Cover Sheet

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Title: “You can’t do it...it’s theory rather than practice”: staff use of the practice/principle rhetorical device in talk on empowering people with learning disabilities.

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Abstract

This study explored the discourses of support staff of people with learning disabilities talking about how choices and control are promoted or denied for service-users. A semi-structured interview based on issues identified in the white paper, 'Valuing People,' (Department of Health, 2001) was administered to fifteen professional care givers of people with learning disabilities. These were transcribed and analysed using discourse analysis. The analysis demonstrated the use of two dominant discursive themes: increasing autonomy and practicalities talk. These themes were frequently mobilised together in a manner which paralleled what Wetherell et al (1987) termed a 'practice/principle rhetorical device,' to argue against increasing choices and control. The implications of this are discussed, as are the subject positions offered to staff and service-users.

Keywords

Learning Disability, Intellectual Disability, Discourse Analysis, Choice, Control, Empowerment.

Introduction

A recent UK government document 'Valuing People' (Department of Health, 2001), which set out the future priorities and principles for services for people with learning disabilities, stated that a major problem was that people labelled in this way often have little choice or control over their lives. Since then, researchers such as Ramcharan and Grant (1997) have explored the concept of empowerment in the everyday lives of people with learning disabilities, whilst, Walmsley (1999) has

discussed the dilemmas involved in providing the additional support which would enable individuals to gain more control over their lives. According to Agich (1993) and Cullen (1999), choice is fundamental to empowerment, however it is sometimes obstructed by a culture of professionals deciding on what is better for the individual. In the UK, the Mental Capacity Act (2005) stated that any actions made with a person's 'best interests' in mind, should not be based simply on, 'a condition of his, or an aspect of his behaviour' (p. 3) and should involve encouraging as far as reasonably possible the person's participation in any decisions affecting them. However as Finlay, Walton and Antaki (in press) point out, goals of empowerment are often difficult to implement in practice as they conflict with other agendas and values within the service as well as with how care staff strive to accomplish a high standard of work. Policy documents therefore minimise and overlook other concerns that care staff may have. Although the empowerment of people with learning disabilities is treated in policy documents as straightforward goals, this may not always be the case. Walmsley (1999), however, warned that this conflict may produce the opposite response from support staff. She emphasized that in order for people with learning disabilities to lead ordinary lives within the community they require more than ordinary support to ensure that they achieve the maximum level of control and independence to lead their own lives. This, however, is in conflict with principles of normalisation which have guided changes towards empowering people with learning disabilities. According to these principals, individuals with learning disabilities should be not be allocated any special treatment. Therefore staff may be reticent in taking any form of pro-active role in supporting their clients. This has resulted in inadequate service provision within the community and thus a continued lack of choice and control for people with learning disabilities.

Previous research on autonomy and people with learning disabilities has focussed on the following areas: moving away from oppressive institutionalised environments (Bogdan and Taylor, 1994; Goffman, 1961); overcoming control from health and social care professionals (Dowson, 1997), increasing choices and control through advocacy (Dowson, 1997) and self advocacy (Goodley, 2000) and capacity and rationality and how these are implicated in increasing choice and control (Harris, 2003; Jenkinson, 1993; Thompson, 2003). For example Jenkinson (1993) reported that certain models of decision making value competence in a person's capacity for decision making. However historically learning disabilities included impairments to qualities considered imperative for decision making, such as cognition, discretion, social competence and understanding of one's own self-interest. As a result autonomy in decision making is often withheld from people with learning disabilities on the basis of a perceived lack of capacity. This is contrary to the recent UK legislation set out in the Mental Capacity Act (2005). Care-givers may be tempted to act in service-users' best interests or be influenced by their own values and preferences, which could affect how they approach and question people with learning disabilities about their choices. Therefore there are also social influences on making decisions (Jenkinson, 1993).

Jenkinson also noted that personal liberty may conflict with the acquisition of certain skills that are crucial for other institutional goals such as independence and normalisation. Consequently autonomy may be restricted by limiting service-user input into treatment goals and procedures and teaching behaviours which are in the interests of family and advocates whilst overlooking service-user wishes. Certain

studies have focused on similar dilemmas faced by care staff when empowering people with learning disabilities. For example Van Hooren, Widdershoven, van den Borne, and Curfs, 2001 examined the incompatibility of facilitating autonomy on the one hand, whilst providing care for people with Prader Willi Syndrome on the other. They found that complete freedom of choice was rarely given. Instead, participants reported that autonomy was increased through moral discussions which enabled service-users to reformulate their goals and aspirations. Therefore choices were influenced by what staff felt were in the service-users best interests. These studies are useful in forming a backdrop of current understandings of empowerment and highlighting the dilemmas involved in increasing the choices of people who receive support.

Discourse analysis has remained an underused method in learning disability research. Studies that have adopted this approach have examined constructions of learning disabilities and the effects of being positioned within certain discourses. For example, Peter (2000) examined a case file of an individual labelled as learning disabled and found that the text, which emphasised negative professional language, contributed to the thirty-five year incarceration of the individual. Therefore constructions of a defective learning disabled identity were used to legitimise social control. Many other studies examine the dilemmas experienced by paid support staff in their everyday interactions with service-users and how these conflicts relate to identity and autonomy. For instance, Wilcox, Finlay and Edmunds's (2006) analyses of carer explanations of aggressive challenging behaviour described primary themes: an individual pathology discourse and a context discourse. They suggested that service-users were disempowered by individual pathology discourses, whilst context

discourses enabled staff to manage blame. This management of blame was particularly striking in accounts of challenging behaviour and was unsurprising given the staffs' duty to facilitate adaptive behaviours and ensure service-user safety.

