

Perfect etiquette

On diplomatically arguing with members

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Abstract

As a starting point for this article, the concept of diplomatic ethnography inspired by the work of Bruno Latour is presented as an ideal: a model for ‘good anthropology’, which truthfully follows members’ actions and the associations they form with others, simultaneously respecting their values. The workability of this ideal is then ethnographically tested in a research setting where direct communication with actors about the results of the researcher’s work is inescapable, while arriving at a common description of networks and values is difficult, as one group of actors routinely disqualifies members of another group by including them in the strongly naturalised category of ‘people with mental impairment’. How to understand and interpret the life of Pete, a resident of a ‘home for persons with health impairment’, who strives to rein in his hearty appetite while those taking care of him describe him as a ‘wicked child’ whose actions reflect only his syndrome? On the basis of my negotiations about his case, I come to the conclusion that the project of diplomatic ethnography is viable, if the obduracy of the ordering arrangements is duly taken into account and values are honoured, and, while arguing with members is inevitable under given circumstances, it is potentially productive for envisioning change in existing modes of ordering.

Keywords

diplomatic ethnography, modes of ordering, dis/ability, relational theory of care, residential social services, Prader-Willi syndrome



Serving food in a residential institution. The place and the person in the picture have no direct connection to the places and people described in the article. Copyright: Petr Králík; used with permission.

Speaking well: Describing networks, respecting values

In my research in residential institutions called ‘homes for persons with health impairment’,¹ I try to follow Bruno Latour’s (2013, 46) maxim that to do good ethnography means to ‘speak well to someone about something that really matters to that person’. But what exactly does this mean in a setting where many of the important actors have limited opportunity to voice their matters of concern, while their actions, according to others around them, make

¹ The phrase in the quotation marks is the official name of the social service offered by the institutions where I conducted research for this article. While some ‘homes for persons with health impairment’ offer services to people with so-called physical impairment, a necessary condition for admission into most of them is a diagnosis of ‘mental impairment’. The Czech equivalent of the term ‘mental impairment’ (*mentální postižení*) is still used in the official discourse of Czech social services and the corresponding medical diagnosis is called ‘mental retardation’, but various other labels are used as well, including ‘mental disability’, ‘mental handicap’, and ‘learning difficulties’, a term preferred by some participants in international and Czech advocacy and self-advocacy movements. In this article, I use emic terms where I quote or paraphrase member accounts, while when talking about modes of ordering I write ‘disability’ as ‘dis/ability’, with a slash, to deconstruct the seemingly self-evident dividing line between disabled and nondisabled, as has been done for example by Ingunn Moser and John Law (1999) and more recently by Dan Goodley (2014).

no sense at all? Doesn't insistence on 'speaking well' make impossible any project aimed at creating space for hearing the voices of people identified as incapable of relating a meaningful account of their actions, needs, and worries? Is not 'arguing with members'² – a vice rejected by ethnomethodologists and mocked as an arrogant habit of critical sociologists (Gubrium and Holstein 2012; Latour 2013) – in fact the only appropriate tool for research done in such situations? And, if that is the case, could it be done diplomatically? These are the questions I would like to assay in this text, where the methodological advice to 'speak well' is put to the test by ethnography and writing. But before I start to examine its workability and convenience by bathing it in the *aqua regia* of practice, let me explain what I understand by 'speaking well' to someone about important matters of concern.

First, according to Latour (2013, 46), a good ethnographer cannot rely on 'resources of critical distance', which means that 'she knows that a contemporary anthropologist has to learn to talk *about* her subjects of study *to* her subjects of study'.³ While this maxim only mentions 'speaking', both listening and talking are at stake. Whatever the language of the communication – listening is in fact often described as 'following' (Latour 2005) and reporting could be done by many different means (Latour 2005, 123, n172) – ethnography (or anthropology, or sociology, the name hardly matters here) is first and foremost a situation of mutual exchange, a negotiation, a work being done together. The ethnographer, if she is serious about what she is doing, could not presume to lecture actors. On this point, diplomatic ethnography (if I may devise such a term) is in agreement with ethnomethodology: 'actors know what they do and we have to learn from them not only what they do, but how and why they do it' (Latour 1999, 19). Drowning out actors' language in one's own metalanguage, or framing their account with an explanation that relies on some external, unaccounted-for forces would mean 'substituting the researcher's meaning for the meanings of those being studied' (Gubrium and Holstein 2012, 85), and thus constitute a case of analytically unproductive 'arguing with members'. This, however, does not necessarily mean that the actors themselves know better. 'The fact is', writes Latour (2005, 138), 'that no one has the answers – this is why they have to be collectively staged, stabilized,

² The term 'member' denotes one of the key concepts in ethnomethodology (see, for example Garfinkel and Sacs 1970). The notion of member 'refers to capacities or competencies that people have as members of society; capacities to speak, to know, to understand, to act in ways that are sensible in that society and in the situations in which they find themselves' (ten Have 2002). The alternative term 'actor', used here with the reference to its connotations in actor-network theory (see Latour 2005, 43–62), stresses specifically the capacity of various entities to act, that is to influence other people and things. Both terms might denote human individuals; the later could pertain to nonhuman entities as well.

³ The first emphasis is in the original; the second is added here.

and revised'. Both the ethnographer and the members participate in this endeavour, and if the game is to be played meaningfully, they have to be relevant to each other.

So, secondly, the ethnographer not only has to speak directly to the people she is working with, but also has to be speaking about something that interests them, and she has to be speaking well. The exact nature of such speaking well is at the heart of Latour's (2013) far-reaching project of diplomatic inquiry into the modes of existence and as such is a part of a rather complex structure of ideas. But its main characteristics, as well as its aims, could be fruitfully related to the basic activities of any ethnographic research.

To speak well to her informants, the ethnographer should, in the first place, describe accurately the actions they carry out and the associations they form, in order to act, with others. The heterogeneity of the networks thus described might be surprising to the members at first, as according to the modernist version of the world, they are used to separating actors and relations into discrete ontological domains (for example, society vs nature). But at the level of actual practice, it should not be that difficult to 'verify with these same practitioners that everything one is saying about them is indeed exactly what they know about themselves' (Latour 2013, 65). At the same time – if the ethnographer wants to speak well to someone – she should respect the precise '*ontological tenor* of the value that matters to him and for which he lives' (Latour 2013, 144; emphasis in original), or, to use the technical language of the inquiry into the modes of existence, truthfully document the 'felicity conditions' according to which he judges the truth of his actions.

