure is in the application of the concept ‘child’ to an adult, and the failure seems obvious where the person to whom it is applied has a statistically typical level of adult cognitive functioning. Is it also a conceptual failure in cases of cognitive disability? I argue that it is. It is a conceptual failure because an adult of forty or eighty is not a child, whatever their cognitive abilities. It is a conceptual failure as an approximation of a person’s subjectivity and personhood, as in the case of mental age theory, because any such approximation is misleading, inaccurate, and serves to limit their identity and development.

When we interact with adults with profound cognitive and communicative difficulties, our typical conceptualisation of adults may fail us. To understand the adult with whom we are interacting, and decide how best to interact with them, we need some workable concept of the subjectivity and personhood of the person with whom we are engaged. ‘Child’ may seem like the closest available conceptual option. Through it, “that which is familiar provides the metaphoric grounding for knowledge of that which is less familiar” (Hepworth, 1996, p. 425). The experience of cognitive

disability is broad and includes a complex range of cognitive, communicative, emotional, and adaptive functioning. We lack – philosophically, clinically, and in popular understanding – the conceptual resources to correctly understand the subjectivities and life experience of many cognitively disabled adults. The use of 'child' as a stand-in concept may not therefore be strictly blameworthy, but it is still a conceptual failure.[4] Infantilizing an adult – conceiving of an adult as having the subjectivity or personhood of a child – is a failure to conceive of the person in a way that is accurate to their subjectivity and experience of the world. As I will discuss in detail in Chapter 2, it has repercussions; in conceiving of another as being externally/physically an adult but internally/subjectively a child, child-appropriate treatment is directed toward them, and adult-appropriate rights, opportunities and permissions are denied to them. When an adult is conceived of as a child, it is incomprehensible that they would engage in romantic or sexual relationships, have children, drink alcohol, or even swear and curse. Such behaviour in people conceived of as children inspires revulsion or resistance because of the conceptual conflict created when adults are infantilized: their behaving in adult ways, or participating in the norms of adulthood, is in conflict with their being conceived of as children. This conceptual failure, and its repercussions in the treatment of infantilized adults, is distinctive of infantilisation; this is not seen in cases of severe paternalism.

### 1.12 **Paternalism, Infantilisation & Cognitive Disability**

As discussed in earlier sections, there is a strong link between paternalism and perceived or actual cognitive capacity. It seems easiest to justify paternalism where a person's cognitive abilities are significantly lower than the statistically typical adult norm; in these cases, it is easiest to argue that the person is either temporarily or permanently unable to make sensible decisions about their own welfare or act in their own best interest. As I have noted, paternalism has historically been justified

[4] I return to questions of wrongfulness, harm and blame in detail in Chapter 3.

on this basis even where assumptions about cognitive capacities were based solely on racist or sexist biases. There are close ties between paternalism and perceived or actual cognitive capacity; in some instances, this shows paternalistic attitudes to be discriminatory and wrongful; in some cases, paternalism may be reasonable, appropriate, and justified.

Some level of paternalism may be reasonable, appropriate, and justified in some instances of cognitive disability. The level of justifiable paternalism will vary considerably depending on the type and severity of disability in question: an adult with Downs syndrome may need only limited assistance or guidance in decision making and day-to-day care, whereas far less autonomy will be available to an adult with late-stage dementia. For adults with profound cognitive impairments, it may be justified and appropriate for others to make decisions about almost all areas of their lives and welfare. With cognitive disability, "paternalism seems at once vitally necessary and potentially dangerous" (Bérubé, 2009, p. 359). Historically, the abuse of cognitively disabled people under the guise of paternal care has been commonplace. The level of intervention can be extremely difficult to gauge and historical assumptions and biases about cognitive disability very difficult to overcome. Yet some level of paternalism can be, as Berubé says, "vitally necessary". When coupled with and rooted in respect for the abilities, potential and identity of the cognitively disabled adult, such paternalism can be necessary, appropriate, and justified.

Infantilisation is not justifiable in the same way. It is not necessary to conceive of an adult as having the personhood or subjectivity of a child in order to make decisions in their best interest on their behalf. So, while cognitively disabled adults may be paternalized *and* infantilized, the resulting treatments are not grounded in the same concepts. Paternalism may be justified, to an appropriate extent; infantilisation is not. This difference in justifiability further points to the distinction between the two concepts.

## 1.13 **Chapter Summary**

In this chapter I have aimed to clarify the conceptual aspect of infantilisation. I have defined this aspect as *conceiving of an adult as having the subjectivity or personhood of a child*. In plainer language, it is understanding someone as being a child in the body of an adult. I have argued that infantilisation is therefore conceptually distinct from paternalism. It might seem unnecessary to fret about whether infantilisation is a distinct concept or merely a kind of paternalism. This might seem like unnecessary shuffling of conceptual furniture. However, I believe a defined concept and theory of infantilisation is necessary in order to understand how people are treated, why that treatment happens, and what is wrongful about it. An understanding of infantilisation is necessary because it frequently occurs in situations where some level of paternalism is appropriate. We need to be able to separate paternalistic attitudes and treatment, which may be justified and appropriate, from infantilizing attitudes and treatment, which are wrongful and harmful. With an understanding of the difference in the conceptual foundations of these two concepts, we can correctly understand the differences in how they are enacted. In the next chapter, I examine infantilisation in practice. This will show the treatment *which results from* conceiving of adults as having the subjectivity or personhood of children.

Chapter 2

# A Theory of Infantilisation

## 2.1 Chapter Outline

In Chapter 1, I clarified the concept of infantilisation, distinguished it from paternalism, and explained why this distinction in necessary. In this chapter I will aim to sketch out a theory of infantilisation. That is, I will explain how infantilisation is enacted. I will show the treatments and behaviours which result from, and which are motivated by, the conceptual foundation of infantilisation. A theory of infantilisation should pick out those actions and ways of treating people which are rooted in the concept of infantilisation developed in Chapter 1. A theory of infantilisation should explain how infantilisation manifests in practice.

As I have previously noted, most existing attention to infantilisation is focused on infantilisation as a way of treating others. Now that the conceptual aspect of infantilisation has been defined, this treatment will be examined. This chapter has two sections and a concluding summary. First, in section 2.2: 'Features Distinct to Infantilisation', I will lay out those ways of treating others which I propose are distinctive to infantilisation. From my study of available empirical research on infantilisation in care services, healthcare, and the community, I have framed recurring patterns of treatment under four headings:

i) Infantilizing speech and engagement ('baby talk')

ii) Infantilizing activities and environment

iii) Desexualisation

iv) Stasis

In section 2.3: 'Features Shared with Paternalism', I will examine features of infantilisation which are or may be shared with paternalism:

v) Denial of personal autonomy

vi) Limits on liberty and mobility

vii) Presumed cognitive incapacity

As argued in Chapter 1, it is important to distinguish infantilisation from paternalism because infantilisation seems to occur most frequently in situations where some level of paternalism is (or may be) justified. I will discuss how the core features distinct to infantilisation can be used to distinguish instances of potentially benign paternalism from instances of infantilisation, but also show that the conceptual influence of infantilisation may affect judgements about otherwise appropriate paternalism, even where the core features of infantilisation are not evident.

## 2.2 **Features Distinct to Infantilisation**

I propose that four core features are distinct to infantilisation as a way of treating others. These features result from the conceptual aspect of infantilisation; they are the *results of* the conceptual failure which occurs when an adult is conceived of as having the subjectivity or personhood of a child. These four core features are:

i) Infantilizing speech and engagement ('baby talk')

ii) Infantilizing activities and environments

iii) Desexualisation

iv) Stasis

In the first three features, it will be noted that child-appropriate norms are *applied,* and adult-appropriate norms are *withheld*. The fourth feature, Stasis, demonstrates most clearly the difference between the infantilized adult and an actual child; the infantilized adult is thought of and treated *like* a child, but not *as* a child. This stasis has profound implications for the infantilized adult.

i) Infantilizing speech and engagement

Infantilized adults are spoken about, spoken to, and engaged with in ways otherwise reserved for infants. This happens because of the conceptual assumption that they are a child in the body of an adult. They are spoken to using 'baby talk'[5], where the speaker uses more words at greater amplitude and higher frequencies; in essence, speaking as though they were addressing a small child (Cassidy, 1997; Robey, et al., 2006; Nario-Redmond, et al., 2019). The speaker uses "extreme facial expressions and exaggerated phrasing" (Salari, 2006, p. 68). They often use collective pronouns (eg. "Are *we* going to have *our* dinner now?"), instead of addressing the person directly. They may use childish nicknames and overly intimate endearments, frequently referring to the infantilized adults with epithets like 'sweetie', 'kiddo', 'buddy' and 'honey', and shortening their names to "Mikey", "Susie", etc. (Brady, et al., 2014; Cassidy, 1997; Johnson, 1993; Agmon, et al., 2016). Staff members in multiple care settings used the terms "good girl" and "good boy", and "bad girl" and "bad boy", to praise and reprimand their adult clients (Dolinsky, 1984; Capri & Swartz, 2017; Salari, 2006). A staff member in one study referred to the elderly and cognitively disabled adults in her care as "the kids" and herself as "mom" (Salari, 2006, p. 69). The director of another care setting referred to the adult clients as either "cute" or "brats" based on "how well they behaved" (ibid., p.68). Infantilized adults are teased and joked about using child-appropriate language (Capri & Swartz, 2017). They are

[5] 'Baby talk' and 'elder speak' are closely equivalent terms in social science literature on infantilisation, with the latter term referring only to these speech patterns as they are used in elderly care settings.

instructed in their behaviour as though they were children and threatened with child-appropriate punishments where their behaviour is seen to transgress child-appropriate norms.

'Baby talk' is therefore not only a tone of voice or manner of speaking; it is the means through which infantilized adults are engaged and their behaviour regulated. It carries the system of reprimands, scolding, admonishments, praise, and rewards otherwise reserved for relationships where adults engage with children. Child-appropriate norms are applied through baby talk and the infantilised adult's behaviour is expected to reflect these norms. Infantilized adults are praised, scolded, teased, and punished depending on how well their behaviour conforms to these child-appropriate norms. In respite centres where infantilisation was widespread, elderly and cognitively disabled adults were required to remain seated, not stand up without giving a reason to the staff, not go to the bathroom without asking, not engage with or talk to other residents during activities, and not nap or fall asleep (Salari, 2006). Adults who fell asleep during the day would be loudly woken by a staff member shouting "Wakie Wakie" close to their ear, and then scolded and reprimanded for napping. Infantilized adults are threatened with 'time outs' for transgressions such as walking around without permission. One study describes how a cognitively disabled woman was infantilized at home, punished like a child by her brothers. It says "they will send her to the naughty corner, or… she's not allowed to watch TV for 3 weeks . . . And she will say, 'I tell them I am 33. I'm an adult. I'm an adult.'" (Dorozenko, et al., 2015, p. 293)

Adult-appropriate norms of speech, such as swearing, telling jokes with sexual innuendo, complaining about their treatment, or engaging in conversation with other residents during activities, were punishable offences in situations where adults were infantilized. In one residential care centre, two elderly women were placed separately on 'time outs' in the respite centre kitchen, one with her wheelchair brakes locked so she could not move, as punishment for swearing and

expressing gratitude that a mandatory activity was over (Salari, 2006). Such adult-appropriate norms of speech and interpersonal engagement are seen as unacceptable transgressions once the adult is conceptualised as a child.

