

# Flourishing Bodies: Disability, Virtue, Happiness

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Boston College  
The Graduate School of Arts and Sciences  
Department of Philosophy

**FLOURISHING BODIES:  
DISABILITY, VIRTUE, HAPPINESS**

a dissertation

by

**ELIZABETH B. PURCELL**

submitted in partial fulfillment of the requirements

for the degree of

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## **Abstract**

### ***Flourishing Bodies: Disability, Virtue, Happiness***

**Elizabeth B. Purcell**

**Advisor: Dr. Richard Kearney**

The pursuit of living a good and moral life has been a longstanding ideal of philosophy, an ideal that dates back to the writings of Plato, and more specifically, Aristotle. This ideal establishes that a good life as a happy and flourishing life is pursued by developing the right motives and the right character. And in order to live this life, one must, then, develop a virtuous character, i.e., be a virtuous person, who desires the good. Finally, in the pursuit of the good, one must not do so alone; rather, one should pursue the virtuous life with others, i.e., friends, because they enhance our ability to think and to act. This specific position which is taken up by Aristotelian virtue ethics, however, has recently come under scrutiny by certain studies in social psychology. Particularly, the concept of character has been discredited by empirical studies. Furthermore, the classic model of the virtuous person has assumed only persons with able-bodies. As a result of these two criticisms, Aristotelian virtue ethics has been discredited as a fantasy ethics available for only a few to achieve.

The principle aim of this dissertation is to develop and defend an account of Aristotelian virtue ethics which is grounded in empirical psychology and enables people with disabilities to flourish as moral exemplars within a society. The value of virtue and character for ethical debate is imperative for human happiness within moral life. Instead

of happiness being something an individual strives to acquire or feel, Aristotelian virtue ethicists have argued that true happiness is *human flourishing*. In other words, in order to be happy, humans should focus not just on what it is good to do, but also, and more importantly, focus on *who it is good to be*. To live a good life, then, it is necessary that one is a good person, or has a good character. Thus, to acquire virtues such as charity, benevolence, honesty, and generosity and to shun vices such as dishonesty, cruelty, or stinginess, is the task, Aristotelian virtue ethicists have argued, that leads to *eudaimonia*, i.e., human flourishing. The person who has acquired virtuous character traits, then, is the person who is most happy in life.

However, the attempt to understand human happiness as a result of a virtuous character has become vulnerable to criticism from philosophical positions grounded in empirical psychology and disability theory. In light of the charge that virtue ethics is a fantasy ethics, many philosophers argue that Aristotelian virtue ethics should be abandoned because it is an ethics with little or no scientific basis. In my defense of Aristotelian virtue ethics, I first address the objection that Aristotelian virtue ethics is a "fantasy ethics" which has no grounding in empirical psychology, and thus, as a result, should not be used for moral theory. This objection has been put forth by certain "Situationist" philosophers, who cite psychological studies which demonstrate that the idea of a virtue as a "global character trait" is something that humans do not actually, or very rarely, possess. This objection to Aristotelian virtue ethics has dealt a devastating blow. In response to this objection, philosopher Nancy Snow has mounted a defense of Aristotelian virtue ethics which is grounded in empirical psychology.

Snow's defense, though superficially appealing, has two intractable problems. I address the failure of her proposal in *Chapter One: The Problem of Virtue as Social Intelligence*. The first problem Snow faces concerns her use of CAPS as a method for virtue ethics to be used *throughout life*. I call this problem the *longitudinality problem*, which argues that Snow's proposal for the constancy of virtue for longer than a period of six weeks is overreaching. The second problem Snow faces concerns her reliance on virtue as social intelligence for the *actual achievement of being virtuous in daily living*. This problem turns on the empirical criteria for what makes a person capable of virtuous action and I call this problem the *exclusivity problem*, which excludes people with "Autism" from being virtuous.

As an alternative to Snow's account, I begin my defense of Aristotelian virtue ethics by developing the following account of empirical virtue based on a narrative identity which desires and actively pursues the good in life-long striving. This moral desire is encouraged through the shared dialogue of virtuous caregiving, which enables a moral novice to flourish and grow into a moral expert. This pursuit of the good enables everyone to flourish and incorporates insights from disability, embodied cognition and social psychology.

To accomplish this task, I begin with an examination of the first of two foundational components of character, i.e., the four processing levels of CAPS theory in *Chapter Two: Moral Perception*. Although CAPS theory provides a solid beginning for an account of virtue, it is not a sustainable theory *throughout life*. This theory of social-cognitive moral psychology needs to be supplemented by developmental moral psychology. CAPS theory also assumes the individual's perspective in the dynamic

interaction between situation and character. It assumes a person's intentions, and this assumption of intentionality - desires, intentions, and beliefs - assumes a person's embodiment in that situation. In other words, CAPS theory assumes lived embodiment. In this chapter, I turn to the method of phenomenology used by both psychologists and philosophers of embodied cognition to account for the moral "interpretation of the situation" experienced by people with illness or impairment.

As a complimentary to CAPS and the second foundational component for character, certain moral psychologists have argued for the narrative development of Event Representations for virtuous character. This development begins with the shared dialogue of the caregiver and dependent asking the dependent to recall events which have just occurred. In this practice, the caregiver's aim is to help the dependent form memories and incorporate those memories into the creation of a narrative identity. In *Chapter Three: Representations of Moral Events*, I extend the caring relation to this practice of shared dialogue to incorporate certain forms of intellectual disability, such as "Autism" and Alzheimer's disease. To accomplish this, I incorporate the roles of narrative and trust in order to construct the relation of dependency and interdependency as trusting co-authorship rather than reciprocal capability. After establishing the importance of the caregiver in the development of one's narrative identity, I employ the *life narrative* longitudinal psychological approach to moral development as a structure for the moral event representations and schemas guided by the caregiver. Finally, I argue that the co-authorship of one's life story animates one's moral desire for the good and as a result, leads to the development of *interdependent virtues*.

In *Chapter Four: Moral Self-Coherence through Personal Strivings*, I examine the importance of personal strivings for a sense of lived self-coherence for character over time. My argument is that our personal strivings are unified by the life story which animates and directs those strivings throughout our lives. Although our personal strivings may be altered or deterred due to life transitions including accident, illness, and “disabling injury,” they still retain a sense of unity through our overarching life story. It is this narrative which gives unity to both our psychological intentions and bodily intentions, even when they are experienced as a phenomenally lived dualism due to illness, stroke, or impairment. In order to make my argument, I examine ten case studies from medical patients. I argue that our personal strivings toward the *good* guide our growth of character from a moral novice to become a moral expert.

In *Chapter Five: Flourishing Bodies*, I develop an empirically grounded model of a virtuous character which begins with interdependent virtues and eventually grows into independent virtues. To do this, I draw on the two foundational components of character: CAPS theory and event representations. From the caring relation and shared dialogue of the caregiver, an individual begins to develop basic moral schemas, tasks, and scripts. This is when the individual is a moral novice. As the novice pursues excellences in these practices, the novice grows into a moral expert according to those virtues and becomes virtuously independent. The moral expert, unlike the moral novice, executes virtuous action with ease. Having acquired skills of virtue and knowledge, the moral expert knows the right thing to do at the right time and does so with the right reasons.

MacIntyre, however, acknowledged the limit of ethics and turned to politics to address specific needs for people with disabilities such as care, financial support,



educational support, and political proxy. The purpose of the final chapter, *The Virtue-Oriented Politics of Interdependence*, is to follow MacIntyre's endeavor and to propose a virtue-oriented politics of interdependence as an initial solution. First, I examine the various forms of oppression facing people with disabilities in society. In order to address these forms of oppression for people with disabilities, I argue that a shift in the central component of a political framework is needed. Instead of focusing on *distribution* or *recognition*, one should focus on *education* in the broad sense.

In conclusion of my dissertation, *The Fragility of Virtue*, I provide a perspective of our human condition that is a vulnerable one. In this final section, I discuss the role of our collective vulnerability and the fragility of human goodness with regard to illness and impairment. And that our interdependence is strengthened through the virtue of friendship. I finish with a proposal of the role of sacrifice as a way to reconcile the pursuit of a flourishing life in the face of our own fragility.

In loving memory of  
Elizabeth Rangel Vargas

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## INTRODUCTION:

### *The Need for an Empirically Grounded Theory of Virtue*

*kai neois de pros to anamartēton kai presbyterois  
pros therapeian kai to elleipon tēs praxeōs  
di astheneian boētheia, tois t' en akmē pros tas kalas praxeis*

[Friends] direct young men toward correctness  
and to the elderly, they give care  
and help to supplement their failing sensory powers,  
and to those in their prime they direct toward noble actions  
(Aristotle 1999, 1155a).

The pursuit of living a good and moral life has been a longstanding ideal of philosophy, an ideal that dates back to the writings of Plato, and more specifically, Aristotle. This ideal establishes that a good life as a happy and flourishing life is pursued by developing the right motives and the right character. And in order to live this life, one must, then, develop a virtuous character, i.e., be a virtuous person, who desires the good. Finally, in the pursuit of the good, one must not do so alone; rather, one should pursue the virtuous life with others, i.e., friends, because they enhance our ability to think and to act.<sup>1</sup> This specific position which is taken up by Aristotelian virtue ethics, however, has recently come under scrutiny by certain studies in social psychology. Particularly, the concept of character has been discredited by empirical studies. Furthermore, the classic model of the virtuous person has assumed only persons with able-bodies. As a result of

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<sup>1</sup> *Kai gar noēsai kai praxai dunatōteroi* (Aristotle, 1999, 1155a).



these two criticisms, Aristotelian virtue ethics has been discredited as a fantasy ethics available for only a few to achieve.<sup>2</sup>

The principle aim of this dissertation is to develop and defend an account of Aristotelian virtue ethics which is grounded in empirical psychology and enables people with disabilities to flourish as moral exemplars within a society. The value of virtue and character for ethical debate is imperative for human happiness within moral life. Instead of happiness being something an individual strives to acquire or feel, Aristotelian virtue ethicists have argued that true happiness is *human flourishing*. In other words, in order to be happy, humans should focus not just on what it is good to do, but also, and more importantly, focus on *who it is good to be*. To live a good life, then, it is necessary that one is a good person, or has a good character. Thus, to acquire virtues such as charity, benevolence, honesty, and generosity and to shun vices such as dishonesty, cruelty, or stinginess, is the task, Aristotelian virtue ethicists have argued, that leads to *eudaimonia*, i.e., human flourishing. The person who has acquired virtuous character traits, then, is the person who is most happy in life.

Further, the Aristotelian view claims that our character is foundational for both moral philosophy and moral life. The virtuous person is the person who has and exercises the virtues such as honesty, courage, justice, and *phronēsis* (practical wisdom). The virtues are global traits that an individual has acquired and exercises in both ethical actions and ethical judgments. The right thing to do, then, is what a virtuous agent would do in the circumstances. Finally, the task of developing a virtuous character in order to become a virtuous person is one that should not only be appropriated from time to time. Rather, the task of developing virtue in pursuit of the good should be the task pursued *throughout one's life*. In order to live well, one must engage in

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<sup>2</sup> Throughout this dissertation, I use the phrase “Aristotelian virtue ethics” to differentiate my position from a Humean virtue theory such as Slote (2001) or other virtue theories such as J.J. Thomson (1996, 1997).

practices which seek and promote the good over a life time. This is how one becomes happy and flourishes.

We begin, then, with insight into the character of happiness by noting that as humans we pursue what is *good*, and the *good life* is achieved in the activity of that pursuit. This pursuit of the good is directed by a *desire for the good*. Because of this pursuit, the intentions of the virtuous person are always ordered toward the good and this is what makes his or her practices excellent. Thus, to become a virtuous person, one must first order one's desires to become virtuous and then perform the virtuous actions the person of moral excellence would perform.

This Aristotelian virtue ethics view has been espoused, with some variations, in the works of philosophers such as: Elizabeth Anscombe, Philippa Foot, Rosalind Hursthouse, Alasdair MacIntyre and Paul Ricoeur.<sup>3</sup> One of the appealing features of Aristotelian virtue ethics is that it captures the good of human desires, while also capturing the good of human action in the world. Both of these elements provide a viable way of leading a happy life as a moral life, without reducing human happiness to psychological egoism or utilitarian calculus.

However, the attempt to understand human happiness as a result of a virtuous character has become vulnerable to criticism from philosophical positions grounded in empirical psychology and disability theory. In light of the charge that virtue ethics is a fantasy ethics, many philosophers argue that Aristotelian virtue ethics should be abandoned because it is an ethics with little or no empirical basis. And in many cases, contemporary Aristotelian virtue ethicists have not done much to respond to prominent criticisms.

In this dissertation, I argue that this form of virtue ethics can withstand the most serious objections against it. In order to do so, though, it will require formulating a position which in

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<sup>3</sup> See Anscombe (1958, 2006), Foot (2001, 2003), Hursthouse (1999), MacIntyre (1984, 1990, 1999), and Ricoeur (1992).

some ways departs from virtue ethicists such as Foot but appropriates insights from authors like Hursthouse and MacIntyre. I also aim to show how the appeal to the development of virtue as a goal should be pursued *throughout life*. To do so, I analyze the intentional desire of the good exhibited in social psychology by moral exemplars. After I have developed an empirically grounded Aristotelian framework in the first five chapters, in the final chapter I argue for the need of Aristotelian virtues and moral education in the contemporary discussion about the oppression of people with disabilities and the possibility of virtuous political action.

In my defense of Aristotelian virtue ethics, I first address the objection that Aristotelian virtue ethics is a "fantasy ethics" which has no grounding in empirical psychology, and thus, as a result, should not be used for moral theory. This objection has been put forth by certain "Situationist" philosophers, who cite psychological studies which demonstrate that the idea of a virtue as a "global character trait" is something that humans do not actually, or very rarely, possess. Because people only exercise virtues "locally," or only in specific circumstances, these philosophers argue that virtues as character traits lack a "cross-situational consistency." In other words, virtues are only pulled out at specific times, rather than exercised throughout life and across many different activities. Instead, people's actions are determined by the situations in which they find themselves, rather than by the character they may have developed. This objection to Aristotelian virtue ethics has dealt a devastating blow. In response to this objection, philosopher Nancy Snow has mounted a defense of Aristotelian virtue ethics which is grounded in empirical psychology.<sup>4</sup>

Snow's defense, though superficially appealing, faces two intractable problems. I address the failure of her proposal in *Chapter One: The Problem of Virtue as Social Intelligence*. In order to make her case, Snow draws upon the social-cognitive theory in psychology known as CAPS.

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<sup>4</sup> See Snow (2010).

This theory understands an individual's personality as a Cognitive Affective Processing System. The advantage of understanding the development of human character as CAPS is twofold. First, according to this theory, psychologists understand human action as a result of the dynamic interaction between the situation of the individual and the interpretation of that situation, i.e., the perspective, of the individual. This is significant for Aristotelian virtue ethics because it brings back the relevance of character for ethical action. Second, CAPS theory accounts for traits which individuals exhibit over time and across situations. This "cross-situational" evidence of traits has breathed new life into the development of virtues. In order to account for the *flourishing* of the virtuous person, Snow argues that Social Intelligence guides our virtuous action. Although Snow's attempt to ground virtue ethics in CAPS theory and Social Intelligence is on the right track, her theory proves inadequate on two accounts.

The first problem Snow faces concerns her use of CAPS as a method for virtue ethics to be used *throughout life*. I call this problem the *longitudinality problem*. Virtues as a subset of CAPS traits, Snow argues, have the ability to grow from these local, domain-dependent situations into more global virtues over time. There is, however, a problem with Snow's proposal of widening virtue using the method of CAPS theory: the tests of the behavioral signature only warrant the conclusion of the constancy of character over a period of six weeks and not throughout life. In short, Snow's proposal of the behavioral signature indicating the constancy of virtue for longer than a limited period, such as six weeks, is overreaching.

The second problem Snow faces concerns her reliance on virtue as social intelligence for the *actual achievement of being virtuous in daily living*. This problem turns on the empirical criteria for what makes a person capable of virtuous action and I call this problem the *exclusivity problem*. In order to make her account of virtue empirically grounded, Snow departs from the

traditional reliance on *phronēsis* (practical wisdom) and argues that the virtuous person is the socially intelligent person. This part of her argument proves problematic for those with cognitive impairments such as “Autism” to become virtuous. Because of empirical evidence from disability specialists and real life counter examples such as moral exemplar Temple Grandin, who has a form of “Autism,” Snow's account of virtue ethics fails to recognize those who actually are virtuous within society. The account I take up in this dissertation is the *life story as striving for moral expertise* and draws from moral expertise theory for character rather than the theory of social intelligence.<sup>5</sup> The *life story model* provides a more solid foundation for character that is empirically grounded, cross-situationally consistent and sustainable throughout life for people with disabilities.

As an alternative to Snow's account, I begin my defense of Aristotelian virtue ethics by developing the following account of empirical virtue based on a narrative identity which desires and actively pursues the good in life-long striving. This moral desire is encouraged through the shared dialogue of virtuous caregiving, which enables a moral novice to flourish and grow into a moral expert. This pursuit of the good enables everyone to flourish and incorporates insights from disability, embodied cognition and social psychology.

To accomplish this task, I begin with an examination of the first of two foundational components of character, i.e., the four processing levels of CAPS theory in *Chapter Two: Moral Perception*. Although CAPS theory provides a solid beginning for an account of virtue, it is not a sustainable theory *throughout life*. This theory of social-cognitive moral psychology needs to be supplemented by developmental moral psychology. CAPS theory also assumes the individual's perspective in the dynamic interaction between situation and character. It assumes a person's

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<sup>5</sup> Hereafter, I shall refer to this model as the *life story model* which is drawn from McAdam's life story model of identity for developmental psychology (1987, 1989, 1994a) and Narvaez and Lapsley's model of moral expertise (2004, 2005).

intentions, and this assumption of intentionality - desires, intentions, and beliefs - assumes a person's embodiment in that situation. In other words, CAPS theory assumes lived embodiment. In this chapter, I turn to the method of phenomenology used by both psychologists and philosophers of embodied cognition to account for the moral "interpretation of the situation" experienced by people with illness or impairment. To ensure that my account is grounded in science, I consider two perspectives of human consciousness: the existential perspective of lived embodiment as well as the neurobiological perspective to avoid the criticism that this might be a "fantasy body." In this chapter, I construct both the first-person and third-person accounts of intentional consciousness for "I" intentions, "You" intentions, and "We" intentions. In this construction, my aim has been to show that as humans, our dynamic interaction with situations involve interdependent relations with others because our intentional consciousness is relational.

As a complimentary to CAPS and the second foundational component for character, moral psychologists Narvaez and Lapsley have argued for the narrative development of Event Representations for virtuous character. This development begins with the shared dialogue of the caregiver and dependent asking the dependent to recall events which have just occurred. In this practice, the caregiver's aim is to help the dependent form memories and incorporate those memories into the creation of a narrative identity. In *Chapter Three: Representations of Moral Events*, I extend Noddings' account of the caring relation to this practice of shared dialogue to incorporate certain forms of intellectual disability, such as "Autism" and Alzheimer's disease.<sup>6</sup> To accomplish this, I incorporate the roles of narrative and trust in order to construct the relation of dependency and interdependency as trusting co-authorship rather than reciprocal capability. After establishing the importance of the caregiver in the development of one's narrative identity,

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<sup>6</sup> See Noddings (2002, 2003).

I employ McAdam's *life narrative* longitudinal psychological approach to moral development as a structure for the moral event representations and schemas guided by the caregiver. Finally, I argue that the co-authorship of one's life story animates one's moral desire for the good and as a result, leads to the development of *interdependent virtues*.

In *Chapter Four: Moral Self-Coherence through Personal Strivings*, I examine the importance of Emmons' psychological account of personal strivings for a sense of lived self-coherence for character over time.<sup>7</sup> My argument is that our personal strivings are unified by the life story which animates and directs those strivings throughout our lives. Although our personal strivings may be altered or deterred due to life transitions including accident, illness, and "disabling injury," they still retain a sense of unity through our overarching life story. It is this narrative which gives unity to both our psychological intentions and bodily intentions, even when they are experienced as a phenomenally lived dualism due to illness, stroke, or impairment. In order to make my argument, I examine ten case studies from medical patients. I argue that our personal strivings toward the *good* guide our growth of character from a moral novice to become a moral expert.

In *Chapter Five: Flourishing Bodies*, I develop an empirically grounded model of a virtuous character which begins with interdependent virtues and eventually grows into independent virtues. To do this, I draw on the two foundational components of character: CAPS theory and event representations. From the caring relation and shared dialogue of the caregiver, an individual begins to develop basic moral schemas, tasks, and scripts. This is when the individual is a moral novice. The task of the moral novice is to develop moral desires which animate those schemas, tasks and scripts. In other words, the caregiver guides the desires of the

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<sup>7</sup> See Emmons (1986, 1989).

novice to become directed toward what is good. In this stage, the moral novice develops interdependent virtues with others such as trust, truthfulness, and genuineness. The moral novice begins to learn procedural moral knowledge - knowing the right thing to do at the right time - and also declarative knowledge - having the right reasons and knowing why this action is important. As the moral novice begins to grow her personal moral goals of the local domains into a more global concern which animates her life, the novice develops a life-long personal striving. This unifying moral goal is dedicated to the pursuit of the good, not just in one situation, but in many. It is at this point that the interdependent virtues grow into virtuous practices. As the novice pursues excellences in these practices, the novice grows into a moral expert according to those virtues and becomes virtuously independent. The moral expert, unlike the moral novice, executes virtuous action with ease. Having acquired skills of virtue and knowledge, the moral expert knows the right thing to do at the right time and does so with the right reasons. Striking examples of the moral expert as the virtuous person are the moral exemplars Martin Luther King, Jr. and Mother Teresa.

MacIntyre acknowledged the limit of ethics and turned to politics to address specific needs for people with disabilities such as care, financial support, educational support, and political proxy.<sup>8</sup> The purpose of *Chapter Six: The Virtue-Oriented Politics of Interdependence* is to follow MacIntyre's endeavor and to propose a virtue-oriented politics of interdependence as an initial solution. First, I examine the various forms of oppression facing people with disabilities in society. In order to address these forms of oppression for people with disabilities, I argue that a shift in the central component of a political framework is needed. Instead of focusing on *distribution* or *recognition*, one should focus on *education* in the broad sense. Thus, a virtue-oriented politics focuses on *Moral Education* by directing its attention to the *moral schemas* its

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<sup>8</sup> See MacIntyre (1999).



citizens are being taught to uphold. A shift in moral schemas signifies a *moral revolution*. This re-evaluation of values occurs through three areas: education, technological media, and close associates such as family members and caregivers.

In conclusion of my dissertation, *The Fragility of Virtue*, I provide a perspective of our human condition that is a vulnerable one. In this final section, I discuss the role of our collective vulnerability and the fragility of human goodness with regard to illness and impairment. And that our interdependence is strengthened through the virtue of friendship. I finish with a proposal of the role of sacrifice as a way to reconcile the pursuit of a flourishing life in the face of our own fragility.

## I.

### *The Problem with Virtue as Social Intelligence*

#### **1.0 The Situationist Challenge to Virtue Ethics**

The term “Virtue Ethics,” specifically Aristotelian virtue ethics, is often in reference to distinguish an approach in normative ethics which emphasizes *who a person should be* by focusing on virtues and character from *what a person should do*, which focuses more on duties or rules (deontology) or consequences of action (utilitarianism). Specifically, Aristotelian virtue ethics focuses on *eudaimonia* or human flourishing and how that flourishing involves human happiness, the role of emotions in human life and how one should live. In short, one develops a virtuous character in order to live well. Recently, however, virtue ethics has become vulnerable to two criticisms: first, that as a moral theory it lacks an empirical grounding in psychology and as a result, is not an actually achievable ethics, and second, that its emphasis on acquiring virtues which foster independence rather than interdependence make it impossible for many people with disabilities to become virtuous. The principle aim of this dissertation is to defend an empirically grounded account of virtue ethics through which people with disabilities can flourish.

For a long time the central tenets of Aristotelian virtue ethics, espoused by thinkers such as Anscombe, MacIntyre, Foot or Hursthouse, have remained unchallenged. The core of virtue ethics is the virtuous person. Character is at the heart of virtue ethics: the virtues are dispositions or “global traits” which are deep, stable, and interwoven with other traits and dispositions. A virtuous act is one that a virtuous person would do, done for the reasons a virtuous person would do it. Having the virtues contributes to one having a flourishing life (*eudaimonia*). The virtues are what makes life worthwhile so they are intrinsically worth having. To illustrate a virtuous

character, Hursthouse famously gives the example of the Good Samaritan who stops to help the person in need on the side of the road (1999, 6). The Good Samaritan exhibits the virtue of charity and we expect reliability or consistency in her actions. We expect that she is not only charitable to strangers in need whom she passes by, but also to her friends, family members, and colleagues. In other words, we assume that her virtue of charity is generally a character trait which she possesses. And we assume that this virtue of charity is firmly entrenched because it is a virtue rather than a mere tendency.

Opposed to the virtues stand the vices, which are to be shunned. Vices are deeper and more interwoven than bad habits. Hursthouse gives a list of vices to avoid:

Courses of action that are irresponsible, feckless, lazy, inconsiderate, uncooperative, harsh, intolerant, indiscreet, incautious, unenterprising, pusillanimous, feeble, hypocritical, self-indulgent, materialistic, grasping, short-sighted... (1999, 42).

Vices contribute to unethical actions and are the result of defects in character. Thus, there are three key claims to Aristotelian virtue ethics:

- (1) The right thing to do is what a virtuous agent would do in the circumstances.
- (2) A virtuous person is one who has and exercises the virtues.
- (3) A virtue is a character trait that a person needs in order to have *eudaimonia*, i.e., in order to live a good life.

The task of virtue ethics, then, is to discover what traits of character we need in order to live well.

But developing certain kinds of virtues in order to flourish has proved difficult for some people with certain disabilities. For those with cognitive impairments or within the Autistic spectrum, special education and care is necessary to begin to develop a virtuous character. Certain Aristotelians, most notably MacIntyre (1999) and Nussbaum (2006), have sought to rectify this problem by including virtues of dependence and the important role of caregiving, and by addressing the challenge of proxy and accountability.

Although this turn to include the difficulties facing people with disabilities has been admirable, a further challenge to Aristotelian ethics remains and is one to which virtue ethics is quite vulnerable. Certain philosophers, calling themselves “Situationist” moral psychologists have launched a critique of virtue ethics drawn from behavioral studies in social psychology (Harman 1999, 2000, 2003; Doris 1998, 2002, 2005; Merritt 2000). From those studies, these philosophers have concluded that there are no such things as *global traits* in people’s personalities. Because there are no such things as global traits, they conclude, then that there is no such thing as *character*. A dilemma follows: either the virtue ethicists have not told us about the virtues we can cultivate or it turns out that the kinds of lives we are supposed to lead in order to flourish turn out to be unachievable. In both cases, therefore, virtue ethics turns out to be an unachievable fantasy ethics.<sup>9</sup>

Because most virtue ethical theories have not relied on psychological studies to make their claims, virtue ethics has proven vulnerable to this attack. In order to respond, virtue ethics, specifically Aristotelian virtue ethics, needs a firmer empirical grounding. In addition, this new

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<sup>9</sup> See Appiah (2008), for a more extensive list of all of the troubling case studies for virtue ethics.

account needs to afford people with disabilities the chance to flourish as well. It is to these two challenges that this dissertation will respond.

## **1.1 Virtue as Social Intelligence**

### *1.1.1 Troubling Case Studies for Virtue Ethics*

The central challenge to virtue ethics is exhibited in certain behavioral studies appropriated by the Situationist philosophers. For instance, the global trait of honesty is considered a virtue and someone possessing this virtue should consistently display honest behavior in many objectively different types of situations such as sharing with friends, taking an exam, and filing her taxes. Her honest behavior is something temporally stable because she also manifests this honesty over time. Yet, behavioral studies show evidence to the contrary. The 1928 study by Yale psychologists Hugh Hartshorne and Mark May observed some ten thousand American schoolchildren, giving them opportunities to lie, cheat, and steal in various academic and athletic situations. In this study they found the opposite of what they expected: rather than honesty being a global character trait which was exhibited across situations (a child who follows the rules at home will consistently be honest at school and not cheat on an exam), the character trait of honesty instead was limited to only certain situations (knowing a child cheated on a spelling test would not tell you if he would cheat on a math test).

Situationist philosophers such as Harman, Doris, and Merritt cite other troubling case studies as well for evidence that global character traits do not exist. Concerning the virtue of charity, Situationists turn to the 1972 study by Alice M. Isen and Paula Levin which found that when someone dropped one's papers outside a phone booth in a shopping mall, one was far more

likely to be helped by people if they had just had the good fortune of finding a dime in the phone's coin-return slot. Likewise, in 1973, John Darley and Daniel Batson discovered that Princeton seminary students, even those who had just been reflecting on the Gospel account of the Good Samaritan, were much less likely to stop to help someone "slumped in a doorway, apparently in some sort of distress," if he had been told that he was late for an appointment. And finally, Robert Baron and Jill Thomley (1997) showed that one was more likely to get change for a dollar outside a fragrant bakery shop than standing near a "neutral-smelling dry-goods store." (Appiah, 2008, 41).

It would seem from such studies that the "virtue" of charity is not a global trait, but something that is induced by certain characteristics of situations. From such studies, the Situationists draw their name, because they argue that it is the situations (such as finding a dime) which determine our ethical actions, rather than our character understood as a deep, stable and interwoven set of traits. Thus, this notion of developing a virtuous character is irrelevant for moral theory.

### 1.1.2 *The Current Rebuttal: CAPS theory as Character*

In order to defend Aristotelian virtue ethics from the charge of being a fantasy ethics made by Situationist moral psychologists, Nancy Snow draws on the theory of CAPS traits (Cognitive-Affective Processing System) developed by social-cognitivist psychologists Walter Mischel and Yuichi Shoda (Snow, 2010).<sup>10</sup> Her basic rebuttal to the Situationists is that the studies they cite failed to include the *meanings* these situations had for the participants. It is CAPS theory which takes into account these meanings. CAPS theory includes social-cognitive units, or psychological

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<sup>10</sup> See specifically Cervone and Mischel (2002), Cervone and Shoda (1999), Mischel (1968, 1973, 1999, 2007), Mischel and Shoda (1999), Mischel, Shoda, and Ayduk (2008), Shoda and Mischel (1993, 1996, 1998), Shoda, Mischel and Wright (1989, 1993, 1994) and Shoda and LeeTiernan (2002).

“traits,” which are variables that become activated in response to situational features or in response to internal stimuli. These internal stimuli are processes of factors internal to the agent such as thoughts, imaginings, or practical reasoning. When these meanings are taken into account, she argues, global character traits become empirically defensible. If a case can be made that virtues are a subset of CAPS traits, then it will have been shown that virtue ethics is not a fantasy ethics.

Turning to the specifics of the argument, the first new appealing feature of CAPS theory is that it provides a radically new definition of a “trait.” Previously, both philosophers and psychologists had assumed that a trait was a completely stable part of a person’s disposition which was attributed to that person from the “outside-in.” In other words, one labeled a person’s character as honest from the observer’s point of view. It is this view of traits which the Situationists have criticized. What CAPS theory does is change the perspective to recognize that a trait is something that is also developed from the “inside-out.” Thus, the new definition of a trait that CAPS theory provides is the following: *a trait is a stable psychological structure composed of cognitive-affective units.* A cognitive-affective unit can be a belief, desire, expectation, value, or even self-regulatory strategies and plans. In general, it is an intentional state.

This new definition of a trait is important for virtue ethics because it takes into the account the belief of the agent as part of the mental state when she is acting virtuously. Take, for example, the virtue of honesty. In her action, her cognitive-affective units, which are part of the stable trait of honesty and are part of the psychological structure the agent possesses, have been activated. The units of this psychological structure can be activated in response to stimuli. This is

why the belief of the agent at the time of acting virtuously is necessary for her virtuous disposition.

The second feature of CAPS theory which is appealing to virtue ethics builds upon the first: *the perception of the agent in those situations matters*. A person's beliefs and interpretations of the stimuli he or she responds to is important. This second feature is also important as a rebuttal to the Situationists' charge. The Situationists are guilty of having forgotten that "objective" features of situations have meanings for people. People always interpret the situations in which they are placed. An example of the importance of people's perceptions can be found in a study certain psychologists conducted for young Catholic women in college. The researchers had the young women read a sexually exciting passage and then after that divided them into three groups for a bogus reaction test of clicking a button every time they saw a light flash: a control group which only saw the flashing light and then two groups that each saw a different picture flash briefly four times throughout the test. For one group, the picture was of Pope John Paul II scowling and the other was a picture of a random stranger scowling. After the experiment, the women were instructed to rate their self-esteem. Overwhelmingly the young Catholic women who had seen the picture of Pope John Paul II rated their self-esteem much lower than the other two groups. In other words, the picture of the Pope was a stimulus that had a special meaning for the women and activated feelings associated with low self-esteem (Baldwin, 2005, 47). By accounting for the meanings of situations, Mischel and Shoda have found empirical evidence of behavioral regularities across objectively different situation types when situations have similar psychological meaning for subjects. This stability across situations provides an empirical rebuttal of the Situationists' criticism that people do not behave consistently across situations found in studies such as Hartshorne and May.



As traditionally understood by Aristotelian virtue ethicists, a virtue is deep, stable, and interwoven with other traits and dispositions. In accord with this definition, Snow argues that virtues could be understood empirically as a subset of CAPS traits. Traits provide an empirical basis for virtues because a trait is a structure or "set of variables" which has been frequently activated in response to stimuli (Mischel and Shoda, 1999, 46-53). These variables are interconnected and thus when one is activated, they can set off a chain of reactions and activate others. Trait structure, then, can be conceived of as a "network of interrelated variables" (Snow, 2010, 20).

Through traits, we dynamically interpret and respond to the situations in which we live. The dynamic process of trait activation varies according to the different variables activated on different occasions. Thus, each trait has a structure which consists of a distinctive and relatively stable set of characteristic variables (beliefs, desires, affects, plans, etc...). Consider, for example, the virtue of compassion as a subset of CAPS traits. Rather than being simply an "affect" or a feeling one feels, like sadness, compassion as a trait includes the following variables in its structure: being moved to sadness or sorrow by the misfortune of another, believing that one can or should help, and desiring to help. These three variables are "linked together" or interconnected. As a result, the triggering of one, activates the rest, and produces a compassionate response, which would then be appropriate to the situation at the time.

The third appealing feature of CAPS theory for virtue ethics is important for an empirical basis for character. Mischel and Shoda provide behavioral studies which demonstrate how a subject could be able to develop virtues and behave consistently over time and across situations. This third feature is that *trait structures in individuals follow an "if...then" structure and as a result give "behavioral signatures."* These profiles relate an agent's actions to her interpretations

of situations over time (Shoda and Mischel 1996, 421-422). For example, suppose Jill reacts fearfully when she is teased by playmates but in other social situations exhibits confidence. In this case, we know that "if" Jill is teased "then" it is likely that she will react fearfully. It is this "if...then" structure which designates a behavioral signature for Jill (Mischel 1999, 53; Shoda, Mischel and Wright 1994, 674; Mischel and Shoda 1999, 207-209). What is important about the "ifs" is that they are not merely physical stimuli from the environment, but also that they include the meanings those stimuli have for people (e.g., Jill's interpretation of peer teasing). This "if...then" structure gives a consistency to behavioral reactions under certain psychological conditions and thus allows for a typical predictability of behavior and attribute traits. With enough evidence and repetition we can say that "if Jill perceives that she is being threatened by her playmates, she will typically be timid." Whether Jill actually reacts that way, though, will in the end be determined by how she interprets or perceives the situation, rather than solely on the situation's "objective" features (and one might note that the data suggest only probabilities).

Thus, the value for virtue ethics provided by Mischel and Shoda's finding is the following: for Situationist philosophers, my behavior in the world is determined by the situations in which I find myself, but for social-cognitivist psychologists, like Mischel and Shoda, and by extension virtue ethicists like Snow, *not only am I influenced by those situations but also I have the power to affect those situations and can influence the quality of the world in which we live.*

This ability to change myself and interact with the world in which I inhabit is evidenced when we return to the virtue of compassion as an example. Suppose that as a subset of CAPS traits, our agent's virtue of compassion begins as local or domain-dependent. Our agent may have only compassion for her close friends or family members. But then she decides that she wants to extend her compassion to a larger circle, or even to the domain of "people" in general.

