

**Dehumanizing the Cognitively Disabled:
Commentary on Smith's *Making Monsters***

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“No one is doing better work on the psychology of dehumanization than David Livingstone Smith, and he brings to bear an impressive depth and breadth of knowledge in psychology, philosophy, history, and anthropology. *Making Monsters* is a landmark achievement which will frame all future work on the psychology of dehumanization.” So says Eric Schwitzgebel on the back cover of the book, and we stand by that assessment. Today we aim to extend Smith’s framework to cases of cognitive disability.

According to Smith, “we dehumanize others when we conceive of them as subhuman creatures” (p. 9). However, Smith argues, since it is rarely possible to entirely eradicate our inclination to see other members of our species as fully human, dehumanization typically involves having contradictory beliefs, or at least contradictory representations. On the one hand, the Nazi looks at the Jew, or the southern slaveowner looks at the Black slave, and they can’t help but represent them as human. On the other hand, the Nazi and the slaveowner accept an ideology according to which the Jew and the Black slave are subhuman. The Jew or the Black slave are thus, on Smith’s view, cognitively threatening. They are experienced as confusing and creepy. They seem to transgress the boundaries between human and non-human, violating the natural order.

Smith briefly discusses disabled people. Sometimes, disabled people appear to be dehumanized in Smith’s sense. Smith quotes the Nazi doctor Wilhelm Bayer as saying that the fifty-six disabled children he euthanized “could not be qualified as ‘human beings’” (p. 250). Perhaps more commonly, however, people guilty of ableism regard disabled people as humans, but humans who are “chronically defective, incomplete, or deformed” (p. 261). Even in the

notorious tract which set the stage for the Nazi euthanasia program, “Permission to Destroy Life Unworthy of Life”, Karl Binding and Alfred Hoche describe those they seek to destroy as “human” (*Menschen*).

However, we recommend not relying exclusively on explicit language in thinking about dehumanization of people with disabilities. It is entirely possible to represent people as subhuman while still verbally describing them as “human” when explicitly asked.

Dehumanization in Smith’s sense involves powerful conflicting representations of the other as both human and subhuman. Verbal evidence is important (and we will use it ourselves), but dehumanization does not require that both representations be verbalized.

We focus on the case of adults with severe cognitive disabilities. Amelie Green is the daughter of Filipino immigrants who worked as live-in caregivers in a small residential home for severely cognitively disabled “clients”. Throughout her childhood and early adulthood, Amelie witnessed the repeated abuse of cognitively disabled people at the hands of caregivers. This includes psychological abuse, physical assault, gross overmedication, needless binding, and nutritional deprivation, directly contrary to law and any reasonable ethical standard. This abuse is possible because the monitoring of these institutions is extremely lax. Surprise visits by regulators rarely occur. Typically, inspections are scheduled weeks or months in advance, giving residential institutions ample time to create the appearance of humane conditions in a brief, pleasing show for regulators. Since the clients are severely cognitively disabled, few are able to communicate their abuse to regulators. Many do not even recognize that they are being abused.

We’ll describe one episode as Amelie recorded it – far from the worst that Amelie has witnessed – to give the flavor and as a target for analysis. The client’s name has been changed for confidentiality.

As I stepped out of the kitchen, I heard a sharp scream, followed by a light thud. The screams continued, and, out of curiosity, I found myself walking towards the back of the house, drawn to two individuals shouting. Halfway towards the commotion, I stopped. I witnessed a caregiver strenuously invert an ambulatory woman strapped to her wheelchair. Both of the patient's legs pointed towards the ceiling, and her hands clutched the wheelchair's sidearm handles. As the wailing grew louder, the caregiver proceeded to wedge the patient's left shoe inside her mouth, muffling the screams.