Other studies using a conversation analytic approach, such as, Antaki, (2001), Antaki, Young, and Finlay (2002), Jingree, Finlay, and Antaki (2006) and Rapley and Antaki (1996b), have examined power relations and institutional practice in interactions between service-users and health-care professionals. These have suggested, among other issues, that the goal of empowering service-users often appears to come into conflict with other goals such as upholding the routines, practices and policies of the service. For example Antaki et al (2002) suggested that support staff face a dilemma when interviewing service-users about their quality of life, sometimes treating them as unable to understand interviewer questions. Consequently there is a tendency for staff-interviewers to administer their questionnaires sensitively and liberally (therefore embodying their duty of care) rather than objectively as impartial evaluators of that care. As a result, service-user responses may be up-graded or improved to represent better perceptions of their quality of life in what should be a neutrally administered interview. Similarly, Jingree et al (2006) examined advocacy meetings in a residential care home for people with learning disabilities and found that staff were faced with a conflict between their roles of empowering service-users by facilitating interaction and encouraging them to voice preferences and concerns. Staff were found to adopt various techniques which enabled them to guide the conversation, ignore complaints and produce certain statements favourable to the institution. Consequently the objectives of the advocacy meeting were undermined. Rapley (2004) examined the construction of acquiescence and incompetence in people with

learning disabilities and suggested that these were the result of a joint interactional management between support staff and service-users.

Thus a conflict has been identified between pursuing a range of institutional goals and enabling service-users to take control over their own lives (see Antaki, Young, and Finlay 2002; and Jingree, Finlay, and Antaki 2006). This has previously been examined in studies conducted from a realist framework, using qualitative analyses to examine interviews of carers of people with Prader Willi Syndrome (see van Hooren et al, 2001). However there has not previously been a discourse analytic study examining staff talk on empowering service-users. The study reported here examined staff talk on choices and control in the context of other institutional policies and practices. Of interest was how these tensions were organised in participant talk in the management of certain ideological dilemmas (Billig et al, 1989). The way in which staff positioned themselves within the discourses invoked was also examined, as were the constructions of the learning disabled identity.

Method

The Interview

The data consisted of audio footage of semi-structured interviews with 15 support staff working in services for people with learning disabilities. Potter and Wetherell (1987) noted that an interventionist/confrontative style of interviewing should be adopted where many interpretative contexts are generated by revisiting the same issue during the course of an interview under a number of different topics. This would allow the accounting practices and their functions observed in participant talk to

become clearer. Therefore the question of increasing the choice and control of service-users was posed in many different contexts. Areas were chosen by reviewing current literature and government policy on empowerment and learning disabilities (Valuing People, Department of Health, 2001). These areas seemed to capture the main concerns relating to autonomy discussed by the Government in their White Paper.

The interview started with a warm up section beginning with a series of general questions about the participant's work, and their ideas about empowerment and choice, such as:

- 'How would you describe the people you work with who have learning disabilities?'
- 'The Government recently made new proposals concerning people with learning disabilities. One of their objectives was to increase the choice and control people with learning disabilities have over their lives. How do you feel about this?'

Following this it was then divided into seven sections (finance, health, diet, employment, housing, social and sexual relationships and alcohol). Questions in each of these sections followed a similar pattern to that of the warm-up section where a broad question was posed initially, for example, the social and sexual relationship section included:

- The Government want to see an increase in opportunities for people with learning disabilities in becoming less socially excluded, leading fulfilling lives and becoming full members of the community. What do you think about this?

This was then followed by a series of questions and prompts when required:

- How do you think someone with learning disabilities would integrate into the community?

- Why?
 - How about in terms of developing friendships with non-disabled people?
 - How would you feel if these relationships or relationships with other people with learning disabilities were sexually intimate?
- What about having children?

Due to the semi structured nature of the interview, these questions varied according to the interviewees' responses and any areas that arose spontaneously were followed up and explored further.

Staff

Twelve female and three male staff agreed to participate in the study. All were between the ages of 22 and 59 (mean age 43.13) and were white British. All had also been employed by the service for between 4 months and 19 years (mean employment period 8.85 years). The service was an epilepsy trust involved in providing residential and day support for people with learning disabilities and epilepsy. Five of the carers were managers of various units within the service. As well as a duty of care, many staff also reported having other roles within the service, for example as instructor for the gym, workshop or cooking and administrator for the day centre.

Interviewing Process, Transcription and Analysis

Interviews were conducted at the service in order to ensure a relaxed and familiar environment. These took between 60-90 minutes and were transcribed verbatim. All identifying names and locations were changed. The data was analysed using the recommendations of Potter and Wetherell (1987), Coyle (2001) and Wetherell, Taylor and Yates (2001). Transcripts were read and re-read in a manner that was mindful of the discourses being drawn on to explain and justify how choice and control were

promoted or restricted. Of interest was the subject positions offered by the various discourses and the functions and effects of engaging in them. The analysis therefore sometimes required a micro-level examination of the rhetorical devices used in participant accounts, as well as a global consideration of the interpretative repertoires (Potter and Wetherell; 1987) being drawn on.

Analysis

Three dominant discursive themes are presented here. The first two were ‘Increasing Autonomy’ and ‘Practicalities Talk.’ These were often mobilised together to argue against increasing choices and control, which was presented as a separate third theme: ‘Mixed Increasing Autonomy Talk and Practicalities Talk.’ This also contained a sub-theme entitled ‘Risk.’

Increasing Autonomy

This theme focussed on discourses about rights and freedom of choice encompassing talk which Wetherell, Stiven and Potter (1987) described as a ‘moral language of should’s, ought’s, fairness and duty’ (p. 62). It was evident in all the interviews and typically exemplified by maxims such as ‘it’s their choice, it’s their life,’ ‘no one should do what they don’t want to do,’ and ‘everybody has a right to a child.’ Considering the prevalence of terms such as autonomy, control, choice and empowerment in policy documents and psychological literature on people with learning disabilities, it is perhaps unsurprising that these philosophies have entered the language of care staff and are mobilised in many of their arguments concerning giving choices and control. As Ramcharan and Borland (1997) noted, these terms are used as a rationalisation for almost any work concerning people with learning disabilities.