She would then develop the goal of becoming a more globally compassionate person. To accomplish this, she might then attempt to generalize her “local” compassion by self-scrutiny and practical reason. She may even enlist the help of others. With a plan of self-development, she would reflect on her own actions, reactions and feelings to evaluate her growing compassion. She would then try to “habituate” herself to recognize cues from her environment and react compassionately. Slowly over time, her local trait of compassion would widen, possibly, to become a global character trait, or stable virtue.

### 1.1.3 “*Doing what the Virtuous Person does*” or *Virtue as Social Intelligence*

At this point Snow’s argument faces a specific difficulty. For Aristotelian virtue ethics, the virtues enable us to flourish because they help us achieve goals which are necessary to live well. The argument thus far has only established that there are empirically grounded global traits and that some of these traits might be construed as virtues. *In order to show that these traits are in fact virtues, Snow must show that these traits make our lives go well.* In order to do this, Snow argues that virtues are a form of social intelligence.

Social intelligence can loosely be defined as the knowledge, cognitive abilities, and affective sensitivities, such as empathy, that enable us to navigate our social world (Goleman, 2006; Snow, 2010, 63). It would seem that social intelligence would be of importance to virtue ethics because it enables us to perceive and respond to the interpersonal dynamics of situations just as the virtuous person knows the “right thing to do” at the “right time” in the “right respect.”

In order to make the empirical case that the “virtuous person” is the “socially intelligent” agent, Snow argues that virtues – as a subset of CAPS traits – are distinctive as forms of social intelligence because of their distinctive motivations (2010, 86). Social intelligence consists of

two initial factors: social perception and social knowledge. Social perception includes the ability to accurately interpret verbal and non-verbal social cues as well as to be aware of the affect or emotion that others experience. Social knowledge, by contrast, concerns the “conceptual or propositional knowledge of social concepts, awareness of social norms and conventions, and procedural knowledge of how to act in various social situations” (2010, 69). Finally, social intelligence is goal directed (Cantor and Kihlstrom, 1987). Building upon the virtuous character grounded in CAPS theory, then, the virtuous person is distinguished by her normative beliefs and these beliefs provide the motivations for the virtuous person’s actions (Snow, 2010, 87). In order to act virtuously and to meet the three key claims of virtue ethics in an empirically grounded theory, the virtuous agent uses not practical wisdom, but *social intelligence*. To review, the three key claims of virtue ethics are as follows:

- (1) The right thing to do is what a virtuous agent would do in the circumstances.
- (2) A virtuous person is one who has and exercises the virtues.
- (3) A virtue is a character trait that a person needs in order to have *eudaimonia*, i.e., in order to live a good life.

The socially intelligent virtuous person monitors and manages her interpretations and reactions. By using both social perception and social knowledge, she assesses the emotions of others and is able to act in an appropriately virtuous way. For example, when she perceives that another is in distress, she perceives that person’s distress, which in turn sets off a chain-like reaction of her social-cognitive units. In response, because she has virtuous motivations, affects, and beliefs, and

in addition social knowledge, she gives the appropriate ethical response to the person in distress. She knows the “right thing to do” in the “right time” under the “right circumstances.” Furthermore, since social intelligence is goal-directed, the socially intelligent virtuous person has the ability to shape her own character and develop virtues in a goal directed manner, thus enabling her to achieve goals in her life and to flourish.

## **1.2 Two Objections to Snow’s Account**

Snow’s defense of an empirically grounded virtue ethics has some appealing features. The first of these is her appropriation of CAPS traits in order to give an account of virtues in behavioral psychology. This appropriation by itself is enough to provide a launching point for virtue ethics to counter the initial criticism by the Situationists. Furthermore, Snow tries then to develop an empirically grounded way of how virtuous individuals might flourish – this time with the help of social intelligence rather than the more traditional use of *phronēsis*, or practical reasoning. This move to social intelligence, too, does have an allure.

### *1.2.1 Objection 1: The Longitudinality Problem*

Snow’s account, nevertheless, fails on two accounts. The first problem Snow faces concerns her use of CAPS as a method for virtue ethics to be used *throughout life*. I will call this problem the *longitudinality problem*. According to CAPS theory, an individual exhibits a behavioral signature following the “if...then” structure. In this structure, we can observe predictable virtuous behavior which considers both the situations and the interpretation of those situations by the agent. Thus, as a dynamic agent I am both affected by the situation, and in turn, have the power to respond or direct the situation in which I am placed. Virtues as a subset of CAPS traits,

then, Snow argues, have the ability to grow from these local, domain-dependent situations into more global virtues over time. Just as the virtuous person learns to develop the virtue of compassion locally within her family domain, slowly over time, Snow proposes, she could develop this virtue into a global trait of compassion for her community, animals, and humanity at large.

There is, however, a fundamental problem with Snow's proposal of widening virtue using the method of CAPS theory: *the tests of the behavioral signature only warrant the conclusion of the constancy of character over a period of six weeks and not throughout life*. In short, Snow's proposal of the behavioral signature indicating the constancy of virtue for longer than a period of six weeks is overreaching. This problem with the duration of CAPS has been well-documented in psychology, which is why most psychologists have turned to alternative methods for observing personality coherence over time (Caspi, 1987, 1204-1205). Personality psychology has struggled to solve the personality paradox of "stable traits and inconsistent behavior" (Epstein, 1984; Caspi, 1987, 1204). To solve this puzzle, there have been two general types of studies conducted. The first type concerns *longitudinal studies*, which observe extensive periods of time, but often neglect situation parameters (e.g., Block, 1971; Costa and McCrae, 1980). The other type concerns situation *consistency research*, which observes limited time periods of week, hours, minutes, and seconds (e.g., Mischel and Peake, 1982). Psychologists break these two branches of theories of personality coherence into four kinds of measures:

- (1) Time-free and situation-free measures
- (2) Time-specific but situation-free measures
- (3) Time-free but situation-specific measures

#### (4) Both time-specific and situation-specific measures

The first kind of measurement, i.e., *time-free and situation-free*, uses measures that represent central tendencies over relatively large time frames and measures that have a high degree of generality with regard to situation domains (Caspi, 1987; 1204). An example of this kind would be trait models of personality such as the Five Factor Model (Costa and McCrae, 1980; McCrae and Costa, 1996). The challenge this strategy faces is *specificity*: the attribution of traits is made without reference to specific situations and with reference to time period whose meaning is poorly understood. The second kind, i.e., *time-specific but situation-free*, appeals to developmental psychologists. Here, the time period is more specific, but the situations are not. An example of this kind of measurement is illustrated by the theoretical framework of Erikson (1950). The challenge of this second kind concerns the possibility that certain situations may account for individual differences, and thus provide situation-related variance. The third kind of measurement, i.e., *time-free but situation specific*, is exemplified in social psychological approaches like CAPS theory. This kind answers the question concerning how people change their behavior under specific conditions. This approach documents consistency of behavior over shorter periods of time such as hours, days, or weeks, and is used for Mischel and Shoda's observation of behavioral signatures for a period of *six weeks*. This kind of measurement, however, has "limited use in describing and explaining long-term changes" (Caspi, 1987, 1204). Furthermore, the "situations investigated in such research have a diffuse temporal boundary and are of only temporary psychological significance to the individual" (1987, 1204). This third kind of measurement often loses individual differences because it overlooks the longitudinal aspect. Finally, the fourth kind of measurement, i.e., *time-specific and situation-specific*, focuses on

situation-specific behavior “that is relevant to specific time periods (or developmental phases)” (1987, 1204-1205). This method is “very cumbersome,” but has the potential to yield the most satisfying results. To make this kind of measurement useful, it needs (a) a construction of longitudinal sequence of measures which explain long-term change and consistency and (b) some organizing principle or data reduction strategy to overcome the problem of the burden of “voluminous data generated by this strategy” (1987, 1205).

Because Snow’s dependence on CAPS theory uses the third kind of measurement, it is vulnerable to the *longitudinality problem*. The goal of virtue ethics is to develop a virtuous character which enables one to flourish *throughout life*, not just for a limited period of six weeks. Aristotle, himself, specifically remarks in Book I of the *Nicomachean Ethics*, that concerning human happiness this activity must be for “a complete lifetime; for one swallow does not make spring, nor does one [nice] day; thus one day or a brief period of time does not make one blessed and happy.”<sup>11</sup>

In order to correct for this problem of length of time, Snow might have recourse to turn to her proposal that virtue is developed by goal-dependent automaticity and is a form of social intelligence, which someone should continue to develop throughout life. Although this proposal might be appealing, there are some drawbacks to this defense. To begin, one notes that the shift away from CAPS already demonstrates a fundamental correction of her entire work, which understood virtues to be subsets of CAPS traits. Second, relying solely on goal-dependent automaticity for the demonstration of virtue over a longer period of time only accounts for a *procedural knowledge* of virtuous behavior and leaves out the role of *declarative knowledge*: one knows *how* to be virtuous and acts just so, but does not know *why* (Lapsley and Narvaez, 2004).

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<sup>11</sup> *en biō teleiō; mia gar khelidōn ear ou poiei, oude mia hēmera; houtō de oude makarion kai eudaimona mia hēmera oud’ oligos khronos* (Aristotle 1999, 1098a).



To include declarative knowledge, then, Snow might rely on overarching goals directed by socially intelligent life tasks developed by Cantor and Kihlstrom (1987) as culturally valued life tasks (2010, 72-73). Although this may provide a form of *declarative knowledge* – one knows why to perform this virtuous action because of one’s social intelligence – relying upon social intelligence for virtuous decision making has empirical evidence to the contrary. It is to the challenge from empirical evidence that I will turn to next.

### 1.2.2. *Objection 2: The Exclusivity Problem*

The second problem Snow faces concerns her reliance on virtue as social intelligence for the *actual achievement of being virtuous in daily living*. This problem turns on the empirical criteria for what makes a person capable of virtuous action, and I will call this problem the *exclusivity problem*. To recall, for the virtuous person, social intelligence guides his ability to both perceive others in distress and to take the appropriately virtuous action. One develops virtuous social intelligence in order both to help others and to aid oneself in the pursuit of one’s goals. Remembering our familiar example of the virtue of charity and our Good Samaritan, in Snow’s account our virtuous Good Samaritan first socially perceives another in distress on the side of the road, has virtuous motivations to help, and uses his social knowledge to virtuously act and help the unfortunate bystander. In order to develop virtuous habits and capabilities, Snow argues, one must also develop one’s social perception and social knowledge. Social intelligence, thus, guides one’s moral development and those who choose not to develop it – those who *choose* to remain socially “obtuse” – are morally blameworthy or vicious (2010, 96). Yet, the question remains, does her proposed theory work?

The problem facing Snow's insistence on virtue as social intelligence turns on one of the two empirical criteria she develops for the flourishing virtuous individual: the capability of *social perception*. Social perception, according to Snow, includes empathetic abilities, the ability to pick up on the affect or emotion others experience, and the ability to interpret facial expressions (2010, 69, 78).<sup>12</sup> This definition of social perception, however, might prove a barrier to virtuous development rather than an aid, because certain people with disabilities who *might* be considered virtuous in the more traditional understanding of "virtue" would not be considered virtuous by Snow's account (2010, 77-78, 90). As a result, her account of virtue ethics would prove inadequate or inaccessible for many people with disabilities. To illustrate this empirical barrier for certain "virtuous" people, I will raise three counter examples to Snow's virtuous socially intelligent person.

The first counter example to Snow's insistence on social perception as necessary for virtuous action is the case of political activist Helen Keller. At the age of nineteen months, Keller, as is well known in the United States, contracted an illness and became "blind" and "deaf" in the early 1880s. Because of her impairments, Keller dedicated her life to developing institutes and government programs which aided the poor, the malnourished, and those with disabilities. Many of us today would consider Keller a generally "virtuous person" based on her *dedication to* and *actions on behalf* of those suffering. But according to Snow's insistence on "social perception" for virtuous behavior, Keller's own impairments would make her unable to

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<sup>12</sup> It should be noted that Snow does not distinguish between types of empathetic abilities one should have. In general, the psychological understanding of empathy is multidimensional, but psychologists have determined that there are two types of empathy that operate in prosocial behavior: one that is affective and one that is cognitive. Many people with forms of "Autism" are known to experience affective empathy but do not experience cognitive empathy due to their cognitive impairment. By contrast, "psychopaths" are known to experience cognitive empathy – they know what the other is feeling – but lack affective empathy (i.e., they do not care). See (Krahn and Fenton, 2009, 149; Blair, 2005, 711; Blair, 1995, 1996, 1999, 2008).

“perceive” the “facial expressions” of others (Snow does say “facial expressions”, 2010, 78). Thus, Keller’s virtuous actions would prove incompatible with Snow’s account.

The second counter example to Snow’s account is the case of United States abolitionist Harriet Tubman who had severe vision impairment, epileptic seizures and long fainting spells due to a head wound she suffered as a child when enslaved. These impairments notwithstanding, Tubman’s subsequent actions would be considered virtuous by many. To recall, she was remarkably instrumental in freeing slaves through the Underground Railroad. Yet, due to her impairments, her “perception” of others emotions might render her virtuous actions questionable for Snow’s account as well. It was instead Tubman’s *desire for freedom and empathy for others*, not her social intelligence, that led her to dedicate her life to freeing people from slavery and enabling them to flourish.

The final counter example I raise is a direct reply to Snow’s admission that certain people with disabilities would be a “moral zero” for her account (2010, 96). The counter example of a virtuous person that I raise is Temple Grandin, who is both internationally famous for her “virtuous” actions and has “Asperger’s Syndrome” (i.e., she was born with “Autism” and is considered higher functioning). Grandin, author of *Thinking in Pictures*, is both a disability rights activist and an animal rights activist. According to Grandin, she has poor social intelligence and fears social relations with others because she always “gets it wrong.” Her *life purpose*, as she describes in her book, is to reduce animal suffering and to help children along the Autistic Spectrum develop their unique talents and gifts. Most people would consider Grandin’s motivations and actions “virtuous.” Snow, however, specifically uses the case of the boy with “Autism” from Mark Haddon’s novel *The Curious Incident of the Dog in the Night-Time* as an example of a person who would not be considered virtuous by her account and

instead would be considered a “moral zero” due to his “cognitive-affective impairment” (2010, 78, 96). In addition to excluding people with disabilities along the “Autistic Spectrum”, Snow includes other “disabling challenges” and claims that a person with depression could have a virtuous motive, but be unable to achieve the right action (2010, 92). As a result, Snow’s theory proves vulnerable to the *exclusivity problem* because it excludes people who would usually be considered virtuous according to a traditional account of virtue ethics.

### 1.2.3. Conclusion

The two problems, i.e., the *longitudinality problem* and the *exclusivity problem*, point to the inadequacy of Snow’s account. First, her proposal that virtues are a subset of CAPS traits that could possibly be expanded from situation specific domains into larger global domains over a period longer than six weeks is overreaching. Second, her reliance on virtue as a form of social intelligence that would enable one to flourish, openly excludes people with disabilities – even virtuous ones. As a result, Snow’s account is constitutively *able-ist*.

A new account, then, is necessary to resolve these two problems. Snow is right, I believe, to try to develop an account of Aristotelian virtue ethics grounded in empirical psychology. Also, I think she is right to rely on CAPS traits in her account of virtues. CAPS theory, however, does not provide an adequate method of empirical measurement to account for virtue throughout one’s lifetime. Furthermore, virtue as social intelligence does not give us the right empirical theory for how to lead a flourishing life. It does not capture and support the virtuous actions exhibited by Keller, Tubman and Grandin (among others). “Having an impairment” is a poor reason to designate a person’s character as a “moral zero.” Thus, Snow’s account of virtue as social intelligence proves insufficient as a complete normative theory. Although she is on the right

track, a new empirical theory which enables people with disabilities to flourish throughout life will need to be developed.

### **1.3 A New Model for Character: *Life Story as Striving for Moral Expertise***

The failure of Snow's account of "virtue as social intelligence" to be useful for flourishing throughout life and to enable people with certain disabilities to flourish is significant. As a result, such a conception of virtue will fail to yield a satisfactory normative theory. To correct this failure, two solutions will be necessary. First, a measurement that is both *time-specific* and *situation-specific* is needed to provide a lifetime pursuit of virtue. Second, a new model of virtue will need to supplant her current theory of virtue as social intelligence. I argue that these two problems can be solved by turning to the *life story perspective* as a new time-specific and situation-specific model *for virtue as moral exemplar* (Lapsley and Narvaez, 2004; McAdams, 1987, 1989, 1993, 1996; Matsuba & Walker, 2005).

Snow's attempt to give Aristotelian virtue ethics an empirical grounding, however, is quite admirable. Her adaptation of CAPS theory for *virtues* and the "if...then" structure for behavioral consistencies across situations demonstrating *character* is an excellent beginning for an empirically grounded virtue theory. I believe Snow has made the right innovation by relying on CAPS, but her further innovation to construe virtue as a form of social intelligence is insufficient for people with certain disabilities, especially those who are in fact virtuous. Because Snow provides no other alternative position for these people than "moral zero" in her normative theory, she does not aptly capture a sense in which people *are actually good* in spite of the lack of social intelligence they may have.

In the following chapters, then, I defend and develop an alternative way by which people with disabilities can flourish in an empirically grounded Aristotelian virtue ethics.<sup>13</sup> To accomplish this task, I will take up the fully developed model of the *life story as striving for the moral expertise* developed from the research by psychologists Emmons (1989), McAdams (1996), and Narvaez et al. (2005). By means of this account, I argue that we begin as *moral novices* and through the aid of caregivers learn to develop *interdependent virtues*.<sup>14</sup> Through the development of moral desires which animate the pursuit of a virtuous life purpose, it is possible for moral novices to develop into *moral experts* and appropriate *independent virtues*. This pursuit of a moral life purpose or striving enables the flourishing of individuals. Finally, the virtuous person as moral expert becomes a true model for virtue as a *moral exemplar* within society at large. One of the moral exemplars I will consider is animal and disability rights activist Temple Grandin, who has “Autism.”

*Eudaimonia* for people with disabilities and by extension everyone, according to Temple Grandin, begins with the sensory, i.e., it begins with *touch*. Grandin describes her experience of learning the virtues of gentleness and kindness in the following passage:

To have feelings of gentleness, one must experience gentle bodily  
comfort...After I experienced the soothing feeling of being held

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<sup>13</sup> I use this term “Aristotelian” for virtue ethics to distinguish my account of virtue ethics from two other kinds of accounts which might cause some confusion. My account has affinity with Aristotelian virtue ethicists such as Nancy Snow (2010), Alasdair MacIntyre (1984, 1999) and Rosalind Hursthouse (1999). My account differs from other theories of virtue in the following ways. First, I mean to distinguish my account from the “Humean” tradition of virtue ethics espoused by philosophers such as Slote (2001) and Merritt (2000). Second, I also wish to distinguish my account as a normative virtue ethical theory rather than simply a normative ethics which makes use of virtue theory espoused by philosophers such as Driver (2001) and Thomson (1996, 1997). Hursthouse (2007) discusses the distinction between virtue ethics and virtue theory.

<sup>14</sup> Here, I take my cue from MacIntyre’s virtues of acknowledged dependence (1999), but prefer the term “interdependent” because it better indicates the relational role of our moral development. See also Baldwin (2005).

[in her squeeze machine], I was able to transfer that good feeling to the cat. As I became gentler, the cat began to stay with me, and this helped me understand the ideas of reciprocity and gentleness (Grandin, 1996, 84).

Grandin's insight into the particular role our bodies play for the cultivation of virtues, recalls MacIntyre's lesson for moral philosophers *to acknowledge our embodiment for theories of virtue* (1999).

Grandin's insight, however, also indicates something Snow overlooked when she adopted CAPS traits for virtue ethics: the importance of the role of biological processes when developing virtue. For CAPS theory, there are *four* dispositional levels which interact with our social-cognitive units. But Snow only appropriates three of those four levels for her theory (2010, 19-25):

- (1) The psychological processing level (our thoughts, affects, behavioral strategies),
- (2) The behavioral level (the "if...then" behavioral signatures)
- (3) The perceived personality level (what other's see and infer)

Yet, there is a fourth level Snow overlooks:

- (4) The biochemical-genetic level (also known as one's pre-disposition) (Mischel, 1999, 54)

The biochemical-genetic level influences our personality-relevant qualities such as our sensory or psychomotor sensitivities. In addition, it includes our *vulnerabilities*, skills and competencies, temperament, chronic mood, and affective states. This level interacts with situations as well throughout our development and influences how a person thinks, feels, and acts. Grandin's "Autism" operates on this biochemical-genetic level and it was through the sensation of *touch* that her psychological processing level (her Social-Cognitive Unit) changed so that she learned the virtue of kindness.

This virtue of kindness began, just as Snow hypothesized, as a local, domain-dependent trait – petting a cat – but then grew wider to a larger domain and global trait. But before it could do so, her virtue of kindness prompted her to an existential crisis. Oliver Sacks recalls the day Grandin broke down and wept:

And I was awed, as we drove to the airport before my departure, by a sudden revelation of moral and spiritual depths which I had thought no ["autistic"] person would have. Temple was driving, when suddenly she faltered and wept, and said, "I don't want my thoughts to die with me. I want to have done something... I want to know that my life has meaning...I'm talking about things at the very core of my existence. (Grandin, 1996, 22, Forward).

What Temple wanted was a *life purpose*. She wanted to use her different body – her *gift* – to accomplish two things: relieve cattle from suffering and to help children with ASD [Autistic Spectrum Disorder] develop their unique talents and flourish. What guided Grandin's ability to



flourish was not her social intelligence, for she had none, but her *commitment to a moral life striving*. By desiring the good and pursuing a moral life purpose, Grandin transitioned from a moral novice into a moral exemplar who is internationally recognized for her virtuous character.

The alternative way, then, that I propose for an empirically grounded Aristotelian virtue ethics available for people with disabilities rests on the following claims:

- (1) That the right thing to do is what the *virtuous person as moral expert* would do in the circumstances
- (2) A virtuous person is one who has and exercises the virtues:
  - a. The virtues and vices as CAPS traits we develop must also include a reference to our embodiment, i.e., the biological-genetic processing level.
  - b. The virtues must accord with the *personal strivings* theory of personality coherence initially developed by psychologists Emmons (1989).
- (3) That the *life-story model of moral expertise* drawn from McAdams (1987) and Narvaez et al. (2005) enables agents to flourish throughout life.
  - a. This model includes a construction of the longitudinal sequence of measures which explain long-term change and consistency and

- b. Utilizes the organizing principle of a life-long moral goal to simplify and unify this coherence over time through the form of a narrative identity.

In order to develop this proposal, in the next few chapters, I will turn to an empirical investigation of disability which focuses on the lived experience and embodiment of people with disabilities and illness to ground a theory of virtue. In the fifth chapter, I will turn to *the life-story model as striving for moral expertise* to enable people with disabilities, like Grandin, to live well. In the final chapter, I will consider the way oppressive situations inhibit the flourishing of people with disabilities and how a virtue-oriented politics can correct this problem.

## II.

### *Moral Perception: Perspectives on Embodied Cognition*

#### **2.0 The Four Levels of CAPS Theory**

In this chapter and the following chapter, I will turn to the methods of psychology and phenomenology to analyze the two foundational elements of character: the CAPS system of the virtuous agent and the activation of event representations developed by virtuous caregiving. Because CAPS theory unifies the dynamic interaction between the situation and the individual, i.e., the individual is both affected by the context and can affect and make changes to the context, I will turn to phenomenology in order to give an account of *moral perception* which considers the perspective of those with disabilities. Specifically, in this chapter, I will outline two modes of intentional consciousness developed from the perspective of the CAPS subject.

The first component of the foundation of a virtuous character begins with the CAPS system of the individual. Although Snow only addresses three levels of the CAPS system, there are actually four dispositional levels. The first, and foundational, level is the *biochemical-genetic level*. This level is pre-dispositional and influences personality relevant qualities such as sensory or psychomotor sensitivities. It also affects vulnerabilities, skills and competencies, temperament (including activity level and emotionality), as well as chronic mood and affective states. These pre-dispositions interact with conditions throughout development and play out in ways that influence what the person thinks, feels and does. For people with illnesses such as depression or other “disabilities” such as Alzheimer’s, one’s virtuous action might be impaired at this level. CAPS theory assumes that these genetic individual differences may indirectly affect how people

construe or encode and shape their environments. As a result, this interaction in turn produces important person-context dynamism throughout the life course. These differences may even include variables of temperament such as irritability, tension, and distress which are often witnessed early in life (Bates and Wachs, 1994) and seem to have complex interactive links to emotional and attentional processing and self-regulation. This level is extremely important to consider for the virtuous behavior of those with impairments because this level can enable or hinder the second and third dispositional levels of the CAPS system (Mischel,1999).

The second level is the *psychological processing level*. This level is the more familiar CAPS level and includes a characteristic set of cognitions, affects, and behavioral strategies. These cognitions, affects, and behavioral strategies can be activated in response to situational features. But, this dynamic interaction can be self-activated through attention to one's strengths, resources, vulnerabilities, conflicts, ambivalences, and anticipated future as well.

The third level of the CAPS system is the *behavioral level*. This level concerns directly observable behavior. It extends to the "If...then" situation behavior profiles, or behavioral signatures, which *characterize* the exemplar's dispositions and illuminate the processes underlying them.

Finally, the fourth level concerns the *perceived personality level*. This level takes the perspective from the *observer's view*. This level includes the behaviors which are manifest to the observer. The observer may be a psychologist or a lay person. From observing these behaviors, the observer can often encode a person with traits or can infer cognitions or affects such as motives, goals, plans, and other person variables.

CAPS theory, then, accounts for the *phenomenological sense of self-coherence* that orders our goals, preferences, and values. It gives meaning to personal striving and motivated

behavior. This social-cognitivist approach to character gives psychological coherence and viability to behavior across situations by acknowledging one's intentions when committing actions: it accounts for the dynamic interaction "among organized knowledge structures, affects and social context" due to the "causal mechanisms, structures, and processes of social information-processing" (Cervone, 1997; Lapsley and Narvaez, 2004).

The CAPS system of an individual may change, however, due to modification in the biological substrates or due to developmental changes or significant life events. When the system changes, the effects will also be perceived at the behavioral level as changes between the "ifs" and the "thens" in the behavioral signatures. Thus, what will be observed is a change in behavior, indicating the change in the subject. This might take place due to a prescription drug taking effect at the chemical level or a grasp of new knowledge or a new perspective based on education or therapy. Finally, a shift in a behavioral signature might take place due to a *conversion*.

## **2.1 Perception and Two Forms of Embodiment**

In the next two sections, I will consider this phenomenological sense of self-coherence from the perspective of people with disabilities and the particular challenges they face due to the impairment of the biological-processing level of the CAPS system. Instead of emphasizing the "having" side of character as trait theory does, CAPS theory emphasizes the "doing" side (Cantor, 1990; Lapsley and Narvaez, 2004). Part of how we recognize who the virtuous person *is*, we know by observing what the virtuous person *does*. Because of this, character should be understood as the dynamic, reciprocal interaction between the dispositions, interests, capacities, and potentialities of the agent and the changing contexts of learning, socialization, and

development (Lapsley and Narvaez, 2004). Both the *interior* of the person and the *situation* are implicative in accounting for this behavior. In other words, we need to not only understand *what* action one committed, but also *why* one did it. This interdependent interaction forms the union of person and context. Thus, the CAPS approach looks for intra-individual stability and personality coherence over time.

To illustrate this dynamic interaction between the person and context, we must first then consider the role of intentionality with regard to embodiment. For those with or without disabilities, embodied cognition is central to how we make decisions, set goals, and achieve tasks in our day to day living throughout life. In order to illustrate this dynamism at work and to serve as a recurring example, I will first turn to a dramatic example for the disability rights movement, before addressing its significance for embodied intentional consciousness.

### 2.1.1 *Deaf Culture and the Power of Cooperation*

The year was 1988 and hundreds of Deaf students at Gallaudet University, Washington, D.C., were yelling and, with outstretched arms, signing “Deaf President Now.” Lined with Victorian red-brick buildings, Gallaudet had prided itself on preparing Deaf students for the hearing world, yet the administration had decreed “a deaf person not ready to lead a deaf university”(Shapiro, 1993). This decision sparked a student protest which was to be a defining moment for the Disability Rights Movement.

Although this was to be a student protest, it was the anger of the young alumni which set it into motion. In August of 1987, Gallaudet’s hearing president Jerry Lee announced he would leave the university in December. By February of 1988, six graduates met and decided the next

president should be *deaf*. These students decided to host a campus rally on March 1st. Two local alumni entrepreneurs, John Yeh and David Birnbaum, were angry because of the exclusion and discrimination they had experienced from the hearing world after they had left Gallaudet. They financed the rally and lent support to the students by making fliers to promote the rally. The fliers read:

It's time! In 1842, a Roman Catholic became president of the University of Notre Dame. In 1875, a woman became president of Wellesley College. In 1886, a Jew became president of Yeshiva University. In 1926, a Black person became president of Howard University. AND in 1988, the Gallaudet University presidency belongs to a DEAF person (1993, 76-77).

At the rally, 1,500 students, alumni, and faculty chanted and waved “high fives” – which is “the deaf sign-language applause of hands stretched straight up and fingers fluttering” (1993, 77). Just before the rally, the three finalists for the position of president were announced.

I. King Jordan, deaf since young adulthood, was Gallaudet's popular dean of the college of arts and sciences. Harvey Corson, deaf since birth, was the president of a Louisiana residential school. Elisabeth Zinser, the one hearing candidate, was an administrator at the University of North Carolina at Greensboro (1993, 77).

On that same day, blond, preppy Greg Hlibok became the new student body president. He would be one of the leaders of the protest. After the rally, the students then waited five days to learn the

results of who would be Gallaudet's next university president. On Sunday, March 6 at 8:30pm at the main gate on campus, the board of trustees announced their decision: "Elizabeth Zinser, the lone hearing finalist, was the new president of Gallaudet University" (1993, 78).

A commotion of angry protest rose up in response. The students suddenly starting shouting and signing "Deaf President Now" and marched a few miles downtown to the Mayflower Hotel to address the party of the celebrating trustees. Police blocked the hotel entrance, but Hlibok along with two other student leaders were allowed inside. Jane Bassett Spilman, the chairwoman of Gallaudet's board of trustees had never learned to use American Sign Language. Through an interpreter, she "gave the insulting explanation that 'Deaf people are not ready to function in a hearing world'" (1993, 78).

At 5:30am the next morning, in reaction to her statement, students closed down the school. They hotwired university cars and buses and parked them in front of all campus entrances. The provost of the university pushed past angry protesters only after "security guards cut a hole in a chain-link fence" (1993, 79). Classes were cancelled and a rallying group of students, faculty and staff sent a list of demands to Spilman. At the top of these demands was to rescind the choice of Zinser and appoint a *deaf* president. In response to the protest, Spilman agreed to hold an assembly but she refused to go back on the board's logic of choosing Zinser.

The assembly was a disaster. One thousand angry students "screamed and rhythmically swayed their arms to sign 'Deaf Power,' which was formed by holding the left hand over the left ear to signify 'Deaf' and raising the other fist in the air for 'Power'" (1993, 79). Spilman ordered them to be quiet because they could not have a dialogue over such noise. Enraged, the



students shouted or signed back “What noise?” And one student responded, “If you could sign, we could hear you” (1993, 80).

This protest grabbed national attention. As cameras and news reporters gathered, students started speaking out. One student leader, Bridgetta Bourne told a reporter: “We want to be free from hearing oppression. We don’t want to live off the hearing world, we want to live as independent people” (1993, 80). The protest lasted through Tuesday and Wednesday, spreading to *schools for the deaf* from Georgia to California. People wrote letters of support and organized nationally:

Some students and alumni even came from around the country to the Gallaudet campus to help out. Local businesses sent fruit baskets, pizza, soda, and other provisions. A linen company donated forty bed-sheets for banners. A local law firm offered pro bono representation. The students, improvising as the protest grew, put together a sophisticated operation. The protest leaders camped out at the alumni house, where, fortunately for them, the school had set up a bank of telephones and TDDs, telecommunications devices for the deaf, for the semiannual Alumni TDDathon (1993, 80).

The students used these devices to make hundreds of calls to reporters and to raise funds. On campus, students kept up their barricades and insisted on keeping the new university president, Elisabeth Zinser, out. Although Zinser fought against the students at first, by Thursday of that week, she resigned. By Sunday, the administration gave in to the students’ demands and

appointed a *deaf* president. They appointed I. King Jordan, the popular dean and replaced half of the board members on the board of trustees with *deaf* members. Spilman herself announced her resignation as well. There were no sanctions against the protesters. Hlibok, the student body president, wrote Zinser personally to make peace: “You were, of course, an innocent victim and unfortunate target of our collective anger” (1993, 84).

At this protest, students equated disability with civil rights. To them, “deafness is not a disability but a culture – like being Jewish, Irish, or Navajo” (85). Many *deaf* people even capitalize the letter *D* in Deaf to make the distinction between *Deaf* as culture and *deaf* as an auditory condition. As the Gallaudet football player, John Limnidis explained: “Deafness is not a handicap. It’s a culture, a language, and I’m proud to be [D]eaf” (1993, 85).

### 2.1.2 *Two Models of Embodiment*

The Gallaudet student protest proved to be the impetus for the American with Disabilities Act, which was introduced two months after the protest and signed by President George Bush in 1990. This act led to the need to define disability and to define the experiences of those with disabilities. In order to differentiate between “disability” at a biological level, i.e., what I will call “impairment,” from “disability” at the social or contextual level, i.e., “dis-ability,” I will turn to two models of embodiment used to characterize disability (Shriempf, 2001, 57). I aim to return to these two models in the final chapters concerning a virtue-oriented politics as well.

The first model of the body used to define “disability” was the biological or medical model and this model should be understood as it concerns one’s *biological impairment*. Drawn from the initial model of the Cartesian corpse (Leder, 2004), this model of the body treated

disability as a disorder or disease that needed to be corrected or minimized. With the aid of medicine, the goal was to cure the impairment and return the body its “original, healthy state.” Thus, the body that “has the ‘right’ number of smoothly functional limbs and organs,” does not “drool, spasm, jerk, wheeze, wheel, limp, stutter, piss, or fart uncontrollably either in private or public realms” (Shriempf, 2001, 58). The power to define and regulate impairment, disorder, malfunction, disfigurement, or dysfunction in either the body or the brain, lay in the hands of medical practitioners. How one was to understand, interpret, and incorporate one’s disability into one’s identity is determined largely by medical authorities, institutions, governments and court systems (ibid). According to this model, a paraplegic suffers from an impairment of mobility due to being paralyzed from the waist down, “who may or may not have bladder and rectal control or sexual function, and who most likely cannot walk unaided” (ibid). From the medical perspective, the “disability” of our paraplegic is viewed as something to be overcome and, if it cannot be overcome, then the individual with this impairment is either recommended to an institution or medical care at home and to be kept out of the public eye (ibid). In the cases of those persons with cognitive impairment, it was not until the Supreme Court’s *Olmstead* decision chose to uphold the American with Disabilities Act provision against discrimination that “disabled persons and their families” were allowed to “receive support services in the setting they determine most appropriate” (Kittay, 2000, 65).<sup>15</sup> In this model of the body, “disability” is located within the individual and biology. Thus, the decisions made about the body are medical decisions and other concerns or experiences the patient may have are relegated as unimportant or secondary to medical concerns.

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<sup>15</sup> In 1999, by rejecting the state of Georgia's appeal to enforce institutionalization of individuals with disabilities, the Supreme Court affirmed the right of individuals with disabilities to live in their community in a 6-3 ruling against the state of Georgia in the case *Olmstead v. L.C and E.W.* For general information about *Olmstead* see (<http://www.accessiblesociety.org/topics/ada/olmsteadoverview.htm>) and for the legal information see <http://www.law.cornell.edu/supct/html/98-536.ZS.html>.