Where adults are infantilised, child-appropriate speech patterns are applied, and adult-appropriate speech patterns are withheld. These speech patterns shape interpersonal engagement, where child-appropriate admonishments, threats, praise, and ridicule dictate the child-appropriate norms of behaviour to which the infantilised adult is expected to conform. These patterns of speech and engagement are distinctive of infantilisation; they are the result of the conceptual failure which occurs when an adult is conceived of as having the subjectivity or personhood of a child.

ii) Infantilising activities and environments

Infantilised adults are often provided with, or presumed to be interested in, child-appropriate activities, while adult-appropriate activities are withheld or denied. Their living and social environments are often child-appropriate, and adult-appropriate norms of privacy and environmental regulation are withheld or denied. In these ways, the social and physical world of the infantilised adult is constructed and regulated on the basis that they are an adult with the subjectivity or personhood of a child.

Within residential and respite care settings for elderly, physically disabled, and cognitively disabled people, studies have observed the use of child-appropriate décor such as cartoon window stickers of flowers and small animals, paper bunting and dolls (Cassidy, 1997; Dolinsky, 1984; Brady, et al., 2014). Activity rooms resembled children's classrooms. At centres where infantilisation was widespread, activities provided for residents and clients were appropriate for infants, with songs and

craft projects typical of school or preschool settings for small children (Agmon, et al., 2016; Salari, 2006). Such activities were often mandatory; the service-users were required to attend and participate and were reprimanded or punished if they refused to do so. During activities they were reprimanded for talking to each other, standing up, joking, objecting to the infantile nature of the activity, napping, or failing to pay attention (Salari, 2006). Their participation in such activities is mandated and overseen on the assumption that such activities are appropriate for them; this assumption *results from* conceiving of them as having the subjectivity, personhood, or cognitive capacity of children. They are conceived of as child-like and provided with child-typical activities, yet in inhabiting the unruly bodies of adults they must be strictly instructed and restrained.

Such assumptions are not confined to residential and respite care settings, though they are perhaps most obvious in such environments. Philosopher Sophia Isako Wong describes how her friend assumed child-appropriate interests in Wong's brother, Leo (who has Down syndrome), even though she had heard him speak of his adult-typical hobbies before. Wong writes: "Although she had spoken with Leo previously about his interests in opera and basketball, her [birthday] gift to him was a colorful toy fire truck suitable for a small toddler" (Wong, 2002, p. 107). Where an adult is infantilised, child-appropriate interests are assumed, and adult-appropriate interests are denied. Adult-typical social norms like drinking alcohol, attending dances or events, and socialising with age-equivalent peers are seen as confronting and inappropriate where the adult is conceived of as a child. Infantilised adults are often denied access to books, films and other cultural material with adult themes, and restricted to cultural material appropriate for children (Dorozenko, et al., 2015). Their internet access may be limited by digital parental controls designed for use with children (Gardiner, 2018). Such restrictions reflect the foundational assumption that adult cultural activities or materials are not appropriate, because the adult in question is understood to have the subjectivity or personhood of a child.

Adult-typical norms of environmental regulation are denied once an adult is infantilised. Across studies, infantilised adults complained that they had no privacy, or their lack of privacy was observed by researchers. Staff in residential settings entered residents' rooms at any time without knocking. Toilets for residents were not private, and the personal care and toileting needs of residents was discussed loudly by staff members in public areas. No space was allowed for residents to withdraw from common areas to be alone, and they needed staff permission just to move around the centre or use the bathroom (Capri & Swartz, 2017; Salari, 2006; Muswera & Kasiram, 2019). Such extreme denial of privacy and basic autonomy may seem justified in residential care settings – after all, many people reside in such centres precisely because some level of oversight is necessary for their care, welfare, or safety. Severely cognitively disabled people may require near-constant observation in the interest of their well-being. Some cognitively disabled people may need or benefit from assistance in making decisions about what to do, where to go, or how to get there. Such assistance or observation can be part of a system of appropriate care and support. However, the infantilised adult is assumed to need supervision at all times; they are assumed to be "always in need of control and protection" (Goyal, 2017, p. 138). In many of the studies referenced here, this assumption is not based on actual or specific cognitive disabilities. It is rooted in a conception of the infantilised person as a child in the oversize and potentially dangerous body of an adult. Adult-typical norms of privacy, time alone, and the opportunity to just decide how to move and exist within one's own physical and social space, are routinely denied once an adult is infantilised. While some level of paternalistic oversight may be appropriate in cases of cognitive disability, infantilisation is a distinct concept and process and it is not cleanly tied to actual cognitive ability or disability: the same infantilizing environments and activities are observed when non-disabled adults are infantilized. These activities and environments *result from* that conceptualisation, and the effects far outstrip any connection to specific disabilities or levels of cognitive capacity.

Infantilised adults are frequently segregated from the general population in their activities and environments, even when they are not resident in care settings. Conceived of as having the subjectivity or personhood of children, they are not considered part of adult society. Yet they are physically adults, and therefore cannot be part of the social world of children; indeed, they may instead be perceived as a danger in such environments. While their environments and activities are often child-appropriate or child-typical, they do not have the free access to socialisation, friendships, and socially integrated activities typically available to children. They do not have the physical and social liberty of children. Once infantilised, they are neither adults nor children; their segregation from the physical and social spaces of both groups then easily follows.

iii) Desexualisation

When an adult is conceived of as having the personhood of a child or infant, it is inconceivable that they would engage in sexual or romantic relationships. An adult assigned the mental age of six, for example, is typically understood as having the personhood of a six-year-old child. Any expressions of physical attraction, sexuality, or romantic interest from a six-year-old seem grossly inappropriate and objectionable. A six-year-old has not reached the physical, psychological, or emotional developmental stages necessary to engage in such relationships. They are neither physically, psychologically, nor emotionally mature enough to be *interested* in romantic or sexual contact, and they do not have the emotional or cognitive capacities to *understand* their agential position in such issues.

There are important and difficult issues of self-knowledge, understanding and consent which must be considered when some cognitively disabled people engage in romantic or sexual relationships, but the presence of a cognitive disability does not rule out such relationships. Cognitively disabled adults are physically mature and typically have similar desires for romantic and sexual contact and relationships as non-disabled people. (Dorozenko, et al., 2015; Fitzgerald & Withers, 2011; Muswera & Kasiram, 2019; Wong, 2002; Alexander & Taylor Gomez, 2017) Their desexualisation stems primarily from their infantilisation, not from legitimate, individual-specific concerns about self-knowledge and consent.

This is evidenced in the desexualisation of non-cognitively disabled groups also; desexualisation is also experienced by elderly people and physically disabled people who are infantilised (Addlakha, et al., 2017; Agmon, et al., 2016; Goyal, 2017; Özen, 2019). Infantilised adults are denied adult-typical sexual and romantic norms and expected to conform to child-typical sexual neutrality. As with infantilising speech, engagement, environments, and activities, child-appropriate sexual norms are applied, and adult-typical sexual norms are withheld. Desexualisation occurs to varying degrees of severity, from general discomfort at the sexual maturity of cognitively disabled adults, to biomedical interventions preventing infantilised adults from having romantic or sexual lives. I will here outline desexualisation as it presents through these degrees of severity, and note that the denial or inhibition of sexual *agency* does not prevent infantilised adults from being instrumentalised as passive sexual objects. A seemingly paradoxical result of this desexualisation is that it leaves infantilised adults more vulnerable to sexual abuse. This complicates the contours of the desexualisation of infantilised adults; were they fully desexualised, they would be denied sexual agency and sexuality, but would also not be viewed as potentially sexually active or as targets of sexual abuse. Yet even where adults are severely infantilised, it is still recognised that they are (in some cases) physically capable of intimate or sexual relationships, or that they desire such

relationships. This is evidenced in the segregation of male and female residents in institutions, the prohibitions on physical contact, and the attempts to restrict or remove the infantilised adult's ability to pursue their desires. The high rates of sexual abuse experienced by cognitively disabled adults (those most likely to be targets of infantilisation) also complicates their desexualisation. If infantilised adults were completely desexualised, we would expect that they would neither have sexual agency, nor have their potential sexuality recognised, nor be sexually objectified and abused.

The recognition of the infantilised adult as potentially sexually mature or sexually active initiates the restrictions and prohibitions mentioned above and detailed below. In this way, the desexualisation of infantilised adults in an active process; a network of structural and linguistic practices which aim to neutralise their seemingly incongruent sexual or romantic desires and conform them, as far as possible, with their assumed child-equivalent subjectivities. This process is detailed in the rest of this section. However, the way in which the high rates of sexual abuse experienced by cognitively disabled adults (and the sexual objectification this entails), forms part of their desexualisation, or departs from it, requires further study. Comprehensively understanding this problem would constitute a significant project in itself; therefore, in what follows, I focus on the features of desexualisation as experienced by infantilised adults, specifically the effects on their sexuality, sexual identity, opportunity for relationships, and sexual agency.

Once adults are infantilised, their sexuality or romantic attraction becomes a problem. The sexually mature adult body is understood to 'contain' the personhood of a child. Expressions of physical or romantic attraction by infantilised adults therefore inspire discomfort or even revulsion. A staff member from one community service for cognitively disabled adults described how the general public are "confronted" when the members displayed adult behaviours like having sexual relationships or getting married (Dorozenko, et al., 2015). Infantilised adults merely holding hands or

kissing may be perceived as 'cute', much as though they were children; this is especially the case in attitudes to elderly people expressing romantic affection (Salari, 2006). Desexualisation is also apparent through indifference: Sophia Isako Wong describes how her adult brother Leo, who has Down syndrome, was allowed to accompany her to an otherwise strictly all-female group, because the women there "assigned him the status of a small (presexual) child, like the two-year-old boys who are allowed to accompany their female caregivers into women's bathrooms" (Wong, 2002, p. 107). Leo is understood has having no sexuality to worry about; no sexual aspect to his person at all, despite his (sexually mature) adult body.

The discomfort or revulsion inspired by the sexual or romantic interests of the infantilised adult lead to interventions to prevent sexual or romantic activity. These interventions may be passive, resulting from the assumption that infantilised adults have no sexuality to account for (Noonan & Taylor Gomez, 2011). Cognitively disabled people are assumed cisgender and heterosexual by default, as the development of sexual and gender identity is a rite of adulthood which is seen as irrelevant for infantilised adults (Noonan & Taylor Gomez, 2011). One review of current research found that physically disabled people are "systematically denied access to knowledge about sexuality, sexual behaviour and services" (Addlakha, et al., 2017, p. 5). Many care settings simply do not allow the privacy necessary for sexual activity (Muswera & Kasiram, 2019). Until recently, few material or technological supports existed to facilitate sexual activity for people with different physical disabilities or mobility requirements. Where the adult has been conceptually infantilised, no provision is made for their sexual lives because it is assumed no such provision is necessary. The infantilised adult is first desexualised conceptually, then prevented from expressing their sexual maturity by passive omission.

However, most interventions are intentional and aimed expressly at preventing the infantilised adult from having or pursuing a sexual life. Residential care settings for elderly, physically disabled, and cognitively disabled people may forbid residents from spending time alone in their rooms, or from spending time in each other's rooms. They may be forbidden from hugging or touching each other. Research with women with an intellectual disability found that they felt prohibited or barred from sexual activity; they felt "they were not 'allowed' to have sex with their boyfriends and feared the consequences of getting 'caught'." (Fitzgerald & Withers, 2011, p. 8) In another study, two elderly people in residential care, who liked to hold hands while sitting close to each other, were physically separated and forbidden from sitting together at all (Salari, 2006). Once an adult is infantilised, there is something *wrong* with their sexual desire; it is disturbingly at odds with their presumed child-equivalent personhood. Expressions of sexuality then seem morally transgressive, wrongful; potentially harmful. It then seems legitimate to prevent them. This prevention can extend to legal prohibitions on relationships, marriage, pregnancy, and parenthood for infantilised adults. Thus, although it is somehow acknowledged that the infantilised adult is – at least physically – sexually mature, this sexuality must be fenced off, managed, suppressed, defused, or preferably eliminated.