Such statements also have another important function of allowing participants to present themselves positively as liberal minded. Later, under ‘Mixing Increased Autonomy and Practicalities Talk,’ by presenting themselves as *otherwise* liberal and *endorsers* of rights and choices, it will be shown how staff use this talk to argue against giving choices and control to service-users. However before turning to this it is important to first demonstrate the characteristics of ‘Increasing Autonomy Talk.’

The following extract concerns institutional routines such as set meal times and day-centre sessions. It is presented here because it exemplifies how the increasing autonomy theme is used to advocate that residents should not be made to do things at set times because ‘it’s their life’ (line 1215).

Extract 1 Amanda-Lines 1195-1219

1195 A And I think if they wanna have a lie in, they have a lie in. If they
 1196 feel like they want to lounge on the sofa for the day and but I
 1197 think some staff think that if it’s their programme to be down the
 1198 daycentre they should be here. (RYeah) And I think well I’ve had
 1199 residents come down to my sessions and they’re like ‘oh not
 1200 feeling very well.’ And I’m like ‘well well do you want to go
 1201 back and have a lie down then.’ And they’re like ‘d’you mind?’
 1202 And I’m like ‘no.’ And they say, ‘well will the staff say
 1203 anything?’ And I say ‘well it’s got nothing to do with what the
 1204 staff it’s what you want to do.’ (R Yeah) And I think sometimes
 1205 staff are set that they’re that they’re meant down the daycentre so
 1206 that is what they’re doing. And I think some of the time if we’re
 1207 wanna lounge on the sofa for the day or sommink, we can. Or if
 1208 we want to get up late we can or if we want an early night we can

1209 and I think but I think that's going back to sort of some of the
 1210 older staff but I think more now that younger staff are coming in,
 1211 I think it helps because they sort of see that side. Some of the
 1212 older staff are like well no you've got to get up, you've got to get
 1213 to daycentre, you've got to do that. And someone said to me 'oh
 1214 don't fancy going to the daycentre or anything today.' I'd be like
 1215 'yeah fine okay.' Because it's their choice, it's their life, we
 1216 don't run their lives. And I think sometimes staff need to sort of
 1217 sort of sit back and realise that huh. That they're that this this is
 1218 their home.

The structure of this account is *particularly* conducive to allowing Amanda to formulate a persuasive description of how she facilitates choice in contrast to other staff. Notice how she follows her opening (lines 1195-8) with an example (lines 1198-1204) which enables her to illustrate through genuine experience how she allows residents to do what they like. This is followed by a counter example (lines 1204-1209), of the contrasting experiences of choice and control that non-disabled individuals like Amanda have. Next Amanda adds a comparison, relating how she is different to other old staff. Finally, at the climax of the extract, Amanda ends with a moral statement that, 'it's their life, we don't run their lives,' which enables her to neatly and irrefutably demonstrate that she, in comparison to other staff, champions service-users' rights and choices.

The extract opens with Amanda stressing that residents should be allowed to do as they wish (1195-6). Between lines 1206-1209 (in the counter example) these phrases are repeated almost word for word, however this time using 'we' as the actors; and demonstrating that in contrast to 'they,' 'we' have freedom of choice. Horton Salway

(2001) noted that this form of we/they categorisation is a powerful discursive way of ordering the world. In the current context the category 'they' calls attention to the difference of service-users. Contrasting categorisations are used again between lines 1204-1214 where older staff are described as more concerned with institutional rules in comparison to younger staff who place more importance on facilitating freedom of choice. This contrast between old staff and young staff was a common theme in most of the interviews, especially in increasing autonomy talk and descriptions of the past. Interviewees frequently positioned themselves as new/young/good staff whilst contrasting their practices to that of old/bad staff. For example Harvey noted, 'when I first started up there it was er the old regime of staff who all seemed ... really did limit the residents in what they could do...and the residents were actually erm didn't dare do anything unless they asked to staff first if they could. I've changed all that.' Eve described other staff as having, 'no patience, absolutely no patience...our unit you have to have total patience don't you? You have t you have t be really really patient! I am patience, very very patient, that's my biggest thing!' Such a use of contrasts in identity categorisations has also been seen in a study by Williams (2005) where speakers with learning disabilities used contrasting identity categorisations between themselves and others in their narratives. These speakers were at risk of having their accounts treated as unreliable on the basis of being labelled as learning disabled, therefore these contrast categorisations functioned to increase the authenticity of their accounts. The staff in these interviews also use contrasting identity categorisations to bolster their accounts. As will be seen below, Amanda referred to the distinction between old/young staff on several occasions throughout this extract.

As well as having a duty of care where she is required to provide ongoing support to service-users on behalf of the service, Amanda is also an instructor at the day-centre. Therefore it could be assumed that one of her primary concerns is that residents attend her sessions. However, this conflicts with allowing service-users to do what they want. Notice how she distances herself from this identity. She begins by naming an obstacle to service-user freedom of choice, ‘some staff,’ who ‘think that if it’s their (i.e. the service-users) programme to be down the daycentre they should be here.’ Therefore only some staff are at fault here, and as she notes below, these tend to be older staff. Secondly, she describes how some residents have come to her sessions feeling unwell, an example which makes these other staff appear unreasonable. Here reported speech is used which demonstrates that, without residents having to ask, she has voluntarily suggested that they go back and lie down (1200-1202). This reported speech preserves the authenticity of another’s voice, making her account appear more factual (Wertsch, 2006). This is reinforced when the residents check that the other staff would not question her decision ‘well will the staff say anything?’ (1202-3). Notice the way in which service-users are portrayed here as orienting to their staff as though they control their lives. Again using reported speech Amanda’s contrastingly liberal response is; ‘well it’s got nothing to do with what the staff it’s what you want to do.’ This presents Amanda as encouraging service-users to challenge their staff and take control of their lives. Thirdly, Amanda distances herself from a restrictive ‘older staff identity,’ by also using a three-part list where she states, ‘Some of the older staff are like well no you’ve got to get up, you’ve got to get to daycentre, you’ve got to do that.’ The vagueness of ‘that,’ in the list suggests that older staff could potentially present any number of demands which hinder resident choice. Therefore Amanda presents herself as more reasonable than other staff,

constructing herself as championing resident rights and engaged in a struggle against these ‘more controlling older staff.’