Unlike the medical model of the body, the second model drew a distinction between impairment in the biological body and “disability” in a cultural and social context. The “social” or social construction, model of the body considers society and culture to be at the heart of shaping one’s experience of disability and examines how one’s environment or context *dis-ables* one’s intentions and goals. In the social model, the body is situated within society: one’s impairment is biological while one’s dis-ability is social. Thus, in the case of the paraplegic, her dis-abling condition “exists not as a one-to-one correspondence between impairment and the restriction of activity, but as a result of society’s failure to have universal access for wheelchair users, such as curb cuts, ramps, elevators, and power doors, integrated in the environment” (Shriempf, 2001, 59). “Disability” is, therefore, a social condition rather than a medical condition. Oppression and prejudice function according to the social model insofar as they “dis-able” someone through discrimination, inaccessible environments and inadequate support. Thus, the social model provides the necessary frameworks from which to critique the medical model for the system of able-ist values it oppresses on people with disabilities.<sup>16</sup>

While both models have their disadvantages, they each provide valuable insights for understanding the dynamic interaction between the person and context at all four levels of the CAPS system. Because the perspective of the individual is essential to the interpretation of the situation, I will turn to phenomenology in order to describe both the biological and the social aspects of “disability” and its effect on the development of *moral perception*. Phenomenology can articulate the experience of dis-abled embodiment as *lived* embodiment by both grounding the body in realism as well as capturing its subjective meaning. What the Gallaudet protest shows is the dynamic interaction between people and situations at a collective level. This

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<sup>16</sup>For the power of the social model in re-structuring disability perspectives, see Morris (2001).

dynamism and cooperative ability are the result of our conscious intentional states. Intentionality is always *about* or *refers* to something. As the protesters were living bodies in this world, so their intentions such as signing “Deaf President Now” were meaningful intentions in reaction to the injustice they were experiencing. Our intentionality takes different forms as we relate to objects and others in this world: “I” intentions, “you” intentions, and “we” intentions. These three intentions form the building blocks of language and our everyday lived experience.

### 2.1.3 *Two Forms of Embodied Cognition*

Our intentional states of consciousness consist of certain structures of consciousness and the specific content of those states. Both the structures and the content can be analyzed from different perspectives in phenomenology. The first perspective is what one normally means to describe human experience as it *means to us*. I will call this perspective the *Existential Perspective*. Describing our being-in-the-world was the challenge of philosophers such as Martin Heidegger (1962), Jean-Paul Sartre (1992), Simone de Beauvoir (1989), and Maurice Merleau-Ponty (2008).<sup>17</sup> In *Being and Nothingness*, Sartre describes how we are always beings “in situation”:

Thus in what we shall call the world of the immediate, which delivers itself to our unreflective consciousness, we do not first appear to ourselves, to be thrown subsequently into enterprises. Our being is immediately “in situation”; that is, it arises in enterprises and knows itself first in so far as it is reflected in those

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<sup>17</sup> In *Being and Time*, Heidegger discusses how our being-in-the-world is structured by *care*. Beauvoir describes woman’s being-in-the-world as being compelled by men into the status of the Other.

enterprises. We discover ourselves then in a world peopled with demands, in the heart of projects “in the course of realization.” I write. I am going to smoke. I have an appointment this evening with Pierre. I must not forget to reply to Simon. I do not have the right to conceal the truth any longer from Claude (1992, 77).

This phenomenological way of describing our being-in-the-world considers how our different modes of consciousness such as thought, perception, fear, love, imagination and so on color our world with a sense of meaning. To discuss the existential form of the “I” intention, I will be drawing primarily from Maurice Merleau-Ponty’s *Phenomenology of Perception*.

This existential perspective is also present in our encounter with others, specifically through the “you” intentions, i.e., intentions directed from the “other.” The encounter of the “you” intention was developed and explored by phenomenologists Jean-Paul Sartre, Emmanuel Levinas (2005), Martin Buber (1996), and Simone de Beauvoir. Levinas writes, in *Totality and Infinity*,

To approach the Other in conversation is to welcome his expression, in which at each instant he overflows the idea a thought would carry away from it. It is therefore to *receive* from the Other beyond the capacity of the I, which means exactly: to have the idea of infinity. But this also means: to be taught (2005, 51).

This “inverted” intentionality from the other to the I, was expanded into the caring encounter in the work of Nel Noddings. For an account of the second-person intention, I will consider

Noddings' *Starting at Home: Caring and Social Policy* because it is most pertinent to those issues facing "disability."

The other perspective of intentional consciousness, I take up from John Searle's work, which considers the way consciousness is structured. This form I will call the *Formal Perspective*. This structural perspective is a phenomenology grounded in neurobiology. According to Searle:

We have to start with intentionality because to understand society, you have to understand collective human behavior. Collective human behavior is a manifestation of collective intentionality, and to understand this you have to understand individual intentionality. Indeed, to understand any of this you have to understand consciousness, and of course a deep understanding of consciousness would require an understanding of how consciousness is caused by, and realized in, brain structures (2010, 26).

While the aim of existential perspective is generally to give a subjective description rather than explanatory account of intentionality, the formal perspective gives an objective, or "third-person" view of our intentional structures. It is through the formal perspective that we gain a greater understanding of both the intentional states and their propositional content with relation to our personal experience.

Both perspectives offer valuable insights into our lived experience in the world and are both experienced through our lived embodiment. While the existential perspective gives us

access to the subjective experience of being-in-the-world, it is the formal perspective which grounds our intentional consciousness in objectivity. Because CAPS theory relies on the meaning given to the situation by the individual from both the existential and formal perspective, I will now give accounts of how three forms of intentionality – I, you, and we intentions – interact with the social world. In doing so, many of my examples will draw from insights in disability and medical research.

## **2.2 The Formal Perspective of “I” Intentions**

### *2.2.1 Conscious Intentional States*

In this section, I will briefly outline the characteristics of our conscious intentional states from the formal perspective. When Bridgetta Bourne told a reporter, “We want to be free from hearing oppression,” the objective structure of her intentionality consisted of two things: a psychological mode of desire and the propositional content “to be free from oppression.” As our intentional states form the same structure as language, so likewise the proposition content of an intentional state can be true or false and follows the basic structure of S(P). Broken down, according to Searle, the intentional state consists of a type of state or psychological mode such as fear, desire, belief, etc., and its propositional content. For example, the intentional state, “I believe it is snowing” can be broken down into these two parts. The psychological mode is “I believe” while the propositional content is “it is snowing.” I can “believe” that it is snowing, “fear” that it is snowing, or “desire” that it is snowing. Likewise, just as I can change my intentional states to fit the specific propositional content, so I can change the propositional content of my intentional



state: I can believe “it is snowing,” “it is raining,” or that “it is sunny.” The point is, when we consider our intentions from a structural perspective, our intentions are made up of intentional states which correspond to their propositional content.

What is important about Bridgetta’s intentional state is that her psychological mode was one of desire for political change. What she desired to have was not yet a reality. This structural form for a desire or an intention is different than for a belief. They differ in how they “map onto reality.” In the case of belief, the aim of a belief is to be true, such as “I believe it is snowing.” This aim fails if it is false: it turns out, in fact, it is raining outside rather than snowing. When we consider its structure, what we discover is that if it is snowing, then my belief actually “matches” or “fits” or represents the world. If it is not snowing, then my belief does not and is false. Thus, belief, according to Searle has what he calls a “*mind-to-world* direction of fit ↓” (2010, 27). This means that what is in my “mind”, e.g. belief, actually represents or “fits” what I experience in the world.

Intentional states such as desires and intentions, however, have a different “directions of fit” from beliefs. According to Searle, desires and intentions have a “*world-to-mind* direction of fit ↑” (2010, 28). Desires do not try to represent the way the world is but rather *how we would like it to be*. For instance, if I desire to eat chocolate ice cream, I am not testing whether my desire is true or false. Instead, this object in the world, e.g. the ice cream, is something out there that I want to eat. And my desire will be satisfied when I eat it. Thus, the object in the world, e.g. the chocolate ice cream, satisfies my “mind” or my desire when I eat it or if it does not – because that particular scoop of ice cream was terrible – then it is the “world” which is at fault. Likewise, intentions follow a *world-to-mind* direction of fit because they concern how we intend to make the world be. For example, if I intend to open the door then the position of the door, that object

in the world, is what I intend to change. If I cannot open the door, then again the “world” is “at fault” rather than being a case of truth or falsity. In the case of Bridgetta, her desire to be free from oppression had not yet come true and the “world” was at fault. Thus, her goal along with her fellow students was to *change the world*, or social reality, in which they lived.

Yet, how would Bridgetta and the other protesters’ desire become realized in the world? How would their desires become actual? According to Searle, in order for these desires to become actual, they must meet what he calls *conditions of satisfaction*. On the one hand, these conditions are truth conditions for beliefs while on the other, they concern fulfillment for desires and intentions. When I have an intention to do something, say, open up a door, I have to actually “carry out” my intention and open the door in order for my intention to be satisfied. In the case of Bridgetta and the other protesters, their desire to be free from oppression is still a desire which has yet to be fulfilled.

### *2.2.2 Network and Background*

As the Deaf protesters marched on campus in Washington, D.C. and later marched to the Capital, they did not march with only one intentional state, but a whole series of intentional states within an interdependent web of beliefs, desires, intentions, capacities, abilities and skills within the CAPS system. This interdependent web is what Searle calls the interplay of Network and Background.

Broadly speaking, a Network is a network of intentional states (beliefs, desires, etc.) which are intricately linked to my current intentional state. Searle gives the example of going to the movies as a way to illustrate a Network:

I cannot intend to go to the movies unless I have a whole lot of other beliefs and desires. I have to believe that movies are forms of public entertainment, that often one sees a movie by going to the movie theater in which the movie is being shown, that one enters after paying the price of admission, that one sits in the theater and watches the movie on the large screen, and so on with a whole lot of other intentional states (2010, 31).

Background, by contrast, is a set of presuppositions for the application of intentionality which include “abilities, capacities, dispositions, ways of doing things and general know-how that enable us to carry out our intentions and apply our intentional states generally” (2010, 31). Both Network and Background are often taken for granted because many times the unconscious elements of the Network overlap with the abilities and capacities of the Background in simple tasks such as driving one’s car to work. As the protesters hotwired buses and cars to block the university’s entrances and to keep Zinser out, so they assumed many abilities and capacities along with the belief and desire for a common cause. The entire protest assumed an intricate Network and Background.

### 2.2.3 *Prior Intentions and Intentions-in-Action*

But, there is a distinction between when I *intend* to do something and when am actually *doing* it. As in the case of Elizabeth Zinser, the chosen hearing university president, she intended to take office but was forced to resign. This difference between what I intend to do and actually doing it is the difference between what Searle calls *prior intentions* and *intentions-in-action*. A prior intention is an intention I have prior to the performance of an action: for example, when I

intend to raise my hand. An intention-in-action, by contrast, concerns the intention I have during the performance or execution of an action. It is the psychological mode which accompanies my bodily movement of raising my hand. All actions, of course, require intentions-in-action but not all actions require prior intentions. We need only think of spontaneous or impulsive actions which lack prior intentionality such as when I raise my hand to swat a bee away from my face. The prior intention, ontologically speaking, is a state of mind whereas an intention-in-action is an actual (psychological) event. And it is the intention-in-action which causes my body to move. When we consider the structure of an intention-in-action, it is made up of two components: the psychological event and the bodily movement. The psychological event, i.e., the intention-in-action, causes the bodily movement when it is successfully performed. Searle explains that the best way to think of the intention-in-action is as “trying.” When I “try” to open a door, my bodily movement either succeeds or fails, but in either case I still have an intention-in-action.

Unlike desires and beliefs, prior intentions and intentions-in-action must function causally in the production of the action in order to achieve their conditions of satisfaction. If I have the prior intention of opening the door, but then forget to open it, then my intention has not been satisfied. Likewise, if I am in the act of trying to open the door, but fail to open it, e.g. because it is locked, then my conditions are not satisfied. In order to be successful in each case, my prior intention and my intention-in-action must cause the movement to occur. As was the case with Zinser, her prior intention of getting on campus never materialized into action because the students blocked her passage.

Another feature to note about prior intentions and intentions-in-action which set them apart from desires and beliefs is that they are causally self-referential insofar as “the content of the intention makes reference to the very intention of which it is a content” (2010, 34).

According to Searle, “we can say that these intentions are causally self-referential, since the form in which the content sets a condition of satisfaction is a causal one that refers to the intentional state itself” (2010, 34). Thus, my prior intention of raising my hand makes reference to the actual achievement of the action of raising my hand. In like manner, the intention-in-action of raising my hand sets the condition of satisfaction for causing the raising of my hand. In other words, as I am “trying” to raise my hand, my “trying” sets the conditions which need to be “carried out” in order for my intention-in-action to be satisfied. I try to raise my hand (the psychological event) which causes my hand to raise (bodily movement) and thus satisfies my condition. In the cases of desire and belief, however, the content is not causally self-referential. This becomes clear when we return to my belief “it is snowing.” In no way does my belief cause the snow to fall. Thus, this condition, i.e., causal self-reference, is particular to prior intentions and intentions-in-action.

Yet, up until now, I have been discussing simple actions such as raising hands and opening doors. What about more complex actions which involve my intentions but do not involve a direct one-to-one cause of the action, like organizing a protest or signing “Deaf Power”? For these more complex actions, Searle designates two kinds which involve intentions-in-action. The first occurs when someone does something *by way of* something else. An example of this kind would be when I vote by means of raising my hand. Here, two actions occur simultaneously: (1) the raising of my hand and (2) voting. This is what took place when the students signed “Deaf Power.” They protested by way of raising their left hands to their ears and right fists toward the sky. The second kind of complex action occurs when someone does something *by means of* something else and this action causes something else to occur. Searle gives the example of firing a gun: when I fire a gun, I do so by means of pulling a trigger. Here,

my pulling of the trigger causes the gun to fire. This second form of complex action was what took place when the students hot-wired cars and buses. They started the cars by means of hot-wiring them.

This brief outline of the following characteristics of the formal perspective – conscious intentional states, network and background, prior intentions and intentions-in-action – is significant for understanding the dynamism of the social-cognitive CAPS system. The case of the students protesting at Gallaudet University demonstrates the agent’s position to be affected by the social context and likewise the agent’s ability to change, alter, or interact with that situation. Unlike the Situationists’ thesis which argues that an individual’s action is determined by his or her situation, the formal perspective of intentional consciousness provides a phenomenological conception of how individuals perceive those situations and as a result, interact with them. While the formal perspective illuminates how individuals perceive their environments, it is not able to provide an explanation of how we *interpret* them. For the agent’s specific interpretation of events, which is the linchpin of social-cognitive theory – I now turn to the existential perspective.

### **2.3 The Existential Perspective: “I” Intentions**

The question remains: why did the students rise up in protest in the first place? Why did they rally to have the first *deaf* president in the history of the school? Why was it significant to them? Although the formal perspective of intentional consciousness grounds our intentions objectively, it is the existential perspective which can shed light on why this protest was personally significant to the students of Gallaudet University.

The interpretation of the Gallaudet students' witnessing of Zinser being chosen was essential to their protest: the *meaning* of the choice was interpreted as a form of *able-bodied prejudice*. Being *deaf* and being part of Deaf culture is a dynamic way of being-in-the-world. The existential perspective concerns our being-in-the-world because we experience the world directly in a particular time and place. This perspective describes our lived experience (*erlebnis/vécu*) which is affected by our history and by others' and provides a common "horizon" for all of our experience. It provides my access to objects as how those objects appear to me as a particular subject. And this mode of my subjective experience, or access to the world, is what Merleau-Ponty calls *perception*.

Perception is our direct, pre-reflective involvement in the world. When we perceive one object, we always perceive it in relation to others, i.e., we perceive the world as a whole rather than as a series of parts. Because an object is always in relation to others, it necessarily points beyond itself and gives us meaning. Thus, we experience things and people as wholes, and how each part gains its meaning is derived from the whole. Thus, perception is a direct contact with the world and that contact takes the form of actively engaging with the objects and others around us.

This very access to the world is given to me through my body, but this subjective, embodied experience of the world is not based on my biological body. Rather, it concerns how we live through our body, how we act in the world, our feelings and hopes or fears about the world, and our various ways of being. Merleau-Ponty describes our access to the world through our body as follows:

Consciousness is being-towards-the-thing through the intermediary of the body. A movement is learned when the body has understood it, that is, when it has incorporated it into its 'world,' and to move one's body is to aim at things through it; it is to allow oneself to respond to their call, which is made upon it independently of any representation. Motility, then, is not as it were, a handmaid of consciousness, transporting the body to that point in space of which we have formed a representation beforehand (2008, 159-161).

As perceiving subjects, we are embodied subjects who have both biological bodies and living bodies. As a biological body, I am a biological organism in the world and affected by the relation of space and time and causal relationships. As a living body, I am an internally directed being which acts on the world around me. The students at Gallaudet University were living bodies who experienced oppression by their own administration. As living bodies, their being-in-the-world became one of angry protest as together they sought political change. Their access to being-in-the-world was given to them through their lived embodiment.

For Merleau-Ponty, the theory of the body is already a theory of perception. Thus, my body both schematizes my being-in-the world and gives that world existential meaning. In any space, when I move around the room, the room presents itself to me from various angles but it is pulled together in one habitual perspective – my own embodiment. Our relations to spaces and objects form a system of subjective experience in which we recognize things as wholes rather than as a series of parts. Merleau-Ponty gives the example of a six-sided cube to make this point:



From the point of view of my body I never see as equal the six sides of the cube, even if it is made of glass, and yet the word ‘cube’ has a meaning; the cube itself, the cube in reality, beyond its sensible appearances, has its six equal sides. As I move round it, I see the front face, hitherto a square, change its shape, then disappear, while the other sides come into view and one by one become squares. But the successive stages of this experience are for me merely the opportunity of conceiving the whole cube with its six equal and simultaneous faces, the intelligible structure which provides the explanation of it (2008, 235-236).

Drawing from Gestalt psychology, Merleau-Ponty argues that our lived-through correspondence with things is to experience objects and others as *wholes*, rather than a collective of parts. Yet, when we perceive the cube, we also perceive it as an object in space. As Merleau-Ponty writes: “[t]he thing, and the world, are given to me along with the parts of my body, not by any ‘natural geometry,’ but in a living connection comparable, or rather identical, with that existing between the parts of my body itself” (2008, 237). As the students in protest raised their left hands to their ears and punched the other fist to the sky, they formed the whole “Deaf Power” rather than just a series of bodily movements. The insight from Merleau-Ponty is that we perceive the world as a series of wholes. So when the students raised their hands in protest, everyone perceived the whole “Deaf Power.” He continues:

The theory of the body schema, is implicitly, a theory of perception. We have relearned to feel our body; we have found underneath the objective and detached knowledge of the body that

other knowledge which we have of it in virtue of its always being with us and of the fact that we are our body. In the same way we shall need to reawaken our experience of the world as it appears to us in the world through our body, and in so far as we perceive the world with our body (2008, 239).

My external perception and the perception of my own body “vary in conjunction” because they are part of one and the same action (2008, 237). Thus, it is my body which schematizes my being-in-the-world and is why I see this cube as a whole rather than as parts. It is why the students signed “Deaf Power” and the administration understood.

Although perception creates and gives us access to the world perceived, it is only *my* world which I have access to and not *your* world or anyone else’s world. To return to our example of the simple intention-in-action of trying to open a door, when I try to open the door, this act of trying and carrying out this action is meaningful particularly to me. My whole Network and Background – what Merleau-Ponty would call my “world” – set the conditions for the meaning I take from my world. For instance, if I am carrying a cup of hot coffee and go to open the door, but when I yank on the handle, my jerking motion causes the coffee to spill all over my clothes. This is meaningful to me. Filled with anger and distress I would then respond with a whole series of prior intentions and intentions-in-actions as I ran to dry my clothes off as soon as possible. In this instance, my experience would be flooded with a mixture of emotions along with quick actions as I frantically ran warm water over paper towels and scrubbed at my favorite jacket to remove the stain. But, because the elements of *my* world - the desires, beliefs, intentions, habits, and abilities activated in my individual CAPS system - are all tied together, they can burst forth with meaning in a single instance when something I usually do with ease

becomes a struggle. In the case of opening the door, if I am running late for a class I am about to teach and run up to open the door to the stairs I normally take to get to class, but when I yank on the handle I discover to my dismay that the door is locked, again this situation is meaningful to *me*.

Although my world can be directly influenced by others and I can influence the worlds of others, I only gather meaning and *interpretation* from my world. So the meaning of my world may be influenced by another, but it is only meaningful *to me* because it is my own subjective experience. Furthermore, this subjective experience and mode of interpretation can change with the sudden onset of illness or impairment. Susan Wendell, in her work *The Rejected Body*, describes her changing experience of her body as follows:

Recognizing myself as disabled certainly required that I change my self-identity and adopt a radically new way of thinking about myself. This included accepting the reality (though not the justice) of the stigma of being chronically ill, especially the shame of being unable to do many things that people still expected me to do. It also required reimagining my life with a new, much more limited, and perpetually uncomfortable body, and then reorganizing my work, home, and relationships to make this different life possible (1996, 26).

This world is independent of my wishes and whims and so I find meaning in it rather than create meaning. As in the case of impairment or illness, the culture and way of being-in-the-world as “*dis-abled*” is a life-changing experience. As both actor in the world and the one who is acted

upon, so my being-in-the-world is shaped by constructions and prejudices within my society and culture. Thus my connection to others, my activities, thoughts, feelings, and so on constitute my present world by virtue of what I am doing or (not doing).

The existential perspective concerns my beliefs, desires, fears, and other modes of access to the world. It describes my particular way of moving through the world, i.e., of walking, standing, sitting or talking. And how I move through the world is how I gain meaning from the world. My perception of situations is given to me by my living body, which schematizes my access to the world. As a result, my lived embodiment is pre-reflectively given and comes before my conscious thought because I am an active being always actively engaged and in relation to the world around me. My existential perspective of the CAPS system is a dynamic form of perception which is capable of influence and change in social reality. Thus, my perception as a virtuous or vicious person is a *moral perception* when I am interacting with others in an ethical context. As in the case of Gallaudet University, the students committed moral actions in the world against a perceived injustice and by mobilizing together were able to change the actions of others to bring about ethical and political change.

#### **2.4. The Existential Perspective with Others: “You” Intentions and “We” Intentions**

An element which CAPS theory neglects to discuss is the role of other individuals in moral situations. Our ethical interactions with others can take place with others directly addressing us through a “you” intention or by collectively acting with us through a “we” intention. In the following two sections, I will discuss the significance of these two forms of intentionality and then review their significance for the role of *moral perception* within the CAPS system.

#### 2.4.1. “You” Intentions

To bring about this ethical and political change, the students had to gather support from others and encounter and challenge the administration. This encounter with the other is what is at the heart of the “you” intention. The second-person intention, or “you” intention, concerns my relation to others. For my relation to intentional objects, the directionality of my intention is toward that object, such as when “I intend to open the door.” The relation between myself and the other, however, is a relation between two subjects and the directionality of intention is from the other to me. When we consider one student’s reaction to Spilman, we recognize the “you” intention. As Spilman had ordered the students to be quiet, one student had responded, “If you could sign, we could hear you.”

The “you” intention is significant for the development of active ethical moral representations and is directed by others, specifically our caregivers when we are young. It comes from the encounter of myself and the other where the other intends something to me and describes a relational intention of *I-You* rather than *I-It*. Thus, the intentional direction is in reverse of the “I” intention insofar as it comes from the other. Unlike the relation of the students with Spilman, the most important intentional relation to the other is found in the *caring relation*. This caring relation can be found in the support and direction given to the students by the two alumni, John Yeh and David Birnbaum.

This phenomenological encounter of the caring relation is most notably described by Nel Noddings. Influenced by Emmanuel Levinas and Martin Buber, which will be discussed in the following chapter, Noddings argues that the caring encounter involves the relation of me with the other as the relation of Carer with the one Cared-For (not necessarily respectively). My response

to the other is a relational intention in which I am attentive and receptive to the other's intention: the other desires to be cared for. Noddings describes the encounter in her work *Starting at Home: Caring and Social Policy*, in "caring encounters I receive the other person and feel what he or she is feeling even if I am quite sure intellectually that I would not myself feel that way in the given situation" (2002, 14). It is important to note that the directionality of intention is from Cared-For to Carer because it follows the structure of a "you" intention. This caring encounter is a fragile one because not only can I become distracted or forgetful of the other but I can also reject, ignore, or be repulsed by the other. Thus, the vulnerability of this encounter brings us to four conditions which must be in place for the encounter to be considered ethical (Noddings, 1995). Moral psychologists Narvaez and Lapsley have argued that the activation of event representations is one of the fundamental building blocks of cognitive development and ethical character. Now, I will briefly outline the phenomenological caring relation and then later discuss role of the caring encounter for the development of event representations in the next chapter in more detail.

The first condition of the caring relation is that is one of receptive attention and is given in a relation of reciprocity. Noddings describes how receptive attention is an essential characteristic of the caring encounter:

The carer, A, receives what-is-there in B. But clearly more than attention is required. A must respond in some way. If B is trying to accomplish something he may want A's help, or perhaps – as is often the case with children – B is simply calling out, "Watch me, watch me!" (2002, 17).

Although the relation may be one of asymmetry, such as a parent caring for a child, the reciprocity occurs in the Cared-For's desire to be cared for, the Carer responding to this intention, and the Cared-For receiving or acknowledging this care being given. It is a moment of "pure relation" and then one must think of what to do. When John Yeh and David Birnbaum heard about the six Gallaudet graduates wanting to hold a rally for a deaf president, they responded with receptive attention and empathetic support.

This alumni support came from what Noddings calls the second condition of the caring relation: *motivational displacement*. This second condition is the motive energy which flows when I care about the other's projects, goals, and concerns. Noddings gives the example of a math teacher caring about her student to illustrate this motivational displacement:

Ms. A, a math teacher, stands beside student B as he struggles to solve an equation. Ms. A can almost feel the pencil in her own hand. She anticipates what B will write, and she pushes mentally toward the next step, making marks and erasures mentally. Her moves are directed by his. She may intervene occasionally but only to keep his plan alive, not to substitute her own. She introduces her own plan of attack only if his own plan fails entirely and he asks, "What should I do?" (2002, 17).

It is at this point where the caring relation can begin to break down. Even if the Carer is openly receptive and attentive to the Cared-For at first, she may resist motivational displacement: "she may think, 'Uh-oh. I can see where this is leading. I don't have time for this' (or 'I can't handle this,' or 'Why me?' or 'Not again!')" (2002, 18). The way to restore motivational displacement

would be through effort, continued conversation and compromise, but Noddings cautions that it is neither necessary nor ethically desirable for the Carer to say yes to every request the Cared-For makes. Although some phenomenologists such as Levinas have argued that the ethical relation with the other should be a total and asymmetrical “yes,” this relation is not the caring relation of interdependence. Both Buber and Noddings argue for an ethical relation of reciprocity, which can be asymmetrical, rather than one which gives over to total demand.

The third condition of the caring encounter is that we must act. From the flow of motivational displacement, I, as Carer, must act according to the needs of the other. This acting may come in the form of listening, of giving advice, “lending a helping hand,” or some other form of assistance. This action may even come in the form of a quick disciplinary action, as in the case of a parent quietly correcting a child when the child misbehaves in order to gain attention. For the Gallaudet students, John Yeh and David Birnbaum acted by providing financial support for the printing of fliers and the manufacturing of buttons for students to wear which said “Deaf President Now.” Motivated by their own struggles and the needs of the students, they provided the necessary support to mobilize the students to action.

The fourth and final condition of the caring relation is the realization of reciprocity: the other recognizes that I care for him or her. It is at this point that the Cared-for recognizes, realizes or acknowledges the Carer’s care. Thus, the caring encounter always concerns an interdependent relation that is based on reciprocity. This relation is initiated and sustained by the second-person singular, or “you,” directional intention which initiates the relation and acknowledges its shared sympathy between two people.



This relational aspect of our moral perception is paramount in our caring encounter with family members who may suffer from dementia. Caring for a loved one with dementia is a form of reminding and reconstructing his or her identity. The practice of reminding in dementia care is a process of aiding the patient in his or her memory loss of past abilities and experiences. This process is a relational process: “minding and reminding come through the interaction that is at bottom about the exchange of meaning – the expression, offering, interpretation, and reception of meaning” (Jennings, 2010, 172). Because our identities are dynamic and relational, they are constructed “tissues of stories,” which involve both our first person experience of them but also involve the “important acts, experiences, relationships, and commitments” that are shared with and given to us by others (Lindemann, 2010, 162). The caring encounter experienced with the loved one suffering from dementia, such as a grandmother, involves the caring practice of “holding” her identity in reality.

Thus, as *my* world interacts with the worlds of others through encounters such as the mode of *caring*, so my world is a shared and interdependent nexus of desires, beliefs, intentions, needs, wants, wishes, fears and hopes. This shared nexus, an interdependent Network and Background, shapes the very person I am in relation to the others who surround me, nurture me, and influence me. It is this working with others in our interdependent nexus which we will turn to next: namely, the “we” intention.

#### 2.4.2 “We” Intentions: Collective Intentional Practices

Although “I” intentions and “you” intentions explain much of the being-in-the-world of the protesters, they do not explain the construction of the protest itself. The students came together

and mobilized under a shared belief: *that the next president of Gallaudet should be deaf*. Their collective anger at the injustice they experienced caused them to cooperate and to gather support beyond the university. This ability to cooperate under a shared belief is what Searle calls the “we” intention.

“We” intentions, also called “collective” intentions are the fundamental building block of human social practices and institutions. They differ from “I” intentions and are not reducible to “I” intentions in both biology and social practice. Science has not been able to locate the “we” intentionality in individual brains by substituting the “we” for an “I.” For social practice, first-person singular intentionality governs a range of actions that I directly cause whereas collective intentionality usually functions in group or cooperative action and extends beyond my direct causation of the action. In other words, my intention in a collective action is not necessarily self-referential. Other actor’s intentions-in-action are at work as well. Third, and finally, many forms of collective intentionality, e.g. being a member on a team, require that the content of what I am doing differs from the content of what another is doing in order to reach the same goal. In this case, as with the others, trying to reduce the collective intention of members on a soccer team trying to score a goal against their opposing team cannot be reduced to an “I” intention. Thus, in both science and social practice, the “we” is just not reducible to the “I” intention.

Two features of collective intentionality set it apart from “I” intentions and “you” intentions: (1) that it exists prior to the exercise of language and makes the use of language possible and (2) that it involves cooperation. As for existing prior to language, when we consider our earlier discussion of Networks and Backgrounds, what we come to realize is that our conversations presuppose a Background capacity to engage in conversation. Thus, our Background capacity presupposes a pre-linguistic form of collective intentionality. But collective

intentionality also involves cooperation. Let us consider the following example. I could be driving from Boston to California and you could be driving from Boston to California but this would not be a case of collective intentionality. Even if we informed each other of our intentions to drive to California, this would still not be a case of collective intentionality since collective intentionality must involve some form of cooperative behavior. For a second example, we might consider the case in which both of us have the same goal but would not be in cooperation together. An example of this instance would be if we both were trying to do things to aid in animal rescue. Although we would both have the same goal, I would not need to cooperate with you in order to achieve this goal. Besides having some common belief or common goal, in order for an intention to be a collective intention it must involve some form of cooperation. There are numerous cases of intentions which involve a common or similar goal but would not be considered cases of collective intentionality.

This engagement in cooperation was witnessed in the protest. Students from around the country came to help students protest at Gallaudet. Local businesses organized and sent fruit baskets, pizza, soda, linens and other provisions. Law firms offered pro bono representation. Students worked together under the common belief “Deaf President Now” and this way of being-in-the-world was made possible by collective intentionality.

When my intentions are collective with others through collective behavior I have to assume or believe that others are cooperating with me and that their intentions-in-action specify the same goal, although we may have different means to that goal.<sup>18</sup> And, I do not necessarily need to know what their contributions are. Instead, we both act according to the belief that I will

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<sup>18</sup> Although belief is involved in collective intentionality, this belief is not part of the content of my intention-in-action. We have to remember that my intention-in-action only makes reference to things I can cause or I believe can cause.

do my part and you will do your part. Students worked together by hot-wiring cars and buses and acted under the common belief that each student would do his or her part.

The dynamic interaction of collective intentions works like the following example of playing a symphony. Unlike individual intentions-in-actions, our collective intention-in-action – our playing – does not cause the symphony to be performed. Rather my individual playing along with the other members’ playing constitutes the performance of the symphony. Thus, I have a collective intention-in-action that we are performing the symphony by way of me playing my part and the assumption that everyone will play his or her part. So, what has to be assumed is that each member of the group has the same collective intention-in-action which has the same goal, but this goal can only be achieved if we each do our own individual parts.

For the concerns of “disability,” my “I” intention-in-action may no longer be able to “cause” my bodily movement in a particular part of my body. This may be the case of someone who uses a wheel chair for his or her motility. In this case, “I,” in the wheel chair, may need to depend upon another person, “you,” for my actual movement. In other words, in our collective intention-in-action that I move forward, it may be the case that the shared belief that we each do our parts consists in you causing my body to move forward through the action of pushing my chair forward. The movement of my body becomes the *collective aim that we share*. And I trust that you will help me achieve this goal.

## **2.5 Moral Perception**

The four levels of CAPS demonstrate the dynamic interaction between a person and the context. In the case of impairment, the biological processing level can have an effect on the other three

levels. Likewise, the situation or context can dis-able persons with disabilities when they interact with the world. The dynamism of CAPS is most prominent in the individual's interpretation of the situation, that is, the *perception* of the individual from the existential perspective. It is through perception, and specifically *moral perception*, that an individual gives subjective meaning to the situation. The CAPS system provides an empirically grounded model for personality coherence; personality is organized into coherent, integrated systems that impose constraints on the range of possible interpretations and actions (Lapsley and Narvaez, 2004). Our moral perception unifies not only our interpretation of a situation with that situation, but it also unifies certain forms of behavior across different settings and over time. Finally, our existential perspective provides an account of our phenomenological sense of self-coherence. Thus, it is our moral perception which gives order to our ethical goals, preferences, and values as well as giving meaning to our personal striving and motivated behavior (2004).

Yet, this moral perception is developed and maintained with the help of others either from “you” intentions from caregivers and other agents or “we” intentions with shared agency in collective practices. These collective practices can be foundational for moral practices and moral traditions. The development of this moral perception, however, relies on two foundational components: CAPS theory and the activation of event representations developed by caregivers. It is to the second foundational element that we will turn in the next chapter.

### III.

#### *Representations of Moral Events:*

#### *Caregiving, Narrative Identity & Interdependent Virtues*

*dokei d'en tō philein mallon ē en tō phileisthai einai*

[Friendship] seems to be more about loving than being loved

(Aristotle, 1999, 1159a).

### 3.0 The Caring Relation

In the previous chapter, I briefly outlined the role of the “you” intention in the caring encounter. Historically, there have been two dominate formulations of the second-person intention, or “you intention,” as our encounter with the other person: one put forth by Levinas and the other put forth by Buber. In phenomenology, the first-person singular “I intention” has a direction of intentionality which extends from the self to the other person or object. For instance, when I intend to grasp this cup in front of me, the direction of my intention moves from myself to the cup; my consciousness is *of* the cup. By contrast, for the “you intention,” the direction of intentionality moves in the opposite direction: it moves from the other to me. The other person is aware of me, and I am aware *of* that awareness. The second-person singular intention thus reverses the directionality of the first-person singular intention.

Levinas’ account of the “you-intention” adds something more to this simple reversal of intention. Our encounter with the other, he argues, is an asymmetrical intentional relation in which the other demands of us a response, makes us respons-ible, and so adds an ethical

dimension to this form of intentionality. This asymmetrical demand, he hopes to show, is attested in our “face to face” relation with the Other. In *Totality and Infinity*, Levinas describes this ethical relation as follows:

The Other does not only *appear* in his face, as a phenomenon subject to the action and domination of a freedom; infinitely distant from the very relation he enters, he presents himself there from the first as an absolute. The I disengages itself from the relationship, but does so within relationship with a being absolutely separated. The face with which the Other turns to me is not reabsorbed in the representation of the face... The Other who dominates me in his transcendence is thus the stranger, the widow, and the orphan to whom I am obligated (2005, 215).