While describing the networks, the anthropologist might encounter a number of controversies regarding the character of social groupings, nature of agency, heterogeneity of actors, and dual entity of facts/matters of concern (Latour 2005). These controversies have to be carefully redeployed, without closing them for, and instead of, the members. In documenting values, different ways of judging good from bad might be discovered. These should be respected as well, without substituting them with some other set of felicity conditions. But here comes the difficult part. The members' accounts of actions and relations come together with descriptions of related institutions, which might seem not to harbour in the best way members' guiding values, endangering them and creating (or feeding) conflicts and misunderstandings.⁴ Then, the ethnographer should 'propose a different formulation of the link between practice and theory that would make it possible to close the gap between them and to redesign institutions that could harbour all the values to

⁴ When I talk here about describing, negotiating, and redesigning 'institutions', I do not mean formal organisations, as in the expression 'residential institution', but rather structures, or patterns, of social ordering, the same 'thing' which I call below 'modes of ordering'. See also footnote 21.

which the Moderns hold, without crushing any one of them to the benefit of another' (Latour 2013, 65).⁵ This task, the riskiest part of speaking well, calls most urgently for the tools of ethnographic negotiation. It is also the part, we might add, that leads us most decisively onto the thin ice of critique, inviting, perhaps inevitably, an argument with members.

Tools of diplomatic ethnography: Modes of ordering dis/ability

The research project that I use in this text as a laboratory for testing the workability of Latour's methodological advice is, it seems to me, exceptionally suitable for this task. That's because it is, by its very nature, inseparably bound to speaking directly to members and being relevant to them, and, at the same time, especially diplomatically demanding, as one group of participating actors routinely silences members of another group by including them into a strongly naturalised disabling category. I will now try to explain the basic characteristics of the project: first its boundedness with diplomacy, then the difficulty in abstaining from critique under given circumstances, and finally the diplomatic tools with which I am coping with this boundedness, trying to deal with the difficulty at the same time.

Firstly, it is an action research project, aimed at improving ways of cooking, serving, and eating food in residential institutions for people identified as disabled (Zgola and Bordillon 2001).⁶ As such, it is designed to have direct consequences for people involved, the staff of the institution and the inhabitants alike. And because dining is a simple, down-to-earth activity, and caring for better dining is continuous 'tinkering' (Mol, Moser, and Pols 2010),

⁵ In Latour's work, the term 'Moderns' refers to the people believing in what he calls 'modern constitution', a specific division between domains of human activity and their related objects (for example, between natural sciences and humanities and between nature and culture). Historically, this refers roughly to what is called modern Western civilization, with its beginning dated approximately to the seventeenth century. See especially Latour 1993 and 2013.

⁶ This ongoing project is a part of a broader research/intervention programme aimed at improving services offered in 'homes for seniors', 'homes with special regimen', and 'homes for people with health impairment'. It has been funded by the regional government and implemented by a multidisciplinary team made up of physicians, an ergotherapist, a sociologist, an organisational development specialist, and an ethicist, since 2010. The component concerned with dining has focused on ten residential institutions, in each consisting on average of hundreds of hours of individual interviews, group interviews, observations, document analyses, consultations, and seminars. In at least some of the institutions, the project has initiated significant changes to procedures of cooking and dining, menus and time schedules, and other important institutional routines, and some of those changes affected the site where the story described in this article took place. An interested reader could find more about the project in Hradcová et al. forthcoming.

rather than a coordinated intervention implemented according to a sophisticated plan, most of the ‘having consequences’ takes place in direct exchange with actors, inside their everyday practice. To put it simply: the researchers in this project are not paid to talk to their peers and to policy makers – even though this kind of talk is encouraged as well – but primarily to address staff members themselves, saying and doing things they understand and find relevant for their life and work. Thus, from the very start of the project, the researchers have built their understanding primarily on the members’ experiences and meanings and have tried to employ as much as possible members’ own ethnographic resources (Holmes and Marcus 2008). Workers in social services became our collaborators in doing and writing ethnography (Lassiter 2005), formulating key research areas, questions, and concepts, and writing texts that were incorporated into the articles published (see, for example, Synek and Carboch 2014).

But then, secondly, there is the difficulty. Quoting from the mission statement of the institution where this action research is being done, its ‘target group’ consists of ‘men and women with mental impairment and mental impairment combined with physical impairment’ and does not include ‘persons without mental impairment’. Every visitor of a ‘home for persons with health impairment’ soon discovers that here the actors are divided into two groups by an almost impermeable borderline, drawn by the diagnosis of mental impairment. While members of one group – the staff – are granted full human agency and accorded the full range of psychological and social motives, members of the other group – the inhabitants – are understood as primarily and most importantly mentally impaired, their life being explained as a ‘reflection of syndrome’ (Goodley 2001, 224; 2000, 39). This situation, as the story told here clearly shows, complicates any efforts at speaking well, making arriving at a common description of networks and values difficult.⁷ What options does an ethnographer/diplomat have in such situation?

While concrete protocols and cautionary notes could be better inferred from the proceeding of the negotiation itself, one thing is clear from the start: the negotiations must first centre

⁷ From the very beginning, the research team tried to initiate the participation of both staff members and residents in the project’s design and implementation. But while it was relatively easy to include at least some members of the first group – they formulated research areas and questions, took part in observations and interviews, suggested ways for service delivery improvement, and coauthored conference presentations, etc. – including the institution’s clients has proven to be, partly due to reasons analysed in this text, an ongoing struggle. The increasing doubts about the possibility of such inclusion under current circumstances – that is inside the residential institutions – has led to a recent shift in the project’s strategy towards activities focused on self-advocacy. That said, it is not meant to say that action research with people identified as mentally disabled is impossible – on the contrary, it is a thriving enterprise, as studies like Stack and McDonald 2014 clearly show.

on the ‘thing’ that makes arriving at common description of networks and values difficult, that is on the notion of mental impairment itself. In fact, before any serious negotiations could start – be it on improvement of dining, or of any other institution – the silencing and disqualifying weight of mental impairment has to be lifted away. As a lever for doing this, I propose a diplomatic tool called, in the jargon of science and technology studies, ‘modes of ordering’, or, more specifically, ‘modes of ordering dis/ability’ (Moser 2005; Law 1994, 20–22, 73–93; 2003).