Nonetheless, the way in which both older staff and younger staff such as Amanda are portrayed, could also be described as odd. If these staff had been employed and paid by non-disabled individuals (for example as a butler or secretary), would they be so restrictive and commanding (as older staff) or indeed so liberal and supportive (as younger staff) towards their paying employers? The way in which facilitating choices and control for people with learning disabilities is constructed in this extract seems to fit Dowson’s (1997) depiction of empowerment as an illusion within services, where empowerment is something that is loaned by staff rather than given.

Finally, at the climax of her account, again using reported speech Amanda issues a moral statement, ‘it’s their choice, it’s their life, we don’t run their lives,’ which reinforces the contrast between herself and the ‘older staff.’ This statement draws on liberal philosophies of freedom of choice commonly seen in the increasing autonomy discourse and is used as an obvious and indisputable reason why Amanda’s response carries more weight than other staff.

Practicalities Talk

The practicalities talk theme focused on why choices and control could not be facilitated in certain situations. This competing theme was based on practicalities constructed as an unalterable reality, which participants had to work around. A similar construction of practical considerations has been noted by Wetherell, Stiven and Potter (1987) in their analysis of unequal egalitarianism in discourses of gender

and employment opportunities. They found that practical considerations appealed to discourses of a 'biological inevitability,' (p. 62) of the differences between men and women. Likewise many of the practical obstacles noted by participants were also based on internal factors. For example Jack noted that, 'it really boils down to their er their learning or physical disability that ha is restricting their choices.' Participants spoke of deficient cognitive abilities which contributed to behaviours such as a lack of understanding or a lack of verbal ability. They also occasionally accompanied these with environmental obstacles such as a lack of staffing to support clients with higher needs, for example Eve described a resident as 'one in a wheel chair who can get out and crawl about but again without the staff you can't because you you know to supervise.' Katie noted that, 'it has to fit in with the organisation whether we're allowed to go out, what time we come back.' A similar mixing of internal and external obstacles called an 'individual pathology discourse' and a 'context discourse' has previously been noted by Wilcox et al (2006).

In the following extract Delia has been asked how much control she thinks service-users have over their lives.

Extract 2 Delia-Lines 130-160

130 D Erm control, I'd rather say choices. Those who are able to
 131 choose, get they choose. And because quite often erm, within
 132 the sessions it'll be, 'I really would rather do something else.'
 133 So 'what what.' Sometimes we can't do it immediately
 134 because the session they want is full or but we want to (ask)
 135 giving them the choices. Rather than control I think. You
 136 know it's. I think I don't like the word control anyway. Sorry,
 137 it's it's quite a harsh

- 138 R No that's fine.
- 139 D You know I don't think, again it's erm I think we give choices
 140 as much as we possibly can. But sometimes it's not as easy.
 141 Again (I mean it's)
- 142 R Can you think of a. Can you think of any situations where it's
 143 not so easy? Can you describe any?
- 144 D Well of basic things like erm think maybe they want to go
 145 downtown, they want to go to the pub they want to do this
 146 some can do this quite easily, others need staff support and if
 147 the staffs not there you know if say the unit is short staffed, it
 148 can't happen. (R Yeah) That that type of thing, erm they
 149 might want to go out but there isn't a minibus. (R Yeah)
 150 Huhuhu basic things like that erm takes away the choice.
 151 We're not short staffing takes away a lot of choice. (R Umm,
 152 tricky) Yes it is extremely tricky! (R Yeah) Because
 153 practicalities erm rule rather than what we would like to
 154 happen. I think I think we try to do as best as we can given all
 155 the things that are stopping them.

The extract above follows the interviewer question of how much control Delia thinks service-users have over their lives. Notice how Delia immediately argues against the word 'control,' stating that it is 'harsh,' and instead substitutes it with the notion of giving more choices, 'I'd rather say choices.' The way in which Delia separates the notion of 'choices' and 'control' and orients completely towards 'choice' may suggest that 'control' is more of an important thing to facilitate in contrast to the more moderate notion of increasing 'choices.' She orients to choice in particular before going on to describe how difficult even this is to operationalise in practice. Therefore

as the extract continues we see her abandon the notion of clients having control over their lives completely.

When talking about facilitating choices, Delia draws on practicalities which are constructed as both internal and external/social obstacles to increasing client choice. Unlike the concept of control, increasing choices is talked about as a desire (134-5 and 142-3) and something staff would ideally like to be able to do. However obstacles such as sessions being full (134), there not being a minibus (152) and short staffing (155) limit the extent to which this desire is fulfilled. These are environmental/external barriers to choice which staff work around and might overcome later, demonstrated by the way in which Delia states ‘sometimes we can’t do it immediately.’ External obstacles prevent staffs’ desire (to increase choices) from being realised: ‘practicalities erm rule rather than what we would like to happen.’ However, they do as much as they can, and therefore are not responsible or at fault ‘I think we give choices as much as we possibly can. But sometimes it’s not as easy’.

Internal factors are also presented as barriers to choice. For example Delia notes that ‘those who are able to choose, get they choose,’ implying that as a result of their impairments, those who are less able do not have choice. This is also a practical barrier to choice whereby residents who are constructed as less capable are simply unable to choose. Between lines 147-151 Delia combines both internal and external obstacles to choice, stating, ‘some can do this quite easily, others need staff support and if the staff’s not there you know if say the unit is short staffed, it can’t happen.’ This combination of presenting internal and external factors mitigates against staff accountability and preserves a positive identity, excused further when ‘sometimes it’s

not as easy' to do this, since constructions of practicalities as internal factors limit the extent to which staff are able to increase choices. In the words of Delia 'I think we try to do as best as we can given all the things that are stopping them.' This again directs blame away from carers, by referring to things stopping 'them': indeed the staff are doing as much as they can. Thus a practicalities discourse is advanced to excuse why staff cannot give choices to some residents. By separating the notions of 'choice' and 'control,' the possibility that people with learning disabilities could be in control is left behind. Meanwhile constructions of a lack of choice because of internal factors or environmental factors allow staff to position themselves as facilitators of client choice, whilst justifying a lack of success in overcoming any obstacles encountered.