My initial reaction was to walk away from the scene to compose my thoughts quickly. Upon reflection, I assumed that the soft thud I heard was the impact of Anna's wheelchair. Anna's refusal to stop crying must have prompted the caregiver to stuff a shoe inside Anna's mouth. I assumed that Anna was punished for complaining. After some thought, I noticed that I involuntarily defended the act of physical abuse by conceptualizing the caregiver's response as a "punishment," insinuating my biased perspective in favor of the workers. From afar, I caught the female staff outwardly explaining to Anna that she would continue to physically harm her if she made "too much loud noise." From personal observation, Anna struggled to control her crying spells, oblivious of the commotion she was creating. Nonetheless, Anna involuntarily continued screaming, and the female staff thrust the shoe deeper.

Amelie has witnessed staff members kicking clients in the head; binding them to their beds with little cause; feeding a diabetic client large amounts of sugary drinks with the explicit aim of harming them; eating clients' attractive food, leaving the clients with a daily diet of mostly

salads, eggs, and prunes; falsifying time stamps for medication and feeding; and attempting to control clients by dosing them with psychiatric medications intended for other clients, against medical recommendations. It is not just a few caregivers who engage in such abusive behaviors. In Amelie's experience, a majority of caregivers are abusive, though to different degrees.

Why do caregivers of the severely cognitive disabled so frequently behave like this? We have four hypotheses.

Convenience. Abuse might be the easiest or most effective means of achieving some practical goal. For example, striking or humiliating a client might keep them obedient, easier to manage than would be possible with a more humane approach. Although humane techniques exist for managing people with cognitive disabilities, they might work more slowly or require more effort from caregivers, who might understandably feel overtaxed in their jobs and frustrated by clients' unruly behavior. Poorly paid workers might also steal attractive food that would otherwise not be easy for them to afford, justifying it with the thought that the clients won't know the difference.

Sadism. According to the clinical psychologist Erich Fromm (1974), sadistic acts are acts performed on helpless others that aim at exerting maximum control over those helpless others, usually by inflicting harm on them but also by subjecting those others to arbitrary rules or forcing them to do pointless activities. It is crucial to sadistic control that it lack practical value, since power is best manifested when the chosen action is arbitrary. People typically enact sadism, according to Fromm, when they feel powerless in their own lives. Picture the man who feels frustrated and powerless at work who then comes home and kicks his dog. Cognitively disabled adults might be particularly attractive targets for frustrated workers' sadistic impulses, since they are mostly powerless to resist and cannot report abuse.

Dehumanization. Abuse might arise from metaphysical discomfort of the sort Smith sees in racial dehumanization. The cognitively disabled might be seen as unnatural and metaphysically threatening. The cognitively disabled might seem creepy, occupying a gray area that defies familiar categories, at once both human and subhuman. Caregivers with conflicting representations of cognitively disabled people both as human and as subhuman might attempt to resolve that conflict by symbolically degrading their clients – implicitly asserting their clients’ subhumanity as a means of resolving this felt tension in favor of the subhuman. If the caregivers have already been mistreating the clients due to convenience or sadism, symbolic degradation might be even more attractive. If they can reinforce their representation of the client as subhuman, sadistic abuse or mistreatment for sake of convenience will seem to matter less.

Retaliation. All parents will know this reaction. Your two-year-old is hollering bloody murder *yet again* about having his face rubbed with sunscreen. He’s striking you and trying to squirm free. It can feel like defiance. It can feel like the child *won’t* do something that they can and should do (sit still for one minute while you apply the sunscreen); and it’s understandable to feel a temptation to be rough with them, or alternatively to give up and let them get the sunburn they “deserve”, rather than having the saintly patience that parenthood sometimes demands. Caregivers face analogous defiance from some of their cognitively disabled clients, and might feel some inclination to retaliate, either actively (for example, by striking or binding them) or passively (for example, by not feeding or washing them). But as with the case of young children, retaliation of this sort can be inappropriate, undeserved by the target who lacks a full comprehension of the significance of their defiant act. If our adaptation of Smith is correct, and caregivers have conflicting representations of their clients, retaliatory impulses might be aggravated: The caregiver, perhaps, can’t help but on some level misrepresent the client as like

an ordinary adult person, who has an ordinary adult-like understanding how awfully frustrating they are being, who should know better and who is capable of acting differently – misrepresentations that might aggravate the retaliatory impulse. This tendency to implicitly misrepresent might be enhanced if the client physically looks like an ordinary adult and their cognitive incapacity is not as visually obvious.