The starting position for using the diplomatic device of modes of ordering dis/ability is acknowledging that we all are – in certain situations, under certain circumstances, and in certain regards – dis/abled, and that our ability or disability is not, at least not completely, given by the natural state of our bodies and minds but co-constituted by other human and nonhuman actors, with whom we form more or less solid bonds (Moser and Law 1999). This recognition, while not altogether habituated, could be taken as commonsensical and is fairly easily demonstrable, for example in situations where food consistency and staff’s willingness to tinker with it seriously transform diners’ abilities to eat. Dis/ability, therefore, ‘is not something a person *is*, but something a person *becomes*’ (Moser 2005, 668, emphasis in original).

The next step consists of agreeing that there are different ways of talking about dis/ability and that the stories we tell about it radically alter the ways we deal with it, and therefore co-constitute what dis/ability is. This, at least in the setting in question, is again fairly commonsensical and easily demonstrable – after all, the staff of the residential institution know very well that there are various approaches to dis/ability – medical, social, educational, etc. – and that those approaches differently and with varying results influence the well-being of the people who are taken as their objects. And here is where modes of ordering enter the negotiation. Modes of ordering are stories that we tell about the world and about how it is and how it should be; they are recursive patterns that could be usefully imputed to the materially heterogeneous networks of associations. But then, they are not only stories or patterns, as they are embodied, performed, or enacted – each of these words has its own particular charm – in a ‘concrete, non-verbal manner’ (Law 1994, 20). As such, they do not exist outside the material world, as somehow unreal narratives about something real, but rather are embedded in it: they are formed by relations of actors and in turn shape them by recursively repeating themselves.

On a more theoretical level, it could be said that ‘in many ways they are like Michel Foucault’s discourses: they are *forms of strategic arranging that are intentional but do not necessarily have a subject*’ (Law 1994, 21, emphasis in original). But, in comparison with them, they are somehow smaller, multiple, more local, more precarious, and always emergent. The concept

of modes of ordering enhances the Foucauldian definition of discourses as ‘strategies in materials’ (Foucault 1980, 194–96; 1981, 94–95; see also Law 1994, 105–110; Agamben 2009, 2; Bussolini 2010) with the following accents: (1) an emphasis on the material heterogeneity of the conditioning arrangements; (2) a cognizance of the emergent, precarious, and recursive process of ordering; (3) a modesty in empirical scope and claim; and (4) a basic assumption of the multiplicity of relations among arrangements, productions, and settings (Moser 2005, 669). So, the modes of ordering are, to conclude by a simplified definition, collectively told stories about how the world – in our case the world of dis/ability – is and should be, stories that are told in words but sometimes in other materials too, stories that sometimes almost come true.

For our diplomatic endeavour, such stories or modes of ordering might have certain advantages. They enable the actors behind the negotiating table to tidy the field of their interests by describing in sufficient detail and depth the institutions about which they are going to negotiate, without foreclosing the possibility of formulating other versions of these institutions. In another word, they allow for multiplicity. Also, as they are in principle nonsubjective, they lift the weight of total mastery from the actors’ shoulders, without robbing them of their agency and responsibility. In such a way, they open up a space for critically evaluating the impact of ordering arrangements with which the actors are actively engaged. And, by facilitating the conceptualisation of multiplicity and relational agency, they facilitate change. But perhaps I am asking too much from the humble diplomatic tool of modes of ordering? To assess their usefulness and diplomatic worth, let’s see what they can do in practice.

Lunch with Pete: Ethnography of two modes of ordering dis/ability

As a tentative answer to the questions posed at the beginning of this text, I would like to tell a story about my lunch with Pete, one of the residents of the ‘home for persons with health impairment’. I select this event from many other similar encounters with clients and workers of the residential institution, because it shows in a succinct manner the limitations and potentials of speaking well in an environment where the voices of some actors are being routinely silenced by others.

He might be around twenty. He is strongly built, and has dark hair and a round face with a sweet smile. He talks slowly and thoughtfully; his dining manners are excellent. The mention of etiquette is relevant in the framework of the dining improvement programme, which brought us together, and which explicitly is not about manners, but is often understood by the staff as a way to improve clients’ ‘challenging behaviour’ at the table. Pete’s story came to

me first in the form of a medical diagnosis. I received by email his ‘dining plan’, an observation form that I use as a starting point to discuss dining needs and preferences, plus a link to the webpage of the nongovernmental organisation For Prader-Willi. According to one of the medical texts I have found on the web, ‘of all the characteristics of individuals with PWS [Prader-Willi syndrome], hyperphagia [abnormally increased appetite for food] and obesity appear to have the most debilitating effects. Due to hyperphagia, individuals with PWS are thought to have a delayed satiation response to food’ (Singh et al. 2011, 91). In the column ‘General information about the client’, the dining plan said: ‘As a result of his illness, the user [of social services] exhibits strong voracity, he takes food from others, eats scraps from the floor, eats out of the cat’s bowl’. Information about Pete having Prader-Willi syndrome – a medical diagnosis – was not included in the dining plan, as it is understood to be confidential and thus reserved only for the attending physician and the medical staff of the institution.⁸ Pete’s mental disability, wrote the department head, is ‘in the mild zone’ (email, head of the department).⁹

I did some further research on the internet, looking for texts about social aspects of the problem, and did not find much: a brief mention in a behaviourally oriented textbook on managing challenging behaviour (Emerson and Einfeld 2011) and a text about a mindfulness-based health program for individuals with Prader-Willi syndrome (Singh et al. 2011).¹⁰ Still, feeling sufficiently armed, I set out to discuss the case with the staff members.¹¹ It soon became evident that my feeble research had unearthed more about Prader-Willi syndrome than the staff members had done during their long acquaintance with Pete (except for the head of the department, who sent me the email).