The infantilised adult may be physically and psychologically desexualised through the suppressant effect of medications, which may be administered without their understanding or consent. Women may be placed on contraceptive medication to minimise or eliminate menstruation; they often have no choice in this regard, with parents or medical staff making decisions about contraception without the involvement of the women concerned (Fitzgerald & Withers, 2011; Muswera & Kasiram, 2019). Infantilised adults may thus be forcibly prevented from becoming pregnant or giving birth. Involuntary sterilisation was widespread since the beginning of the eugenics movement (Trent,

2017; Ilyes, 2020; Wilson, 2021).[6] With infantilised adults, sexually mature bodies do not match the presumed child-like immaturity of their inner person: the body is therefore physically desexualised, removing the conflict created by their sexual maturity.

Sterilisation is a surgical procedure which directly intervenes in the physical, sexually mature, adult body of the infantilised adult, removing those bodily features of sexual maturity which are so at odds with the perceived child status of the person. Such surgical interventions, often involuntary, were for a long time not uncommon in the treatment of infantilised adults. Often promoted as a preventative measure for cognitively disabled women at risk of sexual abuse, sterilization of course only prevents pregnancy, not abuse. There is some evidence that women who have been sterilised are in fact at greater risk of rape and sexual assault (Bjornsdottir, et al., 2017). Although involuntary sterilisation is now banned in most jurisdictions, surveys of the attitudes of educators, carers, and parents of cognitively disabled adults have found that most of them were in favour of sterilization of people with intellectual disabilities, even though it was against the law (Aunos & Feldman, 2002; Bjornsdottir, et al., 2017). As a further preventative step, people may be prevented from attaining adult sexual maturity at all, using puberty blocking medications and early surgical procedures. In the case of Ashley X, the parents of a cognitively and physically disabled young woman received legal permission to have her sexual organs removed, and for surgical and chemical procedures to prevent her from growing any further physically (Lamp & Cleigh, 2011; Wilson, 2018; Carlson, 2010). Conceived of as a perpetual child, her physical body was brought into line with the assumed stasis of her personhood; following the Ashley X case, “what is now known as the “Ashley treatment” [was] used on more than a dozen children by 2012”. (Wilson, 2018, p. 95)

[6] Many ethnic and indigenous groups, and many women deemed to be morally deficient, were also forcibly sterilized as part of the eugenics movement. As I have said previously, the same actions may be motivated by different concepts. The sterilization of other groups of people was motivated by concepts of racial purity, white supremacy, imperialism, and misogyny.

The use of medications and surgeries to suppress libido, prevent sexual maturity, prevent or end pregnancy, or make sexual relationships impossible, are most common in instances of cognitive disability. These are cases where there may be legitimate concerns about a person's self-awareness, self-understanding, or their understanding of issues of power, agency, and responsibility which are part of any sexual or romantic relationship. Cognitively disabled people may benefit from guidance and support in understanding and acting on their romantic and sexual desires, or in recognising and responding safely to the romantic or sexual desires of others. Negotiating these issues should be part of the individualised care relationships and support systems of cognitively disabled adults. The cognitively disabled adult has a right to their own sexually mature body and the expression of their sexuality; that expression can be safely facilitated even in paternalistic care relationships. That expression is not possible where they are infantilised. Additionally, cognitively disabled adults are disproportionately targeted for sexual abuse and exploitation; one recent review of research in this area found prevalence rates of 25-50% (Fitzgerald & Withers, 2011); another estimated 50% (Bjornsdottir, et al., 2017); another as high as 90% (Gehrig, 2020). Denying access to knowledge, discussion, and experimentation leaves them dangerously unaware of sexual and relationship behaviours. Their desexualisation thus paradoxically leaves them more vulnerable to sexual abuse and exploitation (Alexander & Taylor Gomez, 2017).

A child is pre-sexual; their sexuality lies in the future. The infantilised adult is not pre-sexual because there is no point in the future where they are expected to develop the personal capacities necessary for sexual maturity. The infantilised adult is non-sexual[7]. The conception of them as having the

[7] The term 'asexual' has been used in discussion on the desexualization of infantilized adults (for example, in Addlakha, et al., 2017; Aunos & Feldman, 2002). However, 'asexual' is a specific sexual orientiation of autonomous adults, recognised as the 'A' within the LGBTQIA+ community. Infantilized adults are not assigned the status of 'asexual': they are denied any sexual identity whatsoever. 'Non-sexual' seems to me the more appropriate term.

subjectivity or personhood of children is static; these child-like persons do not grow up. Yet this conception of their personhood is at odds with their sexually mature adult bodies and their desires for romantic and sexual contact. Desexualisation is necessary to resolve the conflict between the sexually mature body and the perpetual child assumed to inhabit it; it both denies or removes their sexual agency and sexuality, while perversely leaving them at higher risk of sexual abuse. Infantilised adults are prevented from attaining the norms of adulthood regardless of their chronological age because they are assumed to remain in a child-like state permanently. This is the subject of the next section.

### iv) Stasis

I have defined the conceptual aspect of infantilisation as conceiving of an adult as having the subjectivity or personhood of a child. As I have shown in this chapter, this means that the infantilised adult is treated like a child, but not *as* a child. Although the concept 'child' is applied, the infantilised adult remains an adult in at least two respects: the maturity of their physical body, and the accumulated narrative of their life experience. In both respects, the adult presents a challenge to their infantilisation. Through infantilising speech, engagement, activities and environments, their lived social and physical worlds are shaped into those of (restricted) children. Through desexualisation, their physical maturity can be forced more into line with their presumed internal immaturity. With these features, child-typical norms are applied, and adult-typical norms are withheld.

Stasis is a global feature of the conceptualisation of the infantilised adult; one which is neither child-typical nor adult-typical. Infantilisation places the adult in a static, child-like state, and it places them in that state indefinitely. A child grows and develops through childhood and into adulthood. The

infantilised adult has no such exit. Though they may move within the category 'child' – viewed as becoming more or less infantile through time – their subjectivity and personhood is conceptualised as a perpetual or eternal child. As mentioned in Chapter 1, mental age theory is a major contributor to this stasis, especially in cases of congenital cognitive disability. Cognitively disabled adults, once infantilised, are not only contingently or approximately child-like. There are viewed as "perpetual children, misplaced into sexually mature bodies" (Wong, 2002, p. 108). The categorisation of old age and age-related cognitive decline as a return to childhood or a second childhood performs a similar conceptual move; although elderly people, unlike congenitally cognitively disabled adults, have had a lifetime of statistically typical cognitive functioning, once they 'return to childhood' their identities are placed in stasis. Their life narrative is discontinued. This static conceptualisation of adults as being in a state of perpetual childhood both erases their accumulated life narrative and denies them futurity.

The erasure of accumulated life experience is evident in the treatment of infantilised adults. They are assumed to have not only the subjectivities but the life experiences of children. Recall Sophia Wong's friend gifting her brother Leo a toy fire truck for his birthday (Wong, 2002): Leo's previously expressed interest in – and *experience of* – basketball and opera are erased when it is assumed he is at the life-stage of a child. One study, in care settings for (non-disabled) elderly people and those with cognitive disabilities, noted that creative activities based around memories and narrative focused exclusively on the residents' memories of their own childhood. Residents were encouraged to recall and draw pictures about their childhood years; never their years living and working as adults (Salari, 2006). The accumulated narrative which accompanies any journey into and through adulthood – regardless of the cognitive ability of the adult – is largely erased or ignored when an adult is infantilised.

Stasis is also apparent in the lack of futurity attributed to infantilised adults. The infantilised adult differs markedly from a child in this respect. The infantilised adult is typically not encouraged to project a life narrative forward; unlike children, they are not repeatedly encouraged to imagine who they will be, where they will go, or what they will do. They are not asked about their hopes and expectations for education, employment, travel, or family. The infantilised adult is expected to remain static - the same person through chronological time. This expectation is reflected in attitudes to the care of infantilised adults. Their lack of potentiality and futurity is used to argue that their care is an unnecessary burden on the economies to which (it is assumed) they will never materially contribute. Cognitively disabled people have long been denied educational and training services and supports on the assumption that they cannot learn or develop beyond the level of infants. Basic healthcare for preventable conditions (such as the heart problems commonly associated with Down syndrome) have historically been denied on the assumption that saving the lives of people with no futurity was a pointless and wasteful exercise. In 2008, Baroness Warnock, a medical ethicist and advisor to the UK government, proposed that people with dementia have "a moral duty to die" because they are a burden to their families and are "wasting the resources of the National Health Service" (quoted. in Malpas, 2009, p.53). Philosophers Peter Singer and Jeff McMahan have argued that infanticide is permissible in cases of 'severe' cognitive disability, but not in cases of non-disabled infants, precisely because cognitively disabled people do not (they claim) have potentiality (Carlson, 2010).

The proximity of such claims to the claims of eugenics has not gone unremarked. The assumed stasis of the infantilised adult means they lack potentiality. Without potentiality, they lack futurity: not only within their own life narrative, but as worthwhile members of the species. Thus, infantilisation runs as a supporting undercurrent through contemporary discussions on late-term abortion, pre-natal screening, assisted dying, and the provision of life-saving healthcare. It runs through debates

on the provision of educational, social and community support services for elderly, physically disabled, and cognitively disabled people. The presumed stasis of the subjectivity or personhood of the infantilised adult justifies the denial of such supports. In the looping effect, which I will discuss in Chapter 3, the absence of such supports serves to inhibit their development and exacerbate the symptoms of cognitive decline and cognitive disability.

The assumed stasis of the subjectivity or personhood of the infantilised adult – that they are not simply child-like in some respects, but a perpetual child – is a distinctive feature of infantilisation as a conceptual failure. Its repercussions in the treatment of infantilised adults are severe.

### 2.3 **Features Shared with Paternalism**

In the first section of this chapter, I outlined the four core features distinctive of infantilisation. Those are:

i) Infantilising speech and engagement

ii) Infantilising activities and environment

iii) Desexualisation

iv) Stasis

In this section I will consider features of infantilisation which are (or may be) shared with paternalism. Those are:

v) Denial of personal autonomy

vi) Limits on liberty and mobility

vii) Presumed cognitive incapacity

These features may be evident in instances of both paternalism and infantilisation; as I emphasised in Chapter 1, the same treatment may be rooted in and motivated by different concepts. I have stated that, in some cases, paternalism may be justified and appropriate, while infantilisation is not[8]. It is therefore important to be able to distinguish treatment rooted in infantilisation from treatment rooted in paternalism, even where such treatment seems the same in practice. As outlined in Chapter 1, it is reasonable to state that *some* level of paternalism *may* be justified and appropriate in *some* cases. That justifiability, especially in such cases as are my focus here (cognitive disability, physical disability, and old age), will greatly depend on the primacy given to the desires, preferences, aversions, and identity of the agent in question.

I will briefly outline the shared features of infantilisation and paternalism, mentioning differences in how they may manifest. I will then argue that the four core features of infantilisation discussed in the previous section should be used to distinguish treatment rooted in infantilisation from treatment rooted in paternalism. I will then mention issues of overlap, noting that the conceptual influence of infantilisation may impact decisions on paternalistic intervention, even where the four core features are not evident.

v) Denial of personal autonomy

Although different conceptual and metaphysical positions on personal autonomy exist in the philosophical literature, I believe the following definition is relatively uncontroversial: To say that someone has personal autonomy is to say that they are self-governing. They think, choose, and act as they see fit. Their own judgement about their own life is the authoritative judgement (even where

[8] I will argue that infantilisation is wrongful and harmful in Chapter 3.

such judgement is heavily informed, as it usually is, by external factors and the opinions and judgements of others).