Mixing Increased Autonomy and Practicalities Talk

Here participants strenuously appealed to the rights and choices talk characteristic of discourses of increasing autonomy, but counteracted it almost immediately with practical considerations. For example throughout her interview Delia explicitly stated that the idea of increasing choices and control had her full support 'in theory;' however in practice the idea came up against 'great big obstacles.' Extract 3 is an example of this. Here she is discussing her thoughts on allowing service-users to have control over their money. Notice how certain medical understandings are drawn on, situated within an individual model of disability (Oliver, 1996) which position service-users as, for example, incapable, irresponsible and vulnerable. These operate in conjunction with practical considerations to naturalize and justify a continued denial of choices, control and segregation from the community.

Extract 3 Delia-Lines 493-507

- 493 R The Government have also looked at erm giving direct
 494 payments to people with learning disabilities so they can
 495 control their own money. Erm what do you think about that?
- 496 D I think it's theory (word) again the idea is great because it's
 497 giving them the ability and the (where of all) to choose. But to
 498 be fair it depends on their level of disability because some of
 499 our clients couldn't. So what happens then to the money, who
 500 chooses? You know I think that choices, these choices would
 501 need to be made for them. I think they they need to start
 502 learning numeracy sessions, because some of them could just
 503 go out and blow it on fags, to be perfectly, to BE HONEST!
 504 There are smokers here there are you know erm and they
 505 would see it as heyyyyy! I'm not saying they would do all that
 506 to all their money but if they had more money they would
 507 spend it!

Delia puts together a persuasive account in several ways, which has the effect of naturalising service-user dependence on care staff. Firstly the 'practice/principle rhetorical device,' comes into play where initially Delia strongly affirms the idea of allowing service-users to have control over their money. However this statement is perforated with dilemmatic words such as 'theory' and 'idea,' which Billig et al (1989) argued can carry much argumentative potential. The expression of support for increasing control also acts as a disclaimer (Hewit and Stokes, 1975) for what follows, 'these choices would need to be made for them' (500-1). The effect is that because Delia positions herself as an enlightened individual, 'the idea is great because it's giving them the ability and the (where of all) to choose,' she is able to convincingly

produce practical arguments which counteract enabling choice and control. Therefore Delia *would* support the idea of allowing people with learning disabilities to control their own money, *but* ‘some of them could just go out and blow it on fags.’

Secondly, as well as explicitly stating that ‘choices would need to be made for them,’ Delia positions certain service-users as lacking capability, noting that consideration would depend on ‘their level of disability.’ She additionally describes certain behaviours which position residents as irresponsible and impulsive, stating that ‘some of them could just go out and blow it on fags,’ and ‘if they had more money they would spend it.’ Here an extreme negative case is given justifying why choices need to be made for clients. This was frequently seen in the interviews, for example when discussing taking risks Martha stated, ‘if it was one of my residents who really didn’t realise that bungee jumping without a bungee was going to end in death, then I’m sorry you know I would feel that my duty of care would be such that I’d have to, in that circumstances do something really strongly.’ Similarly in considering allowing service-users to have choice over where they lived, Olivia advanced a description of a resident who had chosen to live in a small unit within the community. She commented that, ‘she put on a huge amount of weight and she actually deteriorated her vocabulary deteriorated her just her whole cos she spent a lot of time in her room on her own just watching tele.’ When justifying giving residents a non alcoholic wine, Irene noted that, ‘if somebody were to knock back erm four glasses of wine in you know you know and that wouldn’t be good for them because of their medical condition’ (see also extract 5). Over the dataset as a whole staff rarely described marginal or positive incidences of increasing choices and control. The implications

of this are that such extreme/irrational cases could function as a powerful argument against empowerment.

Delia also talks about giving service-users numeracy sessions, offering up identities of residents as people who are in need of skills training (501-2). This contradicts the previous statement that ‘choices would need to be made for them,’ and is reminiscent of the ideological dilemmas proposed by Billig et al (1989). This simultaneous presentation of dilemmatic, contrasting social beliefs allows for several functions (Billig et al, 1989): a speaker is able to ward off negative criticism and maintain the appearance of reasonableness, whilst continuing to uphold a strong argument. Therefore by proposing a way of enabling clients to gain control of their money Delia demonstrates that she has considered ways around the problem. This makes her account appear more reasonable and balanced, whilst the use of the statement, ‘to be perfectly, to BE HONEST,’ allows her to present potentially disagreeable information under the guise of truth and reality. However a show concession (Antaki and Wetherell, 1999) towards the end of the extract (lines 505-7- I’m not saying they would do all that to all their money), marked with the concession marker ‘you know’ and the reprise marker, ‘but,’ ensures that Delia successfully manages stake whilst defending her claim against allowing service-users to have control over their money.

Risk

Risk was widespread in the interviews and was talked about in two distinct ways. One way involved maxims such as ‘risk is part of our lives,’ and ‘there are risks that you need to take.’ This was only found in a few interviews and appealed to notions of personal growth and self determination, characteristic of the increasing autonomy

talk. However, speakers who constructed risk in this way also engaged in another discourse where it was constructed as something that had to be avoided/balanced against increasing choices and control. This was found in all interviews and is discussed in a section in the Green Paper, 'Independence, Well-Being and Choice,' called 'Managing Risk,' (Department of Health, 2005). Here it was noted that though a high value is placed on increasing autonomy, for some people in receipt of social care, with 'varying capacities,' (p. 28) this is not always possible. Therefore social care is responsible for ensuring that a balance is struck 'between enabling people to have control over their lives and ensuring they are free from harm, exploitation and mistreatment' (p. 28). Similarly many speakers who talked about risk used a practice/principle rhetorical device.