Consider the example of Anna. To the extent the caregiver's motivation is convenience, she might be hoping that inverting Anna in the wheelchair and shoving a shoe in her mouth will be an effective punishment that will encourage Anna not to cry so much or so loudly in the future. To the extent the motivation is sadism, the caregiver might be acting out of frustration and a feeling of powerlessness, either in general in her working life or specifically regarding her inability to prevent Anna from crying or both. By inverting Anna and shoving a shoe in her mouth, the caregiver can feel powerful instead of powerless, exerting sadistic control over a helpless other. To the extent the motivation is dehumanization, the worker is symbolically removing Anna's humanity by literally physically turning her upside-down, into a position that human beings don't typically occupy. Dogs bite shoes, and humans typically do not, and so arguably Anna is symbolically transformed into a dog. Furthermore, the shoe symbolically and perhaps actually prevents Anna from using her mouth to make humanlike sounds. To the extent the motivation is retaliation, the caregiver might feel angry at Anna for her apparent continuing defiance.

These four hypotheses about caregivers' motives make different empirically distinguishable predictions about who will be abusive, and to whom, and which abusive acts they tend to choose. To the extent convenience is the explanation, we should expect experienced caregivers to choose *effective* forms of abuse. They will not engage in abuse with no clear

purpose, and if a particular form of abuse seems not to be achieving its goal, they will presumably learn to stop that practice. To the extent sadism is the explanation, we should expect that the caregivers who feel most powerless should engage in it and that they should choose as victims clients who are among the most powerless while still being capable of controllable activity. Sadistic abuse should manifest especially in acts of purposeless cruelty and arbitrary control, almost the opposite of what would be chosen if convenience were the motive. To the extent dehumanization is the motive, we should expect the targets of abuse to be disproportionately the clients who are most cognitively and metaphysically threatening – the ones who, in addition to being cognitively disabled, are perceived as having a “deformed” physical appearance, or who seem to resemble non-human animals in their behavior (for example, crawling instead of upright walking), or who are negatively racialized. Acts manifesting dehumanizing motivations should be acts with symbolic value: treating the person in ways that are associated with the treatment of non-human animals, or symbolically altering or preventing characteristically human features or behaviors such as speech, clothing, upright walking, and dining. To the extent retaliation is the motive, it should disproportionately target clients who seem to have a partial understanding of, and inconsistent pattern of adherence to, rules and it should manifest especially when clients fail to engage in obedient actions that they are sometimes capable of. It might also be enhanced among clients with relatively more ordinary appearance compared to clients who are more visually obviously incapacitated.

We don't intend convenience, sadism, dehumanization, and retaliation as an exhaustive list of motives. People do things for many reasons, including sometimes against their will at the behest of others. Nor do we intend these four motives as exclusive. Indeed, as we have already suggested, they might to some extent support each other: Dehumanizing motives might be more

attractive once a caregiver has already abused a client for reasons of convenience, sadism, or retaliation. Also, different caregivers might exhibit these motivations in different proportions. As we hope is also clear, the fact that the majority of caretakers observed by Amelie have engaged in abusive behavior suggests that something about the situation of caregiving is responsible for the patterns of abuse. The caregivers themselves are ordinary people who have chosen to enter a helping profession, and who in fact typically do quite a lot of good for their clients on the whole. Something about the job, perhaps particularly in certain institutional settings, seems to exhaust caregivers, wearing them down, so that when they are not closely supervised, these ordinary well-meaning people often fall into some combination of convenient corner-cutting, sadism, dehumanization, and retaliation.