In this ethical relation, one must respond to the other. But, in this response, the self must be radically passive insofar as the self is receptive to the demands of the other. I respond, but I do not reciprocate. Were it possible for me to reciprocate, the demand, the ethical imperative of the other, would not be categorical—one could avoid it. Thus, it is the radical asymmetry of the second-person singular intention, encountered in the face-to-face confrontation that grounds my obligation to the other.

Buber, by contrast, gives an account of our encounter as a relation of reciprocity where love grounds our responsibility to the other (1996, 62, 66-67). Buber’s *I-Thou* relation, or dialogic principle, reaches beyond discursive language and sets the ground for both our religious and ethical relation with the other: “[t]he You confronts me. But I enter into a direct relationship

to it. Thus the relationship is at once being chosen and choosing, passive and active” (1996, 124). Unlike Levinas, Buber’s relation is not asymmetrical; rather, it is reciprocal. Buber is very clear about this unmediated relation with the other: “relation is reciprocity” (1996, 58, 62). As a reciprocal relation, the relation is both active and passive. This simultaneous activity and passivity grounds the ethical encounter.

One might note that although both thinkers developed accounts of the second person intentionality, neither did so with respect to *moral education*.

In order to discuss an account of “you-intentionality” grounded in moral education, then, I will turn to the work of Noddings. Influenced by both Levinas and Buber, Noddings developed an account of the “you-intention” centered on the *caring relation*. This relation between the caregiver and individual receiving care is significant according to psychologists Narvaez and Lapsley for the activation of mental representations of moral events (2004, 2005). These event representations are preserved in memory and form the second element of the foundation of moral character. The attentive caregiver aids the individual in the formation of these event representations and in the development of a narrative identity. To prepare the way for Noddings’ work on the caring relation, I begin by reviewing the early stages of development between the parent and child.

### 3.0.1 *Dependency and the Construction of Identity*

Work conducted in developmental psychology suggests that our concept of self and our ability to form attachments depends on the relations we have with others. Both psychoanalysis and developmental psychology have described how the relation between the child and his or her



primary caregiver leads to the development of the *ego*, or the self. In psychoanalysis, this development takes place through the Oedipal Stage. In the works of Sigmund Freud (1960), Jacques Lacan (2004) and later developed by Julia Kristeva (1987), the child is first in union with his mother. The child believes that he is one with the mother and that the mother satisfies all of his desires. In the beginning of their relation, the child is unable to tell the difference between himself and his mother. This forms an initial bond, called primary identification, with the mother. Then, the father enters the relationship and breaks the relation between the child and the mother by laying down the “law.” The father breaks up this relation by taking the mother’s attention away from the child. The father, metaphorically, tells the child “no” and thus establishes for the child that the “little boy” is separate from the mother. This “no” forms the beginning of the child’s separate identity. According to Kristeva, two possible identifications can be formed in this Oedipal Stage:

a primal one, resulting from a sentimental (*Gefühlsbildung an ein Objekt*), archaic, and ambivalent affection for the maternal object, more frequently produced by the impetus of guilt-producing hostility; and the other, which underlies the introjection into the ego of an object itself already libidinal (*libidinöse Objektbildung*), providing the dynamics of the pure loving relationship (1987, 33).<sup>19</sup>

Thus, our early relations with our “mother” and “father” shape the relation of our ego, the development of our identity, and frame our future relations with others. Similarly, developmental

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<sup>19</sup> German spelling errors corrected.

psychology ascribes the same value to our initial relations with our primary caregivers. Yet, developmental psychology differs in what is most important for forming a healthy initial relation.

Departing from Freudian psychoanalysis, psychologist and psychoanalyst John Bowlby developed an alternative theory of attachment between children and the primary caregiver. While in Freud's theory, the child's attachment to the mother arises through gratification of the drives such as hunger and thirst, Bowlby based his theory on the *security* and sense of safety provided by the caregiver as the basis of emotional attachment (1988). I will be drawing primarily from Bowlby's work because this secure attachment is at the heart of the caring relation.

In *A Secure Base: Parent-Child Attachment and Healthy Human Development*, Bowlby describes the initial interaction of attachment of the mother and male child as follows:

When a mother and her infant of two or three weeks are facing one another, phases of lively social interaction occur, alternating with phases of disengagement. Each phase of interaction begins with initiation and mutual greeting, builds up to an animated interchange comprising of facial expressions and vocalizations, during which the infant orients toward his mother with excited movements of arms and legs; then his activities gradually subside and end with the baby looking away for a spell before the next phase of interaction begins. Throughout these cycles the baby is likely to be as spontaneously active as his mother. Where their roles differ is in the timing of their responses. Whereas an infant's initiation and withdrawal from interaction tend to follow his own

autonomous rhythm, a sensitive mother regulates her behavior so that it meshes with his. In addition she modifies the form her behavior takes to suit him: her voice is gentle but higher pitched than usual, her movements slowed, and each next action adjusted in form and timing according to how her baby is performing. Thus, she lets him call the tune and by a skillful interweaving of her own responses with his creates a dialogue.

The speed and efficiency with which these dialogues develop and the mutual enjoyment they give point clearly to each participant being preadapted to engage in them. On the one hand is the mother's intuitive readiness to allow her interventions to be paced by her infant. On the other is the readiness with which the infant's rhythms shift gradually to take account of the timing of his mother's interventions. In a happily developing partnership each is adapting to the other (1988, 7-8).

This model of attachment forms the foundation for our larger network of embodied relationships. The child communicates through gesture and sounds and the primary caregiver answers in return. These networks form the healthy (or unhealthy) development of the child's attachments to his or her peers. Our relations with others develop first in a secure relation with my primary caregiver and this security, (or insecurity), shapes the relations I will have later with others. Thus, it is this relation of healthy interdependence with others, which begins in childhood, that grounds the "you intention" of the caring relation.

### 3.0.2 Reciprocity and the Caring Relation

According to Noddings, my access to the other is an unmediated access. This access exists prior to language, when the child is in the womb, but continues with language afterward. For Noddings, the most salient example of the “you-intention” is given in the parent-child relation. As an other person, the child’s intentions and desires are directed at the primary caregiver. As a dependent and potentially interdependent other, the child’s intentions are answered by the primary caregiver. In seeking to answer the child’s needs, the primary caregiver takes on the role of the One-Caring while the child is the one who is Cared-For. Reciprocity comes from the child’s recognition that the primary caregiver cares and has responded to the need. Noddings describes this relation from the perspective of the child as follows:

You are there! That is the child’s inner reaction to the parent’s response, “I am here.” That constant response, “I am here,” is the foundation of a relation of care and trust... *You are there.* Experienced by the child, this is the beginning of a life of healthy interdependence, not one of lonely autonomy (2002, 129).

Both the primary caregiver and the child develop through the reciprocal relation of caring. This model of the parent-child relation is the model for our encounter with others. Noddings nicely summarizes:

Both carer and cared-for develop as human selves through interactions in which the response is treasured. The young child

learns that she is valued and has some control over her own fate; she can summon the one who-is-there. The caregiver learns to appreciate the full range of human response. And in old age, when the body again becomes dependent, connection with one who understands can make the difference between relative security and terror (2002, 134).

In this caring relation, Noddings identifies two sentiments which take place in the caregiver. The first sentiment is the feeling of natural caring, or sympathy, and the second sentiment occurs in response to our memories of natural caring. This second sentiment, also, it should be noted comes in the form of “I must.” In short, a normative dimension enters here.

This “I must” comes to us in the form of an obligation, and as a *desired obligation*. Many times this “I must” will be conflicted. The caring encounter requires a commitment at some level: “I commit myself either to overt action on behalf of the cared-for (I pick up my crying infant) or I commit myself to thinking about what I might do” (1995, 11). Yet, there may be reasons to reject this feeling if I know there is nothing I can do. This is why the caring encounter of our being-in-the-world is always *relational*: we reach out to the other and grow in response to others.

In the caring relation, these two sentiments are transformed through a reciprocal relation which consists of four conditions discussed in chapter one: (1) receptive attention, (2) motivational displacement, (3) some form of action, and (4) recognition or acknowledgement of care. Receptive attention is the initial response of the One-Caring to the Cared-For. Motivational displacement is part of the energy and desire driving behind the “I must.” This is the energy to

maintain the appropriate feelings for the encounter. Action concerns the particular action taken or the reflection necessary at that moment to take the right actions (which might include asking for someone else's aid in this situation). Finally, recognition of the caring relation completes, or reciprocates, the relation. Just as the directionality of the "you intention" is invoked care from another so also it completes the caring encounter with an acknowledgement of the care given. As Noddings writes:

What the cared-for gives to the relation either in direct response to the one-caring or in personal delight or in happy growth before her eyes is genuine reciprocity. It contributes to the maintenance of the relation and serves to prevent the caring from turning back on the one-caring in the form of anguish and concern for self (2003, 74).

This double nature of the "you intention" takes place in the caring encounter as both the invocation and the recognition complete the intention of the One-Caring. This point completes as the One-Caring finds in the Cared-For through a reciprocal relation.

Although Noddings was influenced by Levinas and Buber's accounts of the "you intention," she departs dramatically from them by circumscribing the limit of our obligation to others: *we are only obligated to care for others in so far as we find the possibility of completion in the other*. She elaborates:

we shall limit the calls upon our obligation quite naturally. We are not obliged to summon the "I must" if there is no possibility of completion in the other. I am not obliged to care for starving children in Africa, because there is no way for this caring to be

completed in the other unless I abandon the caring to which I am obligated (1995, 15).<sup>20</sup>

Thus, my obligation is limited by my relation to others: I am obligated most to those closest to me. When the other has addressed us, we must respond as those caring provided there are no conditions to prevent the other's response to us. Our caring is completed in the other through a recognition of that caring and built upon a reciprocal relation. This relation may be asymmetrical at times, i.e., children, those suffering from illness, and the elderly, but there is always a potential for response. The possibility of the relation is dynamic and grows with "respect to reciprocity" (1995, 16). She describes this relation as follows:

What I seek is completion in the other – the sense of being cared-for and I hope, the renewed commitment of the cared-for to turn about. I am not justified but somehow fulfilled and completed in my own life and in the lives of those I have thus influenced (1995, 23).

For the caring encounter, the self and the other are not separate. I am always in relation to another in the situation of One-Caring and the Cared-For. This relation is part of a larger interdependent web of caring and trust within a community. Thus, just as the collective intentions of the first person plural give rise to general social acceptance and recognition, so the caring relations of the second person singular intentions give rise to the development of individual agents within the community.

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<sup>20</sup> I disagree with Noddings on this point and later argue for a refiguring of the Caring Relation in order to address a lack of reciprocity.

### 3.1 Disability's Challenge to the Caring Relation

What happens, however, when our relation with the other is a dependent relation? Although Noddings stresses the necessary completion in the other as part of the reciprocity of the caring relation, what happens when the other cannot recognize or acknowledge this care? What happens when the “bodily dialogue” between infant and caregiver break down? In other words, what happens when the One-Caring cannot be cared-for in return? Certain cases in disability, and specifically some forms of cognitive disability or who are diagnosed along the lines of “Autism Spectrum Disorder,” pose a challenge for recognition in Noddings’ account.

#### 3.1.1 Case # 1: *Autism Spectrum Disorder*

Children with “Autism” may not respond to eye contact, smiles, and may be withdrawn. Among other behavior patterns, children with “Autism” may appear to “lack empathy.”<sup>21</sup> Noddings herself maintains that the caring encounter is constituted by some form of reciprocity on account of the Cared-For:

I have claimed that the recognition of caring by the cared-for is necessary to the caring relation. It is clear, however, that the cared-for need not be one-caring in order to constitute the relation. He does not have to receive the one-caring as she receives him. Yet he must respond to her somehow. There is, necessarily, a form of reciprocity in caring (2003, 71).

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<sup>21</sup> See PubMedHealth on Autism <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002494/>.



Yet, cases like “Autism” pose a problem for reciprocity in the caring relation because the child might very well not respond. According to Stanley Greenspan and Serena Wieder in *Engaging Autism*, children diagnosed along the “Autism Spectrum Disorder” (ASD) normally show challenging signs for caregivers in different stages of development:

### Stage One

A typical infant connects his emotions to his actions and sensations. For example, he sees his mother’s big smile and hears her warm voice, and turns his head to see her. An infant at risk for ASD is often unable to form complete links between his emotions and his sensations and motor actions. Signs of this difficulty appear at a number of levels. First, he finds it hard to use movements purposefully to do things like turning to see his mother. Second, he may find it hard to regulate and coordinate movements in general. Movements may lack an organized pattern and may seem random. Third, the infant may have difficulty synchronizing his movements with his caregiver’s (2006, 31).

In Stage One of early development, a child may have trouble acknowledging her primary caregiver’s receptive attention and motivational displacement. This might prove challenging for a parent or primary caregiver whose child cannot show “personal delight” or some form of response. By Stage Two, according to Greenspan and Wieder, the child’s response and ability to return affect may be so limited the caregiver may become frustrated:

### Stage Two

At this stage, infants who can't connect sensory to emotional and motor experiences are unable to engage others as richly and fully as infants without these problems. They may feel pleasure and experience a deep sense of intimacy, but demonstrating these feelings with joyous smiles and facial expressions and focused, pleasurable interest in their caregivers is difficult. Consequently, such interactions are briefer and the children take little initiative. Caregivers, without the magic of the baby's smile and joyful sounds, may be less drawn in and motivated to keep engaging and playing with him or her. However, if they can intuitively sense the baby's underlying delight (in spite of his difficulty in showing it), they may be able to woo the infant and sustain intimacy (2006, 31).

It is at this point where the relation between One-Caring and Cared-for could be asymmetrical and incomplete. Without the child being able to demonstrate some form of recognition or acknowledgement, the caregiver may not find this caring relation to be reciprocal.

This state of the caregiver requires one to consider the role of the One-Caring in an asymmetrical or dependent relation with regard to a lack of this completion: what happens to the primary caregiver or dependency worker when his or her care is continually not recognized? Many dependency workers and caregivers of dependent children and elderly parents may not find themselves in relations of reciprocity with those for whom they care. Cases such as "Autism" and Alzheimer's show us that many of these caring encounters can suffer from a lack of recognition. In response, Noddings would argue, this lack of reciprocity eventually leads to burnout among dependency workers, caregivers, teachers, social workers, and others. While this

might be true, the philosophically pertinent question to be raised is the following: is it still the case that our caring relation to others must break down as well?

### 3.1.2 Case # 2: *Profound or Severe Cognitive Impairment*

In order to answer this question, Eva Kittay, in her work *Love's Labors*, develops what she calls the *transparent self* (1998). According to Kittay, the transparent self is “a self through whom the needs of another are discerned, a self that, when it looks to gauge its own needs, sees first the needs of another” (1998, 51). This is the self of the dependency worker who may or may not be a primary caregiver. The relation between the dependency worker and the dependent brings to light that our bodies are both interdependent with other bodies and dependent upon other bodies – even that other bodies are dependent upon our bodies. Kittay draws on her own experiences raising her daughter Sesha to elaborate her point:

While the image of mutuality and interdependence among persons is an important one, life with Sesha, underscores that there are moments when we are not “inter” dependent. We are simply dependent and *cannot* reciprocate. Furthermore, while dependence is often socially constructed – *all* dependence is not. If you have a fever of 105, the dependence you have is not socially constructed. Sesha’s dependence is not socially constructed. Neither “labeling” nor environmental impediments create her dependence – although environment modifications are *crucial* for her to have a decent life (1998, 180).

Kittay's daughter Sesha has cerebral palsy and has profound cognitive impairment. These aspects about Sesha create a fundamental dependence in her relations with others around her. As a result, Sesha's "you intention" asks for the care of others continually. In other words, Sesha will always be vulnerable in her relations with others.

Thus, cases like "Autism," Alzheimer's and other forms of severe cognitive impairment call for a refiguring of the Caring Relation for the model of event representations for people with disabilities. This refiguring will need three elements: (1) a reconsideration of interdependency not as capability but as co-authorship, (2) an exploration of the role of narrative in self-development, and (3) a rethinking of the virtue of trust in the caring relation. In order to address this refiguring, I draw insights from the work of MacIntyre (1984, 1999), Paul Ricoeur (1992), and Annette Baier (1996).

## **3.2 Refiguring the Caring Relation**

### *3.2.1 Refiguring Dependency: Interdependent Narratives*

The development of a narrative identity has been a central component for the constancy of character for some time (MacIntyre 1984). Our sense of self is unified over time through our narrative understanding and by the practices in which we engage. These practices are part of a larger moral tradition within our community (MacIntyre 1984, 1990). It is through our constancy of performing these practices in our pursuit of the good that we develop virtues by habit over time. These virtues may be of "acknowledged independence" such as courage and justice or they may be of "acknowledge dependence" such as *misericordia* or pity (MacIntyre 1999). I am not

only the subject of my own history, but my history is co-authored with others. The specific development of this narrative co-authorship can be found in the work of Paul Ricoeur.

It is Ricoeur's account of narrative identity of the self in relation to others, I believe, is able to shed light on Kittay's concern for dependency in the *caring relation*. In his work *Oneself as Another* (1992), Ricoeur develops MacIntyre's account of the self as a *narrative identity*. As individuals, we grow, change and develop over time through our encounters with others. How we define and identify ourselves is due partly to the actions we commit and partly to the sedimented character that we develop throughout life.

According to Ricoeur, how we come to find consistency in our identity while remaining dynamic, relational and continually in flux individuals is through our narrative relation with ourselves, with others, and with society. This consistency with dynamism is a dialectical relation that begins with the recognition of two parts of our identity: what Ricoeur calls "*idem-identity*" and "*ipse-identity*" (1992, 3). Idem-identity, as Ricoeur writes, "unfolds an entire hierarchy of significations... In this hierarchy, permanence in time constitutes the highest orders, which will be opposed to that which differs, in the sense of changing or variable" (1992, 2). Simply put, idem-identity concerns our character or sameness. Ipse-identity, by contrast, is that which idem-identity opposes and it concerns our personhood or selfhood. While idem-identity seeks to answer the question "What?", it is ipse-identity which seeks to answer the question "Who?". Just as in literature the plot mediates between the disconnected events and the story, so our narrative identity is the mediation of idem-identity and ipse-identity over time as we grow, develop, change and remain in many ways the same. It provides a dynamic unity-in-time to our selfhood.

Idem-identity and ipse-identity are interwoven in a dialectic of identity. Although Ricoeur does not write at length how this narrative identity affects our embodiment, he does describe it in the following manner:

Insofar as the body as one's own is a dimension of oneself, the imaginative variations *around* the corporeal condition are variations on the self and its selfhood. Furthermore, in virtue of the mediating function of the body as one's own in the structure of being in the world, the feature of selfhood belonging to corporeality is extended to that of the world as it is inhabited corporeally (1992, 150).

As my lived body mediates my being-in-the-world, so that mediation is a narrative mediation of my existential perspective. This narrative, lived embodiment is shared with and affected by others. As Ricoeur writes: "with need and lack, the otherness of the 'other self' moves to the forefront. The friend, inasmuch as he is that other self, has the role of providing what one is incapable of procuring for oneself" (1992, 185). Even though I myself have the world mediated to me through my narrative embodiment, I am not the sole author of my embodied existence. Instead, I am the co-author and my embodied existence is co-written with other people.

Like Noddings, Ricoeur stresses the role of reciprocity in our relation to the other. But this reciprocity is developed from neither capacity nor response. Rather, for him, our relation to the other is dialectical because our own selfhood is. Who I am is constituted by the other. This constitution takes place through solicitude: reciprocity takes place "in the exchange between human beings who esteem themselves" (1992, 188). This dialectic of solicitude, which is the

second movement in self-esteem, involves the exchange of giving and receiving.<sup>22</sup> Within this fragile balance of giving and receiving, friendship lies in the middle of the spectrum. In friendship, according to Ricoeur, giving and receiving are equal and we share an equal vulnerability in interdependence.

Yet, many times our relations with others are unequal. Ricoeur designates one side of the unequal spectrum as *benevolent spontaneity*. In benevolent spontaneity, there is a dissymmetry in the relation “resulting from the primacy of the other in the situation of instruction, through the reverse moment of recognition” (1992, 190). Here the self recognizes the authority of the other. This might be an instance of justice but might also be an instance of care. In the caring relation, this constitutes the parent-child relation or relation of the primary caregiver in a relation of development, instruction, and authority. And in this relation, many times the self is dependent upon the other.

In contrast to benevolent spontaneity, Ricoeur names the other’s dependency on the self as *suffering*. When the other is a suffering being, the other is dependent and has had a reduction or destruction in the capacity for acting (1992, 190). Ricoeur describes this relation:

here initiative, precisely in terms of being-able-to-act, seems to belong exclusively to the self who *gives* his sympathy, his compassion, these terms being taken in the strong sense of the wish to share someone else’s pain. Confronting this charity, this benevolence, the other appears to be reduced to the sole condition of *receiving* (1992, 190).

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<sup>22</sup> For Ricoeur, self-esteem is the arc of reflection on the ethical aim: aiming at the good life, with and for others, in just institutions. Solicitude is the second moment on this arc.

But this suffering is also a *giving* from the other for Ricoeur. Although the self and other are in a position of unequal vulnerability, the other when he or she is suffering reminds us of our own fragility and mortality. The other summons us to be ethical and to recognize value of human life as irreplaceable.

At this point, I will now examine how embodiment and impairment refigure this intention. To do so, first, I note that I will use the terms “dependent” or “dependency” in replace of Ricoeur’s “suffering.” Furthermore, it is necessary that one recall the caring relation and consider the role of narrative in our interdependent relations. Our relations with others constitute the construction of ourselves. As children, we recognize our interdependence with others through our caring relations. As our bodies are relational bodies so others co-author our narratives with us. My series of caring relations finds a unity in the narrative that is my identity. When Noddings describes the four conditions of a caring relation, she is describing our interdependent relations which develop into interdependent narratives. Just as I am a narrative unity of idem and ipse over time, so my narrative unity is affected, mediated, and co-authored by other narrative unities. My narrative identity is affected and constructed by other narrative identities.

And these narratives involve dependent relations with others. McCoy (*Forthcoming*) argues that this dependent relation with others is part of our “existential vulnerability” and that our identities are only complete through our commitment to others. Kittay describes the powerful story of her daughter Sesha’s narrative identity as already interwoven with her own mother and Sesha’s dependency caregiver Peggy:



I am Sesha's one mother. In truth, however, her mothering has been distributed across a number of individuals: her father, various caregivers, and Peggy.

Sesha was four when a woman walked into our lives who came and stayed. How and where we acquired the instincts I don't know, but we knew immediately that Peggy was right. She was scarcely interested in us. Her interview was with Sesha. But she wouldn't take the job. Peggy feared the intensity of the involvement she knew was inevitable. We pleaded and increased the salary. She told me later she would never have taken the job if the agency hadn't urged her to do a trial week. At the end of the week, it was already too late to quit. Sesha has worked her way into Peggy's heart (1998, 156-157).

Although Sesha is fully dependent in her abilities, her participation in the construction of her parents' and primary caregivers' narrative lives is not. As both receiver of care and giver of care, Sesha has co-authored the narrative life of Peggy and others by adding dimensions to their worlds that they had not anticipated. Peggy describes Sesha's co-authorship as the following:

I had been with Sesha in Central Park and I was working on some walking exercises that the folks at Rusk [Rusk Institute at New York University Medical Center, Sesha's early intervention program] had assigned. I was working terribly hard trying to get

Sesha to cooperate and do what I was supposed to get her to do. I sat her down in her stroller and sat down on a park bench. I realized that I was simply exhausted from the effort. I thought, how am I going to do this? How can I possibly do this job, when I looked down at Sesha and saw her little head pushed back against her stroller moving first to one side and then to another. I couldn't figure out what she was doing. Until I traced what her eyes were fixed on. She had spotted a leaf falling, and she was following its descent. I said "Thank you for being my teacher, Sesha. I see now. Not my way. Your way. Slowly" After that, I fully gave myself over to Sesha. That forged the bond (1998, 157).

As both giving and receiving, Sesha and Peggy share lived experiences together even though Sesha is dependent and Peggy is her dependency worker. As narrative identities, together they co-author each other's lives. Their interdependent narrative is the gift they share with each other. And this interdependent narrative underscores the fragility of the human condition. Kittay describes this fragility as follows:

As I write this essay, a much older Peggy still cares for a much older Sesha in many of the same ways. But as Peggy and Sesha age, we reach the limits of the laboring aspect of caring... This is a difficult and troubling state of affairs – for us as parents, for Peggy, and, if Sesha understands it, for her. Sesha's possible future without Peggy troubles me profoundly – not simply because we have come to so rely on her, but because I cannot bear the thought

that such a central relationship in Sesha's life could be sundered (1998, 157).

Thus, the fragility of our relations with others affects the narratives we share. Interdependency means shared vulnerability as well as capability, but it also means co-authorship. Our narrative identity is constructed and co-authored by other identities.

As a relational, narrative, dynamic agent, I am in interdependent and dependent relations with others. But these relations are not constructed strictly by capabilities; rather they are developed through a dialectic of giving and receiving. My relation to others in friendship forms a bond of equal vulnerability as we co-author each others' lives. As Aristotle advised, friends were necessary for *eudaimonia*. Yet, I can also form unequal friendships. I am also possibly in the position of caregiver or dependent. As a caregiver, I care for the dependent other and our relation is of unequal vulnerability. But that is not to say that there is unequal giving. My relation to the dependent other reminds me of my own fragility and vulnerability. I am only myself through the co-authorship of another and my narrative is shared with the one for whom I care. As Kittay's transparent self who gauges her own needs through the needs of a dependent other, so those needs are caught up in interdependent narratives of the One-Caring and the Cared-For. Thus, in the case of "Autism," the One-Caring does not need the recognition or acknowledgement from the Cared-For: by having their relation, their narratives are already interwoven to develop an interdependent gift which reminds of that fragile bond.

If our embodied interdependent narratives, which form through reciprocal caring relations, are not built upon a foundation of recognition, then what is the foundation that keeps our interdependent and dependent relations in tact? The answer, I believe, is trust. In order to

consider the role of trust in our embodied interdependence, I now turn to the work of Annette Baier.

### 3.2.2 *Refiguring Dependency: The Virtue of Trust and the Caring Relation*

The virtue of trust is necessary to sustain friendships and caring relations with others. In the dependent relation between the infant and caregiver, the infant forms basic trust in the relation with his or her primary caregiver. And this basic form of trust can be violated when it is abused. In her work *Moral Prejudices*, Baier describes trust as an “accepted vulnerability to another’s possible but not expected ill will (or lack of good will) toward one” (1996, 99). Trust relies on another’s good will and, thus, relies on another’s *care*.

Many times trusting relations can be defined according to this very simple structure: A trusts B with valued thing C (1996, 101). Although this is an oversimplification, it points to another element of the trusting relation: according to Baier, trust is “letting other persons (natural or artificial, such as firms, nations, etc.) take care of something the truster cares about, where such ‘caring for’ involves some exercise of discretionary powers” (1996, 105). As a result, the most basic forms of trust are (a) trusting one’s vulnerability to another’s good will and (b) trusting something valued to another person. Both of these forms can be found in the infant relation with the primary caregiver.

The infant’s trusting relation with the primary caregiver is a dependency relation of unequal *power*. Although both the caregiver and the infant are sharing vulnerabilities, the caregiver has more power in the relationship. Baier describes the situation as follows: a “young child too is totally dependent on the goodwill of the parent, totally incapable of looking after

anything he cares about without parental help or against parental will” (1996, 106). This trust between infant and primary caregiver is not a trust that needs to be won. She continues:

infant trust, although extreme in the discrepancy of power between truster and trusted, is to some extent a matter of mutual trust and mutual if unequal vulnerability. The parents’ enormous power to harm the child and disappoint the child’s trust is the power of ones also vulnerable to the child’s at first insignificant but ever-increasing power, including power as one trusted by the parent (1996, 107-108).

This trust eventually grows and develops into stronger and more complex forms as the infant matures and becomes interdependent with others. As the child ages, so the relation of power may be reversed while the form of mutual trust remains the same. Once grown, the child-now-adult may find herself in the position of taking care of her now dependent primary caregiver. Thus, trust is passive and fragile but founds an infant’s initial relation with others in the world.

As a passive and fragile gift, trust is what grounds the interdependent narrative of the *caring relation*. As Noddings writes: “You are there! That is the child’s inner reaction to the parent’s response, ‘I am here.’ That constant response, “I am here,” is the foundation of a relation of care and trust” (2002, 129). The primary caregiver’s initial response, namely, his or her “I am here!” to the “you intention” of the child’s invocation, is an invitation to trust and the form of a *promise*. The caregiver is committing to the child’s well-being and the child trusts the parent in the reaction “you are there!” Promises create trust and obligations within the caring relation.

Promises add a futural element to our narrative identity. According to Ricoeur, as our character shows the overlap of idem-identity and ipse-identity in permanence over time, so the ability to promise opens up a gap between the two identities by orienting our narrative identity toward the future. Thus, when the One-Caring promises “I am here!” what she is saying to the child “I am here and I will be here.” Her narrative identity promises a trusting relation with the child. This promised trusting relation co-authors and co-constructs the child’s own narrative identity. Likewise, by saying “You are there!” the child co-authors and co-constructs his caregiver’s narrative identity. Thus, the trusting relation founds the interdependent narratives of lived experience, which strengthen our phenomenological sense of self-coherence over time.

### **3.3 Event Representations and Interdependent Virtues**

The development of interdependent narratives through shared dialogue with caregivers plays a significant role in the development of the second component of the foundation of a virtuous character. This second component concerns beginning event representations, which are developed through the aided guide of caregivers, mentors, teachers, friends, and significant others. The CAPS theory model assumes the *activation of mental representations* is a key component of coherent personality functioning. These representations include: "knowledge of social situations, representations of self, others and prospective events, personal goals, beliefs and expectations, and knowledge of behavioral alternatives and task strategies" (Cervone and Shoda 1999, 18; Lapsley and Narvaez 2004). These representations are routinely conceptualized as schemas, scripts, prototypes, episodes, competencies and similar constructs. These stable goal systems account for the differences among individuals: not only do individuals have life-long

goals which animate their lives, but also they exhibit behavioral signatures (if...then structures) when responding to situations with respect to those goals or schemas. The dynamic interaction of perception and response contributes to an individual's "recurrent style of planning, interpreting and responding to events" (Cervone and Shoda 1999, 20; Lapsley and Narvaez, 2004).

Toddlers begin to form event representations through the rituals of family members and interactive dialogue with caregivers (Thompson 1998; Lapsley and Narvaez, 2004). These scripted knowledge structures encode family routines and rituals and take the form of generalized *event representations*. These event representations become more elaborate and develop into broader knowledge structures as the child grows with age. According to Narvaez, "these representations serve as working models of what to expect of early social experience, and allow the child to both anticipate and recall events" (Lapsley and Narvaez 2004). These representations support early episodic memory and have been considered the "basic building blocks of cognitive development" (Nelson and Gruendel 1981, 131). Event representations achieve greater organization through a shared dialogue with caregivers (Nelson 1989, 1993a, 1993b).

Caregivers enable the flourishing of these representations through early conversations by reviewing, structuring or consolidating memories in a script-like fashion (Fivush, Kuebli and Chubb 1992). The more elaborate the scripts, the more likely children are to develop a rich contextual background for understanding and remembering events (Reese and Fivush 1993; Reese, Halden and Fivush 1993). Lapsley and Narvaez (2004) argue that this capacity for event representation is not only one of the building blocks of cognitive development, but also one of the building blocks of moral character: "the foundation of the moral personality is laid down in the early construction of generalized event representations, prototypic knowledge structures,

behavioral scripts and episodic memory.” These representations are then transformed into autobiographical memory through narrative that “references a self whose story it is” which is constructed with the aid of social dialogue (2004). This beginning story and identity shaped by caregivers helps the individual develop a *life story* over time (McAdams 1992, 1994b; McAdams, Diamond, de St. Aubin, and Mansfield 1997).

This self-narrative begins through the social construction of an autobiographical memory and a “web of interlocution” prompted by the caregiver. Narratives are constructed by asking children to recall past events such as “Where did we go yesterday?” “What did we see?” “Was Aunt Tessa there?” “What did we do next?” Lapsley and Narvaez propose that this scripting of simple events could be adapted for moral development. Kearney (2004) proposes a similar account of the role of narrative, but points to the particular significance of narrative in shaping the identity of the moral agent which takes place not only between the caregiver and the young listener, but also to include the cross-sharing and cross-shaping of identities for mature moral self-hood. Thus, as this co-authorship begins with the caregiver shaping the event representatives of the individual, so we continue to cross-culturally share our narratives and cross-shape the identities of others as they do us throughout our lives.

Lapsley and Narvaez propose developmental moral schemas could have scripts like the following: “What happened when you pushed your brother?” “Why did he cry?” “What should you do next?” These questions would prompt children to construct action-guiding scripts such as “I share with him” “I say I’m sorry” which would aid in the development of a moral self-narrative. These scripts would become overlearned, frequently practiced, routine, habitual, and automatic over time. In this way, caregivers “help children identify morally relevant features of



their experience and encourage the formation of social cognitive schemas (scripts, prototypes) that are easily primed, easily activated and chronically accessible” (Lapsley and Narvaez, 2004).

My argument is that it is through this shared dialogue which develops and co-authors a narrative identity that an individual would begin to develop the foundational *interdependent virtues* such as kindness, genuineness and trust. To recall, Temple Grandin learned the virtue of kindness from her caregiver, i.e. her mother, showing her how to pet the cat when she was a little girl. This incident is significant for two reasons. First, it demonstrates how a virtue can begin as a subset of a CAPS trait; it was local and domain dependent, but had the possibility to grow over time. Second, it demonstrates how a virtue is *developed* over time: Grandin remembered how the gentle squeeze machine had soothed her fears, she then connected this affect and memory by forming a goal to pet the cat gently under her mother’s guidance. This direction provided a significant activation of the mental representation of the virtue of kindness. This virtue of kindness began as something interdependent – Grandin needed instruction and aid from a more experienced moral teacher, i.e., her mother. Later this mental representation formed the foundation of this virtue of kindness which animated her overarching life goal: being kind to other humans and animals and using her gifts to help them flourish just as her mother and others had helped her live well. In the next chapter, I will discuss the moral significance of overarching personal strivings toward life goals and life transitions from biological impairments and “disabling injuries or illnesses” and the role they play for a narrative identity.

## IV.

### *Moral Self-Coherence through Personal Strivings: Life Transitions and the Unity of a Narrative Identity*

#### **4.0 Personal Intentional Striving**

As an agent, I live dynamically in the world as an internally goal-directed being. My dynamic living is animated by my dynamic personal striving as I interact with the situation in which I find myself. My argument in this chapter is that our personal strivings are unified by the life story which animates and directs those strivings throughout life. Although our personal strivings may be altered or deterred due to life transitions including accident, illness, and “disabling injury,” they still retain a unity through our overarching narrative identity. It is this narrative which gives unity to both our psychological intentions and bodily intentions, even when they are experienced as a phenomenally lived dualism.

The psychological idiographic approach to goals of *personal strivings* was developed in order to account for the recurring, characteristic goal-striving behavior of individuals (Emmons 1986, 1989, 1999; Emmons and King 1988). Personal strivings are coherent patterns of goal strivings and articulate what the individual agent is *trying to do*. This approach indicates the particular differences of the individual by characterizing that individual according to the unique set of “trying to do” tendencies which animate her life. For instance, a person may be “trying to appear attractive to the opposite sex,” “trying to be a good listener to his or her friends,” or “trying to be better than others” (Emmons 1997, 496). Emmons writes: “Personal strivings can be thought of as superordinate abstracting qualities, or motivational organizing principles that render a cluster of goals functionally equivalent for an individual” (1997, 496). A personal

striving is a unifying construct which unifies various goals or strivings around a central theme. Because of this unifying construct, an individual striving can be achieved in a variety of ways and satisfied by way of any number of concrete goals (1997, 497). Personal striving must refer to a repeating, recurring goal, not a one-time concern. Distress occurs when there is conflict between individual strivings and can even lead to physical illness (Emmons and King 1988).

