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PERSON-CENTERED PLANNING ON THE FRONT-LINE: EXPLORING  
PRACTICE FRAMEWORKS OF DIRECT SUPPORT STAFF IN  
COMMUNITY PROGRAMS FOR INDIVIDUALS WITH INTELLECTUAL  
AND DEVELOPMENTAL DISABILITIES

By

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## ABSTRACT OF DISSERTATION

### **PERSON-CENTERED PLANNING ON THE FRONT-LINE: EXPLORING PRACTICE FRAMEWORKS OF DIRECT SUPPORT STAFF IN COMMUNITY PROGRAMS FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES**

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**Background:** The Department of Health and Human Services estimates that by 2020 the number of direct support professionals (DSPs) needed to meet the care of the projected increase of 1.4 million individuals with intellectual and developmental disabilities (ID/DD) will rise sharply to approximately 1.2 million full-time employees. A long acknowledged challenge of the ID/DD field is how to hire, retain, and train DSPs to carry out the person-centered plans (PCPs) in a way that improves clients' quality of life and supports increases in their levels of independence. Literature has shown the importance of DSP practice behaviors as they relate to client outcomes, and the skills, knowledge, and values that are necessary to carry out person-centered plans. To date, there have been few studies focused exclusively on how DSPs understand, interpret, and put into daily practice these same skills, knowledge, and values. This study examines the ways in which individuals who are employed as DSPs in congregate or group home settings for individuals with

ID/DD perceive and approach practice decisions within a framework of person-centered planning.

**Theory:** The theoretical framework developed in this study combined a critical realist ontology with recognition theory, interbehavioral psychology, and street-level bureaucracy to envision the multiple generative mechanisms that may influence a DSP's daily decision making. These daily decisions, and the attitudes, opinions, and viewpoints that reinforce them, require a fairly sophisticated understanding of the types of practice behaviors that encompass choice and autonomy. This study used the framework above in conjunction with the existing literature to explore the habitual practice behaviors of DSPs as viewed from a critical realist perspective to determine what types of "real level" variables (i.e., levels of recognition, paternalism, self-referential decision-making, agency policy and resources influence, and group home culture) are expressed by DSPs as significant "actual level" or activating factors in their day-to-day use of discretion at the "empirical level" of service provision.

**Methods:** Primary data were collected in a mixed method fashion from in-person interviews and the application of Q methodology to elicit consensus viewpoints from 30 DSPs working in two ID/DD support organizations in New Jersey. This was accomplished through the development of 48 statements (i.e., Fisherian concourse) which represented the six areas introduced above which participants sorted according to their own subjective view on what areas were most influential to their daily practice. All participant sorts were analyzed in PQmethod, using the sequential application of three sets of statistical

procedures: 1) correlation, 2) factor analysis and 3) the computation of factor scores. The quantitative data analysis was followed by a qualitative analysis in which the factors were interpreted using the post-sort interviews and theoretical considerations to allow participant voices to provide meaning to the statistical results

**Key Findings:** The results of the factor analysis and qualitative thematic analysis revealed five factors explaining 60% of the variance among the individual Q sorts. The five factors showed consensus on how DSPs carried out their work in the following ways: (1) Focus on recognition and agency policy; (2) focus on barriers to work; (3) focus on being a role model; (4) focus on self-referential thinking; and (5) focus on pushing back against agency policy.

**Implications:** The theoretical framework, methodology, and findings of this research highlight the critical need to envision person-centered plans and their implementation as a process generated by various mechanisms at the micro, mezzo and macro levels which culminates in the DSP/client relationship. The five factors that arose from the qualitative and quantitative analyses reflect how DSPs manage their discretion on the job in the context of person-centered plans (factors 1, 3 and 4) and how structural level mechanisms (factors 2 and 5) can hinder DSP's ability to do their work. Recognition theory and its operationalization of recognition into three areas of self, rights, and community worth was found to resonate strongly with most DSPs that participated in this study and could be a theoretical tool useful to adding context and philosophical grounding for the implementation of person-centered planning. Substantial

support for viewing DSPs as street-level bureaucrats was also found among these respondents, adding insight into how policy at the macro level is interpreted by groups of program staff at the mezzo level and put into practice at the micro level of DSP to client interaction.

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To those that got me here, thank you for making the journey not only possible, but pleasurable. Every one of you are represented in the hard work, dedication, and perseverance required to complete this voyage. In striving to say something meaningful about the world, I've discovered new ways of looking at science, social work, myself, and those that I worked to support before joining this PhD program. I am grateful to all the varied and numerous types of support I have received towards completing this degree and hope to honor these sacrifices no matter how big or small by continuing to dedicate myself to improving the lives of others through research, teaching, and service.

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## **CHAPTER 1**

### **INTRODUCTION**

According to the U.S. Department of Health and Human Services (2012), the number of individuals living with intellectual (ID) and developmental disabilities (DD) in the United States is at least four million. That number has grown steadily as the life span of adults with ID/DD has increased due to advances in medical interventions, and is expected to continue to rise exponentially (American Association of Intellectual and Developmental Disabilities, 2015). Researchers have long hypothesized that these increased numbers can create “a powerful synergy that is stretching state service-delivery systems well beyond their capacities to meet current and projected residential, vocational, and family support services for individuals with developmental disabilities” (Braddock, 1999, p. 156). Continued evidence and support for this statement has followed in subsequent years (Lakin, Hewitt, Larson, & Stancliffe, 2005; Robertson, Emerson, Hatton, Elliot, McIntosh, Swift, Krinjen-Kemp, Towers, Romeo, Knapp, Sanderson, Routledge, Oakes, & Joyce, 2007). According to researchers and policy makers, one of the elements central to the future success and effectiveness of services for people with ID/DD is a well-trained work force of direct service providers (DSPs). Paradigms of care for individuals with ID/DD have shifted during the past decades to a model of community-based, person-centered planning (PCP), which aims to empower individuals with disabilities to have increased self-determination and

independence (Taylor & Taylor, 2014). Within this framework, DSPs are expected to be able to provide care and programming that advances individualized choice, autonomy, and community inclusion (Beadle-Brown, Hutchinson, & Whelton, 2012; Hatton, Khan, & Oranu, 2008; Lakin, Hewitt, Larson, & Stancliffe, 2005; Sanderson, 2002; Taylor & Taylor, 2014). Despite the critical importance of this work force and their skill set, little empirical research is available on the ways in which DSPs understand and act on the practice decisions and behaviors that embody PCP within community based settings at the point of service and policy delivery.

The purpose of this study is to examine the ways in which individuals who are employed as DSPs in congregate or group home settings for individuals with ID/DD perceive and approach practice decisions within a framework of person-centered services. Specifically, this study collected primary data from in-person interviews and the application of Q methodology to elicit viewpoints from 30 DSPs working in New Jersey to determine what factors arise from these viewpoints. For the purpose of this study, DSPs are defined as people who provide support, training, supervision and personal assistance to individuals with ID/DD through basic self-care and independent living activities with the goal of helping them lead self-directed lives of active participation and contribution within their communities (Hewitt & Larson, 2007).

### **Significance of the Proposed Study**

The Department of Health and Human Services (HHS) estimates that by 2020, the number of DSPs needed to meet the care of the projected increase of 1.4

million individuals with ID/DD will sharply rise to approximately 1.2 million full-time employees (U.S. Department of Health and Human Services, 2006). A study by the American Health Care Association (AHCA) in 2008 found approximately 110,000 DSP position vacancies in ID/DD service organizations across the United States. Underscoring the critical importance of this labor force, it is estimated that DSPs are responsible for providing 80-90% of all daily interpersonal communication and skill building exercises (e.g. adult daily living skills) for individuals with ID/DD in residential care arrangements (Harris-Kojetin, Lipson, Fielding, Kiefer, & Stone, 2004). Given these numbers, it is clear that if the human services system is to address this dire situation, it must continue to explore how to develop and retain a professional and highly skilled DSP workforce.

The current chasm between supply and demand for DSPs is exacerbated by several diverse demographic trends. These include, but are not limited to: the increased life-span of individuals with ID/DD (with the number of adults with ID/DD aging 60 years and older expected to nearly double from 641,860 in 2000 to 1.2 million by 2030) (Davidson, Heller, Janicki & Hyer, 2003; Heller, Stafford, Davis, Sedlezky, & Gaylord, 2010); high rates of DSP turnover, which are estimated at 50% for residential settings within one year of hire (Hewitt & Larson, 2007); extremely low entry-level pay for DSPs, with a national average of \$9.37 per hour (ANCOR, 2010); structural and cultural workplace issues (e.g., high levels of stress, work overload, role ambiguity, lack of participation in decision-making, etc.) that combine to produce physically and emotionally draining workloads for DSPs (Hatton, Rivers, Mason, Mason, Emerson, Kiernan, Reeves



& Alborz, 1999); and finally the lack of respect the position of DSP enjoys in the ID/DD field and the general population (Hewitt, Larson, Edelstein, Seavey, Hoge & Morris, 2008). These factors, when viewed from a service outcome perspective, may lead not only to a negative compounding effect on DSP turnover but may also decrease the quality of care provided to individuals with ID/DD. Higher expectations with regard to service delivery and DSP performance are difficult to establish when “people with disabilities experience a revolving door of strangers to whom they must subject themselves for the most intimate interactions of daily life” (Macbeth, 2011, p. 3).

Research addressing these work force issues has zeroed in on areas including how to recruit and how to retain a workforce of qualified DSPs (Harris-Kojetin et al., 2004). Recruitment, retention and quality issues have been addressed, in part, by studies advocating hiring practices focused on employee and organizational fit (see, for example, Hatton et al., 1999; Robson, Abraham & Weiner, 2010). The concept of “fit” is taken from the organizational psychology literature and is used to explore the congruence between an individual and an organization’s culture (Schein, 1985). Often this relationship between person (P) and organization (O) is typified by the equation P—O Fit, which represents “the compatibility between an individual and a work environment that occurs when their characteristics are well matched” (Kristof-Brown, Zimmerman, & Johnson, 2005, p. 281). A discrepancy in this relationship, often due to differing values, can create increased work stress and poor morale, both of which are leading indicators

for high staff turnover (Kristof-Brown et. al., 2005). Organizational culture has been defined as:

...a pattern of basic assumptions invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration that has worked well enough to be considered valid and therefore to be taught to new members as the correct way perceive, think and feel in relation to those problems. (Schein, 1985, p. 9)

Within the ID/DD field, such “fit” includes recruiting staff that are capable and interested in the delivery of person-centered care. Studies in the organizational psychology field, as well as the ID/DD field, have suggested that a lack of fit between an organization and its individual staff members is linked with a variety of negative staff outcomes including increased turnover, poor job performance, low job satisfaction, and high levels of employee stress (Hatton et al., 1999; Schein, 1985, 1996). Hatton et al. (1999) find that DSPs who expresses a moral commitment to the work of an agency have a much greater “fit” than those employees who do not.

To better address this concern of “fit” and enhance the recruitment, retention, and quality of care, research in the ID/DD field has identified several employee related strategies for use by organizations and their managers. These include providing referral bonuses to current employees (Hewitt & Larson, 2007; Larson, Lakin, & Bruininks, 1998; Wanous, 1992); using realistic job previews (Hewitt & Larson, 2007; McEvoy & Cascio, 1985; Premack & Wanous, 1985); and using standardized structured behavioral interviewing techniques or situational interviews (Buckley & Russell, 1999; Hermelin & Robertson, 2001; Hewitt & Larson, 2007). These strategies are aimed at better capturing which

prospective employees might best “fit” the realities of the job. While the evidence from the organizational psychology field suggests that utilizing these and other hiring practices should reduce turnover issues for DSPs, little empirical evidence is available regarding effects, and high levels of DSP turnover remain a nationwide phenomenon (Hewitt et al., 2008; Taylor & Taylor, 2013).

Another workforce development strategy involves staff training, and it has been argued that it is essential to enhancing DSP retention and the quality of care they provide (O’Neill & Hewitt, 2005; Reid, Parsons, Lattimore, Towery, & Reade, 2005). At the individual level, DSP training has been found to be related positively to job satisfaction, lower levels of job related stress, and commitment to their employer as evidenced by increased tenure (Ejaz, Noelker, Menne, & Bagaka, 2008; Hatton et al., 1999; Hatton, Emerson, Rivers, Mason, Swarwick, Mason, Kiernan, Reeves, & Alborz, 2001). A lack of training has also been shown to impact DSP job satisfaction negatively due to awareness of the skill deficiencies present among their co-workers, supervisors, and themselves in the workplace (Hewitt, Larson, & Lakin, 2000; Larson, Lakin, & Bruininks, 1998). However, some studies find limited or no evidence that training is linked to workforce retention among DSPs (Castle, Engberg, Anderson, & Men, 2007; Larson, Doljanac, Nord, Salmi, & Hewitt, 2007; van Oorsouw, Embregts, Bosman, & Jahoda, 2009).

To address the issue of DSP training, the National Alliance for Direct Support Professionals (NADSP) issued a report in 2011 strongly urging the human services system to develop a professional direct support workforce through

efforts including: easy access to high quality, competency based training; developing effective and supportive mentors; and creating an employment culture that fosters trust and excellence by removing employee “cliques.” This edict echoed a 2006 report to Congress, which declared it critical to improve retention of existing DSPs along with efforts to attract new ones while providing both with the skills and judgment necessary to succeed as their role takes on more autonomy and responsibility within the PCP model (Health and Human Services, 2006). To this end, a national validation study was supported by the National Institute for Disability and Rehabilitation Research (NIDRR) in 2007 to develop a standard set of competency areas for the DSP position (Larson, Doljanac, Nord, Salmi, Hewitt, & O’Neill, 2007). These competencies have since been adopted by the NADSP and include the broad areas shown in table 1:

Table 1.  
*NADSP Competency Areas (Larson et.al., 2007, p. 11)*

Participant Empowerment	Communication	Assessment
Community and Service Networking	Facilitation of Services	Community Living Skills & Supports
Education, Training, & Self-Development	Advocacy	Vocational, Educational & Career Support
Crisis Prevention and Intervention	Organizational Participation	Documentation
Building and Maintaining Friendships and Relationships	Provide Person Centered Supports	Supporting Health and Wellness

These 15 broad competency areas comprise the basis for the online College of Direct Support (CDS), which was created and continues to be maintained by the University of Minnesota's Research and Training Center on Community Living for the training of DSPs. The courses offered are reviewed by a group of content experts from the National Board of Editors, who serve as editors and advisors for all courses. These resources have been available to service providers for 10 years. However, it is not currently known how many service providers actively seek to engage their DSPs through this paid educational program and what the effects of the training are with regard to DSP turnover and performance.

Given the concerns about DSP workforce development, retention, quality and performance, a key piece still missing in the ID/DD literature is an understanding of how DSPs carry out their roles as providers of care and builders of individual autonomy within a person-centered services framework. These daily decisions, and the attitudes, opinions, and viewpoints that reinforce them, require a fairly sophisticated understanding of the types of behaviors that encompass choice and autonomy, and the ways in which they can be facilitated within a context of a population also in need of supervision and direction. Scant research has focused on how DSPs navigate the practical tensions that exist between goals of providing care, supervision, and maintaining a safe environment to a vulnerable population while also striving to increase their independence and self-determination (Gaventa, 2008).

These issues of workforce development and performance are, as such, intertwined: staff are most likely to be capable of delivering high quality person-centered services when they are a good “fit” with the mission and goals of ID/DD person-centered services; when they are motivated and compensated well enough to stay on the job and develop expertise in these areas; and when they truly understand (through training and/or practice) how the decisions they make in daily work routines do or do not advance person-centered care.

Efforts to enhance DSP workforce development must include a basic understanding of how DSPs approach person-centered care decisions in their day-to-day work. That understanding informs subsequent efforts to train, develop, and enhance staff abilities to deliver such care.

### **Implications of the Proposed Study**

The purpose of this study is to explore the viewpoints that exist among DSPs about their work, particularly their practice habits with regard to decision making that facilitates autonomy and self-determination, while simultaneously providing supervised care that ensures the safety of the ID/DD population. The tensions inherent in such practices and decision making will be explored, in part, through the theory of recognition, which describes full individual autonomy as something dependent upon how people are viewed and accepted by others in one’s society (Honneth, 1995), and to add insight into previous works exploring the DSP/client relationship within the framework of person-centered services (see for example Antaki, Young, & Finlay, 2002; Dunn, Clare, & Holland, 2010; Hawkins, Redley, & Holland, 2011; Henry, Duvdevany, Keys, & Balcazar, 2004;

Jingree, Finlay, & Antaki, 2006; McConkey & Collins, 2010). In addition, a critical realism perspective is utilized as the overarching theoretical paradigm in which the subjective phenomenon of DSP on-the-job practice decision-making patterns is conceptualized. This combination of theories, in concert with Q methodology, will allow for a complex and intricate phenomenon to be teased apart, utilizing past research, and prospectively forge a path to move the dominant force driving today's ID/DD service frameworks (i.e., person-centered services) towards a fuller understanding of how full recognition among individuals, their staff, and their surrounding communities can be achieved.

By seeking to explore the range of viewpoints present in DSP decision-making around the issue of supervised care versus autonomy, the question of how DSPs view their work and the decision making frameworks they use on a daily basis may emerge from the arising factors and post-sort interviews. This self-reflective viewpoint is necessary, from a critical realist standpoint, to begin development of agency level interventions and staff trainings, which can effectively infuse PCP services with the “why” of the important work they do. The development of this “why” may also provide the ID/DD field with another tool to insure that the implementation of PCP plans adheres to the larger philosophical undercurrents of social justice by utilizing guiding principles from theory to inform everyday service interactions and practice decision-making dilemmas.

A useful metaphor for the importance of this line of inquiry can be drawn from how the car manufacturer, Toyota, changed the face of assembly

manufacturing from the worker up with an andon cord by instilling a similar “why” within their workforce (Surowiecki, 2006). The andon cord allowed any worker on the assembly to stop production by the simple action of pulling a cord. This permitted each and every worker on the assembly line to become empowered within what had previously been a mechanistic process. This empowerment through individual intervention saw the rate of production actually increase as mistakes could be caught at any point within the assembly process instead of at the end point of construction. This use of the individual as a quality control measure was possible because each worker had a clear conception of what the “theory” or finalized outcome of the assembly process was. By furthering our understanding of how DSPs carry out their jobs, it may be possible to envision ways to similarly empower them by using “theory” or the “big picture” behind PCP practices, highlighting the relevant principles of social justice to insure each and every individual’s plan of care is implemented with the goal of building the individual’s served autonomy. In addition, this could inform future training practices within the ID/DD field at the individual, agency, and policy maker arenas (O’Brien, 1994; O’Brien & O’Brien, 1991; Racino, Walker, O’Connor, & Taylor, 1993; Taylor, Bogdan, & Racino, 1991; Walker & Salon, 1991).

To carry out this endeavor, the subsequent theoretical application of critical realism and recognition theory will provide a possible framework for how DSPs develop their own guiding principles to cope with the daily pressures of their multifaceted job. This intellectual venture will also introduce the concepts from Kantor’s interbehavioral psychology to the ID/DD field and expand the uses



of critical realism and recognition theory towards a more practice-oriented position.

**The primary research questions for this study are:**

1. What are the various viewpoints that exist among DSPs about their practice decisions within a person-centered services framework within community-based care settings?
2. In what ways do the decision-making viewpoints of the DSPs reflect domains including recognition, self-reference, paternalism, agency resources, agency policy, and group home culture?
3. To what degree do the concepts presented in Recognition Theory describe and explain the decision-making viewpoints emerging from the DSP Q sorts?
4. Do the viewpoints of experienced DSPs (more than 18 months experience in the field) and inexperienced (less than 18 months experience in the field) DSPs differ?
5. What are the implications of the findings for the development of DSP training curricula and supportive resources focused on person-centered practices?

## CHAPTER 2

### Review of Empirical Literature

#### Service Provision: Trends and Approaches

According to the National Residential Information Systems Project (RISP), the number of individuals with ID/DD receiving long-term care services from public and private institutions in 2010 was 56,813. This same year, 455,839 individuals were receiving residential services in a group home or supported living environment (Larson, Hallas-Muchow, Aiken, Hewitt, Pettingell, Anderson, Moseley, Sowers, Fay, Smith, & Kardell, 2014).<sup>1</sup> In addition, another 115,059 individuals were on the waiting list within their perspective states to obtain a residential placement. These are the individuals that require support by a DSP workforce on a day-to-day basis. The model of care provided in these types of residential settings has been evolving since the 1960s towards a service approach that seeks to maximize individual choice (O'Brien, 1994; Taylor, Bogdan, & Racino, 1991). The model of care currently utilized in the U.S. is termed person-centered planning (PCP), which is defined as a set of approaches

- 
1. Supportive living is a program movement developed in the United States to move individuals with ID/DD back into community settings in place of institutional locations. These community settings are required now by the Olmstead Act of 2001 to house individuals in the least restrictive environment possible, allowing for individuals to integrate back into the community and provide more choice in regards to where they live. Direct support services are provided within these community settings by agencies that hire, train, and place staff to meet the needs of each individual within these community settings. Supportive living programs bridge the housing gap between institutional care and independent living, ideally building the skills of each individual to live as independently as possible. (Bradley, 1994; Racino, Walker, O'Connor, & Taylor, 1993).

intended to assist someone with an ID or DD to design the supports they need to live their life as they wish (Kincaid & Fox, 2002). PCP is used within community support agencies as a life-planning model to empower individuals with disabilities to increase their self-determination and expand their own independence.

This evolution in the dominant principles of care is perhaps most clearly illustrated in the transition begun in the 1970s from institutional settings towards community-based residences for individuals with ID/DD. A main reason for this historically driven change in services is a paradigm shift more than 50 years in the making (Bigby & Frawley, 2010). This shift coincides with the development of theoretical models of disability that have moved beyond a medical model of service provision to include a social concept of disability (Taylor & Taylor, 2013). The medical model of disability is historically centered on a physical or biological flaw originating from within the body of an individual (Bickenbach, 1993). The process of support within this model begins when a person follows the prescribed course of a patient within the healthcare system: discovery of the problem, diagnosis (and label), and treatment or intervention. Some analysts assert that within this model, individuals with a disability are either cured or remain a perpetual patient (Smart & Smart, 2006). Here lie the seeds of logic for the institutional ID/DD settings still in existence today. If an individual, often a perpetual patient, is labeled as “untreatable” and “flawed,” then it can be argued that it is a public service to provide continuous medical care in specialized facilities (Taylor & Taylor, 2013, p. 214).

## **The Concept of Normalization**

A shift from a medical model of care toward one that focused on individual outcomes and community-based care was precipitated, in part, by the emergence of the principle of *normalization* (Parish, 2005). Normalization is defined as “the use of culturally valued means in order to enable, establish, and/or maintain valued social roles for people” (Wolfensberger & Tullman, 1982, p. 131). The concept of normalization was embraced by the disability movements of the 1970s as a way to reduce the social stigma faced by individuals with disabilities, and to refute the belief that a disability is devaluing on a personal level (Wolfensberger & Tullman, 1982). Wolfensberger (1977, 1982, 1985) championed normalization models with ID/DD populations and other devalued groups. The principle advocates for social, economic, and housing conditions “at least as good as that of the average citizen” in order to “as much as possible enhance or support their behaviour, appearances, experiences, status and reputation” (Wolfensberger & Tullman, 1982, p. 141). According to this model, people who do not integrate with the general population, and therefore remain “different,” may find it difficult to become valued by others. Society may then attribute additional stigma to those who are regarded as “different,” which Wolfensberger (1982, p. 132) terms “negatively valued differentness” or “social devaluation.” Furthermore, society is likely to perpetuate such devaluation through stereotypical labels and attitudes. It should be noted that while researchers and advocates supported and promoted the concept of normalization, little empirical work examined the practice issues of how it was to be

implemented and realized (Oliver, 1993; Wolfensberger, 1977, 1985; Wolfensberger & Tullman, 1982). Some expressed concern that while seeking to instill equality, the normalization model of service could in fact perpetuate the process of social devaluation, as an individual with a disability would need to conform in order to gain acceptance (Culham & Nind, 2003; Hornby, 1999; Low, 1997).

The principle of normalization became influential in subsequent policy developments during the next decades, and it was foundational in state regulations requiring further deinstitutionalization (Taylor & Taylor, 2013). It also provided the conceptual and theoretical rationale for the service delivery model currently in use for all community residential placements within the United States, which is termed person-centered planning (O'Brien & O'Brien, 2002). The emergence of PCP as the dominant service paradigm was also influenced by the advent of a social model of disability, in which disability is explained within the context of individuals' interactions within the structural and attitudinal environments in which they live (Taylor & Taylor, 2013). This perspective of person/environment interaction allowed for the focus of disability to be removed from the "perpetual patient" and on to the world outside the individual. This switch in focus from person to environment may have also provided the rationale for the care paradigm, decades later, to remove the medical specialists as the authorities on the disability experience and transfer it to the individuals with ID/DD who were living with attitudinal and environmental barriers (Taylor & Taylor, 2013). However, despite this dramatic shift regarding the contextualization of

“disability” as something created by society either architecturally or socially, few changes to care provision emerged through the 1980s. During this decade, a “functional model” of disabilities and the goal of habilitation gained precedence in service provision, which still held vestiges of the medical model at its core. There were, however, changes in policy across the United States that brought transformation to standards of quality for community-based programs. The main architect of this was the Commission on Accreditation of Rehabilitation Facilities (CARF) which was jointly created in 1966 by the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP). Through the development of an accreditation process for community based agencies that supported individuals with ID/DD, CARF’s continued work to in conjunction with the passage of the American’s with Disabilities Act (ADA) further pushed the narrative of disability away from medicalization towards the establishment of disability as a definable minority group with rights above and beyond those of typical citizens.

### **Functional Models and Habilitation**

The functional model of disabilities sought to define disability “in relation to the skills, abilities, and achievements of the individual in addition to biological/organic factors” (Smart & Smart, 2006, p. 32). Here we can see the movement toward the framing of the conceptualization of a disability and it’s lived experience to extend beyond just the person to the interaction of the person within the environment. However, whereas the social model focused solely on the barriers and limitations that can create an experience of disability, the functional

model (as it was used in practice) focused more on individual skill acquisition and remediating deficits, keeping the care solutions focused primarily on individual change (Bigby & Frawley, 2010). This focus on change as residing primarily within the individual with a disability led to individualized treatment plans, and these tended to be developed primarily by professionals rather than in concert with the clients (Rea, Martin, & Wright, 2002; Taylor & Taylor, 2013). In addition, the purpose of service within this model was, as previously mentioned, focused on habilitation. Habilitation services have been defined by the U.S. government as services that “help you keep, learn, or improve skills and functioning for daily living” (Healthcare.gov, 2014). This focus on individual skill improvement and deficit remediation led to a service environment in which the daily activities of individuals with ID/DD were carried out within sheltered workshops, which minimized individual choice and preference (Rea et al., 2002). Some researchers and critics noted that the sheltered workshops contained the specter of the medical model, as these services were provided in segregated settings apart from the general public, and sought to examine and treat the perceived deficits of the person with ID/DD, albeit through skill acquisition (Bigby & Frawley, 2010; Rea et al., 2002).

### **Emergence of Person-Centered Program Models**

Critiques of habilitation services by academics and advocates alike in the 1990s influenced the emergence of PCP, as both groups called for services that emphasized the rights and citizenship of individuals with ID/DD over professional control (O’Brien & O’Brien, 2002). The following quote from Smull and Lakin

(2002) exemplifies why this switch from habilitation to person-centered services was desired:

Plans began to be written to the rule—not to help the person achieve a desired lifestyle. Goals were written vaguely by interdisciplinary teams to pass inspection in quality assurance reviews and to avoid modification when changes in a person’s life required new learning. It became important for plans to meet criteria, not for them to be useful. There seemed to be universal requirements for goals to be measurable and for data to document the process. As a result, many people who created the plans learned how to write goals that were measureable, but not meaningful. (Smull & Lakin, 2002, p. 383)

These types of well-documented issues within the service paradigm led to a realization that deinstitutionalization, in and of itself, did not provide individuals with ID/DD the type of choices or control that this new recognition of individual rights within the service process called for (Kilbane & Thompson, 2004). This issue of care versus compliance in service provision is a key issue—and gap—within the research literature with regard to how ID/DD service practices developed, and how they are carried out on the ground level by DSPs.

It was a staunch belief of the disability advocates who were pushing for more individually driven services that “real change would not occur until persons with ID were recognized as individuals with the capacity for more self-direction regarding their treatment plans” (Taylor & Taylor, 2013, p. 217). This signaled a paradigm shift, which began with the social model of disability, and came to fruition as it became accepted that professionals should relinquish control to the individual receiving services, in theory making services truly person-centered (Smull & Lakin, 2002). However, researchers have struggled to come to agreement on a consensus definition of what PCP should entail (Mansell &



Beadle-Brown, 2004a; Schwartz, Jacobson, & Holburn, 2000). Rather, a variety of service types have developed that meet the key assumptions behind PCP—that despite cognitive impairments, persons with ID/DD have the capability to determine how they want to live their lives (Bigby & Frawley, 2010). While these different approaches to PCP will not be explored individually here, it will be helpful to explore what they hold in common, as these are the principles guiding DSPs as they carry out their day-to-day activities while supporting individuals with ID/DD.

### **Common Themes within PCP Approaches**

All PCP models of service currently utilize a planning team consisting of family members, friends, community advocates, professionals, and at times DSPs. The role of this team is to assist in converting the plans and goals of the individual with a disability into actuality (O'Brien & O'Brien, 2002). It should be noted that within PCP services it is expected that individuals with ID/DD should be responsible for selecting their team whenever possible (Rudkin & Rowe, 1999). The other essential features of PCP interventions, as listed by Schwartz et al. (2000), are:

- 1.) The person's activities, services, and supports are based on his or her dreams, interests, preferences, strengths, and capacities.
- 2.) The person and the people important to him or her are included in life-style planning, and have the opportunity to exercise control and make informed decisions.

- 3.) The person has meaningful choices, with decisions based on his or her experiences.
- 4.) The person uses, when possible, natural community supports.
- 5.) Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity, and respect.
- 6.) The person's opportunities and experiences are maximized, and flexibility is enhanced within regulatory and funding constraints.
- 7.) Planning is collaborative, recurring, and involves an ongoing commitment to the person.
- 8.) The planning is satisfied with his or her activities, supports, and services. (p. 238)

It is through these guiding principles that PCP interventions are aimed to develop supports and assistance outside what the traditional service system alone can offer, to include as many formal and informal supports as necessary to achieve a future based on the individual seeking or currently receiving services (Kincaid & Fox, 2002; Mansell & Beadle-Brown, 2004b). The eight principles listed incorporate language encouraging community involvement, increasing quality of life, fostering dignity and respect, and valuing the dreams and goals of service recipients. Examination of the research literature, however, indicates that these residential placement outcomes (primarily within a group home setting) are not easy to attain (Kincaid & Fox, 2002; Mansell & Beadle-Brown, 2004a; Robertson, Emerson, Hatton, Elliot, McIntosh, Swift...Jocye, 2007; Taylor & Taylor, 2013).

Indeed, the most recent literature examining issues within PCP has identified several problems that may be preventing people with ID/DD from living a truly person-centered and inclusive lifestyle. As one researcher has noted, “Despite its relative importance and growing influence in policy and practice, the effectiveness of PCP as a practice for persons with ID still remains a mystery” (Taylor & Taylor, 2013, p. 219). In an example parallel to that raised with the normalization issue, it could be argued that PCP likewise provides the “what” of care and how services should be provided, but not the “why” behind them. The problematic “why” in this case is twofold: 1) *Why* is PCP superior to any previous or currently existing service paradigm; 2) *Why* are we pursuing PCP services from a theoretical standpoint? This twofold conundrum trickles down to the DSP level of service delivery.

The first challenge, showing the effectiveness of PCP, has long plagued the research and service domains in the United States and abroad (Mansell & Beadle-Brown, 2004a; Ratti, et al., 2016; Robertson et. al., 2007). Several methodological issues have been raised regarding research on outcomes and effectiveness including: 1) A simple independent variable (the PCP plan) and dependent variable (individual outcome) representation is far too simplistic to account for the complexities inherent within the PCP service process to be able to show causality for positive outcomes residing in any one part of the plan (Halle & Lowrey, 2002; Holburn, 2002); 2) PCPs are inherently individualized to a specific person, which does not allow for the anticipation of predetermined outcomes across cases (Holburn, 2002); 3) a PCP may face barriers from a lack of systemic

resources such as a limitation in housing opportunities, waiting lists, and limited assistance or aid from community resources (Robertson et al., 2007) and 4) a PCP may suffer from a lack of treatment fidelity in regards to how plans are implemented by staff (Kincaid & Fox, 2002). It is this final barrier of PCP plan implementation that is inextricably linked to the DSP workforce and shall be explored by the proposed study from the perspective of the DSPs themselves.

Treatment fidelity and plan implementation, of the utmost importance within any service setting, have challenged the effectiveness of PCP, as the plan's realization is reliant upon the personnel and resources existing in the service system and agency providing services (Kincaid & Fox, 2002). When specifically considering the DSP, a lack of trained personnel and staff involved with PCP interventions has been shown to be a significant barrier to the implementation of the plan (Robertson et al., 2007). However, the issue of plan implementation, especially where DSPs are concerned, is a more complex issue than just adding additional training in the principles of PCP. As noted earlier, Coyle and Moloney (1999) found in a study of 27 DSPs who had just received a PCP training, that about one-third stated that their training regarding PCP was insufficient to prepare them to carry out a PCP plan. Reid and Green (2002) proposed that support agencies should ensure that only staff with extensive training in PCP interventions should be responsible for carrying them out. This prompted researchers to examine the discrepancy between the planning phase and the action phase of support. Some contend that this discrepancy occurs due to "too much emphasis on

the ‘planning’ for the individual with a disability, and too little emphasis on actually bringing the plan to fruition” (Taylor & Taylor, 2013, p. 222).

This brings us to the heart of the current study: competent and well-trained DSPs are necessary to not only implement a PCP but also operationalize and implement the agreed upon goals and objectives with meaningful day-to-day activities and interactions. This can be especially important when supporting individuals with severe impairments and communication deficits, as research has shown that DSPs who lack empathy and knowledge of alternative communicative methods outside of traditional verbal cues struggle to implement PCP (Mansell & Beadle-Brown, 2004b). Researchers examining treatment fidelity and plan implementation for PCP have called for more attention to this very issue, citing DSPs as playing a “vital role”. (Ratti et al., 2016, p. 79). Taylor and Taylor (2013, p. 227) second this stating, “There must be a qualified and sustainable workforce (DSPs) if a realistic vision of PCP is to be achieved.”

The second “why” is a question of linking theory to practice, a problem seen in a variety of arenas and certainly within social work. To start, imagine the difficulty in trying to assemble an object from its various pieces if no image or concrete idea of the finished product is available. How do we start and with what pieces do we begin? If it is a two-dimensional picture puzzle, we can rely on the pieces with flat edges to allow us to create a frame of what we are trying to assemble. But, what rules or principles do we follow if we attempt to put together a three-dimensional object? Now let us consider an even greater challenge: how do we determine what day-to-day interactions or activities should be carried out

by a DSP, and in what order, to realize an individualized PCP? For all three of these examples we can see the clear need for guiding principles to assist with the task. Whether it is the flat edges of a two-dimensional puzzle or theoretical principles from which to guide decision making, it is clear that these tools are essential not only to attempt, but to succeed at the task at hand. A similar conclusion is reached by Parley (2001) who concluded that successful PCP implementation was predicated upon a change in attitudes, values, and knowledge among front-line workers.

If we take a second glance at the essential features of PCP listed on page 20, we can reach the following conclusion: While these eight criteria address the expected outcomes of the planning process (e.g., how choices are to be made and by whom; to achieve relationships, inclusion, and respect) and what the planning process should look like (e.g., collaborative, reoccurring, and ongoing), these guidelines do not speak to the theoretical reasons for pursuing these particular outcomes and using this particular planning process. Taylor and Taylor (2013, p. 229) echo this conclusion as they cite a lack of theoretical backing for PCP as one of several decades long “pitfalls” that have troubled practitioners and researchers alike. It is clear then that theory is a lacking piece to the puzzle of how to translate PCP into a daily process or routine to be carried out by DSPs. But why is this lack of theory so troubling? To have a clear understanding of the impact of this second “why,” the why of pursuing PCP, we must examine the empirical outcomes of residential placements for individuals with ID/DD to see if this lack of a framing

concept or concepts towards service provision can lead to inherent difficulties or tensions for the DSPs looking to implement these plans.

As we move from considering the social and intellectual influences on PCP towards the physical environment it is provided in, let us remember that this study specifically seeks to explore the supported living environment. Supported living as a type of residential service format arose in much the same way PCP did, as a response to the paradigm shift away from institutionalized settings towards a more individualized and person-centered approach (O'Brien, 1994; O'Brien & O'Brien, 1991; Racino, Walker, O'Connor, & Taylor, 1993; Taylor, Bogdan, & Racino, 1991; Walker & Salon, 1991). The following description of this shift is provided by O'Brien (1993, p. 1):

Supported living expresses a fundamentally different relationship to people with developmental disabilities than most other approaches to service do: instead of controlling people with disabilities in order to fix them, supported living workers (DSPs) seek to cooperate with people with disabilities in order to develop the assistance they need to get on with their own lives.

Within this description, we see a clear reference to the medical model (e.g., controlling in order to fix) and how cooperation and assistance subsumes this model by giving control back to the individual receiving services, much like PCP grew out of the medical, social, and functional models to achieve the same thing. It is this idea of cooperation and assistance that will deserve a more thorough examination once we come full circle back to the DSP.

### **Empirical Literature Regarding PCPs**

Numerous empirical studies have examined human services organizations in the U.S. and internationally that provide supported living situations from a PCP

framework to see if the five principles related to outcomes (principles 1, 2, 3, 5 & 6) are being accomplished (Ager, Myers, Kerr, Myles, & Green, 2001; Emerson, Robertson, Gregory, Hatton, Kessissoglou, Hallam et al., 2000; Heller, Miller, & Factor, 1999; Horner, Stoner, & Ferguson, 1988; Kearney, Bergan, & McKnight, 1998; Kozma, Mansell, & Beadle-Brown, 2009; Perry & Felce, 2005; Ratti et al., 2016; Robertson, Emerson, Hatton et al., 2001; Stancliffe, Abery, & Smith, 2000; Verdonschot, deWitte, Reichraft, Bruntinx, & Curfs, 2009; Young & Ashman, 2004). In relation to the first three principles, which focus on individual choice and self-determination, several studies find that smaller community settings do in fact provide more opportunities for individuals to make their own choices than larger, congregate settings (Emerson, Robertson, Gregory, Hatton, Kessissoglou, Hallam et al., 2000; Kearney, Bergan, & McKnight, 1998; Robertson, Emerson, Hatton et al., 2001; Stancliffe, Abery, & Smith, 2000). The largest scale of these studies, by Robertson et. al. (2001), examined 500 individuals with ID/DD living in various types of supportive living and institutional settings across the U.S. They found that people living in small community settings had larger social networks and greater opportunities for self-determination than those in institutional settings. However, for an individual living in a community-based small sized home, this increase in choice did not necessarily translate into better quality of life outcomes. For instance, staff practices related to individual empowerment (i.e., encouraging self-determination and allowing individuals the dignity of risk) was found to be critical in stimulating choice-making opportunities (Robertson et al., 2001). In addition, people with ID were found in



some studies to have “very limited choice-making behaviors that are restricted to relatively minor, everyday decisions” (Kozma, Mansell, & Beadle-Brown, 2009, p. 199). This echoes earlier studies, which found that individuals with ID/DD had little to no control over the most important aspects of their lives (Heller, Miller, & Factor, 1999; Emerson, Robertson, Gregory, Hatton, Kessissoglou, Hallam, et al., 2001; Stancliffe & Abery, 1997).