In a group interview with social services staff, one of the staff members repeats that Pete suffers from ‘voracity’ and ‘steals food from others’. He also ‘steals’ cat food. From the ensuing debate, I conclude that far from being explained on medical grounds, Pete’s behaviour is judged ethically, giving the client autonomous, if somewhat twisted, moral

⁸ Legal rules for safeguarding confidentiality of medical information might in fact differ from their interpretation by the staff.

⁹ Wherever it seems appropriate, I specify the source of information by noting its form (email, interview, group interview, etc.) and the work position of the informant (worker in social services, head of department, etc.).

¹⁰ Of course, there is much more, as I have found out along the way (see, for example, Hooren 2007).

¹¹ In most instances, the term ‘staff’ designates ‘workers in social services’ (that is employees of the institution most directly involved in direct care for the clients), heads of departments (medical nurses or special needs education specialists), and educators (responsible largely for the administrative work).

agency. When I question the interpretation of taking food from others as ‘stealing’, the offended staff member answers that the word does not matter, because its substitution with another word ‘does not return the stolen food to its owner’ (group interview, worker in social services). Inspired by Emerson and Einfeld (2011, 91), I stress the ‘constructional approach’, quoting the authors who write that ‘people with genetic disorders causing intellectual disability may also have behaviour disturbance attributable to environmental circumstances or learned experience’. But the staff members find Pete’s behaviour not susceptible to environmental changes and do not try to find more about suggested management strategies (such as mindfulness training or menu adjustment). As for the aggressive behaviour mentioned in connection with the syndrome in the work of Emerson and Einfeld, there was only one such incident, apparently caused by a grievance, when Pete was refused food that had been previously promised to him. Notwithstanding his motives, the staff members think that their firm stance on refusal was the main reason why Pete did not repeat his attack (group interview, worker in social services).

Our first lunch together took place the day after the discussion, in the framework of training in observation methods aimed at identifying possibilities for dining improvement.¹² Here is an excerpt from my notes:¹³

While training participants stand behind the glass wall [separating the dining hall from the hallway], so they do not disturb the serving of lunch, I ask Pete if I could accompany him and when he nods with a smile, I sit at his table (he has been eating alone for some time, because [according to the staff members] he took food from his mates) and wait for him to start gulping down food or stealing water from me; but nothing like that happens; Pete eats very decently, slowly, and spends the bigger part of his lunch talking to me (mostly about food); when I interrupt his dining with a question (do I do it on purpose, to test his – what? – self-control?), his hand bringing a mouthful to his lips stops in the mid-air and Pete slowly and thoughtfully answers my question, finishing the bite later; but his interest in food is reflected in his stories, and then in the moment when serving tables are being brought into the room and he says: ‘The scoops are ready!’ and rubs his hands together; he knows well he has problems with food and diabetes – he says he had good results lately, so he could eat some sweets from time to time; besides, [he admits,] he sometimes eats piece of a

¹² During such trainings, I play the double role of a researcher and a trainer. The participants are workers in social services, educators, and heads of departments.

¹³ The observations in the notes are my own, or, where indicated, Pete’s. Information in the square brackets has been added later for clarification.

cake ‘when nobody watches him’; he is looking forward spending the weekend with his mother, with whom he is planning a trip to the IKEA store in Brno – in one of restaurants in the mall (he knows exactly where they are situated) he will have fried cheese and French fries; he eats with great restraint – he fills his cup with some tea (according to carers he always spills), he eats very slowly his sirloin steak with French fries (a small portion for such a big man [it seems to me]); when he spills a drop of the sauce on the tablecloth, his eyes look around for a napkin, but there isn’t any in the dining hall, so he wipes it with his finger and licks it off.

When we sit down with the training participants to discuss our observations, they are stunned: they ‘did not recognise Pete’, ‘he was not himself’. They never had a similar experience, they insist, he always gulps food, steals it, and soils himself, and when somebody sits at his table it does not change anything. Even radically modifying the setting does not help: he behaves the same way even during trips outside of the institution (group interview, worker in social services). They do not simply consider Pete’s behaviour highly unusual, brought about by rare and unrepeatable circumstances; it is rather totally incomprehensible, impossible to incorporate into their experiences and conceptual frameworks. When I visit the place three weeks after the encounter, the head of the department is still pondering Pete’s ‘inexplicable’ perfect etiquette. The workers in social services, she says, will have difficulty with incorporating this experience into their routine interpretation of his conduct, because they ‘do not like him’.

As an ethnographer trying to ‘*deploy actors as networks of mediations*’ (Latour 2005, 136, emphasis in original) and a diplomat needing an interpretative key useful for improvement, I conceptualise carers’ ‘not liking’ Pete as an interplay of two parallel, but somehow paradoxical, modes of ordering mental dis/ability.

The first one, which I call the ‘wicked child mode’ (here I paraphrase Carlson 2010, 28–33),¹⁴ performs the client as a semiautonomous person with his own psychological motives, combined with limited or no ability to weigh the consequences of his own actions. His semiautonomous agency is tainted with two distinctive personal traits, inscribed deeply in his natural disposition: wickedness and childishness. According to the wicked side of his nature, the client’s challenging behaviour is being done on purpose; its aggressive nature and its

¹⁴ By borrowing terms belonging in Carlson’s ‘conceptual pairs’, I do not want to suggest that I talk about the same orderings of dis/ability as she does when subjecting the world of America’s nineteenth-century asylums for the ‘feebleminded’ to Foucauldian analysis. ‘What we see’, writes Carlson (2010, 82), ‘is that the history and nature of this classification cannot be abstracted from the complex matrix of power relations out of which it emerged’.

basic orientation toward harming others are stressed, and in the tense routines of the residential institution, the workers in social services are often the victims. The childish face of the wicked child could be seen in the apparent triviality of some of the client's wicked deeds and in the infantile joy expressed at their negative effects (group interview, worker in social services). But while childish drives are surely hard to suppress for somebody with restricted powers of self-reflection and will, the client could master them, if he has a higher, less trivial wicked aim in mind. So, clients with challenging behaviour sometimes behave decently when somebody who could criticise the conduct of the staff is present (group interview, worker in social services).

