Choice, Ideology & the Challenges of Applying Social Role Valorization in Mental Health Work

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This article emerges from a series of conversations between two author practitioners: one an author/practitioner/senior trainer in Social Role Valorization and person-centred responses, and the other, an engaged scholar/practitioner in community development, with a particular interest in the fields of disability and mental health. Working together for 15 years, we share an interest in the liberation of devalued people, and the promotion of people as the architects of their own lives. Much of this work occurs in what Donald Schön refers to as the 'swampy lowlands' of professional practice. Schön argues that unlike work in the 'hard' rational sciences, working with people means that problems are crucially important but also messy, confusing and incapable of technical solutions (Schön, 1995, 28). The ongoing challenge is to find ideas, frameworks and theories that help practitioners to navigate this complex terrain. The article is necessarily theoretical. However, for us, the theories become more accessible by exploring their application to practice and by paying particular attention to places of resistance and unease for practitioners. We use the word 'practitioners' inclusively and in a spirit of solidarity, to refer to people with a lived experience of disability which includes those with mental health issues, their family members, their allies, and paid service workers who are engaged in this struggle for a life filled with meaning, purpose and a sense of belonging.

In problematizing the relationship between theory and practice, we are conscious of Westoby and Kaplan's qualification that

> *Practice informs theory, but is also informed by it, and in this way, there is a constant sense of practice being 'tested out' and 'applied' in a process that is 'forever evolving'. Practice, in this usage, is taken to mean that which is understood as 'skilful means' that is constantly altering, exercised and rehearsed with a view to improvement. (Westoby & Kaplan, 2014, 214)*

The article proceeds by checking assumptions about SRV, naming the key dilemmas emerging from a consideration of SRV and work with people with mental health issues, and then exploring both the potential and limitations of the application of SRV to the field. It concludes with a summary of the key insights. The article is deliberately written in a dialogical style to capture this sense of a dynamic and evolving, messy, yet crucially important terrain.

Lynda: Jane, let me spend some time outlining the assumptions I bring to this dialogue so you can make sense of where I am coming from. Then I will pose the key challenges I am wrestling with and invite your response.

Over the last fifteen years, in my work alongside people living with heightened vulnerability, their

families and allies, and the services seeking to support them, I have found the theory of Social Role Valorization (SRV) particularly illuminating and useful. Although it has always been a contentious theory (see for example, Wolfensberger, 1995), it is in the field of mental health–the field in which I am currently engaged–that I have found the most struggle and resistance to its application. In this discussion, I seek to explore with you–if not resolve–the tensions of applying SRV in efforts to support people with mental health issues. Although mental health is my focus, other fields of practice will be relevant and possibly helpful in this discussion. Before jumping into these tensions, let me outline some of my starting assumptions and invite your clarification.

I understand SRV to be a meta-theory, meaning that it draws together a range of social theories including social perception, semiotics, labeling theory, role theory, the developmental model, expectations and self-fulfilling prophecy, and the issue of personal competency enhancement (Lemay, 1995). Through this rich pedigree, SRV emerges as both a tool for social analysis and a practical process for intervention. The origins and the main application of SRV theory lie in disability and in particular, intellectual disability (Lemay, 1995; Wolfensberger, 1998). The theory has been applied to other fields of practice, including with older people (Schultz, 2004; Stirling, 2010), people requiring palliative care (Sinclair, 2007), and asylum seekers (McDougall & Fletcher, 2002). SRV has been utilized with regard to the experience of children with disabilities in schools (Mann, 2012), residential environments (Burchard, 1999) and employment arrangements (Sandys, 2009). SRV has also been utilized to deepen the understanding and practice of social inclusion (Lemay, 2006; Sherwin, 2011).

What SRV offers to all of these fields is an explanation of the process of social devaluation, that is, how people with certain characteristics and identities are routinely and systematically marginalized and 'wounded' (Wolfensberger 1998, p. 12). However, SRV does more than this. It also provides a set of ideas and strategies to counter this wounding. Proponents of SRV argue that as a tool of social intervention, SRV has the potential to help people who have been devalued by society to gain greater access to the good things of life (such as higher status, positive regard, relationships, a home, the experiences of contribution and belonging to community life) and to be spared at least some negative effects of social devaluation. It does so through the "enablement, establishment, enhancement, maintenance and/or defence of valued social roles for people, particularly for those at value risk, by using as much as possible culturally valued means" (Wolfensberger, 1992, 21).