This extract concerns enabling service-users to gain employment and exemplifies increasing autonomy talk in the construction of risk. Neil is asked how he would feel about service-users working if they were perceived to be at risk. He responds:

Extract 4 Neil-Lines 490-492

490 N Umm yeah, why not? Risk is in every part of our lives, our
 491 everyday lives, if they can deal with risk why not, they should
 492 be allowed to.

Firstly, by responding positively and following this up with his own question 'why not?' there is the sense that Neil resists the subject position of hindering client choice and control through a practicalities talk discourse. This accords with how he then constructs risk. He states 'Risk is in every part of our lives, our everyday lives,'

which categorises service-users as belonging to the category 'us.' Potter and Wetherell (1987) noted that inferences could be made relating specific activities to category membership. Therefore an 'all the same,' theme, is used which is compatible with the category-bounded activity of allowing service-users to manage risk. However, despite classifying service-users as 'us,' Neil nonetheless goes on to refer to them as 'they,' (491) which has the discursive effect of rendering them different. This reference to 'they,' accompanied by the question 'if they can deal with risk,' effectively constructs some service-users as incapable and vulnerable. This implies that if considered incapable of dealing with risk, then risks should not be taken in allowing service-users to gain employment. Additionally as seen in extract 1, the way in which Neil judges whether or not service-users 'should be allowed,' would be unusual if he were talking about a non-disabled paying employer. This again is reminiscent of Dowson's (1997) discussion of empowerment as something that is loaned rather than given.

Unlike the last extract, risk is constructed below as a practical consideration against enabling service-users to make their own decisions. Barbara has been describing how compromises would have to be made in allowing someone with weight problems to choose what they eat. The interviewer (TJ) asks whether risk and safety is considered more important than giving choices. This is how Barbara responds:

Extract 5 Barbara- Lines 491-511

491 B (Sighs) I would be most annoyed if somebody took my choices
 492 away from me and my rights. But I think I mean I just found
 493 out I have high cholesterol. So I got to change my because I got

494 twenty percent of having a heart problem and it killing me. But
 495 how do you say that to someone who has disabilities and that
 496 can't comprehend what you're saying and then those lines I can
 497 say that can't I, it's my problem. If I choose to eat all the wrong
 498 foods and die of a heart attack because my arteries have furred
 499 up with cholesterol and all the rest of it but how can you put that
 500 across to someone who hasn't got the knowledge, the
 501 understanding that situation. And it is a fine line between rights
 502 and choices and taking risks. But if the evidence is there, that
 503 you as a resident is eating all the wrong foods and we just
 504 saying okay then because it's your rights and choices, are we
 505 killing them? Where does the where does the fine line come in
 506 where we do have to maybe say 'no you can't do that.' I can't I
 507 can't you know I can't be giving you this food knowing there's
 508 a possibility you know if you're diabetic, went into a coma,
 509 didn't come round, erm and furring up your arteries and it's
 510 gonna kill you.

Barbara begins by resisting the subject position offered to her, and intentionally takes on a second-order positioning, drawing on the taken-for-granted strength of rights and choices discourse to express annoyance at its potential infringement. However, using a practice/principle rhetorical device she then invokes a practicalities discourse, therefore maintaining her positive identity whilst arguing against choice and control. Between lines 493-503, she puts across a persuasive argument by advancing an account of a personal (non-learning-disabled) heart condition. This she compares and contrasts directly to the circumstance of individuals constructed as lacking understanding, a characteristic typical of learning disabilities. By constructing herself as an autonomous and independent agent, 'I can say that can't I, it's my problem,' she

takes responsibility for her own choice of avoiding a particular health risk ‘If I choose to eat all the wrong foods and die of a heart attack because my arteries have furred up with cholesterol’. This personal example serves to make her account less open to attack, whilst contrast structures (Potter and Wetherell, 1987 and Speer, 2002) enable her to draw the comparison between herself as an autonomous individual and ‘their’ position of lacking comprehension (496), knowledge, and understanding (501). This also legitimises the inference that decisions should be made for them to avoid health risks (495-502).

Barbara then questions, ‘because it’s your rights and choices, are we killing them?’ and ‘where does the fine line come in where we do have to maybe say ‘no you can’t do that?’ Here other devices are used to settle this question. For example, a ‘fine line’ dividing risks, rights and choices suggests that though these may be separate issues, they are interrelated. By increasing rights and choices, the possibility of risk is also increased. Staff are portrayed here as operating within a bounded frame of empowerment, allowing service-users to only make decisions within the realms of what is considered safe. This was frequently observed in staff interviews, particularly in talk on health, safety, normalisation and risk. Bounded empowerment may be a way in which staff realize both goals of increasing choices whilst simultaneously maintaining a certain standard of care. In line 508-9 Barbara again draws on a practicalities discourse of ‘acting in one’s best interests,’ where she states, ‘I can’t be giving you this food knowing there’s a possibility you know if you’re diabetic...’ Here an extreme negative case, ‘are we killing them,’ and ‘it’s gonna kill you,’ persuasively suggests that increasing service-user rights and choices could amount to murder. As was seen in extract 3, this substantiates her claim that increasing choices

could be dangerous, if not deadly. What could be stronger than denying choice because allowing it would amount to murder?

Discussion

Current research suggests that staff face many conflicting practical dilemmas when incorporating agendas of empowerment into the everyday support of people with learning disabilities (Antaki et al, 2002; Finlay et al., in press; Jingree et al., 2006). This study examined the discourses of care staff around promoting choices and control. Three discursive themes were identified, which illustrated how staff organised their talk around issues relating to empowerment. These themes were: 'increasing autonomy talk,' 'practicalities talk' and 'mixed increasing autonomy talk and practicalities talk.' The 'increasing autonomy' theme centred on discourses about freedom of choice and individual action. This talk also provided dilemmatic and contradictory argumentative resources, which when combined with practicalities talk, argued against giving choices and control. The strong representation of the 'increasing autonomy' discourses in all interviews accorded with current aims found in government policy and other literature on empowering service-users with learning disabilities (E.g. Department of Health, 2001; Department of Health, 2005). With this talk staff were able to present themselves as enlightened individuals and position themselves as facilitators of client choice. These discourses acted as the guiding principle of staff conduct whereby giving choices was upheld as the priority. It was presented as natural, obvious and taken for granted and strong opposition was expressed at its potential infringement.