The individual goals pursued in one's personal striving are unified in a sort of goal complexity. This unification is a structural aspect of goal systems and has two components: differentiation and integration (Emmons 1997, 504). The first component references the complexity within the overall goal system while the second component references the complexity of the individual goals strived after. The first component, *differentiation*, refers to the degree of interdependence and independence among the goals in the system. Thus, goals with a high degree of interdependence have low differentiation among the goals in the system. In contrast, goals which are highly independent have a high differentiation within the goal system. Interdependent goals can interact in an instrumental or conflicting way. When there is a lot of similarity among goals, the goal system is considered simple, whereas greater differentiation indicates complexity in the system. The second component, *integration*, concerns the number of linkages between goals. Integration exhibits complexity among the different plans or means-ends connections associated with each goal. In the case of integration, complex goals are goals which can be achieved in a variety of different ways.

In order to make my argument, I examine the following 10 case studies from medical patients.

#### 4.1 Personal Strivings as Personal Meaning

My aim in this section is to elaborate the aspects necessary for successful lived personal striving as recovery from a health condition such as a stroke. The four characteristics I shall emphasize for the success of personal striving are: *meaningful tasks, meaningful spaces, meaningful sequences and meaningful relations.*

In the practice of nursing and in the majority of rehabilitation settings, the goal is functional independence. Medical practitioners measure functional independence through physical, visible signs of self-care. Examples of these tasks would be the ability to put on one's shoes, buttoning a shirt, or brushing one's teeth. Thus, health care workers usually focus on having patients complete physical, visible tasks and achieve objective goals (Doolittle 1994, 216). But this kind of focus does not articulate the experience of rehabilitation. As Case # 1 will illustrate, recovery depends not only on the completion of functional tasks, but the completion of *meaningful tasks.*

##### Case # 1

At the age of 54, Mr. Ward had a lacunar stroke of the internal capsule of his brain. This stroke affected the strength and control of his left arm and hand. Before the stroke, Mr. Ward had been a dedicated fisherman. After the stroke, in order to judge his recovery process, Mr. Ward measured his progress by how well he could fish: his progress was discussed in terms of reeling and casting with his left arm and hand.

Mr. Ward lived and understood his progress through fishing experiences for the next six months. He would report how well he could cast and reel in each interview with a health care worker. As months passed, the frequency of his fishing trips increased. Soon he was finally able to walk down the long distance of the pier on his own (Doolittle 1994, 216).

Mr. Ward's "point of reference" for recovery was fishing. His ability to fish signified not only his functional independence but also the recovery of his social body. Fishing was the meaningful task which organized and animated his life. While health care workers may focus on functionality, meaningful tasks like fishing constitute what is valuable in the patient's life. Even though a patient may not be achieving functional independence in the "proper order," he or she may be accomplishing meaningful activities which indicate more of a sense of recovery for the patient. Thus, for the person who has experienced dramatic bodily change such as a stroke, recovery is not the completion of functional tasks prescribed by others. Instead, it is the gentle and slow return to important and valuable activities one had enjoyed before.

But a patient's recovery does not take place in a vacuum. The *space of recovery* has a great effect on the patient's ability to make progress as well. The space allows a patient to reconnect with the community of which he or she was once a part. Sometimes, the *medical space* makes a patient feel out of place. By changing the space to a *familiar space*, the patient's progress can be greatly increased. Consider, for example the story of Ms. Jones in Cases 2 and 3.

#### Case # 2

Ms. Jones had an extremely slow recovery after she had had a stroke. From the stroke, she experienced severe weakness on the left side of her body. Health care workers pushed and prodded her to perform minimal rehabilitation activity. She had barely walked a few steps in the hospital setting.

When she was discharged, though, there was dramatic transformation. "She was carried up the front steps of her home, and with great delight at being home again, stood alone and walked into the house, crossed the living room, and seated herself in her favorite arm chair." When she entered her living room, she was transformed by the familiar setting of her home. And over the next few months she learned to walk again.

In her home, Ms. Jones, with the prodding of her husband, walked through her house several times a day. Within a short time, she was able to walk unassisted and without a cane (Doolittle 1994, 217).

In the case of Ms. Jones, the familiar setting of her home proved to be a meaningful solicitation for recovery. This return to a familiar and meaningful setting encouraged her to make dramatic progress. At the hospital, Ms. Jones was unable to *dwell* and find a familiar foothold; in her home, by contrast, she was able to dwell in a meaningful space. Thus, her functional tasks became meaningful tasks because she was in a meaningful space. She was not just walking fifteen steps; she was walking *across her living room*.

While the setting of her home provided a meaningful space in which Ms. Jones could complete meaningful tasks of recovery, she also organized and accomplished these bodily tasks in order of importance to *her*. Thus, as Case # 3 will illustrate, she accomplished her tasks in a *meaningful sequence*.

### Case # 3

When she returned to her home, Ms. Jones focused on walking for the first few months. She made amazing progress with her left leg, but did virtually nothing with her paralyzed left arm. Her left arm was in many ways “useless” and so her complete and total attention and energy were focused on walking again. After five months in her home, she had mastered walking. At that point, her attention turned to the recovery of her left arm (Doolittle 1994, 218).

It was not the case that Ms. Jones had simply “forgotten” about her left arm. Because lived meanings and priorities change over time, Ms. Jones had chosen to focus her attention first on what seemed more important to her: her ability to walk. Thus, her meaningful, bodily tasks were

prioritized according to the values and feelings of Ms. Jones. While a health care provider may have focused only on the functional accomplishment of these tasks, the patient chose to accomplish these tasks according to a *meaningful sequence*. It was in this way that Ms. Jones gave a sequential ordering to her body and her experience.

The cases of Mr. Ward and Ms. Jones indicate that the lived experience of bodily illness and recovery operates not only by functional independence, but primarily according to meaningful tasks which are accomplished in a meaningful and familiar space as well as according to a meaningful sequence. But the cases of Mr. Ward and Ms. Jones also indicate that these tasks are *relational*. While the medical gaze may choose to focus primarily on efficiency and functionality, the patient's recovery is not something experienced by the patient alone: the patient recovers in relation to family, friends and health care workers.

This relational aspect of the completion of meaningful tasks is illustrated best in the case of Thomas, the courageous premie newborn.

#### Case # 4

Grayson Hill, Thomas' mother, describes her frightening experience with Thomas' difficult birth as follows:

“Thomas was born by cesarean section at 27 weeks, 3 days gestation. He weighed 2 pounds, 6.5 ounces... We both had confidence in the two physicians delivering our son. Charlie and I were terrified, but we knew that we had done everything that we could do for Thomas. He was so tiny and was whisked away to the NICU [Neonatal Intensive Care Unit] immediately. It seemed like hours before the neonatologist came to talk to us, but when he did, he was courageously optimistic. He was encouraged by what he saw on initial assessment with Thomas. This message was repeated to us many times during the first 48 hours. Then, doctors became concerned that he was going to need an oscillating ventilator. A decision was made to move him to another facility in anticipation

of this need. The nurses and doctors answered our questions, compassionately; however, in this new NICU, we felt as if we were unwelcome or in their way. Yet the child in that bassinet was ours. We were ‘the parents of the two-pounder’” (Discenza 2010, 400).

What the case of little Thomas the courageous premie portrays is that patients are always already in relations with others when in recovery. As his mother Grayson describes “we were ‘the parents of the two-pounder.’” When a patient like Mr. Ward or Ms. Jones is recovering, their meaningful tasks are also made meaningful by their surrounding relations. Ms. Jones was encouraged to walk around the house by her husband. And in the case of little Thomas, his recovery was central to the happiness of his parents.

As patients’ intentional strivings are caught up in a meaningful nexus of tasks, space, and sequence, their strivings are also interwoven with the intentions of those who support, love, and care for them. But these tasks are bodily tasks and as a result, when a patient experiences impairment or stroke, their bodily perception and experience fundamentally changes. Thus, these strivings must change and alter in response to a *life transition*.

#### **4.2 Personal Strivings, Handling Setbacks and Life Transitions**

These next three cases follow a particular patient, Mr. Rowland, who at age 66 experienced a right lacunar stroke. To recover from his stroke, Mr. Rowland set a particular goal and strived to achieve it. He then experienced a setback when trying to accomplish his goal. Finally, because he could not fully achieve his goal, he needed to make a life transition from his previous lived body into his “new” lived body based on his biological transition.



## Case #5

Mr. Rowland and his wife were planning to fly to the Midwest to attend their son's graduation from medical school. Two days prior to the flight, while packing and preparing to see his son, Mr. Rowland suddenly developed severe weakness in his left arm and leg. His wife took him to the hospital where he was told he had experienced a stroke.

Mr. Rowland was very distraught over the news of his stroke and sad about missing his son's graduation. But he had a new event to look forward to. In two weeks, his son was getting married. Mr. Rowland's physicians told him that if he were strong enough, he would be allowed to travel to attend his son's wedding in the Midwest. The possibility of being able to attend the wedding motivated Mr. Rowland and he achieved an extremely dramatic recovery. Within 12 days, he was walking with a tripod cane and at the wedding, he even danced (Doolittle 1994, 213).

The case of Mr. Rowland demonstrates an individual's personal striving to recover from a medical condition. Mr. Rowland was not only completing functional, objective tasks set forth by the medical professionals, but he was completing these tasks in a meaningful way: his goal was to attend his son's wedding. What Mr. Rowland's case demonstrates is that a patient's recovery and experience of a disability or illness is experienced as a meaningful personal striving. This specific meaning *motivated* Mr. Rowland to achieve his goal within a specific time frame. For Mr. Rowland, attending his son's wedding gave a personal meaning and time-frame to accomplish the functional medical tasks he needed to complete for his recovery.

## Case # 6

For the first seven weeks following his stroke, Mr. Rowland kept a daily schedule outlined in his little black book and made dramatic improvement: a couple of hours each day for meals, 1 hour for bathing, 2 hours for a mid-day nap, and 6 hours for exercise

sessions. He was determined to recover his prestroke body. He was convinced that organized exercise and willpower would return his weak arm and leg to not only their prestroke ability, but surpass the unaffected side in ability. His prestroke life was always his point of comparison. Because of this, he was distressed by what his left arm would not do.

Progress was slow during the ninth and tenth week. Mr. Rowland spoke of how frustrating and degrading the experience had been:

“I didn’t want my friends to see me, I didn’t want to see anybody, I just wanted to hide. I couldn’t speak right, my arm and leg didn’t work right, and I was only in a position of being pitied. And the one thing I couldn’t stand was pity. Everything had closed in on me. I got so low I didn’t want to live anymore. I would rather die than have this happen again” (Doolittle, 1994; 214)

For the next 4 or 5 weeks Mr. Rowland struggled with his plateau in recovery. Even though he was retired at the time of his stroke, he visited his former work setting four months after the stroke:

“And I tried to meet all the workers. But I felt as though I could not tell them I had a stroke. I’m not proud of the progress I’ve made, not until I am like what I was before the stroke. When I was in the office before, I worked really hard. That’s why I don’t want people to know I’ve been sick” (1994, 215).

At this point, Mr. Rowland experienced a setback in his personal striving. What he was *trying to do*, he was struggling and failing to accomplish. Mr. Rowland’s struggle to recover his previous ability and movement made his social reintegration much more difficult. He had reached a point of crisis by not being able to return to his prestroke ability and way of life. This struggle was both frustrating and terrifying, so Mr. Rowland isolated himself from others and felt shame about his “new” body. What Mr. Rowland was experiencing was a gap that had opened up between what Searle calls our intentions-in-action and our bodily movements. For Searle, when I raise my

hand, I have a psychological event – my intention-in-action – which comes in the form of “trying” and I have my bodily movement. Mr. Rowland’s frustration with his intention-in-action being unable to cause – or to cause in a limited way – his bodily movement, made Mr. Rowland feel like he had a “broken” body. His intentions-in-action were caught up in his old Network but instead of his old Background of abilities, Mr. Rowland had to develop different abilities. Thus, his Network and Background – or what Merleau-Ponty calls “world” - had changed. This frustration and despair flooded his “world” and interfered with his relations with others. In other words, Mr. Rowland’s “unruly” *body* had changed his “world” without his intention.

#### Case # 7

At six months into his recovery, Mr. Rowland described his body as an *objectified body*:

“When I start walking, things are normal. But then when I reach that other corner, it’s as if I’m going back to the time when I think more about my left side. I have to instruct the arm [to swing]. That’s what I’ve learned from the stroke. There must be some instruction coming from your mind... to do it... to walk erect... In other words, my mind tells my body to do it this way or that way. I have to have the instructions, and then my muscles will follow” (Doolittle 1994, 215).

At this point, for Mr. Rowland, even after six months, he had not returned to this prestroke life. His habitual bodily acts had not returned to the way they used to be. For him, his body had become an unreliable “object” that he struggled to “live through.” His arm and leg had become passive objects which did not always follow the control of his mind. His struggle to attain bodily reintegration was also manifest in his struggle with social reintegration: he had always been seen as a strong, active and successful person. Now his movements were awkward and constrained. It

was at this point that Mr. Rowland's temporary setback had become a *life transition*. With the slow realization that he would not be able to return to his prestroke life, the personal strivings of his life would need to change.

The challenge of setbacks and life transitions present opportunities for changes in the personal strivings that animate the stories which structure who we are. Yet, sometimes the setbacks we experience due to illness and disability can present themselves as a breakdown between our personal intentional strivings – Searle's prior intentions – and our corresponding bodily intentions. In the following cases, I consider how our impaired embodiment can lead to a sense of disunity or *lived dualism* for our embodied perception.

### **4.3 Breakdown in Bodily Intentional Striving**

#### *4.3.1 The Phantom Limb*

The activities I find meaningful in my life are meaningful because they are shared purposes with other human beings within my culture. To illustrate how we live through our bodies as meaningful subjects, rather than as objects, Merleau-Ponty gives the famous example of the *phantom limb*. In the case of the phantom limb, Merleau-Ponty describes two cases of amputation: in the first case, he describes a patient who has lost his leg, and the second case, he describes a patient who has lost his arm. At first, following the amputation, in both cases, the patient's "imaginary limb" feels enormous. In the particular case of the patient who has lost his leg, he tries to walk on that leg and falls down. Merleau-Ponty highlights the case of the phantom limb to make three points.

First, that there is neither a physiologically nor a psychologically satisfying explanation for this imaginary limb: it is both a presence which has become absent yet is also simultaneously an absence which is now present much like a dear friend whom we have lost and whose absence is later made present to us by a familiar reminder. In response to this paradox, Merleau-Ponty calls for a “middle term” and considers the case of the phantom limb an “ambivalent presence” (2008, 94).

Second, Merleau-Ponty, introduces the case of the phantom limb to draw a distinction between two layers of the body: the “habit body” and the “body at this moment” (2008, 95). The ‘habit-body’ is much like the Searlean “background” insofar as the “habit-body” consists of our general habitual movements of the body: how we manipulate objects, how we move around our homes, and the daily habits we perform. The “body at this moment”, by contrast, is the body’s movement in the actual moment it is performing, trying to perform, or failing to perform an action. It is these two layers which come into conflict in the case of the phantom limb. This clash occurs when I can no longer manipulate an object as I have habitually done in the past: an example of this would be chopping vegetables to prepare a meal. In the case of the patient who has lost his arm, the knife now feels awkward in a different hand and he struggles to keep the vegetables steady on the chopping board. It is in this “present moment” that his “body at this moment” conflicts with his “habit-body.” The resulting insight born of this conflict is that I no longer view the object as “manipulatable for me” but rather, it is now “manipulatable in itself.” It is from this insight that Merleau-Ponty recognizes that I begin to understand my body from an objective perspective as well: “correspondingly, my body must be apprehended not only in an experience which is instantaneous, peculiar to itself and complete in itself, but also in some general aspect and in the light of an impersonal being” (2008, 95). This experience of the

phantom limb, Merleau-Ponty says, is akin to the psycho-analytic repression, and functions as a traumatic experience which the patient struggles to accept because his lost limb is meaningful and he has not yet accepted his loss. As the patient deals with his loss, the size of his imaginary limb shrinks.

The third point that Merleau-Ponty draws from the case of the phantom limb concerns our being-in-the-world. Merleau-Ponty's description of our subjective being-in-the-world is a description of our body schema, i.e., how we schematize space, time, movement and our interaction with others and objects through our lived experience. Our bodies are the locus for this schematization, and that schematization is the *body schema*. This body schema is what constructs our subjective "I" and gives a "wholeness" to my being-in-the-world (2008, 94). But in the case of the phantom limb this *wholeness* is called into question:

What it is in us which refuses mutilation and disablement is an *I* committed to a certain physical and inter-human world, who continues to tend towards his world despite handicaps and amputations and who, to this extent, does not recognize them *de jure*... To have a phantom arm is to remain open to all the actions of which the arm alone is capable; it is to retain the practical field which one enjoyed before mutilation (2008, 94).

Because the body is the vehicle for being-in-the-world, the amputated limb proves unruly for the body schema because it is both revealing and concealing: the phantom limb *conceals* the absence of the limb because I still feel like my limb is there and move in the anticipation of my lost limb

but it is also revealing insofar as every time I reach for an object with my phantom limb, the world *reveals* to me that my limb is no longer there. What all three of these phenomenological points indicate for Merleau-Ponty is that our bodily being-in-the-world is a *lived unity*, which is why the “cripple” struggles to find the “guarantee of his wholeness” (2008, 94).

#### 4.3.2 *Lived Dualism and the Body as Object*

When the body experiences impairment or illness such as a stroke, like in the cases of Mr. Rowland, Mr. Ward, and Ms. Jones, patients concentrate deliberately on making movement. The process of recovery takes place in the body’s ability to move. It is the body’s conscious attempt to return to meaningful, bodily activities. In this process, however, the lived experience that patients often describe is that of the mind trying to “talk to” the body. In other words, their minds relate to their bodies as objects. In this way, as Cases 8-10 will illustrate, their lived bodily experience is a *lived dualism*.

#### Case # 8

Mr. Butler described his experience after a stroke as a “mind in control of the body” experience:

*Mr. Butler:* It feels like my brain is saying to my left foot, “step forward.” Instead of doing that, my left leg says “I am too tired, your knee is going to collapse, and you’re going to go down.”

*Intern:* So your brain is saying one thing, but your leg is talking back to you?

*Mr. Butler:* Right. Exactly (Doolittle 1994, 220).

In this case, Mr. Butler is giving orders to an objectified and alienated body. His limbs are refusing to cooperate with his mind. Patients often refer to their arms and legs as “it.” The loss of

bodily continuity indicates a kind of lived Cartesian dualism insofar as the patient's intentions and desires have no effect or have little effect on their body. Patients recovering from a stroke describe their experience as a struggle between the mind and the body (1994, 220). Their hope is that through mental effort and will power they can recover their mind and bodily "unity" once again.

This phenomenal experience of this lived dualism is even more pervasive in certain rare conditions such as Body Integrity Identity Disorder and Alien Hand Syndrome which cases 9-10 will demonstrate.

#### Case # 9

Thomas is a 39-year-old teacher, married for 15 years with one daughter, who had his left leg electively amputated above the knee. Tom has always felt that having two arms and two legs made him 'incomplete' and that the amputation has, paradoxically, finally made him 'feel complete'... He reports that prior to amputation his left leg did not feel any different from his other limbs nor did he perceive it to be ugly or deformed. He denies that a desire for attention was a motivation for the amputation, noting that he always wears a prosthesis when he is out in public.

Tom recalled first wanting to be an amputee around the age of 8 years, the age that he started folding his leg up in order to pretend that he was an amputee. He remembers seeing several amputees as a child and being interested in them, but does not recall any one particular exposure as particularly significant. Tom's desire increased progressively over his early adult years and would intensify when he was under stress. He continued to pretend at home (around 3-4 times per week) using crutches, especially at times when he was feeling anxious or depressed, experiencing the pretending behavior as a 'safety valve'.

Tom first sought psychological treatment at age 29 years, when his frustration over not being an amputee resulted in his becoming depressed and feeling suicidal. He began weekly insight-oriented



psychotherapy (which he experienced as useless) and also was prescribed trials of a variety of antidepressants, anti-OCD medications and antipsychotic medications. He reported that they did not reduce his desire in any way and only made him feel worse. Deciding (after 18 months of treatment) that the psychiatric profession had nothing to offer him, he commenced his quest to find a surgeon who would be willing to do the amputation electively. He arranged for consultations with two psychologists (one with an interest in gender identity disorder) in order to document that he had no other psychiatric conditions and that the psychologists supported the surgical option. He then presented various surgeons with the limited literature about this condition and the results of the psychological evaluations. During this time, pessimistic that he would never find a surgeon willing to perform the amputation, he tried (unsuccessfully) to crush his left leg under weights. Finally after 2 years of trying, he found a general surgeon who agreed to do the surgery. Four years after the amputation, Tom reports no regrets whatsoever about having had the surgery: 'My only regret is that I did not have it done sooner' (First 2005, 919-920).

Tom has a relatively new and rare condition called Body Integrity Identity Disorder (BIID). In this condition, there is a "mismatch" between the patient's phenomenal experience of his or her body and the actual structure of the patient's body (Bayne and Levy 2005, 76). The strongest theory is that BIID is a neurological condition in which the brain's perception of the body, or "visual map," and the actual visual feedback of the body, i.e., what the eyes see, are in conflict.

This condition is different from a mismatch between the person's body schema and their actual body as in the case of phantom limb. In the experience of phantom limb, the patient feels like the limb is still there and many times employs it to carry out actions such as answering the telephone. In the case of phantom limb, the patient has a body schema which includes body parts the patient lacks (Bayne and Levy, 2005).

In the case of BIID, however, there is not a mismatch between the body schema and the actual body; instead it is believed that there is a mismatch between the body *image* and the actual body. According to Bayne and Levy,

One's body image is a consciously accessible representation of the general shape and structure of one's body. The body image is derived from a number of sources, including visual experience, proprioceptive experience, and tactile experience. It structures one's bodily sensations (aches, pains, tickles, and so on), and forms the basis of one's beliefs about oneself (2005, 76).

Thus, for the patient like Tom who has BIID, there is a gulf that opens up between their actual body and their lived body. Patients desire amputation in order to 'restore' their true identity. They are not delusional. Often times patients say things like: "I feel like an amputee with natural prostheses – they're my legs but I want to get rid of them – they don't fit my body image" (First 2005, 922). They also report: "I feel myself complete without my left leg... I'm overcomplete with it" and "I felt like I was in the wrong body; that I am only complete with both my arm and leg off on the right side" (First 2005, 922). When these patients do amputate, they do not develop unwanted phantom limbs.

Patients with BIID are unlike patients with somatoparaphrenia, who experience parts of their body as *alien*. Somatoparaphrenia is "a rare condition, usually following a stroke, that causes damage to the parietal lobe of the brain. As patients recover they typically deny ownership of one of their limbs, often experiencing it as 'alien' or belonging to someone else"

(Ryan 2009, 25). A patient with BIID, by contrast, recognizes that leg or arm as her own and does not identify it as someone else's leg or arm. Patients with BIID, like Tom, desire an amputation because they would rather change their body to fit the way they experience it. Thus, their experience before the amputation is that of a frustrated *lived dualism*.

The experience of the patients with BIID, like Tom, is one of frustration viewing their actual bodies as the Cartesian objects. They do not feel complete with their actual bodies and their desire to remove "the unwanted part" has been so intense that some patients have resulted to using chainsaws, dry ice, and wood chippers. After their amputation, many patients report relief and finally a "unity" of sorts because their actual bodies now match their body images. Thus, the experience of BIID points to a split between the mind and the body in our lived experience. The gap opens up between our mental "visual map" or bodily image, and what our eyes actually see. For those patients with Body Integrity Identity Disorder, their lived experience is one of a *lived dualism* between the mind and the body.

#### Case # 10

Karen Byrne, age 55, who lives in New Jersey, had severe epilepsy since the age of 10. After trying numerous medications unsuccessfully, she underwent surgery to cure her epilepsy which would involve cutting a small part of her brain. When this first surgery did not work, her surgeon cut her corpus callosum, a band of nervous fibers which keeps the two hemispheres of the brain in constant contact.

The surgery had appeared to go well, but then Karen began experiencing strange symptoms in her left hand. Her left hand would begin unbuttoning her blouse in public spaces and take things out of her own hand bag. Karen described her situation as follows:

“I’d light a cigarette, balance it on an ashtray, and then my left hand would reach forward and stub it out” (Mosley 2011).

Karen was diagnosed with Alien Hand Syndrome and has lived with it for eighteen years. Alien Hand Syndrome is a rare condition that can appear after strokes, bleedings, or tumors in the corpus callosum or in the medial frontal cortex. It can also occur in epilepsy patients after the corpus callosum has been cut in surgery. Alien Hand Syndrome can manifest itself through patients perceiving their left hand as alien and cannot identify it as their own. In more severe cases, the hand can become “anarchic” and act against the intentions of the patient (Müller 2009, 39).

In the particular case of Karen, her hand was “anarchic” and was clearly “goal directed” (Marchetti and Della Sala 1998, 200). In alien or “anarchic” hands, the hand is goal-directed and well-executed but unintended by the patient. Sometimes the movements of the alien hand will directly interfere with the desired actions of the “healthy” hand. Often patients report that the hand “has a will of its own” but they never “deny that this capricious hand is part of their own body” (Marchetti and Della Sala 1998, 196). Patients have experienced a variety of strange actions which border on comic: a patient was at dinner and much to her dismay her left hand was taking fish bones from leftovers and was shoving them in her mouth; another patient experienced problems watching television channels because “no sooner had the right hand selected one station the left hand would press another button” (Marchetti and Della Sala 1998, 196). In other cases, patients reported that “my left hand takes my cigarette out of my mouth while I’m smoking,” and even some patients have even reported violently slapping their unruly hands or talking to them in anger (Zaidel 1994). In some extreme cases, patients have even feared their hands may strangle them or smother them in their sleep (Marchetti and Della Sala 1998, 201).

The alien or “anarchic” hand is understood in cognitive terms as “as a lack of inhibition of an unwanted action triggered by environmental stimuli and conflicting with the consciously set overall goal” (Marchetti and Della Sala 1998, 203). The phenomenal experience, though, of the alien hand is that of a *lived dualism*. In the case of the alien hand, the patient, like Karen, not only experiences her body as an other, but as an other with its own intentions and desires. This alien hand had its own intentions-in-actions and executes those intentions. It even thwarts the “healthy” intentions-in-actions of the other hand. In the case of alien hand syndrome, the body is lived not just as a split between the body and the mind; rather it is a split between “two minds” which live through their respective sides of the body. In Alien Hand Syndrome, not only is my body alien or other to me, but so is my mind. Thus, for patients like Karen, they have immediate access to their body as an *other* to themselves. This otherness accounts for the lived dualism of the lived body.

#### **4.4 Personal Strivings unified in Life Narrative**

##### *4.4.1 Personal Strivings and Narrative Identity*

This personal strivings approach to goals compliments and is completed by the overarching motivation dispositional approach in psychology which focuses on the theory of identity *as life story* developed by McAdams (1987, 1989, 1992). This *longitudinal* approach to identity both contextualizes *situation-specific* goals and also structures these goals throughout an overarching *times-specific* life course. McAdam’s empirical approach to identity ties together elements from our past, present, and future. In addition, this approach gives unity and purpose to our personal strivings which make up our selves as dynamic goal systems. This life story gives purpose to our personality and enables us to adapt to changing contexts and life transitions such as a stroke.

McAdams's theory of identity relies on two central components: *imagoes* and *thematic elements*. Imagoes are idealized and personified images of the self. Imagoes organize our personal strivings and as a result, our identity. Specifically, imagoes are "broad, superordinate constructs which encompass interpersonal styles, values, and beliefs, and personal needs and motives" (McAdams 1987; Emmons 1997, 489). Imagoes manifest the central thematic elements, the second component, in two forms: agency and communion (McAdams, 1992). Personal strivings animated by agency themes focus on goals of power, mastery and separation. By contrast, personal strivings animated by communion themes focus on goals of surrender, intimacy and union. These components of identity are unified through a personal story which is set in an historical context and follows the person from birth to death.

#### 4.4.2 *Unification of Lived Dualism through the Narrative Identity*

Personal striving toward goals for medical recovery affects my Network and Background, i.e., my world, and changes my intentions at times to interdependent intentions and brings forth new capabilities. Before injury or illness, my Network is a web of intentions, beliefs, and desires which help to coordinate my bodily action as I move about a room. When caught in the middle of writing, I may get up from my desk to go look for a photograph because I suddenly remember it is my grandmother's birthday next week and I want give her a specific picture. Likewise, my Background, which is my series of capabilities, abilities and training is caught up in this motion. My ability to get up and walk across the room is *assumed*. I do it without reflecting on it and trust my body through my movements. I move through space with the expectation that my body will move as it has habitually moved and that the space I call home will accord with my movements.

In the particular cases of pain, illness, and disability, my Network and Background radically change. If I am not able to walk, how I move about my room must fundamentally change. I may need to move by means of a wheelchair, a cane, or on crutches. Stairs may become difficult or impossible for me to maneuver. If the picture I was reaching for suddenly becomes too high or in a place where I cannot reach, I may need to rely on the help of another. In this moment, my Background abilities and capabilities have changed. What I used to expect of my body, I can no longer expect. And this may be for a short time or absolute. My Network of desires, beliefs and intentions changes as well. My desire for the picture, may now involve a desire for the help of another. Shifting from an individual intention to a collective intention, my means of mobility may require another's aid in order to achieve my desired aims. My beliefs and perceptions about my own body will change as well. I may no longer trust my body to do what it once did and this may initiate a negative self-image and cynical expectations. Or I may become frustrated when I try to achieve my intentions and can no longer do so. "Disability" fundamentally changes my personal strivings, my identity and thus, my being-in-the-world.

My personal strivings may also be affected by stigma and values. I may feel a certain prejudice against my own body or a certain pride in my difference. My Network is a value-laden web of intentions, beliefs, and desires. How I choose to perceive my disability and difference and how others choose to perceive this difference are laced with values which are many times filled with prejudice.

The different *abilities* and *capabilities* which emerge are evident in the example of a baby born with visual impairment. A baby becomes interested in the world through her senses of sight, smell, hearing, taste, and touch. She turns her head to follow her mother's face and voice. Her mother smiles and she smiles back. This is how she develops a "visual map" of the world. In the

particular case of a baby with a visual impairment, however, although the baby cannot see, she follows and localizes where her mother is by her movement and voice. Through hearing, she develops the sense of where things are in space. In their work *Engaging Autism*, Greenspan and Wieder point to the significance of this new and different ability:

Sometimes it's difficult for parents and other caregivers to put themselves quite in the child's shoes if they don't share the visual deficit... Such a child has come to know the world in ways other than sight and may even have a heightened understanding of the world through her existing senses that we don't have; we want to help the child develop pride in that (2006, 155).

Our bodily awareness is a theory of perception which is developed by our various senses. Our body schematizes its way of being-in-the-world by giving a "visual map" of space through our sense of hearing. What disability teaches us is a new way of how we think about our bodies in space and in relation to others. Disability teaches us new possibilities and new ways of thinking about the human body.

The onset of stroke, Body Integrity Identity Disorder or Alien Hand Syndrome demonstrates that our personal strivings can experience setbacks and even life transitions which can lead to a phenomenological experience of *lived dualism*. How I live this dualism is structured according to the meaningful tasks I undertake, the meaningful spaces in which I undertake them, and the meaningful sequence through which I set about to accomplish them. This dualism is animated by my personal strivings, i.e., intentions, beliefs and desires, which may be



interdependent with others as in the case of therapy and care. Thus, my goals for recovery are not only interdependent and complex within my own “goal system,” but they can also be interdependent and integrated with others who help me achieve that recovery or transition with my life change. In proper care, new abilities and capabilities are developed, encouraged, and flourish. This lived dualism is given a sense of unity through the narrative I construct and co-author with others. The lived dualism of disability is radical because it affects both the idem-identity and ipse-identity of my narrative identity. Disability can change my idem-identity – my matter, my sameness or character – insofar as the physicality of my body is now different. Furthermore, disability can change my ipse-identity – my personhood or selfhood – because it structures the *whole* that I am and affects the narrative I have lived in the past and the possibilities I intend for the future. Thus, it is the lived dualism of my body as both *me* and *other* that becomes unified through the personal striving of my life story.

## V.

### *Flourishing Bodies:*

#### *From Moral Novice to Moral Expert*

*Dittēs dē tēs arêtes ousēs, tēs men dianoētikēs  
tēs de ēthikēs, hē men dianoētikē to pleion ek  
didaskalias ekhei kai tēn genesin kai tēn auxēsīn,  
dioper empeirias deitai kai khronou,  
hē de ēthikē ex ethous periginetai, hōthen kai tounoma  
eskhēke micron paregklinon apo tou ethous.*

As we have seen, virtue being of two kinds,  
intellectual and ethical. The intellectual [virtue]  
for the most part, is both generated and increased by teaching  
and thus requires experience and time;  
ethical virtue, on the other hand, is generated by habit (*ethos*),  
and its name, ethics, is derived, with a small variation  
from habit (*ethos*)

(Aristotle 1999, 1103a).

### **5.0 The Foundation of Character: A Narrative Identity**

To recall, the central tenet of virtue ethics is the virtuous person. The virtuous person demonstrates the right actions and right reasons for those who are less virtuous to imitate. The character of the virtuous person is primary and contributes to making one's life a good one. It contributes to one's *eudaimonia*, or flourishing. The goal, then, of virtue ethics is to develop a virtuous character in order that one may flourish.

This virtuous character, however, is not simply a "bag of virtues" one develops (Kohlberg 1969) or a collection of "traits" (Doris 1998, 2002, 2005; Harman 1999, 2000, 2003; Merritt 2000). Both of these formulations mischaracterize the intricacy of how one develops an

empirically grounded virtuous character over a long period of time. After all, the goal of virtue ethics is not to develop a virtuous character that one only exhibits from time to time; instead, the goal is to develop and exhibit the virtues *throughout life*. Thus, one constructs a *narrative* of one's life and develops *practices* which involve a standard of excellence and which contribute to and exhibit a larger *moral tradition* of a community. Not only am I the subject of my own story and history, but also I am a part of the stories of others as they are part of mine. These *interdependent narratives* are developed over time through shared dialogues and shared practices. It is through this sharing that we first develop *interdependent virtues* to help us flourish and then later develop *independent virtues* to guide our life plans.

In this chapter, my aim is to outline the life progression and education of how one might become virtuous by drawing on research from moral psychology. This progression begins with the psychological foundations of character through CAPS traits and the development of event representations. With this foundation, one learns to develop interdependent virtues and a narrative sense of self. These virtues are accessible to those who are cognitively able-bodied and to those with cognitive impairments. I argue that flourishing begins with development of interdependent virtues and slowly grows wider over time with the appropriation of the independent virtues. One accomplishes this growth by expanding one's virtuous goals, as Temple Grandin did, into virtuous life-long personal strivings.

Before we begin, I want to review the following elements necessary for an empirically grounded theory of character for Aristotelian virtue ethics. They are as follows:

1. That the right thing to do is what the *virtuous person as moral expert* would do in the circumstances

2. A virtuous person is one who has and exercises the virtues:
3. The virtues and vices as CAPS traits we develop must also include a reference to our embodiment, i.e., the biological-genetic processing level
4. The virtues must accord with the *personal strivings* theory of personality coherence initially developed by psychologist Emmons (1989).
5. That the *life-story model of moral expertise* developed by McAdams (1987) and Narvaez et al. (2005) enables agents to flourish throughout life:
  - a. This model includes a construction of the longitudinal sequence of measures which explain long-term change and consistency and
  - b. Utilizes the organizing principle of a life-long moral goal to simplify and unify this coherence over time through the form of a narrative identity.

In the next sections of this chapter, I will delineate how one progresses through these elements from interdependently virtuous into independently virtuous as a moral expert.

## **5. 1 The Foundational Components of Character**

### *5. 1.1 CAPS, Biology, Developmental History, and Psychological Features*

CAPS theory forms one of the two foundational elements of character. The four levels of CAPS theory accounts for our phenomenological sense of self-coherence as lived bodies in the world. The four processing levels – bio-chemical, psychological, behavioral, and observer’s view – account for the observed dynamic interaction between the person and the context. CAPS orders our *moral perception* of the world and structures our goals, preferences and values. When we interact with a situation as agents, we draw from a set of affects, cognitions, schemas, scripts, and plans for how to interpret and execute the appropriate action. CAPS theory gives meaning to our personal striving and motivated behavior.