But in what proportion? Convenience alone cannot always be the motive. Caregivers often mistreat clients in ways that, far from making things easier for themselves, require extra effort. Adding extra sugar to a diabetic client's drink serves no effective purpose and risks creating medical complications that the caregiver would then have to deal with. Another client was regularly told lies about his mother, such as that she had died or that she had forgotten about him, seemingly only to provoke a distressed reaction from him. This same client had a tendency to hunch forward and grunt, and caregivers would imitate his slouching and grunting, mocking him in a way that often flustered and confused him. Also, caregivers would go to substantial lengths to avoid sharing the facility's elegant dining table with clients, even though there was plenty of room for both workers and clients to eat together at opposite ends. Instead, caregivers would rearrange chairs and tablecloths and a large vase before every meal, forcing clients to eat separately at an old, makeshift table. Relatedly, they meticulously ensured that caregivers' and

clients' dishes and cutlery were never mixed, cleaning them with separate sponges and drying them in separate racks, as if clients were infectious.

But do caregivers really have dehumanizing representations in Smith's sense? Here, we follow Smith's method of examining the caregivers' words. In Amelie's experience over the years, she has observed that caregivers frequently refer to their clients as "animals" or "no better than animals". In abusing them, they say things like, "you have to treat them like the animals they are". Caregivers also commonly treat clients in a manner associated with dogs – for example, whistling for them to come over, saying "Here [name]!" in the same manner you would call a dog, and feeding them food scraps from the table. (These scraps will often be food officially bought on behalf of the clients but which the caregivers are eating for themselves.) The caregivers Amelie has observed also commonly refer to their clients with the English pronoun "it" instead of "he" or "she", though of course they are aware of their clients' gender. Some employ "it" so habitually that they accidentally refer to clients as "it" in front of the client's relatives, during relatives' visits. This pronoun is perhaps especially telling, since there is no practical justification for using it, and often no sadistic justification either, since many clients aren't linguistically capable of understanding pronoun use. The use of "it" appears to emerge from an implicit or explicit dehumanizing representation of the client.

Despite speech patterns suggestive of dehumanization, caregivers also explicitly refer to the clients as human beings. In their reflective moments, Amelie has observed them to say things like "It's hard to remember sometimes that they're people. When they behave like this, you sometimes forget." In Amelie's judgment, the caregivers typically agree when reminded that the clients are people with rights who should be treated accordingly, though they often seem uncomfortable in acknowledging this.

Although the evidence is ambiguous, given caregivers' patterns of explicitly referring to their cognitively disabled clients both as people and as non-human animals or "it"s, plus non-verbal behavior that appears to suggest dehumanizing representations, we think it's reasonable to suppose, in accordance with Smith's model of dehumanization, that many caregivers have powerful contradictory representations of their clients, seeing them simultaneously as human and as subhuman, finding them confusing, creepy, and in conflict with the natural order of things. If so, then it is plausible that they would feel the same kind of cognitive and metaphysical discomfort that Smith identifies in racial dehumanization, and that this discomfort would sometimes lead to inappropriate behavior of the sort described.

There's another way to reassert the natural order of things, of course. Instead of dehumanizing cognitively disabled clients, you might embrace their humanity. There are two ways of doing this. One involves preserving a certain narrow, traditional sense of the "human" – a sense into which cognitively disabled people don't easily fit – and then attempting to force the cognitively disabled within that conception. Visiting relatives sometimes seem to do this. One pattern is for a relative to comment with excessive appreciation on a stereotypically human trait that the client has, such as the beauty of their hair – as if to prove to themselves or others that their cognitively disabled relative is a human after all. While this impulse is admirable, it might be rooted in a narrow conception of the human, according to which cognitively disabled people are metaphysical category-straddlers or at best lesser humans.

A different approach to resolving the metaphysical problem – the approach we recommend – involves a more capacious understanding of the human. Plenty of people have disabilities. A person with a missing leg is no less of a human than a person with two legs, nor is the person with a missing leg somehow defective in their humanity. However, our culture

appears to have instilled in many of us – perhaps implicitly and even against our better conscious judgment – a tendency to think of high levels of cognitive ability as essential to being fully and non-defectively human. Perhaps historically this has proven to be a useful ideology for eliminating, warehousing, drugging, and binding people who are inconvenient to have around. We suspect that changing this conception would reduce the abuse that caregivers routinely inflict on their cognitively disabled clients.

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