Research has also examined principles 5 and 6, which look at quality of life outcomes (e.g., relationship development, community inclusion, increased opportunities). Some studies have found that quality of life (QOL), a multidimensional concept frequently used within ID/DD services, improves when an individual relocates from an institutional setting to a community placement (Ager, Myers, Kerr, Myles, & Green, 2001; Young & Ashman, 2004). However, there were substantial fluctuations among these improvements in QOL associated with individual characteristics, service processes, and DSP practices (Young & Ashman, 2004), including the staff practice of allowing individual choice only from prepared limited options and whether staff engaged in active learning with the residents. Notably in these studies, DSP practices were found to play a clear role in establishing the desired treatment outcomes. Research indicates that this association between DSP and client outcomes is correlated with specific dimensions of QOL. In regards to relationship development, studies that have focused on individuals with ID/DD and their social networks have found that these systems primarily consisted of paid staff, other individuals with ID/DD and their families (Horner, Stoner, & Ferguson, 1988; Verdonschot, deWitte,

Reichcraft, Bruntinx, & Curfs, 2009). The size of the social networks for individuals with ID/DD has also been shown to be dramatically different from that of the general population. A 2001 study examining the size of the social network for 500 individuals living in residential service settings found a median of two people when paid staff was excluded (Roberston, Emerson, Gregory, Hatton, Kessissoglou, Hallam, & Lineham, 2001). This startling number, when compared to a 2003 study looking at the social networks of non-disabled individuals, paints a picture of enormous inequality as a typical individual's social network is seen to average up to 125 people (Hill & Dunbar, 2003). This enormous gap in social network size between typical individual and individuals with ID/DD must have palpable effects on QOL. Some of these effects could be an increase in feelings of loneliness (Margalit, 2004; Sheppard-Jones, Prout, Kleinert, & Taylor, 2005; Stancliffe, Lakin, Taub, Doljanac, Byun, & Chiri, 2007). Returning our focus to how a DSP is involved within this issue of social inclusion and relationship development, Perry and Felce (2005) found that staff performance, defined as the amount of assistance and attention given by staff to the individuals with ID/DD they support, was strongly correlated with a resident's social engagement and the frequency of community activities.

Clearly, the fulfillment of PCPs and the principles it represents is tied closely with DSP involvement and performance within a residential setting. However, even the level of involvement of DSPs has come into question within the literature, as their complex role as a caregiver is convoluted by issues of rapport building and friendship with the clients they support. While some within

the ID/DD community take no issue with DSPs being considered “friends” by the individuals they support, others oppose this level of fraternization as they view anyone receiving compensation as unable to fulfill this role of “friend” while being paid to be present and active in an individual’s care (Cummins & Lau, 2003; Marquis & Jackson, 2000; Traustodottir, 1993). It can be argued that this possible role confusion around the concept of friendship between client and DSP is the tip of a theoretical iceberg surrounding the DSP/client relationship. To dip below the surface of how this phenomenon is formed (DSP/client relationship) and determine what accounts for the visible portion of this iceberg (empirical data), a critical realism ontology will be introduced. Through the use of critical realism, Kantor’s interbehavioral psychology, and recognition theory, these empirical outcomes of DSP practice behavior will be hypothesized as originating from a cyclical habit formation process that may be influenced by multiple *activating* factors. It is these factors, like the main body of an iceberg concealed below the water, that are sought to be brought to light by this study.

## CHAPTER 3

### THEORETICAL FRAMEWORK

In this section, a theoretical framework for the current study is introduced. Given the complex nature of the issues surrounding the hands-on work of DSPs, this framework is established by considering not only the empirical evidence presented in the literature review and problem statement, but also several new conceptualizations of theoretical work as it is relevant within practice and community care settings. The theoretical framework includes Axel Honneth's theory of recognition (1995), Kantor's interbehavioral theory (1958), and with an overarching ontological perspective of critical realism as originally presented by Bhaskar (1978a) and infused into the disability studies conversation by Danermark (2002) and Houston (2001). Through the synthesis of these theories as discussed below, the intricacies of the practice tensions arising within DSPs' daily practice duties will be envisioned. This will be in such a way as to provide a formal structure to encompass the phenomena of care-giving to a vulnerable population among DSPs who seek to meet the conflicting goals of increasing their independence while also providing a basic level of care required to meet each individual's needs.

DSP care-giving can be explained as a matter of individual choice and decision making which is influenced by factors as varied as: (1) *paternalistic attitudes*, (2) *self-referential standpoints*, (3) *an increased or decreased level of recognition at both the direct practice and agency level*, (4) *group home culture*, and (5) *structural factors arising from agency policy* and (6) *agency support*

(Amando, Stancliffe, McCarron, & McCallion, 2013; Bigby, Knox, Beadle-Brown, Clement, & Mansell, 2012; Bigby, Clement, Mansell, & Beadle-Brown, 2009; Dunn, Clare, & Holland, 2010; Fyson & Cromby, 2013; Hillman, Donnelly, Whitaker, Dew, Stancliffe, Knox, Shelley, & Parmenter, 2012; Jingree, Finlay, & Antaki, 2006; McConkey, Morris, & Purcell, 1999; Robey, Beckley, & Kirschner, 2006; Waggett, 2013; Williams, Boyle, Jepson, Swift, Williamson, & Heslop, 2014). It will be useful to turn here to a social work practice perspective.

Longhofer and Floersch (2012, p. 507), in presenting a critical realist approach to social work practice, state that “...practices cannot be described as statistical averages; we *conform to practice* and our conformity shapes not only our practices but also our identities as social workers.” In the context of DSPs, their everyday practice should be recognized as how they employ “identifiable, conventional, repeatable, and ethical actions or activities: practices” (Longhofer & Floresch, 2012, p. 508). This definition of DSPs’ daily work allows us to see that their actions are not likely to be arbitrary but rather conforming to a set of patterns or habits, which an individual draws upon as they interact with a multitude of open systems (i.e., group homes, neighborhoods, agency cultures, communities). It is this interplay among the individual DSP, the person being supported, and the various open systems at play within any given service interaction that often creates situations where DSPs must improvise and adapt to both the environmental factors and the individuals they support. This may cause them to depart from established routines and rational practice decision-making as

they instead lean on their personal pre-existing political, moral, and ethical beliefs, habits, and behaviors.

This perspective on practice behavior may be illuminated, in part, by the work of Alva Noë (2009), in which he explores the phenomenon of human consciousness. Noë starts his treatise with the goal of rattling the foundation of cognitive science by retreating from a purely empirical pursuit, which claims the phenomenon of consciousness exists within us, and more specifically within our brains. Instead, Noë (2009, p. 24) asserts:

...we have been looking for consciousness where it isn't. We should look for it where it is. Consciousness is not something that happens inside us. It is something we do or make. Better: it is something we achieve. Consciousness is more like dancing than it is like digestion.

Starting from the assumption that consciousness is formulated by the relationship of whole, individual beings within the context of their environment and experiences allows us to conclude that no matter where consciousness resides, it exists due to a larger system of influence rather than merely our individual brains (Noë, 2009). This assumption intersects with the proposed dissertation research project when we consider the practice habits of individual DSPs and how they are formed, carried out, and modified by the surrounding environment. Further examining the work of Noë (2009, p. 100), it is useful to consider the distinction placed between the “expert” and the “novice” as it relates to skill use, or in the language of the proposed dissertation research, “DSP practices.” As DSPs move through their daily tasks, they may be constantly faced with stimuli from not only the individuals they support, but also their peers, managers, and the community at

large. In order to navigate this complex system, it is likely necessary for DSPs to create patterns or systems of decision-making allowing them to fluently overcome the challenges, barriers, and crises that often arise within a direct care setting.

Noë (2009) describes something similar within the transition from novice to expert as it relates to the amount of focused attention required to complete a task. Where the novices can improve their performance by focusing on the mechanics of a task, the experts will see a *decrease* in performance of a familiar task with a similar focus on mechanics (Gray, 2004; Milton, Solodkin, Hlustik, & Small, 2007). As the two neuroimaging studies just mentioned have confirmed, experts succeed by mainly focusing their attention outward to the given situation and environment in which the task needing to be completed takes place, having already mastered the skills needed to complete the task. Noë (2009, p. 104) provides a useful example through the game of chess. Of the multitude of legal chess moves available to a player during their turn, only a handful would be deemed helpful or appropriate within the context of the game being played. The expert in this situation can easily distinguish this handful of moves, applying the context of the other pieces and their positions on the board to deduce the best course of action. An amateur playing the same chess game may focus more on the multiple moves available to each individual piece, losing sight of the larger flow and context of the game. This ability of the expert is further elaborated by Noë when he states, “The expert isn’t someone who simply uses rules quickly or unconsciously; the expert is someone for whom, a good deal of the time, the question of rules does not even arise” (2009, p. 111). This ability to leave rules to

the subconscious is built upon the development of habits, “for habit is the foundation of skill” (Noë, 2009, p. 118).

Applying this line of thinking to the earlier definition of practice behaviors used in the proposed study would seem to support the notion that there are habitual ways in which each individual DSP confronts the realities of hands-on caregiving to accomplish daily tasks while caring for the individuals under their supervision. Further, it follows that the formation of these habits is predicated upon the social and physical environment within which they are formed. Additionally, if the distinction made by Noë about how experts interact with their environment and where their attention is focused holds true for DSPs, then the habits underlying the skills used by DSPs on a daily basis are worthy of scientific study.

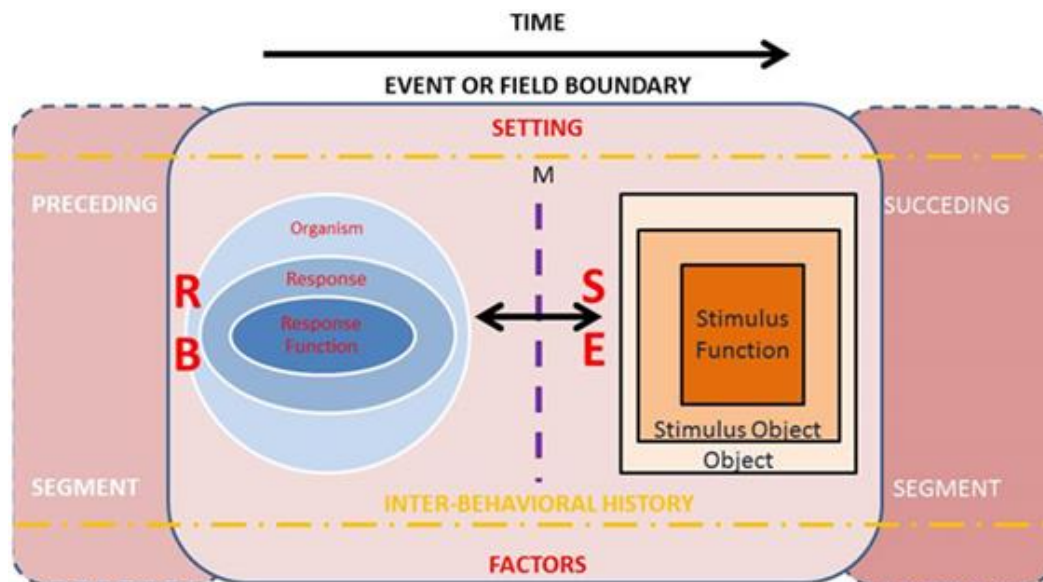
### **Interbehavioral Psychology**

To explore this notion of habit formation as it relates to practice skills, the work of Kantor (1958) and his interbehavioral psychology is now introduced. Kantor developed his psychological interbehavioral (IBF) theory after his analysis of the historical development of science, and psychology in particular, believing as Infeld and Einstein (1938) did that field theory represented the third state or evolution of science (Delprato & Smith, 2009). The dual concepts contained within the term *interbehavioral* were not chosen without careful thought towards the essence of what Kantor saw as his driving thesis. *Behavior* acknowledges the dynamic or active nature of all psychological events (Delprato, 2003); for the purpose of this dissertation this would be specifically focused on the practice and



decision making behaviors of DSPs within their work setting. *Inter* accentuates that the actor's, or DSP's, actions are coordinated with specific objects (e.g., the individual being supported, the group home environment, the coworkers of the DSP, the activity being participated in) such that action and object are *always* reciprocally linked (Delprato, 2003). This allows Kantor to visualize a field-oriented science of psychology which views actions, or DSP practice behaviors, as systemic patterns of events built upon the interdependence or mutuality of all participating factors (e.g., the individuals, their previous exposure to individuals with disabilities in general, as well as the specific individuals they provide services to, the setting, and the medium of contact to name a few).

This holistic style of approaching behavior calls to mind Noë's view of how consciousness develops and the core principle of critical realism with regard to a stratified reality consisting of multiple interlocked levels. Hence, the causal powers determining an individual DSP's practice behavior, from this perspective, do not exist in any one part of a psychological event (e.g., the brain, individual choice or behavior, the object or individual being responded to, or the situations within the environment). Instead, cognition, consciousness, or practice behaviors are simultaneously biological, ecological, and social (Delprato & Smith, 2009). This interactive and cyclical process, as presented by Kantor (1946, p. 262), can be viewed here in Figure 1:



RB= Reactional Biography, SE= Stimulus Evolution, M= Contact Medium

Figure 1. Kantor's representation of a psychosocial event

From the above figure we can see both the individual (the blue circle) and the object or individual being responded to (the orange square) linked in an ongoing temporal chain of interactions. Within each encounter, Kantor accounts for the possible varied functions of the past history of interactions between the two (reactional biography and stimulus evolution); the setting factors (such as a group home versus the community); and the medium of contact (sight versus touch or smell).

In proposing this study, it is acknowledged that the influence of these identified factors (on the bottom of p. 31 in *italics*) may take on different levels of salience for an individual DSP in the context of personal viewpoints towards the social construction of disability as they operate within agency and state policies, which provide the structured goals of day-to-day tasks. Recent research exploring

this phenomenon has acknowledged that this tension can be dominated by risk management (Hawkins, Redley, & Holland, 2011); power relations between DSPs and the individuals they support (e.g., Cullen, Buron, Watt, & Thomas, 1983; Markova, 1991; Antaki, Young, & Finlay, 2002); DSP understanding of policy principles and their applications (Finlay, Antaki, & Walton, 2007; Bigby, Clement, Mansell, & Beadle-Brown, 2009); the substitute decision-making processes of individual DSPs (Dunn, Clare, & Holland, 2010); the roles that support staff undertake or which they are equipped and encouraged to fulfill as part of their daily roles (McConkey & Collins, 2010); organizational factors such as agency culture and staff “fit” (Jenkins & Allen, 1998; Hatton et al., 1999); work stress as it relates to a DSP’s response to a service user’s behavior (Kowalski, Driller, Ernstmann, Alich, Karbach, Ommen, Schulz-Nieswant, & Pfaff, 2010; Thomas & Rose, 2010); the personality dimensions of DSPs, specifically extraversion and neuroticism (Parkes, 1994; Rose, David, & Jones, 2003); and DSP training (Grieve, McLaren, Lindsay, & Culling, 2008; Hewitt & Larson, 2007; Jones, Felce, Lowe, Bowley, Pagler, Strong, Gallagher, Roper, & Kurowska, 2001; Mansell, Beadle-Brown, & Bigby, 2013; Singh, Lancioni, Winton, Singh, Adkins, & Singh, 2009).

As noted in the review of literature, this complex interweaving of internal personal factors related to an individual DSP, the agency providing the structure of care-giving tasks, the idiosyncrasies of the individuals receiving services, in addition to the historical context of the social construction of disability and its relation to the dominate service paradigm of person-centered services, have left

many in the service community searching for concrete answers towards resolving the practice tension noted above. Perhaps this is most clearly seen by the following two quotes, taken five years apart in the peer-reviewed literature surrounding the services provided to individuals with ID/DD:

You cannot effectively support someone unless you know them and they you and they trust you and you them. Direct support professionals are involved in the most intimate aspects of people's lives. They know their hopes and dreams, comfort them through disappointment and tragedy, celebrate the good times, provide reassurance when sick or even dying. How can this be done if the individual does not have a relationship with the staff person? How can a relationship be built when there is a different person every few weeks or months or worse when a position is vacant, a substitute or a different temp each day. If a person does not feel supported, then are we really providing support? (Kathy Walsh, Associate Director, Arc Bergen County. Survey response taken from Gaventa, 2008, p. 601)

It is, moreover, a call for policy-makers and practitioners to take responsibility for the choices they impose on people with ID. People with ID do not choose to be poor. They do not choose to live in disadvantaged neighborhoods. They do not choose to have empty days, devoid of social relationships. These conditions are imposed upon people with ID by societies and welfare services which are inequitably structured by the dominant ideology of neoliberalism. Human rights purport to challenge—or, at the very least, ameliorate—the subjugation of the most vulnerable members of society. However, in relation to people with ID, human rights cannot be made effective unless and until more inclusive conceptions of personhood are adopted. (Fyson & Cromby, 2013, p. 1171)

We can see that the first quote from Gaventa is primarily focused on the role of the DSPs and the relationship that they establish with the client as crucial to good quality of life outcomes for the individuals they support (2008). Gaventa, a pastoral educator who also has specialized in DSP workforce development within person-centered supports for more than 20 years, identifies the need to enhance DSP levels of commitment to their work. The second quote reveals an even deeper layer of understanding or recognition may be necessary to truly facilitate

the type of relationship advocated by Gaventa (2008) as a more inclusive conception of personhood is required system wide.

To address these two striking issues, the concepts of critical realism and recognition theory will be utilized to delve into the intricacies presented by these two identified short-comings of the DSP and client relationship within the structure of person-centered services. However, prior to this exploration, it is necessary to conceptualize fully the ontological underpinnings of this phenomenon through the use of critical realism. I will argue in the same vein as Archer (1998, p. 194) and Danermark (2002, p. 56) that the ontological perspective, in this case critical realism, should determine the methodology and explanatory theories used.

### **Critical Realism**

Building upon the arguments put forth by Houston (2001), one of the central challenges facing the social work profession, and I would claim disability studies, is how to promote a theory that embraces human agency while also accounting for the impact of social structures. Houston (2001), Danermark (2002), and Williams (1999) have turned, as will I, to the works of Roy Bhaskar and his principles about the social and natural worlds. One of the foundational principles of critical realism is the existence of a reality, independent of human thought, which can be conceptualized into three levels: the empirical, the actual, and the real. The empirical realm is constituted of our experiences or those events and phenomena that we can witness with one of our senses and the apparatuses we use to magnify our sensory capabilities. The actual realm is inhabited by

things that happen independently of our observation, even though we may at times be able to observe them. The final realm, the real, is the, “the deepest level of reality constituted by mechanisms with generative power” (Bahaskar, 1978a, p. 56). While it can be difficult to ascertain how this stratified version of reality plays out within a practice setting, I have written a scenario of an Individual Habilitation Plan to illustrate:

Imagine the typical Individual Habilitation Plan (IHP) utilized by support agencies across the United States. To insure plans conform with Medicaid reimbursement criteria, each IHP needs to contain measurable and obtainable goals, typically developed to increase independence and written in conjunction with the wishes of the individual being supported. A given goal in an IHP should be written as such: Individual will sort his dirty laundry into piles of colored, lights, and whites once a week with 80% success. Our phenomenon for this thought experiment is the individual’s ability to complete the identified task, sorting laundry. At the level of the empirical, we can easily observe the IHP tracking sheet that is a written indication of an individual’s progress towards these goals. We could also observe the individual and DSP interacting as they work towards this goal to determine how instructions are being given and if the step by step guide to the goal has been followed. These interactions between staff and client, observed or not, are similar to the actual realm. Other activating factors could include the different approaches certain staff employ in helping the individual achieve this goal, how each DSP measures success or failure, and the types and colors of clothing being sorted. Now let us imagine that the individual

has completed this goal by empirical standards, completing the task close to 100% successfully during the course of several weeks. However, when we give the individual a test without staff assistance to see if they are able to complete the task of sorting clothes they fail. Here we can turn to the realm of the real to imagine possible reasons for this apparent inconsistency. Perhaps the staff provided facial or body language clues that aided the individual in completing the task successfully. Perhaps the individual has extenuating circumstances that has left them unprepared to complete the task that day, such as a death in the family. Perhaps the individual refuses to complete the task due to an undiagnosed anxiety disorder, which only arises from test taking or performance based situations. All of these possibilities are within the realm of the real. Whatever is the true reason for the failure of the individual within this given circumstance brings the causal mechanism from the realm of the real into the realm of the actual, activating the chain of events that brings about the empirical result of an the individual failing the test for a skill thought to have been mastered.

While this example is simplistic in nature, it allows to us to imagine the challenges facing a DSP within the routine of this daily work. It also show us the intrinsic value of a critical realism approach towards the daily practice of routine care providers and the limitless possible challenges that they can face within the scope of their job.

A second key foundational idea of critical realism that relates to this study is that causal mechanisms occur in “open systems” (Houston, 2001, p. 850). Analogous to the interbehavioral field of Kantor’s IBF and Noë’s explanations of

habit formation, critical realism, "...does not promote a hard determinism; rather, it posits that mechanisms produce 'tendencies'. In doing so, it (re)directs our attention to an understanding and explanation of those tendencies" (Houston, 2001, p. 850). Applying this to the chess player analogy introduced on page 34, we would expect certain players to have "tendencies" in response to certain game conditions, just as we would expect a DSP to have certain "tendencies" when responding to conditions faced on the job, such as the practice dilemmas arising between developing a service recipient's independence and providing care based on skill or physical deficits. Bhaskar (1989) similarly sees this type of contextual action as being *influenced* by innate psychological mechanisms as well as wider social mechanisms. Importantly, Bhaskar, reflecting critical realism, views the mechanisms outside of an individual as not so powerful and all-consuming to eradicate human agency (1989). Human agency, and therefore DSP agency, is then seen within critical realism as the "indispensable starting point of social enquiry" (Bhaskar, 1998, p. xvi).

A final piece of the critical realism ontology, which plays an important role in the selection of theories and methodology of this dissertation, is Bhaskar's (1991) call for social scientists to develop "a priori" hypotheses about the underlying mechanisms generating patterns of social behavior, especially in cases where these behaviors lead to oppression (Houston, 2001). Within the context of social work and the study of DSP practice behaviors, a critical realism ontology's starting point must be the attempt to understand and explain the practice behaviors of the individual DSP, as the research previously outlined shows a strong link



between the DSP profession and the quality of life of the individuals they support (Horner, Stoner, & Ferguson, 1988; Perry & Felce, 2005; Verdonschot et al., 2009; Young & Ashman, 2004). This is done by the use of explanatory theories to highlight the possible causal mechanisms for these behaviors within the individual, their social networks (e.g., agency and coworkers), and wider society (e.g., the concepts of disability, independence, and care provision). It follows that theory must be a guiding force for formulating hypotheses related to causation in levels of reality outside the empirical realm. Houston (2001) further clarifies this use of theory as “depth theory,” citing White (1997) to provide the preferred method in testing these hypothesis as the “...use of information gathering techniques and reflective processes drawn from qualitative research methodologies” (p. 854). Bhaskar’s own views strongly coincide, as he urges critical realists to examine the “*reasons*” people give for their actions (Houston, 2001, p. 854). Given this outline of how a critical realist examination of a phenomenon must be envisioned and carried out, Axel Honneth’s (1991) recognition theory is next introduced. The appropriateness of Q methodology as a critical realist tool is discussed in the Methods section.

### **Recognition Theory**

The utilization of Honneth’s account of recognition has recently caught hold among academics in looking at issues of ethics, politics, work, communication, and perspectives on disability (Danermark & Gellerstedt, 2004; Garrett, 2010; Houston, 2008, 2009; Houston & Dolan, 2008; Petersen & Willig, 2004; Sayer, 2005). Honneth’s work appears to be especially salient to the

phenomenon that encompasses the tensions encountered in DSP practice between instilling autonomy and providing care as he has stated that “individuals can become members of society only by developing, via the experience of mutual recognition, an awareness of how rights and duties are reciprocally distributed in the context of particular tasks” (Honneth, 2002, p. 501). With this sentiment combined with Honneth’s (2002, p. 509) stated goal of recognition as “human autonomy,” we can see that the conceptual framework of recognition theory nestles not only within the current best practices of the ID/DD field (e.g., person-centered planning, increasing independence and self-directed services), but also with critical realism’s viewpoint on individual agency. Perhaps this association is seen most clearly and concisely when Honneth (2002, p. 509) declares, “only the person who knows he/she is recognized by others can relate to himself/herself rationally in a way that can, in the full sense of the word, be called ‘free’.”

Honneth’s concept of recognition, a word with a multiplicity of meanings, is defined for this study as the ways in which individuals, institutions or groups understand and relate to one another (Laitinen, 2009). At the core of recognition theory is the assumption that certain types of recognition represent not only a satisfying manner of interaction in itself, but a psychological and social necessity through which all individuals grow and perpetuate positive relations to self (Laitinen, 2009). This infers that misrecognition or a lack of recognition must conversely lead not only to distressing interactions, but also to negative relations to self (Laitinen, 2009).

To further illuminate the concept of recognition, I will first give an overview of the ontological beginnings of Honneth's theory before examining his operationalization of recognition into three sub-types. Of these three sub-types of recognition, first-order recognition will be utilized to examine the potential effects that recognition or a dearth of recognition can have on DSP practice behaviors in the context of instilling autonomy and providing care. This should not be a sign that the other types of recognition are not impactful within the DSP/client dynamic, only that first-order recognition is the most intimately involved in the practice tension faced by DSPs. In fact, it could be argued from Honneth's standpoint, that any association to first-order recognition within the DSP/client dynamic would be increasingly impactful on second- and third-order recognition as they are both predicated on the acceptance of the "other" as a moral and rational agent.

Drawing from the early works of Hegel, Honneth desires to construct the formal conditions of human self-realization as stemming from an anthropological quality anchored in the development of personal identity. For Honneth (1995), personal identity cannot be formed without the recognition of others, as the question "who am I?" if left unanswered, creates an individual unable to consciously relate to the inner self. The concept of recognition is viewed here as necessary to form community and society. In the state of nature, property and culture are unknown to us. A violation to our property or person, even by another human, is seen as a transgression akin to a natural disaster or an animal attack as the transgressor is not "recognized" as human. From this starting point, both

Hegel and Honneth see the concepts of property, and later culture, developing from this intrinsic failure to recognize the other, which leads inevitably to acts of violence, such as murder, and escalating into wars between developing tribal communities.

The above process is set into motion by this failure of recognition on the part of one party in relation to another. In the ensuing cycle of retributive acts, the struggle for recognition is born as the assailants must either destroy one another in a continuation of the cycle or come to recognize one another. It is here that *mediation* is constructed, which in itself requires each party to have developed a level of self-consciousness. Honneth (1995) defines the struggle for recognition as this process by which two unmediated self-consciousnesses come into direct confrontation, leading each self-consciousness to mediate the development of the other. This process of repeated experience and relationship with the “other” strongly echoes the interbehavioral position towards association (i.e., spatiotemporal relationships bound by the conditions of the environment) between stimulus and response functions. Kantor states, “Each interaction is always absolutely specific. What the reacting organism and the stimulus object do in each interaction constitutes a distinctly unique relational happening” (1977b, p. 38). Thus, we can see Honneth’s struggle for recognition developing not only as a slow acknowledgement of the “other,” but an ongoing interaction between agents heavily contextualized by their environments.

In the state of nature, this early form of mutual recognition would be dictated by one party and not the other. This means that, initially, there will be

one party who is still not recognized within this given social arrangement and is still subjected to incursions on their livelihood, property, and honor. The unrecognized or excluded party must “struggle” until the other develops a consciousness for the “other” and their rights. Once this stage of mutual self-consciousness has been reached, it allows for the formation of the concept of rights, but does not create the conditions necessary for the emergence of individuality in the sense that a subject still does not recognize itself and others as having an identity that is unique and of having differentiated value from another’s.

For this final piece, Honneth examines what he calls “an inter-subjectively shared value-horizon,” or the opportunity for a person to participate in activities, that are considered of value to the community (1995, p. 121). Again, we can turn to Kantor to explore how the phenomenon of recognition may operate on not only an interpersonal but cultural level. If we consider the process of developing recognition as one of reoccurring exposure and eventual acceptance to a new stimulus or “other,” then it follows that it may be a form of habituation. Kantor (1977a) defines habituation as the building up and constant performance of habits (e.g., recognition) as an especially prominent type of psychological adaptability (e.g., the struggle for recognition), which, as previously stated, takes place within a myriad of environments (e.g., group homes, communities, families, schools).

Geographer David Sibley’s work can also add crucial understanding to recognition at a societal or community level within the need for spatial separation from the impure or unclean “other.” Sibley (1995) examines the spatial problem

in relation to a community's perceived safety and determines that it culminates in the desire to segregate or contain that which is deemed impure or unclean. One can see reference to such sanctity within the North American suburb through the hierarchy of acceptance (see Dear, 1992), which actually rates the acceptance of a particular group with regard to neighborhood inclusion. Some argue that within these suburbs there is a preoccupation with order, conformity, and social homogeneity (Sibley, 1995). Sibley further explains the inner machinations of this process by stating that "family, suburb, and society all have the particular connotation of stability and order for the relatively affluent, and attachment to the system which depends for its continued success on the belief in core values is reinforced by the manufacture of folk devils, which are negative stereotypes of various 'others'" (1995, p. 18).

This space, or place where the two categories mix and become indistinct from one another, is called a liminal zone (Sibley, 1995). According to Sibley, a liminal zone is almost always present in any categorization system and this ambiguity causes anxiety within civilization because it creates a zone where civilization is not in control. Sibley concludes that the list of people that comprises a society's liminal zone is flexible and ever-changing depending upon the current situation. This is aligned with Takahashi and Dear's (1997) hierarchy of acceptance, which they believe is volatile and synergistic. It could be argued that both a culture's hierarchy of acceptance, liminal zones, and folk devils are based, in part, upon a lack of or misrecognition for the "other." In addition, we see that liminal zones and the hierarchy of acceptance within a culture bring to

mind Kantor's assertion that all psychological events, no matter how habitual, can be shifted and changed by interactions from environmental and societal factors along a temporal plane.

Returning to the interpersonal level, from this progression of self-consciousness, Honneth operationalizes three coinciding methods of recognition that must be met in some respect for an individual to have positive relations-to-self. Honneth contends that these three modes of recognition represent the few, but fundamental, conditions in which an individual's self-realization can be reached. Kompridis puts it in another light when he states, "We do not just desire recognition, we need multiple kinds of recognition—respect in the political sphere, esteem in the social sphere, and care in the intimate sphere of the family" (Kompridis, 2007, p. 278). The three spheres of recognition theorized by Honneth (1995) are: (1) the private sphere, which centers on an individual and their need/emotions within relationships to friends and family, which impacts basic *self-confidence* (2) the political sphere, defined by an individual's rights and legal entitlements, which relates to *self-respect*, and (3) The social sphere comprised of cultural recognition stemming from individual traits, abilities, and achievements, which are acknowledged by a community of interest, which affects *self-esteem*.

It is Honneth's (1995) contention that all human beings need and desire to be recognized through all three processes to establish positive relations to ourselves in terms of self-confidence, self-respect, and self-esteem. If recognition is lacking in one or all of these categories, harm is done. However, the harm caused by a lack of recognition or misrecognition can in turn lead to collective

action by the unrecognized as they struggle to obtain recognition. To examine further the relationship between types of recognition and their corresponding threats, Honneth presents a table to show the structure of relations of recognition:

Table 2.

*The Structure of Relations of Recognition (Honneth, 1995, p. 129)*

Mode of Recognition	<i>Emotional Support</i>	<i>Cognitive Support</i>	<i>Social Esteem</i>
Dimension of Personality	Needs & Emotions	Moral Responsibility	Traits & Abilities
Forms of Recognition	Primary Relationships	Legal Relations	Community of Value
Practical Relations to Self	<b>Self-confidence</b>	<b>Self-respect</b>	<b>Self-esteem</b>
Forms of Disrespect	Abuse & Rape	Denial of Rights	Denigration/ insults
Threatened component of Personality	Physical integrity	Social integrity	"Honor," dignity

### **Recognition and Primary Relationships**

The first mode of recognition, dealing with self-confidence, is developed through the concept of love established by the parent-child relationship (Honneth, 1995). Honneth sees self-confidence as having less to do with an individual's high estimation of abilities and more with their ability to express desires and needs without fear of abandonment. Danermark and Gellerstedt (2004, p. 348) assert that this first type of recognition is "more or less permanently present" in a group home environment within the client and staff/caretaker dynamic. This may be due to the tension created between attempting to improve the service recipient's autonomy while also focusing on providing support to an individual who may be viewed as dependent upon a system of care (Danermark & Gellerstedt, 2004). This strain would seem to be most evident with those individuals who are



medically fragile, exhibit challenging behavior, or have difficulty communicating their needs. In this way the system of care provided to individuals with ID/DD may, in itself, be at least partially responsible for instances of misrecognition as DSPs struggle to balance the opposing missions of instilling independence/autonomy for a group of individuals present in their current placements because they require care and cannot be fully independent.

Gaventa (2008) sees this dichotomy in another light, citing Ivan Illich (1976), in which the current systems of care push provider agencies away from a culture of commitment towards relying on compliance as their driving force of change. This can create a paradoxical “counterproductivity” in which a system trying to help people be safer may actually cause the inverse (Illich, 1976, p. 86). Gaventa (2008) goes on to conclude that DSPs have become trapped in an increasingly rigid system that requires a significant amount of effort and time on issues of compliance instead of quality of care. Let us also consider this tension from the perspective of individuals with ID/DD as it relates to the first form of recognition. The service recipients, the alleged epicenter of the care being provided, find themselves not only reliant on their direct care staff for opportunities to increase their adult daily living skills and hence their level of independence, but also for the meeting of their basic needs. This power dynamic would seem to place individuals with ID/DD in the tenuous and unenviable position of appeasing the very people hired to care for them for fear of not having their basic needs met.

Current and past research examining this practice tension, which at its core centers around issues of self-determination, seems strongly linked to Honneth's first type of recognition. It is proposed that to give this level of recognition to an individual receiving care, DSPs must view the individual as an agentic person (i.e., an individual capable of making decisions self-sufficiently). This may be especially problematic given the heterogeneous nature of the ID/DD population when it comes to their individual capacities for reasoning (Fyson & Cromby, 2013).

Self-determination (SD) within persons has been characterized as an individual who is the "origin of his or her actions, has high aspirations, perseveres in the face of obstacles, sees more varied options for action, learns from failures, and overall, has a greater sense of well being" (Little, Hawly, Henrich, & Marsland, 2002, p. 390). Studies looking at the levels of SD for individuals with ID/DD living in care settings have found them to be less than optimal. For example, several studies have shown people with ID/DD have less SD than their nondisabled peers (Stancliffe et al., 2000; Wehmeyer, Kelchner, & Richards, 1995, 1996; Wehmeyer & Meltzer, 1995). In addition, people with ID/DD also experience fewer opportunities to exercise SD in their daily lives within both community and institutional settings (Stancliffe et al., 2000; Stancliffe & Wehmeyer, 1995; Wehmeyer & Bolding, 1999, 2001; Wehmeyer et al., 1995). Also, many people with ID/DD who are shown capable of SD are often shackled by broad substitute decision making arrangements (Stancliffe, Abery, Springborg, & Elkin, 2000).

Research specifically looking at how DSPs approach the concept of SD within their work has shown that individuals with ID/DD obtain a greater level of SD when DSPs view supporting the SD of their clients as a crucial aspect of their position (Abery, Ticha, Smith, Welshons, & Berlin, 2013). Finally, Wehmeyer and Abrey (2013, p. 406) conducted a robust examination of the state of SD for individuals with ID/DD, calling for a paradigm shift to highlight the key role DSPs play in fostering or hindering the process of an individual's SD:

As part of this paradigm shift, future research will need to better account for the fact that, in the large majority of cases, self-determination is exercised within the context of relationships (with people, organizations, systems, etc.) and that as a result, relationship factors need to be taken into account. This conceptualization of self-determination being exercised within the context of relationships must also take into consideration how the ecological context (home, community, school, work, etc.) influences such relationships and thereby opportunities for and the exercise of self-determination.

This paradigm shift, as expressed here, stalwartly coincides with what has been presented from interbehavioral theory's view of psychological events as happening in an interactive field, Noë's idea of individual consciousness existing in concert with the environment, and Honneth's recognition developing within the context of interpersonal relationships. This gives us tangible abductive reasons to assert the potency of a DSP's possible daily impact on an individual's SD.

We can reach this same conclusion inductively, when viewing the specific results of a variety of qualitative and mixed methods studies investigating how DSPs manage the tension between protecting service users from risk and promoting SD (Dyken, Goff, Hoddapp, Davis, Devanzo, & Moss, 1997; Holland & Wong, 1999; van Hooren, Widdershoven, van den Borne, & Curfs, 2002,

2005). A more recent ethnographic study completed in the setting of a group home specializing in care for individuals with Prader-Willi syndrome used a grounded theory approach based on participant observation and analysis of semi-structured interviews. DSPs at this home described that they “experienced a conflict between protecting residents and acknowledging residents’ autonomy” (Hawkins, Redley, & Holland, 2011, p. 878). One worker is quoted as saying, “...on the one hand the residents are told they are ‘adults’ but on the other hand they are told they are vulnerable...these two don’t go together because adults, who choose what happens to them, cannot be vulnerable too” (Hawkins et al., 2011, p. 878). This same DSP goes on to explain that she sees no difference between “bringing up” her son and “bringing up” the residents. This statement could represent a lack of first-order recognition towards the individuals she works with, which presents as a paternal viewpoint towards practice behavior (also see Robey, Beckley, & Kirschner, 2006), or she might be expressing a strong level of attachment with regard to the clients in her care. Another theme arising from the DSP interviews was how independence, as a service outcome, was fabricated. DSPs within this program described independence as “something that had to be granted within the existing residential system and was defined by staff as residents doing activities on their own (unsupported)” (Hawkins et al., 2011, p. 878).