Both the bio-chemical processing level and psychological processing level of CAPS, then, play important roles for the flourishing of people with disabilities. The biological level can affect the other levels of CAPS, which is why a person with disabilities may need particular assistance as in the case of Kittay’s daughter Sesha. Likewise, the psychological level may be affected as in the case of an individual soldier returning from combat who has PTSD (Post-Traumatic Stress Disorder). The ability to develop virtuous moral perception comes from the aid of caregivers which may be parents, therapists, teachers, friends or significant others. Psychologists Narvaez and Lapsley (2004, 2005) argue that the moral schemas which we develop on the psychological processing level are significant for developing *virtuous moral schemas*.

The cognitive substrate in the second level of CAPS consists of three elements: schemas, tasks, and strategies. These three elements will be foundational for the development of a virtuous character. According to Cantor, Lapsley and Narvaez, schemas are "organized knowledge structures that 'channel' and filter social perceptions and memory" (Cantor 1990; Lapsley and Narvaez 2004). Schemas are organized around particular aspects of our life experience. They are

the broadest of the three elements and shape what tasks we choose to pursue. Tasks, the second element, are "culturally prescribed demands of social life that we transform or construe as personal goals" (Lapsley and Narvaez, 2004). These tasks can be developed for specific situations or maintained throughout a life time as a "life task" or life purpose. Both life tasks and schemas provide a cognitive representation for dispositional strivings (i.e., what goal animates our life), but also help us maintain and foster dispositionally relevant behavior (i.e., they guide what actions we choose to make based on that goal) (Cantor 1990; Lapsley and Narvaez 2004). Strategies, the third element, are what we use to accomplish our tasks within our given schema. They are "an intricate organization of feelings, thoughts, effort-arousal and actions" which form a "collection of goal-directed behavior unfolding over time in relation to a self-construed task" (Cantor 1990, 743; Lapsley and Narvaez 2004).

### 5.1.2 *Event Representation, Narrative Identity & Interdependent Virtues*

Event representations form the second foundational component of character and are activated through the shared dialogue individuals experience with caregivers. This is especially important with children learning to develop moral schemas. Through the caring relation, the caregiver guides the individual to recall, understand and contextualize events which have just occurred. From this dialogue, the individual soon develops a self-narrative in which to incorporate these events: *I am the subject of my own story*. The representations I develop are conceptualized as schemas, scripts, prototypes, episodes, or competencies which make up my goal systems. The events which are interwoven into my self-hood account for my difference from others as an individual but also provide a behavioral signature (if...then structure) of the consistency of my action to the observer's eye. These event representations form the basic building blocks of

cognition, and by extension moral character, by co-creating an identity with a caregiver who helps shape the self I am striving to become.

This shared dialogue develops and co-authors a narrative identity. In this development of moral schemas through moral event representations, the individual begins to develop *interdependent virtues* such as trust, genuineness or kindness as exhibited by Grandin's experience petting the cat. First, these virtues begin as habits of feeling, which the caregiver guides and can later become habits of reasoning (Byrne, 1997, 174). These interdependent virtues develop into interdependent practices that an individual begins to develop over time. The virtue begins locally and is initiated not only by the situation, but also by the "you" intention of the caregiver – the caregiver guides the individual to action and understanding. Virtuous practices begin as *shared practices* and thus enable or inhibit the flourishing of interdependent virtues. This individual learns which moral schemas to use for which action: *what is the right thing to do at the right time in the right respect*. But the individual learns these virtues under the guidance of a moral teacher just as in the image of the cave. For most of us, the need for continual virtuous guidance in certain weaker areas of our lives is something that will remain over time. As we personally strive to appropriate a virtue independently of others, there will be times that we will need to rely on the support of others to help us execute virtuous action: this may be in the case of illness or impairment, addiction, trauma, or poor understanding. It is in this way that we all begin as *moral novices* and continue to *strive throughout life* to become *moral experts*.

## **5. 2 Educating the Moral Novice: Moral Schemas and Desiring the Good**

It is at this point that one begins to become a “moral novice” with the development of interdependent virtues. As the individual ages, he or she may learn throughout life to become a “moral expert” through the development of independent virtues. Parents, teachers, friends, relatives, therapists, and many other influences act as caregivers in individuals’ lives. Caregivers teach individuals how to begin as *moral novices* in three ways:

1. By developing moral schemas
2. Directing desires to become moral desires
3. To begin to practice virtuous habits over time as moral chronicity.

I will elaborate all three of these elements in this section and their importance for moral character.

### *5.2.1 Development of Moral Schemas*

To properly construe what is the right thing to do at the right time in the right respect, an individual must develop an understanding of the right moral context in which to construe a situation. To develop the right construal, one must develop the right moral schemas. Thus, the first element of educating a moral novice to develop interdependent virtues involves teaching moral schemas. Drawing from the work of Cantor, Laplsey and Narvaez, self-schemas can be moral schemas (Cantor 1990; Cantor & Kihlstrom 1987; Lapsley and Narvaez 2004). Schemas are the cognitive carriers of dispositions and "demarcate regions of social life and domains of



personal experience to which the person is especially tuned, and about which he or she is likely to become a virtual 'expert'" (Cantor 1990; 738; Lapsley and Narvaez 2004). Cantor designates three functions of schemas which moral novices learn: (1) chronic accessibility, (2) chronic salience, and (3) have a highly practiced behavioral routine.

A schema begins to exhibit *chronic accessibility* when it *directs one's attention to certain features of experience and away from other features in the moral novice*. The chronic accessibility depends upon a person's level of expertise. While an "expert" is likely to notice key features of domain-relevant activity, a "novice," on the other hand, may be unable to distinguish those key features. The virtuous person as moral expert differs from moral novice insofar as she is able to determine the right action at the right time in the right respect. The virtuous person as moral expert may exhibit the virtue of generosity when she stops to help feed a hungry family that is in need of financial assistance, whereas as the moral novice may feel conflicted over the choice between a new television set or giving assistance to that family.

In addition to chronic accessibility, a schema also begins to exhibit *chronic salience* in the memory of the moral novice. This chronic salience is *compatible with our life tasks, goals or settings and determines which of those are more likely to be selected or sought*. This chronic selection serves to maintain dispositional tendencies. Those who are moral experts choose settings, set goals, or engage in activities that support or reinforce schema-relevant interests (Lapsley and Narvaez 2004). But a moral novice is still learning to choose moral tasks. The difference between a budding moral expert and a moral novice can be witnessed in the example of teen peer pressure: the mature teenager who is a budding moral expert would not "go along with the crowd" in an act that was morally vicious. This is very much like Augustine's situation

with his friends when he stole the pears. As a moral novice, he was still struggling to find the right moral life-long task in pursuit of the good (Augustine, 1998).

Finally, after the moral novice begins to develop schemas which are chronically accessible and chronically salient, the moral novice will tend to develop *behavioral routines*. Schemas give us an automatically available plan of action in life contexts that we can draw from and which are reinforced by routine. As a result, experts develop both procedural knowledge and routines which *exhibit a high degree of automaticity as virtuous habits*. Novices, by contrast, lack this sustained automaticity and as a result, must continually work at mastering their skills and developing these virtues through moral habituation and practice.

Both schema accessibility and its conditions of activation are important for understanding how individuals interpret and respond to ethical situations (Lapsley and Narvaez 2004). But moral schemas are not enough to animate the ethical strivings of the development of the virtuous person. We also need to consider the individual's moral desires.

### 5.2.2 Moral Desires

The virtuous person must not only understand situations within the right context; she must also have the *right reasons*. In order to have the right reasons, one must have the *right desires*. So, the second element in moral education consists of teaching the moral novice to develop moral desires. In other words, the caregiver must teach the novice to *desire the good*. To do this, I argue that the interdependent virtue of *genuineness*, or the beginnings of “correct desire,” is necessary (Byrne 1997, 165).<sup>23</sup> A person develops the virtue of moral genuineness through the

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<sup>23</sup> For this virtue of genuineness, I have in mind something akin to Lonergan's paradox of genuineness concerning human development. For Lonergan (2005, 500-503), genuineness should be understood in two respects. In the first respect, used in the more common way, it refers to the “simple and honest soul innocent of introspection” (501). Yet, in the second respect, in a more complex way, it refers to the “admission of that tension in consciousness” and

right moral desires, which in turn can eventually lead to the development of the virtue of *phronēsis* (practical wisdom) that helps us deliberate about “what is good for human life as a whole” (Byrne, 1997, 166). After the virtue of genuineness, the next step is to develop moral integrity over a period of time and exhibit chronicity, i.e., constancy of action over time. An individual begins to become a moral novice by developing genuine *moral desires*. These moral desires guide other virtues and give our actions and commitments moral significance (Blasi 2005). The right moral desires actually desire and tend toward the moral good. The term “desire” has specific advantages according to psychologist Blasi, insofar as it indicates a “certain intensity of affect” and belongs solely to one person. As an intense affect, a moral desire fits the Aristotelian notion of the virtues as human excellences. As this desire grows over time and becomes more animated, it can provide part of the stability to one’s character and give effective direction in one’s life. Second, as a specific moral desire belongs to a specific person, a subject’s moral desire indicates the embodiment of virtuous practices and individual differences which result.

### 5.2.3 *Moral Chronicity and Behavioral Signature (If...then)*

The third and final component in the foundation of moral education involves the development of *right action*. A moral novice must develop *moral chronicity exhibited in a behavioral signature*. Moral integrity involves a certain wholeness or unity of one’s desires. Moral integrity, is a narrative integrity and as a result, includes a “person’s serious concern for the unity of his or her subjective sense of self, as manifested in consistency with one’s chosen commitments” (Blasi

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prompts one into serious self-reflection and self-scrutiny (502). My account of genuineness as a virtue is similar. As an interdependent virtue that begins, it is a simple and honest moral desire. After much guidance and caregiving, it structures our goals and has the ability to become an independent virtue. As an independent virtue, genuineness prompts one to engage in serious self-reflection and to structure one’s strivings in a moral and harmonious way in pursuit of the good.

2005, 90). The virtue of moral integrity begins to exhibit itself through the moral novice's development of moral chronicity.

To review, schema accessibility is an important feature for the development of moral chronicity. Moral schemas are taught to moral novices by caregivers. The more frequently the schema is activated, or the more recently it is primed, the more accessible it should be for processing social information (Lapsley and Narvaez 2004). This frequent activation over time causes the schema to become more and more accessible. Schemas of high chronic accessibility can be produced so efficiently as to approach automaticity (Bargh 1989, 1997). Automaticity allows for virtuous action to become habitual and automatic.

In addition to moral schemas, moral desires and moral commitments are important features in the construction of one's moral narrative self. Lapsley and Narvaez (2004) argue that the moral personality can be understood in terms of chronic accessibility of moral schemas for construing social events. That is, a "moral person" would be a person for whom moral constructs are chronically accessible and easily activated for social information-processing. This moral person would learn to draw on the moral categories (schemas, episodes, scripts, and prototypes) necessary and central for interpreting the social landscape. These categories would always be accessible, and once activated, "would dispose the individual to interpret these events in light of their moral elements" (Lapsley and Narvaez 2004).

Accessibility of these schemas and scripts is assumed to result from a developmental history of frequent and consistent experience with a specific domain of social behavior. Likewise, this chronic accessibility would also influence our impression of others and memory of social events (Narvaez et al. 2005). Because of a difference in developmental history with a frequent experience of a specific social domain, individuals with non-overlapping accessible

constructs could quite possibly have different interpretations and recollections of the same event. These differences become most apparent in cases of privilege and its inverse experience, namely, discrimination and oppression. Those who have worked to develop overlapping schemas with those who are oppressed, we would call advocates.

I will turn to three studies in order to examine the accessibility of *moral chronicity*, which can be understood as the chronic accessibility of moral constructs for construing moral events. This understanding of moral chronicity is essential for understanding *moral character*. This moral chronicity accounts for both individual differences and for the automaticity with which these moral individuals access these moral categories. According to Narvaez et al., “virtuous individuals are those for whom moral constructs are chronically accessible, but individuals may well differ in the sort of moral constructs that are available, and, indeed, for many individuals, it is non-moral constructs that are chronically accessible for processing social information” (2005, 969). In order to illustrate moral chronicity, I will first discuss the classic study from Higgins et al. (1982), and then turn to two more recent studies conducted by Narvaez et al. (2005).

### *Study 1: Trait Chronicity*

This particular study measured chronically accessible constructs by asking them to list the traits of a person they liked, disliked, sought out, avoided, and frequently encountered. Researchers determined trait chronicity by primacy of output.

A trait was considered “chronic” if it was listed first in response to one or more questions, and “non-chronic” if it was not listed at all for any question. One week later subjects returned to participate in an ostensibly unrelated study on “psycholinguistics” conducted by a different experimenter. Each subject read individually tailored essays containing trait-related descriptions of a target person. Half of the traits used in the target descriptions were chronic for each subject, and half were non-chronic. On measures of spontaneous impression and recall subjects were significantly more likely to include information related to chronic traits than non-chronic traits. Moreover, there is evidence that the effect of chronic accessibility on impression and memory are stable over time and guide the processing over a wide variety of objects (Narvaez et al. 2005, 968-969; see also: Anderson, Glassman, Chen, and Cole, 1995; Bargh et al. 1988; Higgins and Brendle 1995; Higgins et a. 1982).

In this initial study, which moral traits were chronically accessible from moral schemas used by the subjects to make decisions and judgments. The results from this study led researchers to conclude that there is some evidence of chronic accessibility of schemas which is stable over time. The next two experiments conducted by Narvaez et al. (2005), test moral chronicity from two opposing angles. The first experiment (Study 2), i.e., Spontaneous Trait Inference (STI), tests whether subjects have developed an accessible moral schema from which to draw inferences for cued recall and focused more on memory. Thus, in this experiment, the subjects

who were “moral chronics” were those expected to recall target sentences which included moral cues. In contrast, the second experiment (Study 3), i.e., Lexical Decision-Making Task, focused less on memory and more on interpretation. In this experiment, subjects were asked to evaluate the moral action of a character in the story. It was hypothesized that those with highly developed chronic moral schemas would have faster reaction times than those who were considered morally “non-chronic.”

### *Study 2: Spontaneous Trait Inference (STI) Paradigm*

The spontaneous trait inference paradigm assumes that the meaning of social events is constructed routinely, habitually and unintentionally (Uleman 1989). Spontaneous trait inferences (STIs) are said to occur when attending to another person’s behavior produces a trait inference without an explicit intention to infer traits or to form an impression (Uleman, Hon, Roman, and Moskowitz 1996; Uleman, Newman, and Moskowitz 1996). This is typically demonstrated using a cued-recall procedure. The typical design includes two conditions, a spontaneous processing condition and a deliberate processing condition. Chronically accessible traits were those that participants listed first in response to each question (Narvaez et al. 2005, 969-971).

Narvaez et al. compared moral chronics and non-chronics in how well they recalled sentences when prompted with dispositional and semantic cues, under two conditions. In the spontaneous processing condition, participants were instructed to memorize target sentences. In the deliberate processing condition, participants were instructed to memorize target sentences. In the deliberate processing condition, participants were instructed to form an impression of the characters in each of the sentence and to memorize the sentences. Narvaez et al. hypothesized that moral chronics (vs. non-chronics) would recall more target sentences when cued with moral dispositional cues than semantic cues, when told simply to memorize the target sentences (“spontaneous processing”). In contrast, they hypothesized that non-chronics would rely upon semantic cues to recall the sentences when told to simply memorize them. They did not expect to find recall differences between moral chronics and non-chronics in the deliberate processing condition (Narvaez et al., 2005, 974).

The results supported these expectations. Moral chronics, when instructed to memorize target sentences, appeared to form spontaneous trait inferences of characters featured in the sentences. Narvaez et al. showed that individuals also have more general constructs (“moral character”) chronically accessible, and that individual differences in the accessibility of the moral character construct influences information-processing (Narvaez et al. 2005, 974).



### *Study 3: Lexical Decision-Making Task*

In this study, Narvaez et al. attempted to assess the generality of moral chronicity and its influence on social information processing by using a text comprehension paradigm that is novel to this question. Text comprehension also depends critically upon schema activation, particularly in the form of elaborative inferences that readers generate from prior knowledge to make sense of the text (van den Broek 1989). General knowledge about the world is activated by readers to explain the focal event or to fill in a missing causal link to the focal event (e.g. Singer, Revlin, and Halldorson 1990; van den Broek 1990). Moreover, elaborative inferences are influenced by individual differences in background knowledge as indexed by culture and domain familiarity (e.g. Chiesi, Spilich, and Voss 1979; Harris, Lee, Hensley, and Schoen 1988; Singer 1994). Individual differences in moral development also influence the processing of moral stories and narratives. Narvaez (1998) showed, for example, that individual's prior moral knowledge greatly influenced the recall of moral narratives. Developmental differences in moral judgment schemas influenced what was remembered accurately and what was invented during the recall of moral narratives (Narvaez et al. 2005, 975-976; Narvaez 1998; Narvaez and Gleason 2007).

The stories were broken down into “help” stories and “no-help” stories, each approximately 400 words long. Both kinds of stories had characters that were on their way to fulfilling personal goals. In addition they provided “filler” stories which had nothing to do with the altruistic or egoistic perspectives of the first two kinds of stories (Narvaez et al. 2005, 976-977).

It was assumed that high moral chronics, that is, individuals for whom moral categories are chronically accessible, in comparison to non-chronics, would show faster reaction time to probes that reflect moral evaluations about the actions of story characters. It was anticipated that the chronic accessibility paradigm for studying personality coherence would demonstrate the dispositional qualities of moral information processing on an inference generation task during reading (Narvaez et al. 2005, 980).

The results showed that moral chronicity influenced the evaluative moral inferences that participants generated while reading. As expected, high moral chronics were equally fast in responding to the two types of probes, those that reflected positive judgments of character that helped and those that reflected negative judgments of a character that did not help, indicating that they activated expectations for helping while reading both types of target stories.

In contrast, non-chronics responded differentially to the two types of probes. Their reaction times to probes reflecting negative evaluations of characters that did not help were significantly slower than the chronics' reaction times, indicating that no generalized schema for helping was activated while reading the no-help stories. Alternatively, it would appear that non-chronics activated moral schemas only when story characters dropped personal goals and actively embraced the altruistic alternative; but otherwise did not notice the moral implications of not helping (Narvaez et al. 2005, 980).

These findings suggest that those who more frequently think of relationships with others in moral terms, high chronics, are as likely to make moral evaluations of people who help as of people who do not help when expected. High chronics activate moral schemas in a general fashion when judging other people's behavior, regardless of the outcome, suggesting that moral responsibility may be paramount to high moral chronics regardless of the situation (Narvaez et al. 2005, 980).

Moral rationality is part of this controlled processing. It is the "making of explicit choices for considered reasons" (Lapsley and Narvaez 2004). It is *declarative knowledge* and is *knowing why* rather than simply *knowing how* which is *procedural knowledge*. Both declarative

knowledge and procedural knowledge are necessary for moral performance. On the one hand, many of our responses to situations are highly automatized and unreflective. This is a result of procedural moral knowledge that has become implicit, procedural, scripted and automatic. On the other hand, many of our difficult moral decisions do require reflection or adherence to moral rules. These moral decisions are the result of declarative moral knowledge. Virtuous moral habits would be a result of this procedural moral knowledge that had become automatic through scripted behavioral sequences, self-regulation, chronic accessibility of knowledge structures and moral perception. These virtuous habits would be part of our *character* and would fall under the category of *knowing how*. Being conscious of moral rule systems and being able to articulate and reason about them, however, would be declarative moral knowledge. This aspect of our character might be more aptly considered *phronēsis* or practical wisdom and concerns *knowing why*.

CAPS system and Event Representations form the foundation of moral character. Through shared dialogues and the beginning of the development of a narrative identity, caregivers help individuals develop into moral novices. Caregivers guide moral novices in the development of moral schemas, which become chronically accessible, and aid in the appropriation of *genuine* moral desires. Soon, the moral novice appropriates and exhibits interdependent virtues in specific domains. Later, those specific domains expand to become larger domains. These virtues are considered interdependent because the novice still needs the moral support to exercise these virtues across situations. Interdependent virtues include virtues such as genuineness, trust, empathy, courage, compassion, and truthfulness. Moral chronicity begins when the novice starts to acquire both procedural moral knowledge – the right moral skills and know-how – and declarative moral knowledge – the right reasons and moral

motivations. Through the support of the caregiver, the moral novice will over time rely upon these accessible moral schemas and soon begin to exhibit a moral behavioral signature.

#### *5.2.5 The Limit of the Behavioral Signature: Development over Time*

There is a deficiency, however, which plagues all social-cognitive theories: *the longitudinality problem*. CAPS theory and other social cognitive theories address the mechanisms and consequences of social cognition from the perspective of adult functioning. As a result, they do not usually plot the developmental trajectory that makes adult forms of social cognition possible (Lapsley and Quintana 1985; Lapsley and Narvaez 2004). Tracking developmental features is important for moral character: the central assumption in Virtue Ethics is that one is not only virtuous for a limited amount of time such as six weeks, but rather that one is *virtuous throughout one's life*. Mischel and Shoda's behavioral signature has only been observed over a limited period of six weeks or less. Because of this, we will need to turn to a theory of development to track how moral chronicity is exhibited over a longer period of time. To do so, we will turn to Emmons' theory of life-long *personal striving* and how our personal strivings are shaped by moral schemas, moral practices and a pursuit of the good.

### **5.3 Pursuing the Good: Life-long Personal Strivings and Life Practices**

The moral novice begins to develop interdependent virtues and through guidance eventually develops independent virtues. The development of these virtues is connected to exercises which help us to achieve those goods internal to practices. A virtue is a good by which we define our interdependent relations with others who share the kinds of purposes and standards which guide those practices (MacIntyre 1984). Through these relationships we develop interdependent virtues

such as truthfulness, trust, and justice. Common virtuous practices may flourish in societies which have different moral codes. They flourish because the integrity of the practice depends upon those who partake in the activity. Thus, unfortunately, practices are likewise vulnerable to the corruption of institutions and those who are vicious. The transition from these interdependent virtues, which begin in the development of shared practices and shared dialogue, to independent virtues occurs with the expansion of a particular practice, or set of practices, into a *life-long personal striving*.

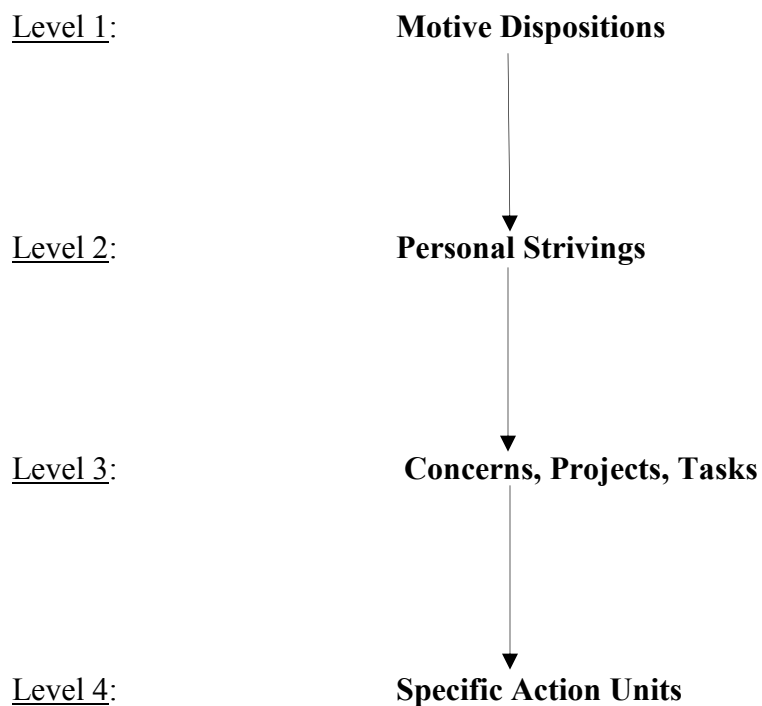
Emmons proposes that the Personal Strivings model of motivation can pick up where CAPS theory leaves off: sustained striving after personal goals throughout one's life. This model of personality motivation can offer broad *nomothetic motives* – which might be construed as virtues – while maintaining the particular individuality of a person's recurring, typical, goal-seeking behavior (Emmons 1989). A personal striving might be better characterized as a *life purpose* (Emmons 1989; Allport 1937).

### 5.3.1 *Personal Strivings*

The psychological approach to goals of *personal strivings* accounts for the recurring, characteristic goal-striving behavior of individuals. Personal strivings are unified patterns of goal strivings and articulate what the individual agent is *trying to do*. Personal striving must refer to a repeating, recurring goal.

Personal striving is a contemporary descendent of the psychological theory “teleonomic trends” study of personality developed by Floyd Allport in 1937. In this theory, Allport focused more on what individuals were *trying to do* as a structure for personality rather than personality as a matter of *acquiring traits*. Emmons' *personal strivings* model takes up this central piece

from Allport's theory. Personal strivings concern the motivations and goals that each person is trying to accomplish in different situations. The "personal striving" is a unifying concept that brings together goals, schemas, scripts, affects, cognitions and actions under a common quality or theme (Emmons 1989). Examples include "Do as many nice things as I can" or "Avoid maliciously gossiping about others." According to Emmons, personal strivings are situated between "global, diffuse motives" such as affiliation or intimacy and "concrete, specific actions" (Emmons 1989, 93). Thus, strivings are the link between an overarching *good* or ill and the action one performs. The four level Hierarchical Model of Motivation is as follows (1989, 93):



An example of this structure can be illustrated as the following. On Level 1, i.e., Motive Dispositions, an overarching motive might be Intimacy. On the level of Personal Striving, Level

2, the striving might be *Make Life Easier for My Parents*. This striving would fall into concerns, projects and tasks, Level 3, such as: (a) handle trauma by myself, (b) save money, and (c) get along with siblings. Finally, this striving would be executed as multiple actions on Level 4. From (a) handle traumas by myself, this might include: (1) find job on my own, (2) get car repaired, and (3) write in diary. For (b) save money might include: (1) open bank account, (2) drink cheap wine, and (3) wear old clothes. For (c) get along with siblings might include: (1) invite them over, (2) compliment them, and (3) call them.

Personal strivings are not restricted to the behavioral domain; rather, they may be cognitive, affective or behavioral (Emmons 1989, 94). These strivings can be identified as “enduring” rather than simply “current concerns” or only motivated by the situation at hand. According to Emmons, with a study done on 40 college students, 45% of these students maintained the same or similar personal strivings over a period of 18 months (Emmons 1989, 99). Personal strivings are not quite values which specify what one *ought to do*; instead, they designate what one *wants to do* (Emmons 1989, 96). This difference is important for virtue ethics because the virtuous person not only performs virtuous actions, but *desires the good* and *desires to perform the virtuous action*. Empirical studies on personal strivings for Striving Assessment Scales of 18 dimensions have stabilities of individual scales ranging from .58-.91 for the 1-month interval (with a mean of .73), and from .47 to .70 for the three month period (with a mean of .60) (Emmons 1989, 99). Although strivings are relatively stable, they can change over time and on account of life transitions or life changes such as an illness or “disabling injury.”

The first virtue that is most essential for the personal strivings model is the virtue of *genuineness*. This is because strivings which conflict with each other such as “to appear more intelligent than I am” and “to always present myself in an honest way” will have a harmful effect



on the subject. By contrast, moderated by the virtue of genuineness, two strivings which are helpful to each other might be “to help others when they are in trouble” and “to get to know others better.” Strivings such as these would be held by Hursthouse’s Good Samaritan. Strivings are thought to function in a similar way to schemas, scripts and other superordinate organizing structures and guiding principles (Emmons 1989, 101; Singer 1987). Virtuous strivings which are not in conflict with each other can lead to subjective well-being. Emmons has observed that subjective well-being is better understood “in terms of individuals’ perceptions of their idiosyncratic goal strivings rather than in terms of nomothetic traits” (Emmons 1989, 103).

Although strivings guide our concerns, projects, and tasks, which eventually lead to action, they do not necessarily include foresight into the consequences of our actions (Emmons 1989, 101; Gregory 1945). In addition, people may be unaware of the *maladaptive* or *vicious* foundation of some of their strivings. Thus, lack of foresight, maladaptive foundations, and even conflicting goals can lead to poor subjective well-being and interfere with an individual’s *flourishing*.

According to Emmons, in their empirical studies of personal strivings and subjective well-being, “individuals who experienced much negative affect and who were low in life satisfaction reported greater ambivalence over their strivings as well as greater conflict between their strivings” (1989, 104). What is meant by “conflict” is the following: *situations in which one’s striving is seen by the person as interfering with other strivings in the individual’s striving system*. Whereas, the second term, “ambivalence,” means specifically: *the person’s feeling that he or she has a desire to achieve and yet not achieve in the same striving*. Both of these tensions lead to psychological unhappiness and injury (Epstein 1982a; Pervin 1983). It is believed that chronic motivational conflict can even lead to lower physical well-being, such as in the case of

inhibited power motive syndrome (McClelland and Jemmott 1980; McClelland 1982; see Jemmott 1987). Specifically, in the study by Emmons and King (1988) of 88 individuals, it was found that conflict and ambivalence have been associated with neuroticism, depression, negative affect, and psychosomatic complaints. After removing neuroticism and depression, it still held that there was a relationship between a conflict in strivings and physical illness. Thus, both ambivalence and conflict between strivings can inhibit an individual's flourishing.

Emmons and King (1989) asked a further question: *what sorts of strivings are people ambivalent and conflicted over?* To their surprise, they found much correlation between "ambivalence" and the inhibition or curtailment of emotional expression, management or regulation. Examples these conflicted strivings include "keep jealousy under control," "express myself honestly," and "deal with anger constructively" (1989, 107).

The second virtue that is important for individual striving is the virtue of *integrity*. Emmons and King performed a further study with regard to the subject's well-being and the possibility of conflict, specifically with regard to emotional reactivity (1989). In this particular study, they focused on the relation of goal or strivings differentiation and affective reactivity. To recall, differentiation within an individual's goals system can either be complex or simple. For individuals who have complex goal systems, their systems usually maintain multiple independent personal strivings such as intimacy, achievement, and power, which do not overlap. For example, an individual may have the achievement goal of getting good grades in school, the intimacy goal of spending more time with grandma, and the power goal of being the president of a student club on campus. All three of these strivings are independent and thus indicate a complex goal system within this individual. By contrast, an individual may have a simple goal system which has overlapping, interdependent personal strivings such as intimacy/affiliation and

power/achievement. In this case, the individual may be “putting all his eggs in one basket.” An example of this simple goal system would be the individual whose strivings are goals such as writing a best-selling book (an achievement goal) in order to be popular (an affiliation goal) and recognized as famous or important (a power goal). These three strivings now overlap into one project: writing the book. What Emmons and King hypothesized was that there was a strong correlation between emotional affectivity and simple goal systems. That is, individuals who “put all their eggs in one basket” would experience greater emotional intensity in their striving and as a result would experience extreme elation if their projects were successful or extreme despair if they were not (1989, 110). *What Emmons and King found was the opposite* (1989, 111). It was actually those individuals who had complex goal systems with multiple unrelated and dissimilar strivings who experienced greater emotional affectivity. And their negative affect – despair, frustration, anger – was specifically associated *with having limited means available in their repertoire for achieving each striving*. Thus, complex goal-systems fall into the realm of emotion-provoking activities, which in turn can inhibit one’s ability to flourish if one lacks appropriate resources.

This unification of strivings through the virtue of integrity which overlaps with the virtue of genuineness to avoid striving after conflicting goals exhibits Aristotle’s unity of virtues. Personal striving accounts for a person’s apparently inconsistent behavior – as in the case of Hartshorne and May (1920) – bring the behavior patterns together under a *unifying theme* or *unity of virtue*. Emmons gives the following example to demonstrate this unity:

... [C]onsider a man who is aggressive, dominant, and competitive at work. At home, however, he is passive, submissive, and

cooperative. Merely counting behaviors is likely to paint a picture of a severely disheveled personality. Actually, his actions become increasingly lawful (McClelland 1981) if we consider what he is *trying to do*. Perhaps he has the striving “trying to be liked by others.” At work, he seeks the approval of his superiors and so acts competitively and aggressively. At home, he recognizes that those same actions are not going to produce the desired outcome, so his behavior is an abrupt about-face with his wife and children. What appears to be inconsistency at the surface level is lawful and understandable with recourse to the genotype (McClelland 1981). Thus, for people to be consistent with themselves, their behavior must often be inconsistent (Hogan 1983, makes a similar point), as the same striving will often lead to very different actions in different situations (1989, 113-114).

Personal strivings unify and provide a consistency of character which can be demonstrated across different situations such as the behavioral signature but it also provides unity to apparently inconsistent behavior patterns. Because personal strivings are individualized and idiographic, an individual’s strivings are unique to that individual. In addition, personal strivings indicate what a person is *trying to do*, but do not indicate successful action. A man may be trying to exercise the virtue of fidelity by being faithful to his spouse, but failing to *actually* do so. Furthermore, strivings are directed toward some value, whether it is good or ill (Lonergan 2003, 35). Finally, personal strivings should not be confused with skill sets. Because personal strivings are

motivational dispositions, they answer the question of *why* someone is acting virtuously, but they do not answer *how* one can do so successfully. Therefore, we must turn to *goal-automaticity* and *moral expertise* to answer how a moral novice eventually develops into a moral expert.

### 5.3.2 *Virtuous Habits and Automaticity*

The caregiver's role is to help direct the moral novice's desires and strivings toward what is good and to help develop interdependent virtues which can be executed according to moral schemas or scripts. These virtues begin to become *habits* through their *goal-dependent automaticity*. Much of human behavior is governed by automaticity, because many of our "cognitive processes are engaged unintentionally, involuntarily, with little or no expenditure of attention or cognitive resources, without effort, and outside of conscious awareness" (Narvaez et al. 2005, 144). Automaticity usually comes in three forms: (1) preconscious automaticity, (2) post-conscious automaticity, and (3) goal-dependent automaticity. The actions of a virtuous expert include moral automaticity in all three forms.

The first form, *preconscious automaticity*, concerns our (a) involuntary activation of social constructs such as moral schemas, scripts, or stereotypes, (b) pervasive moral interpretative influences over our social-information processing and as a result affects our social judgments, and (c) strong feelings of certainty or moral conviction regarding social judgments. An example of this kind of preconscious moral automaticity would be the case of a mother running into the road to save her child from being hit by oncoming traffic. By perceiving her child in danger, the mother would exhibit the virtue of courage and unreflectively run to get her child.

The second form, *post-conscious automaticity*, by contrast, operates after a recent conscious experience or use of intentional resources. In post-conscious automaticity, there is a reverberation effect or reciprocal influence at work. This effect “reverberates” from the one event to affect or activate other related social constructs, judgments, and affects. This occurs specifically by activating the mental representations an individual has in memory. An example of post-conscious automaticity would be a young man who learned to feel the virtue of compassion toward people who were sick in the hospital by taking repeated trips to visit his sick grandmother. This experience and local virtue begins to spill over into the young man’s goals and judgments about others who suffer. His choice to volunteer at children’s hospitals later in high school exhibits the *post-consciously automaticity* of this virtue of compassion.

The third form of automaticity is *goal-dependent*. A specific form of goal-dependent automaticity is *intended goal-dependent automaticity* and is “evident as a consequence of skilled or expert performance” (Bargh 1989; Narvaez and Lapsley 2005, 145). These behaviors are usually the result of repeated practice toward developing skills as well as procedural knowledge. An example of intended goal-dependent automaticity can be found in the particular case of abolitionist Harriet Tubman. Tubman dedicated years of her life to freeing fellow slaves through the Underground Railroad. To do this, her personal striving to be free became a life-long goal which expanded to include helping others to safety and freedom as well. Tubman exhibited virtues such as courage, justice, empathy and loyalty *automatically* as she pursued her goal.