The interpretation of 'mental impairment' as natural childish wickedness – applied most often to 'problematic clients' – has direct ramifications on the routines of social services' provision. Ill-behaving clients are closely watched, and the constant monitoring and documenting of their behaviour, which is one of the most time-demanding activities in the institution, finds its rationale in the maliciousness of the wicked child (interview, worker in the social services). But most importantly, the wicked child mode interferes with attuning the actions of staff to clients' individual needs and preferences. The wishes of wicked children are often viewed with suspicion, as their motives are most probably morally questionable, and, towards their ever-changing needs, the staff members must take a firm stand. As one of the workers in social services explained in an interview: 'If you give an inch, *they* will take a mile. They really *are* like that. If you do not want them to push you too far, you can't budge'. Thus, the wicked child mode serves as a rationale for and an ordering principle of certain ways and tools of social services' provision: cautious monitoring and documenting behaviour, distrust towards registering and documenting preferences and needs, and unwillingness to make compromises.

The second ordering, the 'medical/personal trait mode' (Carlson 2010, 6, 4–9), enacts Pete's behaviour as a manifestation of his medical condition, in this particular case materialised in the form of missing genes and characterised by mild mental impairment and the uncontrollable urge to eat (group interview, department head). But this clear and unequivocal-sounding explanation remains esoteric for the workers in social services. As the medical care is performed and supervised by the medical nurses and a visiting general practitioner, people directly taking care of the client hardly ever come into contact with Pete's behaviour understood as a symptom of illness. Because of the confidentiality of his medical documentation, constructing him as a patient with Prader-Willi syndrome and mental impairment, information about his diagnoses comes to the lower strata of the organisation hierarchy blurred and distorted (interview, head of department).

Recently, the medical/personal trait mode has been losing its power due structural and organizational changes in the system of social services. Based on the Goffmanian critique of

‘total institutions’ (Goffman 1961), as invoked in the discourse of social services ‘transformation’ (MPSV 2013a, 11), and the critique of the medicalisation of social services, medical approaches and personnel are being scaled down or pushed outside of residential institutions. In such a way, the providers of social services strive to make room for the ‘normal life’ of the clients, characterised (in the Goffmanian sense) by distribution of various life activities between different institutions and sites.¹⁵ However, given the persisting power of the medical mode of ordering dis/ability in the networks of residential services and the confidential treatment of medical information, medical explanations of clients’ behaviour still play the role of indisputable and at the same time inaccessible facts about the client.

Because of the mysterious nature of Pete’s ailments, the medical diagnosis of mental impairment can serve as a complement to his wicked childish nature, as far as it is understood as the main reason for arrested or slowed mental and moral development. The man is ill, and, because he is ill, he is voracious, unclean, disobedient, and wicked. But he could master many of his symptoms, if this mastery is driven by the central nature of his illness, which is the wickedness itself. The medical mode offers a strongly naturalised explanation of the client’s behaviour, and strives for indisputable dominance over other modes of ordering dis/ability, endorsed by expert authority, special institutional arrangements, and the esoteric organisation of knowledge. The wicked child mode, on the other hand, while it does not strip the person identified as mentally impaired of all his agency, nevertheless grants him only a limited range of behavioural patterns and motives, giving his relationships with the staff members a decidedly negative value. The combined wicked child-medical/personal trait mode thus leaves the staff in the situation where they have to deal with largely unchangeable ‘problematic behaviour’, which is located firmly in the body and mind of the client, but which is nevertheless purposely aimed against them.

In the majority of everyday situations, the wicked child and the medical/personal trait modes work smoothly together, and, in fact, reinforce each other. For example, the unworkability of environmentally based interventions, often explained by the unchangeable nature of a wicked child, finds its official justification in the duty to solve any serious problems with medical tools (educator, group interview). And, the other way around, the application of various ad hoc ‘medical’ fixes is sometimes facilitated and made easier by references to the wicked child’s compromised faculties of will and judgment. But the two modes crash and start to contest each other as soon as the question of the moral status of the disabled-identified person is brought up.

¹⁵ The critique of medicalisation of dis/ability is a well-rehearsed theme of disability studies. For an overview, see, for example, Shakespeare 2014, 56–66.

The reason for this is the contrary way the two modes of ordering perform agency and responsibility. In this specific case, while the carers explain a client's 'usual' behaviour as a childish, almost animal-like 'voracity' tainted with malice, the head of the department, struggling for a more positive interpretation, attempts a radical medicalisation of his conduct (group interview, workers in social services and department head). The question is: who, or what, is responsible for the client's behaviour? While in the medical/personal trait mode responsibility lies with the disease, and so any modification of behaviour could be attempted only on medical grounds (by prescribing medicines, dietary regimens, physical rehabilitation, etc.), agency as played out in the wicked child mode is more complicated. While the client is largely responsible for his wicked deeds (actions despised by staff members), acting them out on purpose, his good deeds (actions liked by the staff) are usually interpreted as result of disciplinary efforts (staff members often say that they 'have made' the clients 'into' something).

Another paradox afflicts the interpretation of the 'problematic behaviour' and its possible solutions. While the client is thought to do bad things at will, he is not seen as fully responsible for his actions. As one worker in social services said in a group interview, 'he does not bear the fruits of his deeds'; that is, while he surely suffers and enjoys the results of his actions physically, he does not do so mentally, because he is not – due to his mental impairment – able to understand the causative relations between the actions and their outcomes. As a consequence of this, the moral responsibility lies fully on the shoulders of the staff members, who not only are accountable for them before the law and authorities but who also pay for them emotionally, experiencing resulting joy or suffering (group interview, worker in social services). Such a mode of ordering dis/ability not only puts a heavy load on the staff members, making them the sole victims of the wicked child's harmful designs, but also complicates and puts under question any possible intervention. If the person identified as mentally impaired is not able to connect his deeds with their results, then any attempt to influence his behaviour by environmental changes must seem questionable; or more precisely, no realistic interventions could count on his understanding and conscious effort.