The notion of 'culturally valued means' reminds me that there seem to be several sticking points that I would welcome your feedback on, my friend.

As a starting place I am thinking about one of the central tenets of SRV. The theory asserts that the more different one is from the norm, the more likely one is to experience the impacts of social devaluation. Thus people who speak differently, or dress unlike others, or who have a different body shape, or who don't think or act the same way that most other people do, become targets for social exclusion, hostility, harm and an ongoing cycle of social rejection. Or, to posit the converse, if people have culturally valued roles in the community–which includes looking, sounding and acting more like what we think is typical–then they are more likely to escape devalued roles and receive the good things in life (Thomas & Wolfensberger, 1999). Although proponents have always been clear that SRV 'emphasize[s] both capitalizing upon cultural values and the need to change at least some of them' (Wolfensberger, 1995, 366), what seems not to be up for grabs is the idea that central cultural norms are referenced; for example, to have a job, to live in a typical kind of home, to have family and friends, to dress in particular ways, and to live a certain kind of lifestyle (Burton; 1983, Chappell; 1992,

Bleasdale, 1996). Yet some of the people I've chatted with who live with mental health challenges are very clear about their preferences. They live in the way they have chosen, they prize their individuality and unique perspective on life, and they don't think their lives should be dictated by greater society and what others might deem to be 'normal.' One of the critiques that I hear about SRV is that it's all about promoting middle class values and doesn't respect diversity and difference. To put it another way, 'who defines what is normal, and in whose interest are such cultural norms promoted and maintained? And why should we pay that any attention?'

Jane: Thank you so much, Lynda, for the opportunity to have this conversation with you. Yes, they are questions that often arise, and not just around people with mental health issues–it will be great to explore them.

There are some key words you mention: normal, cultural norms and values. Let's begin by briefly considering your first question about 'who defines what's normal.' Normal is a problematic word–it is a value-laden expression and is made additionally complex by SRV being grounded historically in normalisation theory (see Flynn and Lemay, 1999, for a rich discussion on the relationship between normalization and SRV). One of the ways that SRV leads us to think about 'normal' is to think about those things in our society regarded as typical or usual. So a 'normal' life would be thought about as a life path, a pattern of life circumstances and lifestyles that are usual, depending on age, gender and culture, and which are typically taken for granted. These would be considered cultural norms.

In answer to your question about who defines what is valued, it is the more powerful groups in society that define not only what is valued, but also what is desirable. It is in their own tribal, economic and identity interests that such norms are promoted and maintained. By 'tribal' and 'identity interests,' I mean that as humans, we work out who we are by who we are not, thus perpetuating the 'thems' and the 'us' by instigating circumstances that keep the thems as thems (Hewstone, Rubin *&* Willis, 2002). In terms of economic interests, great numbers of people now make their living out of the existence of people with a devalued status by, for example, working with them or building facilities for them.

I wonder whether, before we further explore the questions you have posed, we might touch base with the societal dynamic that is foundational for understanding and applying SRV, and which you mention: social devaluation. A key point to make here is that it is only if the difference is valued negatively by the more powerful groups in society, that the people are more likely to be subjected to harmful responses from citizens and society at large. A difference like wearing glasses is not negatively valued, and therefore does not lead to devaluation. In part, this is because wearing glasses is not, by and large, contrary to any values of a Western culture. In contrast, differences like hearing voices or having compulsive behaviors are negatively valued. In short, no one with a positively valued status entertains wishes for difficulties with psychological wellbeing.

Lynda: That makes sense, Jane, and there is a lot of evidence outside of the SRV literature about how negatively valued mental illness is. While disclosure of mental health issues is increasing (Reavley *&* Jorm, 2014), there are still significant negative repercussions of being identified with mental illness. The 2013 study by the Mental Health Council Australia reveals that only a third of people with a current or past mental illness have disclosed it to their current employer, and that 22% of people surveyed report having experienced or observed discrimination against someone with a mental illness in a place where they have worked (Morrison, 2013). The social devaluation of mental health issues can be seen clearly in the reluctance of

people to admit publicly to their own mental health struggles.