These three forms of automaticity are important for ethics because the habits and virtuous actions of everyday life are integrated with the automaticity of everyday life. In the case of preconscious automaticity, the virtuous person has developed moral schemas which are always accessible when making moral decisions. As a result, habitual virtuous action developed over

many years could be understood as “automatic.” Post-conscious automaticity is important as well for our moral functioning. It would become apparent in its ability to prime the accessibility of the virtue-relevant social constructs, “which are made available to interpret, appraise, and evaluate social information long after the trait-term has left conscious awareness” (Narvaez et al. 2005, 146). In addition, “goal-dependent automaticity, the automaticity that attaches to scripts, routine action sequences, and highly skilled performance, is a source of integrative insights concerning moral conduct” (Narvaez et. al 2005, 147).

### *5.3.3 Goal-Dependent Automaticity and Expertise*

Moral goal-dependent automaticity has been developed by the virtuous expert. The virtuous person has chronic accessibility to moral schemas which is why he knows what right action to do at the right time in the right respect. The virtuous person as moral expert has developed a more complex understanding of the specific virtue-domain in terms of "conceptual associations, action skills, and conditional knowledge" (Narvaez et al. 2005, 150). Through practice and over time the moral novice progresses up the scale to moral expert by desiring the good and habituating automatic virtuous habits through moral practices.

According to Narvaez and Lapsley who draw on expertise literature in psychology, experts differ from novices in the three following ways:

1. Experts have a different set of representations (i.e., schemas) from which to draw knowledge: these are usually large organized networks of schemas which contain both procedural knowledge

(*how*) and declarative knowledge (*why*). Novices, by contrast, have a smaller and shallower organization of schemas and knowledge.

2. Experts "see the world differently" (Narvaez et al. 2005, 150).

Drawing from these developed schemas, experts perceive different affordances in situations and select specific information from situations which is important or relevant. Novices, on the other hand, simply become overwhelmed by information. The expert will quickly apprehend information which is relevant to the immediate goal.

3. Experts have a different set of skills. Experts draw on elaborate schemas and previous experience to define problems and then to solve them. The expert recalls problems solved in memory and then reflect on what knowledge to access, which procedures to apply, how to apply them, and when it is appropriate (Narvaez et al. 2005, 151). Novices, however, use simple heuristics and do not define the problem before they try to solve it.

According to Narvaez et al. (2005, 151), moral experts, "like experts of all kinds, can be expected to perceive and act upon the world in a markedly different way than do moral novices." For example, experts in "moral sensitivity are able to more easily pick up on the morally relevant affordances in the environment (e.g., What is my role in this situation? What should I do? What



am I capable of doing? What does the context allow?)” (ibid). Experts use goal-dependent automatic processing, which allows for faster decision making. Expertise allows for humans to routinize behaviors beneath consciousness. Narvaez et al. argue that this model of expertise can be adapted for the model of the moral expert, i.e., the virtuous person. Like the expert, the moral expert, or virtuous person, has developed different sets of moral schemas, they see the world differently concerning moral actions, and they have a different set of skills to make moral decisions and execute moral actions.

#### **5.4 The Moral Life Story: *The Moral Expertise of the Virtuous Person & Independent Virtues***

The virtuous person relies on the chronic accessibility of moral schemas for construing social events (Lapsley and Narvaez 2004). The virtuous person constructs a “moral self” which is unified around moral strivings and exhibits moral chronicity over time in pursuit of those moral goals. These moral categories which include goals, schemas, episodes, scripts and prototypes are an essential and important part of one’s self-identity and are chronically accessible for the virtuous person’s moral perception of the social landscape. Thus, features of situations would activate or trigger these schemas, affects, or goals and influence the interpretation of the events and action on behalf of the virtuous person.

The overarching unity to the virtuous person’s actions and desires is a moral narrative identity which has been guided by caregivers and moral teachers. As the moral novice develops the appropriate moral desires, schemas, strivings and automatic habits of interdependent virtues, the moral novice grows into a moral expert who exercises the virtues both interdependently and independently. To exercise virtues interdependently is to exercise virtues with others. An

example would be Harriet Tubman and the other people she worked with to help bring individuals to freedom and safety. Tubman and her team exhibited interdependent courage: they braved death to bring others to justice. Independent virtues, by contrast, are exhibited alone, or nearly alone, by the moral agent. These actions are more challenging, require stronger desires and commitment to what is good, and involve more risk. An example of independent virtue can be found in the case of moral exemplar Mother Teresa who committed her life to caring for and loving the poor in India (Matsuba and Walker 2005, 276). The moral expert construes her life practices as part of her life story which is carried out in an overarching moral tradition. Animated by moral strivings, the virtuous person as moral expert is both future-oriented toward committing interdependent and independent virtuous actions and draws from automatic habits and schemas developed by her past practices. Her identity is animated by her life story and by the virtuous imago or image of who she strives to be. Her life story is co-authored with others who influence her and shape her moral perception throughout life within her moral tradition.

It at this point that I have given an empirically grounded account of Aristotelian virtue ethics which enables people with disabilities to flourish. The right thing to do is what the *virtuous person as moral expert* would do in the circumstances. The virtuous person is one who has and exercises the virtues. The virtues and vices are to be understood as a subset of CAPS traits which are developed through the activation of event representations and connected to a personal narrative by the aid of a caregiver. At this point the virtues are interdependent. This is in development of a virtuous narrative identity which is co-authored as in the case of Sesha who has profound cognitive impairment<sup>24</sup> and in the case of Temple Grandin who has higher functioning

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<sup>24</sup> Kittay (2005) describes Sesha's enjoyment of Beethoven and her excitement about listening to the music. Also, H. Young et al. (2011) use multi-sensory storytelling of life transitions for adolescents with profound intellectual disabilities to help the adolescents understand their own bodily changes. These narratives about the adolescents'

“Autism.” But this virtuous narrative identity is also maintained by caregivers in the case of the patient with Alzheimer’s disease who is slowly losing her memories and identity. In this case, the role of caregiver is to “hold” her in her identity and help the patient be interdependently virtuous. The caregiver initiates and cultivates a desire for the good in the individual and constructs moral schemas and scripts that become chronically accessible for the moral novice over time. After much practice, the moral novice pursues his moral strivings which provide a sense of unity to his virtues and a sense of coherence to his character. The moral novice is directed by the imago of his virtuous self which animates his desire to become a moral expert and to develop his interdependent virtues into independent virtues. Thus, this *life-story model of moral expertise* enables individuals to flourish throughout life.

This model meets the two challenges facing Snow’s model: *the longitudinality problem* and *the exclusivity problem*. The longitudinality problem states that the difficulty facing Social-Cognitive theories of personality such as CAPS theory do not warrant conclusions over one’s life course because they use only a *situation-specific* method and not a *time-specific* method. Thus, the only conclusions that can be drawn about character from CAPS alone are of a short time period such as six weeks. The *life-story model*, by contrast, meets the demands posed by the longitudinality problem in two respects. First, it appeals to Emmons model of *personal strivings* which have been measured and sustained over a period of eighteen months, which is longer than Mischel and Shoda’s behavioral signature of six weeks. Second, Emmons model of *personal strivings* is compatible with and part of the overarching *life-narrative* model by McAdams. This *life-narrative* model is by definition a *longitudinal* model. Thus, the personal strivings model bridges the gap between the *situation-specific* social-cognitive model of CAPS theory and the

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identities were co-authored with their parents and caregivers. The narratives were told repeatedly as the adolescents reacted and understood and gained knowledge of their own bodily transitions in life in such cases as puberty.

*time-specific* developmental model of the Life Narrative approach to personality theory. The *life-story model* includes a construction of the longitudinal sequence of measures which explain long-term change and consistency. This model also utilizes an organizing principle of a life-long moral goal to simplify and unify this coherence over time through the form of a narrative identity.

The *life-story model* meets the challenges of the exclusivity problem as well. The exclusivity problem states that the difficulty facing Snow's choice of virtue as social intelligence is that social intelligence necessarily excludes moral exemplars like Helen Keller, Harriet Tubman and Temple Grandin who have disabilities within society. Snow's model is empirically problematic because this exclusion designates people like Grandin as a "moral zero." The life-story model, by contrast, meets the challenge of the exclusivity problem head on. It accounts for the virtuous development of people with disabilities in two ways. First, the virtuous person is not the socially intelligent person. Instead, the virtuous person begins as a moral novice and over time through practice can become a moral expert. This is a scalar model rather than a binary one. Moral novices can be found anywhere along the scale of moral progression (or regression). Second, moral novices begin by developing interdependent virtues and these virtues can grow from being local into global virtues which can eventually become independently exercised by the moral expert. The foundational interdependent virtue is the virtue of *genuineness*. Although Grandin may need help understanding social situations, she is independently virtuous in her dedication to reduce animal suffering and to help other people along the Autism Spectrum flourish within society.

In conclusion, the life story model of an empirically grounded Aristotelian virtue ethics is sufficient to enable individuals to flourish throughout life regardless of biological impairments.

The task that remains for this model is its execution: *how do we enable and educate moral experts within a society?* This question will be addressed by turning to the need for virtue-oriented politics in the final section.

## VI.

### *The Virtue-Oriented Politics of Interdependence*

*Respondeo dicendum quod, secundum philosophum,  
en VIII Ethic., non quilibet amor habet rationem amicitiae,  
sed amor qui est cum benevolentia,  
quando scilicet sic amamus aliquem ut ei bonum velimus.*

I answer that, according to the Philosopher in Ethics VIII,  
not every love has the character of friendship  
but love which is with benevolence  
when, to wit, we love someone so as to wish good to him  
(Aquinas, *Summa Theologiae, Secunda Secunda Partis, Q. 23, A. 1*).

#### **6.0 The Need to Extend the Five Faces of Oppression to Disability**

Iris Marion Young's "Five Faces of Oppression" has become a staple in contemporary social and political philosophy. In her essay, she articulates and extends a Marxian account of oppression to include not only the exploitation facing women and racial minorities, but also to address four additional forms of oppression: marginalization, powerlessness, cultural imperialism, and violence. The purpose of the present chapter is not to question what Young has succeeded in articulating, but instead to add three new faces to her account and discuss the need for a Virtue-Oriented Politics.

I am motivated to interrogate Young's "Five Faces" because it does not seem to me that the problems facing people with disabilities are adequately addressed in what she argues in her essay. Because the spectrum of disability is so vast, ranging from physical impairment to cognitive disability, from impairments due to age to psychological illness and trauma, some "faces" of systemic oppression that people with disabilities face find no voice in Young's work.

In particular, it seems to me that there are three such forms, though one of them at least is experienced by other oppressed groups such as racial minorities and non-heterosexuals as well. The first of these faces is Stigma, which concerns an “undesired difference.” Persons with disabilities are *stigmatized* within a society. Stigma disvalues people with disabilities and does not grant them societal recognition, or if it does, it mis-recognizes them through stereotypes and poor representation. One example of this stigmatization is the medical gaze, which, though trained to aid people, often slides into viewing the “disabled” body as a body “with broken parts.” A second face of oppression is Questioned Personhood. Currently, people with disabilities face educational and other forms of institutional oppression which questions their status as persons at biological and psychological levels. For people with cognitive disability, for example, their personhood has come under scrutiny and has included a history of abuse and human experimentation. It is still not uncommon to find people, even academic philosophers, who routinely compare such people with non-human animals, such as chimpanzees, dolphins, or household dogs, thereby intentionally stripping these people of human dignity and any human rights that might serve to protect them. Lastly, the third form is Societal Incapacity. This form of oppression concerns the social and environmental factors which give advantages to people with “able” bodies such as constructing buildings in which the only fire exits are via a stairwell. This form does not ensure capacities for all of its citizens within a given society, and thus systemically oppresses those the society has disregarded.

My hope is that these three new faces oppressing people with disabilities, namely Stigma, Questioned Personhood, and Societal Incapacity, strike one, at least intuitively, as serious and as deserving of more careful social reflection. I elaborate on them below. In the argument that follows, I need to demonstrate two points: first, that these three new faces are not accounted for

with Young's framework, and second that they are in fact forms of oppression and not merely discriminatory incidents. The latter task requires that I demonstrate that each of these three new faces has systemic implications, while the former requires that I show how they slip through Young's existing framework. In what follows I begin with a more careful review of Young in order to assess to what extent each of her forms of oppression is capable of addressing these particular faces of oppression. Afterward, I turn to a more detailed account of these three new faces in order to show that they are in fact forms of oppression. It is my hope that by identifying these forms new methods and plans of action can be developed for countering the particular forms of oppression which persons with disabilities face. In the final section, I offer a brief proposal of a virtue-oriented politics which could begin to counter these forms of oppression facing people with disabilities.

### **6.1 The Five Faces of Oppression**

In order to address Young's five faces of oppression adequately, I first treat each of them separately and then consider them as overlapping forms of oppression. In "The Five Faces of Oppression" Young reconsiders the term "oppression" in its systemic and structural forms rather than as the violence and injustice some people suffer because a tyrannical power "intends to keep them down" (1990, 40-41). Her account of the five faces illuminates how oppression makes up much of our social experience. Furthermore, she argues that oppression is a systemic and structural problem latent within the major economic, political and cultural institutions but is not simply reducible to institutions themselves.

A second point of conceptual clarification distinguishes oppression from discrimination. The concept "discrimination" refers to the "conscious actions and policies by which members of



a group are excluded from institutions or confined to inferior positions” (1990, 40-41). Oppression differs because it exists in absence of overt discrimination. Young expands on the definition of oppression as follows:

[t]he concept [of oppression] names the vast and deep injustices some groups suffer as a consequence of frequently unconscious assumptions and reactions of well-meaning people in ordinary interactions, media and cultural stereotypes, and structural features of bureaucratic hierarchy and market mechanisms, in short, the normal ongoing processes of everyday life (1990, 41).

Oppression differs from discrimination because it concerns the often invisible barriers which immobilize a particular group of people. It is either structural or systemic and thus does not require that there is a correlated “oppressing” group for any specific group suffering oppression. Instead, for every oppressed group there is a corresponding *privileged* group within society.

With these conceptual distinctions in mind, I turn to the specific forms of oppression themselves. The first form Young describes is *exploitation*. Young draws here from Marx’s theory of exploitation and then expands it to address issues of race and gender. The Marxian theory of exploitation answers the paradox of capitalism: “when everyone is formally free, how can there be class domination? Why does there continue to be class distinction between the wealthy, who own the means of production, and the mass of people, who work for them?” (1990, 48). Capitalism systematically transfers the powers of the laborer to augment the power of the one who owns the means of production. Thus, the capitalist is able to maintain an “extractive

power,” which allows for the continual extraction of benefits from workers. This extractive power extends beyond the transfer of power: it also deprives workers of their sense of control and self-respect. It can also accumulate passively for the capitalist, so that he may not even be aware that he is the beneficiary of such oppression.

A similar kind of transfer of power may be seen to occur with respect to gender and race as well. In the case of gender, according to Young, there is a systematic transfer of powers from women to men. This systematic transfer takes place on two planes: (1) in the transfer of nurturing and sexual energies to men and (2) in the transfer of powers in domestic labor as a form of capitalist exploitation. Young writes:

As a class, however, women undergo specific forms of gender exploitation – ways the energies and power of women are expended, often unnoticed and unacknowledged, usually to benefit men by releasing them for more important and creative work, enhancing their status or the environment around them, or providing men with sexual or emotive service (1990, 51).

Likewise, a similar systematic transfer of powers occurs for race from non-whites to whites. One might recall, for example, how in the United States there is an imbalance of power for private household services and “menial” labor. These laborers are usually servants for business executives, government officials, and other high status professionals. Young notes: “[i]n our society there remains strong cultural pressure to fill servant jobs – like bell hop, porter, chamber maid, bus boy, and so on – with [B]lack and Latino workers” (1990, 52).

I believe this form of analysis does, in some respects, speak to the concerns of people with disabilities. Specifically, it seems to me that race, gender, and class exploitation intersect with the case of the dependency worker, or professional caregiver, for a person with a disability or (even) illness. The majority of care workers within the United States are women, and many of those women are of certain ethnic or racial minorities. These workers, specifically in the field of healthcare, experience systemic exploitation. While they experience a transfer in power from their skill sets to those who employ them, they are often little remunerated and little respected. Much of their work goes “unseen” and unappreciated within society: they are usually paid little, work long and exhausting hours, and take care of those with profound physical or psychological needs (Young, 2002, 41-42).

Even granted this analysis, it does not seem to me that exploitation adequately addresses Stigma, Questioned Personhood, or Societal Incapacity. None of these difficulties concern the systematic transfer of value or power from one group to another, which is the hallmark of exploitation. While Young’s account targets certain people with disabilities who are employed by the labor market, and as a result, are exploited, exploitation is not the only face of oppression these people experience. Certain people with disabilities may also experience societal incapacity and struggle to maneuver around their work space due to a building that has limited wheelchair accessibility. Likewise, they may experience stigmatization and exclusion from their work associates because of this lack of motility such as being excluded from being on teams for company softball games.

Young’s second face of oppression is *marginalization*. The “marginals” in society differ from those who are exploited, because marginals are the people the labor market does not employ. Many of those who are included in this group are certain racial minorities, elderly

people, and people with disabilities (Young, 2000, 169). A large proportion of the United States population are marginals. Often these include: those who have been laid off from work and are struggling to regain employment, young people and people of color who cannot find first or second jobs, many single mothers with children, people with cognitive or physical disabilities, and Native Americans who live on reservations. Young describes the oppression they experience:

Because they are dependent on bureaucratic institutions for support or services, old people, poor people, and mentally or physically disabled people are subject to patronizing, punitive, demeaning, and arbitrary treatment by the policies and people associated with welfare bureaucracies (1990, 54).

The forms of oppression which occur come both from the social service providers who enforce rules with which these “dependents” must comply and from medical and social service providers who insist on having a right to claim they know what is best for these dependents. Thus, part of this systemic oppression includes the suspension of rights to privacy, respect, and individual choice.

Here again, while I find Young’s articulation of this kind of oppression insightful, neither stigmatization, nor the questioning of personhood, nor even societal incapacity concern the labor market directly. Such that concern with the labor market is constitutive of marginalization, I do not think marginalization is able to address these three specific difficulties facing persons with disabilities. In the specific case of people with cognitive disability such as mental “retardation”

or dementia, these people would not only experience the oppression of marginalization from the labor force, but also the oppression of questioned personhood as well. Because they are viewed as “dependents” by the state they experience marginalization, but because they differ in psychological ability, their human dignity and moral status are questioned and discounted by various members of that state.

The third face of oppression Young articulates is *powerlessness*. This form of oppression can be witnessed in the social division of labor between the “middle class” and “working class” or professionals and non-professionals. This form of oppression concerns *status* rather than class. As Young says, “[b]eing a professional entails occupying a status position that non-professionals lack, creating a condition of oppression that non-professionals suffer” (1990, 56). Powerlessness describes the lack of work autonomy that non-professionals experience: they have little opportunity to exercise creativity or judgment in their work, have little technical experience or authority, express themselves “awkwardly,” and “do not command respect” (1990, 56).

Powerlessness appears to address at least two of the new faces of oppression I am seeking to articulate. Questioned Personhood certainly looks like another sort of oppression, but perhaps Stigma could be construed as a kind of powerlessness. Some people with disabilities, depending on the impairment, do express themselves with difficulty. Yet, at the heart of the concept of powerlessness for Young, one finds that it stems from the advantages gained by people with professional class status. Powerlessness is, for her, clearly linked to class, and stigma is not. Even professionals with disabilities suffer from stigma. People with disabilities suffer a stigma which is similar to the stigma a Black person experiences with “Black Exceptionalism”: no matter how much wealth this person has acquired and how much status he or she has achieved, he or she will always be “marked” or “branded” by his or her color. Societal Incapacity is also

unaddressed by powerlessness, since this difficulty is not a class difficulty. Lacking wheelchair access is something that faces professionals and the working class alike, even if a member of the professional class may be able to afford a motorized wheelchair while a member of the working class may not.

The fourth face of oppression is *cultural imperialism*.<sup>25</sup> While the first three forms operate according to power structures, this fourth form concerns both power and recognition. In cultural imperialism, one dominant perspective renders another perspective as Other and often as of less worth, as occurs, for example by stereotyping. At its heart, cultural imperialism “consists in the universalization of one group’s experience and culture, and its establishment as the norm” (1990, 59). Not cognizant of what they are doing, the members of the dominant group project their own experiences as representative of humanity as such. The result is that victims of cultural imperialism are paradoxically only recognized as stereotypes and at the same time treated as invisible. According to Young, “[t]hose living under cultural imperialism find themselves defined from the outside, positioned, and placed by a system of dominant meanings they experience as arising from elsewhere, from those with whom they do not identify, and who do not identify with them” (1990, 59).

This consciousness is double because the oppressed desires recognition within her society but is only stereotyped and marked as different or inferior. In response, this group tries to express itself as a subculture. One’s consciousness is double because one finds oneself defined by two cultures – a dominant one and a subordinate one. Thus, this is the injustice of cultural imperialism: “that the oppressed group’s experience and interpretation of social life finds no expression that touches the dominant culture, while that same culture imposes on the opposed

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<sup>25</sup> See also Kearney (2007) and Kristeva (1991) for similar accounts which develop this ostracism and rejection of the other on communal and cultural levels.

group its experience and interpretation of social life” (Young, 1990, 60). An example of cultural imperialism is witnessed in the oppression of Deaf culture as in the case of Gallaudet University discussed in Chapter Two. Deafness, unlike other forms of disability, is not considered an impairment by those who are deaf. Instead, it is considered its own culture or subculture within American society and has its own language, American Sign Language (Dolnick, 1993). Yet, this culture is almost always silenced, ignored or unrecognized by a hearing community, which dominates the United States (or any other country).

While cultural imperialism is a face of oppression which affects people with disabilities, it does not oppress people with disabilities in the same way as Stigma, Questioned Personhood, and Societal Incapacity. For example, unlike Deaf culture, which is its own oppressed culture, people who suffer from terminal illnesses are not a culture. They form support groups and try to educate the public, but it is not a culture or subculture.<sup>26</sup> People who are deaf have loudly proclaimed that they do not want to be “cured.” In contrast, most of those with a terminal illness desire to be cured or to have relief from painful physical, emotional or mental suffering. A prime example is a patient with Alzheimer’s disease. The patient with Alzheimer’s disease experiences tragedy not only alone, but with those who love her. A daughter may come home from work to find that her mother has “gone out for a walk” and gotten lost, unable to remember how to find her way home. Alzheimer’s Patients may not recognize their own danger: they may wander out into oncoming traffic, become lost in wooded areas or start fires. These dangers for loved ones can cause terror for family members and caregivers who worry about their safety.

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<sup>26</sup> Young herself describes the discrimination that people with disabilities face as sometimes being a form of cultural oppression in “Social Movements and the Politics of Difference” on page 175 but then at other times in that essay describes those with disabilities as “unhealthy” and thus different from “normal” pregnant women. Likewise, for the status of work, she argues that “[t]he variability of condition of people with disabilities is huge, however, and many of those brought together under this label have nothing at all in common in the way of experience, culture, or identity.” (“Disability and the Definition of Work,” p. 171). Thus, Young’s concern for those with disabilities moves beyond the idea of one culture oppressing another.

Researchers from the School of Nursing and Midwifery at Trinity College Dublin have identified the various forms of Stigma, Questioned Personhood and Societal Incapacity facing those with Alzheimer's. According to Mary McCarron, the principle investigator, the challenges facing those with this disease include "social isolation, fragmented, unsuitable and poorly-resourced services, lack of information about the services available and the difficulty navigating a complex health and social care system in which services are often unresponsive to the real needs of people with dementia and their carers" (Hunter, 2012). The patient with Alzheimer's experiences *Stigma* both from the public and from the healthcare system. In the public eye, patients with this disease are viewed in terms of negative images, stereotypes and fear. As a result, many individuals shun or are reluctant to engage patients with Alzheimer's. This stigmatization leads to further social isolation for those individuals suffering from the disease. Furthermore, from the healthcare system, patients with Alzheimer's experience stigmatization in terms of policy and resource allocation: in most cases, their illness is not viewed as a priority for care. This stigma reverberates into the life of family members and caregivers who may experience anger, hurt, frustration, and shame when others witness difficult or "inappropriate" behavior in public and they may feel guilt for being unable to meet a "perceived societal expectation to continue caring on an indefinite basis" (ibid.).

In addition to Stigma, a patient with Alzheimer's may experience *Societal Incapacity*. The individual with this disease experiences Societal Incapacity in three ways. First, she may experience a "loss of place" insofar as she encounters enforced isolation from being placed in certain living facilities and enforced social isolation due to a withdrawal of friends and family. Carers and loved ones describe themselves as being at risk for something similar because they are forced to redefine their life spaces and develop new roles (ibid.). Second, she may encounter



institutional barriers when trying to “navigate the system” in healthcare. Oftentimes these services are found to be “fragmented, inadequate and inflexible and [have] failed to offer choice or meet their needs” (ibid.). Third, she may encounter “unsafe environments” which include environments unsuitable for her needs or dangerous for her. Caregivers also must worry about their loved one being subject to critical or hostile gazes from others in public places.

Finally, a patient with Alzheimer’s may also endure *Questioned Personhood*. Her personhood status is questioned first by her society because she is deemed a “dependent,” and with this designation, she loses certain rights she once had. She may also experience ageism and discrimination from a healthcare worker’s patronizing actions (ibid.). Many times those with Alzheimer’s are not treated with the loving care and respect that they deserve; instead, some have been referred to as “burdens” on family and society or interpersonally treated as children rather than adults.

Thus, while cultural imperialism does illuminate some facets of the oppression facing those with disabilities, it does not illuminate the three forms currently under consideration. The stigmatized are not uniformly a culture, and neither are those who have their personhood questioned or suffer from societal incapacity. McCarron et al. have found that conceptualizing dementia in terms of disability has generated positive steps to advance measures to counteract these forms of oppression facing loved ones (ibid.).

The final face of oppression is systemic and legitimate *violence*. In this case, the oppressed group knows that they must fear violent, unprovoked attacks at random to their persons and property with the motive to “damage, humiliate, or destroy a person” (Young, 1990, 62). An example of this would be that any woman, because she is a member of the group

“women,” has a reason to fear rape. In the particular case of disability, “disabled women are raped and abused at a rate more than twice that of nondisabled women” (Davis, 2000, 332). People with disabilities are targets for such violence both in public places and in private institutions or group homes. Often, people with disabilities and deaf people are targets for verbal, physical and sexual abuse. In general, much of this kind of violence surfaces in the form of hate crimes, hate speech or psychological violence and often goes unpunished within a society.

This violence and marginalization may be the result of stigma in some cases, but I think it is clear that the systematically legitimated forms of violence are one matter, while stigma is another. A similar point holds for Questioned Personhood. While this practice does legitimate violence against people with disabilities, violence itself is a different matter than the act of stripping human dignity from a segment of the population for legal, political or ethical purposes. Finally, Societal Incapacity does not appear to be addressed in any direct fashion by violence. While a person may experience any one of Young’s faces individually, it is more likely that he or she will experience them in an overlapping effect. Furthermore, it is possible that this person could experience these three new faces in addition to Young’s overlapping framework as further dimensions of oppression. The overlapping of these forms becomes apparent in numerous cases.

For example, consider the case of a gay Black man who lives in a conservative Christian area in the South. In this area, he may struggle to find work and be marginalized because of the racist and homophobic culture in which he lives. Because of this, he may experience a sense of powerlessness for being in a lower economic class than a Christian white heterosexual male lawyer. He may also experience Cultural Imperialism because of an overwhelming Christian homophobia which may force him to hide or silence his homosexuality: he may not be able to hold hands with his lover in public for fear of being chased out of town. This fear is linked to the

violence he may experience or anticipate for being in an oppressive cultural area. But he also experiences one of the three new faces as well: Stigma. Here, his stigma is double because of racism and homophobia. This stigma, because of the “branding” and negative values it attaches to his body, i.e., his sexual orientation and the color of his skin, may lead to marginalization and violence.

In another example, these three new faces overlap with some of Young’s faces with the case of a woman diagnosed with a “disorder” along the “Autism Spectrum.” Because she may not be able to speak with ease and jerk her hands or bang her head in frustration, she experiences Stigma in her society because her body is not an “able” body. This stigma may lead to marginalization insofar as she is denied work because she may “scare” customers. Within the United States, it is documented that workers with “Autism” have a combined unemployment and underemployment rate of around 90 percent and only 56 percent in a study done in 2011 have graduated high school (Wilkie, 2012). As a result she experiences powerlessness because she is dependent upon government programs and considered a “mooch” by a professional class. But she may also experience Questioned Personhood: due to her “poor ability to express herself” and difficulty taking exams, she may be diagnosed with “mental retardation” (sic). If she is diagnosed as a “dependent” by the state, then she is denied certain rights but also her biological and psychological abilities are used as a way to deny her life intrinsic and equal worth with others within her society. Finally, she may experience societal incapacity in the educational system because she cannot speak “well” or sit still for long periods of time and as a result her education must be taught within the home or by specialists.

The result of the foregoing, then, is that Young’s account looks as though it needs to be augmented to address the concerns of people with disabilities. Still, one could argue that it may

be the case that Young's account does not address these concerns because they are discriminatory rather than oppressive matters. It is in order to address this concern, then, that I turn to elaborate just what is at stake in Stigma, Questioned Personhood, and Societal Incapacity.

## **6.2 Disability and Oppression**

In her analysis, Young articulates oppressive structures which operate according to power (the first three), recognition (the fourth) and violence (the fifth). My hope here is to bring three new faces of oppression to light which are not present in Young's account. These three new forms of oppression operate according to a "social framing" of the *able-body* as a site of privilege. In order to make my case I shall draw rather freely from some of the existing narrative literature on disability.

### *6.2.1 Disability's 1<sup>st</sup> Face: Stigma and the "Broken Part" Narrative*

The first form of oppression that occurs for people with disabilities is the phenomenon of *stigma*. In his work *Stigma*, Erving Goffman describes how the word "stigma" originates from the Greek practice of branding or marking slaves and criminals as well as from the wounds of saints in Christianity (1963, 1-2) Stigma, according to Goffman, marks "different" physical or behavioral traits and devalues those traits. Thus, to stigmatize someone is to mark that person as different, abnormal or deviant and assign negative values to their "difference."

Wolf Wolfensberger, in his Social Role Valorization theory, discusses a similar account of stigma for people with disabilities and who are in vulnerable positions in society. Throughout history, there has been the symbolic stigmatizing of roles and attached to this stigmatization are messages conveyed which devalue a person and reinforce certain perceptions or stereotypes

about them. With this stigmatization, people with disabilities were cast into negative roles such as “wastes” or “rubbish,” “objects of pity,” “burdens of charity,” or “non-human” (Race, Boxall, and Carson 2005, 510).

What can be noted in both Goffman and Wolfensberger’s accounts about stigma is its double function: it both designates or brands a person as *abnormal* and simultaneously *devalues* that person. What stigma assumes is the social framing of the “healthy” body as normal and thus renders all other different bodies as *bad*.<sup>27</sup> According to Goffman, there are three types of physical or behavioral characteristics which can be stigmatized: (1) physical disability, (2) individual behaviors such as addiction or certain sexual habits, and (3) race, religion, ethnicity or gender. What stigma thus accomplishes is a move from the particular focus and oppression on the individual body, to an oppressive “social framing” of *the body*. This kind of oppression can also be found in the “white racial framing” of the body found in Joe Feagin’s work *The White Racial Frame*. Oppressive framing of the body includes a “general worldview, oppressive ideas, terms, images, emotions and interpretations” (Feagin 2010, 3). The oppressive social frame of the body for people with disabilities is most evident in the *medical gaze*.

The medical gaze occurs between the medical practitioner and her patient. In this relation, the social framing of the body is assumed and that social frame is that the body should be a “healthy” or “finely operating” machine. Thus, any part of the body that does not align with this frame is deemed “unhealthy” or in “need of repair.” As a result, the doctor is the only one who can “repair” or “fix” this body made up of “broken parts.”

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<sup>27</sup> Young herself uses Stigma to describe one of the challenges people with disabilities face, but for her it operates according to discrimination rather than oppression. She has in mind Martha Minow’s “dilemma of difference” concerning the discrimination people with disabilities face in the workplace (see “Disability and the Definition of Work,” pp. 169-70). I disagree, however, and believe that stigma forms a more over-arching frame of oppression.

In her work *The Rejected Body*, Susan Wendell describes her personal experience of living with Chronic Fatigue Syndrome and argues that this medical social framing is a form of able-bodied prejudice and oppression. She extends this criticism to other examples of illness and impairments. In particular, she cites the case of a deaf child born to hearing parents. Viewed from either the medical practitioner's or hearing community's point of view, the deaf child "suffers" from disability because of her inability to hear. Thus, everyone focuses his or her efforts in order to "normalize" the child. Yet, from another and equally warranted point of view, "the same child is [impaired] by hearing people's (often including her parents') ignorance of Sign. In a Deaf, signing community, she is already normal, assuming that she has signing ability appropriate for her age" (1996, 29).

What we recognize from Wendell's description is that the stigmatization of the "disabled" body is to view it as a body with "broken parts." This is the perception of *able-bodied privilege*. What stigma obscures from view is that to live one's life as *dis-abled* whether with an impairment or illness is to have a shift in identity. It is to have an identity which is both unrecognized and misrepresented within society. What the medical gaze of the practitioner projects onto people with disabilities is a social narrative – a social construction – that the "disabled" body is a body that has "broken down" or has "broken parts" which need to be fixed and need to be made whole again. It is this socially constructed "broken part narrative" that undergirds the stigmatization from able-bodied privilege.

The goal, then, from the perspective of the medical practitioner and the able-bodied community is to "cure" or return to normalcy these unruly bodies. One becomes a "hero" if one can overcome the broken part. As a result, the narratives which are recognized within society are the narratives of those who have overcome their "broken parts" rather than recognizing those

who live as different. Joseph P. Shapiro in his work *No Pity*, describes this narrative of a “hero” overcoming a “broken part”:

Nondisabled Americans do not understand disabled ones. That was clear at the memorial service for Timothy Cook, when longtime friends got up to pay him heartfelt tribute. “”He never seemed disabled to me,” said one. “He was the least disabled person I ever met,” pronounced another. It was the highest praise these nondisabled friends could think to give a disabled attorney who, at thirty-eight years old, had won landmark disability rights cases, including one to force public transit systems to equip their buses with wheelchair lifts. But more than a few heads in the crowded chapel bowed with an uneasy embarrassment at the supposed compliment. It was as if someone had tried to compliment a black man by saying, “You’re the least [B]lack person I ever met,” as false as telling a Jew, “I never think of you as Jewish,” as clumsy as seeking to flatter a woman with “You don’t act like a woman” (1994, 3-4).

The aim of people with disabilities is not to be pitied but to be validated and recognized. The narrative of able-bodied privilege which affects the “disabled body” is that the body is a body with “broken parts” that must be fixed, corrected, overcome, or returned to normalcy.

Because being able-bodied is valued as *good* within society, people with disabilities are stigmatized for having “bad” bodies. This form of stigma functions differently from normal practices of group solidarity insofar as these “broken” bodies are collectively devalued, and as a result, oppressed. According to Rosemarie Garland-Thomson, in her work *Extraordinary Bodies*, “[s]tigma creates a shared, socially maintained and determined conception of the normal individual, sculpted by a social group attempting to define its own character and boundaries” (1997, 31). Stigma, then, is paramount for the construction of normalcy within a given society: whatever is not “normal” is thus marked as inferior, unwanted, abnormal, or deviant. Marked or branded as *bodies with broken parts*, individual people with disabilities suffer a form of systemic oppression because they do not “conform” to an able-bodied society’s social construction of normality. Thus, stigma of unruly bodies leads to violence, social stereotypes and lack of recognition. It is systemic because it is latent within the practice of a whole culture, is part of our social imaginary, and is even institutionalized in our medicine.

### 6.2.2 Disability’s 2<sup>nd</sup> Face: Questioned Personhood

While people with disabilities are stigmatized within society, those who have a form of cognitive disability face another form of oppression: *questioned personhood*. Some philosophers have called into question the “equal value and dignity of all human life.”<sup>28</sup> Their aim is to reconstruct our concept of “personhood,” and with that human dignity, to provide a graduated form of moral status to humans and nonhuman animals. Although on the surface this seems like a noble attempt to recognize the dignity of certain species of nonhuman animals, it relies on a systemic form of oppression: namely, that those who are cognitively impaired should not qualify as “persons.”