Jingree and his colleagues pursued a similar line of inquiry by observing and recording two residents’ meetings at a group home in England using conversation analysis (Jingree, Finlay, & Antaki, 2006). Resident meetings are

typically a forum in which the individuals living within a supportive environment are able to express their needs, wants, and desires around the services provided to them in an empowering way. However, it was discovered that even the agenda at some of these meetings was fully dictated by the manager and staff (Jingree et. al., 2006). The researchers also noted that a tension seemed to exist between encouraging the individuals to make their own choices and “shepherding” them towards a particular decision preferred by staff (Jingree et. al., 2006, p. 216). In addition, they found that when residents tried to express legitimate complaints during these meetings, staff often ignored these concerns or reframed the concerns in a positive way (Jingree et. al., 2006). These patterns of interaction between DSP and individual underscore issues of an imbalanced power dynamic possibly existing within care settings as shown by previous research and the potential impact daily DSP and client interactions can have on SD and first-order recognition (see Antaki, Young, & Finlay, 2002; Markova, 1991; McConkey, Morris, & Purcell, 1999; Rapley & Antaki, 1996).

Placing this evidence within the presented framework of how consciousness, habituation, and practice behaviors are developed and possibly linked to levels of recognition, we might expect to hear this lack of recognition verbalized when DSPs talk about their work. This very phenomenon was found in a secondary analysis of a large scale qualitative study which used ethnographic and action research methods to observe the day-to-day operations within multiple group homes (Bigby, Knox, Beadle-Brown, Clement, & Mansell, 2012). These researches determined that DSPs had an “underlying assumption that residents

were fundamentally different from them: ‘not like us’” (p. 457). It was also noted that DSPs often referred to residents as if they “...were children who participated in childlike activities” (Bigby et. al., 2012, p. 457). A final and perhaps most poignant example of DSPs’ lack of recognition towards the individuals they supported was in the relationship dynamic the researchers termed as “othering” (Bigby et al., 2012, p. 457). “Othering” within this context was described as the DSPs failing to recognize residents as individuals with whom the DSPs could interact with on an interpersonal level (e.g., seeing them as equals with whom they could form reciprocal relationships). While it should be noted that it would blur the line of professionalism for a DSP to establish a close interpersonal relationship with the individuals they support, this concept of “othering” is taken to mean that DSPs could not imagine a relationship outside of a professional one existing with the clients they supported due to a lack of reciprocity (Bigby et al., 2012, p. 457). These results should strongly remind us of David Sibley’s above-mentioned concept of the “Other,” the hierarchy of acceptance, and what effects these types of habitual dynamics can have on a supported individual’s sense of self-confidence and equality.

If the types of attitudes presented by some DSPs described in the above studies are a widespread phenomenon, it should appear empirically in the practice behaviors of DSPs at large within the current literature. We can confirm this by referring to research which shows DSPs view their work as primarily to do things for the individuals they support instead of with them (Bigby et. al., 2012), managing risk for the individuals they support as they “lack insight” or the ability

to SD (Williams et. al., 2014, p. 82 ), having more to do with providing care than with social inclusion (McConkey & Collins, 2010), needing to base decisions around an individual's care and social inclusion opportunities on their own personal values and opinions of what constitutes a meaningful life instead of the individuals' (Dunn, Clare, & Holland, 2010).

This empirical evidence, along with the inductive and abductive logic presented here, allows a tentative theoretical framework for how DSPs may attempt to manage the practice tension of providing care and instilling autonomy as well as some of the possible factors influencing their practice behavior. Below is a visual representation of this framework in Figure 2.

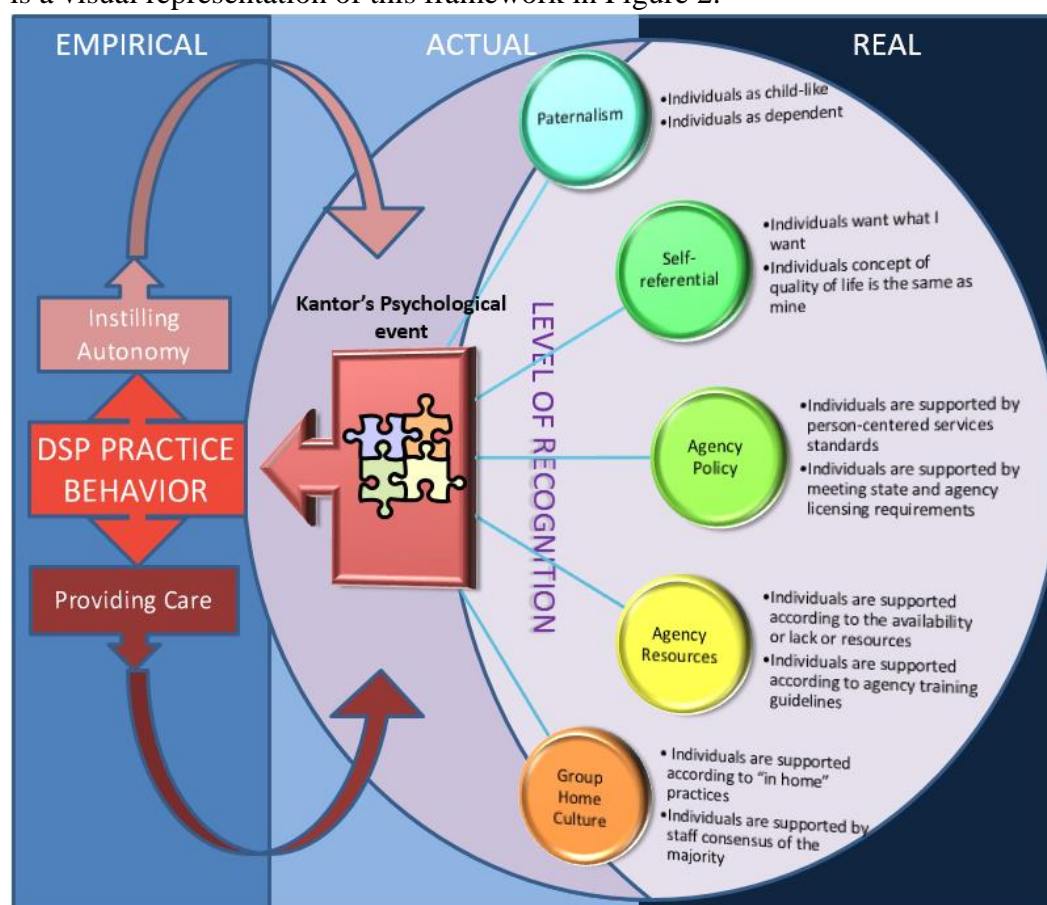


Figure 2: Conceptual Framework of DSP Practice Behavior

## Decision Making and Discretion

DSPs are a vital component of the service framework that aims to help individuals with ID/DD achieve their aspirations. The issue of DSPs' practice behavior and their perspectives toward traversing the tension between providing care and instilling autonomy has been shown to be a key feature in the outcomes of person-centered community-based services (Castro, Rehfeldt, & Root, 2016). This impact of individual decision-making (i.e., DSP practices) on agency policy (i.e., person-centered services) outcomes was first introduced as a critical phenomenon by Michael Lipsky. The term "street-level bureaucrat" was coined by Lipsky (1980) to label a front-line worker within a social services position (e.g., police officer, social worker, welfare case manager) who has "...*an irreducible core of discretion*" at the point of policy delivery. While an in-depth review of Lipsky's work will not be presented here, it is clear that DSPs fit the definition of a street-level bureaucrat and that how they use their discretion (i.e., practice behaviors) constitutes a phenomenon of great importance towards service outcomes for individuals with ID/DD.

The relevance of the current study, which explores DSP viewpoints towards their practice behaviors, can be further highlighted by briefly examining how the street-level bureaucracy literature has framed discretion as a type of routine. Discretion, within this context, is often defined as "a sphere of autonomy within which one's decisions are in some degree a matter of personal judgment and assessment" (Galligan, 1990, p. 8). It has been argued that to cope with their discretion, street-level bureaucrats cultivate routines to circumvent making



ceaseless individual choices in a challenging and complex environment (Loyens, 2010). This conceptualization of discretion and how it leads to routines strongly aligns with the theoretical framework presented and the concepts of habit formation from Noë and Kantor (as it relates DSP practice behaviors). Hence, the proposed study aims to explore the habitual practice behaviors of DSPs as viewed from a critical realist perspective to determine what types of “real level” variables (i.e., levels of recognition, paternalism, self-referential decision-making, agency policy and resources influence, and group home culture) are expressed by DSPs as significant “actual level” or activating factors in their day-to-day use of discretion at the “empirical level” of service provision.

The implications for this line of inquiry are particularly salient when considering that research has shown that DSPs generally identify care-related tasks as having a higher priority over tasks related to promoting social inclusion and independence (McConkey & Collins, 2010). The orientation of DSPs towards practice in general, may inform how DSPs’ discretion can “affect the extent to which the philosophy of inclusion of people with intellectual disability is implemented...” from a treatment adherence perspective (Henry, Duvdevany, Keys, & Balcazar, 2004, p. 26). It can be argued that developing self-reflective typologies of decision-making frameworks utilized by DSPs while on the job is essential to furthering the quality of services for individuals with ID/DD within the community. Q methodology is now introduced as a tool to obtain these typologies within a critical realism research paradigm.

## **CHAPTER 4**

### **METHODS & DESIGN**

The purpose of this study is to examine the ways in which individuals who are employed as DSPs in congregate or group home settings for individuals with ID/DD perceive and express their attitudes and beliefs about how they make decisions within a framework of person-centered services. Specifically, this study used the Q method approach to explore these perceptions among 30 DSPs working in New Jersey at two organizations that residentially support individuals with intellectual or developmental disabilities. IRB approval for the study was obtained from Rutgers University in December 2015 and from the Division of Developmental Disabilities in February 2016, and written informed consent was obtained from each participant. Each participant completed a “Q sort” administered by the author in which they ranked statements regarding how they make decisions when working with their ID/DD program. They also subsequently answered a set of open-ended questions to further clarify these views. Data collection at the first agency was completed between June 2016 and September 2016. Data collection at the second agency was completed during June and July 2017. This project was concluded with the quantitative and qualitative data analysis in December 2017.

#### **Q Methodology**

A brief overview of Q methodology will be provided to establish its relevance for the proposed study as it provides a strong method of critically exploring the subjective phenomenon of DSP attitudes and viewpoints within a

critical realist research paradigm. In brief, Q is a method in which respondents receive a selection of viewpoint statements (termed a *concourse*), and sort them according to a ranking system specified by the researcher (and meant to explore hierarchies of meaning of the viewpoints held by the respondents). The “sorts” are then factor analyzed to identify areas of consensus held by the participants. By relying on Q’s unique conceptualization of measurement and factor analysis, these personal viewpoints are examined from a truly person-in-environment perspective. As we will recall from critical realism’s trifurcation of causality towards natural phenomenon, to focus on a purely empirical conceptualization of DSPs viewpoints we would be akin to describing a three-dimensional object as only existing on one plane. In the context of this study, however, we are guided by the theoretical framework introduced on page 58 which provides us with six domains possibly linked to DSP decision-making outcomes: First-order recognition towards the individuals supported, paternalistic thinking, self-referential thinking, agency policy, agency resources, and group home culture.

Herein lies the strength of Q method for this study, for when coupled with a Fisherian block design (which is a system for sorting viewpoint statements by theoretical area) guiding *concourse* development, it allows every participant to consider the proposed activating factors in relation to their lived experiences, the building blocks of attitudes and viewpoints. At the completion of each sort, we can also conceptualize where individuals place themselves within the environmental tension created by the competing policy goals of care versus independence. Finally, by utilizing the post-interview sorts to add depth and

breadth to each individual's attitudes in conjunction with the arising factors, we can determine what types of viewpoints exist among DSPs concerning the practice challenges facing them on a daily basis. From the standpoint of these factors, or views, we can also identify implications for agency training curricula, the supportive resources available to DSPs, and policies that guide them as they attempt to carry out quality services informed by a person-centered practices framework.

The beginning of what we call Q methodology today started as the invention of psychologist and physicist William Stephenson to provide a way to measure subjectivity scientifically (Brown, 1993; Stephenson, 1953). Stephenson first introduced Q in 1935 as an alternative or supplement to more traditional qualitative and quantitative methods within the field of psychology (Ellingsen, Storksen, & Stevens, 2010). When Stephenson wrote his initial letter to *Nature* in 1935, his core reason for proposing an alternative method of factor analysis to the field of psychology was to address what he saw as the unfortunate continued sovereignty of objectivity in behavioral and social sciences. In a stance similar to Bhaskar (1978), Stephenson saw the dominance of psychometrics in the social sciences as a general misunderstanding of the nature of science and his proposal of Q methodology was his way of attempting to correct the outmoded paradigm of positivism seen in his day within the field of psychology. While the ontology developed by Stephenson to support Q methodology does not explicitly address the multi-layered reality established by Bhaskar (1978), implicitly we can see that Q permits the social sciences a way of exploring some aspects of reality which

some positivists would describe as nonmeasurable and nonquantifiable (i.e. opinions, attitudes, and beliefs). These emergent structures (i.e. the factors resulting from a Q study) instead of providing causal attributions, gives the social scientist the opportunity to explore how certain mechanisms (i.e. level of recognition towards people with ID/DD, group home culture, or agency resources) tend to impact this group of workers as a *whole* within their workplace. As Brown and Steuernagel (1985, p. 12) note, “structure and form take precedence in a subjective science, as opposed to testability and predictability to which the external world is amenable.”

Today the use of Q methodology is seen as particularly relevant in social work when seeking to distinguish people’s perceptions about complex issues that do not lend themselves easily to quantification from a self-referential vantage point (Ellingsen et al., 2010; McKeown & Thomas, 2013). Thus, Q methodology is an appropriate choice whenever a researcher wants to explore and describe the various perspectives and consensus within a group regarding any topic (Brown, 1980). Q also has the added benefit of reducing the potential preconceptions a researcher may have about a particular topic (Ellingsen et al., 2010). It also allows highly effective studies (i.e. statistically sound) to be carried out with fewer participants than most other types of research methodologies because of its unique approach to factor analysis (Watts & Stenner, 2005, 2012). Within the continuum of qualitative and quantitative research, much debate has arisen concerning where Q methodology should be placed. Q has been termed a “qualiquantological” method in which the qualitative and quantitative aspects are inextricably linked at

almost every step within the research process (McKeown & Thomas, 2013; Stenner & Stainton Rogers, 2004). Various researchers describe different steps or phases that can be used in applying Q methods (Cross, 2004; Dennis, 1986; Ellingsen et al., 2010; Stainton Rogers, 1995). However, Brown (1980) lays out 5 steps in his fundamental text that are seen as most consistent with Stephenson's original design. These five steps are:

1. Identifying a concourse on the topic of interest
2. Developing a representative set of statements (Q sample)
3. Specifying the respondents for the study (P-set) and conditions of instruction
4. Administering the Q sort
5. Factor analyzing and interpretation

Inherent within these 5 steps are three crucial principles: subjective communicability, concourse of communication, and operant subjectivity (McKeown & Thomas, 2013). Subjectivity is seen as innately expressive, meaning that the process of articulating beliefs internally (within the self) and externally (to others) is anchored self-referentially and is linked to our capacity for sharing impressions through verbal and non-verbal communication (McKeown & Thomas, 2013, p. 2). Q methodology chooses this definition to focus on what is measurable (i.e. behavior through sorting as a manifestation of an individual's subjective opinion or viewpoint) and moves to eschew a mentalistic conceptualization of subjectivity that is often confused with consciousness. Stephenson was explicit on the need to separate subjectivity from consciousness as he states, "Subjectivity is behavior" whereas "consciousness is

something else” (Stephenson, 1953, p. 347). Examples of subjective communications include self-referential statements such as “It seems to me...,” or “In my opinion...” These types of personal opinions are neither seen as provable nor disprovable, but as “pure behavior” (Brown, 1980, p. 46).

Take for example the statement “That is a nice picture.” This assertion carries with it the implicit prefix of “*I believe* that is a nice picture.” This same self-referential process of subjective communicability is what takes place when an individual interacts with the Q methodology sorting process (i.e. they sort the statements according to their perspective unless instructed otherwise). It is important to note that the statements used for a Q methodology project should not be facts as they typically have no extension beyond themselves. For example, “One pound equals sixteen ounces” leaves little room for subjectivity. Instead of facts, the sorting process should consist of statements of opinion. Opinions, in terms of Q methodology are “as numerous as the waves of the sea” (Stephenson, 1953, p. 22). When an individual sorts a collection of statements, what we have referred to earlier as a *concourse*, the result of a sort as well as the statistical factors created by multiple sorts are models of the structure of subjective communicability present within the group (or individual).

It is these types of statements, described above, that go on to form a *concourse of communication*. The term *concourse* is defined in the Q literature as the communication of all possible aspects surrounding a particular topic (Ellingsen, et al, 2010; Stephenson, 1978). Stephenson (1982, p. 239) chooses the term *concourse* to reference “Cicero’s *concursus fortuituous*, the action by which

according to the theory of Leucippus and Democritus, the universe came into being by the fortuitous concourse of atoms.” In expansive terms, Stephenson refers to concourses as “extending infinitely” lacking beginning or end while also containing statements or pictures of shared understanding or “common knowledge” (1982, p. 239). This makes the concourse both an empirical entity and one that is naturally occurring (i.e., the opinions, views, and attitudes within a concourse are already in existence). On a more technical note, the concourse provides the raw material for Q studies and is parallel to a target population for the sampling of persons in survey research (Stephenson, 1953). In addition, each item within a concourse is deemed equally probable a priori in regards to its potential placement in any one square on the distribution grid (Stephenson, 1982).

While limitless in potential, the concourses of Q methodology should be built with an eye towards adequately saturating the topic or phenomenon of interest while taking into account the uniqueness of the study group. A concourse could contain 100 pictures of differently styled chairs if the phenomenon of interest is shared perspectives on the most aesthetic chair designs. These 100 pictures of chairs may also vary depending on if the study group consists of office workers or kindergarteners. These characteristics of a concourse show them to be not reductionist in nature, but instead inclusive and malleable to the agents and structures intertwined with the phenomenon or mechanisms of interest.

From a critical realist perspective, the Q methodology approach towards building an appropriate concourse is akin to judgmental rationality. The researcher collaborates with a target group of people to construct a plausible and

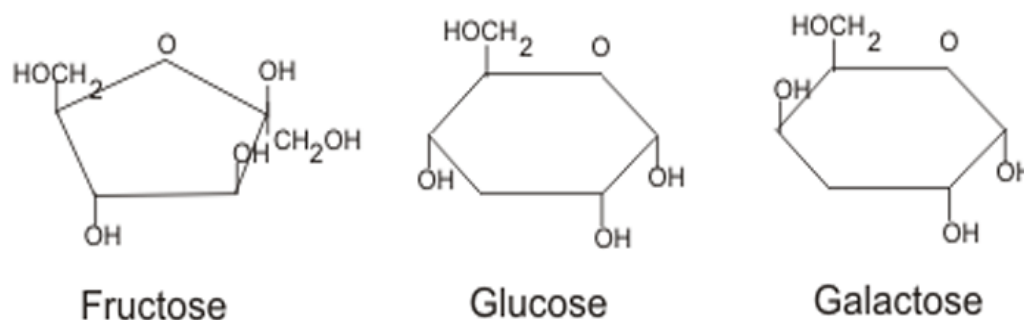


representative model of the phenomenon or mechanisms of interest. Through this process of concourse development, there may be additional phenomena or mechanisms discovered or existing ones may not be salient with the group and jettisoned. A critical realist Q project would use judgmental rationality to bring the threads of a concourse together, braiding it into a coherent and inclusive universe of statements that is capable of revealing something about the world.

In this study, the concourse in question consists of different statements expressing opinions and views about how DSPs make decisions in their daily work within a person-centered services framework. The final principle of operant subjectivity is the end result of an individual completing a Q sort, or an individual making meaning of the concourse from his or her own point of view. Operantcy is achieved within Q method by obtaining outcomes that are unfettered by instrumental effects (Stephenson, 1977). As stated by McKeown and Thomas (2013, p. 4), “In Q methodology, the observer and the observed are identical; only the individual can measure his or her subjectivity. The methodology seeks to reveal these subjectivities without confounding them with operational measurements.” In other words, the statements within the concourse do not have meaning attached to them *a priori*: it is through the act of sorting these statements according to a participant’s point of view (Q sort) that the statements take on their subjective meaning.

Through the Q sort process, this allows the participants to, in effect, “create their own categories” (Brown, 2005, p. 201). From this methodology, it follows, that if all DSPs participating in the Q sort were to hold the same beliefs

and attitudes, the factor analysis performed in step 5 would register a single factor or viewpoint. Likewise, if there are two belief systems, there would be two factors, and so on. The number of factors that emerge is therefore a purely empirical matter and not a theoretical one as they emerge naturally from the Q-sorts of the participants. The coalescing of factors from individual Q sorts is described by Stephenson as being mediated by Pierce's (1940) law of mind which states "ideas tend to spread continuously and to affect others which stand to them in a peculiar relation of affectability" (p. 340). Brown and Steuernaegel (1985) further explain this process referencing Pierce again, describing that an idea has an "intrinsic quality as a feeling" and tends to gather similar ideas around it eventually coalescing into one general idea (p. 345). This process of gathering and assimilating ideas will ultimately develop into a naturally occurring structure of subjectivity as denoted by Pierce's law. Brown and Steuernaegel (1985, p. 12) provide a useful analogy between the formations of structured subjectivity within individuals and how they give rise to factors with the molecular structure of the sugars. Consider glucose, fructose, and galactose, which all have a similar composition of  $C_6H_{12}O_6$ . All three sugars share the same molecular components yet have small identifiable difference in structure as seen in Figure 3.



*Figure 3: Molecular structure of simple sugars*

In a sense, all three sugars come from a concourse of matter consisting of carbon, hydrogen, and oxygen. However, as with operant subjectivity, the structure of each sugar is uniquely its own, just as each participant's Q sort will have a unique structure compared to other participants. Likewise, the structure of each sugar is naturally occurring, as is the structure of a participant's Q sort.

From a critical realist perspective, operant subjectivity gets to the core of actors' perspectives on any number of important or relevant social science topics, which Bhaskar (1998, p. xvi) has stated "form the indispensable starting point of social enquiry." Taken as a whole, Q methodology and its ontology and epistemology seem readily applicable to a critical realist research project, allowing the social scientist to explore the different structures naturally occurring within a group around any given topic. In addition, Q methodology is a unique version of methodological pluralism which if deployed appropriately can add depth and increased understanding to a topic of interest within a larger post-positivist research program (Durning, 1999). This is a vital reason why Q methodology was selected to answer the study research questions: it appears that no research to date has examined the subjective decision making behavior of DSPs, and how many and what type of factors may arise are completely unknown.

### **Research Questions**

The primary research questions examine the range of viewpoints and attitudes that exist among DSPs about their work, specifically their on-the-job decision

making within the framework of person-centered services. The primary research questions are:

1. What are the various viewpoints that exist among DSPs about their practice decisions within a person-centered services framework within community-based care settings?
2. In what ways do the decision-making viewpoints of the DSPs reflect domains including recognition, self-reference, paternalism, agency resources, agency policy, and group home culture?
3. To what degree do the concepts presented in Recognition Theory describe and explain the decision-making viewpoints emerging from the DSP Q sorts?
4. Do the viewpoints of experienced DSPs (more than 18 months experience in the field) and inexperienced (less than 18 months experience in the field) DSPs differ?
5. What are the implications of the findings for the development of DSP training curricula and supportive resources focused on person-centered practices?

### **Constructs and Methodological Context**

Individual DSP viewpoints and the corresponding factors that they form towards job related tasks are the central, relevant constructs within this study.

Given the line of logic present within the theory section, it is necessary to explore DSP viewpoints in relation to their job activities as their daily decisions have tangible impacts on service recipients' quality of life. It is supposed that DSPs possess different views of their work. Combine this with the various training completed by DSPs, which may fluctuate from agency to agency, and the vastly

differing amounts of knowledge and skills each DSP brings into the workplace and we likely have a complex and varied set of viewpoints and decision making strategies that DSPs apply to carry out person-centered services.

Q methodology allows for the exploration of these viewpoints, informed by a DSP's training, background, skills, and knowledge, in an advantageous way when compared to survey research. While surveys are undoubtedly one of the most common ways used to collect feedback, they allow participants to give identical or similar ratings to many or all items (Dennis, 1986). Missing data is also a common problem with survey-based research (McKeown, 2001; Sexton, Snyder, Wadsworth, Jardine, & Ernest, 1998). Missing data or non-response bias resulting from respondents is a non-issue with the use of Q methodology as data is collected one-on-one (Dennis, 1986). Scales, polls, and surveys are able to spotlight shared and common opinions that exist across a population, but they do not provide any empirical insight into the differing factors/views within that same population (Collins, 2009). Q methodology specializes in this very area by employing a by-person factor analysis in order to identify groups of participants who make sense of a pool of items (the concourse) in equivalent ways through the Q sort (Watts & Stenner, 2005). Through the data analysis techniques of Q, correlations and factors among persons are revealed, while in survey research what are obtained are the correlations and factors among traits, not individuals. In Q methodology, the correlations found are based upon the assumption that "persons significantly associated with a given factor...share a common perspective" (McKeown & Thomas, 2013, p. 6). Thus, Q is a beneficial tool in

understanding participant viewpoints within groups (Cross, 2004; Leary, Gallagher, Carson, Fagin, Barlett, & Brown, 1995; Steelman & Maguire, 1999; van Exel, de Graaf, & Brouwer, 2007).

Like critical realism, Q methodology has faced its share of skeptics and detractors (see Kampen & Tamas, 2014 for a recent example) since its inception, often from dogmatic objective-positivist critiques. For Q methodology this has, most frequently, manifested as it being viewed as nothing more than a quantitative method with a qualitative piece or vice versa (Stephenson, 1986). However, this is a poor description of what Q is and shows a lack of understanding towards its ontology and epistemology. Q methodology is viewed by its creator and practitioners as a true hybrid of qualitative and quantitative methods with both approaches linked in each and every step of the Q study. This inability to accept Q methodology as something distinct in the qualitative/quantitative divide has been best described by Stenner and Stainton-Rogers (2004, p. 101):

Hybridity ought to be discomforting, since any genuine hybrid represents a significant reformation in the bodies that are brought together in forming it. Hybridity pierces the boundaries of identity and opens up the difference of otherness. By contrast, merely adding a qualitative dimension to a quantitative study and vice versa does not constitute hybridity and may be far from discomforting. Q operates with an ontology in which the ultimate realities are neither subjects nor objects, but actual occasions of experience...this is no ordinary “mixing” of methods and it is precisely not a matter of an objective “natural world” being contrasted with a socially constructed and subjective “human world”: it is a qualiquantology.

Here, the critical realist should note that Q methodology comfortably situates itself in the acceptance of structure and agency being indivisibly tied together in

actors real world experiences. It also portends of the substantial epistemological shift that is required for many social scientists to accept Q methodology as the common relationship of the observer and observed is flipped. As has been noted earlier, Q methodology operates from an assumption that *"...measurements and observations of a person's subjectivity can be made only by himself."*

(Stephenson, 1972, p. 17). Lastly, we must note that at its core, Q methodology seeks to provide structure to the internal occasions of experience by the group of actors being studied. To conceptualize this possibility of structure and form to experience, Stephenson (1978, 1982, 1990a, 1990b) turned to Kantor's interbehavioral psychology which was presented on page 35. Stephenson, looking to translate Kantor's work into Q methodology noted the important difference between the two in terms of the psychological field which for Kantor merely was the canvas upon which action occurred. For Stephenson and Q, the psychological field was a concrete entity which could be represented by an appropriately developed concourse. Stephenson (1982, p. 242) states that "in Q...the concourse, as psychological field, is the individual's cultural heritage, born of history. It is the single most significant contribution to subjective science. All Q sorts dip into it, as an empirical field out of which new subjectivity grows."

In the field of social work, where issues of empowerment within a research setting are an important consideration, Q provides a methodology that enables all participants to take an active role throughout the entire process (Donner, 2001; Ellingsen et al., 2010). From the building of the concourse of communication, derived from research literature and the opinions of current

DSPs, through the Q sort process and post-sort interview, it is the participants themselves that ascribe much of the final meaning of the emergent factors. It is for this reason, combined with Q's benefits over survey methodology, that the research design outlined below has been chosen to pursue the research questions listed above.

## **Research Design**

Within the continuum of qualitative and quantitative research, much debate has arisen concerning where Q methodology should be placed. Q has been termed a "qualiquantological" method in which the qualitative and quantitative aspects are inextricably linked at almost every step within the research process (McKeown & Thomas, 2013; Stenner & Stainton Rogers, 2004). It may be most helpful to view Q as a unique type of mixed methods approach (Newman & Ramlo, 2010). This section will show the step-by-step succession of actions that are viewed as essential for obtaining objective, reliable, and valid information from this investigation. This dissertation was reviewed and initially approved by the Institutional review board of Rutgers University on 12/23/15 and the New Jersey Division of Developmental Disabilities on 3/21/16.

### *1. Identifying a concourse on the topic of interest*

Concourse development refers to the creation of a set of statements which encapsulate the "viewpoints" or "vantage points" on a particular issue (McKeown & Thomas, 2013, p. 18). The ideal concourse contains all the relevant aspects or themes identified about the topic of research (de Graaf & van Exel, 2008).

Prominent Q methodologist, Steven Brown has stated:



The concourse is the flow of communicability surrounding any topic. Concourse is the very stuff of life, from the playful banter of lovers or chums to the heady discussions of philosophers and scientists to the private thoughts found in dreams and diaries. From concourse, new meanings arise, bright ideas are hatched, and discoveries are made: it is the wellspring of creativity and identity formation in individuals...and it is Q methodology's task to reveal the inherent structure of a concourse. (1993, pp. 94-95)

The concourse of this study was developed from a hybrid approach from two separate areas as they pertain to DSPs subjective decision making within a person-centered service framework: a.) Reviewing literature (theoretical) and b.) Interviewing four DSPs with more than one year experience in the field (naturalistic). An extensive literature review was conducted on the given topic of the challenges facing DSPs within their daily jobs. This literature review allowed the researcher to formulate six broad theoretical areas (Table 3) which in turn informed the semi-structured interviews conducted with the four DSPs and two agency administrators (Appendix A).

Table 3.  
*Six Theoretical Areas for Concourse Development*

Theoretical Area	Issues involved
Issues of Recognition/ Misrecognition	<ul style="list-style-type: none"> <li>• The concept of personhood for individuals with disabilities</li> <li>• The value of an individual with disabilities to the community</li> </ul>
Issues of Self-Referential Decision Making	<ul style="list-style-type: none"> <li>• Choices are made for individuals based on "what I would want"</li> <li>• I assume my wants, needs, desires are similar to the people I support</li> </ul>
Issues of Paternalistic Thinking	<ul style="list-style-type: none"> <li>• Decisions are based upon the assumption that individuals cannot make decisions for themselves</li> <li>• Decisions are made while viewing the individual supported as "child-like"</li> </ul>

Issues of Policy	<ul style="list-style-type: none"> <li>• Decisions are based upon my duty as a caretaker</li> <li>• Decisions are based upon person-centered practices</li> <li>• Are there allowances for the <i>dignity of risk</i>?</li> </ul>
Issues of Agency Support and Resources	<ul style="list-style-type: none"> <li>• Decisions based on availability or lack of resources</li> <li>• Decisions based upon training I have received</li> <li>• Decisions based upon a lack of staffing or constant turnover within the program</li> </ul>
Group Home Culture	<ul style="list-style-type: none"> <li>• Decisions based on “in-home” practices</li> <li>• Decisions based upon consensus decisions made by the majority</li> </ul>

These semi-structured interviews served several purposes related to the rigor of the study and the selection of the final items present in the Q sample. McKeown and Thomas (2013) detail that the Q sample should ideally be composed of “naturalistic” statements, or statements written in the language of the participants. These initial interviews allowed DSPs to discuss the relevant theoretical concepts in the terms with which they are more familiar and comfortable. This, in turn, ensured that the items comprising the concourse are developed in the lexicon of the DSP position and do not include statements that may be too esoteric or theoretical to resonate with the study participants. These participants were selected using a purposeful qualitative sampling strategy of *maximum variation* (Patton, 2002, p. 243). Maximum variation sampling is a technique in which the researcher purposefully picks individuals that exemplify a wide range of characteristics and aims to capture and describe the central themes that arise across these individuals and their variation (Patton, 2002). This sampling strategy was ideal given the small number of concourse development interviews completed and is seen to turn the limited numbers from a weakness

into strength within the research design as Patton (2002, p. 235) states, “Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared dimensions of a setting or phenomenon.”

To ensure the second requirement of concourse development, comprehensiveness, was met, the semi-structured interviews also allowed each interviewee to discuss issues related to his or her subjective decision making that were not included within the initial six-category framework (McKeown & Thomas, 2013). These interviews were carried out using the theoretical perspective of *reality-oriented* qualitative inquiry. This method of inquiry was chosen as its base assumptions closely correlated with the intertwined qualitative and quantitative pieces of Q methodology.

Reality-oriented inquiry assumes that all scientific methods, in and of themselves, are imperfect and that to generate and test theory successfully, both qualitative and quantitative pieces must be used (Patton, 2002). The primary purpose for using reality-oriented inquiry for the concourse development within this study was to test the theoretical areas created through the literature review with DSPs to distinguish between belief (view of the researcher) and valid belief (view of the DSPs) (Patton, 2002). As is customary in a reality-oriented approach, these interviews were used as a form of analytic induction, a process that starts deductively. The six deductive theoretical areas hypothesized to influence DSP decision making within person-centered services were then examined within each interview to determine if the experiences of the DSP supported them. After each

interview, the fit of all six areas was examined, as well as any additional areas brought up by the interviewee. These new areas then became a part of the subsequent DSP interviews with the aim of having a satisfactory explanation of the phenomenon (DSP decision-making within person-centered services) for the development of the final concourse (Taylor & Bogdan, 1984). After these interviews were completed and analyzed, a finalized list of concourse statements was completed to reflect the clarification of the above theoretical areas. The concourse for this study was comprised by a list of 48 statements, which is considered satisfactory (Stainton Rogers, 1995).

## *2. Developing a representative set of statements (Q sample)*

Q methodology relies on two forms of sampling; the first involves how a researcher chooses to select statements from the larger concourse to create a finalized “Q sample”. As with sampling from a population of individuals, this can be done in a structured or unstructured manner. For the purpose of this study, the creation of the Q sample was undertaken through a procedure commonly known as a Fisherian balanced block design (Stephenson, 1953, p. 66). This method allows for “the systematic sorting of the concourse and generating a number of statements that represent the different aspects of the concourse” (Ellingsen et al., 2010, p. 398). In addition, the Fisherian design when used appropriately, promotes theory testing by structuring the concourse around the six categories established through the literature review and inductive categories arising from the DSP interviews (McKeown & Thomas, 2013). The formula used for this design is laid out in table 4 as:

$$Q \text{ Sample } (N) = (\text{Main effects})(\text{Replications}) = ([A][B])(m) = N \text{ statements}$$

Table 4.  
*Fisherian Concourse Design*

Area of Focus		
(A) Theoretical Area	(a) Recognition (b) Self-referential	
	(c) Paternalism (d) Policy (e) Agency	
	(f) Group Home Culture	
(B) DSP focus	(e) Autonomy	(f) Care

As there were no other theoretical areas identified by the DSP interviews, 4 replications (m) from each area was deemed as comprehensive, we have the following formula dictating the Q sample formulation:

$$Q \text{ sample } (N) = ([6] [(2)] (4)) = 48 \text{ statements}$$

Two additional steps were taken once the Q sample was finalized to ensure rigor within the study: (a) Expert review and (b) trial Q sorts. Two experts within the field of intellectual and developmental disabilities familiar with the issues facing DSPs were identified and given the finalized Q sample to review and critique regarding its comprehensiveness and naturalism of language. Finally, two trial Q sorts were given to DSPs with at least one year of experience in the field to identify issues of confusion or comprehension that may arise within use of the Q sample, and subsequent adjustments made. One such adjustment was the changing of the word “client”, which was used to denote the service recipient, to the native language of the provider agencies (i.e. “person served”). The finalized list of statements and their theoretical areas and origins are presented below in appendix D.

### 3. *Specifying the respondents for the study (P-set)*

Q methodology studies do not require a large number of participants to reveal the main viewpoints favored by a particular group of participants (Ellingsen et al., 2010; McKeown & Thomas, 2013; Watts & Stenner, 2005). A sample range of 20 to 50 participants is typically considered adequate to obtain the main emergent factors. For the purpose of this study, a P-set consisting of 30 participants was recruited to complete the Q sort process (this does not include those participating in the trial Q sort process). As is mentioned by Watts and Stenner (2005, p. 79) the precise composition of the P-set must be carefully considered, allowing the researcher to “strategically sample” participants. This is especially important if a certain type of participant is likely to express a unique point of view. The literature on Q methodology also warns prospective researchers away from relying solely on demographic characteristics to form a P-set as these rely on a researcher’s preconceived notions (Watts & Stenner, 2005). Respondents consisted of individuals who were in part-time or full-time employment as Direct Service Providers for New Jersey service agencies residentially supporting individuals with intellectual or developmental disabilities. Purposeful theory-based sampling was used to include DSPs who have the following characteristics:

- a. DSPs with 6 to 18 months experience as direct support professionals
- b. Experienced DSPs with more than 18 months experience as direct support professionals

The final sample of 30 participants was tailored to include at least 10 DSPs with 9-18 months experience, 10 DSPs with more than 18 months experience. The respondents were drawn from two support agencies in New Jersey that receive state funding and provide housing to individuals with ID/DD in congregate settings such as group homes and supervised apartments.

Agencies were contacted by the researcher by email and a follow-up phone call to request their support to advertise to their DSPs about the opportunity to participate in the research study. The type of solicitation included: posting study advertisement flyers within the agency's programs, introducing the study opportunity at staff meetings by the researcher, advertising the study within the agency's monthly newsletter, and distributing study advertisement flyers to program managers so that they could dispense them to their staff. Those who responded were screened by the researcher to determine their length of experience in working as DSPs, and their ability to participate. Those selected were scheduled to complete the Q sort and interview process at a location convenient to them, such as a private meeting room within the agency's main office when they were not working. Upon meeting with each DSP, the researcher presented the informed consent forms for the study and verbally went through the studies protocols and prupose with each perspective participant as well as allowing them time to read the informed consent documents for their participation in the study and consent to have their participation audio recorded . Participants received a \$20 reimbursement for their time. The final make up of P-set and the corresponding demographic information can be seen below in Table 5.