Jane: Yes indeed. Understanding the dynamic of devaluation leads us to consider why it is that people with mental health issues are particularly vulnerable to shunning, stigma and discrimination. This is one place where values come into play. Western societies value things like independence, attractiveness, financial wellbeing, employment, economic participation (for example, purchasing items or contributing through taxes), education, thinking abilities, and acceptable social behaviour. Those people who have characteristics that do not reflect these western values are more likely to experience social devaluation and its impacts. The larger the number and the more severe the negatively valued characteristics are, the more vulnerable the people are likely to be.

For example, I'm reminded of a person I have met who, due to an old injury, walks with an odd gait. Poverty and poor nutrition have left him without his front teeth and he struggles to speak clearly. When people encounter a toothless man, mumbling and staggering towards them, they tend to move to the other side of the street or refuse him service in shops. Pain and reduced mobility make life difficult, but these other characteristics compound to greatly increase his isolation.

If we apply an understanding of this dynamic to the perception of and reactions to people with mental health issues, then some things become clearer. Consider someone whose mental health issues impair their thinking and behaviour, whose drugs have impaired the way they move, and where their capacity to look after themselves and to contribute to society is lessened. Some of the things that are done to people with these characteristics include rejection, separation from ordinary life through, say, living in some sort of group accommodation, and control by professionals in the mental health system. This person is also likely to experience a loss of roles: the role of student, employee, tenant and neighbour. For some, they even lose the roles of son or daughter and sibling. Some roles are stripped from people when they are rejected, like wage earner, club member, homemaker, and even voting citizen.

Some people are much more vulnerable than others. For example, those who might have a mental health issue but who are still working, or who do not look different from how they used to, are less vulnerable than the picture described above. Mind you, people with mental health issues who are still working have heightened vulnerability to losing their social status if they lose their job, and especially if they then lose their home.

The consequences of being perceived and judged negatively can be vast. Wolfensberger (1998) describes impacts such as: being equated to one's impairment, thus losing one's authentic identity; rejection by family, community and others; being marked in some way as negatively different; losing control of one's lifestyle decisions; being put into negative roles (known colloquially as stereotyping) like sick, menace and burden; being socially distanced from ordinary people and places and being congregated with others with whom one has nothing in common other than a shared diagnosis. In everyday parlance, this is understood as prejudice and marginalisation. What Wolfensberger has done is to articulate the forms that prejudice and marginalisation and their consequences can take. I wonder if the construct of social devaluation as I have explained it here, and its implications for people with mental health issues, resonate with your observations and conversations?

Lynda: Thanks, Jane, for engaging with me and for helping deepen the discussion. The issue of social devaluation is obviously at the heart of much of what we are discussing here. These ideas certainly resonate strongly. But if I can push us a little further, you make the point that if a difference is valued negatively by the more powerful groups in society, then the people are more likely

to be subjected to harmful responses from citizens and society at large. So this raises the question of who is considered powerful and how we know whether those characteristics are valued or not. For example, I can easily imagine someone saying 'But I'm white/educated/employed. I don't devalue people', or a worker proclaiming, 'Sure, some people would devalue that quality–but there are plenty of others who do not', or even, 'I treat everyone equally, it's what's under the skin that counts.'

Jane: I think what you are naming here is the denial of a societal pattern by finding exceptions to the pattern. It could even be an example of denying personal actions that are unconsciously devaluing. First, let's be clear that it is not the purpose of a theory to validate whether a person or group does or doesn't devalue others. However, the theme of 'unconsciousness' in SRV reminds us that there is merit in working towards consciousness about these matters, and being wary of assuming the moral high ground. For example, do our words match our actions? In what ways might there be disconfirming evidence? To what extent are we conscious of the range of influences in our lives in terms of our perceptions of certain groups of people, given that humans mostly absorb values and perceptions unconsciously? Is it possible that we consciously work to value one group yet remain unaware of our devaluing of another?