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<sup>28</sup> See Singer, (2010) and McMahan, (2002). For a philosophical response to Singer and McMahan, see Kittay, (2005) and Kittay, (2010).



The implications of questioning, or disqualifying, those with cognitive disability from the status of personhood are frightening.

Peter Singer, in his essay “Speciesism and Moral Status,” compares the various skill sets of animals, like the great ape Koko who have basic language skills and score between 70-95 on the IQ test with people who have severe or profound mental “retardation” (sic) or severe dementia. His comparison draws from capacities listed with the American Association on Intellectual and Developmental Disabilities: (1) Intellectual Quotient (IQ), (2) the need for supervision, (3) capacity for speech, (4) following simple directions, and (5) social isolation. He uses these factors to compare humans with severe mental “retardation” with non-human animals such as apes, border collies, and grey parrots which have these capacities and perform these specific tasks “more efficiently.” After his comparison he asks: “can we justify attributing equal value to all human lives, while at the same time attributing to human life a value that is superior to all animal life?” (2010, 335).

Singer asks us to reconsider the statement “we” for the discussion of personhood. Rather than granting personhood to all biological humans, instead, he argues, we should “abandon the idea of equal value of all humans, replacing that with a more graduated view in which moral status depends on some aspects of cognitive ability, and that graduated view is applied both to humans and nonhumans” (2010, 338). This desire by some philosophers to “open up for discussion” the moral status of those with severe cognitive disability constitutes a form of oppression. Would we consider questioning someone’s personhood today based on race, gender or ethnicity? Why, then, is it socially acceptable to question the personhood of a person with disabilities? Beyond the ethical inequality here, the matter is patently systemic since a person’s status as a person directly grants that person rights within existing political and legal institutions.

Denying a person's status as a person is tantamount to directly subordinating that person in all such institutions. It is difficult to imagine a more directly oppressive practice. This form of oppression differs from practices concerning immigration and citizenship as well as tacit practices of racial segregation insofar as philosophers like Singer are drawing these distinctions based on biological and psychological differences rather than political status. To elaborate these points, I turn to consider a few cases that will, hopefully, "flesh out" the character of this oppression.

Questioning the personhood of someone's race in the United States was part of the horrific and oppressive history of slavery, which treated people who were slaves to be only worth three-fifths of a person and later continued in the practice of racial segregation (e.g. the case of the *Dred Scott* Decision and the case of racial segregation in *Plessy v. Ferguson*). This same questioned personhood was used in the racist Tuskegee Syphilis Experiments in the United States and by Nazi Germany to experiment on and exterminate Jews, homosexuals, and people with mental illness or physical impairments. In the 1960s within the United States, one need only remember the atrocities of Willowbrook State School on Staten Island, New York, which was home to children with severe cognitive impairment. Prior to the mid-1800s in the United States, those who were cognitively disabled were largely taken care of by their families and communities. After the mid-1800s, the "state institution" developed and its aim was to prepare the "feeble-minded" for "productive work" (Kittay 2000, 66). During this time was witnessed a similar oppression of "able-bodied" Blacks who were deemed "feeble-minded" as well (Brosco 2010, 40). But for the cognitively impaired and mentally insane, these particular institutions were terrible places to live. After World War II, there was rapid growth in the United States economy, and with it came the expansion of these institutions, but by the 1960s there were cutbacks and

this greatly affected the quality of care at those institutions. At Willowbrook, children were covered in filth, and there was overcrowding and outbreaks of disease such as hepatitis. Furthermore, some of the children were subjected to human experimentation insofar as they were deliberately injected with hepatitis to “find a cure” (Boleyn-Fitzgerald 2005, 411). It was not until 1965, when Robert Kennedy spoke out against Willowbrook and by 1972, that Geraldo Rivera, in a televised exposé, awoke the national interest to the horrors which were taking place there. These horrors were the result of a society that did not give equal moral status, and with it human rights, to the cognitively impaired.

Questioning the personhood of the cognitively impaired is a systemic devaluing of disability. This systemic devaluing leads to oppressive practices such as abuses within institutions and opens the door for outright violations of human dignity. This form of systemic oppression is prevalent because many think that to be a “fully functioning” human being one needs to be “normal.” What this kind of oppression does is base the dignity and value of human life on capacities rather than on human nature. Instead of respecting differences within humanity, it points to the generally held belief that “normal” humans are “worth more” than those who “cannot qualify.”

### 6.2.3 Disability's 3<sup>rd</sup> Face: Societal Incapacity

The final form of systemic oppression for people with disabilities that I would like to address is *societal incapacity*. This form concerns the physical environment or learning environments people with disabilities encounter. Many buildings and vehicles for transportation have either limited access or no access for people with physical impairments. Consider how in the Northeast in the United States or much of Europe the majority of homes were built without the

accommodation of a body with physical impairments. These homes include non-standard doorways, narrow staircases, and small bathrooms. Many of these homes would prove difficult or impossible to navigate for a person in a wheelchair. As a result, these structures and vehicles *dis-able* people with physical impairments and are thus a form of systemic spatial oppression. Similarly, many educational structures do not accommodate or accommodate poorly other forms of learning. As in the earlier example of the female diagnosed along the lines of Autism Spectrum Disorder, an educational system may have trouble accommodating her different type of learning because it is difficult for her to communicate her thoughts orally.

Like Stigma and Questioned Personhood, Societal Incapacity is a form of oppression which also functions according to the social framing of the able-body. The preferred social body is the able-body, which determines the form of public and private buildings and learning environments. Although this social body is invisible, its residue is left on the architectural design and blueprints of any structure or educational institution. As a result, the able-body creates the *standard* for spaces and modes of transportation and *standard* ways of learning. This *standard* becomes apparent when anyone who does not conform to this standard tries to move through this space or educational environment. Tobin Siebers, in his work *Disability Theory*, describes his own home's lack of accessibility, which was built in 1939. He describes the wheelchair inaccessibility of his house as follows:

All of my entry doors are too narrow, and they also have metal, unbeveled thresholds that a wheelchair user would need to “jump.” Of course, if a wheelchair user were lucky enough to get into my house, it would still be impossible to use any of the bathrooms.

The largest entry is the door to the master bedroom at 29 inches, but it is located on the second floor. The first floor half-bath has the smallest passage, 22.5 inches, and would not hold a wheelchair in any event. All of the toilets are too low for a wheelchair user, and there are no grab bars in any of the bathrooms. Nor could a wheelchair user sit easily at table in my house because the large table and small dining room leave little room to maneuver (2008, 87-88).

The Americans with Disabilities Act of 1990 requires State and local governments to make their programs and services accessible to people with disabilities, but many times city governments do not abide by this act. Some city governments try to take exemption from the ADA by arguing that they are a small entity and thus it is not necessary for them to make any changes. Similarly, many government organizations are housed in historic buildings. Often, the argument is made that these buildings are historically significant and as a result should not be modified. This lack of modification leads to inaccessible environments for many people with disabilities and disables their participation in civic life. Furthermore, city governments do not usually provide direct and equal access to 9-1-1 systems or similar emergency response systems for individuals who are deaf or hard of hearing and use TTY's (TDD's or text telephones) or computer modems. The result is that they enforce societal incapacity in public safety.

This sort of able-bodied privilege indicates on its flip side a systemic and structural oppression for those who lack "able" bodies. The able-bodied privilege of spaces and learning forms becomes apparent in their social construction: for those whose bodies do not conform,

these spaces and educational structures present challenges and difficulties for actual living and functioning in their environment. Thus, these constructed buildings and vehicles for transportation as well as schools present oppression in the form of societal incapacity insofar as they enable some while *dis-abling* others.

### **6.3 The Need for a Virtue-Oriented Politics and Moral Education**

#### *6.3.1 The Inadequacy of a Distributive or Recognition-theoretic Paradigm for Disability*

Iris Young described five faces of oppression which overlap to systematically and structurally oppress people within a given society. What disability particularly teaches us is that there are three more faces of oppression which take place and overlap with Young's account. These three forms are *stigma*, *questioned personhood*, and *societal incapacity*. All three of these forms assume the social frame of a "normal" and most of the time "able" body. Thus, able-bodied privilege and value are given to some while oppression and dis-value are forced upon others.

Stigma, in particular, marks the body of a person with disabilities as "broken." This branding not only results in ostracism, violence, and stereotyping but also encourages the desire to "repair" or "cure" this unruly body. Thus, stigma assumes both Foucauldian sovereign power and biopower: on the one hand, the physician holds ultimate authority over one's condition and on the other hand, one conforms to the self-regulatory desire to be cured of one's "broken parts." If one resists, then one is criticized or ostracized.

Questioned personhood presents a form of oppression which dis-values the moral status of those with cognitive impairments. By asserting a hierarchy of dignity, this form of oppression

calls into question not only the practices of “disabled” bodies, but also their human rights. With a long history of violence and abuse in its past, the present day practice of questioning one’s personhood is a form of systemic oppression which afflicts those with severe or profound cognitive impairment. This form of oppression points to the able-bodied privilege that certain “normal” bodies are valued and thus “worth more” than those bodies which prove deviant.

Finally, societal incapacity is a form of oppression latent within one’s environment. One finds one’s environment either enabling or dis-abling. The fact that universal access to buildings and vehicles as well as access to accommodating learning environments is restricted or simply forgotten leads to a systemic oppression for people with physical impairments and other forms of learning. Curb cuts, ramps, elevators, and power doors are necessary spatial elements which have often been left out of designs or included as after thoughts in hard to reach places. Likewise, providing multiple forms of accessibility in learning environments such as captions in videos shown in class, extended time for exams or the assistance of a reader, scribe, or word processor for exams are often forgotten by educational systems or teachers in classrooms. The able-bodied privilege is one that assumes the “able-body” as the “normal” body in social spaces and learning environments and designs housing, commercial buildings, vehicles, and schooling accustomed for this body.

With the analysis of these three new forms of oppression I hope that new sites of political change and resistance can be developed. The first site of political change might be bureaucratic. With the regulation and development of policies for integration in school systems and working environments, people with disabilities will become less subject to stigma and isolation. The second site of political change might be economic: more structures should be constructed with

the aim of universal access and this should include the addition of more businesses developing products with “different” bodies in mind.

The final site of political change is perhaps better understood as a task for new research, a new problematic in social and political philosophy. I raise this point because, one must recall, Young’s original essay was only the second chapter within a larger work on the politics of difference, a political conception of justice that sought to move beyond the standard debates concerning redistributive paradigms (as one finds in John Rawls’ thought, for example). I put the matter as follows: with these three new faces of oppression, does disability not call into question our current theories of justice, and challenge us to expand our theories or develop novel ones for the future? Quite specifically, one notes that Young’s later work addressed the topic of difference and oppression at a global level, but she never addressed the faces of oppression discussed in the present essay. Minimally, then, a similar reconfiguration of Young’s thought at the global level is entailed by the foregoing.

More generally, the problematic that I believe is raised by the foregoing concerns a program for justice. Existing theories of justice turn on a commitment to a distributive or recognition-theoretic paradigm (e.g. John Rawls and Axel Honneth respectively). It is not clear to me how the three new faces of oppression can be addressed by either of these models. Stigma concerns social recognition and not “primary goods” (Rawls 2001, 58). Furthermore, since Rawls conceives of social cooperation as one that proceeds by mutual advantage, his basic framework seems inadequate to address the concerns of persons with disabilities (2001, 6). These people suffer oppression, but it is not at all clear that by helping them it will be to our mutual advantage—the loss in time and effort may never be remunerated. In a reciprocal way, Honneth’s concern with recognition does not appear to be up to the task of addressing the



*material needs* required to redress Social Incapacity. Finally, even newer accounts of justice that do specifically address disability, such as one finds in Martha Nussbaum's Capabilities Theory, seem to lack the resources to address oppression as its own problem. My suggestion here, then, is that perhaps people with disabilities might challenge philosophers to develop a new account of justice. In the spirit of Young, who challenged us to rethink our categories of oppression, my hope is to suggest that maybe three new faces of oppression can lead to innovation concerning the way we think about the relation of oppression and justice. Thus, the gesture I turn toward in the final section is a Virtue-Oriented Politics.

### 6.3.2 *Flourishing Bodies in the Social World: The Need for a Virtue-Oriented Politics*

In order to address these faces of oppression for people with disabilities in society, a shift in the central component of a political framework is needed. Instead of focusing on *distribution* or *recognition*, one should focus on *education* in the broad sense. Thus, a Virtue-Oriented Politics focuses on *Moral Education* by directing its attention to the *moral schemas* its citizens are being taught to uphold. The fundamental role of ethics as the forerunner of political change is that it serves as the conduit of values and provider of moral schemas for a political body. The field of ethics, on account of science, anthropology, sociology, psychology, or religion – can provide a foundational questioning and re-evaluation of an existing ethical framework within a society. In order to shift the current central values within a societal framework, one needs to shift the *moral schemas* which are generally embraced by a society. This is exactly what Moral Exemplar Martin Luther King, Jr. and his supporters did during the Civil Rights Movement in the United States. It may have taken forty-four years, but after this movement, the United States elected Barack Obama in 2008 as its first African-American President. This election would have been

inconceivable in 1950. What a shift in moral schemas like this signifies is a *moral revolution* (Appiah 2011). This re-evaluation of values occurs in three areas: education, close associates such as family members and caregivers, and technological media. My proposal is a simple one for a Virtue-Oriented Politics which recognizes and advocates for people with disabilities: *If you change the schemas, then you will see change in the results.*

MacIntyre acknowledged the limit of ethics and turned to politics to address specific needs for people with disabilities such as care, financial support, educational support, and political proxy (MacIntyre 1999). In this admission, MacIntyre recognized that the political schemas and moral schemas currently held within the Western philosophical tradition were inadequate to grant the political legitimacy such as the status of being declared “independent” and human rights, the political recognition for educational and medical care, and the political virtue to orient itself toward the flourishing of all of its members within a given society. Although Nussbaum, a virtue “ethicist,” has proposed a “top-down” beginning solution to these inadequacies such as the need for a competent proxy or needed economic assistance for certain public programming, her political theory has ceased to depart from the schemas which guide Western political thought: *people with disabilities are necessarily dependent. Hence, the term “disability” means a person who “lacks the ability” to be a recognized, individual participant in the political system.*

Instead, I argue that we need a “bottom up” approach to a Virtue Politics. First, this schema that “disability means a person who lacks the ability” is essentially *able-ist* and *inaccurate*. This schema focuses on *autonomy* and essential *individual rights*. The assumption here is inherited from the Kantian Enlightenment: that through *autonomy* we gain *dignity*. However, having an inability to “vote” in an election does not entail a cognitive impairment, a

lack of autonomy, and therefore, a lack of dignity: first, children under the age of eighteen and illegal immigrants are prohibited from voting and second, considering the history within the United States, both women and people of color were disenfranchised for centuries. This reliance upon the “vote” as indicative of a certain social group’s political recognition within a society is misplaced. Furthermore, within a society, there is a difference between *speaking-for* and *speaking-with*. Because an individual lacks *physical autonomy* does not mean that people must *speak-for* that individual. The role of a proxy should not be to “speak for” an individual’s interests; rather, it should be to “speak with.” The *politics of speaking-with* is founded on Aquinas’ virtue of *caritas*.<sup>29</sup> The virtuous person who exhibits the virtue of *caritas* is Kittay’s caregiver who maintains the image of the *transparent self*.

For Aristotelian Virtue Ethics and specifically MacIntyre, ethical change occurs during the transpersonal interactions between people as in the case of the children with cognitive impairments and their caregivers. I believe that political change occurs on this level as well. This “bottom up” solution begins with a *fundamental shift in schemas*: this can be accomplished through education, media technology and close associates such as family members or clinicians. MacIntyre famously gives the example of the French Revolution to demonstrate how impossible it is to make a society ethical if we begin with moral traditions in a society in which the “very idiom of morality which you seek to re-invent is alien in one way to the vast mass of ordinary people and in another to the intellectual elite” (MacIntyre 1984, 238). According to Clegg, “virtue ethics requires that people learn through experience what it is to act in a virtuous way and identify ethical goals; only then can that knowledge become the core of subsequent decisions”

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<sup>29</sup> On the subject of charity as wishing for another’s good.  
<http://www.logicmuseum.com/authors/aquinas/summa/Summa-IIb-23-26.htm#q23a1arg1>

(Clegg 2000, 2). A virtue-oriented politics approach is to extend this ethical learning experience to the field of moral education.

Narvaez et al. (2005) have emphasized the role of moral education and the development of moral schemas for ethical change within a society. "For all learning, interaction with the social and physical environment plays a large role in what is learned" (2005, 152). Environments provide "learning structures," which shape our intuitions, interactions, schemas, and scripts. The associations we develop are either rewarded or punished through relationships which encourage memories and expectancies to form and later develop perceptions and judgments. Specifically, in a society, people considered experts have a different sort of education. According to Narvaez et al. (2005), experts learn from interaction or education that has three characteristics:

1. Experts learn in situations which reward appropriate behaviors  
- behaviors that lead to success in the domain.
2. Experts learn explicit theory as they build tacit knowledge, in other words, strategy instruction and meta-cognitive coaching.
3. Experts experience extensive, focused practice.

Unlike most novices, experts master their skills from favorable (well-structured) environments: this includes "interactive situations that provide mentoring from experts, who offer precise feedback on whether they are learning what works to solve problems in the domain and guide them with one-on-one coaching appropriate to their level of skill" (2005, 153). Experts put in a lot more time and focused practice in the domain. They "have networks of schemas linking their tacit and explicit knowledge banks. They develop a whole set of skills including reflective,

deliberative skills, routines, and superior processing capabilities” (2005, 154). Narvaez et al. has specifically adapted this model of expertise for character education. Their model, called Integrative Ethical Education (IEE), understands *character* as a set of component skills that can be cultivated to high levels of expertise. One develops an ethical character through practice and apprenticeship. Ethical expertise includes judgments, decision making, and the ability to dynamically respond in “real time” to events in the world (2005, 154). These skills extend four psychologically distinct processes ((a) *ethical sensitivity*, (b) *ethical judgment*, (c) *ethical motivation*, and (d) *ethical action*) by outlining a set of social, personal, and citizenship skills.

*Ethical Sensitivity* experts are better able "to read" a situation and to figure out what is the best action to take. They are better at proposing solutions to ethical problems and are better able to anticipate future consequences of actions. *Ethical Judgment* experts are skilled at solving complex ethical problems and access multiple schemas when solving those problems. Their "information processing tools are more complex but also more efficient" (2005, 155). *Ethical Motivation* experts possess skills which maintain their focus on an ethical ideal. This focus is directed by "an organized structure of moral self-identity" (2005, 155). *Ethical Action* experts stay focused and accomplish the ethical task at hand. They "demonstrate superior performance when completing an ethical action" (2005, 155). All of these ethical skills can be developed as children learn to construct ethical schemas of the world (Narvaez 2002). In order to accomplish this shift in ethical schemas, three changes in our political framework will be necessary.

First, schools should maintain *inclusive learning styles* to ensure inclusion of people with disabilities. *To educate a child to become virtuous, then, that child will first need to be placed into a well-structured ethical environment.* A Virtue-Oriented Politics would seek to assist and provide funding for these sorts of environments. This environment would include well-

structured, favorable and friendly contact with children with disabilities. It would also include instruction for students for how to *interact with* and *embrace differences*. Within this environment, ethical "teachers," (which could be parents, teachers, coaches, relatives, neighbors, or friends of the family), model ethical behavior and are committed to the "student's" learning of ethical skills, knowledge, and behaviors and embracing people with different bodies. Next, the "students" must experience ethical instruction which is like that of the expert-in-training. Because tacit knowledge forms the foundation of practical knowledge in any domain, it is necessary that "students" develop a learning of the ethical theory and metacognitive strategies. This is done so by first learning the *big picture*, which includes identifying basic aspects of the domain and building "identification knowledge" from different experiences within the ethical domain (2005, 158). This larger picture would be a *life-story* oriented by the interdependent virtues of empathy and acceptance rather than an insistence on autonomy. Soon after this, awareness and sensitivity to ethical complexity can be coached by "teachers" pointing out *details* of problems and patterns in a society, helping the student construct "elaboration knowledge." The next layer is to build "planning knowledge," which is accomplished by extensive practice of applying both identification knowledge and elaboration knowledge to solving problems in the domain of the classroom. The final step is when students "integrate their knowledge across contexts," which enables them to build execution knowledge in the specific domain and then later expand it to daily living (2005, 158).

Second, *media technology should be implemented for the spread of virtue-based schemas*. This is specifically accomplished through the *telling of stories* in art, literature and film. Kearney argues that we act ethically as *narrating beings* (2004). By telling different stories within a society, the given society's moral schemas can be seen to shift in the social imaginary.

A Virtue-Oriented Politics can provide financial assistance to projects within media technological forms that reshape the societal *imago* of the person with disabilities. For instance, it might focus on shifting the current schema of *beauty* held within a culture (s). This approach of images or stories would not include depictions of the “body with broken parts” or the “hero who overcomes his or her disability.” Instead, it would follow in the footsteps of individuals who, provided funding through Kickstarter, created a film portraying the beauty of “different bodies with disabilities.” Similarly, it might support the production of images of “disabled” Tanja Kiewitz from Belgium, a lingerie model missing the lower part of her left arm who posed in lingerie for CAP48, a Belgium charity for people with disabilities, to raise awareness and funds.<sup>30</sup>

Finally, *close associates such as family members or clinicians can enable the flourishing of people with disabilities to live well within a society by shifting the schemas held by the medical field and the person with a disability.* An example of a Moral Exemplar is Jean Vanier, who began L’Arche, which welcomed those with disabilities who had been rejected in society just after World War II. Today, L’Arche has flourished as a welcoming communal model and has over 130 communities in 33 countries on 6 continents (Kearney 2010; Kristeva and Vanier 2011).

A Virtue-Oriented Political system can also support this shift by passing laws or providing federal healthcare assistance which not only provides basic medical coverage but also includes innovative therapy programs. Laws and federal assistance can be lobbied for by people with disabilities, their family members, healthcare professionals, and clinicians. In addition, healthcare institutions can move away from a consumer model of healthcare and move toward a

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<sup>30</sup> <http://www.youtube.com/watch?v=1rOSibtCWLA>

virtue-model of healthcare. This need for a shift in healthcare schemas from the consumer model to the virtue-model is the central argument in Jennifer Radden and John Sadler's work, *The Virtuous Psychiatrist* (2010). In the field of mental health, over many years professionals have appropriated a "consumer model" from the managed health care system (2010, 19). This model is convenient and operates on the assumption that the healthcare provider's main responsibility is to service her client, i.e., to ensure that her client is pleased, or happy with, her services. While this model may work well in the field of business or other areas of healthcare, its extension into the field of providing care for mental health disorders proves problematic. This problem is most evident in the particular example of a "manic" patient that Radden and Sadler provide:

After treatment with a potent monoamine oxidase inhibitor, a depressed postal clerk has "switched" from depression to mania, over the course of a day or two. He presents to the clinician with a packed briefcase full of notes and briefs. He says: "Thank you Doctor, for making me feel so good...let me tell you the plans I have for a restructuring of General Motors...I have made several calls to Lee Iacocca to share these plans, but he hasn't returned my calls...perhaps I shouldn't have called at 3am this morning" (2010, 40).

This example captures the limitations of the consumer model *as a schema* for mental healthcare. Although this patient considers himself happy because he feels manic pleasure, he is not flourishing. It is this breakdown between the consumer model and the particular needs of the



mental healthcare patient which demonstrates the need to appropriate more than just the *schema* of the utilitarian calculus of pleasure in counseling.

While the “manic” patient demonstrates the need for a shift in the medical schema held by healthcare practitioners, Radden and Sadler also argue for the roles clinicians and family members can play in *shifting the subjective self-image schema* of the person with a disability. This self-image schema, or *imago*, which animates a person’s life story may be negative for the person with disabilities due to the faces of oppression such as *stigma* or *societal incapacity*. Radden and Sadler argue that virtuous counselors need to maintain a balanced view and enable their patient to correct mistaken beliefs and evaluations of himself or herself. By encouraging the patient to question vicious schemas, the clinician or caregiver can help the patient become more realistic and as a result, enable the patient to flourish.

This is only a beginning sketch of what a Virtue-Oriented Politics would entail. My hope is that a politics which focused on shifting the moral schemas held by members of a society through a “bottom up” approach which included the three areas of education, media technology, and close associates can provide the initial framework for an interdependently virtue-based political theory. As MacIntyre has said, we are not the sole authors of the story of our lives; rather we are only co-authors. Thus, my proposal is to begin with a schema of *dignity recognized through co-authorship* rather than a dignity reliant upon autonomy. It is through this shift toward the recognition of our political co-authorship that I believe we can begin a politics of *speaking-with* rather than *speaking-for*.

## CONCLUSION:

### *The Fragility of Virtue*

homōs de kai en toutois dialampeî to kalon,  
epeidan pherē tis eukolōs pollas kai megalas atuxias,  
mē d' analgesian, alla gennadas ōn kai megalopsyuchos

Nevertheless, even in these cases, when someone  
bears many and great misfortunes gracefully  
not from being insensitive  
but from being generous and magnanimous,  
nobility shines through.  
(Aristotle, 1999, 1100b).

### *The Fragility of Human Goodness: A true story*

It was the day of her daughter's wedding. Chivel (pronounced: Chi-bell) listened to the rustle of her daughter's white dress as the young bride hurried to put on her bridal shoes. Her daughter's tan skin flushed with excitement, the brightness of her smile, the happy tears in her eyes. She was going to be married. It had all happened so quickly. *It had to happen so quickly.*

The brief tunes on the piano began to sound and soon everyone was rushed to his or her place. A colorful line of blue dresses and black suits queued around the entry to the white church. Even though it was already October, the oppressive heat of the Mexican sun was beginning to trace lines of perspiration in the make-up on many of the bridesmaids' faces. Soon a hush fell over the assembly. The door opened, the music played, the procession began. Each colorful couple walked up the aisle, pausing to pose for pictures, then turned and went to their positions by bouquets at the head of the church or file into the first few pews. The familiar notes

of the bridal procession echoed from the cool alabaster walls out onto the quiet street. Inside, the congregation rose. The bride, Erica, was walking down the aisle. Her corseted dress, cinched firmly around her waist, was drawn into a cascading long train behind her. Her bouquet gathered together blue and white lilies and her long white veil fell down over her radiant smile. Her long train rustled and brushed up fallen petals. As the bride passed, friends and family nodded, paused, drew in their breaths, smiled. She leaned on her father's arm as he walked her down the aisle toward her groom. Tears welled in his eyes. Chivel waited at the head of the church for her daughter. She had been waiting for this moment for thirty years. And now it had come. She listened to piano and the violins. She was waiting for this moment, for her daughter. *Yet she could not see her.*

At age fifty-five, brain cancer had already ravaged Chivel's body. At first it had begun with a simple tickle, a numbing, a tingling in her left arm. After a month she could no longer move her limb. Specialists had run tests and the diagnosis had been grim: brain cancer. She tried chemotherapy, surgery, and even an experimental treatment all accompanied by hope and prayer. Nothing had worked. Within eight months she had lost most of her vision, most movement in the left side of her body, and even the left side of her face. It was the middle of October now; she would be gone in February.

In her fuchsia-colored nylon and polyester suit, she waited at the head of her church for her daughter. But she did not stand like the others; she could not see her daughter's bittersweet tears as Erica came forward. Quietly, Chivel waited; she waited in her wheelchair, cradling her limp left arm. Soon she could smell her daughter's perfume and heard her nervous laugh. As the minister presided over the ceremony, the bride and groom took each other's hands in their own. Two people, now one couple, one possible ethical relation of sexual difference.

Chivel heard the marital kiss and everyone clapped. She banged her right hand against the handle of her wheelchair. She too wanted to make more noise, to show how happy she was, but her body would not let her. Clapping was not possible. Her own hand reaching out to touch the other hand; the other unresponsive, numb, mute. Her intentions inhibited, she could not reach out in the single act of one hand touching the other and have the other stretch out to touch back. Her “can” had become a “cannot;” not temporarily, but permanently. Her own lived body inhibited her intentions, thwarting the simplest aim. As her daughter had formed a new union, so the very disunity of her own physicality had ruptured her joy.

Erica was her first born, now married, and hoping soon to be a mother. With her new husband she would co-intend a future of limitless possibility – all caught up in hopes of love. She would be two weeks pregnant when she lost her mother.

Thirty years ago Chivel had carried Erica in her womb. Her own flesh enmeshed with the flesh of another, her own child, her first child, her daughter. Her body had swelled and become heavy through the time of her pregnancy. Her body at once so familiar, overnight became foreign, alien, strange as her encounter with this new life questioned all boundaries of identity. Her own sense of self became displaced as she had tried to move down tight hallways, race up stairways, pick up dirty socks, or in the last days raise herself out of a chair. The promise of that human connection, that bond, was worth all the pain and discomfort and confusion. In those final moments of sweating and pushing and losing all sense of control, she thought she had lost herself. And then, Erica was born. This flailing, crying, life – wholly other – had been intertwined with her.

That was thirty years ago. Now her daughter, a beautiful, accomplished young woman linked her arm through her husband’s arm. The ceremony was over. People cheered, laughed,

and cried, while all Chivel could do was murmur her broken blessings. The displacement of language and biology caught in a fractured smile. It was time for the reception. Arm in arm the happy couple walked out of the church, leading the joyous revelers.

Familiar hands touched the back of her wheelchair. “We’re going for pictures now,” her husband said. Chivel tried to smile, but only the right side of her lip curled. She cradled her left hand closer to her body as he pushed her wheelchair. Her motility shared with another, her comportment decentered, her spatiality technologized. No longer free to push through crowded hallways, race up stairways, or raise herself from her chair, her motility was co-dependent, a shared intention, an ethical relation with another, but also a vulnerable one. Her transcendent possibilities of the lived world had become ambiguous. The space she intends, the space she moves through is not moved through by the means of her body. Instead, she moves through her world dependent on other bodies—and dependent on technology. Her intentions are both technologized and discontinuous, yet active and productive.

Her husband’s calm hand touches her right shoulder. An empathetic, loving caress against her flesh. Both passive and active, receiving another so her flesh reaches out to him in the act of touching. The act of feeling another opens up the ethical, the compassionate, the erotic, intertwined as when she reaches her right hand up to touch her own shoulder, the trace of his warmth barely there. Grasping at the warmth she touches herself and feels that she is the one felt. Her flesh, visible and invisible gives her who she is: her intentions, her desires, his warmth. As people approach she slumps forward and gathers up her mute left limb, warm yet unresponsive, against her breast. A jarring reminder to her of her own torn facticity: she is other to herself. The givenness of her flesh has been sundered.

She longs to see her daughter, to find her, to hear her laugh. But the crowd has grown too large. They have stopped moving forward, and her motility is beyond her control. She knows that they are looking at her. She cannot see their gazes anymore; once both a seer and one seen, she no longer is able to look back, to meet their gazes. She cannot see them looking at her, but she can *feel* them. She knows they are looking at her with pity, with disgust, with sadness. The body she had lived and that which she now lives are incommensurate with each other. Now, she is given her own body through her memory of the gaze of the other. Unable to *look back*, she can only be *looked at*. And she cannot tell whether her own beautiful daughter is looking for her.

### *The Fragility of Virtue*

In what one might term “traditional philosophy,” the existence and experiences of people who are physically or cognitively impaired, or who suffer from trauma or the aftermath of abuse have not been of primary concern. In “Western” culture, disability has historically been associated with defectiveness, insufficiency, imperfection; at its most poignant – facing our own weakness and mortality – it set the very limit humans aimed to transcend or overcome. Yet, the case of Chivel prompts some serious reconsideration of our “Western” philosophical thought. Chivel’s body is not an isolated incident. Rather, it common to us all, because we all age and will die some day: it is the realization of our utmost possibilities, which is our vulnerability. *It is our fragility.*

MacIntyre calls on us to remember that although we may be virtuous agents acting in a social world, the condition in which we live is a vulnerable one (1999). All of us, in our lifetime, have been vulnerable at some point, usually childhood, and will most likely return to a state of vulnerability and dependence with greater age. How we choose to cope with our vulnerability is

mostly up to us. This is why, according to MacIntyre, an account of full human flourishing is incomplete without recognizing that we (a) owe much of our survival to others, thus we are dependent rather than autonomous, and (b) that our bodies our animal bodies which are continually vulnerable to bodily illness and injury, inadequate nutrition, mental impairment and disturbance, and human aggression and neglect.

In the preceding chapters, I have attempted to articulate and defend a viable form of Aristotelian virtue ethics grounded in empirical psychology through which all of us who are vulnerable can flourish. Character, I have argued, is constituted by a *life story* that we form through our relational co-authorship with others over time. Thus, Chivel's courage when facing her imminent death was shared with her husband and children as they braced themselves for the inevitable as a family. Just as Chivel's body was vulnerable, so was the familial world in which she lived and had been loved. Courage is a virtue we need to reckon with our own human frailty. Whether as a soldier in battle, such as Achilles in the Battle of Troy, or as a Mexican housewife and mother dying of cancer, like Chivel in Mazatlán, Mexico, knowing when to die when it is more desirable to live seems to contradict our ability to flourish.

Flourishing, however, is not only about being happy. It is also about the recognition of our own weakness and mortality. And it is through the recognition of our own fragility that we begin to acknowledge our dependence upon others and the role of *giving* and *receiving*. The exchange of giving and receiving necessitates the virtues of trust and care and the establishment of a moral interconnectedness among people through the virtue of *friendship* rather than through *mutual advantage*. Thus, the virtue of friendship forms the basis on which to ground our ethical obligation to care for those who are vulnerable and to accept our own dependence as well. When a friendship is good, it is grounded on the virtue of *caritas*.

If a friendship is a *good* friendship, it can grow into *solidarity*. I had known Chivel for nine years when she lost her battle to brain cancer. Every year I would travel with my boyfriend, (who later became my husband), and stay with his family in Mexico. I could barely speak any Spanish and Tía Chivel could barely speak English. Yet, every journey I made she would welcome me into her home with open arms and tell me how much she loved me. Her home was always a lively place to stay with her husband Hugo and their three children Erica, Jessica, and Hugito (all my husband's cousins). Early in the morning when the coffee was made and the birds were out, I would be awakened by the sounds of *las mañanitas* (traditional Mexican music) and Hugo cheerily singing.

Chivel's diagnosis of brain cancer was a shock to all of us. Her husband, Hugo, was a medical doctor and fought to get her every treatment available. Because this was Mexico, there is no health insurance and so that whatever treatment was not performed at a state institution, where Hugo worked, had to be paid in full by the family. When Chivel's hair began to fall out due to the chemotherapy, her youngest son Hugito shaved his curly, untamed locks in solidarity and to *speak with* his mother. Erica, the eldest, moved up the date of her wedding and married her fiancé, Mario, so that her mother could be a part of it. As a family, they bore this burden together; *they bore their fragility in solidarity*.

Jessica, the middle daughter, had always been the good student. Her mother had supported her education and wanted her to become an orthodontist even though it was against the patriarchal customs of Mexico. In order to save money for school, Jessica worked for years teaching English until she had enough money to pay for her tuition. When Chivel's cancer treatments were not working and she had lost her vision and her motility, the whole family was in despair. Hugo did not have any more money to pay for her health care. Although their faith



gave them strength, they braced themselves for the inevitable future. Because Hugo was a doctor, he found out about one last experimental treatment Chivel could try, but because it would be available only at a private institution, it would cost \$20,000 (in U.S. dollars).

In solidarity with her family, Jessica offered to give her tuition money for the chance to save her mother's life. But Chivel refused. Preparing herself for the end of her life, Chivel told her daughter "I will not sacrifice your future. Now my death has a purpose." Jessica pleaded with her, but Chivel would not take the money. She just said "*te amaré siempre*" (I will always love you). Six months later, Chivel passed on.

The possibility of sacrifice and the possibility of redemption are possibilities which animate our fragile life stories. Although Chivel's body had been ravaged by disease, her character and love for her daughter provided her with the courage to make the ultimate sacrifice. The reason I chose to close with this story of a family who faced their collective vulnerability with courage and love, is because our collective vulnerability is a necessary part of our human condition. Because it is a part of human goodness, the sacrifice we give to others provides hope for those in the future. It is the hope to transcend the limit of our own *fragile virtue*.

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