Influences on the personal autonomy of any agent may be subtle or they may be clearly identifiable. Agents may be 'nudged' toward behaving in certain ways. 'Nudging' can influence or weaken their personal autonomy via hidden or subtle means, without over-riding such autonomy altogether. Personal autonomy may be entirely over-ruled; this is perhaps most often the case when the agent in question is deemed temporarily unfit to make sensible decisions in their own best interest. A drunk person may be refused another drink although they demand one. A traumatised person may be prevented from jumping from a bridge although they insist it is their choice to do so. In such instances, an agent's "short-run" personal autonomy may be over-ruled in the interest of their "long-run" personal autonomy (Dworkin, 2020). Although the justifiability of such interventions remains contested, the intervention is at least clear-cut: an agent expresses their own strongly held personal choice of action, and they are prevented from pursuing such action by other parties.[9]

Both paternalism and infantilisation involve a denial of personal autonomy. This denial may be partial or complete. It may be temporary or permanent. Whatever the range or degree, the denial of personal autonomy is seen as justified because it is assumed the person does not or cannot act in their own best interest. That assumption can be rooted in a paternalistic or infantilising concept.

vi) Limits on liberty and mobility

[9] The significance of an agent's being temporarily versus permanently or intrinsically unfit to make sensible decisions in their own best interest will be addressed in subsection vii) Presumed cognitive incapacity.

Autonomous choice can be restrained by practical and physical limits on freedom of movement and social and physical mobility. Such limits frequently feature in instances of both paternalism and infantilisation. In extreme situations, a person may be physically restrained where it is judged they are a risk to their own safety or welfare, or the safety and welfare of others. They may be confined to a single room or single building on the justification that they cannot take care of themselves or that they pose a risk to others. They may be strictly supervised in their movements and activities – as in the example given previously of care home residents requiring permission to move around the building, go to the bathroom, or even stand up. To prevent 'wandering', many autistic adults and adults with dementia live in locked homes or other secure environments, requiring permission and supervision to leave or move around.

Beyond such direct confinement and supervision, limits on liberty and mobility can be structural and social. Where options are limited, choice is limited. Severely paternalized groups – such as those under colonial rule, or women in patriarchal or misogynistic cultures – are limited in their options for work, education, democratic participation, and access to social and cultural resources. These limits are common too in the lives of infantilised adults. Infantilised adults are neither adults nor children; as they belong to neither group, they are segregated from the rest of the population. This segregation is common in the housing, education, recreation, employment, and social activities of infantilised groups. Physically disabled people still have limited access to built environments, public transport, and social and cultural spaces. The historical assumption that they had no need for such access continues to limit physical (and, in turn, social and professional) mobility for disabled people. Cognitively disabled people are treated as a social category of their own, with little access to the social, cultural, professional, or educational environments of the non-disabled population.

Limits on liberty and mobility can be physical, social, structural, and cultural. They can be the result of biased obliviousness: where certain people or groups are simply not considered in the planning of buildings or social environments, no provision is made for their access. The legacy of institutionalisation and the historical segregation of physically and cognitively people from the non-disabled population means that the access requirements of these groups are often simply forgotten. Physical and social environments are therefore often inaccessible by omission rather than intent, where paternalism or infantilisation are operating as background conceptual norms. However, limits on liberty and mobility are often intentional. It may be judged that some people are not suited for some environments and their access to such environments will be intentionally (explicitly or surreptitiously) denied.

vii) Presumed cognitive incapacity

The previous two features – denial of personal autonomy, and limits on liberty and mobility – are typically justified on the basis that the target person or group has some form of cognitive incapacity. This incapacity may be temporary, as in the examples given: drunkenness is a state of temporary incapacity where a person's decisions and desires may be over-ruled by other people on the grounds that they do not know what they are doing. Other temporary states have the same justification. The colloquial terms 'not in her right mind' or 'out of her mind' point to the justification for intervening in someone's personal autonomy, liberty or mobility: the assumption is that they are temporarily cognitively incapable of making short-run decisions in their own best interest. It is then justifiable to intervene, so that their long-run desires and identity are respected.

As discussed in Chapter 1, some groups are presumed, on the basis of racist or sexist ideologies, to be cognitively incapable of full, autonomous participation in society. Restrictions on the mobility,

liberty and autonomy of women and colonised populations reflect this bias. Assuming a diminished cognitive capacity in any group of people leads naturally to paternalism: where people cannot adequately think for themselves, other powers should do the thinking for them.

Such biases are also evident in attitudes toward elderly, physically disabled and cognitively disabled people. Cognitive incapacity is assumed – and even where some cognitive disability is actually present, discrete impairments are interpreted as global incapacities. Such biases affect not only attitudes toward these groups, but assessments of their actual cognitive ability: research has found that elderly people exposed to negative stereotypes about old age subsequently perform worse on cognitive tests (Hess, et al., 2003; Levy & Langer, 1994).

For both paternalism and infantilisation, some level of cognitive incapacity is assumed. Sometimes this assumption is justified. Often it is not. Where presumed cognitive incapacity is temporary – as in the case of drunkenness – even unjustified interventions are at least temporary in line with the agent's state. Their loss of personal autonomy and any limits placed on their liberty and mobility are temporary and contingent. Where the presumed cognitive incapacity is seen as intrinsic and permanent, the effects are permanent and the repercussions profound. It is presumed that something intrinsic to the person renders them permanently unable to make sensible decisions in their own best interest. While a presumption of cognitive incapacity for such decisions may, in some limited cases, be correct, it has historically also been tied to biases and stereotypes rather than actual cognitive ability. This means that infantilisation can have a conceptual impact on decisions about paternalistic interventions, even where the four core distinctive features of infantilisation are not evident.

## 2.4 **Identifying Infantilisation**

As infantilisation shares some features with paternalism (in terms of how people are treated), and as infantilisation often occurs in situations where some level of paternalism may be appropriate, it is important to be able to distinguish one from the other. As I have previously discussed, paternalism may be appropriate and justified whereas, as I will argue in Chapter 3, infantilisation is always wrongful and seems, on evidence, to be always or almost always harmful.

Where the shared features outlined in this section are evident – denial of autonomy, limits on liberty and mobility, and presumed cognitive incapacity – there is already a high standard to be reached for such treatment to be appropriate and justified. However, where such treatment is necessary for the welfare and safety of the person concerned, or the welfare and safety of others, it can be instituted in appropriate ways which respect the desires, aversions, needs and identity of the person to the greatest possible extent. Just how to ensure such treatment *is* instituted in respectful and appropriate ways is the subject of much contemporary debate on assisted decision making, disability self-advocacy, and a range of other areas of practical and theoretical concern. It is sufficient here to note that, although this process is frequently fraught and contentious, such treatment *can* be instituted in a way that it appropriate and justified.

Where the four core features of infantilisation are evident there should be significant cause for concern. Infantilising speech and engagement, infantilising activities and environments, desexualisation, and stasis, are the wrongful and harmful upshots of conceiving of an adult as having the subjectivity of personhood of a child – whatever their actual cognitive ability. Is the presence of all four core features necessary for treatment to be identified as infantilisation? I have not intended

these as necessary and sufficient criteria from infantilisation; however, as all four features interconnect to a significant degree, and importantly, because all four features stem from the same conceptual root, it seems likely that instances of infantilisation would show some evidence of each feature.

In situations where there is *some* evidence of *some* features, it seems far less certain that the conceptual root of infantilisation is driving the behaviour. Consider the following example: an adult is caring at home for an elderly parent with late-stage dementia. One common feature of later stages of dementia is loss of appetite, lack of interest in food, and even an aversion to eating. It can become very difficult to ensure adults with the condition get adequate nutrition and maintain a healthy weight. Suppose the carer in this situation finds that using the same feeding strategy they use for their young child – making a game of mealtimes, speaking in higher pitched, child-appropriate tones – elicits a positive response from their elderly parent. Their parent responds positively to the child-appropriate feeding strategy. As a result, they eat more than they would otherwise, which is to their benefit.[10] Is the carer infantilising their parent in this instance? Where features like 'baby talk', infantile activities, or even desexualisation are temporary responses to the care and support needs of severely cognitively disabled people, these features may not necessarily indicate infantilisation. They may occur spontaneously and temporarily, not necessarily indicating that the conceptual basis of infantilisation is in play. However, there is unlikely to be a clear line, especially in such cases. Carers, even with the best intentions and great affection, may temporarily or gradually conceptualise their patients, clients, or friends and family members as child-like; as equivalent to a child; as *essentially* a child. Infantilisation can occur - indeed, it often occurs - in challenging and difficult care relationships which are motivated by love and devotion. In Chapter 3, I will distinguish issues of blameworthiness from those of wrongfulness and harmfulness. In doing so,

[10] My thanks to Prof. Quassim Cassam for raising this example, and for encouraging reflection on this point.

I aim to center the infantilized adults who are wronged and harmed by infantilisation, while maintaining a pointed consideration of the difficult and unjust working conditions of many carers.

## 2.5 **Chapter Summary**

I have mentioned many instances of troubling attitudes, treatment, and behaviour toward elderly, physically disabled, and cognitively disabled people in this and the preceding chapter. Further examples will be discussed in Chapter 3. What theory can adequately explain such cases? If paternalism involves thinking of others as children or as child-like, it is notable that features such as baby talk, infantilising activities, desexualisation, and stasis are not evident even in cases of severe and discriminatory paternalism, such as that directed at colonised populations and women in some sociocultural contexts. It is notable too that, in the case of cognitively disabled people, severe paternalism can be (and is) enacted without these features. Judging – rightly or wrongly - that some individual or group is not capable of making sensible decisions on their own behalf is not the same as conceiving of them as having the subjectivity or personhood of a child. In trying to explain what is going on (and what is going wrong) in the real-world examples I have used, infantilisation is the root concept from which this treatment stems. The results of infantilisation far outstrip, and differ markedly from, even severe paternalistic interventions. A theory of infantilisation – what infantilisation is and how it works – is required to explain and understand these cases. I have aimed to develop that theory in these first two chapters. A summary is as follows:

Infantilisation involves conceiving of an adult as having the subjectivity or personhood of a child and treating them accordingly. Infantilised adults are denied personal autonomy and are limited in their liberty and mobility, based on their presumed cognitive incapacity. These features may be shared

with instances of paternalism, but four core features are distinctive to infantilisation. Infantilised adults are subject to **infantilising speech and engagement**, and **infantilising activities and environments**. They are conceptually and sometimes biomedically **desexualised**. Child-appropriate norms are applied to them and expected of them, and adult-appropriate norms are withheld or denied. Infantilisation places the person in **stasis**: they are not only child-like in some respects but considered a perpetual child. This feature shows that infantilised adults may be treated *like* children, but they are not treated *as* children because of the conceptual mismatch between their presumed 'inner' child and their physically and sexually mature adult bodies. Infantilisation is a conceptual failure: it is failure to accurately or adequately conceptualise the actual subjectivity or personhood of the individual or group in question. This conceptual failure is the root of the four core features of infantilisation.