Lynda: OK, but even if we work towards consciousness, the issue of what is socially valued still sits there. I understand that we are referencing what is culturally normative, so therefore in Australia, a Western values perspective would be dominant. Obviously we are working with some pretty broad generalisations. But even within that space there are some practices where the shared social value is highly disputed. For example, the shaving of body hair for either men or women, tattooing and body piercing are good examples of practices that are normative and even desirable in certain sub-cultures, yet would not be seen as desirable by all. So what happens when a subculture values particular practices differently from the main culture? Cross-cultural examples are rich with tensions. Let me play the devil's advocate for a moment. If an Australian woman is Muslim and her religion and culture value modesty and deem the wearing of the hajib, chador or burka appropriate, then would SRV actually suggest that this is inappropriate as it subjects her to negative stereotypes and potential racism in broader Australia? Would it insist that she give up her cultural and religious practices just to fit in?

Jane: To answer this, we need to return to the tricky issue of what is considered 'valued.' SRV asks us to be 'cultural readers,' referring to what is typical in terms of age, gender and culture. This is because it is members of the culture who determine what is culturally normative. Think of a bell curve. Some actions and images are culturally normative because they occur frequently and are considered typical, such as having friends, family, interests, and a home. Others are highly positive, even if they are not very commonly seen, such as a bride wearing a wedding dress on her wedding day. On this bell curve are also actions and images that are perceived as negatively valued, for example, smelling offensively, having a body that doesn't look 'typical' such as through being badly burnt, or wearing a wedding dress to do the weekly shopping.

Not only does SRV lead us to consider cultural norms, but also the values of a subculture. If an individual wants to be valued within a subculture, then it is the values of the subculture that are the guiding values. For example, in a prison subculture, helping to move drugs around a prison could be valued by at least some prisoners but would not be valued in the broader community outside of prison.

The above prison example illustrates that one consideration depends on who you–or the person you are seeking to support–want to be per-

ceived positively by. To return to your example, if a woman wears a burka and wants to be valued by members of the burka-wearing community, then that acceptance is likely to happen. If she wants to be valued by the non-burka-wearing community, that is less likely to happen, unless there are other mitigating factors, such as people perceiving her to be highly competent in something and/or that people get to know her personally.

This way of understanding the application of SRV is very potent. SRV does not say what we 'should' or 'shouldn't' do. 'Shoulds' are in the realm of values and ideology. For example, I might personally believe that of course non-burka-wearing communities should welcome and accept all women who wear burkas, but that doesn't change our societal reality. In Australian society, as many Muslim women would attest, women wearing burkas are not as easily accepted by a Western community as someone who doesn't wear a burka.

Lynda: Thanks, Jane, this is helpful and I particularly like the phrase 'cultural readers.' What this tells us is that the degree to which the characteristics of a person or group are valued by a culture or a subculture will very likely affect the way they are treated by that culture or sub-culture. I'm reminded of numerous parent-adolescent conflicts that echo this dynamic, with the parent referencing broader social values, and the adolescent referencing their peer sub-culture. The parent knows that particular choices will bring rejection from wider society ('You'll never get a job looking like that!'), whereas the adolescent knows that conforming to mainstream values may actually result in social rejection from their peer group. So if the young person is keen to get a job in hospitality, the removal of facial jewellery prior to an interview would be a helpful strategy and mean that potential employers are more likely to see them–and treat them–positively (McElroy, Summers *&* Moore, 2014). However if this same young person is desperate to be accepted by the metal-core subculture, abundant piercings are 'scene currency' and will aid their transition (Rowe, 2012, 13). It is unlikely they will be successful at both of these ambitions. This means that there needs to be some trade-off or surrender of one set of values to the other. In turn, the right to choose needs to sit alongside an understanding of the consequences of that choice.

Jane: That's a good example, thanks. I especially like how you've raised the points about consequences of choices and the need for trade-offs, depending on what outcomes are desired.