Table 5.  
*Demographics of P-set*

Variable	Number	Percent
Participation Rate		
Agency 1	20	66.7%
Agency 2	10	33.3%
Type of DSP		
New (6 to 18 months)	11	36.7%
Experienced (over 18 months)	19	63.3%
Gender		
Male	13	43.3%
Female	17	56.7%
Ethnicity		
White	2	6.7%
Hispanic/Latino	1	3.3%
Black	24	80.0%
Multiracial	3	10.0%
Current Education Level		
High school/ GED	7	23.3%
Some College	19	63.3%
Bachelor's Degree	4	13.3%
Level of Difficulty in Supporting Clients		
Easy to Moderate (1-5)	20	66.7%
Moderate to Difficult (6-10)	8	26.7%
Multiple Programs	2	6.7%

#### *4. Administering the Q sort*

The next step, administering the Q sort, was done with each chosen study participant. The conditions of instruction given to each individual was as follows: Please sort the statements provided from those that are most like (+4) how you make decisions while working within your program to most unlike (-4) how you make decisions at your program. The Q sort and follow up questions took on average 65 minutes to conduct, and was administered by the author.

This way of ranking statements from the participant's point of view makes it clear that the statements being sorted are not of a factual nature, but subjective.



The polar titles of “most like” to “most unlike” are necessary to insure the scalability of the intensity each individual feels for each statement (Brown, 1980). Statements ranking in the 0 category are deemed neutral or of little significance to the person completing the Q sort (Brown, 1980). While research has shown that a forced distribution is not entirely necessary to produce relevant factors, it can be preferable for the participant as it makes the task clear (Cottle & McKeown, 1980). In addition, unlike surveys and Likert scales, sorting into a grid insures each participant makes explicit choices about the ranking of the statements relative to all other statements (McKeown & Thomas, 2013).

Once the participant was given the pack of randomly numbered cards, he or she was shown the distribution grid which was contained on a piece of poster board. The participant was reminded that there was no right placement of any of the statements and that each statement might mean something different to each person participating in the study. Each participant was instructed to read through all of the statements and was asked to sort the statements into three separate piles corresponding to the two poles and the neutral middle. First, a pile was made on the left corresponding with statements with which the individual felt were most unlike how they made decisions on their job. Second, a pile was made on the right corresponding with statements with which the individual felt were most like how they made decisions on their job. Finally, a pile in the middle was made up of statements with which the individual had neutral feelings (Ellingsen, et al., 2010).

The participants were then instructed to go to each pile and place the statements they felt most appropriately matched their beliefs or attitudes to the

corresponding column in the number dictated within the structured distribution grid presented in Figure 4. Once both of the polar piles were placed into the forced hierarchy structure to the satisfaction of the participant, he or she continued to place the larger number of statements towards the neutral 0. Once all cards were placed within the hierarchy, the participant was asked to examine all placements to insure that there was nothing that he or she would like to rearrange. The researcher then recorded the final arrangement of the statements so that they could be entered properly during the data analysis portion of the project.

To ensure that no information was lost during the Q sort process, the activity was audio recorded, as the participants often asked questions of the researcher or chose to expound on certain statements unprompted that were later valuable for the interpreting process (Ellingsen et al., 2010). Following the sorting process, each participant was then asked several follow up questions, which were also audio recorded. This was done, again, to ensure that no vital information about the choices made by the participant were lost.

Following the sorting process, each participant was asked several follow up questions, which were audio recorded. This was done, again, to ensure that no vital information about the choices made by the participant was lost. This interview, much like the interviews preceding the finalized Q sample, was semi-structured and can be found in Appendix C.



Watts & Stenner, 2005). Stephenson's breakthrough in factor correlation allowed for all observations in Q technique to be placed on a firm psychometric footing as they "*are premised on a common unit of measurement, 'self-significance'*" (McKeown & Thomas, 2013, p. 49). This means that the "traits" composing a Q data matrix are singly centered on a mean of "importance to me" (McKeown & Thomas, 2013, p. 49). This allows the overall configurations produced by each participant to be correlated with the overall configurations of every other participant, and not individual statements to each and every other statement.

The researcher utilized the well-known Q methodological software PQMethod for the data analysis. Each individual's entire sort was entered into PQMethod as this software provides a variety of outputs, such as correlation matrix, factor loadings, distinguishing statements, and consensus statements (Schmolck & Atkinson, 2002). Data analysis occurs with factor analysis highlighting intercorrelations of the Q sorts as variables of persons. The combined participants' factor loadings indicate the extent to which each Q sort is similar or different to all others (McKeown & Thomas, 2013). The researcher then looked for areas of agreement or similarity among sorters. A factor analysis is applied to the results, looking for patterns that arise from among the sorts. This by-person factor analysis reveals how participants are grouped through the Q sorting process and also what statements are characteristically rated positively or negatively by individuals loading on the same factor (McKeown & Thomas, 2013). This is known as the key element within the Q analysis as the factor loadings indicate how each Q sort correlates with each factor (Ellingsen et al., 2010). The number

of factors that may materialize is “...purely empirical and wholly dependent on how the Q-sorters actually performed” (Brown, 1991/1992). In other words, DSPs who share similar subjective viewpoints on how they make decisions on the job will end up on the same factors in a Q study.

The procedure for determining whether a factor is significant can be thought of as a decision making process by the researcher that should include statistical significance as well as theoretical considerations (McKeown & Thomas, 2013). The most often used statistical criterion is the *eigenvalue criterion*, which determines a factor’s significance by looking at the sum of its squared factor loadings. Typically, any factor with an eigenvalue greater than 1.00 is considered significant. However, discussions within the Q literature warn that “Caution should be exercised when such purely statistical criteria are used” (McKeown & Thomas, 2013, p. 53). It is here that theoretical considerations again come into play, as a factor with an eigenvalue less than 1.00 can hold special interest when guided by theory. An example that may arise from the current study is as follows: following the statistical analysis, four factors may arise with only three meeting the eigenvalue threshold. Upon examining the factor loadings, it becomes apparent that the fourth factor was deemed statistically insignificant because all but one participant loaded marginally. However, the one participant loading on the fourth factor could exhibit a unique point of view worthy of exploration based upon his or her demographic information or the “social and political setting to which the factor is organically connected” (Brown, 1980, p. 42).

After identifying how many factors have arisen from the data, PQMethod will automatically determine an “exemplar” of each factor. The “exemplar” is created by merging all the Q sorts of the participants that load on a given factor to yield an interpretable best-estimate of the pattern or item configuration that exemplifies a factor (Watts & Stenner, 2005). These merged Q sorts are used for further interpretation.

The qualitative component of Q method analysis involves producing a series of summarizing accounts, each bringing further understanding to the subjective viewpoints being expressed by each factor. The researcher constructed these summaries by first examining the two poles of each factor, which express the items participants loading on the factor felt strongly about; and second, closely examining the location of statements within the more neutral categories to add further detail and explanation to each factor. Stenner and Watts (2005, p. 84) state the necessity of this examination as “...much of (what is) significant can occur in the supposedly ‘neutral’ area of the configuration.” This process of analyzing the post-sort interviews is akin to the qualitative analysis framework of indigenous typologies (Patton, 2002, p. 457). With the exemplar typologies readily provided by the factor loadings through the Q factor analysis, the process of fleshing them out and making them distinctive is done by examining the post Q-sort interviews for the individuals loading on each factor to help verify the researcher’s interpretation and to glean further understanding of their subjective viewpoints. A finalized summation of each factor is presented with the

demographic information relevant to each factor in the next chapter as well as the results pertaining to the other research questions listed above on page 71.

## CHAPTER 5

### RESULTS

In this chapter, the results of the qualitative and quantitative analysis of the study are presented and synthesized to develop a factor solution that is supported by theory, statistical output, and the voices of the participants. The outcomes of these analyses are then used to answer the primary and secondary research questions of this research project:

1. What are the various viewpoints that exist among DSPs about their practice decisions within a person-centered services framework within community-based care settings?
2. In what ways do the decision-making viewpoints of the DSPs reflect domains including recognition, self-reference, paternalism, agency resources, agency policy, and group home culture?
3. To what degree do the concepts presented in Recognition Theory describe and explain the decision-making viewpoints emerging from the DSP Q sorts?
4. Do the viewpoints of experienced DSPs (more than 18 months experience in the field) and inexperienced (less than 18 months experience in the field) DSPs differ?
5. What are the implications of the findings for the development of DSP training curricula and supportive resources focused on person-centered practices?

*(answered in Discussion)*

As detailed on page 86, in the preceding section, the quantitative piece of a Q project utilizes three consecutive analyses to determine the amount of arising



factors and the number of participants that load on them. The finalized sample or P-set, in the terms of Q, was presented on page 83 and shows that of the thirty participants there was a mix of new and experienced DSPs (37% and 63% respectively) with the majority of them being female (57%). With regards to race and ethnicity, the majority of the P-set identified as Black (80%) with the remaining participants endorsing being multi-racial (10%), White (6%) and Hispanic/Latino (3.3%). The majority of members in the P-set reported having some college credit (63%) as their highest level of educational attainment with the rest stating they had obtained their high school diploma/GED (23%) or Bachelor's degree (13%). Finally, when asked the level of difficulty they experienced in supporting their clients, a large majority expressed their daily challenges as low to moderate (67%) with the remaining DSPs stating they faced moderate to difficult challenges (27%). Two participants worked in multiple programs and stated that the difficulty level was different depending on which program they were scheduled to work at that day.

The P-set characteristics were coded as presented in Table 6 to aid in factor interpretation and participant identification. As an example, Sorter #1 (coded A1EFBS1) was from the first agency (A1), had more than 18 months experience on the job (E), was female (F), identified as Black (B), had some college credit (S) and expressed the level of difficulty of their clients as easy to moderate (1). This coding system is used throughout this chapter in all tables.

Table 6.  
*Coding System for Study Participants*

Category	Identifier	Definition
Agency	A1	Agency 1
	A2	Agency 2
Experience on the Job	N	New (6-18 months)
	E	Experienced (over 18 months)
Gender	M	Male
	F	Female
Ethnicity	B	Black
	C	White/Caucasian
	H	Hispanic
	X	Mixed Ethnicity
Current Education Level	G	High school/GED
	S	Some College
Difficulty Level	D	Bachelor's Degree
	1	Easy to Moderate
	2	Moderate to Difficult
	0	Multiple Levels of Difficulty

Following subjecting the 30 Q sorts to a correlation analysis, principle components analysis (PCA) was used to determine a starting point for how many factors to pull from the data. The initial completed PCA showed a large number of potential factors given the purely numeric criterion of a viable factor having an eigenvalue greater than 1.00. In the initial unrotated PCA analysis there were 9 factors greater than the 1.00 threshold with the first factor scoring an eigenvalue of 9.65 and the ninth factor scoring 1.04. However, as explained in the Methods chapter, there are multiple considerations that guide the initial task of drawing out a specific number of factors, which include having meaningful factors in relation to the qualitative data and ensuring that at least two participants load onto a factor as each factor is to represent a commonly shared viewpoint. Given this additional criteria and looking at the drop in eigenvalues between the factors, a decision was

made to keep five factors for Varimax rotation. This decision was supported by the drop in eigenvalues between factors 5 and 6 (1.70 and 1.36, respectively), that all factors above 5 had one or no significant loaders on them, and that each factor in a 5 factor solution had a distinct and different viewpoint (though there was a strong undercurrent of similarity that will be discussed further below).

Having selected a 5 factor solution for Varimax rotation and applied it, the resulting factor loadings for each participant on each factor are presented in Table 7; bold type is used to indicate where participants load significantly on a factor. Out of the 30 participants, only 3 did not load significantly on any of the 5 factors. These three participants did have strong associations with some of the factors but often had competing numbers in multiple factors which kept them from loading on a single factor. For example, Sort 11 (A1EFBG2) had a moderate correlation with both factors 1 (.39) and 4 (.42). It is important to note that only participants loading significantly on a single factor were included in the proceeding qualitative analysis of that factor. To interpret how a participant's sort matched with each factor, the numbers in the corresponding cells represent their loadings with a number approaching 1.00 being highly correlated with the overall factors. Loadings that are negative represent sorts that represent a reverse image of the defining sort for the factor (i.e. a negative loader will have ranked statements in the opposite way as those that load positively on the factor). Among this group of sorters there were no significant negative loadings by any of the participants on any of the factors. The finalized and rotated 5 factor solution and each participant's loadings on those factors are presented below in Table 7.

Table 7.  
*Rotated Factor Matrix with **Bold** Indicating a Defining Sort*

Q Sort	Participant ID	1	2	3	4	5
1	A1EFBS1	-0.0625	0.4439	<b>0.5053</b>	0.0935	0.0168
2	A1EFBD1	0.2765	-0.0699	0.1776	<b>0.6731</b>	0.0133
3	A1NMBS1	0.0932	0.0169	-0.1005	0.5224	<b>0.5921</b>
4	A1EMBS2	0.3642	-0.0519	0.0298	0.2214	<b>0.6266</b>
5	A1EMBG1	<b>0.5238</b>	0.2405	-0.0255	0.3296	0.3810
6	A1NFBS1	0.0625	-0.0612	<b>0.7204</b>	0.0265	0.2188
7	A1NFBD1	0.2270	0.0295	0.3476	<b>0.7217</b>	0.1521
8	A1NMBS2	0.0608	0.0728	0.0668	-0.0980	<b>0.7387</b>
9	A1EMBG1	<b>0.6923</b>	0.2896	0.3165	0.1406	0.1707
10	A1EMBD0	<b>0.7657</b>	0.1602	0.1570	0.1148	0.2532
11	A1EFBG2	0.3898	0.2735	0.0770	0.4231	0.0765
12	A1NFBS2	0.2421	<b>0.7624</b>	0.0580	0.1154	0.0366
13	A1EFXS1	<b>0.6679</b>	0.2139	0.2481	-0.2877	0.1262
14	A1EFCS0	0.1250	<b>0.7141</b>	0.2287	0.0316	0.0815
15	A1EFCG2	-0.0007	<b>0.5369</b>	-0.2735	0.4416	0.1855
16	A1EFBS1	<b>0.6793</b>	0.1326	-0.0302	0.0936	0.4477
17	A1NMBG2	<b>0.6942</b>	-0.0657	-0.0018	0.0806	0.3030
18	A1NFBS1	0.0140	0.3907	0.0026	<b>0.6409</b>	-0.0830
19	A1EMBS1	0.1943	0.1552	<b>0.7244</b>	0.0966	-0.0790
20	A1NFBS2	<b>0.6595</b>	0.1077	0.3841	0.0892	0.2967
21	A2EMBG1	<b>0.6192</b>	-0.0761	0.2333	0.3016	-0.0243
22	A2EFXS2	0.1433	0.3456	0.2320	0.0110	<b>0.5865</b>
23	A2EFBS1	0.4768	0.3423	0.4166	0.1828	0.1582
24	A2EMBD1	0.3520	0.2396	0.2448	0.0077	<b>0.5516</b>
25	A2EMXS1	<b>0.6059</b>	0.0172	0.1862	0.0320	0.0272
26	A2NFBS1	0.0671	<b>0.8294</b>	0.0966	-0.0244	0.2627
27	A2EMBS1	<b>0.6321</b>	0.2962	-0.2378	0.2314	0.2415
28	A2NFBG1	<b>0.7055</b>	0.0118	-0.0473	0.2077	-0.0110
29	A2EMBS1	0.3506	0.0909	0.4133	0.2088	0.1568
30	A2NFHS1	<b>0.5863</b>	0.4882	-0.0590	0.1349	-0.1182
%	Expl. Var.	21%	11%	9%	9%	10%
#	Per factor	12	4	3	3	5
%	Per factor	40.0%	13.3%	10.0%	10.0%	16.7%

Note: The coding for the Participant ID includes the Agency (A1= agency 1, A2= agency 2), experience level (E= experienced, N= New), gender (M= male, F= female), ethnicity (B= Black, C= Caucasian, H= Hispanic, X= mixed), education level (G= High school/GED, S= some college, D= Bachelor's degree), and level of challenge of work (1= easy to moderate, 2= moderate to hard, 0= unsure or worked at multiple programs with different levels of challenge).

Factor 1 had twelve significant sorts and their loadings ranged from 0.52 to 0.77. The first factor also accounted for 21% of the variance among all sorts.

Factor 2 had four significant sorts and their loadings ranged from 0.54 to 0.83 and accounted for 11% of the variance among all sorts. Factors 3 and 4 each had three significant loaders ranging from 0.51 to 0.72 for factor 3 and 0.64 to 0.72 for factor 4 with each accounting for 9% of the variance among all sorts. The final factor had five significant sorts with their loadings ranging from 0.55 to 0.74 and accounted for 10% of the variance within the sample. In total, this solution and rotation accounted for 60% of the variance among all sorts and 90% of participants loaded significantly on one of the factors.

As noted earlier, while each of the five factors represents a unique viewpoint, there was a strong level of similarity between all of the participants' sorts as shown in Table 8, which displays the level of correlation between all the factors. While not all of the factors were correlated at a high level, which is typically delineated by a correlation greater than  $\pm 0.50$ , nearly all factors were significantly correlated at the .05 level (.29 and above) and many were also significant at the .01 level (.38 and above).

Table 8.

*Correlation Matrix of Factors*

Factors	1	2	3	4	5
1	1.000	**0.380	*0.326	**0.414	**0.522
2	**0.380	1.000	0.274	0.254	*0.364
3	*0.326	0.274	1.000	*0.316	0.249
4	**0.414	0.254	*0.316	1.000	*0.300
5	**0.522	*0.364	0.025	0.300	1.000

\*p= .05; \*\*p= .01

This consistent level of correlation between factors would seem problematic if the end goal was to separate out five completely different points of view that could arise from the sorts of the participants. However, in the context of DSP practice

behavior it is noteworthy that there would be many similarities in the ways people describe how they do their job. For one, the overarching service paradigm of person-centered services is a consistent backdrop for many if not all group home programs. Furthermore, New Jersey has a set series of pre-service training modules which cover the same information regardless of which support agency a DSP works. Given this context, it would have been more surprising (and alarming) to have all factors uncorrelated with one another, which would be grounds for surmising that there are vastly different ways that DSPs approach their work. Instead, these results, coupled with the interview data, point to a consistent theme of recognition running through each factor but with different levels of importance and conceptualizations of this concept amongst each factor. In addition, certain participants held either self-referential or paternalistic views about their work while still ranking and acknowledging certain statements on recognition. Other participants melded around issues involving agency structure and resource availability, which were seen either to impede their ability to do their job or as a boon to the success of their program. This can be seen by examining the rank of each statement given by each of the five factors and their corresponding theoretical area which are presented below in Table 10. The numbered score attributed to each factor as it relates to each statement represents the combined viewpoint of all significantly loading sorts on a given factor, which in Q is termed an ideal sort. Also in this table are denotations for those statements that were distinguishing statements (\*) for each factor, which means that the ideal sort score for one factor was significantly different than all other ideal factors

scores. Finally, statements that are marked with a (†) signify a statement that was ranked similarly by all factors; which in Q are called consensus statements. In order to determine the consensus and distinguishing statements, a difference score is calculated within the PQMethod program. A statement's factor score is the normalized weighted average statement score (z-score) of respondents that define each factor. Van Exel (2004, p. 9) describes the difference scores as follows: "The difference score is the magnitude of difference between a statement's z-score on any two factors that is required for it to be statistically significant. When a statement's score on two factors exceeds this difference score, it is called a distinguishing statement." When a statement is not distinguishing between any of the factors it becomes a consensus statement (van Exel, 2005). Given the high level of collinearity among the five factors in this solution, additional statistical work was done to increase the amount of distinguishing statements. The standard error for the factor scores expressed in the +4/-4 format is obtained by multiplying the  $SE_z$  by the standard deviation of the Q-sort distribution ( $\sigma = 2.189$ ). These values are shown in the boldface row below:

Table 9.  
*Factor Characteristics*

	Factors				
	1	2	3	4	5
No. of Defining Variables	11	3	3	3	5
Average Rel. Coef.	0.800	0.800	0.800	0.800	0.800
Composite Reliability	0.978	0.923	0.923	0.923	0.952
S.E. of Factor Z-Scores	0.149	0.277	0.277	0.277	0.218
<b><math>\sigma_e</math> of +4/-4 factor scores</b>	<b>0.326</b>	<b>0.606</b>	<b>0.606</b>	<b>0.606</b>	<b>0.477</b>

In the PQMethod program, the standard error of the difference assumes that the factors are uncorrelated. The standard error of the difference that takes into account the correlations between factors is given by the expression  $\sigma_d =$

$\sqrt{\sigma_x^2 + \sigma_y^2 - (2)(r_{xy})(\sigma_x)(\sigma_y)}$  where  $\sigma_x$  and  $\sigma_y$  are the standard errors for factors  $x$  and  $y$  and  $r_{xy}$  is their correlation. The standard error of the difference for Factors 1 and 2 is therefore  $\sigma_d = \sqrt{(.326)^2 + (.606)^2 - (2)(.3803)(.326)(.606)} = .569$ .

To be considered significant at the .01 level, we multiply  $\sigma_d$  by 2.58, which results in  $(2.58)(.569) = 1.467$ . In the +4/-4 factor score format, of course, differences in factor scores can only be in whole numbers, so to be on the safe side we round up:  $1.467 \rightarrow 2$ . Therefore, any factor score difference between Factor 1 and Factor 2 that is equal to or greater than the critical difference of 2 is considered significant. And it turns out that when the same calculations as the above are applied to all other factor pairs, a difference of 2 is also significant ( $p < .01$ ) for all of them.

The advantage of using the modified standard error above is that it reveals a few other distinguishing statements that did not appear in the PQMethod output:

Factor 1: No additional statements are distinguishing.

Factor 2: No. 26 is also distinguishing, in addition to those in the PQMethod output.

Factor 3: Nos. 19, 22, 26, 27, and 33 are also distinguishing.

Factor 4: No. 19 is also distinguishing.

Factor 5: Nos. 42 and 45 are also distinguishing.



These consensus and distinguishing statements will allow for a deeper exploration into the meaning behind each factor. While it would not be useful to enter into a detailed discussion of how each factor scored each of the 48 statements, it is important to note the three consensus statements that all five factors expressed similar viewpoints. Statement 8 comes from the theoretical area of paternalistic thinking and all factors ranked this statement as unlike how they approach making decisions on their job. The statement presents the possible power gap between clients and staff by positing that in any disagreement with a client, the staff views themselves as being right. It is reassuring that all staff had a strong negative reaction to this statement, as it is the antithesis of what is taught in the state mandated agency trainings and would go against the basic philosophical and ethical principles of person-centered care. There is a similar logic for the next two consensus statements, numbers 24 and 14. Statement 24 is attached to the agency policy theoretical area and is a paraphrasing of how person-centered care should be operating at the client/DSP level (i.e., the client is empowered to make their own choices and staff work to facilitate those choices through respect and advocacy). All factors ranked this statement as strongly positive or most like how they make decisions on their job. The final consensus statement is number 14 and comes from the theoretical area of recognition. The statement is a paraphrasing of the concept of recognition combined with the DSP code of ethics developed by the National Association of Direct Support Professionals (NADSP). All factors identified that this was something that strongly influenced how they made decisions on the job and was often mentioned in the interview data as something

pertinent to ensuring that the people supported had opportunities for growth and happiness.

Taken together, these consensus statements would seem to indicate that within this group of DSPs several key philosophical and ethical principles that have evolved in the field alongside the push towards person-centered supports have found traction and have become key components in how they strive to do their job. However, as will be shown, this baseline of consensus which rejects certain paternalistic elements (i.e., I as staff am always in the right) and highlights the importance of recognition and person-centered services becomes more nuanced within each factor, which lends credence to the level of discretion DSPs operate from in their front-line work, not all of which are in line with the philosophical and ethical drivers behind community support services. This brings us to a point in the analyses where the quantitative structure of each factor's Q sort is combined with their post-sort interviews to add breadth, depth and voice to the factors. Each factor will be presented with: their ideal sort, and tables listing the seven statements most like and unlike how the DSPs loading on the factor make decisions on the job; the distinguishing statements of the factor, and direct quotes of those loading on the factor. These analyses will be used to answer the first two research questions posed by this study.

Table 10.  
*Factor Arrays for Each Statement*

	Statement	Theoretical Area	Factor Arrays				
			1	2	3	4	5
1	The program where I work has developed a good routine to get the work done that needs to get done while making sure the clients are getting the care they need.	Group Home Culture	1	0	2	1	0

2	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups".	Agency Resources	-3	*3	-3	*-1	-4
3	I feel a client's right to make their own decisions is a key part of my work, but at times it needs to be restricted to keep them safe and to manage risky situations	Agency Resources	1	1	0	-1	*4
4	I feel that at my program we have a good handle on getting our work done, at its core it is about doing an ordered set of tasks and we have a system to make sure it all gets done.	Group Home Culture	0	1	2	1	*-2
5	According to my agency's policies, my primary goal is to keep my clients safe, healthy, and help them avoid risky situations.	Agency Policy	3	1	3	1	3
6	In this kind of work, it is necessary to advocate for your client because I have seen many examples of the people I support being "left out". They are treated as if they are not able to do certain things, which limits their independence.	Recognition	*0	2	-1	-2	3
7	My role as a staff person is to provide guidance to the people I support because the clients cannot be expected to always make the right choice.	Paternalistic thinking	†0	†0	†0	†0	†1
8	It is necessary in this line of work to remember that as staff I need to be respected by the clients and that I have the final say in situations where a client and I disagree.	Paternalistic thinking	†-4	†-2	†-3	†-3	†-4
9	In my role as a direct care worker, my work boils down to being in charge of other people's lives by making sure they are kept safe	Paternalistic thinking	2	*-3	*-1	2	*4
10	In my experience, independence is a client's ability to take care of everyday responsibilities. If a client still relies on staff for everyday things they are not independent.	Paternalistic thinking	-3	-4	-2	-3	*2
11	My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible.	Self-referential thinking	-4	-3	*-2	*1	-4
12	Often at work when a client has a difficult decision to make, I take a moment to think, "What would I do in this situation?" This helps me work with the client to solve the issue.	Self-referential thinking	-1	0	1	3	3
13	The more I have gotten to know the clients I work with, the better I understand how to care for them in a way that is respectful and gives them dignity.	Recognition	4	4	2	4	2

14	As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person's value, and help others to understand the individual's value.	Recognition	†4	†4	†3	†4	†2
15	Through my agency's trainings, I feel I know how to appropriately supervise all of my clients according to their individual needs and IHPs	Agency Resources	2	0	2	1	-1
16	I see the work I do as a commitment to caring for the people I support, with all things I do at work flowing from this commitment.	Recognition	2	2	1	0	1
17	I try to be a constant role model for my clients so that they know how to behave, act, and do things the appropriate way	Self-referential thinking	*-1	1	*4	2	1
18	I feel that my agency does a good job of making sure we have the things we need to allow the individuals to do the things they want to do.	Agency Resources	1	*-4	0	-1	-2
19	As a staff person, it is expected that I try to change the minds of individuals I work with when they want to do something that is against agency policy or procedure.	Agency Policy	0	-1	*-3	*2	0
20	When trying to come up with activities or things to do with the clients, I will often introduce them to the things I like to do to get them to try new things.	Self-referential thinking	-2	0	-2	1	0
21	In my experience, it is necessary to understand and do what is best for a client to insure their health and safety even if they disagree with what I decide	Paternalistic thinking	1	*2	*-4	0	1
22	In my experience, to get the everyday requirements of the job completed, my coworkers and I have to be flexible in areas where my agency seems inflexible.	Group Home Culture	-1	*2	*0	-2	-1
23	In my experience, it can be difficult to do the things my clients want to do because we have to get approval from management.	Agency Resources	-3	*1	-1	-4	-2
24	I feel my role is to support each individual in realizing their choices by respecting, honoring and advocating for their choices.	Agency Policy	†3	†2	†2	†4	†2
25	Something that makes my job difficult are agency problems like staff turnover, lack of access to transportation, and funds for activities. These things affect my ability to increase my clients' level of independence.	Agency Resources	-3	*4	-2	*0	-2
26	I feel like I know my clients better than the "higher-ups" and often agency policies and regulations make it difficult for me to do what is best for the client	Agency Policy	-2	*2	*4	-2	*0

27	At my program, when a policy or procedure is not helping the clients or interferes with the work getting done, we decide, "We're not going to do it that way" and come up with a solution that works best for our program and clients	Group Home Culture	-2	-1	*1	-2	-1
28	My agency has provided training which helps me do my work every day, allowing me to think on my feet and not second guess myself.	Agency Policy	1	-2	1	0	-1
29	Client centered services is a great idea, but I feel that the reality of the work I do makes it difficult to actually do it the way it should be done.	Agency Policy	-1	-1	-2	-4	-3
30	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else	Recognition	*0	-4	*3	-3	-3
31	In my experience, my clients need a lot of help with the "big" decisions, but they should still handle the small everyday choices like what clothes to wear.	Paternalistic thinking	0	1	-1	0	-2
32	I feel that my clients have the same right as anybody to make their own choices, but if a client can't quite understand certain things, I don't know how they can be expected to make a good choice	Paternalistic thinking	-1	-1	-1	*-3	*2
33	My caregiving experience has taught me that all people share a common humanity, but also have individual differences. Being aware of this influences the work I do every day	Recognition	2	2	*0	2	2
34	My caregiving experience has changed my views on what the clients I work with are capable of doing. I now see them as more like me than different from me.	Recognition	3	0	*-2	-1	3
35	I feel it is important not to let your personal factors (like culture and religion) to influence how you work with and care for the clients. As staff, we should leave those things at the door.	Recognition	*4	1	0	*-4	1
36	I feel like it is best to treat the clients the way I would want to be treated by somebody else if I was in their shoes.	Self-referential thinking	2	3	4	3	4
37	I try to help my clients be more independent by using myself and my experiences as an example, meaning I get them to understand how I would handle a decision they are facing.	Self-referential thinking	-2	-1	2	2	-1
38	In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care	Agency Policy	*2	-3	-3	*-1	*1

39	In trying to allow my client's to be as independent as possible, I have to walk a fine line between respecting their choices and what my agency expects of me.	Agency Policy	0	0	-1	-2	0
40	In my program we have certain clients we can "trust" more than others. These clients have an opportunity to take certain risks because they have proven they can handle the responsibility.	Group Home Culture	-2	-2	1	0	-1
41	When helping a client make decisions, I find it useful to talk about my values with the client so that they can make an informed choice	Self-referential thinking	-4	-3	1	0	1
42	I often rely on the training I have received to help me understand what my clients want and need. This allows me to understand them at a deeper level and increase their independence.	Agency Resources	1	-1	1	-1	*-3
43	In my program we have a great awareness of what our clients want. Often, we know what choice they will make regardless of the options.	Group Home Culture	0	-1	-1	1	0
44	I make decisions at work according to my agency's policies, with my primary goal to make my clients as independent as possible.	Agency Policy	3	*0	3	3	*-2
45	I know that supporting someone to be more independent is ideal, however my coworkers and I have to be realistic about what these clients can do so we don't waste valuable time:	Group Home Culture	-2	-2	*-4	-2	*0
46	I feel that as a staff person I am a protector, caretaker, and a person who know best what a client needs	Paternalistic thinking	1	3	0	2	0
47	I take lots of pride in my work because my religion and/or culture recognizes helping others as important work	Self-referential thinking	-1	-2	-4	*3	-3
48	With all of the things to get done on my shift, my coworkers and I take care of most of it ourselves, letting the clients assist us or do things on their own if there is time	Group Home Culture	-1	-2	0	-1	-1

Note: Distinguishing Statements marked by \*, and consensus statements marked by †

To help with the interpretation of each factor's ideal sort, the statements have been colored coded to represent the corresponding theoretical area with which they dealt. This allows for the visualization of how each factor interacted with the 6 theoretical areas in consideration with one another and provides a global view of the factor itself. In addition, each ideal sort shows the location of

the consensus and distinguishing statements as identified with the previously used markers of \* and †.

***Factor 1: Focus on Recognition and Agency Policy***

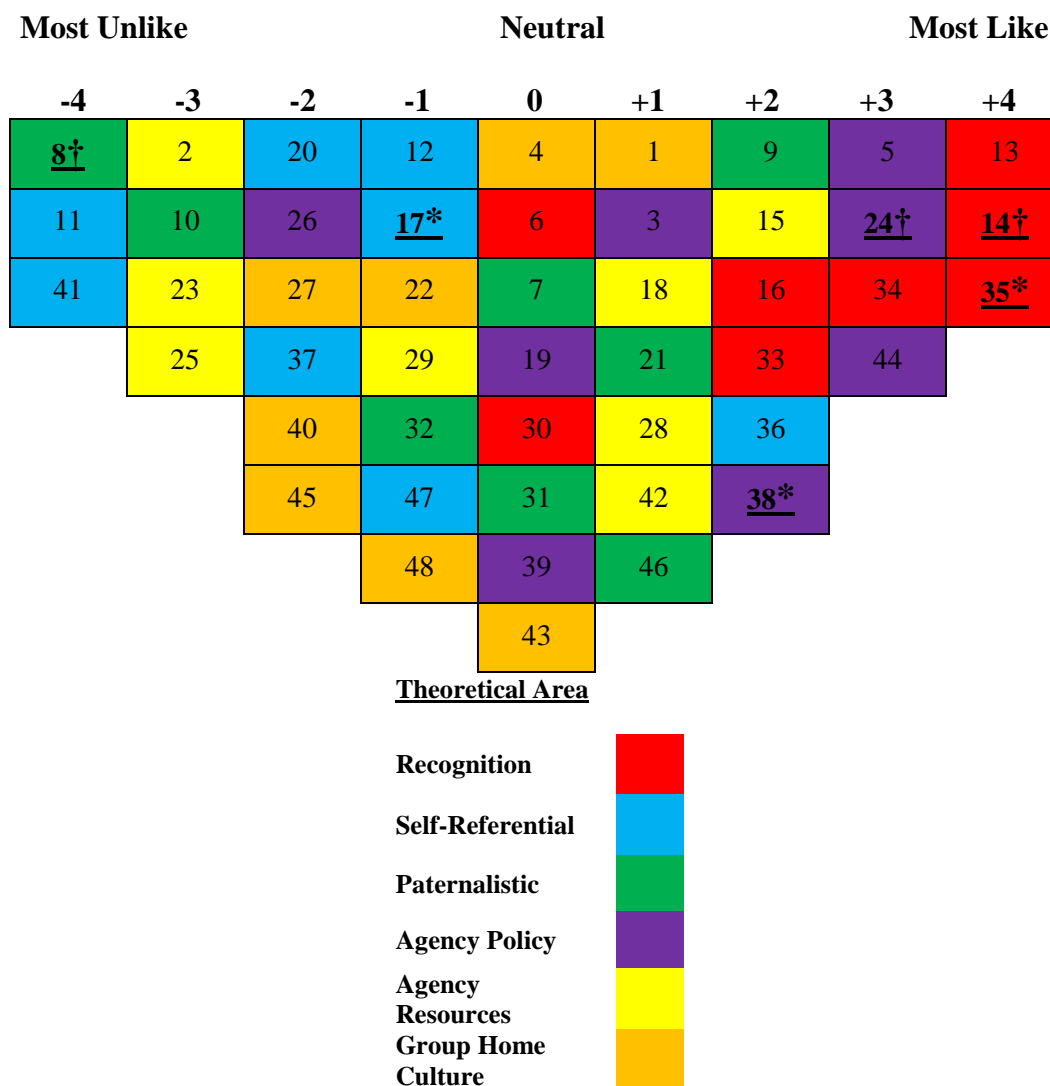


Figure 5. Ideal Sort for Factor 1 with Theoretical Areas

Of the 30 Q sorts, 11 were represented by Factor 1, or what the researcher has termed as DSPs focused on “Recognition and Policy”. These sorts and the participants that produced them shared a similar focus on the importance of recognition and how viewing the clients as equals and capable of making their

own decisions was tantamount to how they approached their work. Agency policy was also extremely important to this factor and was viewed in a positive light. In the post-sort interviews, those DSPs who loaded on Factor 1 often spoke of agency policy as working in concert with their own personal feelings and the goals they have for their clients, one building off of the other. In the event that policy and individual goals did not match up, there was a sense that discrepancy was able to be addressed with the higher ups and there was not a need to skirt policy or develop workarounds within the program. This dual focus is well represented by the color coded ideal factor (see Figure 5 above), as all seven of the top statement selections (i.e., those in the +4 and +3 categories) come from the theoretical areas of recognition and agency policy which are listed below in Table 11, however some of the individual sorts do deviate from this pattern, indicating that other influences are at play other than just recognition and agency policy.

Table 11.

*Seven Most-Like Me Statements for Factor 1: Recognition & Policy Focus*

No.	Statement	Grid Pos.
13	The more I have gotten to know the clients I work with, the better I understand how to care for them in a way that is respectful and gives them dignity.	4
14†	As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person's value, and help others to understand the individual's value.	4
35*	I feel it is important not to let your personal factors (like culture and religion) to influence how you work with and care for the clients. As staff, we should leave those things at the door.	4
5	According to my agency's policies, my primary goal is to keep my clients safe, healthy, and help them avoid risky situations.	3
24†	I feel my role is to support each individual in realizing their choices by respecting, honoring and advocating for their choices.	3
34	My caregiving experience has changed my views on what the clients I work with are capable of doing. I now see them as more like me than different from me.	3
44	I make decisions at work according to my agency's policies, with my primary goal to make my clients as independent as possible.	3

Note: Distinguishing Statements marked by \*, and consensus statements marked by †



Taking a closer look at the seven most-like-me statements for Factor 1 it is clear there is a deep and rich level of recognition established between how the DSPs view their clients and how this in turn informs their daily on-the-job decision making. While all factors shared a similar view on Statement 14 as previously noted, Factor 1 additionally stressed the importance of not letting personal factors influence decision making and that time spent with clients allowed for them to provide better care and expanded levels of recognition. With regards to agency policy, Factor 1 strongly endorsed statements that addressed the dual goals of PCP, developing a client's independence and providing care.

Table 12.

*Seven Most-Unlike Me Statements for Factor 1: Recognition & Policy Focus*

No.	Statement	Grid Pos.
8†	It is necessary in this line of work to remember that as staff I need to be respected by the clients and that I have the final say in situations where a client and I disagree.	-4
11	My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible.	-4
41	When helping a client make decisions, I find it useful to talk about my values with the client so that they can make an informed choice	-4
2	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups".	-3
10	In my experience, independence is a client's ability to take care of everyday responsibilities. If a client still relies on staff for everyday things they are not independent.	-3
23	In my experience, it can be difficult to do the things my clients want to do because we have to get approval from management.	-3
25	Something that makes my job difficult are agency problems like staff turnover, lack of access to transportation, and funds for activities. These things affect my ability to increase my clients' level of independence.	-3

Note: Distinguishing Statements marked by \*, and consensus statements marked by †

Turning to the statements that Factor 1 ranked as most unlike how they made decisions on-the-job we can see from the ideal sort that the theoretical areas of self-referential thinking, paternalism and agency resources are clustered in the -

4 and -3 designations. The self-referential Statements (41 and 11) placed at -4 gives further weight to the notion that this group of DSPs are keenly aware of the need to approach their work in a way that minimizes the impact of their personal values, culture, and religious backgrounds, which speaks to an awareness of how PCP should operate at the direct-care level. It is also important to note that the agency resources Statements (2, 23, and 25) identify that this factor, unlike some of the subsequent factors, had no issues in relation to a lack of financial or operational support from the agency administration.