I stated at the outset that my definition of infantilisation as a concept was intentionally normatively neutral. There is nothing inherently normatively loaded in conceiving of an adult as having the subjectivity or personhood of a child. As I pointed out, it would typically be argued that, in the case of many forms of cognitive disability, it is appropriate and accurate to conceive of the person as a child. However, I also stated at the outset that I would argue that infantilisation is both wrongful and harmful; I have gestured toward the wrongs and harms of infantilisation throughout. In Chapter 1, I aimed to answer the question: What is infantilisation? In Chapter 2 I aimed to answer the question: How does infantilisation work? In the final chapter, the question remains: What's wrong with infantilisation, and who (if anyone) is to blame for it?

Chapter 3

# The harmfulness, wrongfulness, and blameworthiness of infantilisation

## 3.1 **Chapter Outline**

The definition I have so far provided for infantilisation is, for reasons outlined in Chapter 1, intentionally normatively neutral. That definition again is:

*Infantilisation is conceiving of an adult as having the personhood or subjectivity of a child, and treating them on this basis.*

However, I have indicated from the outset that infantilisation is both wrongful and harmful. I have mentioned also that, especially regarding carers (those most often referred to in empirical studies of infantilizing treatment), blame is an additional consideration. This third chapter will assess infantilisation for harmfulness, wrongfulness, and blameworthiness. I will argue that infantilisation is demonstrably harmful and conceptually wrongful, but that a graded understanding of blame-worthiness – one with strong epistemic conditions - should apply to those perpetuating infantilisation.

An act, attitude, or omission may be harmful without being wrongful. This distinction between harmful and wrongful is well marked within philosophy. Mari Mikkola writes: “Not all harms that we suffer are wrongs; for instance, if my computer breaks down without me having backed up my academic work, my carelessness is clearly harmful to me… but this does not wrong me. So I have not been wronged, although I have been harmed.” (Mikkola, 2016, p. 151) She argues that we may

understand “injustice’s harms” without understanding “what normatively underpins those harms” (ibid., p.11). The wrongfulness of various harms is thus generally tied to moral or normative considerations. If I were to break your arm while saving you from falling over a cliff, I would certainly have harmed you, but such harm would likely be seen as a mere side effect of doing the right thing. The harms of infantilizing treatment might be seen in a similar light; merely the unfortunate side-effects of correctly motivated and appropriate behaviour. I will touch on the relevance of moral or normative wrongfulness in relation to infantilisation; however, my primary focus will be on infantilisation as *conceptually* wrongful. The harms of infantilisation will be presented first.

As harmful and wrongful can be distinguished, so too can harmful (or wrongful) be distinguished from blameworthy. My blameworthiness may be mitigated or negated by a lack of knowledge or intent, or commonly, a lack of control for which I am not directly responsible. These mitigating and negating conditions will be discussed as the potential blameworthiness of infantilizing acts and attitudes are assessed later in this chapter.

### 3.2 **Is infantilisation harmful?**

The harmfulness of infantilisation was indicated throughout the preceding chapter. Using baby talk, denying privacy, restricting autonomy, limiting development, and subjecting adults to involuntary desexualisation are practices which seem very likely to cause – at minimum – psychological and personal distress to the infantilized adult. However, there may yet be the sense that while infantilisation is a discomfiting and imperfect way of thinking about or treating others, it is just a necessary method of caring for people – especially those with very high support needs or profound cognitive disabilities. It may be considered that its flaws are justifiable in the name of providing such care.

In this section I will show the documented harms which result from infantilisation; these harms demonstrate that infantilisation cannot be a feature of good care relationships. Infantilisation in fact results in *worse* care outcomes when compared to contexts where recipients of care are not infantilized (Johnson, 1993; Cassidy, 1997; Salari, 2006). This can be seen in several areas.

Infantilisation has been associated with a worsening of symptoms of cognitive disabilities and old age cognitive decline; among them, **social withdrawal**. Infantilized adults with dementia withdrew from social interaction sooner and to a greater extent than their non-infantilized peers. They spoke less, listened less, participated less in jokes and conversation, and were less likely to participate in organized social activities (Dolinsky, 1984; Johnson, 1993; Brady, et al., 2014; Salari, 2006). Encouraging adults with dementia to maintain social contact and interaction, to whatever degree possible, is vitally important as part of their treatment and support. Infantilisation instead *worsens* their social withdrawal. This is harmful to their psychological and physical wellbeing and cannot be viewed as an imperfectly appropriate part of any system of care.

Infantilisation has been associated with **higher rates of aggression and resistance to care** (Salari, 2006; Cassidy, 1997). Care recipients may physically resist being moved, washed, dressed, medicated, or engaged in physical therapy. This can mean being physically aggressive or even violent toward care providers. Such aggression may be harmful to care workers; it is also harmful to the infantilized adult, who cannot benefit from care supports within such an antagonistic environment. Infantilized adults may also be verbally abusive or object strongly to their treatment and care. In one study from South Africa, which found such severe infantilisation of residents (in a care setting for adults with mild to profound cognitive disabilities) that the residents were simply referred to as “the

children", found also that staff used the nickname "*toebekkies*"[11] to refer favourably to residents who did not have the capacity to verbally object to their treatment (Capri & Swartz, 2017). Care settings for elderly, physically disabled, and cognitively disabled adults which demonstrate pronounced infantilisation (in terms of how clients are both thought about and treated) showed higher rates of aggression and resistance to care than settings in which infantilisation was absent or only partially evident (Salari, 2006). While this cannot yet establish a direct causal relation, infantilisation seems to be at least strongly associated with increased aggression and resistance to care. Aggression and resistance to care are psychologically and physically harmful for the infantilized adult. Aggression may also be physically and psychologically harmful to those perpetuating the infantilisation; such effects require further study.

Sonia Miner Salari has documented how elderly residents (without cognitive disabilities) in infantilizing care settings resisted their infantilisation (Salari, 2006). They verbally object to infantile activities and baby talk. They pretend to fall asleep during activities so that they won't be forced to participate. They make sarcastic comments about their infantilisation – referring, for example, to care staff as 'mommy'. They leave, or attempt to leave, the environment – going to other parts of the building or going outside without staff permission. They request or aggressively demand that their family members be contacted and that they be removed from the care setting. They refuse medication and refuse to participate in therapies. They swear and curse. In these ways, they express their opposition to their infantilisation in an attempt to resist it; pushing back against infantilizing treatment and attitudes in an effort to again be recognized as an aware and mature adult with a lifetime of experiences and their own desires and opinions.

[11] Translation: 'shut little traps' (Afrikaans)

Being in need of care and support does not mean that we must accept a care system which is degrading or inappropriate (Capri & Swartz, 2017). We have even stronger grounds for rejecting a system of support which is demonstrably harmful. However, in situations where adults are infantilized, their protestations or acts of resistance are not seen as legitimate. **Strategies of resistance may instead be interpreted as symptoms of cognitive decline** or cognitive disability. Aggression, resistance to care, social withdrawal, demands for rescue by family members and unsanctioned 'wandering' in fact map onto similar or identical behaviours listed as symptoms of dementia and cognitive decline.[12] Attempts by non-cognitively disabled adults to resist their infantilisation can thus be interpreted as symptoms of dementia. For an adult with an existing diagnosis of dementia to display such behaviours is taken as an instantiation or worsening of their conditions. Attempts by infantilized adults to resist harmful attitudes and treatment therefore results in further harm; resisting adults risk being diagnosed with cognitive decline or disability because of their acts of resistance, or being presumed to be at a later stage of dementia than is actually the case.

This process – resistance to infantilisation being interpreted as symptoms of cognitive disability, leading to resistors being further infantilized - begins to uncover the **looping effect** of infantilisation which I briefly mentioned in Chapter 1. In the process just outlined, adults who use resistance strategies may find themselves further enmeshed in infantilizing care relationships as their resistance is interpreted as symptomatic. This means they are more likely to be over-ruled or ignored, more likely to experience baby talk and infantilizing interactions, and may experience further loss of autonomy and privacy. As such, the adult is trapped in a worsening situation; their resistance is counter-productive, and their acquiescence leaves them totally infantilized. However,

[12] It is striking that they also map onto some symptoms of autism. This is merely a speculative observation; no research specifically assessing the infantilization of autistic adults is thus far available.

there is a further effect: infantilisation can actually produce or exacerbate cognitive decline. This can happen as a result of attitudes alone, as such attitudes are deeply entrenched in social perceptions of old age and disability: elderly adults who are first exposed to negative, infantilizing stereotypes about old age subsequently performed worse on cognitive tests, compared to peers exposed to positive vignettes (Hess, et al., 2003). Negative, infantilizing assumptions about their abilities directly affected their performance on the kind of test which is routinely used to clinically assess such abilities. As I discussed in Chapter 1, psychological evaluations of adults with autism, Down syndrome, and other cognitive disabilities are also profoundly context dependent and socio-historically contingent. A person who has been infantilized typically responds to their infantilisation; they grow and live only within the parameters of their infantilized status (Johnson, 1993; Capri & Swartz, 2017; Fitzgerald & Withers, 2011). This is the case in elderly care (with people who have previously lived and been recognized as adults), and it is the case for those who have been infantilized all their lives because of physical or cognitive disability. Infantilisation produces people who assume they are themselves incapable of adult roles, adult relationships, adult learning, or adult participation in society. Infantilized adults often "feel they will never gain independence or get married because they have been told they are children and treated like children for their entire lives" (Smith, 2017). Within academic philosophy, the "severely mentally retarded" have been differentiated from children on the basis that, unlike children, they lack potentiality (Kittay, 2005). Yet infantilisation itself inhibits potential; infantilisation convinces the subject that they cannot develop beyond their mental age, cannot be involved in romantic or sexual relationships, cannot pursue work or education beyond their assumed capacity, cannot be autonomous or trusted to have and express legitimate opinions. A subject so infantilized is not intrinsically devoid of potentiality; they are stripped of their potentiality through infantilisation. They are never allowed to practice or attain the markers of adulthood; then, the absence of such markers is seen as proof of their child-like status. Through pervasive speech patterns and verbal interactions, infantile environments and activities, delegitimizing and disempowering interpersonal relationships, metaphorical and literal

desexualisation, and a static conception of their capacities and potential, infantilized adults are cultured to accede to the limits imposed on them. That they then never attain or develop beyond these limits is seen as proof that they are intrinsically unable to do so. Through this looping effect, infantilisation is therefore deeply harmful in the limits it implants on people's potential and the damage it causes to their cognitive capacities and sense of self.

### 3.3 **Is infantilisation wrongful?**

There are (at least) two senses in which infantilisation might be said to be wrongful: conceptually wrongful, and morally (or normatively) wrongful. My concern is primarily with the former, but I will also make some remarks here on possible framings of the latter.

I have stated previously that infantilisation is a conceptual failure: it is a failure to accurately (or even adequately) conceptualize the subjectivity or personhood of the infantilized adult. The application of the concept 'child' to an adult is a misapplication. This is what I mean by conceptual failure. Infantilisation is conceptually wrongful because the *wrong concept* is being applied to the adult in question. Conceiving of an adult (whatever their cognitive capacities) as having the subjectivity or personhood of a child is untrue; it is mistaken. That's just not who they are. Wrongful concepts crowd out accurate concepts; where a person is infantilized, we are unable to see their actual personal identity and they are prevented from expressing it.

When infantilisation is demonstrably harmful in multiple ways, and is also a conceptual failure, that seems sufficient to demonstrate that it should be actively and urgently avoided. The harms and conceptual failure alone demonstrate that infantilisation is not some imperfect but benign feature of difficult and under-resourced systems of care. People who are infantilized are *badly treated*, and we

typically take bad treatment to be unjust. Their unjust treatment stems from a conceptual failure which is itself harmful, as it erases their actual subjectivity and personhood and replaces it with that of a child. This erasure is in turn harmful because it creates persons who are neither adults *nor* children, who have uncertain access to the rights and claims of either group, and who therefore have no secure place in the moral community. In addition to the harmful treatment and these harmful repercussions of the conceptual failure, is any additional wrongfulness apparent?