As the discussion with the head of the department and the workers in social services about my lunch with Pete shows, for the practical purpose of debating and implementing interventions aimed at improvement of the client's problems with food consumption and enhancing his joy of dining, both modes of ordering dis/ability – the wicked child mode and medical/personal trait mode – have only limited, if any, value. Neither of the two narratives – by now disentangled and competing one with the other in the controversy concerning agency – offers any hope for positive intervention, less for viable explanation of what we have all experienced during our observation session. Could I, as an ethnographer/diplomat, offer an alternative, replacing the existing modes of ordering with a more meaningful and useful version of the experience?

Bringing in the social model: An attempt at replacement

In their foreword to the anthology *Care in Practice: On Tinkering in Clinics, Homes and Farms* Annemarie Mol, Ingunn Moser, and Jeannette Pols (2010, 14) write that good care ‘is attentive to . . . suffering and pain, but it does not dream up a world without lack. Not that it calls for cynicism either: care seeks to lighten what is heavy, and even if it fails it keeps on trying. Such, then, is what failure calls for in an ethics, or should we say an ethos, of care: try again, try something a bit different, be attentive’. It is precisely this ethos of careful attentiveness and persistent experimentation that is compromised by the wicked child and the medical/personal trait modes of ordering mental dis/ability. But as I strive to ward off the emotionally charged ghosts of these modes, I feel – almost physically – how the conditions of possibility for my discourse are limited.

The thing is, I do not want to offer just a meaningful model of dis/ability (that is meaningful to me), but also a model that is useful, one that could be taken seriously (as meaningful) by other participants in the negotiation. And I want to include both the staff members and the clients in this group. And so, while I would like to delete the naturalising, universalising, and homogenising effects of the existing modes of ordering dis/ability with the stroke of a pen, I find myself instead clinging to the ‘social model of dis/ability’, which, as Tom Shakespeare (2014, 12) puts it, shifts ‘attention away from individuals and their physical or mental deficits to the ways in which society includes or excludes them’, while it ‘roots the problem firmly in material social forces and physical environments’.¹⁶ By showing that seemingly natural and personal impairments are in fact the product of specific material orderings and related ways of thinking, the social model – at least in its original ‘strong’ version – denaturalised dis/ability as a form of social oppression and thus opened a road to two important developments: setting barrier removal as the main political goal, and empowering the disabled-identified to reject traditional blame allocation and to fight for equal citizenship (Shakespeare 2014, 13). But even more significantly for this particular situation, the social model’s dual concept of ‘impairment/disability’, differentiating physical and/or psychological otherness from disabling environmental conditions,¹⁷ seemed to me an ideal tool for discussing the impact of various ways of organising social services, without directly

¹⁶ For an historical overview of the social model and a concise survey of its feminist and poststructuralist-oriented critique, see Shakespeare 2014, 11–45. See also Goodley 2011.

¹⁷ This duality is one of the main topics in the feminist critique of the social model, drawing on Judith Butler’s (1990) challenge to the duality of sex and gender. However, other scholars and activists still consider it a useful tool for conceptualising, describing, and changing dis/ability. For the ‘inclusive social model of disability’, adapted to allow for theorising ‘learning difficulties’, see Goodley 2000.

attacking the deeply rooted ideas about the naturalness of the category in question. In my report addressed to the staff members, I wrote:

During the experiment, it became evident that Pete is under certain circumstances perfectly able to master his ‘uncontrollable’ urge to eat. It is worth considering how this experience could be used in everyday practices of care. Apart from that, [during our discussion] we talked about certain methods which have been successfully used in the management of challenging behaviour connected with Prader-Willi syndrome, specifically suitable diet adjustment – the client has a diabetes meal plan, but it is possible that he should avoid some diabetic foods as well – and various methods of ‘mindful eating’.

But while I think that in Pete’s case the social model of dis/ability might be more useful for envisioning change than the medical and wicked child modes, I am aware that in the reality of this part of the institution, it is only a model, and not a mode of ordering, as at the moment there are almost no actors – apart from me and my flipchart – to enact it.¹⁸ It is certainly not the case that the social model is not present here at all: its emphasis on the environmental aspects and impairment/disability duality play a certain role, if only implicitly, in the discourse of the transformation of social services and in the social services quality standards.¹⁹ It is also not so that the staff members do not manipulate physical environments to influence clients’ behaviour. But in doing so, they mostly only go so far as to restrict clients’ access to the direct stimuli causing the trouble (such as food) and do not attempt to change the environment with the aim to arouse more positive behaviour. This failure, however, cannot be adequately explained by incompetence or moral flaws on the part of the staff. Two main components of the social model – namely its emphasis on the disabling or enabling effects of physical environments, and respect for the needs and wishes of the disabled-identified – are not viable, because the dominant modes of ordering dis/ability create the institution as a place of residence for sick wicked children.

¹⁸ Recently, different sites are being constructed in the care home, including sheltered living. Here, the social model of mental disability might have more power, or, different modes of ordering should be added to the analysis, as for example the mental disability performed as a need for inclusion in normal life.

¹⁹ Explicit mentions of the social model in Czech policy writing on mental disability are rare. The *Manual of Institutions’ Transformation* (MPSV 2013a), the key document of the currently ongoing process of the ‘transformation of social services’, defines categories of mental impairment and of impairment in ambiguous terms. While the more general category of ‘impairment’ explicitly mentions the ‘organisation of society’ as one of the main reasons for the low quality of life among disabled-identified people, evoking thus the spirit of the social model, the definition of ‘mental impairment’ is perfectly in line with the medical model.