Table 13.

*Distinguishing Statements for Factor 1: Recognition & Policy Focus*

No.	Statement	Grid Pos.
35	I feel it is important not to let your personal factors (like culture and religion) to influence how you work with and care for the clients. As staff, we should leave those things at the door.	4
38*	In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care.	2
6	In this kind of work, it is necessary to advocate for your client because I have seen many examples of the people I support being "left out". They are treated as if they are not able to do certain things, which limits their independence.	0
30	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	0
17*	I try to be a constant role model for my clients so that they know how to behave, act, and do things the appropriate way	-1

Note: Distinguishing Statements  $p \leq .05$  (\* indicates significance at  $p \leq .01$ )

The distinguishing statements for Factor 1 provide two additional insights that have not yet been addressed. Statements 38 and 17 (referring to agency policy and self-referential thinking respectively) were both found to be significantly different from all other factors at the .01 level. Statement 38 was endorsed at the +2 level and indicates that this factor's DSPs value the IHP document in supporting their work to care for the individuals in the best way possible. All other factors ranked this statement lower. Given that the IHP is the center piece of

a PCP, it is interesting that only this factor showed support for its use in their daily decision making. Statement 17 deals with the appropriateness of staff in displaying themselves as a role model for their clients. Factor 1 was the only factor to place this statement with a negative scoring. This seems to be in line with the importance this factor places on DSPs viewing each client as unique and having an awareness that self-referential thinking can be a slippery slope upon which the power dynamic between staff and client can unduly influence how care is provided. Factor 1 seems to indicate an awareness not only of this power dynamic, but that using themselves as a point of reference for their clients is not necessarily a good or ideal approach to helping someone grow more independent.

Table 14.  
*Selected Post-Sort Interview Responses for Factor 1*

Code & Participant #	Quotations
A1EMBG1 (5)	“This one says that we see them just like us. There is no difference, we and them. The only difference is because they have a disability. That is the only difference. We are the same in the eyes of God, so don’t say that because this person is disabled we are better than that person, No! We are still made in the same image and I treat them just like myself, because they are human beings like me. I brought this view with me when I came to work here.”
A1EMBG1 (9)	“This one says you need to be flexible in areas where your company is inflexible. We are working for the company, so whatever the company wants us to do or what we do in trainings is the right decision we have to make.” “We are all one and the same. I would want someone to treat me the way I would want to be treated and likewise I want to treat them exactly the same. Regardless of ethnicity or religion we are all one and the same regardless of our differences...I look at them as an individual, not as something damaged, broken, or however society wants to label things. I came into this field with that mind frame.”
A1EMBD0 (10)	“When I come to work for (name of agency) I sign a paper. I say I am going to abide by what you ask me to do. So I cannot decide overnight or by myself that I am going to change this. If there is something not working, we need to call and report the situation we are in so the agency can make the necessary adjustment...who am I to decide to change agency policy?” “Each individual and person is unique. We need to understand the big picture, however what I did for client A may not work for client B.”

	<p>According to that person's needs and diagnosis and all these things and also when we are talking about dignity...there is a way you treat the individual that can either promote dignity or we can make them feel really, really bad. For example, the way you talk to someone when you provide care, the way you provide assistance. Let's say somebody can feed themselves, but I rush them to get the job done. Let's say I shovel the food into that person's mouth...there is no dignity there."</p>
A1EFXS1 (13)	<p>"It's not about me. It's about them solving the issue for them. I take myself out of the equation because I have to help them solve the problem according to how much they understand. I've come across situations where because it is the clients right, you have to let them do things whether even if it is against their safety or not. I try to redirect them in a different way to try and maintain their safety. It is what they can do, what they are able to do. I do have a problem because some individuals can do more than they are allowed to do. They are just not given the opportunity to grow."</p> <p>"Your values may not be the same as somebody else's. I would approach that a different way. If you know someone well enough you should be able to integrate their values in to whatever it is that they want to do and show them the good and bad side of it. I don't like to interject my values and beliefs into a situation of decision making with an individual."</p> <p>"We can't go against policy and procedures of the agency, but we can address them with the higher-ups."</p>
A1EFBS1 (16)	<p>"The clients have the right to do as they please, make their own decisions. Sometimes you need to redirect them to help them make better decisions, but they have the right. This is their life. Whatever activities they want to explore, you help them explore in the best way possible."</p> <p>"I feel that my personal views on life and what I think should have nothing to do with the choices the clients make. I am my own person and I have my own experiences and I do the things I do for my own reasons and they should as well."</p>
A1NMBG2 (17)	<p>"I'm here to help them along, but I am not a role model to them. When you are a role model, the person intends to be like you. I don't think that is how it should be. I don't think it is my role to do that...it's not about me, it is never about me. I'm here to help them along."</p> <p>"I have to do things the way my agency has taught me to, so I have to go by what my agency policy says."</p>
A1NFBS2 (20)	<p>"You don't care for each individual the same, because each individual has their uniqueness and how they like stuff a certain way. So I feel that it is very important, as humans we are all very different individuals and you have to respect that. This is something I believed before I came into this field and as time goes on it has come to evolve more as I recognized each person's individuality. They are not the same. Two people could have the same diagnosis but act different. Some people might function better than others. So I feel like working in this field has opened my eyes to more stuff like that."</p>

	“I don’t really bring my...what would I do...to help clients make a decision, unless it is something very, very serious. I let them be their own unique selves unless something is harmful to them.”
A2EMBG1 (21)	“I’m like, my job is to care for you. I don’t want to argue with you. I don’t want to debate with you. I don’t want you to feel like I’m keeping you from doing something you want to do. I just know that providing care comes in an abundance of levels and that is the most difficult thing, providing care. It’s the hardest thing, not to care about them, but to care for them.”
A2EMXS1 (25)	“This one I strongly agree with because I care about my guys. These guys are human beings, not kids. They are adults, so it is important to put yourself in their shoes. So how would you want to be respected? You tell me you want to go out or you want to go swimming and you can’t swim. I’ve got to honor that you want to swim and I’ve got to care about that. Even if you have no arms, I’ve got to respect your decision. So I feel that this is the most important thing, it’s more valuable than anything: Respecting these guys decisions and advocating to show them what is good and what is bad.”
A2EMBS1 (27)	“Our work is about respect and human dignity and no matter what is going on you’ve still got to respect them. Sometimes they can be overbearing and you might need to go take a breather so that you can remember that and come back after 10 minutes, letting your coworker know you need a little break and then come back to it and work things out. This kind of respect has grown since I started in the field 8 years ago. At first when I started I was really young and did it for a job to make money. Over time I understood it more, respect and dignity.”
A2NFBG1 (28)	“Everybody came up different. Sometimes they’re upbringing before they came to program could be way different than mine and my life and sometimes things happen to people. They might be scared to be in a bathroom by themselves. I’m not, but I can’t be sitting there like ‘I’m not scared to go to the bathroom by myself so you shouldn’t either’. You shouldn’t do that because you don’t know what that person has been through.”
	“They are just like us, they are not different. They might not be able to speak, but they still have a personality and can feel what you can feel. So when I go in their rooms in the morning to help them get ready I always say ‘good morning!’ Even if they can’t speak, they get excited to see me. I try and bring light to their lives. They understand. Some people be like ‘they don’t have a personality’. Yes they do. They can feel you.”
	“It’s important to follow agency policy to help the consumers live a long, healthy life.”
A2NFHS1 +(23)	“Doing our job in a way that brings dignity to the client is always important because they are human. I’ve always felt that since I first came into this work. I was a little bit afraid because I didn’t have any experience working with people with disabilities, but as I worked with them I realized that they were just like me. They’re people. You no longer see the disability over time.”

**+ Participant 23 co-loaded on factors 1 & 3**

From the voices of the Factor 1 participants, the focus of recognition and agency policy clearly plays an integral part in how these DSPs describe doing

their work. Recognition was particularly ubiquitous, but how it was framed by the 11 loaders was nuanced and in some ways contradictory as one loader used self-referential comparisons to explain why recognition was viewed as important. This can be clearly seen in the response by Sorter 9 when he states, “I would want someone to treat me the way I would want to be treated and likewise I want to treat them exactly the same.” This is a clear summation of the “golden rule”, to treat others as you would want to be treated, which can be problematic within a PCP framework as the point of reference for services is the staff person and not the individual being supported. Other loaders described their recognition towards the clients as being based in religious beliefs, such as Sorter 5 who explicitly states, “We are all the same in the eyes of God.” However, both the religious and self-referential flavors of recognition were in the minority with this group, with the majority echoing Participant 20 when they state, “You don’t care for each individual the same, because each individual has their uniqueness and how they like stuff a certain way. So I feel that it is very important, as humans we are all very different individuals and you have to respect that.” This interpretation of recognition is more parallel to the theoretical concept proposed by Axel Honneth (1995) and presented in Chapter 4.

An additional point to make about Factor 1 in relation to the focus on recognition is the differing ways DSPs detailed how they came to that place of seeing the clients as truly equal yet unique from themselves. Within this group of DSPs, there were two main ways that developing recognition for their clients and people with ID/DD occurred. The first, as with Participant 5, describes their high

level of recognition for the clients being pre-developed before entering into the field of disability support work as a DSP. This predeveloped level of recognition was also attributed to various origins. Some cited their religion, others spoke about their experiences with siblings and other family members with disabilities, and still others related it to personally held beliefs not linked to religiosity. The second way Factor 1 delineated the formation of recognition was by the DSPs experiences of working with the people they support. This is mentioned by Participant 27 who states, “This kind of respect has grown since I started in the field eight years ago. At first when I started I was really young and did it for a job to make money. Over time I understood it more, respect and dignity.”

In summation, Factor 1 and the participating DSPs loading on to the factor showed the strongest levels of recognition out of all the factors. This runs parallel to the tenets of PCP and the evolving discourses occurring in the disability field, such as Nussbaum’s capabilities approach (2011). The strong influence of agency policy and a consistent feeling of support from the agency administration was also constant among these DSPs. From a service delivery perspective, this group of DSPs hold many ideal viewpoints and decision-making strategies that would seem predisposed to quality service delivery and the development of independence in the clients served.

**Factor 2: Focus on Barriers to Work**

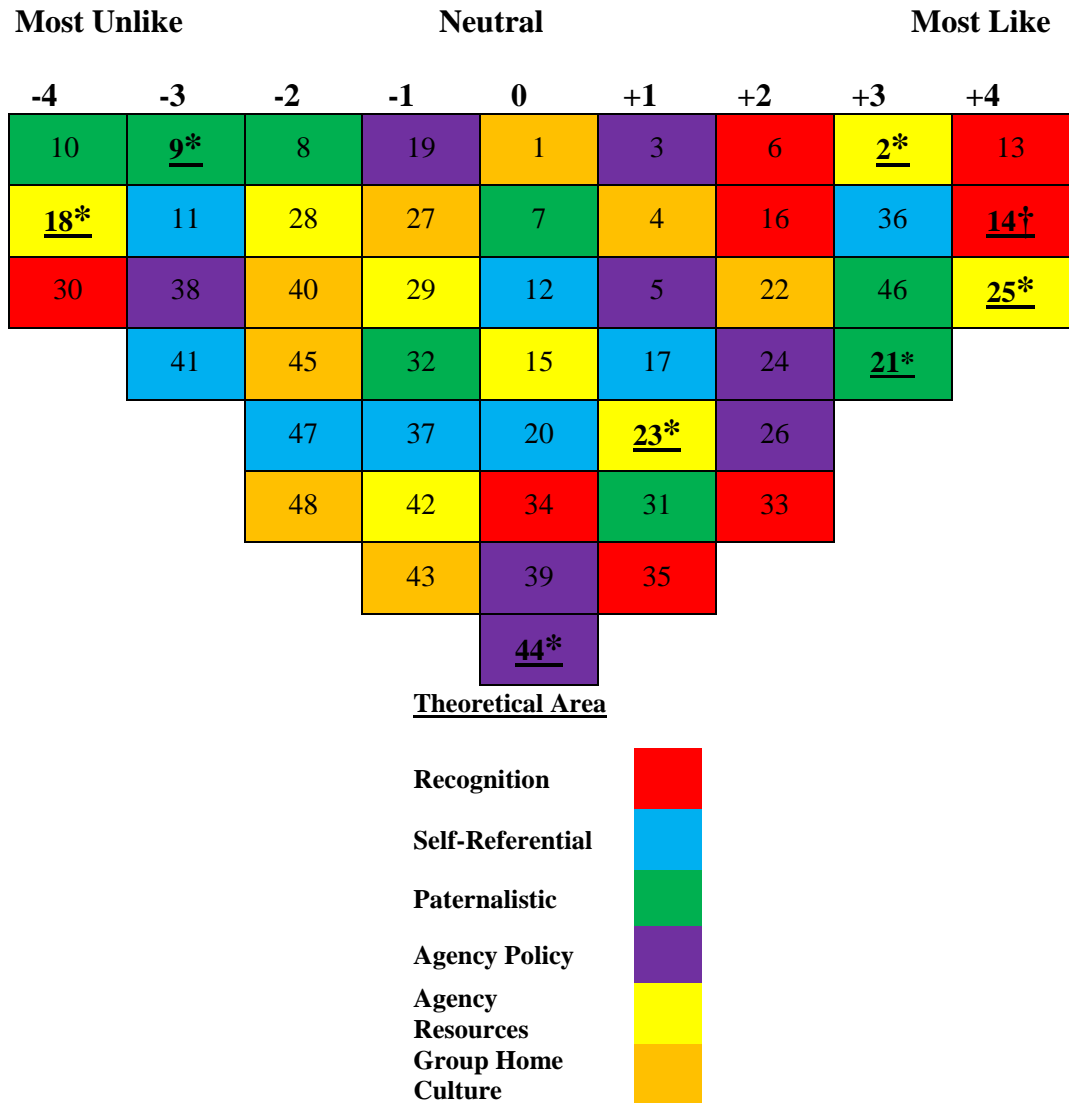


Figure 6. Ideal Sort for Factor 2 with Theoretical Areas

Factor 2 was labeled by the researcher as those DSPs that focused on the barriers they faced in trying to accomplish their work and had 4 of the 30 participants load significantly on it. In looking at the distribution of how Factor 2 (i.e., the ideal sort) sorted the theoretical areas as presented in Figure 6 above, we can observe visually that recognition statements were ranked both high and low



with two in the +4 category and one in the -4 category. We can also see that four agency resources statements were those that were statistically the most identifying statements for Factor 2, with two of the four being placed in the most like or unlike poles (18 and 25). Reviewing the post sort interviews of the four participants loading on Factor 2 it became clear that they shared a strong commonality in a decision making focus on what they perceived as trying to overcome challenges to their everyday work that arose from a lack of resources and support from the administration. While there were certainly contrasting approaches voiced by the participants with some voicing more self-referential approaches to their work and others more focused on recognition (like Factor 1), these differences seemed to be superseded by the experience of working in a program that was fundamentally lacking in some type of support or resource. These challenges, which were experienced by staff in different homes at both agencies, show a coalescing experience of frustration and more specifically a lack of agency support to perform their job the way they envisioned they should be able to.

Table 15.

*Seven Most-Like Me Statements for Factor 2: Barriers to Work Focus*

No.	Statement	Grid Pos.
13	The more I have gotten to know the clients I work with, the better I understand how to care for them in a way that is respectful and gives them dignity.	4
14†	As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person's value, and help others to understand the individual's value.	4
25*	Something that makes my job difficult are agency problems like staff turnover, lack of access to transportation, and funds for activities. These things affect my ability to increase my clients' level of independence.	4
2*	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups".	3

21*	In my experience, it is necessary to understand and do what is best for a client to insure their health and safety even if they disagree with what I decide.	3
36	I feel like it is best to treat the clients the way I would want to be treated by somebody else if I was in their shoes.	3
46	I feel that as a staff person I am a protector, caretaker, and a person who knows best what a client needs.	3

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Note: Distinguishing statements marked by \*, and consensus statements marked by †

For the Factor 2 ideal sort, as mentioned above, there were two agency resources statements (25 and 2) that formed the main point of consensus among the four loading participants on the positive end of the sorting spectrum. These two statements, which can be viewed in Table 15, address what these DSPs saw as a dual failing of their agency to address systemic issues such as staff turnover (Statement 25) in combination with a disconnect of administration staff to the “reality” of the work that the DSPs do (Statement 2). The other positively ranked statement that was statistically different from all other factors was #21. This statement deals with a possible paternalistic outlook in which the DSP believes that regardless of an individual’s choice, if the outcome may negatively impact the clients health or safety, the DSP has a duty to overrule their choice. While there was less interview data to support this statement and outlook as a main feature of the factor, this potential stance towards risk is supported by the ranking of Statement 30 at -4 (Table 16), which also deals with the concept of allowing clients to experience the “dignity of risk”. This term refers to the need for all individuals to take certain risks and to have an opportunity to learn from mistakes even if the consequences of such a mistake may detrimentally impact the client’s health or overall well-being.

Table 16.

*Seven Most-Unlike Me Statements for Factor 2: Barriers to Work Focus*

No.	Statement	Grid Pos.
10	In my experience, independence is a client's ability to take care of everyday responsibilities. If a client still relies on staff for everyday things they are not independent.	-4
18*	I feel that my agency does a good job of making sure we have the things we need to allow the individuals to do the things they want to do.	-4
30	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	-4
9*	In my role as a direct care worker, my work boils down to being in charge of other people's lives by making sure they are kept safe.	-3
11	My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible.	-3
38	In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care.	-3
41	When helping a client make decisions, I find it useful to talk about my values with the client so that they can make an informed choice.	-3

Note: Distinguishing statements marked by \*, and consensus statements marked by †

As with the seven “most like me” statements, the seven “most-unlike me” statements had a mixture of theoretical domains with Statements 18 and 9 being statistically significant to Factor 2's ideal sort. Statement 18, from the theoretical domain of agency resources, continues the narrative that these DSPs feel a lack of support in trying to accomplish the mission of PCP within the context of their program. This statement, in light of the post-sort interviews, also seems to raise the level of interference that a lack of resources has on the DSPs ability to insure individual client choices can be honored and encouraged, something tantamount to a PCP approach. The other distinguishing statement included in Table 16 (#9) is a rejection of the paternalistic notion that the essential quality to direct care work is being “in charge” of someone else's life. This seems to flow with the high negative rating of Statement 10 which may be akin to a view of independence as

not a fixed concept where only self-completing tasks meets the criteria, but instead as something dependent on an individual's abilities and skill level. The other "most-unlike me" statements featured a mixture of theoretical areas addressing recognition (30), self-referential thinking (11 and 41), and agency policy (38). This again, is taken to mean that DSPs loading on this factor may have different views on how they go about completing their daily work, but their ideal job approach is hindered due to external factors.

Table 17.

*Distinguishing Statements for Factor 2: Barriers to Work Focus*

No.	Statement	Grid Pos.
25*	Something that makes my job difficult are agency problems like staff turnover, lack of access to transportation, and funds for activities. These things affect my ability to increase my clients' level of independence.	4
2*	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups"	3
21	In my experience, it is necessary to understand and do what is best for a client to insure their health and safety even if they disagree with what I decide.	3
22	In my experience, to get the everyday requirements of the job completed, my coworkers and I have to be flexible in areas where my agency seems inflexible.	2
23*	In my experience, it can be difficult to do the things my clients want to do because we have to get approval from management.	1
44*	I make decisions at work according to my agency's policies, with my primary goal to make my clients as independent as possible.	0
9	In my role as a direct care worker, my work boils down to being in charge of other people's lives by making sure they are kept safe.	-3
18	I feel that my agency does a good job of making sure we have the things we need to allow the individuals to do the things they want to do.	-4
26	I feel like I know my clients better than the "higher-ups" and often agency policies and regulations make it difficult for me to do what is best for the client.	2

Note: Distinguishing statements  $p \leq .05$  (\* indicates significance at  $p \leq .01$ )

The distinguishing statements for Factor 2 that have not already been discussed begin with Statement 22, which represents the theoretical area of group home culture. In the context of facing a continuous lack of resources and challenges due to inattentive or removed administrators, these DSPs acknowledge

that at times they may need to take matters in their own hands and operate outside of normal policy and procedure. This sentiment is further supported by the location of distinguishing Statement 44 which was rated a 0 (i.e., neutral or no opinion), and distinguishing Statement 26 ranked +2 (i.e., somewhat like me). Taken together with the overarching theme of barriers to work, the consensus among DSPs on this factor seems to be to respond to these barriers by using their discretion in the sense of Lipsky's street-level bureaucrats (1980), although according to the loader's post-sort interviews the types of discretion and the barriers faced were varied. One participant (12) sums up the barriers they faced as stemming from a lack of a consistent manager and how this impacted their ability to perform their job:

I think it's hard when you don't feel like you have the help of management. You're expected to follow policies and stuff, but when you don't have a manager...it makes it hard. I feel like what do you do when you don't have a person like a manager. Then you're like, I can only do the job I am supposed to do. I don't know how I am supposed to do all the other stuff, yet you feel like you will be liable. What does that mean for me you know? I think it is hard when there is that type of politics...like you feel you have to worry more about that then why you are actually here.

Table 18.  
*Selected Post-Sort Interview Responses for Factor 2*

Code & participant #	Quotation
A1NFBS2 (12)	<p>"I think it would be great if the higher ups could come into the homes on a more consistent basis. I think maybe then they would understand, realistically what this job looks like every day. I think in their mind they have an idea of what it looks like, but often I feel like it isn't accurate to what we do. Like they are in the office, don't they see or know that there is no staff here? So it makes me feel like, 'what going on?' I think the other thing is that there will be a lot of appointments or criteria that they expect to be met, and you're like 'that's interesting because I never knew that...I wasn't trained on that.' Don't the people come from up on high down here to tell us how to do things?"</p> <p>"A lack of resources is an ongoing issue I think. It is a problem where I work. Often the biggest problem is with management and that is the sad thing. This is</p>

	<p>an ongoing issue and I'm not sure how to solve it really. I've been here a year and half and there has already been three managers. Dealing with problems like that when you want to be able to have the clients be able to do things, regular day to day things and there is problems with staff or someone didn't come and then all of sudden you're here by yourself and then there is four guys and you like 'oh my gosh'. You still want to be able to keep a routine, but you're faced with a lot of hard decisions."</p>
A1EFCS0 (14)	<p>"You might be three positions above me, but please don't undermine me. That is a problem that many of our staff have dealt with. We'll go somewhere or do something and people will come up and say 'why are you doing it that way? You should do that.' Number one you are kind of disrespecting the individuals by going over things in front of them and you create the anxiety in them of, 'why are they talking about this like I'm not even here?' ...I feel like a lot of the higher ups are harsh to judge, because they forget what it is like. It comes back to having a strong cohesive team, whether it be a house, a region, or the agency in and of itself. I see a lot of fracture there and our individuals are aware of it and at times they thrive on it."</p> <p>"Drama is the hardest part of this field. It's not the clients I work with. Everyone has their troubles and things we have to deal with, but ultimately at the end of the day I've never gone home and say, 'Oh my God, I can't take these clients anymore!' It's more, 'why do staff have to be this way?' And tension between staff trickles down into the clients lives to where they're thinking, 'well we can't go here because the staff can't get along so now we're not a family anymore.' So teamwork is very difficult and I think a lot of that stems from power issues and control issues."</p>
A1EFCG2 (15)	<p>"The lack of transportation and money make the job difficult. One of my clients never has any money and it's sad. Even our group home doesn't have a lot of money. And staff...I can't even tell you how many different staff I've worked with. It's hard. The staffing problems are probably worse than the money. We are very understaffed. That is why I am in three different homes, sometimes four. In my opinion, I know they hire easily. I don't want to say that they give everyone a job, they don't, but they give more people a job than I would. I think that if they waited and were a bit choosier we would have a better quality of staff. I've worked with some awful staff. I don't even know how they got past training."</p>
A2NFBS1 (26)	<p>"Every time we want to do something with the clients, whether it is going out or...we just never have nothing...supplies or money to go out. We just got a second car for the program and we've been asking for the longest. So we just got a second car because we have too many clients to fit into one van. They gave us a car, but we thought we were going to get another van though. It took forever to get that and I feel like that is a big issue in our house."</p> <p>"Like I said before, it is hard to get anything. It takes a long time to get something once you request it. Sometimes we don't even get it. So as far as that, I feel like we don't always have what we need to do what we've got to do."</p> <p>"It's hard because we don't have enough people working at our house. When I first started we didn't have enough people, because a couple of people left. I was told that we would fill those spots in a month and here we are four months later and we are still short staffed and more people have left. So it is hard because they always need people to work those shifts. So I feel like I'm just always working, like I work every shift because we don't have enough people to work. And I don't want to say no, because I don't know who else would come in."</p>

From the voices of the DSPs loading on Factor 2 the consensus of facing barriers at work is palpable and in a sense seems to overwhelm other aspects of the job that should be taking priority. The barriers identified by these DSPs varied and were program contextual with Participants 15 and 26 both expressing a lack of monetary support and staffing being the key contributors to the barriers they faced. The other two loaders (Participants 12 and 14) detailed barriers arising more from the lack of a “cohesive team” and a perceived disconnectedness between the realities they faced on the job and how the “higher ups” perceived the work they do and the condition of their programs. All participants were in agreement, however, about the outcomes and repercussions of these different barriers on the reality of their day to day jobs and its impact on their ability to do their job. Participant 12 sums up these challenges within the frame of daily programmatic structure when she states, “You still want to be able to keep a routine, but you’re faced with a lot of hard decisions. Do you keep the routine? Do you just want to keep them safe and say, no screw the routine?” Participant 14 puts a slightly different perspective on it, approaching it from a more macro view of direct care work stating, “When I first started, I think I had this idea in my mind...like I’d be saving the world! But you know, that is not at all what it looks like. But, I think that you have to remember that it is not about the staffing shortages or managers, or who is coming to work and who is not. What it all boils down to is they (clients) don’t really care about that stuff. It’s really about them and it’s hard not to focus on the other stuff and remember it is about them.”

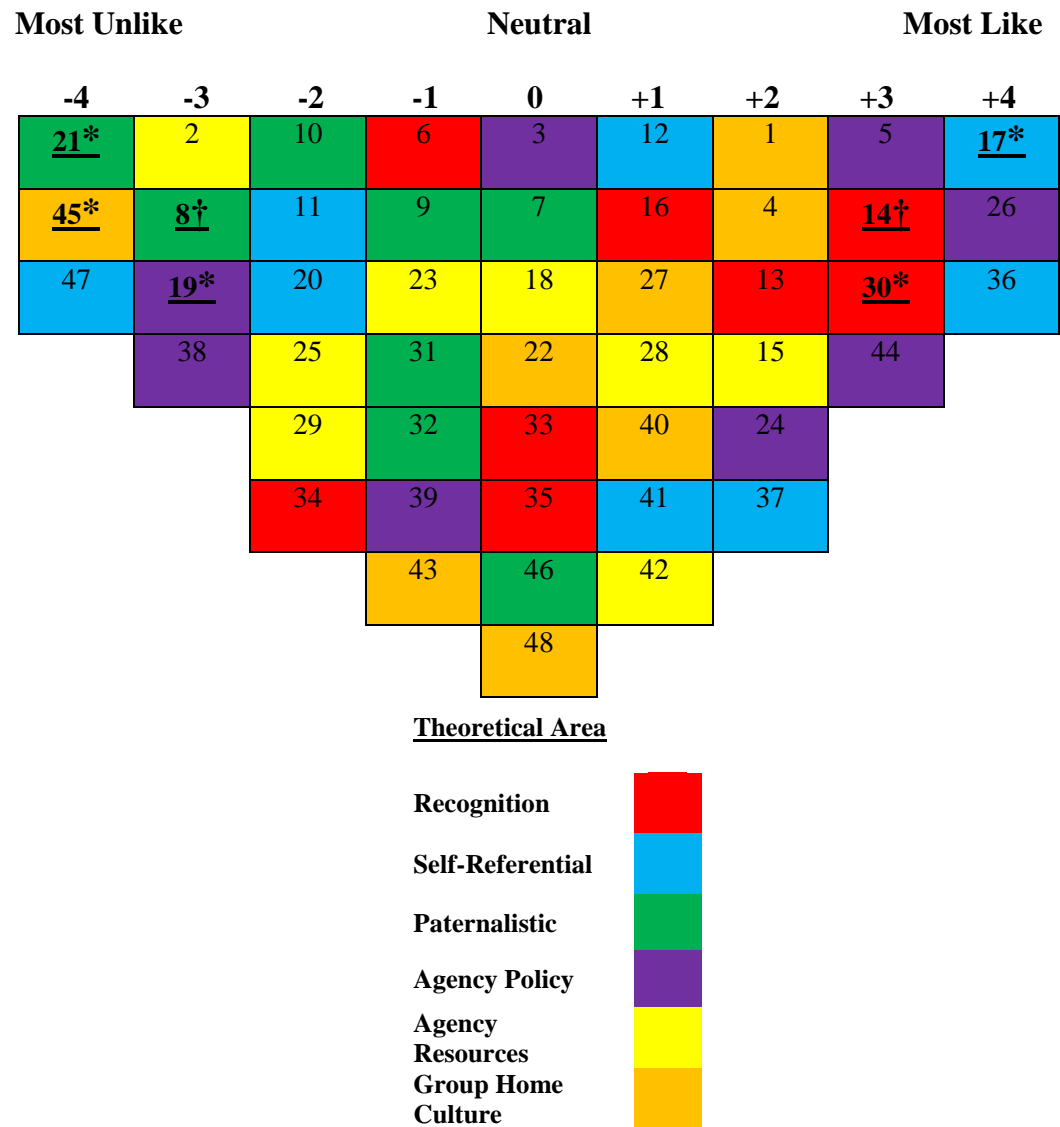
An additional point to make about Factor 2 in relation to the focus on barriers, is the disconnection that most of DSPs described between the front-line workers and their direct managers and administrators. DSPs from both agencies described this phenomenon in very similar terms, from Participant 12 describing the “higher ups” as out of touch with the realities of direct care work, to Participant 14 questioning the knowledge of the “higher ups” in relation to the abilities of the clients. From the second agency, Participant 26 describes a similar type of disconnect with the house manager who would “brush off” their requests because “she doesn’t do the work that we do”. Interestingly DSPs loading on other factors from these same agencies had the opposite opinion with relation to this perceived disconnect and heaped praise upon the “higher ups” depth of knowledge about the clients and direct care work. Participant 25 (agency 2) from Factor 1 details how important the “higher ups” informed him and prepared him for the specific house and clients with whom he was going to work. This sentiment is echoed by Participant 3 (agency 1) from Factor 5 who states, “For me, when I say higher ups, they’re the ones not there as often as the regular staff. But, I feel like they know quite a bit more than I do.” This discrepancy of views within each agency about the potential disconnect between front-line workers and the “higher ups” is an interesting phenomenon and from a programmatic standpoint each agency would do well to further explore what causes the perceived disconnect among certain staff and certain programs.

In summation, Factor 2 and the participating DSPs loading on the factor showed consensus around how facing barriers at work often superseded their



personal outlook of how they should be doing their job. In a sense, the barriers became a prime determinant of on-the-job decision making creating a dynamic where DSPs were forced into being reactive instead of proactive in how they approached their work. These barriers fell into two main themes: lacking resources (e.g., staff, funding, vehicles) and a disconnection or lack of cohesiveness between staff and the “higher ups”. From a service delivery perspective, this group of DSPs illustrate the limiting effects that on-the-job challenges can have on their ability to perform their jobs in the ways they would want, and also indicates the negative impact of feeling disengaged from the administration.

**Factor 3: Role Model Focus**



*Figure 7. Ideal Sort for Factor 3 with Theoretical Areas*

Factor 3 was labeled by the researcher as those DSPs that focused on being role models for their clients, and 3 of the 30 participants load significantly on it. In looking at the distribution of how Factor 3 (i.e., the ideal sort) sorted the theoretical areas as presented in Figure 7 above, we can visually observe that Self-referential, Agency Policy, and Recognition themed statements filled the +3 and

+4 columns. Factor 3 was also the only DSP factor to strongly endorse allowing the individuals they supported to experience “dignity of risk” (Statement 30), meaning they see the value in letting their clients take risks and experience negative consequences from decisions. Participant 6 best typifies this approach when she states, “We are all humans. Everybody takes risks. We all go through bad things. Why can’t they (i.e., clients) do it? Everybody goes through something bad and is like ‘oh my gosh’ and then you wake up the next day and live life. You treat them as a human first and that’s it.” On the negative side of the ideal sort, it is important to note the positioning of Statement 21 at -4 and Statement 19 at -3. This in combination with the narrative described above seems to support further the allowance of “dignity of risk” as participants strongly disagreed with the notion that they should override a client’s choice even if it might affect the client’s health and safety or go against agency policy. In reviewing the post-sort interviews, this factor described the DSPs’ views of the importance of being a role model in mostly self-referential terms. However, religious and cultural beliefs were deemed as inappropriate areas for guiding client decisions. Instead, importance was placed on their own personal values and how they envisioned they would want to be supported if they were in a similar situation as their clients.

Table 19.

*Seven Most-Like Me Statements for Factor 3: Role Model Focus*

No.	Statement	Grid Pos.
17*	I try to be a constant role model for my clients so that they know how to behave, act, and do things the appropriate way.	4
26	I feel like I know my clients better than the “higher-ups” and often agency policies and regulations make it difficult for me to do what is best for the client.	4

36	I feel like it is best to treat the clients the way I would want to be treated by somebody else if I was in their shoes.	4
5	According to my agency's policies, my primary goal is to keep my clients safe, healthy, and help them avoid risky situations.	3
14†	As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person's value, and help others to understand the individual's value.	3
30*	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	3
44	I make decisions at work according to my agency's policies, with my primary goal to make my clients as independent as possible.	3

Note: Distinguishing statements marked by \*, and consensus statements marked by †

Turning to the statements ranked “most like me” by this group of DSPs we can see that as described above, Statement 17 was a distinguishing statement and directly supports the notion that this group of DSPs place primary importance on establishing themselves as role models to their clients. The self-referential flare of this factor's signification on being a role model is shown with the +4 ranking on Statement (36) denoting the importance that these DSPs place on framing their work through placing themselves in their client's “shoes” to determine a course of action. The remaining +4 Statement (26), while highly ranked in the ideal sort, was not represented or supported by the post-sort interviews except for Participant 29, who was not a significant loader on Factor 3 due to a co-loading on Factor 1 (.41 and .35, respectively). For Participant 29, this feeling of knowing the clients better than management stemmed from issues they had with their client's IHPs and the IHP planning processes that they witnessed. In their words they expressed this as follows: “I think a lot of times management has these big wonderful dreams for individuals and lots of times it is not going to come true. You can write in the same IHP goals over and over and over again, but unless they are capable...I don't think it should be a goal.” The significance of Statement 30 was

addressed in the opening analysis of factor three and won't be reiterated here. The remaining statements address the importance of recognition and agency policy, which as previously shown was a main determinant in the high correlation of the factors.

Table 20.

*Seven Most-Unlike Me Statements for Factor 3: Role Model Focus*

No.	Statement	Grid Pos.
21*	In my experience, it is necessary to understand and do what is best for a client to insure their health and safety even if they disagree with what I decide.	-4
45*	I know that supporting someone to be more independent is ideal, however my coworkers and I have to be realistic about what these clients can do so we don't waste valuable time.	-4
47	I take lots of pride in my work because my religion and/or culture recognizes helping others as important work.	-4
2	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups".	-3
8†	It is necessary in this line of work to remember that as staff I need to be respected by the clients and that I have the final say in situations where a client and I disagree.	-3
19*	As a staff person, it is expected that I try to change the minds of individuals I work with when they want to do something that is against agency policy or procedure.	-3
38	In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care.	-3

Note: Distinguishing statements marked by \*, and consensus statements marked by †

Table 20, above, lists the seven statements ranked by Factor 3 as most-unlike me as per the ideal sort in Figure 7. As previously discussed in relation to the ideal sort, Statement 21 is a distinguishing statement ranked at -4 and relates to dignity of risk. The next distinguishing Statement (45) represents this factor's rejection of the notion that sacrifices need to be made in regards to giving the clients opportunities to engage in activities to build their independence in the face of daily requirements and expectations. This sentiment is expressed by Participant 6 who states, "This one is saying to be realistic about what clients can do so we don't waste time...I don't think that is a fair way to look at it. We are on their

time, at their house, so like I said, if they decide to do something they're going to do it. The only thing we can do is move forward with it and do something positive afterwards." Also noted earlier was the distinction made by DSPs in this factor between being a role model and relying on their culture and/or religion to provide positive reinforcement for the direct care work that they do. This distinction is again stressed by the placement of Statement 47 at -4, a clear rejection of culture and religion's role in their daily work. Factor 3 loaders also noted that a lack of resources was not something that impacted their ability to do their jobs (statement 2 at -3) and that the IHP was not an important tool to assist them in working with the client (statement 38 at -3).

Table 21.

*Distinguishing Statements for Factor 3: Role Model Focus*

No.	Statement	Grid Pos.
17	I try to be a constant role model for my clients so that they know how to behave, act, and do things the appropriate way.	4
30*	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	3
9	In my role as a direct care worker, my work boils down to being in charge of other people's lives by making sure they are kept safe.	-1
11	My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible.	-2
34	My caregiving experience has changed my views on what the clients I work with are capable of doing. I now see them as more like me than different from me.	-2
45	I know that supporting someone to be more independent is ideal, however my coworkers and I have to be realistic about what these clients can do so we don't waste valuable time.	-4
21*	In my experience, it is necessary to understand and do what is best for a client to insure their health and safety even if they disagree with what I decide.	-4
19	As a staff person, it is expected that I try to change the minds of individuals I work with when they want to do something that is against agency policy or procedure.	-3
22	In my experience, to get the everyday requirements of the job completed, my coworkers and I have to be flexible in areas where my agency seems inflexible.	0
26	I feel like I know my clients better than the "higher-ups" and often agency policies and regulations make it difficult for me to do what is best for the client.	4

27	At my program, when a policy or procedure is not helping the clients or interferes with the work getting done, we decide, “We’re not going to do it that way” and come up with a solution that works best for our program and clients.	1
33	My caregiving experience has taught me that all people share a common humanity, but also have individual differences. Being aware of this influences the work I do every day.	0

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Note: Distinguishing statements  $p \leq .05$  (\* indicates significance at  $p \leq .01$ )

While six of the distinguishing statements have already been addressed (17, 30, 45, 21, 19 and 26) there is one other important statement placement in the middle of the ideal sort that also deserves attention. In further support of this group seeing themselves as role models, but not necessarily using self-referential thinking in terms of their culture and religion, we see Statement 11 placed at -2. This is an important distinction, as we will see that Factor 4 also indicates that DSPs rely heavily on self-referential thinking, but also place a strong value on their cultural and religious backgrounds in helping them do their work the best way possible. This is not the case with Factor 3, as heard from the voice of Participant 19: “The religion and culture thing, I don’t really think that should be a part of our work. I’m the type of person who enjoys caring for other people whether it’s a baby, people with disabilities, or senior citizens. So I really don’t agree with religion or your culture being a part of how we make decisions.” This sentiment is echoed by Participant 1, but in a different fashion. As seen in Table 22, Participant 1 describes the process of having to unlearn some cultural norms and beliefs about disability to do their job in the best way possible.