I'd like to mention an additional complexity: the impact of repeated and long-term devaluation. For some, a dynamic is set up: they internalise the negative perceptions of the larger culture and have low expectations of themselves, and then justify the low expectations by rejecting wider societal values. This can lead to them eschewing roles and behaviours that are within what is culturally typical and valued; perhaps they prefer to be valued by those who do not reject them? In the example above, the young metal-core enthusiast might reject the idea of working for wages because they value more the opinions of fellow enthusiasts. Another example is highlighted in research by Runswick-Cole (2008) and Glenys Mann (2014) into why some parents choose the special school system. The research revealed that while parents might value the typical school system, they also value acceptance for their child, and they find acceptance in the segregated system. For people with mental health issues, they may find greater acceptance in groups of other people with mental health issues (see for example Shevellar, Sherwin *&* Barringham, 2014).

Lynda: What all of this demonstrates is how incredibly complex societal dynamics are, particularly when it comes to perception and values, and how devaluation and its impacts play out in human behaviour. Given this complexity, and if I can return to one of my opening concerns, how

do you see the issue of social values and class playing out in this dynamic? Is there any legitimacy to the claim that SRV promotes so-called 'middle-class' values?

Jane: Hmm, what is socially valued or devalued transcends class. For example, those who are poor or the working poor value having a home, safety, security, health and a positive future, just as the middle class do. If people, regardless of devaluing characteristics, want to be perceived positively by the wider community, then it is those values that inform what is culturally typical and valued.

Lynda: Thanks for that, Jane. So far we've wandered into the terrains of what is valued and who defines it, perception, consciousness, who people want to be perceived and accepted by, and shared societal values. What I'd like to do now is pursue another sticking point in applying SRV in mental health work: the tricky issues of choice and power.

There is a dominant ideology in our society that sees choice as freedom, and in the disability sector at least, equates autonomy with choice, privileging people's 'right' to choose. For example, if someone wants to be homeless, chooses not to bathe for a year or wants to wear pyjamas all day, then that is recognized as the person's choice and deserving of respect. And while there are some useful critiques of perversions of choice (see for example Armstrong, 2005), there is an ongoing challenge for work in mental health when support occurs for an adult rather than a child, for someone who doesn't have an intellectual impairment and whose illness may be episodic. 'Who am I to impose my values?' is an oft-heard cry in human services. The critique is that the implementation of SRV theory is paternalistic, and negates agency, free choice and the possibility of the individual negotiating his or her own subjectivities (Campbell, 1998).

Jane: Yes, it's not uncommon to hear that SRV denies people's choice, thereby taking away people's power. It's as if when people hear or read about SRV alerting us to people's vulnerabilities due to devaluation, they imagine that that means treading all over people's wishes. Relationships and dialogue are key. How we establish relationships with the people we support, and what those dialogues are, obviously are critical when trying to hold the tensions between respecting autonomy yet appreciating the vulnerabilities that people face due to devaluation. But let's return to the issue of choice.

Lynda: Perhaps an example will help ground our discussion? I am thinking of a woman in my network who has numerous mental health challenges; she hears voices, and her communication often makes little or no sense to people who do not know her well. She dresses oddly at times, such as wearing a ballet costume to a conference. People who work with her regularly, and know her and value her, will say to me that they understand her behaviour and communication. They observe that her dress choice is not random or weird, but is a deeply conscious act: the conference colours are reflected in the feathers on her exotic headpiece, or the word 'slip' in the conference title has led her to wear her ballet slippers. Her allies appreciate and respect the deeply symbolic level upon which she thinks and relates. They also wish that people would understand and respect her dress choices as being deliberate and thoughtful. This wish is understandable. However, holding this wish does not change the likely perception of her by other people. It is not typical dress and her choice is not valued in the context of a conference, where most people are strangers. The woman is therefore likely to be perceived as strange, and more likely to be avoided and rejected by others.

Jane: Great example, thanks, Lynda. And yes, an understanding of SRV guides us to forecast the likely consequences and to consider the person's vulnerability to further harm through being personally ostracised and through inequities at a societal level. This understanding of consequences is

a contribution of SRV theory and can be used to guide actions. SRV invites us to not simply hold good wishes for someone but to be mindful of working with the person to compensate for or reduce their vulnerabilities.