The erasure of the infantilized adult's subjectivity or personhood means we are not recognizing them as the person they are. We are obscuring who they are. This intuitively seems degrading and wrong. It seems to represent an injury to their status as a person and as a member of the human moral community; a moral injury which is additional to the wide-ranging harms they experience. If any reader were to imagine that, in later life, they would receive the same treatment and attitudes described in the preceding chapters, they would likely find that possibility unjust and wrong. Infantilisation is not just bad care; it seems also to be an attack on the person.

The wrongfulness of that attack might be explained from a number of metaethical positions. Infantilisation arguably involves an "indefensible setback to some of our legitimate human interests, where this setback constitutes a moral injury" (Mikkola, 2016, p. 8): on Mari Mikkola's account of social injustices, the wrongfulness of infantilisation is therefore that it is dehumanizing. On a consequentialist account the wrongfulness is clear; infantilizing acts, attitudes, and omissions are morally wrong because of the harms which result from them. That infantilisation effects many people – and indeed may await any of us in later life – seems to exclude it from justifiability: the 'common good' is served by its eradication. For the (typically assumed) other extreme of ethical theory, a deontological account would likely see the harms and injustices resulting from infantilisation as falling well outside the moral norms to which we are obliged to conform. Between

these two limiting principles, arguments for or against the moral or ethical wrongfulness-making features of infantilisation are multiple. There is neither sufficient space in this project to tease out each one, nor do I feel such an exercise is necessary for current purposes. The wrongfulness-making feature of infantilisation may vary depending on which metaethical position is adopted, but the following stands: based solely on the harms caused by infantilisation and the conceptual failure it represents, infantilisation is massively normatively weighted to the negative. It is sufficient that it is conceptually wrongful and demonstrably harmful to assert that it is a concept and practice which should be actively and urgently avoided.

### 3.4 **Is infantilisation blameworthy?**

If infantilisation is both harmful and wrongful, who is to blame for it? Who can we say is properly responsible for perpetrating infantilisation, and can we – or should we – hold them accountable? In what follows, I will discuss possible positions on blame and responsibility and how or if they might apply in instances of infantilisation. Three points should be made first:

- I take it for granted that there is a distinction between some act, attitude or omission being *bad* and its being *blameworthy* (Levy, 2005). I hope to have argued persuasively that infantilisation is bad. Blameworthiness remains to be considered.
- Most philosophical discussion on blame and blameworthiness is concerned with *moral* wrongfulness. As I concluded in the preceding section, the harmfulness and conceptual wrongfulness of infantilisation make it a candidate for moral wrongfulness in any number of ethical or moral traditions. Whatever one's moral position, the harms of infantilisation make it (at least) a candidate for blameworthiness. I will assess it on that basis.
- I do not adopt a categorical position on blame in relation to infantilisation. However, I discuss categorical positions on blame and blameworthiness in order to build and ground a

graded position on blameworthiness with strong epistemic conditions. Infantilisation might always be wrongful and harmful; I do not argue that it is always categorically blameworthy.

### 3.5 **Why and how do we blame?**

For any harm or wrong doing we might ask "Who's to blame?" for at least two reasons. We might hope to stop it from happening, in which case we need to identify the perpetrators. Further, we might wish to sanction those perpetrators. To blame someone is to adopt negative attitudes toward them in the belief that they have behaved (or believed) wrongfully or harmfully. To blame is to hold responsible with a normatively negative attitude. However, there are many cases where we might see someone as being causally responsible for harm without finding them blameworthy. This is clearly the case in instances of accidental or coerced actions, or (perhaps less clearly) where someone is oblivious to some non-moral fact of a situation. (Levy, 2005; Harman, 2011; Kelly, 2013)

On attributionist accounts, an agent is blameworthy for any normatively negative attitude or behaviour which can attributed to her. However, most attributionists extend responsibility beyond a brute tracking of causality. They typically claim that some agent is morally responsible for some act, attitude or omission if it just is properly attributable to her; that is, where that act, attitude or omission is a product of her properly-formed beliefs, desires, values and commitments (and not the product of some hypnotic or otherwise altered state) (Levy, 2005). What would this mean in cases of infantilisation? People in, for example, the care settings referenced in this project, are in control of their actions. They seem to be acting intentionally on the basis that their actions are appropriate. As such, they are responsible for those actions and seem properly blameworthy for the harm that results.

On a volitionist account, blameworthiness does not directly track attribution. We may reach a normatively negative assessment of someone's actions or attitudes without holding them responsible or blaming them for the same (Levy, 2005). Beyond control conditions, there are at least two reasons why we might assess someone as behaving badly without feeling justified in blaming them for it: one is the problem of (moral) luck, the other is the problem of (moral) ignorance. Both point to the epistemic conditions which pertain in differentiating bad from blameworthy, and attribution from responsibility. Both have been subject to extensive debate among philosophers; rather than rehash those debates, I will here focus on the points relevant for infantilisation.

### 3.6 **Is *not knowing* exculpatory?**

In order to behave well and avoid causing harm I must first be able to understand what kinds of actions are good and what kinds are harmful. If I *do not know* that some concept is wrong, I don't seem to be blameworthy for using it. If I don't know that some treatment is harmful, that treatment can still be seen (by others) as bad without their being justified in blaming me for it (Harman, 2011; Kelly, 2013).[13] We regularly mitigate or withhold blame and responsibility for negative acts, attitudes, and omissions on this basis: she *did not know* that she was causing harm or doing something wrong. In addition to standard control conditions, epistemic conditions count strongly (in both interpersonal and legal contexts) when we decide whether some agent is properly responsible and blameworthy for some negative act, attitude, or omission. The 'moral ignorance' involved in not knowing some attitude or treatment is wrong – for example, not knowing that conceiving of an adult as having the subjectivity of a child is wrong and treating them on that basis is harmful – is tied closely to the problem of moral luck.

[13] My responsibility for not knowing will be addressed in the next section.

The cultures, families, economies, opportunities, and historical periods we are born into seem to be a matter of 'luck' (or at least to be a capricious factor *beyond our control*)[14]. As our understanding of right and wrong attitudes and behaviours is pervasively shaped by the social worlds we grow up in, that understanding itself seems to be a matter of luck. On this view, a man who is raised in a deeply sexist and patriarchal culture will have his ideas of right and wrong powerfully shaped by that culture. He will not know that it is wrong to think of women as mentally inferior to men. He will not know that it is harmful to limit their freedom and opportunity on that basis. We can still judge that his attitude and actions are wrong and harmful, but there seems to be strong mitigating factors when we consider whether he is properly to blame for those attitudes and actions. Moral responsibility and blame are often tied to transgressing moral norms: but in a society such as his, he is abiding by the moral norms. His being born into that society is not something he had control over, and he seems never to get the chance to learn the wrongfulness and harmfulness of the attitudes and actions which he has learned are just and appropriate. Responsibility requires control, and control requires knowledge. It seems reasonable that this combination of control conditions and epistemic conditions should apply too in cases of infantilisation.

However our assessment of responsibility and blame for infantilisation proceeds, one thing is clear: in the vast majority of cases, the perpetrators of infantilisation are not *intentionally* causing harm. Infantilisation typically seems a clear case of people unknowingly and unintentionally thinking of and treating others in wrongful and harmful ways. Where some agent is unknowingly behaving in harmful ways, intervention is possible: the epistemic conditions can be satisfied by telling them that their actions are harmful, perhaps asking them to justify those actions, and expecting them to behave differently from then on. Where they to continue with harmful actions knowing that those

[14] The parameters (and existence) of moral luck have been subject to considerable debate within academic philosophy for at least sixty years: I am here sketching a limited overview which aligns with Nagel's 'control principle' and largely corresponds to the more specific category of 'circumstantial' moral luck. (Nelkin, 2011)

actions are harmful, they would then become the target of justified blame (and potentially sanction). However, in cases where someone *does not know* that their behaviour is wrongful or harmful, but the wrongfulness and harmfulness seem clear to at least some others within the same cultural and historical context, we might justifiably ask: How could they not know?

### 3.7 **Culpable Ignorance**

Lack of knowledge of a moral concern (such as harm) may excuse someone of the responsibility of failing to consider it only so long as they are not responsible for the lack of knowledge itself (Harman, 2011). In some cases, an agent may be responsible for not knowing: they may have ignored available information or simply failed to consider the issue at all (Moody-Adams, 1994). Again, their failure to consider it may yet be non-culpable. There may be harms we now cause unthinkingly which we may later find are harmful. As some harms we cause at any given time likely lie outside our general field of morally relevant considerations, we should be forgiven for failing to exercise any epistemic vigor in assessing such potential harms. But it certainly seems possible that ignorance may be culpable, at least in some instances and to perhaps varying degrees. I will next consider whether not knowing infantilisation is wrongful and harmful is a form of culpable or non-culpable ignorance (first as a form of treatment, then as a conceptual failure), with reference to comparable examples.

### 3.8 **Infantilisation & Institutionalization**

In Chapter 1, I outlined the development of mental age theory and the historical development of ideas around disability, which moved from viewing disabled (and especially cognitively disabled) people as a separate category to humans to viewing them as perpetual children. These conceptual developments happened during a period of mass institutionalization, and infantilisation remains

closely tied to the systems and assumptions of institutions, even when it occurs in the wider community. The effect of infantilisation on the infantilized adult shares features with institutionalization; the infantilized adult typically becomes what they are assumed to be, as the effect of the infantilizing process impacts globally on their self-conception. Infantilisation then is in some ways similar to institutionalization, and it is strongly connected to the history of institutionalization. (Carlson, 2010; Trent, 2017)

This makes it possible to understand how carers too – the most obvious perpetrators of infantilizing treatment – are themselves shaped by the conceptual and practical hangovers of the institutional period. The relationship between the carer and the infantilized adult is a relationship shaped in institutions. While disabled people and elderly people are infantilized in a wide range of social and interpersonal contexts, existing empirical work is largely focused on care homes, residential care settings, hospital wards, and non-residential care services. Recent history has seen a push toward deinstitutionalization for elderly and disabled people, but even outside these settings the institution remains, albeit in dispersed form: infantilized adults are segregated from the rest of the population though housing, educational services, recreational opportunities, transport and mobility, and healthcare. Although many may no longer live within bricks-and-mortar institutions, they nonetheless live within a separate social world. The connection between infantilisation and institutionalization persists: it seems relevant then to ask what effect this might have on the carers enmeshed in such a system. Should we expect them to see the wrongfulness of infantilisation when they are part of a system whose norms and standards of treatment are built upon it? Where harms may be evident – distressed clients, resistance to care, aggression, social withdrawal – would they not see these as unfortunate features of a difficult situation, or simply symptoms of their clients' intrinsic disability? Where the segregation of infantilized adults from the rest of society is so prevalent, how would anyone outside their social world know that harms were occurring within it?

As things stand, it might seem appropriate to conclude that *not knowing* infantilisation is harmful and wrongful is a legitimate mitigating excuse, as there seem to be strong cultural and institutional factors preventing perpetrators from accessing that knowledge. If they are not culpable for not knowing, they cannot be blameworthy for perpetuating infantilisation – whatever its consequences.