Table 22.  
*Selected Post-Sort Interview Responses for Factor 3*

Code & Participant #	Quotation
	“This one says you should treat them just like you yourself. I just believe that. Whatever I think is best for me, it should be best for them too. If I don’t like something, I would not force it on somebody else to like it, so it should be vice a versa.”
A1EFBS1 (1)	“I can understand the big picture now. At first, it was difficult, difficult in the way, culturally...When I first started in this field when I moved here to the United States there was a cultural conflict and I didn’t understand at first. I believe that over time and with the training and also trying to understand the needs of the clients, I think that helped me. And also to understand that sometimes you think that could be me in the wheelchair so I am lucky not to be there. So when you look at it like that, let me try to do the best I can to treat that person the way I would want to be treated.”
A1NFBS1 (6)	“I think it is important to be a role model for the clients. I talked to the client I spoke to you about earlier when I was dieting and she wanted to diet, but she didn’t know how to start because she orders out all of the time. So I was just helping her out, like (clients name) some stuff, if you’re on a diet, wouldn’t be okay, but if you want to eat it you can. Being a role model for them is good. They look up to you and you are with them all the time, so they see you doing something and they’re like ‘maybe I should try that.’”
	“With values, I show them this is what I do, you can try it, but you don’t have to do it. It helps me maybe it will help you. Most of the time they’ll agree with you.”
	“There is one golden rule, treat people the way you want to be treated.”
A1EMBS1 (19)	“I always try to be a role model to my clients, even though they are high functioning. Like for parties, I’ll go to the house in normal street clothes, but then I’ll change into a nice suit for the part so at least they know...or if we go to a fancy restaurant...you get dressed up. So at least they know this is the way you are supposed to get dressed when you out to a fancy dinner or a party or whatever.”

From the voices of the DSPs, loading on Factor 3, a clear narrative arises about how they view their daily work as having substantially to do with them playing a role model for their clients. In the context of PCP service delivery, there are many instances where role modeling is appropriate, such as modeling how a specific task or skill should be completed. However, this is not how these DSPs framed their interpretation of role modeling. As we can see from the statements made by Participants 6 and 19, the vision of their work from the perspective of



being a role model seems to be all-encompassing and not dedicated solely to task or skill acquisition. Participant 6 notes that they specifically use their position as a role model to include discussions around values, and Participant 19 describes “always” trying to be a role model. This type of approach to direct care work, especially from a framework of PCP, could be problematic due to the power imbalance inherent in the DSP/client relationship. In fact, as noted by Participant 6 when referencing talking about values with a client, she states, “most of the time they will agree with you.” The concern would be that this agreement is more predicated on the staff’s influence and less on the individual’s actual wants and desires.

A second takeaway from the views contained in Factor 3 on being a role model comes from how these DSPs anchor this to self-reference. As noted above, establishing yourself as a role model to the client is not always problematic from a practice standpoint. However, continually drawing from personal values, opinions, and experiences is limiting in the sense that a DSP may not fully consider whether their personal views are consistent or relevant with the wishes of the individual. In the context of PCP, this would seem to be a basic misunderstanding of how the process of care and decision-making should take place as being primarily guided by the individual being supported.

In summation, Factor 3 and the participating DSPs loading on the factor indicated consensus on the importance of being a role model to their clients on a daily basis in a wide variety of areas. This is further influenced by these DSPs taking a stance that to be a role model, self-reference was an ideal place to start. It



Factor 4 was labeled by the researcher as those DSPs that focused on self-referential thinking and had 3 of the 30 participants load significantly on it. In looking at the distribution of how Factor 4 (i.e., the ideal sort) sorted the theoretical areas as presented in Figure 8 above, we can visually observe that Self-referential, Agency Policy, and Recognition themed statements filled the +3 and +4 columns. A main difference between Factors 3 and 4 can also be seen in that seven of the eight self-referential themed statements were placed in +1 or above categories with only Statement 41 being placed in the 0 position. This would seem to indicate a much stronger overall influence of self-referential thinking when compared to Factor 3 which placed self-referential Statement 47 at -4 and Statements 11 and 20 at -2. In addition, the placement of paternalistic themed Statements 9 and 46 at the +2 category in the ideal sort of Factor 4 shows a possible penchant for DSPs viewing their work with their clients as coming from an intrinsic place of authority from which they need to restrict their clients in certain areas for their supposed best interest. Participant 18 seems to reflect on the need for this protectionist standpoint when she states, “Sometimes, I think they do have the same rights, sometimes I think they don’t. They might want to go somewhere or do something, but they maybe can’t do it because of their condition. So I’m not saying you don’t have a right to, but you probably can’t do it because of your disability. If you’re in a wheelchair you can’t do something that I can do walking.” While this statement is not overtly paternalistic, this participant seems to take a stance strongly rooted in the medical model of disability, which

assumes there are inherent limitations on a person due to diagnosed conditions and focuses on limitations instead of possibilities.

Another main difference between Factor 4 and the rest of the factors was the strong endorsement by DSPs of the statements describing the influence of religion and culture towards their approach to direct care work. This assumption is directed by the placement of Statement 35 at -4 and Statement 47 at +3. Both statements speak to how culture and religion might play a role in daily decision making. However, as will be seen in the continuing analysis of this factor, religion and culture were not explicitly addressed by the voices of the participants as something driving their work place practices.

Table 23.

*Seven Most-Like Me Statements for Factor 4: Focus on Self-Reference*

No.	Statement	Grid Pos.
13	The more I have gotten to know the clients I work with, the better I understand how to care for them in a way that is respectful and gives them dignity.	4
14†	As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person's value, and help others to understand the individual's value.	4
24	I feel my role is to support each individual in realizing their choices by respecting, honoring and advocating for their choices.	4
12	Often at work when a client has a difficult decision to make, I take a moment to think, "What would I do in this situation?" This helps me work with the client to solve the issue.	3
36	I feel like it is best to treat the clients the way I would want to be treated by somebody else if I was in their shoes.	3
44	I make decisions at work according to my agency's policies, with my primary goal to make my clients as independent as possible.	3
47*	I take lots of pride in my work because my religion and/or culture recognizes helping others as important work.	3

Note: Distinguishing statements marked by \*, and consensus statements marked by †

In Table 23 above, the seven statements "most like me" from the Factor 4 ideal sort are listed. The strong underlying theme of recognition and policy (Statements 13, 14, and 24 ranked at +4) running through all factors has been

previously discussed and will not be reexamined here. Of interest are the three self-referential statements ranked at +3 by the Factor 4 ideal sort. Statements 12 and 36 speak directly to how these staff may often rely on their own experiences, values, and desires as a proxy for what they believe the individual may want. As was noted in the analysis of Factor 3, this framework of making decisions in a PCP context is inherently problematic. Unlike Factor 3, Factor 4 participants strongly endorse their religion and or cultural background as being a primary component to how they go about their daily work and the value they see in their work also stemming from these areas. Factor 4 was the only factor to give a ranking of +3 to Statement 47 which directly addresses whether a DSPs see their work as being valued by their religion or culture. All other factors ranked Statement 47 at -1 or lower. While this statement alone does not necessarily support that these DSPs rely on religious or cultural values/beliefs to make decisions on the job, the post-sort interview responses for these participants do contribute additional confirmation that while DSP's specific religious or cultural values may not consistently be an influence, their families of origin are. For instance, Participant 2 describes the way they approach their work as a DSP has being based on how their mother raised them. Likewise, Participant 18 also describes their experiences growing up and references their mother as a main influence on how they do their job. This was seen by the researcher as the key difference between Factors 3 and 4, as Factor 3 had a DSP focus primarily on being a role model while Factor 4 DSPs relied more heavily on their experiences growing up to inform their practice. While both are self-referential styles of

practice, the difference is an important one to note from a training perspective as substantially different areas would be addressed in the context of PCP and agency policy.

Table 24.  
Seven Most-Unlike Me Statements for Factor 4: Focus on Self-Reference

No.	Statement	Grid Pos.
23	In my experience, it can be difficult to do the things my clients want to do because we have to get approval from management.	-4
29	Client centered services is a great idea, but I feel that the reality of the work I do makes it difficult to actually do it the way it should be done.	-4
35*	I feel it is important not to let your personal factors (like culture and religion) to influence how you work with and care for the clients. As staff, we should leave those things at the door.	-4
8†	It is necessary in this line of work to remember that as staff I need to be respected by the clients and that I have the final say in situations where a client and I disagree.	-3
10	In my experience, independence is a client's ability to take care of everyday responsibilities. If a client still relies on staff for everyday things they are not independent.	-3
30	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	-3
32	I feel that my clients have the same right as anybody to make their own choices, but if a client can't quite understand certain things, I don't know how they can be expected to make a good choice.	-3

Note: Distinguishing statements marked by \*, and consensus statements marked by †

The Factor 4 seven most “unlike me” statements are shown above in Table

24. Among the participant's loading on Factor 4, issues arising from a lack of agency resources was strongly rejected. This is seen by the placement of Statements 23 and 29 in the -4 column as well as from the voices of the participants. While not shown in Table 26, Participant 2 directly addresses the support they feel from the “higher ups” when she states, “I definitely feel like here that the higher ups do know what's going on. It makes everything flows good because they understand what we are doing. In other places I've worked, the people in the offices don't understand what you're doing.” The remaining -4 statement (35) establishes more support for the self-referential outlook of the DSPs loading on Factor 4 and reiterates the importance of how they view their

experiences. While a majority of the participants loading on the other factors specifically stated that they should leave culture, religion, and personal values at the door, this group of DSPs rejected this notion as their personal experiences seemed to form the foundation of how they do their work. Participant 2 sums up this best when they state, “I don’t think you should leave who you are at the door. Whatever you would do for your children, you should do it here too. Don’t leave that at the door. Don’t disengage, make this your family. You know what I mean? That’s why I would never leave what I do with my child at the door.”

Table 25.

*Distinguishing Statements for Factor 4: Focus on Self-Reference*

No.	Statement	Grid Pos.
47*	I take lots of pride in my work because my religion and/or culture recognizes helping others as important work.	3
11*	My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible.	1
25	Something that makes my job difficult are agency problems like staff turnover, lack of access to transportation, and funds for activities. These things affect my ability to increase my clients’ level of independence.	0
2	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the “higher ups”.	-1
38	In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care.	-1
32*	I feel that my clients have the same right as anybody to make their own choices, but if a client can’t quite understand certain things, I don’t know how they can be expected to make a good choice.	-3
35*	I feel it is important not to let your personal factors (like culture and religion) to influence how you work with and care for the clients. As staff, we should leave those things at the door.	-4
19	As a staff person, it is expected that I try to change the minds of individuals I work with when they want to do something that is against agency policy or procedure.	2

Note: Distinguishing statements  $p \leq .05$  (\* indicates significance at  $p \leq .01$ )

Considering the statements now that were placed significantly differently from all other factors we see that 47, 35 and 11, which deal with self-reference, reach a significance level of .01. This is seen as further support to the denotation of the DSPs loading on this factor as relying heavily on self-reference to carry out

their work. The remaining statement that was significant at the .01 level was 32 which the fourth factor ranked at -3. This statement comes from the thematic area of paternalism in the frame of restricting individual choices due to a client's perceived level of disability. While some of the participants had some paternalistic undertones to the way in which they talked about their work (e.g. comparing their clients to their children) this was not a consistent theme running through the factor as the strong negative ranking of this statement would allude to.

Table 26.

*Selected Post-sort Interview Responses for Factor 4*

Code & Participant #	Quotation
A1EFBD1 (2)	"The reason I do my job the way that I do is because of my mother and being raised with 13 other kids, and I have a son of my own. We just care for people, so that helps me do my job better. All that I bring with me to this job is the reason I do a good job."
	"I do feel it is right for them to make their own decisions. I don't think they need to be restricted from making their own decisions. I don't want to restrict them, but I would handle it totally different. Probably try to talk to them. Either try to talk them down from something bad or if I know it's going to go bad. But you can't force someone to do something so I would try to give them the most horrific story about why not to do that. I would let them make their own decisions, but I wouldn't let them make a decision that would put them at risk."
	"With big decisions they definitely need help. With small everyday things, yeah let them go for it. It makes them feel good about themselves."
	"I don't second guess myself ever, even when what I do pisses the client off. 9 out of 10 times I'm doing it right."
A1NFBD1 (7)	"I don't think that you should leave who you are at the door. Whatever you would do for your children, you should do it here too. Don't leave it at the door. Don't disengage. Make this your family. You know what I mean? That's why I would never leave what I do with my child at the door. That's how I care for them, as if they are my own."
	"I do think, 'what would I do in this situation?' and I try and tell them about my experience. Because they've gone through stuff, but I've gone through stuff too and I try and relate to them, try to tell them they are not alone. Because I think sometimes they feel like that. Like when they go through certain things they feel like they are the only one, but they're not the only one. I've been through it too."
	"The role model thing. I do try to be good around them. As far as the way I talk and act, I try to be the best I can be around them so they know what to do."



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	<p>“I always try to go above and beyond to make them feel like a regular person. I think that’s all they want. Even though they might be a little slow, they don’t want to be treated that way. They want to be made to feel like they’re smart.”</p>
	<p>“My one client, he sometimes gets taken advantage of. I do feel like his protector, I feel like his extended family not like he is my job. He kinds of needs me to be like that though, because he is not really close with his siblings.”</p>
	<p>“Everyone wants to be treated well. Treat people the way you would want to be treated.”</p>
	<p>“I try to do things and show them things. I tell them don’t do things I wouldn’t do.”</p>
A1NFBS1 (18)	<p>“The caregiving experience is sort of new to me and it’s sort of not new to me. I’ve been caregiving since I babysat so when you babysit you are caregiving for them. I also have a handicapped niece so I help my sister with her. So, yeah I help out with my sister and my mom, because my mom works with my sister. So I will care for her on certain days to give her a break. So caregiving for my girls (clients) is protecting them and keeping them safe in any type of situation that presents itself.”</p>
	<p>“Sometimes I think they do have the same rights, sometimes I think they don’t. They might want to go somewhere or do something, but they maybe can’t do it because of their condition. So I’m not saying you don’t have a right to do it, but probably you can’t do it because of your disability. If you’re in a wheelchair you can’t do something that I can do walking.”</p>

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From the voices of DSPs loading on Factor 4, the focus on self-reference is palpable. While each loader makes some mention of the golden rule (i.e., treat others as you would want to be treated) and Participant 7 makes mention of the importance they place on being a role model, the overwhelming consensus aggregated around bringing their experiences from their current family or family of origin to inform how they made decisions on-the-job. Participant 2 details how her experiences being raised in a large family and how as a family they had a core value of “caring for people” led her to approach direct care work the way that she does. Participant 18 references her experiences being a babysitter, and assisting her mother with her sister as foundational to how she approaches her work with a focus on protecting and keeping her clients or “girls” safe. This factor’s loaders were also strongly against the prospect of leaving who they were at the door as

they saw their experiences with their children or in growing up as fundamental to how they approached their job and supported their clients. As with the Factor 3 focus on being a role model, using familial experience to inform direct care practice is not inherently problematic, but should instead be viewed as a potentially slippery slope where practice decisions are guided less by policy and PCP frameworks and more from self-referential points of view that may contradict the clients' wishes or goals. This can become more problematic if it is combined with an undercurrent of paternalistic thought which seems to appear in the interview data for this factor. One example is when Participant 2 states, "I don't second guess myself ever, even when what I do pisses the client off. Nine out of ten times I'm doing it right." A second example comes from Participant 7 when she comments that, "I always try to go above and beyond to make them feel like a *regular* person."

In the first example we see a possible example of DSPs relying on their positions as staff to overrule their client, even as they note that at times what they decide upon is not right. In the second example we see the DSPs possibly engaging in a type of "othering" with their clients as they would not need to take special steps to have the client feel like a "regular person" unless they are not "regular". From a programmatic and agency standpoint, these types of attitudes and practice frameworks could at times run contrary to the tenets of PCP as well as the DSP code of ethics and would need to be addressed. Taken together, these two streams of thought could influence a DSP's practice behaviors to limit individual choice under the guise of providing protection. In fact, protecting the

client was something that arose from all three Factor 4 loaders. The most pertinent example of this comes from Participant 7 when she states, “I do feel like his protector, I feel like his extended family not like he is my job. He kinds of needs me to be like that though, because he is not really close with his siblings.” This seems to show a blurring of the lines between personal and professional which could limit client growth. This sentiment is echoed by Participant 18 when she states, “So caregiving for my girls [clients] is protecting them and keeping them safe in any type of situation that presents itself.” Here caregiving is equated to protection and the DSP uses a childlike reference to her clients who were all well into their adult years.

In summation, Factor 4 and the participating DSPs loading on the factor showed consensus on using self-referential thinking and personal family experiences to inform their practice. This seemed to be further influenced by these DSPs having an undertone of paternalistic sentiment as it related to their work and needing to protect their clients as one would a child. From a service delivery perspective, much like Factor 3, this group of DSPs may not be implementing their clients PCPs in a way that is consistent with agency policy and the grounding sentiments of self-directed services.

**Factor 5: Focus on Pushing Back against Agency Policy**

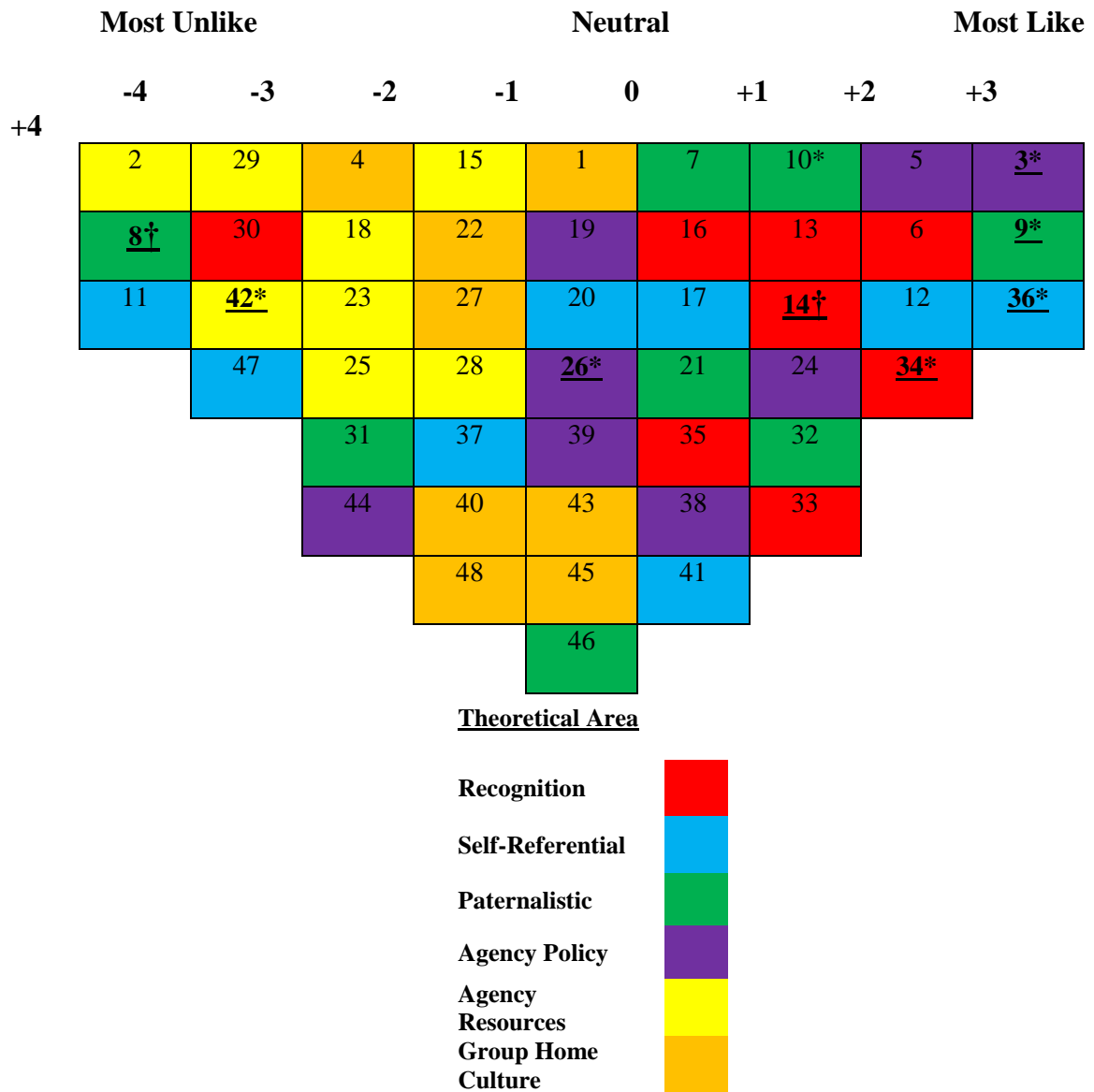


Figure 9. Ideal Sort for Factor 5 with Theoretical Areas

The final factor had five significant loaders and was labeled by the researcher as having a focus for work on pushing back against agency policies that DSPs saw as adversely limiting their ability to support their clients. Much like Factor 2, which had a focus on barriers, this factor seemed to have a

preoccupation with the struggle against agency higher ups about what was best for their clients. It is possible that this factor does not represent so much a practice framework as was present in Factors 1, 3 and 4, but a response to the environment in which the DSPs are executing their jobs. Visually, this is supported when we see that the ideal sort has a mix of conceptual themes about both poles. On the positive or “most like me” side, there is representation of agency policy, paternalism, self-reference, and recognition. On the negative or “most unlike me” side, agency policy is absent and replaced by statements representing agency resources while recognition, paternalism, and self-reference are also present.

Of the five factors presented in this analysis, this was the most difficult to parse to find a consistent theme. Statements in the post sort interviews touched on many of the thematic areas mentioned above. Participant 3 notes the importance placed on self-reference when he states, “Sometimes when the client has a difficult decision, it is good to go from your own experiences.” In stark contrast, Participant 8 notes that self-reference is not a good framework for direct care work with the statement, “you shouldn’t let your personal factors, your religion, or whatever you do at your home come to your workplace. It can mess up your capability at work and how you do your job and your attitude toward the clients.” Similar disagreement between the loaders on Factor 5 can be seen around the area of paternalistic approaches to direct care work. Participant 22 seems to assess clients as incapable of making their own choices when they state, “Most of the time the clients cannot be expected to make the right choice. This is why we are there to assist them, to help them make the decision that is right for them.”

Participant 24 takes the converse stance and expresses doubt over his ability to make better decisions than the clients when he states, “Who is to say that I have the final say? You know I’m not Jesus. Who is to say that I have the right answer? It might be, but it might not be, who is to say?”

As these examples show, there were many instances where the participant’s loading on Factor 5 seemed to have little in common on their basic approaches to direct care work. However, there was an underlying theme of dissatisfaction with either agency policy or the ways administrators influenced their work in a way they saw as detrimental to the clients. This is seen to be inherently different from the barriers experienced by Factor 2 which related to a lack of resources (i.e., staffing shortages, lack of funds, etc.) or a disconnect between what was happening in the home and what administrators had knowledge of. One DSP (Participant 3) loading on Factor 5 confirms this, expressing the following, “For me, when I say higher ups, they’re the ones not there as often as the regular staff. But I feel like they know quite a bit more than I do. Which is expected, I want them to know more.”

For Factor 5, the consistent challenges that the significant DSP loaders spoke about had more to do with restrictive policies or a fundamental misunderstanding by the higher ups of what was best for a client or how a program should operate. This is in a sense also a disconnection, but it seems to relate more to how DSPs perceived the administration’s involvement and was not stemming from a lack of involvement as with Factor 2. Examples of this type of disconnect or barrier are given by the following four participants below:

**Participant 22:** “Most of my issues are with policies and procedures and the things they expect our clients to do and not to do.”

**Participant 8:** “I don’t always follow policy and procedure, but I always do what is best for them, for their safety and their happiness. When we first start training, it is all about them (clients). We get to the house and it is all about them, but with the office it is not all about them.”

**Participant 24:** “The hardest part of my job is all these rules and regulations and things...The company should be focused on the quality of care that you are giving the individual.”

**Participant 3:** “It can be difficult to do those things that the clients want to do and we always have to get the approval from management. As I said, working for the agency you can’t do anything on your own, you have to go according to policy...I would change some of the procedures that we have to go through, because it don’t actually work with the guys [clients].”

As these responses have typified, this factor coalesced around a shared understanding of how agency policy and agency management either impacts their ability to do their work the way they would choose to or shackles them with what they see as onerous and needless regulations and policies.

Table 27.

*Seven Most-Like Me Statements for Factor 5: Pushing Back against Agency Policy*

No.	Statement	Grid Pos.
3*	I feel a client’s right to make their own decisions is a key part of my work, but at times it needs to be restricted to keep them safe and to manage risky situations.	4
9*	In my role as a direct care worker, my work boils down to being in charge of other people’s lives by making sure they are kept safe.	4
36	I feel like it is best to treat the clients the way I would want to be treated by somebody else if I was in their shoes.	4
5	According to my agency’s policies, my primary goal is to keep my clients safe, healthy, and help them avoid risky situations.	3
6	In this kind of work, it is necessary to advocate for your client because I have seen many examples of the people I support being “left out”. They are treated as if they are not able to do certain things, which limits their independence.	3

12	Often at work when a client has a difficult decision to make, I take a moment to think, “What would I do in this situation?” This helps me work with the client to solve the issue.	3
34	My caregiving experience has changed my views on what the clients I work with are capable of doing. I now see them as more like me than different from me.	3

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Note: Distinguishing statements marked by \*, and consensus statements marked by †

As noted above, the overall consensus of this factor was not necessarily tied to the placement of the statements “most like me.” However one statement that was highly ranked (+3) and fits that identified narrative is Statement 6. This statement deals with the importance of advocating for your client as part of the support provided on a daily basis. The overall tone of this statement when chosen for the concourse was to reflect the lack of opportunities that individuals receiving support services can face from the broader community and how staff can seek to alleviate it through advocacy. It was unanticipated by the researcher that those DSPs that strongly identified with this statement in Factor 5 would do so from the perspective of those doing the “leaving out” and would be the agency administration and not members of the broader community. This sense of “leaving out”, and the client from opportunities was primarily seen in two specific ways by the five DSPs loading on Factor 5. The first had do to with policy or procedures that were inapplicable to the clients being supported or limited them in some way. This is seen through the quote of Participant 4 noted above. The other way of “leaving out” clients occurred when administrative staff were involved in some aspect of the daily support of a client and the DSP felt that they had either a poor understanding of the client’s actual abilities or had an alternative agenda to the clients. This is best seen through the voice of Participant 22 when she states,



What I've realized about the office, I know they have a job to get done just like we have a job to get done. But their job and our job don't always coincide together. At the end of the day I know they are a business and they're concerned about money. At the end of the day, my job is about the guys [clients] and their lives and what's best for them. The office looks at things one way and we look at things the other way. So there are times that I have a problem with the decisions they [administrators] make for these guys [clients]."

As noted above in the introduction of this factor, the remaining items rated "most like me" were a mixture of different views the individual DSPs had on how they carried out their work with influences such as recognition, paternalism, and self-recognition coming up in the post-sort interviews.

Table 28.

*Seven Most-Unlike Me Statements for Factor 5: Pushing Back against Policy*

No.	Statement	Grid Pos.
2	In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups".	-4
8†	It is necessary in this line of work to remember that as staff I need to be respected by the clients and that I have the final say in situations where a client and I disagree.	-4
11	My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible.	-4
29	Client centered services is a great idea, but I feel that the reality of the work I do makes it difficult to actually do it the way it should be done.	-3
30	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	-3
42*	I often rely on the training I have received to help me understand what my clients want and need. This allows me to understand them at a deeper level and increase their independence.	-3
47	I take lots of pride in my work because my religion and/or culture recognizes helping others as important work.	-3

Note: Distinguishing statements marked by \*, and consensus statements marked by †

Turning to the statements ranked as "most unlike me," there was more consensus between the DSPs in connecting the ideal sort to the interview data. In the -4 category, Statement 2 along with the post-sort interviews confirms that these DSPs expressed they did not encounter barriers on the job due to a lack of

resources like Factor 2. The placement of Statement 29 at -3 also supports the narrative of pushing back against policy as the DSPs do not view their work as fundamentally flawed (i.e. PCP is inherently difficult to do), but instead it is challenging due to outside influences that could be changed. The lone distinguishing statement at the .01 level for Factor 5 was Statement 42, which talks about the value of agency training towards the DSP's daily work. While not all five loaders addressed the issue of inadequate training, Participants 22 and 3 did. Participant 22 was most passionate about this topic and saw her trainings as inadequate due to their not being broadly applicable to the clients with whom she worked. She states, "As far as the training we get, yeah we get good training on certain things, but they can never train us on our guys. Every person is an individual, so no matter how much training we do in these trainings, every person is different. So they [administrators] can't sit there and say, 'well we did a training on "blank."' You didn't, because we are not trained on every individual, it's generalized. But you will never know how to work with these guys [clients] until you are there day in and day out."

Table 29.

*Distinguishing Statements for Factor 5: Pushing Back against Policy*

No.	Statement	Grid Pos.
3	I feel a client's right to make their own decisions is a key part of my work, but at times it needs to be restricted to keep them safe and to manage risky situations.	4
9	In my role as a direct care worker, my work boils down to being in charge of other people's lives by making sure they are kept safe.	4
32*	I feel that my clients have the same right as anybody to make their own choices, but if a client can't quite understand certain things, I don't know how they can be expected to make a good choice.	2
10*	In my experience, independence is a client's ability to take care of everyday responsibilities. If a client still relies on staff for everyday things they are not independent.	2
38	In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care.	1

26*	I feel like I know my clients better than the “higher-ups” and often agency policies and regulations make it difficult for me to do what is best for the client.	0
4	I feel that at my program we have a good handle on getting our work done, at its core it is about doing an ordered set of tasks and we have a system to make sure it all gets done.	-2
44*	I make decisions at work according to my agency’s policies, with my primary goal to make my clients as independent as possible.	-2
42	I often rely on the training I have received to help me understand what my clients want and need. This allows me to understand them at a deeper level and increase their independence.	-3
45	I know that supporting someone to be more independent is ideal, however my coworkers and I have to be realistic about what these clients can do so we don’t waste valuable time.	0

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Note: Distinguishing statements  $p \leq .05$  (\* indicates significance at  $p \leq .01$ )

Now turning to the distinguishing statements for Factor 5 presented in Table 29, there are two statements (26 and 44) that will be addressed to show further support for the pushing back against policy narrative that brings these DSPs together. Statement 26 was significant at .01, as this was the only factor to rate it at the 0 level with Factors 1 and 4 ranking it at -2 and Factors 2 and 3 ranking it at +2 and +4, respectively. It would seem counterintuitive that a factor having a consistent theme of pushing back against agency policy would rank a statement describing the differences between their (DSPs) view and that of the administration as it relates to the policies and procedures to not be in strong agreement with Statement 26. To explore this further, attention was given to look at each significant loaders score of the statement to see how each individual ranked it. Of the five significant loaders on Factor 5, four DSPs ranked this statement at the +1 level or somewhat “like me”. This researcher’s interpretation of this placement in conjunction with the post-sort interviews is that it is a phenomenon acknowledged by these four DSPs. However, as mentioned earlier, the pushing back against policy consensus is not seen as a particular approach to

how they practice, but rather a reaction to the agency environment in which they practice. The statements ranked in +3 and +4 categories for these four DSPs offer more insight in to their individual approaches to their work, but are not consistent. The final DSP (Participant 3) ranked Statement 26 at a -4 or “most unlike me”. As the quote on page 145 details, this DSP focused on the first part of this statement when sorting (i.e., I feel like I know my clients better than the “higher-ups”). However, in support of the push back against the policy narrative, we can see in Table 30 that this DSP does in fact support the notion that policy and procedure may make a client feel “left out” in a sense. In the last portion of his extended quote we see this sense of being “left out” when he states, “Even though we are ‘the agency’, but once I’m in the house and I close the door, the agency isn’t really there for me. It’s between me and the individual and what is going to make this situation better, make it flow.” This would seem to indicate that in his experience, his group home operates more as a satellite site and is not connected meaningfully to the main office in regards to practice related issues.

The second distinguishing Statement for review is 44, with the ideal sort for Factor 5 ranked at -2. This statement in this location seems to indicate that these DSPs do not always follow agency policy and procedure, especially in instances where they view it as detrimental to the client. This is supported by the interview data with multiple Factor 5 loading DSPs making statements alluding to this type of discretion. Participant 8 discussed how due to agency policy he has to bring multiple clients along on trips because of limits on individual alone time within the site. He saw this from the client’s perspective as being “left out” of

opportunities to build their independence, by not being able to stay at home alone. He states, “It kinda hurts, because I know they want to stay there so they can be independent.” Participant 22 takes a more global approach to her push back against policy stating, “Most of my issues are with policies and procedures and the things they expect our clients to do and not do.” In addition, participant 24 expressed his misgiving about the difficult situation agency policy put him in when he states, “You don’t want to go against the rules...you want to comply and not go against agency policy, because that will get you fired. But, you don’t want to do anything that is detrimental to the clients.” In relation to participant 3, who was noted earlier, he ranked this statement at -1 which adds further evidence the he does share similar feelings even if they were not explicitly addressed in the interview.

Table 30.

*Selected Post-Sort Interview Responses for Factor 5*

Code & Participant #	Quotation
A1NMBS1 (3)	“I feel like the agency doesn’t always have the things or provide the things we need to do what the clients want. I’m not saying I take it personal but, there are a lot of clients in the company and I understand that they can’t focus on every client every second. It’s life. There is a lot going on. Sometimes it is left up to us to step in. Other than just the agency...if the agency can’t provide what would make a situation better than it’s up to us. Even though we are “the agency” but once I’m in the house and I close the door, the agency isn’t really there for me. It’s between me and the individual and what is going to make this situation better, make it flow.”
A1EMBS2 (8)	“You never know what is going to happen in the future. So, from my understanding, most of the clients in this company weren’t always disabled. So if you treat a client a certain way, like very rude or treat them like they are beneath you karma can come and make it so you are just like them. You could be under certain regulations or be limited in your life.”  “I feel like the IHP is just a record. It is kind of comparable to a jail record or criminal record you know? Criminals, they can end up changing after a while, but if an employer looks at the record they won’t really know anything about them, you actually have to know the person to know them instead of just from a book.”

	<p>“I don’t always follow policy and procedure, but I always do what is best for them, for their safety and their happiness. When we first start training, it is all about them (clients). We get to the house and it is all about them, but with the office it is not all about them.”</p>
	<p>“Most of my issues are with policies and procedures and the things they expect our clients to do and not do.”</p> <p>“They’re so special. They make every day...When you deal with ‘us’ people are just rude and ignorant and just nasty and I’m just like I am so over people. But they really appreciate you in their life. Everybody else is like ‘I don’t care if you are here’. But you know when you go to work and you get these hugs, the laughter, they know that you are there for them. And they truly and honestly love you and know that you are there for them. You don’t get that in everyday life. I love my guys, my kids will tell you that I love my guys more than I love them.”</p>
A1NMBS2 (22)	<p>“There were comments in here about the company’s decisions and abiding by the company policy...What I’ve realized is the office, I know they have a job that has to get done. We have a job that has to get done. But their job and our job don’t always coincide together. At the end of the day I know they are a business and they’re concerned about money. At the end of the day, my job is about the guys and their lives and what’s best for them. The office looks at things one way and we look at things the other way. So there are a lot of times that I have a problem with the decisions they (the office) makes for these guys.”</p> <p>“We have a couple of clients that are fall risks and then you have the office saying that there are certain things they want them to do, but it is unrealistic because it is going to affect their health. But like we talked about earlier, that comes down to them knowing the guys or not. You can put anything down on paper, but if you’re not working with them and seeing how they behave on a regular basis then it is easy to say to do this or do that, but we know that we can’t. That is where I have to be able to put my foot down and say we are just not going to be able to do this. It’s not that I am trying to go against the office, but my job is to make sure the clients are good. And at this point it is not even like it is my job, these guys are like my family. I could do this job and not get paid for it because I care about these guys so much.”</p>
A2EFXS2 (24)	<p>“You don’t want to go against the rules...you want to comply and not go against agency policy, because that will get you fired. But you don’t want to do anything that is detrimental to the clients. Like I was telling you before, the administrative part of the company and the actual staff at the houses, the support staff...the administrators think they know the clients, but they really...it’s like how your parents know you compared to somebody just meeting you or somebody at the office where you work. One time one of our residents passed away and one of the other clients got upset and was acting out. They administrator said to just leave him alone, but if you had known the individual (client) he needed something...he needed a hug...you understand? Administrative people want you to do it their way, but they don’t understand that you are with these clients every day. Everybody changes, you are not going to be the same 10 years from now that you are now. You probably gonna think differently.”</p> <p>“The hardest part of my job is all these rules and regulations and things. They seem to change constantly. There is always something new, and it’s not just this company but most companies, they are always requiring you to do more</p>

	<p>paper work or more whatever. That shouldn't be the main thing we focus on. The company should be focusing on the quality of care that you are giving the individual. That's what I'm thinking about, not all of these rules, but I guess to get funding from the state they have to do these things. I understand about documentation, whether you there or not there somebody else can follow your notes."</p>
	<p>"It can be difficult to do those things that the client wants to do and we always have to get the approval from management. As I said, working for the agency you can't do anything on your own you have to go according to policy."</p> <p>"If I could change some of the procedures that we have to go through, because sometimes there are procedures that we have to go through and it don't actually work with the guys. But, because it is company policy we have to go through that procedure."</p>
A2EMBD1 (4)	<p>"I would say that I strongly believe that because the bosses always make sure we go according to agency policy but yet we have to take care of the clients. They need our supervision, they need us. So the program where I work has developed a good routine to get the work done."</p> <p>"Most of the time, the clients cannot be expected to make the right choice. This is why we are there to assist them. To help them make the decision that is right for them."</p> <p>"They shouldn't be allowed to take risks. Because taking risks might probably affect them, because these are people with disabilities."</p>

From the voices of the participants loading on Factor 5, the focus on pushing back against agency policy and procedures becomes salient and also shows the tension these DSPs may be experiencing on a daily basis. This tension seems to be created at the point where DSPs find themselves knowing what they should be doing for their clients, in their understanding of PCP, and what they are allowed to do according to agency policy. DSPs spoke about two main ways in which they dealt with this tension with some, like Participants 8 and 22, expressing that they actively use their discretion to circumvent policy and procedure barriers; others like Participants 3 and 24 acknowledged the tension, but sought more traditional channels to address it, like advocating for a policy or procedure change. The differences between these two practice stances can be

viewed more in depth by reviewing the statements made by each participant in Table 30.