The 'practicalities talk' theme was as widespread as 'increasing autonomy' talk and justified why choices and control could not be increased for some residents. Practicalities were often described as an unalterable reality that had to be worked around. For example in extracts two and three interviewees constructed practicalities as being internal factors within service-users, whereby impairments such as a diminished cognitive ability were described. These internal factors were used as justifications for why attempts to increase client choices were unsuccessful. A comparable construction of practical considerations as internal factors has been noted by Wetherell et al (1987) in their analysis of unequal egalitarianism in discourses of gender and employment opportunities. They found that practical considerations appealed to discourses of a 'biological inevitability,' (p. 62) of the differences between men and women. Similarly Wetherell and Potter's (1992) examination of racist talk found that participants often spoke of genetic differences between groups where negative characteristics such as 'laziness,' (p. 15) would be attributed to one group, resulting in a hierarchy of groups from superior to inferior. Augoustinos et al's (1999) study of racism in Australian talk, found that whilst aboriginal people were not constructed as *biologically* inferior, they were constructed as *culturally* inferior. This was represented as difficulties in adapting to a civilised and superior culture. Such constructions of aboriginal people blamed them for economic disadvantage. In this study, constructions of practicalities as internal factors had the effect of positioning service-users as, for example, incapable, irresponsible and vulnerable. This perhaps enabled staff to allocate some blame towards service-users in instances where efforts to increase choices and control were constructed as unsuccessful.

A few speakers described environmental/social barriers to choice. For example, in extract two, references were made to a shortage of staff and the lack of a minibus. This enabled staff to apportion blame whilst presenting themselves as trying their best. The way in which staff spoke of both internal factors and environmental/social factors, accords with Wilcox et al's (2006) 'individual pathology discourse' and a 'context discourse' respectively. Wilcox et al located the 'individual pathology discourse' within the medical/individual model of disability, whilst arguing that the 'context discourse' was analogous to the social model of disability. Constructions of practicalities as internal factors similarly accords with the individual model of disability (Oliver, 1996), which is incompatible with the notion of empowering people with learning disabilities. Meanwhile environmental obstacles to service-user choice seem more situated within the social model of disability (Oliver, 1996), which if tackled might be more congruent with the notion of empowering service-users.

The way in which increasing autonomy talk was combined with practicalities talk under the 'increasing autonomy and practicalities talk' theme was observed in all interviews, and resembled what Wetherell et al (1987) and Wetherell and Potter (1992) described as a practice/principle rhetorical device. There are many similarities between how this device functions in these previous studies and the current one. For example, in Wetherell et al's (1987) study on sexist talk, speakers would express an important principle such as, 'there should be equalities for both men and women in the workplace' (p. 63), which would be rendered unworkable by raising a practical objection, such as, 'the mother should be looking after the child and bringing it up,' (p. 63). In the present study the expression of an ideal was also nullified by simultaneous engagement in practicalities talk. This was more powerful than simply

presenting practicalities talk alone, as staff were able to maintain credibility through upholding a positive identity as endorser of service-user rights and choices.

Similar findings have been reported in studies outside of the field of learning disabilities. For example a paper by Peräkylä and Vehviläinen (2003) discussed the usefulness of conversation analysis when examining the gap between theory and practice. They focussed on the work of Vehviläinen who used conversation analysis to examine interactions between counsellors and their students in career guidance counselling. The theories said to direct career guidance counselling are based on ideological principles of learner-centredness, self-directedness and empowering students. However these theories are abstract and contain little reference to actual interactional practice between the client and practitioner. Vehviläinen's work examined how the abstract ideology of learner-centredness is operationalised in practice. She found that counsellors are faced with a conflict in that their 'obvious' role as a counsellor is to advise. However, this is at odds with the principle of learner-centredness which guides counsellor practice. By looking closely at verbal interactions in career guidance sessions, Vehviläinen found that one of the ways which counsellors manage this paradox was by orienting to both learner-centredness and the more traditional view of the expert as 'knowing what is best' (p744). Firstly counsellors would begin by eliciting the student's views of their career plans. This fits in with the learner-centred ideology by making students accountable for producing ideas. The counsellor would then make recommendations based on the student's contribution and correct the student plans, which would enable him/her to maintain an expert position. Similarly in our study, staff described themselves as guiding service-users towards making certain decisions. There were two main

methods in which this was achieved: persuading service-users by providing them with the negative consequences to their choices or guiding decisions by ‘educating’ service-users about their choices. The conflict faced by support staff is similar to Billig et al’s (1989) discussion of teaching and learning and the dilemmatic contrasts between freedom and constraint. They argued that such a conflict is not a feature of education alone but appeals to general political debate and polemic where such oppositional philosophies are features of many theoretical positions within the social sciences.

One of the ways in which this study expanded on the practice/principle rhetorical device was through the identification of extreme/negative cases (see extracts two and five), which often featured as part of practicalities talk. This had the effect of performing additional persuasive work to the already potent practice/principle rhetorical device. For example in extract five under the sub-theme ‘risk,’ an extreme case of killing service-users was advanced to substantiate the interviewee’s claim that allowing control over food could be dangerous, if not deadly. Similarly another interviewee claimed that allowing service-users to take risks could amount to them bungee jumping without a bungee unless staff intervened. These cases were used as unarguable examples as to why increasing autonomy was unrealistic and allowed the presentation of alternative agendas such as concerns over health and diet as the ultimate priority. The use of extreme/irrational cases was a frequent occurrence in the interviews. Indeed staff rarely described inconsequential incidences of increasing choices and control, or positive examples of empowerment.