### 3.9 **Infantilisation & Cultural Norms**

It is helpful here to reconsider the example given earlier to illustrate moral luck and moral ignorance: the man who is cultured to think and behave in wrongful and harmful ways towards women, where such attitudes and behaviours are unobjectionable adherences to local norms. We might defend his absence of knowledge, and his absence of control over such knowledge, as factors beyond his influence. No matter how wrongful or harmful his behaviour, and no matter how egregious their impacts on the women with whom he interacts, we should then say that his behaviour is objectively bad – from our standpoint – but that he is blameless for the wrongs and harms attributable to him. It seems to require an exceptional moral leap for him to see the world any differently. However, as in similar defenses of slave-owning in periods where slavery was morally acceptable, there is a power differential here that cannot be ignored. These seem to be cases of *motivated* ignorance: the perpetrators of the harm benefit from maintaining the moral system they inhabit. They are motivated, however indirectly, to ignore evidence of the harm being committed, or any objections or resistance from those being dominated, in the interest of maintaining their position of power (Wieland, 2017). Motivated ignorance such as this frequently does seem culpable: they *should know* that they are doing something wrong, but they avoid such knowledge. Whatever their cultural context, blame often then seems appropriate (Moody-Adams, 1994).

Do instances of infantilisation show a similar motivated ignorance? Certainly, the situations are not the same; far from being in positions of social power and authority, care workers are frequently low paid or unpaid, over-worked and under-resourced, operating in difficult conditions where only short-term goals get room for consideration. The work is so poorly resourced and little respected that posts are often difficult to fill; many residential and day services for elderly and cognitively disabled people are permanently understaffed (Desroches, 2020). In care settings and public or home environments, many carers have little or no pre-employment training. Across cultures, the vast majority of carers are women; in addition to having a lower social and professional status by virtue of their gender, women are assumed suited to the care of adults with high support needs precisely because such care is equated with the mothering of infants (Özen, 2019; Muswera & Kasiram, 2019; Capri & Swartz, 2017). They do not benefit – socially or financially – from infantilizing their clients, patients, or family members. However, within these relationships, the carer does have the controlling role, and it may be the case – at least in some instances – that thinking of and treating adults as children makes their work easier. Conceiving of an adult as asexual or non-sexual may make intimate care less challenging for the carer who must facilitate bathing, toileting, dressing, and other intimate bodily interactions. Desexualisation may be a necessary psychological tool, especially within familial care relationships. In other contexts, "pretending they are caring for a baby, and seeing and treating the older person as asexual, may be a strategy for paid care-givers to deal with having and performing a job socially considered demeaning" (Özen, 2019, pp. 14-15). For some carers, especially those untrained and unpaid providing full-time care to a family member, infantilisation may be a form of self-preservation. In residential and day services, a conceptual stance which allows the requests, objections, and opinions of cared-for adults to be ignored and their lives strictly regulated may create a more controllable environment, and this may take priority over even apparent harms when there are not enough staff, not enough resources, and never enough time (Desroches, 2020). In under-resourced care environments, the objective may be just keeping the place running. The time and resources needed to overhaul entire conceptual

frameworks and standards of treatment may be non-existent. Some benefit may accrue from maintaining infantilisation rather than recognizing the wrongs and harms that stem from it. In some instances, then, motivated ignorance may be a factor.

However, on experience, I take it for granted that, for the vast majority of carers, their primary motivation is the well-being of their clients, patients and family members. Were they aware that they were doing wrong or causing harm through their conceptualization or treatment, I suspect that would be a source of great surprise and regret (to the point that many might resist such a suggestion). We should look beyond those in direct care relationships to understand why this might be the case. The care of disabled and elderly people is not enacted only in one-to-one personal services; it is decided in meeting rooms and board rooms, through financial planning and government policy, within social and professional environments where ableism and ageism are rife (Capri & Swartz, 2017). Physically disabled people, cognitively disabled people and elderly people are among the least valued members in many societies. The 'new eugenics' mentioned in Chapter 2 is an outgrowth of a eugenicist background that never went away; one that frames the dependency of disabled and elderly people as a burden, and where, through infantilisation, their real subjectivities are erased. The infantilized subject who remains sits on the fringe of social concern. Through the denial of personhood seen in some cases of cognitive disability, they may be pushed outside the moral community altogether (Kittay, 2005).

### 3.10 **Discriminatory Obliviousness & Culpability**

Rather than a motivated ignorance, the collective non-recognition of the wrongs and harms of infantilisation might be better called *discriminatory obliviousness*. These wrongs and harms do not register as social injustices because the people they effect are not relevant targets of social concern.

No exceptional moral leap is required to see that infantilisation is wrongful and harmful; the evidence is in empirical work from several disciplines and in the self-advocacy of those affected. This research is mostly recent and self-advocacy work by disabled people is rarely center stage, but it is publicly available. Care workers are perhaps the people least likely to have time to access such resources. What of everyone else? We do not live in a closed society of concrete norms which prevent us from reassessing collectively held assumptions. We are shaped by cultural factors but not limited by them – as Moody-Adams points out, this is the difference between being part of a culture and being brainwashed (Moody-Adams, 1994). We continuously reexamine and reform the assumptions and norms of our cultures. Cultural norms of right and wrong are established and reestablished through individual and collective action. Moody-Adams points to *affected ignorance* as "choosing not to know what one can or should know" or simply "refusing to consider whether some practice in which one participates might be wrong" (Moody-Adams, 1994, p. 296). With infantilisation – supported as it is by a collective indifference toward the well-being of those placed at the fringes of moral concern – even words such as "choosing" and "refusing" seem too active. *Not knowing* infantilisation is wrong and harmful seems closer to passive omission; an obliviousness based on discriminatory norms about the value of disabled and elderly lives. One may, of course, still be responsible for causing harm by omission rather than direct action. While the existing research available on how infantilisation is enacted relates almost exclusively to care situations or care providers, infantilisation is not confined to these contexts. It is a socially pervasive phenomenon, evident far beyond care settings in popular, social, and governmental attitudes. Rather than focus solely on carers, we should ask: Is *our* discriminatory obliviousness exculpatory, or do we share the blame for the wrongs and harms of infantilisation?

Where a faultless lack of knowledge about the harm of some specific action may be exculpatory, the same cannot be said of other forms of obliviousness or ignorance. One might argue that if I do not

know I have culturally acquired discriminatory biases, those biases are not under my control, and any other facts I am oblivious to because of those biases cannot be my responsibility either. It seems to me that for any sense of personal agency and accountability to matter, and any social change to be possible, we must at least allow that we are capable of recognizing our own discriminatory biases – especially (perhaps inexcusably) when the harmful effects of those biases are pointed out to us. This pointing out, of course, satisfies the strong epistemic conditions on responsibility and blame which I claimed at the beginning of this chapter were necessary in any assessment of blameworthiness and infantilisation. If I know infantilisation is harmful and I persist in it, then I am clearly a candidate for blame.

### 3.11 **Infantilisation as Conceptual Obstacle**

However, merely pointing out that some practice is harmful may not be effective in deep-seated cases of discriminatory thinking. The harm may seem to be a justifiable side-effect of necessary treatment. If adults are conceived of as having the subjectivities or personhood of children – especially where those adults have high support needs – decisions on appropriate treatment are bound to differ from those pertaining to non-infantilized adults. Infantilisation creates adults that no one is quite sure what to do with: they cannot be treated as actual children, yet they do not qualify for adult norms and allowances. Aberrant treatment may seem to be simply an unfortunate inevitability for such aberrant kinds of people. Infantilisation as conceptual failure therefore stands as a major obstacle when any argument is made against the harms of infantilizing treatment. There may be the sense that they *just are* imperfect eternal children; their treatment is therefore not expected to conform to typical norms. To test the strength of this conceptual failure, it is helpful to again consider paternalism. Paternalism too can be imperfect and even harmful; as quoted earlier, in cases of cognitive disability especially it seems "both vitally necessary and potentially dangerous" (Bérubé, 2009). What is notable here is that bad paternalism can be fixed. Where the treatment

someone receives within a paternalistic relationship is pointed out to be harmful, that harm can be stopped or mitigated. Harm is not an inevitable offshoot of paternalism. Conversely, treatment rooted in the conceptual failure of infantilisation can perhaps be alleviated slightly, but it cannot be fixed. The harms of infantilisation cannot be eradicated where the concept remains in place.

In terms of blame, this might take us back on another loop: If I am not responsible for acquiring this wrongful concept, how can I be responsible for actions I take (or allow) based on it? I defer to Levy's succinct volitionist response: "I may not be responsible for whether I am in the responsibility ballpark, but I am responsible for what I do when I find myself there" (Levy, 2005, p. 7). Infantilisation as a conceptual failure – conceiving of an adult as having the subjectivity or personhood of a child – reflects deeply dualist popular conceptions of the mind-body connection. That we can comfortably imagine someone as being a child *inside an adult*, and engage with them on that basis, points to this pervasive metacultural background assumption, and to the paucity of conceptual resources available in understanding people who differ from the expected physical or cognitive norms of the species. Physical disability, physical frailty, atypical speech patterns or gait, atypical cognition, or any communicative difference at all can disrupt our acquired interpersonal habits as we attempt to conceptualise the person with whom we are engaged. It is often assumed that these observable differences mean there's a different kind of person in there (Agmon, et al., 2016; Nario-Redmond, et al., 2019; McBryde Johnson, 2005; Taylor, 2016). In many cases of physical disability and old age, this assumption is just grossly inaccurate. The person *in there* is an adult with all the capacities and life narrative of anyone else. In cases of cognitive disability or atypical cognition, we may be correct in assuming that the subjectivity or personhood of the person differs in some significant ways from the statistically typical adult. It may be correct and appropriate and respectful to engage with them differently. But it is not correct to erase that different kind of

subjectivity and replace it with that of a child for our own convenience; or because we lack the conceptual resources to do anything else.

### 3.12 **Culpable Obliviousness & False Belief**

Obliviousness or ignorance may prevent us from reassessing the concepts and practices we use, but the conceptual failure at the heart of infantilisation is not *itself* obliviousness or ignorance. It seems closer to *false belief*. In thinking that some person is a child in the body of an adult, I am simply wrong. Elizabeth Harman has argued that it is false belief that exculpates, not ignorance (Harman, 2011). Our false beliefs about infantilised adults might then be regrettable (and open to revision) but we cannot be blamed for them. Yet this again seems to rest on the assumption that we came about this concept blamelessly. Perhaps we did – the infantilising concept is at least a century strong and extremely pervasive. For those who rarely interact with infantilised adults – because these adults are socially or institutionally segregated – there is rarely opportunity or cause to examine or revise the concept. For those who interact regularly with infantilised adults, and are more directly enmeshed in their infantilisation, it might seem that there would be frequent instigation to revise or dismantle the concept: yet in these settings, some of the strongest evidence of the concept can be found among carers and staff.[15]

Maintaining a false belief requires either active reaffirmation of it, or negligence of it. With infantilisation as a concept, as with infantilising treatment, it seems likely that negligence is the greater cause of its persistence. Yet this negligence itself is not exculpatory. We fail to recognise the concept is wrongful, and fail to develop an appropriate alternative, because the targets of

[15] This is possibly because the majority of the empirical studies are based in care settings: some analysis of wider attitudes seems to find infantilisation – as a concept and as a motivator for infantilizing treatment – is pervasive among other test groups also (Nario-Redmond, et al., 2019; Robey, et al., 2006).

infantilisation belong to categories of people not deemed worthy of full consideration. Discriminatory biases about disability, dependency, and age play a strong role. Discriminatory biases about cognition and intelligence are powerfully influential: within conceptual systems which use 'full rationality' as a defining marker of the species, many cognitively disabled people are pushed outside the moral community by default. The most solid ground for claiming that infantilisation is harmful and wrongful, but that the perpetrators are not blameworthy, is that those perpetrators *don't know* that it is wrongful or harmful. Yet it seems that they (or that we) may, to varying degrees, be culpable for not knowing.