According to these modes of ordering, a large number of mentally defective and morally suspicious people might be collectively housed, fed, cured, and disciplined, with all these efforts bureaucratically planned, recorded, and evaluated, but they cannot at the same time be respected as full human beings, whose wishes and needs are to be reckoned with. The individualised concept of dis/ability, according to Paul Abberley (1987, 18), ‘by presenting disadvantage as the consequence of a naturalised “impairment” . . . legitimates the failure of welfare facilities and the distribution system in general to provide for social needs, that is, it interprets the effects of social maldistribution as the consequence of individual deficiency’. Thus, Peter is offered a diabetic diet, given medication, and strictly controlled in all activities having anything to do with food, but extra healthy snacks, which might quench his appetite without endangering his health, must be provided from outside by his mother. He is punished by being denied extra food when he does not behave as he should and rewarded with favourite titbits when his behaviour is in accordance with the rules of the place, but there is no time whatsoever in the schedule of the institution for mindful eating training, which might possibly lessen his problems with food consumption by allowing for more awareness and control. His problems with housemates, who reportedly dislike his way of eating, are dealt with by exclusion and surveillance, including public mentoring and reprimands. But most importantly, his troubles with overeating, of which he is perfectly aware, are mostly being managed without his consent and active participation, and sometimes even without his knowledge. On the basis of an assumption that he is not able to understand the causal effects of his actions, he is reproached for not observing rules that were not established in dialogue with him, while his achievements are hardly noticed or mentioned. When, for example, he lost 6 kg of weight, the change was dutifully registered by the medical personnel, but not discussed and celebrated with Pete. Such a possibility, in fact, did not even cross the staff members’ minds (group interview, workers in social services).

Current modes of ordering dis/ability vs caring relations: An inevitable argument?

The limitations of the wicked child and the medical/trait modes of ordering dis/ability as interpretative keys for explaining agency and moral personhood, and as a tool for social services’ improvement have been, unfortunately, highlighted by the next episode of Pete’s residence in the institution. Together with the shortcomings and paradoxes of the two modes, it also highlights the difficulties with introducing models of dis/ability based upon recognising social influences in the environment shaped by the existing arrangements.

Pete’s mother was unable to find a place for her son in a sheltered housing facility and his originally provisional stay in the institution continued. His situation had gradually worsened, with ‘fluctuations’ in his physical and mental state attributed by the staff to the changes of

season (an interview, head of the department). A couple of months after my first lunch with Pete, the carers' struggles to rein in his 'challenging behaviour' resulted in open conflict.²⁰ One day, when returning from bowling with six other clients and a couple of workers in social services, Pete refused to get off the bus, arguing that the bus stop had been moved and his medical condition did not allow him to walk the remaining few hundred metres. But his feeling of physical weakness was disregarded by the staff members and appraised instead as another ruse designed to acquire more food or to make more problems. And as staff members' usual ways of persuasion had been already exhausted, because he already had his snack in his pocket, they attempted to make him oblige with other means. They carried Pete out of the public bus and dragged him, kicking, biting, and screaming, to the gates of the 'home'.

When we discussed the event a couple of weeks later during our consultation session, the staff members still blushed with strong emotion. The high emotional charge of the event, however, did not bring us any further in envisioning a more positive development of the situation in question, let alone in appreciating the social model's focus on environmental and social barriers. In their account, they insisted on two basic points: (1) any other action could endanger the client more than what they did, and (2) when 'dealing with people with mental impairment', 'firm limits' are necessary, because 'if you just budge once, it is all over' (group interview, worker in social services).

While it is easy to criticise the staff members' conduct in this situation as needlessly violent, it might be described as functional, or even correct, under actual circumstances by taking into account the existing modes of ordering dis/ability. To better understand the staff members' actions and accounts, while respecting the values that they associate with their efforts, I propose to frame their actions using a relational theory of care, emphasising three basic components of the care practice, namely: (1) understanding and accepting the needs of the person being cared for; (2) motivational displacement, enabling one to act on other person's behalf; and (3) appreciation of the carers' efforts by the cared-for (Noddings 2013). In the official discourse of the state-sponsored social services, 'care' is often criticised for giving too much power to staff members and, in this regard, is contrasted with 'support' (MPSV 2013b, 14). But conceptualisations of care reminiscent of the relational ethics of care

²⁰ As I did not take part in this excursion, the description of the incident is based solely on staff members' accounts.

offer an important set of values by which the staff members judge their activities and their accounts (group interviews, workers in social services).²¹

In this specific case, the staff members took Pete bowling against the wishes of his mother, his legal guardian, because he very much wanted (according to their explanation) to use this opportunity to buy a snack. They considered his wish as a real and acceptable option (Noddings 2013, 19–21), and acted accordingly. They likewise acted in his best interest when they dragged Pete from the bus to the residential institution, feeling it was the only option available to them besides calling an ambulance, which could possibly lead to Pete's hospitalisation in a psychiatric hospital. Their insistence on getting Pete off the bus must be viewed in the light of usual client-carer ratio in residential institutions for the disabled-identified. At the moment of their argument with Pete, the two staff members were accompanying seven clients, for whose well-being and safety they felt responsible; given the perceived needs of the other six, splitting up the group was not an option. But as they cared for Pete and for his wishes and needs, taking the interests of other clients into account as well, they could see that their care was not being fulfilled: the third important component of the care practice, the appreciation of care by the cared-for, was missing. Their caring efforts thus frustrated, they stopped caring for Pete as a human being, as somebody with real, acceptable needs and wishes, and started to care for Pete as a person with mental impairment, ordered as a natural wickedness caused by an esoteric medical condition. If we presume their actions to be rational and beneficial, they could either question the institutionalisation of care values in the existing modes of ordering dis/ability or accept the modes as given and allow the values to be compromised.

So, when in discussion with the staff members I express my worry that the violence of the event could threaten the good relations between them and their client, they respond that their relationship could by no means be threatened, as their professionalism does not allow them to harbour any negative feelings against clients and Pete has no reason to feel hurt. But their strongest reaction is provoked by my use of the word 'violence'. If there was anything violent in the encounter, they argue, it was his behaviour, a result of his wicked child nature and his diagnosis, while their own reaction was 'the least evil' option. Violence is certainly

²¹ A question might be asked whether the 'relational approach to care' could be considered another mode of ordering dis/ability. My answer to this question is rather ambivalent. It could be so in certain sites and situations, where sociomaterial networks are being shaped in such a way that they facilitate caring relations. However, in the framework of this text, I prefer to view it as a guiding value that matters to the staff members and for which they live (Latour 2013, 144), as a felicity condition distinct from the currently active modes of ordering. This allows me to consider modes of ordering as institutions that can be criticised and reformulated to better suit the guiding values. More on this in the conclusion.

not the word they want to hear in connection with the way they are doing care. Now they really feel hurt. And when I eventually discuss the case with the department head, I have a feeling that I have gone too far. 'I am not judging you', I try to excuse myself, 'I am only offering alternatives'. 'Not true', answers the department head, my gatekeeper in the institution and an enthusiastic proponent of social services' improvement, 'you *are* judging us'.