Edwards (1991) argued that categories are organised in ways which have implications for speakers. In this analysis categories were flexibly managed and context dependent. For example in extract four, in 'risk,' an increasing autonomy discourse was advanced where service-users were categorised as 'we're all human,' which allowed the speaker to use an 'all the same' theme. This was well-suited to the construction of risk as a feature of increasing autonomy through personal growth and therefore was more compatible with empowering service-users. In contrast, classifications of service-users as 'they' and staff as 'we,' observed for instance in extract one (where again increasing autonomy talk was evident), demonstrated that in contrast to 'we' (staff), 'they' (service-users) don't have choice. This form of 'difference' categorisation, situated within increasing autonomy talk served to validate staff commitment to empowering service-users as it drew attention to how little choice and control people with learning disabilities have in contrast to other citizens. In extract four and five where a practicalities discourse was invoked, service-users were constructed as 'they,' which produced constructions of incapacity and vulnerability. This 'difference' categorisation had the discursive effect of rendering service-users different and closing down opportunities for allowing them to manage their own risk. Thus this 'difference' theme, when mobilised with practicalities talk, was incompatible with empowering service-users.

Contrast structures (Potter and Wetherell, 1987 and Speer, 2002) also distinguished between constructions of old/bad staff alongside new/good staff. This was shown here in extract one in 'increasing autonomy,' but was also widely seen in progressive talk of how improvements had been made for service-users in comparison to the past. Interviewees positioned themselves as new/young/good staff, contributing to a liberal

present, whilst contrasting their practices to that of old/bad staff. Therefore old/bad staff were constructed as more concerned with institutional rules and routines, to the point of hindering service-user choices, whilst contrastingly, younger staff placed more importance on facilitating freedom of choice. In extract one Amanda positioned herself as defending resident rights for choices and control against ‘more controlling older staff.’ By using these contrast structures, speakers persuasively achieved distancing from the injustices of the past, and therefore undermined the legitimacy of the view that their current practice may be controlling in any way. This was similarly observed in Augoustinos et al’s (1999) study on racist talk, where participants distanced themselves from accusations of overt racism by using distanced footing and attributing racism primarily to the older generations.

Subject positions within the increasing autonomy theme and practicalities talk offered competing identities to staff of being facilitators of service-user independence on the one hand and being good, responsible carers on the other. Consequently opportunities to offer service-users complete choice and control were closed off. This may have produced a ‘bounded empowerment,’ whereby service-users are offered independence as long as it falls within the constraints of safety. ‘Bounded empowerment’ was frequently seen in interviews, e.g. Delia stated, ‘choices yes but healthy eating we tend to we prefer.’ Similarly Barbara (extract five) noted that, ‘it is a fine line between rights and choices and taking risks.’ Therefore bounded empowerment may be a way in which staff attempted to manage their conflicting agendas. A ‘bounded empowerment’ not only afforded staff the position of facilitator of choice, but also enabled them to ensure that clients were safe and well cared for.

However, it could be argued that this bounded empowerment would not be enough to satisfy a non-disabled citizen. What is more, though the desire to increase the choices and control of service-users was strongly evident in all the interviews, it could be said that this was described as form of a temporary or immediate autonomy to allow service-users to do whatever they wanted to do in the short term. Young (1980) reasoned that autonomy should be understood as self-government, whereby the more one is in control of directing their life the more one is autonomous. However, the service-user choices that were described here were not decisions that were driven by self-directedness or a life-plan. Staff talk about choices was directed by a duty to act in the best interests of their service-users, therefore, as Jenkinson (1993) noted, choices were guided or restricted. This goes against Young's (1980) description of 'Global Autonomy' (p. 566) whereby an autonomous person's life is directed by a life plan (including for example career, life-style and dominant concerns) which fully expresses his or her own will through the unification of his/her choices.

Dowson (1997) argued that empowerment is a value rooted in the belief that people with learning disabilities are the same as other people, with the same needs, wishes and rights. However the way in which staff constructed service-users as incompetent and vulnerable here served to justify why choices could not be facilitated in some situations. In extracts one and four we observed how staff described whether or not choices should be given or restricted in ways that would be unusual if they were talking about non-disabled individuals. It could be said that this divides the world into those who have the rights to 'give' and those who can 'receive' the right to choose. Indeed, as Dowson (1997) noted, the very term 'empower' involves action taken by those who hold power, whilst the recipient (or empowered) remains passive.

This raises the question of what could be done to overcome this impoverished conception of autonomy that is offered to service-users? Coyle (2001) argued that discourse analysis has the potential to reveal oppressive discourses, and therefore effect social change. Therefore one strategy may be to challenge disabling and disempowering discourses. Using the insights of the social model of disability (Oliver, 1996), staff could be made aware of positioning service-users within an individual pathology discourse, and the way in which this can limit opportunities to increase choice and control. Additionally staff could be made conscious of how service-users may be constructed as capable rather than incapable, and how this is more conducive to empowerment (Booth and Booth, 1992). Burr (2005) reasoned that change could be brought about by becoming familiar with the positions offered to us and the positions we offer others in our interactions with them. Billig et al (1989) noted that speakers are not always aware of the counter themes within the discursive resources invoked, or the damaging consequences that may arise when they are brought into play. Thus by familiarising care staff with these contradictory themes, strategies could be developed (for example by changing one's response in conversational exchanges) to resist unacceptable positions and take up positions in alternative discourses. One way that this could be achieved is by offering staff training intending to increase familiarity with the individual model and the social model of disability. Workshops could also be organised to increase awareness of the ways in which talk can have implications for empowering service-users. It may also be beneficial to draw attention to the effects of extreme/negative cases and encourage staff to talk about empowering service-users in more positive ways. It should be noted that this data is about staff talking about increasing choices. Other research has

looked at actual interactions practiced in real situations of choice, and training on those issues is also important (Finlay, Walton and Antaki, in press). A further way could be to organise workshops in which service-users with learning disabilities train their own staff about choices, thus revising subject positions. Finally, perhaps the situation could be remedied by looking to Finlay et al's (in press) suggestion that difficulties in increasing the choices and control of service-users will not be resolved through a willingness to challenge discrimination alone, but by changing what it means to be a good worker and to have a well-run service. Therefore, perhaps solutions could be gained by looking to the other agendas of care staff.

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