The other main component of Factor 5 arising from the qualitative data was the instigating feature or precursor to the individual DSPs seeing the need to either bypass or push back against certain agency policies. While there was some consensus noted above on how DSPs dealt with the tension of using their discretion to deal with problematic policies, how they arrived there was unique to each individual. For Participant 3, his awareness of this tension came about through his experiences in working at his programs and noticing the lack of attention or support his clients seemed to receive from the administrative offices. His perception of why his clients were being “left out” seemed to stem from the program’s geographic isolation and lack of involvement from the higher ups in his program. His response was to use his discretion to determine “what is going to make the situation better” when “the agency isn’t really there for me.” Participant 8 seemed to encounter tension with policy earlier on, while transitioning from his new hire training to the reality of the group home. He states, “When we first start training, it is all about them [clients]. We get to the house and it is all about them, but with the office it is not all about them.” This seems to indicate that once in the home, the support felt during the new hire process by this DSP was pulled out from under him putting him in a situation where he needed to “...not always follow policy and procedure.” Participant 22 seems to echo this sentiment of the agency administration not having the client’s best interests in mind as “the office looks at things one way and we look at things another way,” referring to how she



and the other DSPs in her program make practice decisions on the job. Unlike Participant 8, however, this DSP came to this tension with agency policy by a much more personal route. She goes on to state her deep appreciation for her clients and how “I could do this job and not get paid for it because I care about these guys so much.” She further emphasizes her personal relationship to her clients by going on to state that, “I love my guys and my kids will tell you that I love my guys more than I love them.” This deep level of commitment to her clients, while blurring the line between professionalism and personal feelings, speaks to her approach when she forcefully pushes back against agency policy to advocate for her clients. One such instance she describes as follows:

You can put anything down on paper, but if you’re not working with them and seeing how they behave on a regular basis then it is easy to say to do this or do that, but we know that we can’t. That is where I have to be able to put my foot down and say we are just not going to be able to do this. It’s not that I am trying to go against the office, but my job is to make sure the clients are good. And at this point it is not even like it is my job, these guys are like my family.

Moving on to Participant 24, the interview material did not add a definitive window into how he first came to experience the tension between policy and what he deemed best for his clients. From the quotes in Table 30, it seems to be due to a consistent mismatch he experiences between what agency policy dictates he should do in certain situations and what he believes is best for his clients. From this quote it would seem as if the tension is almost an omnipresent situation he is faced with when he states, “The hardest part of my job is all these rules and regulations and things... That shouldn’t be the main thing we focus on.” He also expresses a knowledge that his actions, when they deviate

from agency policy, could be grounds for his termination, but he seems at peace with this risk as he states, “The company should be focusing on the quality of care that you are giving the individual. That’s what I’m thinking about, not all of these rules...” The final DSP in Factor 5, Participant 3, seems to describe his intersection with the tension between agency policy and working with his clients as emanating from his experience working within his program and dealing with what he seems to feel is micromanagement when he states, “It can be difficult do those things that the clients want to do and we always have to get approval from management.” His approach to managing this tension seems to be one of begrudging acceptance as he makes multiple mentions of having to do things the way they need to be “because it is company policy we have to go through that procedure.” He also makes one of the only mentions to the theoretical area of group home culture playing a role in practice decision making when he states, “They [clients] need our supervision, they need us. So the program where I work has developed a good routine to get the work done.” While he is not explicitly stating that his program has developed workarounds to policy in their daily routine that is unique to their house, it seems likely that this may be the approach his and his co-workers have developed to manage the tension between policy and on-the-ground realities of their job.

In summation, Factor 5, much like Factor 3, was not a clear blueprint to how these DSPs carried out their daily practice, but revealed a situational barrier that staff have to address between the competing demands of agency policy and what they think is best for the individuals they support. Much like the various

theoretical areas already addressed, how individuals became aware of this tension and what they did about it was varied and more reflective of their underlying practice frameworks than just a focus on pushing back against agency policy.

To summarize the results of the factor analysis for this study, the data revealed five factors explaining 60% of the variance among the individual Q sorts. The five factors are labeled as follows: (1) Focus on recognition and agency policy, (2) focus on barriers to work, (3) focus on being a role model, (4) focus on self-referential thinking, and (5) focus on pushing back against agency policy.

The next section will address the first and second research questions of this study:

1. What are the various viewpoints that exist among DSPs about their practice decisions within a person-centered services framework within community-based care settings?
2. In what ways do the decision-making viewpoints of the DSPs reflect domains including recognition, self-reference, paternalism, agency resources, agency policy, and group home culture?

### **Analysis of Research Questions 1 and 2**

The first research question for this study asks what types of viewpoints DSPs have regarding how they make decisions on the job. As the detailed analysis of each factor presented, there were three main ways DSPs in this sample viewed their practice behaviors as shown in Factors 1, 3 and 4. In addition, there were two factors, that did not necessarily represent a true practice framework, but instead indicated how certain DSPs in this sample tried to manage environmental or policy constraints within their given programs (corresponding to Factors 2 and

5 respectively). The three practice frameworks identified by the factor analysis included DSPs that focused mainly on concepts of recognition and agency policy, DSPs that focused on being a role model for their clients in a variety of situations, and DSPs that primarily used self-referential thinking to carry out their work with their clients.

The second research question for this study asks for a deeper exploration, beyond the emerging factors, into how DSPs and their perception of their daily work is intertwined with the six theoretical areas outlined by the concourse. As was noted in the earlier analyses of each factor, all theoretical areas seemed to have a strong grounding in the real life work experiences of the participating DSPs, except for group home culture. Of the six theoretical areas, three seemed to have the strongest salience with this group of DSPs: Recognition, agency policy, and self-referential thinking.

Recognition was clearly a defining construct with regard to how most DSPs talked about their work and how it influenced many areas of how they provided supports. Specifically, recognition themes flowed through many DSPs ideological frameworks for why they do the work that they do, especially in Factor 1. Interestingly, while recognition statements in this concourse mainly centered upon level one recognition, or recognition of a person as an autonomous individual with the same level of humanity as the beholder and worthy of respect and dignity, the responses of the DSPs touched on all three areas of recognition. While this phenomenon will be explored in greater depth as it relates to the third research question for this study, it is important to note here that recognition theory

as interpreted by these DSPs clearly has a strong foothold in the zeitgeist of direct care practice regardless of the agency that they worked for.

The second most prevalent area noted by DSPs as influencing their daily work was agency policy; however, unlike recognition, this was a more divisive area. Predominately, agency policy embodied a helpful guiding influence in the completion of the varied and numerous job related tasks that DSPs faced. In this context, policy was seen by some as the law of the land and was treated as sacrosanct, meaning that regardless of personal feelings policy was followed. This attitude is best expressed by Participant 5 who states, “We are working for the company, so whatever the company wants us to do or what we do in trainings is the right decision we have to make.” A parallel discourse to this was how to address issues regarding policy when it became clear to individual DSPs that certain aspects of policy were detrimental to a client’s quality of life. Those that strongly endorsed policy statements as most like them (+3 and +4) often noted that if there were issues, these needed to be addressed through the proper channels and not through individual staff discretion. Participant 10 summarizes this discourses sentiment when he states:

When I come to work for [name of agency] I sign a paper. I say I am going to abide by what you ask me to do. So I cannot decide overnight or by myself that I am going to change this. If there is something not working, we need to call and report the kind of situation we are in so that the agency can make the necessary adjustment...For me, if you want to work for the company the first thing you sign is about policy.

This is echoed by Participant 13 who agrees that “We can’t go against the policies and procedures of the agency, but we can address them with the higher ups...It’s

just getting with the right people, getting the information to someone that will listen for the good of the client.”

As noted earlier, this was not the only discourse among these DSPs about agency policy. A counter narrative also arose, mainly from the individuals loading on Factor 5. These DSPs had a contentious relationship with agency policy, often finding it to be more of a barrier than a tool, which did not assist them or provide guidance in doing their jobs. Participants loading on Factor 5 best embodied this narrative and is recounted in the in-depth analysis presented on page 145. In addition to these issues, another very specific dialogue around agency policy arose among participants in varied factors about the usefulness of the IHP.

Considered the cornerstone of person-centered care plans, this document was seen by some DSPs as unhelpful at best and a hindrance to client development as its worst. For example, Participant 29 (Factor 3) acknowledges the importance of the IHP, but expresses its limitations in informing how to best work with a specific client when he states:

When I read a resident’s chart or IHP it gives me an idea, it gives me a blueprint of what to expect. You can’t just because it is written down that this is going to be exactly how it goes because that is not how it is going to go. I agree that training and reading IHPs is important, but it only gives you a starting point to know the individual.

This same participant goes onto express larger problems with the IHP in relation to the goals that are chosen:

For those folks who you know that they cannot walk, why give them a goal to take steps? It doesn’t make sense. It is going to be a forever goal that will never progress. My whole thing is to give them goals that you can actually see them conquer. I think a lot of times we think we foresee the future with high expectations for the individual but realistically it is not going to happen.

It's farfetched, it's a fantasy. I think a lot of times management has these big wonderful dreams for individuals and lots of times it is not going to come true. You can write in the IHPs over and over again that their goal is to take steps or tie their shoe or something like that, but unless they are capable I don't think it should be a goal.

A second example of this narrative comes from Participant 12 (Factor 2) who expresses concerns about the usefulness of the IHP in providing guidance for their daily work:

I think with the IHPs, I think we learn more from interacting with them on a day to day basis...I just don't understand them (IHPs) and maybe I don't know if there is a preconceived notion of what they are supposed to be. But, I think if you look at the IHPs to get a better understanding of who they are...I think it just doesn't represent them. I think you have to know them or get to know them and then maybe from there something can be built. I don't know that the IHPs are going to be the best way that you will better understand them.

The third most dominant theme of the six areas dealt with self-referential thinking. Self-reference was the dominant theme arising from Factors 3 and 4 as detailed in the analyses presented above. Self-reference in this sample took two primary manifestations in its influence on DSP practice behavior, those that focused on being a role model to their clients and those that drew from personal experiences. These two narratives were not only present in Factors 3 and 4, however, as several DSPs in other factors noted the use of self-referential thinking as helpful in their day-to-day routines. The main vehicle this presented was the use of the golden rule to guide decision-making as stated by Participant 5 (Factor 1), "This one says you should treat them like yourself. I just believe that. Whatever I think is best for me, it should be best for them too. If I don't like something, I would not force it on somebody else to like it." The following

participants, who did not load on Factors 3 or 4, expressed variations of this narrative: 5, 8, 9, 15, 20, 22, 24, and 26. Amongst this sample, it is clear that even if self-referential thinking was not a defining characteristic of how DSPs talked about doing their job, it influenced a great many of them at least to some extent.

It is important to note that there was an equally prominent narrative running counter to the use of self-referential thinking on the job. This was most notable among participants that loaded on Factor 1, but was also present among those that loaded on other factors as well. Generally, these participants had a strong aversion to the statements linked to self-referential thinking and expressed it having no place in their work. The most common theme among these DSPs was to frame the use of self-reference as inherently problematic as it took the focus off the client, who they noted should be the sole focus of their work. Participant 9 summarizes this best in stating, “Ultimately, my opinion should not impact them. It’s not about me; it is about helping them establish their independence. So whatever my decisions in my personal life might be, it should not affect them.”

Turning to the theoretical areas that were less emblematic of DSPs practice behaviors among this sample, there was a notable endorsement of how a lack of agency resources influenced day-to-day work as typified by Factor 2. The majority of DSPs not loading on Factor 2 addressed agency resources as important to their practice, referencing its availability and ease of access as a necessary element to their ability to complete their work. One area not addressed by any of the previous analyses is how staff viewed the resource of agency training. Among this sample, there is a clear split between those that felt the



trainings were invaluable and essential to informing how to perform the DSP job and those that felt the trainings were inadequate within the context of working with the individual clients, as they tended to be too general. Among those that strongly endorsed the impact of agency training, Participant 13 described them as “essential”, while Participant 25 noted, “training is the most important thing.” Participant 30 adds to this dialogue of training as “essential” stating, “When I don’t remember something or I don’t know what to do, I just think back to what we were taught in training. It helps me think of an idea or something to do when I am having trouble.”

Participants who had negative associations with training came from both support agencies and shared a perception that the trainings they received were too general to be of real use at their specific programs. Participant 14 expressed concern about the lack of consistency with training as noted with this statement, “Every manager trains differently, every trainer trains differently. With our program, it is hard for managers or trainers to walk in and frequently they come in and don’t understand what we deal with on a daily basis.” A more in depth critique comes from Participant 15 who focused on annual re-trainings and is included below:

If I could talk about our training... Sometimes I think that our training is just...okay you did it fine and you’re out the door. I feel that way a lot even though I do get a lot from our training. I think in certain areas we need more training or...I don’t want to say better training, because our trainers are awesome but....For example, we took crisis management. I’ve taken it three times already and yet I’ve never done a takedown ever. And at my last CMT training we just watched the videos and then out the door we went. Sometimes when you don’t do it...you need to go through those motions. Stuff like that. I think every CMT training should be you going through the process every time. There are group homes in our area where they do

takedowns daily or weekly. And not that my client doesn't get taken down, I just have personally never done it. So that kind of thing you know. I think they (trainers) let us walk through too easy. But realistically we need it, I need it. I think the retraining lacks a little bit. I think they think that since you've done it three times let's just get you out of here. I'm amazed though, that I will sit next to other staff who have been here for 15 years and they won't know the answers to some of the questions on the test. Or they ask questions and I'm like, "Seriously!?! You don't know that? You have been here for 15 years!" So I think training is the thing here that needs the most help.

From the second support agency, Participant 26 addresses how their training was too general to be of help: "In training they trained us to work with clients like the ones out there [points out high functioning clients at the office day program] that can do things on their own. They didn't train us about lower functioning clients. As far as changing diapers and showering, they did not train us on that. I had to learn hands on here at the home." This narrative is further supported by Participant 22 who discusses the perceived shortcomings of agency trainings below:

As far as the training that we get, yeah we get good training on certain things, but they can never train us on our guys. Every person is an individual so no matter how much training we do in these trainings every person is different. So they can't sit there and say, well we did a training on "blank", you didn't, because we are not being trained on every individual. When we come into these trainings, it's med training, CPI training, but that is for everyone and it is generalized. But you will never know how to work with these guys until you are there day in and day out.

Moving to the second to last theoretical area, paternalism, there was little interview evidence to support that these DSPs operated from practice frameworks overtly influenced by paternalistic attitudes. However, a few DSPs referenced using their experiences raising their own children as a guidepost for how to work

with their clients. Others, like Participant 17, seemed to phrase their relationship with their clients as possessive: “I call them my children, my sons.” In addition, several participants questioned the ability of their clients to self-determine and make choices with the strongest example coming from Participant 3 who stated, “my work as a direct care worker boils down to me being in charge.” This statement and others made by Participant 3 shows them taking a position of authority over their clients, not one of guidance and assistance. One other example of paternalistic attitudes comes from a participant who both had worked at a psychiatric hospital before coming to work at the current support agency. During the post-sort interview, Participant 21 discussed how the increased structure and control staff had at the psychiatric hospital was beneficial to completing their work in comparison to what they faced in the context of the supportive housing program at which they currently work. This DSP further described the differences in the two workplaces as follows:

I have found that working at [name of hospital] versus working in the group home, a big difference is the red tape. There is so much we can't do because they have rights and that's fine. And you are not trying to take that away from them, it's just that you have to...I personally feel that it would be such a benefit to, not just for the consumers but for the staff to do the job comfortably and accurately, if we can inject ourselves in their rights...and do what we feel is the right thing. So, that kind of dilemma is what I find here in the group homes. We have to follow everything because they have their rights and I don't want to take that from them, but sometimes you have to amend their rights and we can't do that so that keeps us from doing our job effectively. I would say this is especially the case in supportive housing.

This kind of paternalistic thinking was a significant minority among this group of participants; it does provide illustrations of how these types of attitudes and practice approaches can appear within a supportive housing setting.

The final theoretical area of the concourse dealt with group home culture. Out of all six areas, this was the least endorsed by staff and did not seem to have a significant influence on how DSPs performed their job. This lack of influence from group home culture is seen in the factor analysis by looking at the placement of the eight statements representing this area. None of the factors placed any of the group home culture statements higher than +2 with only two factors doing that. Factor 2 placed Statement 22 at +2, which conceptually makes sense as this factor was focused on dealing with a lack of resources. Statement 22 deals with group home staff having to be flexible in areas where the agency seems inflexible. In the context of the Factor 2 narrative, this would seem to indicate that staff, due to a lack of resources, practiced flexibility to assist their clients in the best way they saw fit.

Factor 3 placed two statements linked to group home culture at +2, but given the interview data from these participants, this endorsement does not represent their program having a distinct and separate way of doing things. Instead, the focus on these statements dealt with the helpfulness of the program's routine and how this consistent way of doing things helped both the staff and clients on a daily basis. There were several excerpts from the interview data that support this notion. Participant 2 notes that "The routine is important. If you come in and disrupt someone's whole routine and now they are going to have an episode, yelling at you or maybe throwing things. The routine is good and lets a person know how to go to work and fall into place." This sentiment about the

importance of routines is echoed by Participant 4 when he states, “The program I work at has developed a good routine to get the work done.”

In conclusion, statements belonging to five out of the six theoretical areas represented by the concourse did have relevancy to this group of DSPs and how they performed their work. The remaining area of group home culture, was not a significant contributor to how these participants described and talked about how they completed their work. It is important to note that while this group of DSPs did not subscribe to operating within a separate work culture developed at their program, it is possible that other programs at these or other agencies do rely on a program specific work culture to inform their practice behaviors as some researchers have found in the peer-reviewed literature (Bigby et al., 2012).

### **Analysis of Research Question 3**

The third research question for this study asks, to what degree do the concepts presented in recognition theory describe and explain the decision-making viewpoints emerging from the DSP Q sorts? It is useful briefly to summarize the concepts of recognition theory presented in Chapter 3 on page 44 as they relate to DSP practice behavior.

At its core, recognition theory (Honneth, 1995) describes the process of interactions between individuals, groups, and institutions as comprised by three substantive areas (self-confidence, self-respect, and self-esteem) which can either encourage or inhibit self-actualization. This process of interactions takes place first in the family or foundational unit, then with peers and the broader community. With insights from an interbehavioral perspective on habituation (pg.

29), a clear link is established between DSP practices behaviors, use of discretion (pg. 50), and routines as inherently informed by their level of recognition towards the clients they support. A DSP's level of recognition for a client is likely informed by a broad spectrum of influences such as media representation of people with disabilities, previous personal experience (family, friends, school, job, etc...) , as well as social and cultural norms. Like the hierarchy of acceptance (pg. 41) presented by Takahashi and Dear (1997), the levels of recognition held by any individual or DSP are not rigid, but flexible and constantly in flux, intertwining with the historical past encounters and current environment of interaction.

To determine how DSPs interpret recognition-related concepts and how these may inform their daily practice, Table 31 presents the placement of all recognition related statements by factor. The eight statements dedicated to represent varied aspects of the theoretical area of recognition within this study's concourse addressed the following concepts: advocacy (1), recognition growing through interaction (2 and 5), recognition of the client as an equal (3 and 8), person-centered practice (6), dignity of risk (4) and commitment to the relationship with the client (7).

The most notable result was Statement 3 being a consensus statement across all factors. This consistent high placement of Statement 3 would seem to indicate a general awareness and endorsement of all three levels of recognition for the clients they support. This statement addresses a client as being unique, worthy of dignity, having intrinsic value, and the appropriateness of advocating for that

person's value. Support for this assertion comes from the voices of the participants in all five factors. Participant 9 from Factor 1 states, "We are all one and the same...Regardless of ethnicity or religion we are all one and the same regardless of our differences." Participant 12 from Factor 2 goes into greater detail about their strong agreement with the third recognition statement by saying, "I think to me this is a reminder of why you do this job and I don't think you can be in this field unless this is why you do what you do. You want them to be treated equally. You want them to feel like they have a voice...You want to support them in every way possible. For me that is personally why I feel like you can't be in this field just for the paycheck." Another Participant (29) from Factor 3 continues adding credence to this narrative around recognition Statement 3 remarking, "This is always important, because they are human. I've always felt that since I first came into this work. They're people just like me and you no longer see the disability over time." Participant 7 from Factor 4 engages with this narrative by stating, "I always try to go above and beyond to make them feel like a regular person. I think that's all they really want. They don't want to be treated like they are different; nobody wants to be treated that way." Finally, from Factor 5, Participant 24 states, "Not having worked in this field before and now working in it, you see these clients with developmental disabilities and realize they are human beings. They are not the butt of all jokes and stuff like that. You try to put yourself in their situation. Who wants to be humiliated, disrespected or put on blast? Generally everyone wants and deserves to be respected."

As the above quotes and the previous in depth analysis of Factor 1 and the consensus statements among all factors show, recognition as theorized by Honneth (1995) clearly is a fundamental factor in many DSP's practice routines. Interestingly, this endorsement of recognition related concepts was often conflated with self-reference among some of the participants and with paternalistic statements for others. This may indicate that while the concepts of recognition clearly resound with many DSPs, there may be a broader issue of how to conceptualize and integrate these concepts into their day-to-day work and/or have unrecognized biases.

Table 31.  
*Factor Values for Recognition Statements*

Number	Statement	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
1 (6)	In this kind of work, it is necessary to advocate for your client because I have seen many examples of the people I support being "left out".	0	2	-1	-2	3
2 (34)	My caregiving experience has changed my views on what the clients I work with are capable of doing. I now see them as more like me than different from me	3	0	-2	-1	3
†3 (14)	As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person's value, and help others to understand the individual's value.	4	4	3	4	2
4 (30)	When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else.	0	-4	3	-3	-3
5 (13)	The more I have gotten to know the clients I work with, the better I understand how to care for them in a way that is respectful and gives them dignity.	4	4	2	4	2
6 (35)	I feel it is important not to let your personal factors (like culture and religion) to influence how you work with	4	1	0	-4	1



	and care for the clients. As staff, we should leave those things at the door.					
7 (16)	I see the work I do as a commitment to caring for the people I support, with all things I do at work flowing from this commitment.	2	2	1	0	1
8 (33)	My caregiving experience has taught me that all people share a common humanity, but also have individual differences. Being aware of this influences the work I do every day.	2	2	0	2	2

---

†this was a consensus statement, one that does not distinguish between ANY pair of factors

The second result of note is the similarly high ranking of Statement 5 across all factors. While it was not statistically a consensus statement, we can see that most factors gave it a ranking of +4 with the other two placing it at +2. This statement describes the process by which recognition develops for a client as predicated upon the evolving experiences between staff and client, leading to an increased awareness of the client's inherent dignity and how to incorporate that into direct practice. This strongly coincides with the hypothesized practice framework and its relation to how recognition forms and is utilized by DSPs in the interpersonal care-giving process. From the voices of the participants, we can support this through the post-sort interview descriptions of Statement 5 among all factors. Participant 16 (Factor 1) states, "During the trainings we were often told how to deal with clients, but I think when you gain a relationship with them you learn how to deal with them accordingly. I feel like we sometimes forget that they are regular people like me and you, they just have disabilities. Asking them instead of just doing makes them feel like a person." Participant 15 (Factor 2) also describes a strong practice relationship with Statement 3:

I feel like this is exactly how I feel, 'cause I've never done this before. I really like caring for people and I feel like it has kind of changed me in a way that I didn't think would happen. Like, I understand more about disabilities now. It has taught me more patience...I've always been patient because of living at home with my brothers, but it has taught me how to be more patient in different ways. Like, how to deal with their behaviors and stuff.

A slightly different take on recognition as a process was given by Participant 29 (Factor 3), who first described the recognition process as important but not “a constant influence on me every day.” She followed by describing while adding insight into how she viewed the process occurring in others:

... 'cause I'm already there. I'm in it to win it. I already want to help, so I'm doing it out of sincerity because I really care. I really want to help. So that is it from the beginning. I say this all the time in reference to this field...a lot of people don't come in with compassion. Sometimes it takes a situation to have compassion for our folks. Sometimes it has to happen within their family before they can bring that compassion to work.

Participant 2 (Factor 4) comments on how this process eased her daily work, stating, “Knowing the person, knowing your client makes the job 1,000 times easier, 'cause it just flows.” From Factor 5, Participant 24 nicely summarizes this topic by concluding

You know it's like anything else in society...You see people on TV or wherever, but until you get to know the individual close up you don't know exactly where they're coming from. That's what I believe in. I'm not saying I'm right or wrong, but me personally, once I get to know them (client) I feel like I can support them better. That's just me.

The remaining statements and their corresponding areas had less consensus, with Statements 7 and 8 having slight to no endorsement among the five factors. The remaining Statements (1, 2, 4, and 6) presented with strong to slight disagreements in scoring between the factors. To help visualize these

differences, the ranking of recognition statements by each factor is presented spatially with the statements labeled to their corresponding areas in Figure 10.

By reviewing the spatial arrangement of recognition statements, we can clearly see that Factor 1 had the largest endorsement of recognition-informed daily practice in a wide variety of areas. This is consistent with the focus on recognition described by participants loading on Factor 1 as previously discussed. Switching our attention to Factor 3, which focused on being a role model for the client, we see a strong DSP endorsement to allow their clients “dignity of risk”, as they described seeing the value in failure and learning from mistakes. Other areas of recognition did not resonate as strongly, however. Next, we see Factor 4 presenting with a strong DSP endorsement of recognition as both a process and important to how they see their client. We will recall that Factor 4 had a focus on self-referential thinking. This same narrative echoes here, as we can see the areas of person-centered practice, dignity of risk, and advocacy were all seen as not reflective of these participants’ daily practice.

These results indicate that these DSPs do have high levels of recognition for their clients and acknowledge recognition as a process growing out of a deepening staff/client relationship. It is also clear that these DSPs conceptualize and put this into daily practice in a variety of ways. This may indicate that some DSPs are experiencing a theory to practice gap as it relates to person-centered planning and its intersection with the “why” of the work they do. This gap, in the current sample, was sometimes filled with agency policy, self-referential thinking, or paternalistic tendencies.

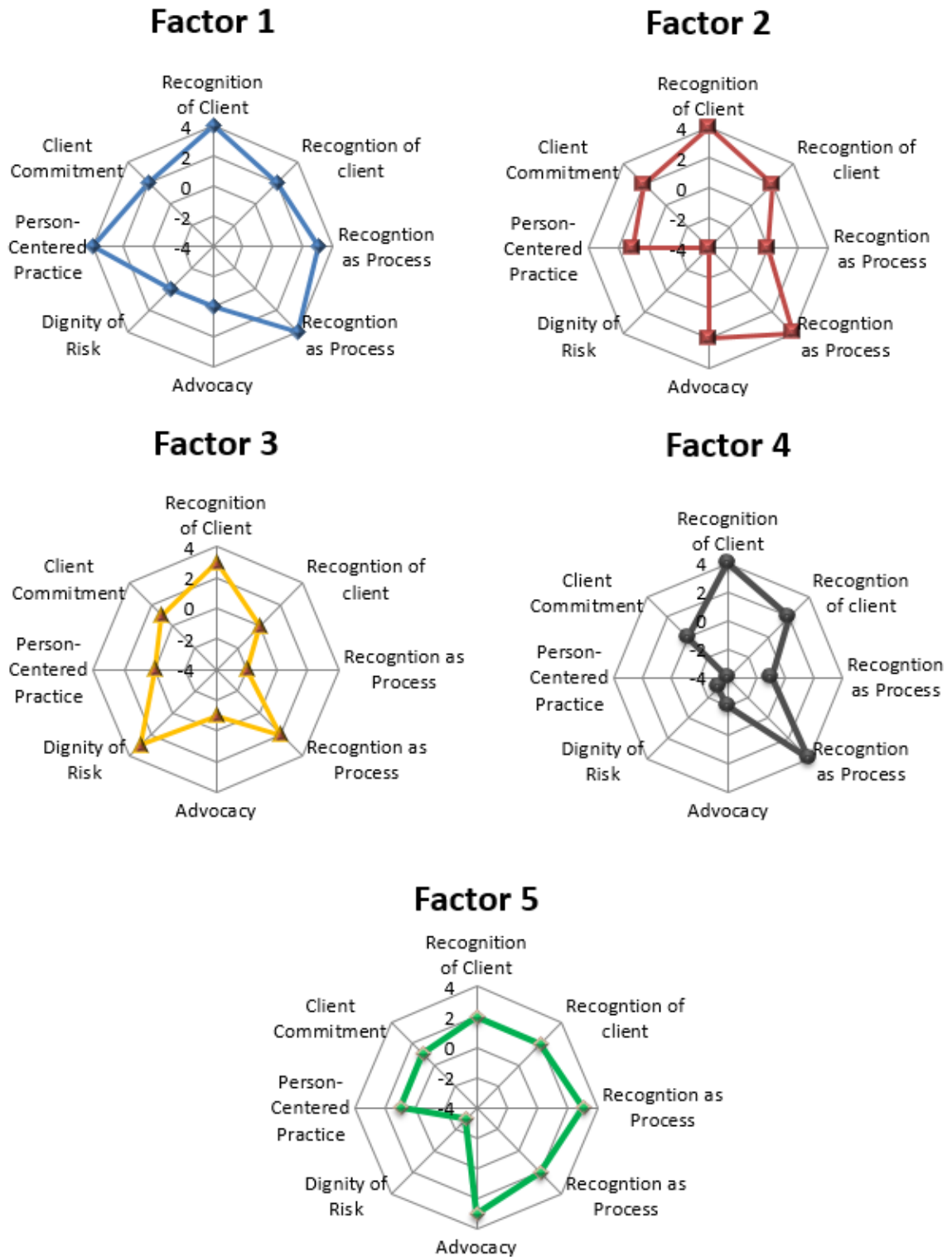


Figure 10. Visualizing Each Factor by Recognition

#### Analysis of Research Question 4

The final research question<sup>2</sup> seeks to determine if there were significant differences in the practice approaches of experienced and new DSPs. Table 32 displays the breakdown between new and experienced staff across factors, with additional demographic variables also displayed.

Table 32.

*Number of Q-sorts in Each Factor by Demographics*

Demographic Variables	Factor					N/A	Total
	1	2	3	4	5		
Agency 1	7	3	3	3	3	1	20
Agency 2	5	1	0	0	2	2	10
Level of Experience							
<b>New (6 to 18 months)</b>	<b>4</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>2</b>	<b>0</b>	11
<b>Experienced (over 18 months)</b>	<b>8</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>3</b>	<b>3</b>	19
Gender							
Male	7	0	1	0	4	1	13
Female	5	4	2	3	1	2	17
Ethnicity							
White	0	2	0	0	0	0	2
Hispanic/Latino	1	0	0	0	0	0	1
Black	9	2	3	3	4	3	24
Multiracial	2	0	0	0	1	0	3
Highest level of Education							
High school/ GED	5	1	0	0	0	1	7
Some College	6	3	3	1	4	2	19
Bachelor's Degree	1	0	0	2	1	0	4
Challenge level of program							
Easy to Moderate (1-5)	9	1	3	3	2	2	20
Moderate to Difficult (6-10)	2	2	0	0	3	1	8
Works at Multiple Programs	1	1	0	0	0	0	2

While the purpose of Q methodology is not to generalize outside of the sample of participants engaged with, it is useful to see if level of experience is associated with differences in actor loadings in this current P-set. As presented in Table 33,

<sup>2</sup> Question 5 is a summation of all evidence and addressed in the Chapter 6.

the three participants that did not load significantly on a factor were excluded from the analysis. The remaining 27 participants did not show a significant difference in factor membership between the two tiers of experience. While these results must be taken in the context of the small nonrandom sample size, the non-significance of work experience on factor loading would seem to indicate that time on the job does not necessarily differentiate between the various practice frameworks developed here. Rather, these results seem to resonate with how the different factors concurred that recognition is a process but incorporated it into their day-to-day work differently. It would also follow that new hire and continued on-the-job training may positively impact some DSPs' practice behavior, but does not influence others.

Table 33.

*Level of Experience—Chi-Square Test of Significance*

Level of Experience		Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Total
New (6-18 months)	Observed	4	2	1	2	2	11
	Expected	4.89	1.63	1.22	1.22	2.04	
Experienced (Over 18 months)	Observed	8	2	2	1	3	16
	Expected	7.11	2.37	1.78	1.78	2.96	
Total		12	4	3	3	5	27*
Statistic	Value	df	Sig.				
Chi-Square	1.319	9	.858				

\*3 participants did not load significantly on any factor and were excluded

## Chapter Summary

This chapter presented the results of this study and the research questions it was designed to shed light on:

1. What are the various viewpoints that exist among DSPs about their practice decisions within a person-centered services framework within community-based care settings?
2. In what ways do the decision-making viewpoints of the DSPs reflect domains including recognition, self-reference, paternalism, agency resources, agency policy, and group home culture?
3. To what degree do the concepts presented in Recognition Theory describe and explain the decision-making viewpoints emerging from the DSP Q sorts?
4. Do the viewpoints of experienced DSPs (more than 18 months experience in the field) and inexperienced (fewer than 18 months experience in the field) DSPs differ?

These results presented the demographic breakdown of the P-set, a discussion of the rotated factors arising from the participant Q sorts, a detailed interpretation of consensus statements across factors, an analysis of each individual factor, an in depth look at recognition in relation to endorsed practice behavior, and the significance of time on the job to factor membership. The following chapter will discuss the findings and implications emanating from this study. Limitations of the project are also detailed.

## CHAPTER 6

### DISCUSSION

At the start of this manuscript, the critical need for knowledgeable and skilled direct service providers was identified as a problem of national scale (Beadle-Brown et al., 2012; Hatton et al., 2008; Ratti et al., 2016; Sanderson, 2002; Taylor & Taylor, 2013). As research has consistently shown, the divide between the demand and supply of qualified providers is growing wider with no signs of abating (Braddock, 1999; Lakin et al., 2005; Robertson et al., 2007). While researchers and providers in the field of intellectual and developmental disabilities have taken steps to identify the skills and knowledge necessary for a DSP to be successful in carrying out person-centered practices (Larson et al., 2007), little is known about how the providers interpret, operationalize, and put into practice these same skills and knowledge. This possible policy to practice gap in community-based services runs parallel to the absence of theory supporting PCP. As was shown in Chapter 2, PCP, while clearly defined as a process, has little to no theoretical or philosophical framework supporting it (Taylor & Taylor, 2013). Metaphorically, (as described on p. 20), this leaves both the ID/DD field, its administrators, managers, and direct care workers with the unenviable task of trying to construct numerous unique three dimensional objects (IHPs and daily practice routines) without the aid of guiding principles or well-tested methods. Given that DSPs often operate unsupervised by management on a daily basis, individual choice and discretion play a key role in their day to day work routines (Dunn et al., 2010; McConkey & Collins, 2010). The past empirical evidence



looking at direct service provider practice behavior in qualitative studies highlighted six key areas identified by DSPs as influencing this process of decision making (Amando et al., 2013; Bigby et al., 2012; Bigby et al., 2009; Fyson & Cromby, 2013; Hillman et al., 2012; Jingree et al., 2006; McConkey et al., 1999; Robey et al., 2013; Williams et al., 2014).

This dissertation sought to investigate the perceptions of DSPs regarding how they viewed their day-to-day practice behaviors in community support programs for people with ID/DD within the six areas of recognition, self-referential thinking, paternalism, agency resources, agency policy, and group home culture. This is the first study of its kind, allowing DSPs to consider the multiple generative mechanisms at play in their practice in a critical and self-reflective way. Furthermore, a theoretical framework for DSP decision-making and use of discretion on-the-job was framed through the theories of critical realism, interbehavioral psychology, and recognition. This line of inquiry was based on the possible gains to be made in the ID/DD field by knowing and understanding the process of how DSPs make decisions on-the-job, and shaping guidance to individual agencies and the ID/DD field in general to reevaluate new hire and continued training efforts to improve direct level care and the policies that govern them. Additionally, this study has significance for linking DSP discretion to concepts introduced by Lipsky (1980) and his work around street level bureaucrats and the influence of recognition (Honneth, 1995) in how DSPs understand and approach their work. Finally, the use of Q methodology is shown

to have value for the ID/DD field as a way of assessing DSP decision-making, use of discretion, and how these either contribute to or hinder the enactment of PCPs.

This study identified three distinct practice approaches of the DSPs within this sample. Additionally, the influence of agency policy and agency resources was identified by some DSPs as a barrier to being able to carry out their work as they envisioned it. A summation of the five factors is presented below in Table 34. As discussed in Chapter 5, the factors identified in this study provide a picture of how DSPs from each factor prioritize and utilize the concepts within the concourse created from the six areas mentioned above. Further, the results indicate that each factor approaches these six areas differently as they relate to their direct practice with clients and provide preliminary evidence as to the existence of gaps between policy and practice in the translation of PCPs to daily work routines.