Lynda: Just to clarify further: if I want to reduce rejection for someone who has already had a difficult life and been hurt a great deal, then this will guide my actions. If I am supporting the woman in the ballet costume, I might respectfully steer her towards a compromise–honouring her symbolism but finding more socially acceptable expressions in her choice of dress, or guiding public and private expressions of her choices. (Perhaps I will ask if we can turn the feathers into a necklace, for example). Alternatively, if I believe that 'the right to choose' and the person's own wishes are all that matter, then I may elect not to intervene. This is ideology. It does not change the fact that there WILL be consequences.

Jane: Ah, you've returned to 'ideology.' Good. And you've made the distinction between a theory that guides our actions, and the ideology that guides whether we act or not.

Applying SRV theory is helpful only once the personal and/or organisational assumptions and beliefs have been brought to consciousness. These beliefs could be, for example, about choice and whether there is a belief that all choice is good choice. Other beliefs could be about whether people with mental health issues can only be treated through medication and in clinical environments, or whether they can ever live typical lives, including having a home and working other than in a sheltered environment. Yet another set of beliefs could be around the place of families and whether they are generally helpful or harmful to the wellbeing of an individual. What we believe sits in the realm of ideology. SRV is a theory–but whether we apply it is where ideology comes into play.

Lynda: The distinction between theory and ideology is useful. Believing that devaluation is wrong, wishing it was otherwise or holding counter-cultural beliefs will not alter the consequences. Or to put it plainly, having nice thoughts doesn't suddenly make the world a nicer place. The consequences of a choice exist regardless of what I believe.

Jane: That's a great summary, thanks.

Lynda: Another of the key critiques of SRV is that it fails to interrogate and challenge dominant or taken-for-granted ideas and simply settles for prevailing norms (Burton, 1983; Chappell, 1992; Bleasdale, 1996).

Jane: Are you suggesting that SRV does not seek to change dominant social values, such as the emphases our Western culture places on beauty and material possessions, and social norms such as dressing appropriately for work and leaving home when of adult age? If so, then I think that is accurate. If one wanted to challenge those values, then another theory would be helpful. But having acknowledged a limit to SRV theory (and understanding that all theories have limits), it is essential to recognize what SRV does offer in terms of societal change.

SRV has an emphasis on changing how people are perceived, through people being positively imaged and in valued social roles. Consequently, there are significant values and beliefs that SRV has challenged and has influenced. Beliefs such as 'people with mental illnesses belong in institutions' and 'older people are useless and a burden' are regularly challenged when people are supported into valued roles that lead to both community presence and social participation. That children with disabilities are worthless is a perception that has been challenged through the expectations of decent education and the success of students with disabilities in valued roles in regular schools. There have been significant world-wide policy changes, such that people

with mental health challenges can expect to live in community as tenants and neighbours. Older people are expected to work for longer and they themselves have hopes and expectations of remaining in their own homes.

SRV is particularly valuable as a theory to use when the intention is to change how people with negatively valued characteristics are perceived. For example, people with mental health issues are often stereotyped as dangerous to the public, burdensome to the economy and the health system, untrustworthy, unpredictable, and incompetent. There might be grains of truth for a minority, for example, some people with mental health issues are violent and many find it difficult to keep a job. However, the stereotypes are very unfair and unjust impressions of people. SRV gives us ways to identify those societal and human service practices that reinforce the pre-existing perceptions of people with mental health issues and to do something about them.

Lynda: That's a great point, Jane. At least in this respect, SRV theory aligns with other approaches to mental health, such as 'recovery' and the more recently named 'discovery' approaches (Scotti, 2009; Glover, 2014). All of these approaches seek a shift away from harmful stereotypes, and from other negative roles (such as patient, or menace) to a full and positive life as a full citizen in society. And these approaches honour the person's own history, context and aspirations.

So, following this argument, if people have negatively valued personal characteristics, then they are vulnerable to bad things happening to them (for example, understanding that a person who dresses quite oddly may leave them vulnerable to being ignored or mistreated by others). And if we wish to prevent further harm from occurring, then how do we know the right thing to do? If not adherence to some grand ideology, like 'the right to choose,' then what guides us in how best to act?