Conclusion: Obduracy and restatement of the diplomatic argument

When I visited the institution a couple of months after the heated argument with the staff, I have learned that 'things have settled down' with Pete (group interview, workers in social services and department head). There were no more open conflicts and occasions of 'stealing food' had become rarer. The quieting of the situation was largely credited to the improvements in medical care provision: Pete had a new psychiatrist and was being prescribed better and more stable medication. But it was not a happy ending yet. For a few weeks, he had been complaining of feeling sick, asking the workers on duty for medicine, which some of the staff members interpreted as a ruse to get an additional glass of water with syrup (group interview, workers in social services). The wicked child and the medical/personal trait modes of ordering dis/ability continued to exert power over Pete's life. However, there had been another significant change as well, a certain softening of the staff's 'attitude' towards Pete, from 'not liking him' to 'being used to him' (group interview, worker in social services). And while it would certainly be presumptuous to attribute this change in attitude solely to the discussions described above, I would like to believe that something from my experience with Pete has influenced – and will influence, as negotiations will continue – the staff's thinking about the man they are trying to care for. So, given the ambiguousness of the results, how did the advice to 'speak well' perform in this laboratory test of ethnographic research and writing? Do the experiences thus gathered offer any answers to the questions posed at the beginning of the enquiry?

The essay has shown, it seems to me, that in a setting where the dominant modes of ordering significantly limit the conditions of possibility for appreciating the actions and values of one group of actors, an attempt at 'speaking well' might – and perhaps should – lead to an argument. By talking solely to the staff, I could not be relevant to Pete in the true sense of the word. I could not obtain his view of the situation, I could not listen to and comment on his worries, I could not experience the pleasures of dining with him, in short, I

could not speak to him well.²² But when I tried to align his experience with the experience of the staff members – trying to include both Pete and them in the negotiations – I found that agreeing on the technical description of practice did not lead easily to common interpretation. Even if we all agreed that Pete behaved decently during our lunch, we did not agree on why and how this happened. And while walking from the bus stop to the gates of the institution could be a real problem for Pete, it might not be real to the people who accompanied him. That is because, as the story above suggests, some of the actors enact versions of Pete that do not allow for taking his actions and motives seriously, as actions and motives of a complete human being.

Thus, wherever disabling modes of ordering are at work, their power and legitimacy must be questioned. But in doing so, the ethnographer/diplomat must respect their obduracy and not pretend that modes of ordering are just stories made out of words. That they could be switched off or changed right on the spot, in the minds of members. Because when the ethnographer pretends that this could be done, her suggestions become uninteresting, and even feel oppressive, to the people who enact the obduracy of the modes of ordering – and collide with it – in their everyday practice. The modes of ordering dis/ability that I have described above resist attempts at change, not because they are good or true stories, but because they have become embodied, through their long cooperation, in a number of remarkably resistant material relations (Law 2003). The wicked child and the medical/personal trait modes of ordering dis/ability are the foundational orderings of Czech residential social services for disabled-identified people. As such, they have shaped buildings and walls, rules and methodologies, knowledges and curricula. They are reality, a reality that affects not only Pete's life but the lives of many others as well, disabled-identified and not, constantly creating experiences of suffering, hopelessness, and pain. Changing the sociomaterial relations out of which this reality is made and shaping them according to different, perhaps more suitable modes of ordering is not a task for workers in social services, situated at one of the lowest ranks in the social services' hierarchy. Or, more precisely, it is not a task only for them. Finding the right balance between respecting the obduracy of existing modes of ordering and envisioning other possibilities is one of the most difficult assignments for conducting diplomatic ethnography.

²² During one of my subsequent visits, I tried to learn Pete's view on the bus incident. He looked away, suddenly somehow gloomy and withdrawn, letting me know politely that he didn't want to talk about it. The incident seemed to be far away in the past, the current joys and worries more important. I felt somehow awkward for trying to elicit his personal account of bad memories, as if his fighting the carers with all his might had not been a sufficient expression of his stance.

So, there is the obduracy of the disabling modes of ordering. But there are also conflicting values and thus possibilities for change. Because my story has also shown that while staff members enact Pete as a sick child, they also care for him, trying to assess and respect his authentic needs, and looking into his behaviour for signs of reciprocity. And such caring does not fit together with some versions of the cared-for, as they are performed by the medical/personal trait and the wicked child modes of ordering dis/ability. Because of this, arguments about these modes of ordering – about the institutions in which members harbour their values – don't have to lead to a break in negotiations, provided that the values themselves are respected and truthfully accounted for. (On the other hand, the failure of negotiations seems inevitable if members' values are trampled upon or ignored.)

But if the questioning of certain institutions based on respect for values can pass as a form of diplomatic ethnography, what about my attempt to bring into the negotiations an external mode of ordering, to suggest an institution that might be more suitable for the values in question? By offering the social model as a replacement for the malfunctioning modes of ordering dis/ability, I had, as Melvin Pollner put it, 'argued with members' (Gubrium and Holstein 2012). So much for the ethnomethodological perspective. But what about the productivity of this move for diplomatic ethnography, whose aim, as we have seen earlier, is to 'redesign institutions that could harbour all the values . . . without crushing any one of them to the benefit of another' (Latour 2005, 65)?

And so, while I strive to respect the values that staff members enact in their everyday encounters with people identified as mentally impaired, or perhaps because I strive to respect them, in this text, which I understand as a next step in continuing diplomatic negotiations, I want to conclude by restating my personal point of view on Pete. A point of view based on the social model of dis/ability. A point of view, or so I believe, that is better suited for harbouring the ethos of care. Pete is a genteel man, with perfect table manners. He has some medical problems he is aware of. He has – and sometimes struggles with – a hearty appetite, which sometimes he is not able to control as much as he would like to. But there is absolutely no reason to believe that supporting him in this effort is useless because he is mentally impaired, because he has Prader-Willi, or because he is a wicked child. As for him being an unpleasant companion, I could only look forward to another chance to lunch with him.

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