### 3.13 **Is blame necessary?**

Why do we need blame? This might be an irrelevant question where blame is seen only as an affective response. Whether we need it or not, we have negative feelings toward someone who has attitudes or behaviour we think are wrong or harmful. I am here more concerned with blame as a justifiable response; where someone is to blame for some act, attitude, or omission because she is properly responsible for it. She is properly responsible for it when she knows what she's doing and has correct control over her actions. She is not responsible when either she has no control, or more relevant here, she *does not know* that what she's doing is harmful or wrongful. However, because she may be responsible (to some degree) for not knowing, we need strong epistemic conditions that extend our assessment of responsibility to cover instances of discriminatory obliviousness: that is, responsibility extends to where she has failed to consider the wrongfulness or harmfulness of her attitudes or actions because of discriminatory biases about the people affected by them. I suggest these strong epistemic conditions should apply when assessing responsibility and blameworthiness in cases of infantilisation.

Assessing whether someone can justifiably be blamed allows us to identify the source or perpetrators of some harm so that the harm can be stopped. Yet we can stop harm through mere attribution – simply identifying the causal source of some harm allows us to arrest it. Responsibility and blame track, to some extent, the feeling that the source of the harm should not have done what they did, and to a further extent, that they should be sanctioned for it. Blame recognises that unjust harm was done *to* someone, and that this person is entitled to some form of reparation. I admit that in my assessment of blameworthiness and infantilisation I have been partially motivated by an aversion to blaming carers for its harms and wrongs, even while the empirical work seems to point to them as the source. Holding under-resourced, disrespected, underpaid, understaffed, under-trained care staff accountable for infantilisation seems callous. Further, it seems unjustified when wider issues of collective, social disregard for the conditions of care are considered. Holding accountable someone who, through chance, found themselves the lifelong, full-time, entirely untrained carer of a family member seems equally perverse. In this assessment, we are in uncomfortable territory between mere attribution and culpable responsibility. Compassion for carers aside, the wronged and harmed infantilised adult must remain central in these considerations.

### 3.14 **Strong Epistemic Conditions & Graded Blame**

In addition to strong epistemic conditions, infantilisation requires an understanding of blame as a matter of degree. We should recognise that different people may be more or less blameworthy for the same actions (Kelly, 2013): a nurse who has been told that infantilisation is harmful and wrongful but who maintains it, conceptually and practically, seems far more blameworthy than the untrained and unaware family-carer who unreflectively infantilises their cognitively disabled parent. The strong epistemic conditions thus partly decide the extent to which responsibility and blame are justifiable.

Positional considerations should also affect our assessments: we should recognise that some people are, through no fault of their own, in situations and environments which make it harder to recognise harms and wrongs, or harder to do anything about it. Staff and family members caring for elderly or disabled people may be severely overworked and under-resourced; we should ask ourselves how we can reasonably expect them to see beyond the pervasive and institutionalised infantilising concept when they operate under such pressure. We should also ask; who is responsible for their being under-resourced and over-worked? Discriminatory biases about disability, dependence and old age create the social and economic conditions in which care work is a low priority for support and disabled and elderly people are low priorities for consideration. If the responsibility for infantilisation – as a conceptual failure and a harmful way of treating others – is distributed, the blame for its effects should be distributed also. While those engaged in care work seem to be the most obvious perpetrators of infantilisation, "sharing in the blame, even remotely, may seem to disqualify us from dishing it out" (Kelly, 2013, p. 5).

In proposing that we adopt a graded understanding of responsibility and blame in cases of infantilisation, I should establish two possible limits on a scale. At one extreme, a person who has been told clearly and emphatically that infantilisation is both conceptually wrong and that the treatments stemming from it are harmful, but who persists in thinking of and treating others in this way, seems outright responsible and blameworthy for infantilisation in that instance.[16] At the other pole, someone who has no idea that infantilisation is either wrongful or harmful, and is not involved in harmful treatment, might reasonably be excused blame: however, as I have discussed previously in this chapter, I am not convinced that such obliviousness is entirely exculpatory.

Again: why do we need blame? Blame recognises that harm has been done and that the target of that harm is justified in holding the perpetrator accountable. There may be a sense that with

[16] They are, of course, not responsible or blameworthy for infantilisation as a whole.

infantilisation the necessary step is to simply stop it happening. There is no space or need for blame; we should just change our attitude and our ways of treating people and move on. Certainly, changing our infantilising attitudes and treatments is essential if the harm to a great many people is to be arrested and prevented from happening in the future. Yet, social change is not social justice. If we recognise that infantilised adults have been wronged and harmed, and that there is culpability for this harm, aren't they owed what anyone else would be owed in that situation?

### 3.15 **Chapter Summary**

In this chapter, I have argued that infantilisation is conceptually wrongful and demonstrably harmful. Infantilisation is heavily normatively weighted to the negative and should be urgently avoided and prevented. I have attempted to balance compassion for carers with the entitlement for recognition and accountability which is due to the wronged and harmed party, infantilized adults. I have proposed that a graded understanding of blame, with strong epistemic conditions, should be used to assess responsibility and blame in instances of infantilisation. Where the harms and wrongs of infantilisation are culpable, perpetrators may be justifiably subject to sanction, and infantilized adults may be justifiably entitled to reparation.

## Concluding Comments

In this thesis I have developed a theory of infantilisation, describing its conceptual foundations and the pattern of treatments which stem from them. To do this, I have drawn on empirical research from multiple disciplines, the testimony and self-advocacy of infantilized adults, informal conversations with carers and disabled people, and personal experience. I have brought together existing claims about infantilisation as a way of treating people and aimed to clarify the concept which grounds and motivates that treatment. In doing so, I distinguished infantilisation from paternalism. I have developed this theory, and emphasized the conceptual architecture, because I believe infantilisation is a distinct phenomenon which is harmful to those affected. I wish to counter what I suspect is the prevailing attitude toward infantilisation – that it is an imperfect but appropriate feature of difficult care relationships – by centering the experience of infantilized adults and showing the effect of infantilisation on their lives, well-being, development, social standing, and sense of self. Infantilisation is not paternalism, and infantilisation is not a benign feature of caring relationships. It is a conceptual failure and a social injustice which results in worse care outcomes and harms those adults effected.

I will not conclude by making sweeping suggestions for how these failures can be corrected. In a project of limited scale, I have attempted to spotlight and clarify a phenomenon and argue that it is both wrongful and harmful and should be avoided. Any attempt to identify corrective measures should be carefully developed, properly researched, and aimed in the right direction. I cannot provide that analysis here. I can, however, point to two areas (the first negative, the second positive) that a corrective project might consider.

First, infantilisation involves an erasure of the actual subjectivity of the infantilized adult, and infantilisation is tied to post-institutional architectures of care. As such, it is part of a wider conceptual and sociopolitical system which excludes "defective" humans, views them as less than full persons or less than fully human, and represents their need for care as a wasteful burden on the economy. While some futurist visions assume the progressive eradication of illness and disability, in fact it seems likely that "the future will be a disabled one: there will be more disabled people, not fewer" (Shew, 2020, p. 609). As people live longer, the incidence of dementia, sensory and mobility impairments, and chronic illness will increase; the expected increase in dementia diagnoses was described in a 2013 UK Department of Health report as "one of the biggest health challenges ever" (quoted in Petherbridge, 2019, p.309). Yet this dimly visible disabled future runs forward from a present where disability and old age are largely reviled, where care systems and care workers are neglected and given low social status (and even lower economic priority), and where the lives of disabled and elderly people are publicly declared burdensome, wasteful, pointless, and unworthy of moral, social, political, or economic inclusion. Contemporary eugenicist thinking (the so-called 'newgenics') totes prenatal screening as a means to eradicate disabled people from the species and infanticide as a morally justifiable means to relieve us of the burden profoundly disabled people represent (Aunos & Feldman, 2002; Kittay, 2005; Kittay, 2009; McMahan, 2008; Singer, 2009; Wilson, 2018; Cokley, 2020). Presumed cognitive incapacity seems now, as it did in the early days of eugenics, to be strongly tied to an individual's ability to contribute to the economy. In their child-like incapacity, the infantilized adult is simply a permanent, static drain on resources. As they are neither adults nor children, they have no secure place in the moral community, live segregated lives, and belong to a peripheral category of social concern. If contemporary eugenicist thinking runs unchallenged in economies struggling to fund their health services (and facing an increase in demand for both elderly and disability services), adults who have been or will be infantilized might logically become "undesirable, expendable" (Shew, 2020, p. 609); justifiably neglected or persuaded that they have "a moral duty to die" (Malpas, 2009). I suggest that the connection between

infantilisation, moral personhood, and contemporary eugenicist thinking should therefore be carefully explored.

Secondly, any corrective project should prioritize the experiences and actual subjectivities of infantilized adults. Recent academic and theoretical work on personhood and subjectivity in dementia and Alzheimer's has begun to conceptualize the subjective experience of those affected and to propose new understandings of personhood accordingly (Jennings, 2009; Petherbridge, 2019), but there is a glaring dearth of philosophical work on subjective experience and personhood in Down syndrome, autism, and other life-long classified cognitive disabilities. This dearth reflects ableist assumptions about the marginal status of minds so classified: rather than attempting to conceptualize the subjective experience of cognitively disabled people, most philosophical engagement with cognitive disability is concerned with whether they should be considered persons *at all* (Carlson, 2009; Kittay & Carlson, 2010; Singer, 2009; Harris, 2010; Crary, 2019). Philosophical attention to the writing, testimony, creative or artistic output of cognitively disabled people, or primary research with cognitively disabled people, could provide the conceptual resources to represent their subjectivities and personhood more accurately. Some studies referenced in this thesis involve the testimony of infantilized adults (Fitzgerald & Withers, 2011; Agmon, et al., 2016; Bjornsdottir, et al., 2017; Alexander & Taylor Gomez, 2017; Capri & Swartz, 2017; Dorozenko, et al., 2015), but significant work is needed not only to identify their infantilisation but to understand their preferred interpersonal and structural norms. Creative and ethnographic projects can have a significant effect on public attitudes and might positively mitigate the discriminatory obliviousness described in Chapter 3: the effect, if any, of TV series such as "Special", "A-Typical", "Love On The Spectrum" and "Deaf U" (all of which are led by or prominently feature disabled people) could be explored in this regard. Any corrective proposals for the wrongfulness and harmfulness of infantilisation should centrally involve adults who are or have been infantilized. With infantilisation,

the affected adult's opinions, desires, personhood, and epistemic legitimacy are disregarded: any corrective project should center their voices as a matter of priority.

The Latin root of infant, *infans*, means "incapable of speech" or "speechless"; in civil law, 'infans' refers to "a child not having the ability to speak" (Merriam Webster, n.d.). Once infantilized, adults are "left without a voice, unable to speak up against [their] treatment" (Brady, et al., 2014, p. 24). Their expressions of resistance – whether verbal or non-verbal – can be disregarded where their subjectivity is conceived of as that of a child. Their experience of infantilisation can leave them unable to form such expressions or may persuade them that they are who they are assumed to be: merely children with the inconvenient bodies of adults. This metaphorical and literal silencing traps the infantilized adult: the solution is not to speak *for* them, but to listen *to* them, attending to whatever forms of speech, expression, or communication they prefer. I have argued that infantilisation is wrongful, harmful, and (to a qualified degree) blameworthy. Infantilized adults may justifiably expect justice; at the very least, they are owed change.

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