Jane: Working out how to respond to someone who seems to be making decisions that are likely to bring, for example, ostracism and low expectations, depends on how well one knows the person. 'Knowing' in an SRV sense particularly refers to how well one is able to discern the needs and the vulnerabilities of the person. This speaks to the challenge noted earlier: 'Who am I to impose my values?'. It is not about imposing my personal values. It is knowing what the person themselves needs and values deeply (such as home or friendships), alongside what society values and penalizes, and trying to hold any tension that might exist, while working through a respectful relationship, to enhance a person's life. The degree of influence I have in someone's life will depend on how well I know them, as well as what role I am in and how skilful I am in working through relationship. Our conversation is moving beyond simply understanding the theory to how we might apply the theory.

Considering the needs and vulnerabilities of an individual or group raises awareness that much more might be at stake for someone than the need to make choices. Depending on people's past experiences, their needs could include (but not be limited to) respect, reconnections to past friends, valued roles, acceptance, belonging, home, transport, purpose, contribution, and so on. Consider some of the needs that might compete with the need for choice. They are often needs for dignity and respect, such as when their own choice raises an image issue and the likelihood of rejection. The need to make choices can also compete with needs for physical wellness and purpose, such as when the choice is to stay in bed all day. It is possible that if we increase our emphasis on 'choice' because of our personal or organisational values without also being mindful of people's vulnerabilities, then we can cause harm in the areas of their other needs.

Recently it struck me that in human services, there is a lot of emphasis on duty of care. This is typically about someone's physical wellbeing:

'safety duty.' Most times there is no debate about whether to act when there is a risk to physical harm. Would it help to see a parallel 'duty' in our discussion? Perhaps we can see the issue that we're discussing as 'roles duty' (helping people maintain or develop valued roles and relationships), 'image duty' (so that observers make up their mind positively about the person or group) and 'competency duty' (so that skills can compensate for other things that are against them)?

Lynda: Responding to needs with the idea of 'roles duty' is intriguing. It also helps contextualise our treatment of risk and extend our understanding of preventing harm.

In doing so, what this discussion gives to me, as a practitioner, is a reminder to consider the larger social and cultural forces that surround us. Discussions of individual choice or individual behaviour stand alongside larger societal dynamics, which we can influence, but that also influence us in turn. We can never truly stand outside of these.

Jane: That's a succinct summary–thank you. In our practice, we tend to focus on the micro as if the macro context doesn't exist. We can still work closely connected to an individual, but we also need to appreciate that many dilemmas come from our societal context.

Perhaps to help us conclude I can offer a summary response to your initial queries? Firstly, we have established that it is the culture and the powerful or dominant groups within that culture that determine whether something is valued or not. This refers to both sub-cultures and dominant cultures; which values matter depends on who one wants to be perceived positively by.

Secondly, choices carry consequences. How well a person manages those consequences will differ depending on their overall vulnerabilities.

Thirdly, there are those situations where someone makes choices that actually heighten their vulnerabilities. Therefore, the following corollaries exist.

(a) An appreciation of the individual's needs and vulnerabilities is an essential starting point. This is not a deficit list but rather those things that, if met, would assist the person to live well and access the good things in life that others take for granted (Sherwin, 2014).

(b) 'Taking away people's choices' is a common critique yet a misinterpretation of SRV theory. Any action is mediated through the relationship. Precisely what happens within the dialogue is outside of SRV theory. Explorations of power-with rather than power-over dialogues, such as work by Kendrick (2000) on 'right relationship,' is very relevant. I am also reminded of comments from our colleague, Neil Barringham, who is so experienced in this area. He said, 'In my mind (as a community worker), one can take the analysis that SRV informs and then ask–how might I dialogue this with the people concerned? It is in this dialogic process that I see emancipation, agency and empowerment happening' (2014).

(c) If someone has no cognitive impairment, then for example, the amount of influence by a worker could be limited to providing information and helping the person forecast the consequences of their decision. On the other hand, if someone has cognitive challenges through being drug affected or having an intellectual or decision-making impairment, then the type of guidance and influence could be greater. This is explained in an SRV theme called the conservatism corollary (Wolfensberger, 1998, 124-127).

SRV invites us into a space where we understand vulnerabilities and hold the tension between competing and complex needs. It is not an easy space to be in, yet is vital if we are to do ethical and helpful work.

Lynda, thank you so much for this interesting conversation. I hope it has been illuminating, and hope others find it informative too. ☙

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