Table 34.  
*Summary of Identified Factors*

Factor	Factor Focus	# of Participants	Variance explained	Summary of viewpoint
1	Recognition and agency policy	12	21%	<ul style="list-style-type: none"> <li>• Strongest levels of recognition for clients out of all factors</li> <li>• Policy was seen as assisting daily work</li> <li>• High levels of recognition for the client was formed either through previous work or life experience or through on-the-job experiences with their client</li> </ul>
2	Barriers to work	4	11%	<ul style="list-style-type: none"> <li>• Barriers at work due to lack of resources (monetary and staffing) obstructed DSPs from carrying out their work how they wanted</li> <li>• Experience a discrepancy between their lived experience of the job and how management sees their job</li> </ul>
3	Being a role model	3	9%	<ul style="list-style-type: none"> <li>• Describe daily work in terms of being a role model for their clients</li> </ul>

				<ul style="list-style-type: none"> <li>• Being a role model was based upon self-referential thinking (i.e., what would I want in this situation)</li> </ul>
4	Self-referential thinking	3	9%	<ul style="list-style-type: none"> <li>• Describe their work as being substantially influenced by their experiences either raising a family or how they were raised</li> <li>• DSPs spoke about their work with paternalistic undertones</li> </ul>
5	Pushing back against agency policy	5	10%	<ul style="list-style-type: none"> <li>• Tension between what DSPs think is best for their client and what agency policy prescribes</li> <li>• Agency policy was willfully circumvented by some, while others advocated for policy change</li> <li>• Each participant described in a unique way the process by which they determined they needed to push back against agency policy</li> </ul>

From the outcomes of the factor analysis and subsequent review of the DSP's interview responses to their interactions with the concourse, the responses to the question of "why I do the work the way that I do" arises in an emphatic way. The majority of DSPs in this sample held a unifying principle, aligned with recognition theory, as foundational to their everyday work. However, as discussed in Chapter 5, the way this unifying value (i.e., a client as being unique, worthy of dignity, having intrinsic value, and the appropriateness of advocating for that person's value) played out in practice behaviors was often unique both across factors and within them. This would seem to support that DSPs do have a strong sense of the zeitgeist behind PCP and their dual roles of providing care and increasing independence, but lack grounding philosophical and/or theoretical guidelines from which to translate these values into direct care work. If we place DSP recognition for their client's in the context of values, these differing practice

responses to the same value set is to be anticipated as values are not accomplished but rather stimulate action (Castro et al., 2016).

Unlike social work, which utilizes the ecological model and various person-in-environment theories to inform direct practice, the ID/DD field has yet to adopt a strong attachment to any theories of human behavior as it relates to the fulfillment of PCPs. It makes sense then that the DSPs in this study spoke in vastly different ways about how they carry out their direct care work even though there was substantial agreement on the “why” of their work. Without a clear guide as to how to operationalize each individual PCP into daily practice, some DSPs in this sample seemed to develop their own picture of what is ideal and the routines and behaviors that best accomplish this self-anchored end goal. This gap between policy and practice as experienced by these DSPs played out through their individual discretion, filling the gap with a diverse set of concepts attributed to self-referential thinking, paternalistic thought, and strict adherence to agency policy to name a few. As such, the results and theoretical framework developed in this study may provide an entry point into the further development of the philosophical groundings of the DSP/client relationship and the implementation of PCPs.

Traditionally, this incongruence between beliefs or values and how they are put into action is an area relegated to new hire and ongoing agency trainings. As was reviewed in Chapter 2, DSP training is acknowledged by the peer-reviewed literature to be essential to DSP retention and skill development (Castro et al., 2016; O’Neill & Hewitt, 2005; Reid et al., 2005). However, until recently,

training programs and new hire curricula have not attempted to address this complex practice issue within the peer reviewed literature. Some of the most recent forays into intervening with DSPs through training have focused on the importance of values, recalling the earlier work of Parley (2001) who declared values and attitude training as fundamental to successful PCP implementation. A group of researchers from Southern Illinois University, drawing upon research in other health-care settings, developed and deployed a values and committed action training intervention for three DSPs at a day treatment program and their results showed it improved the DSPs' level of engagement towards clients with severe disabilities, but no linkage to quality of life outcomes for clients was explored (Castro et al., 2016). These results are consistent with previous research which has tended to see training alone as not sufficient for improved outcomes to a client's quality of life (Grieve et al., 2008; Jones et al., 2001; Mansell et al., 2004b; Mansell et al., 2013; Singh et. al., 2009). The results of this study provide additional insight into why classroom-based training may not be sufficient to modify DSP practice behaviors consistently. As presented in Chapter 5, multiple staff addressed the shortcomings of their agencies' training as related to the information being presented as too general, and not translating easily to the work they do with their specific clients. This would seem to indicate that new hire training curricula should be linked to the work being done in each specific program and be viewed as more of a process in which the DSP is an active participant and not a passive receiver of information.

This view of rethinking new hire training curricula is also bolstered by the results of the current study (i.e., the consistent way DSPs talked about their level of recognition for their clients and how it developed). As shown in Chapter 5, the development of recognition for a client was described by most DSPs as a process which either occurred prior to their working in the field or through the work they did with their clients. This would seem to indicate that increased levels of recognition are not a likely outcome of classroom-based instruction, but instead accomplished through the daily routine of front-line work, which is consistent with the intertwining of interbehavioral theory and recognition theory as presented in Chapter 3. A new hire curriculum that seeks to continually address this process of on-the-job learning by pairing it with ongoing active learning around the values of PCP might be a better fit to produce long lasting positive outcomes in clients' quality of life. However, this is predicated on a consistent theoretical framework from which to envision the DSP, the client, their ideal relationship, and the ideal outcomes of PCPs. While the findings from this study do not necessarily present a finalized solution to an all-encompassing theoretical perspective, which can govern PCPs and the DSPs' role in operationalizing, and routinizing these plans at the front-line, it would appear the concepts from recognition theory and street-level bureaucracy present a tentative framework, which deserves more consideration. This assertion is supported by the results of this study as laid out below.

If we recall Figure 2 (p. 49) from Chapter 3 and its attempt to provide a model of how DSP discretion is formulated and impacted by a variety of

generative mechanisms, we see the initial hypothesis that levels of recognition would act as value-laden lenses from which front-line work was approached is consistent with the results of this study. As has previously been presented and discussed throughout Chapter 5, the four consensus statements (i.e., those ranked similarly by all five factors) seem to support this view of recognition as fundamental to the ways DSPs use their discretion on the job. Also arising from the interview data and factors is preliminary evidence to suggest that the remaining five theoretical areas presented within the concourse and Figure 2 are impactful in a variety of ways to how DSPs carry out their work. In the context of Factors 2 and 5, we see how a lack of resources within the program or a perceived disconnect between agency policy and the realities of front-line work can constrict the ability of DSPs to carry out their work in the way consistent with their values. This confirms prior research which has also found a lack of resources at the program level and lack of fit between DSPs and agency policy to be predictive of DSP burnout (Hatton et al., 1999; Hewitt & Larson, 2007; Robson et al., 2010). It also indicates that recognition functions at multiple levels, not only between the client and the DSP, but also between the DSP and the agency.

Moving to the applicability of street-level bureaucracy and its definition of street-level bureaucrats and discretion, this study provides strong evidence that, within this sample, DSPs in their role as caregivers and purveyors of agency policy is consistent with Lipsky's (1980) theory. Street-level bureaucrats are at their core individual agents, who within the framework of policy delivery make decisions about other people. These decisions rely on the individual agents

(DSPs) to use “discretion” because the nature of street-level work requires human judgment (Lipsky, 1980, p. 161). From a programmatic perspective, this means regardless of how policy reads at the agency, state, or federal level, the ultimate location of policy provision in many circumstances is the direct care relationship between DSPs and the clients they support. The dialogue established by Factor 5 around pushing back against agency policy and how Factors 3 and 4 used self-referential thinking in a variety situations to make decisions on-the-job show clear instances of how DSP discretion can reshape policy. Further, research looking at how street-level bureaucrats handle their discretion shows it is often patterned in consistent ways to allow the worker to operate on-the-fly and avoid being bogged down by minutia (Galligan, 1990; Lipsky, 1980; Lyons, 2010). The results of this study, through the use of Q method, show evidence that DSPs do have consistent patterns about how they carry out their day-to-day work. Further, Q method, as carried out by this study, seems an ideal research tool moving forward, to obtain insight into DSP discretion and how they carry out policy at the front-line.

These findings, along with the current application of theories, provide an opportunity for the ID/DD field to renew the conversation about the lack of theoretical and philosophical grounding for PCPs. In the early stages of this study, DSP work and discretion were anecdotally linked to the andon cord used within Toyota assembly lines (Surowiecki, 2006). While the insertion of a cord at each worker’s station that can stop the production line would seem a counter-intuitive way of speeding up the overall production process, in practice it worked. The success had by Toyota front-line workers is attributed to their ability to use their



discretion to stop the assembly line when mistakes or errors were noticed in the assembly of any particular vehicle, alleviating situations where a completed vehicle would come off the assembly line with mechanical problems. This process of empowering the individual front-line worker to improve quality outcomes was seen to coincide with the current study and DSPs' front-line discretion in relation to PCP plans.

It was initially hypothesized that a current limitation in empowering DSPs in a similar way, was a lack of theory or the big picture behind PCP practices. However, given the results of the current study it would seem, at least in the current group of DSPs, the big picture or theory behind PCP is linked to concepts from recognition theory and arose through the consensus statements within all five factors. This was most clearly seen in Factor 1 and to varying degrees in the other four factors. These results seem to indicate that DSPs may have insight into what the end result of PCP should be (i.e., recognition of the client as an equal, insuring the client has their rights expressed in a way similar to others, and integrating clients into their communities in a way that provides them with a sense of having value). However, as has been discussed, the process by which each DSP took these principles and operationalized them into their daily practice was diverse, and at times inconsistent with the values of person-centered services. So while the "more inclusive conceptions of personhood" called for by Fyson and Cromby (2013, p. 1171) seem to have taken hold in a general sense among this group of DSPs, there is still additional work necessary to assist both DSPs and the broader ID/DD field to conceptualize these value-laden goals into daily practice.

Limitations for the current research project will now be detailed, followed by the implications for the results in the areas of DSP practice, agency policy and trainings, continued research in the area of DSP direct practice and PCP implementation and the field of social work.

### **Limitations**

A Q method study, when properly planned and executed, has some limitations to be acknowledged as part of the process for obtaining subjective perceptions. Often, the limitations of more traditional “R” methodology studies are imposed improperly upon a Q study due to a lack of understanding or familiarity with the methodology. A recent review of these criticisms as well as the response from the Q community was published in 2014 and 2015 in the journal *Quality & Quantity* and will not be reviewed here (see: Brown, Danielson, & van Exel, 2015; Kampen & Tamás, 2014).

The limitations to be noted in this study include the following: First, the selection of the Q set is ultimately at the discretion of the researcher and his or her use of thoughtful sampling of statements created from the literature review and concourse development interviews. The participants in the study were only able to give their subjective opinion about the statements provided. If statements are poorly written or misunderstood by the sorter, issues of internal validity arise. Likewise, if a Q set does not contain statements which participants would have included, then a piece of their viewpoint can be missed entirely. It is for these reasons the current study chose to engage in concourse development interviews, have the Q set reviewed by to subject experts, and administer two trial Q sorts.

A second possible limitation of Q method is that it can make no claim to determine whether the subjective opinions of the participants will be consistent across time or across a larger population. However, given that the research questions at hand only deal with examining the subjective decision making of DSPs at this current point of time, Q remains an appropriate method. Other methods can be used with the results from this proposed study to determine answers to opinion stability across time and how saturated a viewpoint is within a larger sample of DSP workers. Q study results are not meant to be generalized beyond the participants in the study.

Finally, there is a risk of researcher bias at the interpretation stage and when selecting the participants to make up the p-set. At both points, the researcher must make strong use of his or her analytic skills. At the interpretation stage, summaries of the factors should be driven by theory and not the whims of the researcher. Likewise, much thought must be given when choosing a p-set to insure it contains as many possible subjective viewpoints as possible. For the first issue noted above, relating to interpretation, multiple factor solutions were considered starting with two factors and expanding up to six factors. The ultimate determination of the amount of factors to keep for the final analysis relied on a combination of statistical considerations (i.e. eigenvalues and amount of individuals loading or not loading on the factors) and the consensus viewpoints elicited by the individuals loading on each factor. To address the second issue of p-set construction, as detailed in Chapter 4, care was taken to sample a diverse range of DSPs with a variety of educational and ethnic backgrounds, focusing

specifically on time spent working in the field. While it may be impossible to represent every subjective viewpoint that may arise from any DSP within the field, attempts to be inclusive were made, guided by the literature review and theory.

### **Implications for DSP Practice**

One of the main issues in studying DSP practice behavior is the varied and complex intertwining of systems through which they complete their work. Each agency, program, and client present the DSP with a unique set of circumstances from which they utilize their individual discretion to carry out their job responsibilities. To truly capture all of these varied environmental contexts, DSP practice behavior needs to be conceptualized in a similarly complex way. The current study's combination of critical realism, recognition theory, street-level bureaucracy, and interbehavioral psychology provide one such way to model and envision this complex intersection of environmental and personal mechanisms in a holistic fashion. This theoretical framework allows for the meeting of individual agency (the DSP's discretion) and the variety of social and organizational structures present in the ID/DD field to be viewed in the context of generative mechanisms alluding to DSP practice as a continual process evolving alongside their daily experiences within their very specific settings. This informs a perspective of DSP practice which sees the outcomes of PCPs and client quality of life as inextricably linked to the generative mechanisms identified for this study. Further, this multifaceted process view of DSP practice informs that changes to both individual DSP values and their uses of discretion have the

possibility of being modified either through training or experiences on-the-job, and are not inflexible.

Further, this study shows the negative impact agency policy and a lack of resources can have in certain programs, overwhelming DSPs to a point where their individual discretion becomes compromised. While the peer-reviewed literature has identified and documented this phenomenon already (Hatton et al., 1999; Hewitt, 2008; Jenkins & Allen, 1998), the current study adds additional context by framing the relationship between DSPs and the agency administration within recognition theory. While the importance of recognition related concepts has been heavily reviewed within the context of the client/DSP relationship, recognition between DSP and agency administration is of equal importance. This is most clearly seen in two of the narratives arising from the post-sort interviews dealing with issues of policy and a perceived disconnect between the realities of direct-care work and how administrators viewed it. As was detailed in Chapter 5, individual DSPs from both agencies had conflicting views about the “level of recognition” administrators had for DSPs and the work that they did. For a majority of DSPs in this sample, the level of recognition they attributed to their administrators was high, meaning they felt administrators were well-informed of the day-to-day routines they engaged in, saw DSPs as having value, were responsive to programmatic or individual client concerns, and were readily accessible as a resource. However, other DSPs within these same two agencies held a contradictory view of their administrators. These DSPs described their administrators as out of touch with the realities of direct care work, not having

substantive knowledge about individual clients, and were unresponsive or even dismissive of DSP concerns.

This outcome would seem to speak to a breakdown in communication and understanding between certain programs and the administrators that support them. In terms of DSP practice, this disconnect seemed to influence not only a DSP's ability to do their day-to-day routines, but also their morale in a negative fashion. From an agency, programmatic, and DSP practice perspective, identifying and mediating these types of disconnects is of the utmost importance. It also speaks to the influence agency policy and administrators can have on direct level service provision. Clearly, DSP practice behavior does not operate in a vacuum, but is an amalgamation of environmental, cultural, and personal mechanisms and needs to be treated as such.

Finally, one of the main objectives of this study was to determine how DSP practice behaviors were influenced by a wide variety of generative mechanisms, and specifically how recognition and its related concepts might influence their use of discretion. From the DSPs interactions with this study's concourse, the wide range of influences that the six generative areas have becomes readily apparent. While there were consistent patterns supported by the post-interview narratives of how DSPs experienced certain mechanisms, there were also considerable differences. This also alludes to the possibility of mechanisms that were not an influence on a particular DSP becoming influential given the right personal or environmental circumstances. This further supports the need for ongoing training and methods to periodically check-in with DSPs to

insure they are instilling their day-to-day practice with actions and goals consistent with the goals of PCP and self-determination. In terms of recognition, the results from this study give a clear indication that while recognition theory is not a well-known or utilized theoretical framework within the ID/DD field, its concepts may already resonate strongly with how DSPs envision and carry out their work. This should speak to the potential benefits recognition theory has to offer the ID/DD field, not only at the direct practice level, but also its links between DSP/administrator relationships, and how envisioning PCPs through a recognition lens shows three critical areas to develop within each and every client to obtain the ultimate goal of what philosopher's call the good life (Honneth, 1995).

### **Implications for Agency Policy and Training**

As was detailed at the beginning of Chapter 5, the study also sought to address the question: What are the implications of the findings for the development of DSP training curricula and supportive resources focused on person-centered practices? Before we look to integrate the findings from this study into the broader policy and training climates of the ID/DD field, it will be useful to revisit some of the peer-reviewed literature on what is known about training for DSPs.

As noted in Chapter 2, the job duties of DSPs are complex, requiring specialized skills and knowledge (Hewitt & Larson, 1997). Currently, there is a level of agreement about the core content areas in which DSPs need to be fluent to succeed in their roles (Larson et al., 2007). However, training outcomes and the

successfulness of training on DSP practice and PCP outcomes is not well documented with research showing inconsistent results (Castle et al., 2007; Larson et al., 2007; van Oorsouw et al., 2009) as it relates to DSP retention and skill development. Further, there is no known research which examines training practices in relation to the larger environments in which they are completed (i.e. structural and cultural characteristics of agencies and group homes) and how they impact staff development and PCP outcomes.

Given this climate of existing knowledge, an important first step for any care provider agency is to establish a comprehensive evaluation process for their DSPs to determine if gaps in knowledge, skills, or values exist. The methodology presented within this study provides one possible way for agencies to evaluate their DSPs on an individual basis in a way which is both time efficient (the Q sort for this study took an average of 45 minutes to complete) and cost effective (i.e., the only materials needed are paper to place statements on). In the context of DSP evaluation, any agency could institute a pre and post Q sort routine which sees a new hire complete the Q sort after their initial two-week training period, again at their 90 day hire anniversary, and periodically there after (such as once a year or every six months). This type of classic longitudinal set up would not only allow for tracking changes in DSP views over time, but adheres to the conceptualization of DSP development presented here as a process which is likely to mature and change through individual growth within the context of their work environment.

A further benefit of using a Q sort approach in the context of DSP staff development and training is the self-reflective nature of the exercise and the



possibility of personal growth and empowerment from interacting with the concourse. As was noted in Chapter 4, prior research has shown that individuals participating in a Q sort may find the activity itself engaging and transformational as new aspects of a topic are brought forth for the individual to consider and can encourage new insight from the participant (Donner, 2001; Ellingsen et al., 2010). This was an observable outcome in the present study for several of the participants, who noted during the post sort interview that engaging with the concourse “opened their eyes” to new information with some taking away new useful knowledge about their role as a DSP.

Turning from staff evaluation to staff training, the current study provides tangible evidence for provider agencies and the ID/DD field as a whole to consider revamping the new hire training process to match up with the on-going process of learning that DSPs described, especially in relation to levels of recognition. While an overview of best practices in adult learning and an examination of the training best practices was not a focus of the current study, with the main phenomenon of interest on DSP decision-making on-the-job, it can be useful to take the results of this study and frame them into a potential training framework.

From the voices of the participants in Chapter 5, we saw a strong narrative supporting their on-the-job learning process as ongoing and linked to the specific clients they worked with. Another narrative specifically addressed the deficiencies DSPs saw in their agency based training, focusing on the curriculum being too general and not easily transferable to their specific clients and

programs. Given these responses, the following suggestions can be made for envisioning a different format for agency new hire training practices.

First, given the process oriented nature of DSP learning on-the-job and how recognition was described as being related to hands-on practice experiences with their clients, embedded longitudinal training would seem more in line with the realities of front-line work. This could consist of an ongoing training process that runs through a new employee's first 90 days which incorporates shorter more frequent training sessions, often within the program. This would benefit agencies in not having to find extended coverage for staff while in training. This also meets the criteria of being more heavily focused on the DSPs actual work environment and the clients that they support. This could be paired with a mentoring process, having more experienced DSPs acting as a support and sounding board for new DSPs when faced with problems or concerns on-the-job. In addition, training materials that provoke critical thinking and reflection could encourage the development of recognition as it relates to their individual clients and people with disabilities as a whole. Interactive on-site training, with a focus on the values and principles behind PCP, would provide this type of experience with the added benefit of getting immediate feedback on their use of new material and information to problem solve as it relates to their program. A final consideration that impacts DSP training is the overarching culture that is present within the agency and whether it supports and values DSPs as unique individuals who are valued team members. This is necessary in light of the disconnection expressed

by multiple participants between themselves and the administration, which was framed as a lack of recognition for DSPs at the level of the organization.

### **Implications for Research**

Another area of consideration with regard to the implications of the study is continued research within the areas of DSP practice behavior and PCP outcomes. The latter research area has been identified by the peer-reviewed literature as an ongoing critical need for the ID/DD field (Taylor & Taylor, 2014). As was discussed in the Chapter 2, attempts to accurately assess the outcomes of individual PCPs and their relationship with quality of life have proven difficult. From a critical realist perspective, this ongoing challenge of trying to effectively measure the link between a PCP plan, DSP implementation of the plan, and client outcomes is unsurprising due to the multiple generative mechanisms at work within a group home setting. Given the highly individualistic nature of PCPs and the uniqueness of each program in which they are implemented, broad empirical studies would seem an inappropriate way to address the question of quality. As noted in the literature review in Chapter 2, large scale studies addressing PCP outcomes are inherently problematic due to the lack of commensurability between individual plans and how they are implemented within and across different support agencies.

A critical realist perspective can anticipate these empirical problems by noting that the outcome of any individual PCP is not something that can be measured as unique and quantifiable events, but is rather a unique process governed by multiple generative mechanisms at the micro, mezzo, and macro

levels of the social environment. The ID/DD field may in turn find it more productive to focus on understanding this process of PCP implementation. Future research could benefit this specific area by trying to further observe, document and describe how these generative mechanisms (e.g., DSP levels of recognition, group home culture, self-referential thinking, paternalistic thought, agency policy, and agency resources) come to impact a wide variety of programmatic settings.

Another area of consideration for the results of this study and its implications for research is the proposed theoretical framework explaining DSP decision-making and its generalizability to other similar areas of direct practice, such as community living supports for individuals with serious mental illness and direct practice level social workers. Critical realism supports this notion that the generative mechanisms found in the DSP/client relationships could be salient and active influences in a wide variety of settings. These fields and others could benefit from pursuing a similar line of inquiry into the use of discretion at the front line and the mechanisms that influence practice decision-making. The methodological framework incorporated in the current study is readily transferable to many other fields with the only necessary change being the development of a discourse that sufficiently describes and represents the realities of front-line for the group being studied.

### **Implications for the field of Social Work**

Applying the results and conclusions of this study into the broader context of the social work profession, there are several crucial intersections that relate to the area of direct practice. As previously discussed in relation to front-line work

with people with intellectual and developmental disabilities, the use of discretion is a large part of working with and supporting individuals in a range of settings. Social workers have already been identified by theorists and researchers as street-level bureaucrats in a variety of direct practice positions and the influence of their discretion can have both positive and negative impacts on client outcomes.

The core of the discretion of DSPs and social workers is the same; both need to use their judgment (predicated on previous experience, training, education, supports, and resources) to make decisions about other people. However, social workers, given the diverse nature of direct practice settings and clients, may have a more complex puzzle to solve than the one posed to DSPs and their administrators in deciding how to carry out PCPs. The framing concepts for solving this puzzle, as with DSPs, is often the professional values of the social work profession and the policies of the specific field and agency in which they work. A major outcome of this study was the finding that while DSPs in this sample did have a consistent value set across all five factors guiding their daily practice, how it was operationalized and put into practice was unique and also context and resource dependent. It is likely that social workers have a similar relationship with their professional values and how they are operationalized and put into practice. From a critical realist standpoint this is to be anticipated as the generative mechanisms at work in the process of on-the-job decision making and discretion identified in this study are likely similar to those in other human service areas. It follows logically then, that direct practice social workers could benefit from participating in a similar Q-sort activity to help raise their self-awareness of

how they utilize their discretion on-the-job. From an agency or management perspective this could also lead to similar outcomes, as presented in the current study, ensuring practitioners are utilizing their discretion in a way that lines up with agency policy and social work values. In addition, it would allow administrators a further opportunity to locate sites or positions that are lacking the resources needed to effectively carry out their jobs.

In terms of social work training and pedagogy, the Q sort activity could be used in a manner that allows social workers to critically reflect on the importance they place on the core social work values. As noted by several DSPs in the current study, the process of interacting with a concourse allowed them to gain additional insight into the work that they perform, with some walking away with a different view of certain aspects of their work. As was discussed through the street-level bureaucracy literature, policies, rules, and values are not self-enacting entities, but are only and ever realized in the context of individual and group human behavior. Q method and the Q sort process may have much to offer social workers as a way of having them critically reflect on how they subjectively about the values of social work and how that in turn may influence their generalist and advanced practice frameworks.

## **Conclusion**

The purpose of this dissertation was to explore how DSPs make decisions on-the-job and what types of generative mechanisms influence their work. While previous research has used semi-structured interviews and observational studies, there have been no previous studies which allow DSPs to consider all of the

identified mechanisms that concurrently and self-referentially determine the impact of each on their daily work routines and use of discretion. Through the use of Q methodology and a Fisherian concourse design, this study shows one potential way of gaining insight into the factors that influence DSP daily practice at any agency and within any program.

Overall, the theoretical framework, methodology, and findings of this research highlight the critical need to envision PCPs and their implementation as a process generated by various mechanisms at the micro, mezzo and macro levels which culminates in the DSP/client relationship. Five factors arose from the qualitative and quantitative analysis that reflect how DSPs manage their discretion on the job in the context of PCP (Factors 1, 3 and 4) and how structural level mechanisms (Factors 2 and 5) can hinder DSPs ability to do their work. Recognition theory and its operationalization of recognition into three areas of self, rights, and community worth was found to resonate strongly with most DSPs that participated in this study and could be a theoretical tool useful to adding context and philosophical grounding for the implementation of PCP. Substantial support for viewing DSPs as street-level bureaucrats was also found, adding insight into to how policy at the macro level is interpreted by groups of program staff at the mezzo level and put into practice at the micro level of DSP to client interaction.

## APPENDIX A

### Interview guide for Direct Support Professionals (Concourse development)

Two of the main goals DSPs have in supporting the people they work with are: 1) facilitating independence; and 2) providing them with the care they need. In your opinion, what parts of your job pertain to each area?

At what times do you have to make choices to do one or the other?

How do you decide what to do in these situations?

People with disabilities are said to have the same rights as “typical” individuals. Describe the ways in which the people you work with express their rights.

**(Recognition)**

Do you ever help them express their rights? How so? Describe [give examples]

**(Recognition)**

Describe situations during your work make it hard for you to help assist the individuals you work with to express their rights? Why? **(Recognition)**

What roles do the individuals you work with play within their community?

**(Recognition)**

How have you assisted them to take part in their community? **(Recognition)**

What challenges have you faced when taking the people you support into the community? **(Recognition)**

Should the people you support play a bigger role in their community? Why or why not? **(Recognition)**

Tell me of a time when you made a choice for an individual you support because it is what you would have wanted or wanted to have done for you in a similar situation? **(Self-referential)**[clarify?]

How often do you make these kinds of choices? In what situations? **(Self-referential)**

Tell me of a time when an individual wasn’t able to make a choice for themselves and how you handled it? **(Paternalism)**

How often are the people you support unable to make choices for themselves? **(Paternalism)**

Do you believe the people you support can make all their choices by themselves? Why or why not? **(Paternalism)**



Describe a time [? Or did you want a generalization?] an individual wanted to make a choice that you considered “bad” for them? (**Paternalism**)

How did you handle that situation? (**Paternalism**)

Should the individuals you support be able to take risks? Why or why not? (**Paternalism**)

What are the circumstances when you have let someone you support take a risk? (**Paternalism**)

Would you do it again? Why or why not? (**Paternalism**)

Tell me of a time when you had to do something an individual didn’t want to do because of your agencies policies and procedures? (**Policy**)

When and where do these occasions arise? Why? (**Policy**)

What does “person-centered” services mean to you? (**Policy**)

In what situations is it difficult to maintain person-centered services? Why? (**Policy**)

Tell me of a time when you couldn’t help an individual do what they wanted because of a lack of resources at your program (staffing, vehicles, funding)? (**Resources**)

How do you handle those situations? (**Resources**)

How often does a lack of resources impact your ability to do your job? (**Resources**)

Describe routines established in your house that go against agency policy and procedure? (**Culture**)

If, so why do things have to be done that way? (**Culture**)

Describe some ways you were trained by peers or coworkers to deal with specific clients (**Culture**)

Describe some ways you have trained new staff to work with specific individuals (**Culture**)

Does the program you currently work at have a specific way of handling any individuals or circumstances that makes your job less stressful? (**Culture**)

How have the trainings [specify] you have received helped you to do your job? (**Resources**)

Is there any additional training you would like? If so, what about? (**Resources**)

What is the most difficult part of your job? Why? (**Culture**)

In what ways has your manager tried to assist you with these difficult tasks?  
(**Culture**)

What are the most difficult decisions you have to make? Why?

How do you think you are most helpful to the people you support?

Are there areas you wish you could improve on?

Are there any other things that you would like to add that we haven't talked about?

## APPENDIX B

### Demographic information sheet and participant instructions

- 1) Gender:                    \_\_\_\_M    \_\_\_\_F
  
- 2) Ethnicity:(Check  
     one] \_\_\_\_Black\_\_\_\_White\_\_\_\_Hispanic/Latino\_\_\_\_Native American  
                                  \_\_\_\_Asian\_\_\_\_Multiracial  
     Other:\_\_\_\_\_
  
- 3) Current educational level:  
     \_\_\_\_High school/GED\_\_\_\_Some College\_\_\_\_Bachelor's degree  
     \_\_\_\_Master's degree or higher
  
- 4) How long have you worked as a Direct Support Professional in the area of  
     developmental disabilities:  
                                  \_\_\_\_Months\_\_\_\_Years
  
- 5) Have you ever taken courses on the Online College of Direct Support:  
                                  \_\_\_\_Yes\_\_\_\_No
  
- 6) On a scale of 1 to 10, with 10 being very challenging and 1 being very easy,  
     how difficult, overall, are the clients that you CURRENTLY work with?  
     \_\_\_\_\_

**Q Sort Instructions:** Please sort the statements provided from those that are most like (+4) how you make decisions while working within your program to most unlike (-4) how you make decisions at your program.

1. Read through all 48 cards to become familiar with the statements.
2. As you read through the statements for a second time, organize them into three piles:
  - i. On the right of diagram, place the cards that represent the statements that are most like how you make decisions

- ii. On the left of the diagram, place the cards that represent statements that are most unlike how you make decisions
  - iii. In the middle, place the cards that you feel less certain about.
3. Beginning with the pile on the right, place the **two cards** that you **most agree** with under the **+4** marker.
  4. Now, turning to your left side, place the **two cards** that you **disagree with the most** under the **-4** marker.
  5. Continue this process until all the cards are placed. You are free to change your mind during the sorting process and switch items around.
  6. When complete, you should have the following number of cards under the following rows of the diagram:
    - You should have **2** cards under markers **+4** (most **agree**) and **-4** (most **disagree**)
    - You should have **3** cards under the markers **+3** (most **agree**) and **-3** (most **disagree**)
    - You should have **5** cards under the markers **+2** (**agree**) and **-2** (**disagree**)
    - You should have **6** cards under the markers **+1** (slightly **agree**) and **-1** (slightly **disagree**)
    - You should have **8** cards under the marker **0** (**neutral, or not influential to how I make decisions on the job**)

### **KEEP YOUR CARDS DISPLAYED**

Once you have completed this exercise please inform the facilitator and answer the follow up questions.

## APPENDIX C

### Post Q-Sort Follow-up Questions

Participants will now be asked to elaborate on their point of view, especially in regards to the statements made on each pole, or those that were most salient. Finally, participants will be asked a series of questions regarding the decisions they made in performing the Q sorts and why they sorted the Q sample the way they did. Follow up questions will include (but not limited to):

- 1) Briefly describe your reasons for choosing the statements with which you placed in the “most like” (+4) category [might have them give specific examples?]
- 2) Briefly describe your reasons for choosing the statements with which you placed in the “most unlike” (-4) category [specific examples?]
- 3) Were there other statements that you had difficulty placing? If so, please specify which ones and describe why it was difficult to place them.
- 4) Are there any statements missing that you would have like to have seen in the sorting process? If so, what would the card have said? Where would you have placed it?
- 5) What is the hardest part of your job?
- 6) When do you feel it is most difficult to make decisions as a DSP?
- 7) If you could change one thing to make your job easier, what would it be?
- 8) Describe what you think are the most important parts of your job as a DSP

- 9) What do you think is most important for you as a DSP: To increase independence or provide good care? Why?

## APPENDIX D

### Final Concourse with Theoretical Areas

#### Issues of Recognition/Misrecognition

##### Autonomy Statements

- 1.) In this kind of work, it is necessary to advocate for your client because I have seen many examples of the people I support being “left out”. They are treated as if they are not able to do certain things, which limits their independence. **(6)**
- 2.) My caregiving experience has changed my views on what the people I support (changed from client) are capable of doing. I now see them as more like me than different from me. **(34)**
- 3.) As a direct care worker, I always try to do my work in a way that respects the human dignity and uniqueness of the people I support, recognizing each person’s value, and help others to understand the individual’s value. **(14)**
- 4.) When I am working, I am always aware that the people I support should have the opportunity to take risks and make bad decisions just like everyone else. **(30)**

##### Care Statements

- 1.) The more I have gotten to know the clients I work with, the better I understand how to care for them in a way that is respectful and gives them dignity. **(13)**
- 2.) I feel it is important not to let your personal factors (like culture and religion) to influence how you work with and care for the clients. As staff, we should leave those things at the door. **(35)**
- 3.) I see the work I do as a commitment to caring for the people I support, with all things I do at work flowing from this commitment. **(16)**
- 4.) My caregiving experience has taught me that all people share a common humanity, but also have individual differences. Being aware of this influences the work I do every day. **(33)**

#### Self-Referential Decision-making

##### Autonomy Statements

- 1.) I try to help my clients be more independent by using myself and my experiences as an example, meaning I get them to understand how I would handle a decision they are facing. **(37)**
- 2.) Often at work when a client has a difficult decision to make, I take a moment to think, “What would I do in this situation?” This helps me work with the client to solve the issue. **(12)**
- 3.) When helping a client make decisions, I find it useful to talk about my values with the client so that they can make an informed choice. **(41)**
- 4.) My religion and/or culture play an important role with helping me make decisions and do this kind of work the best way possible. **(11)**

#### Care Statements

- 1.) I feel like it is best to treat the clients the way I would want to be treated by somebody else if I was in their shoes. **(36)**
- 2.) I try to be a constant role model for my clients so that they know how to behave, act, and do things the appropriate way. **(17)**
- 3.) When trying to come up with activities or things to do with the clients, I will often introduce them to the things I like to do to get them to try new things. **(20)**
- 4.) I take lots of pride in my work because my religion and/or culture recognizes helping others as important work. **(47)**

#### **Paternalistic Thinking**

##### Autonomy Statements

- 1.) I feel that my clients have the same right as anybody to make their own choices, but if a client can’t quite understand certain things, I don’t know how they can be expected to make a good choice. **(32)**
- 2.) My role as a staff person is to provide guidance to the people I support because the clients cannot be expected to always make the right choice. **(7)**
- 3.) In my experience, my clients need a lot of help with the “big” decisions, but they should still handle the small everyday choices like what clothes to wear. **(31)**



- 4.) In my experience, independence is a client's ability to take care of everyday responsibilities. If a client still relies on staff for everyday things they are not independent. **(10)**

#### Care Statements

- 1.) In my experience, it is necessary to understand and do what is best for a client to insure their health and safety even if they disagree with what I decide. **(21)**
- 2.) In my role as a direct care worker, my work boils down to being in charge of other people's lives by making sure they are kept safe **(9)**
- 3.) I feel that as a staff person I am a protector, caretaker, and a person who knows best what a client needs. **(46)**
- 4.) It is necessary in this line of work to remember that as staff I need to be respected by the clients and that I have the final say in situations where a client and I disagree. **(8)**

#### **State/Agency Policy**

#### Autonomy Statements

- 1.) I make decisions at work according to my agency's policies, with my primary goal to make my clients as independent as possible. **(44)**
- 2.) In trying to allow my client's to be as independent as possible, I have to walk a fine line between respecting their choices and what my agency expects of me. **(39)**
- 3.) I feel my role is to support each individual in realizing their choices by respecting, honoring and advocating for their choices. **(24)**
- 4.) As a staff person, it is expected that I try to change the minds of individuals I work with when they want to do something that is against agency policy or procedure. **(19)**

#### Care Statements

- 1.) I feel like I know my clients better than the "higher-ups" and often agency policies and regulations make it difficult for me to do what is best for the client. **(26)**
- 2.) According to my agency's policies, my primary goal is to keep my clients safe, healthy, and help them avoid risky situations. **(5)**

- 3.) I feel a client's right to make their own decisions is a key part of my work, but at times it needs to be restricted to keep them safe and to manage risky situations **(3)**
- 4.) In my work, I often refer to my clients IHPs to better understand them and know how to provide an appropriate level of care. **(38)**

### **Agency Support and Resources**

#### Autonomy Statements

- 1.) In my experience, it can be difficult to do the things my clients want to do because we have to get approval from management. **(23)**
- 2.) I feel that my agency does a good job of making sure we have the things we need to allow the individuals to do the things they want to do. **(18)**
- 3.) Something that makes my job difficult are agency problems like staff turnover, lack of access to transportation, and funds for activities. These things affect my ability to increase my clients' level of independence. **(25)**
- 4.) I often rely on the training I have received to help me understand what my clients want and need. This allows me to understand them at a deeper level and increase their independence. **(42)**

#### Care Statements

- 1.) In my experience, it can be difficult to provide care to the people I support the way it should be done because there is a lack of resources (staffing, funds, transportation) from the "higher ups" **(2)**
- 2.) Client centered services is a great idea, but I feel that the reality of the work I do makes it difficult to actually do it the way it should be done. **(29)**
- 3.) My agency has provided training which helps me do my work every day, allowing me to think on my feet and not second guess myself. **(28)**
- 4.) Through my agency's trainings, I feel I know how to appropriately supervise all of my clients according to their individual needs and IHPs. **(15)**

### **Group Home Culture**

#### Autonomy Statements

- 1.) I know that supporting someone to be more independent is ideal, however my coworkers and I have to be realistic about what these clients can do so we don't waste valuable time. **(45)**
- 2.) In my program we have a great awareness of what our clients want. Often, we know what choice they will make regardless of the options. **(43)**
- 3.) With all of the things to get done on my shift, my coworkers and I take care of most of it ourselves, letting the clients assist us or do things on their own if there is time. **(48)**
- 4.) In my program we have certain clients we can "trust" more than others. These clients have an opportunity to take certain risks because they have proven they can handle the responsibility. **(40)**

#### Care Statements

- 1.) The program where I work has developed a good routine to get the work done that needs to get done while making sure the clients are getting the care they need **(1)**
- 2.) In my experience, to get the everyday requirements of the job completed, my coworkers and I have to be flexible in areas where my agency seems inflexible. **(22)**
- 3.) At my program, when a policy or procedure is not helping the clients or interferes with the work getting done, we decide, "We're not going to do it that way" and come up with a solution that works best for our program and clients. **(27)**
- 4.) I feel that at my program we have a good handle on getting are work done, at its core is about doing a ordered set of tasks and we have a system to make sure it all gets done. **(4)**

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