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"It's a Limbo": The Moral Scenes of Interpreting Autonomy in Danish Intellectual Disability Care

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ABSTRACT

In Denmark, people with intellectual disabilities who live in supported housing are entitled to both care and autonomy. Catering to these ideals creates situated dilemmas for caregivers and residents, especially when increased attention to autonomy brings "good" care into question. In this article, we demonstrate that individuals with intellectual disabilities express their autonomy by both verbal and non-verbal means, which can be multifaceted and difficult to interpret. As a result, caregivers must continuously experiment with interpreting what we refer to as "expressions of autonomy" while navigating sometimes competing values of autonomy and care on a situated basis.

KEYWORDS

Denmark; autonomy; care; intellectual disability; moral laboratory

When group homes for adults with intellectual disability (ID) were first introduced in Euro-American countries in the 1970s, they were seen as a mitigating response to the clinical and moral failure of the totalizing institution and its coercive care practices (Levinson 2010). Today, the ideals of "good" care in group homes in the Global North center on adapting to the needs and wishes of individual clients, as formulated by the clients themselves (Hawkins et al. 2011; Juhila and Löfstrand 2023; McKearney 2021a; Munson 2020; Pols et al. 2017; Van der Weele et al. 2021). These ideals are affirmed by the Convention on the Rights of Persons with Disabilities (CRPD) (United Nations 2006, Article 3a:5), which highlights the right to "individual autonomy including the freedom to make one's own choices, and independence of persons." Yet, group homes and community-based residential services for adults with ID are often regarded as a setting that is the "opposite of freedom" (Levinson:xi) and have not "delivered in a variety of ways on the promises of rights, self-determination, and integration made more than thirty years ago" (Levinson:xiii). Such concerns about group homes and caregivers' challenges in ensuring that the ideals of autonomy form the backdrop of the ethnographic fieldwork we present in this article.

The article builds on ethnographic fieldwork at a government-regulated and publicly funded Danish housing facility for adults with ID. At the time of our fieldwork, the housing facility – Solar – had received several regulatory injunctions from *Socialtilsynet* (the Danish social welfare authority) stipulating that the facility must improve its work to ensure residents' right to autonomy. In response, the management at Solar had decided to focus on and foster residents' capacity for autonomy by requiring all staff and residents to participate in a course aimed at promoting autonomy. Residents were educated about their right to autonomy and citizenship, while staff received training that focused on identifying residents' perspectives and supporting residents in becoming more independent. This training was underpinned by the introduction of Goal and Behavior (GB) plans and the method "Low Arousal 2" (LA2), which aimed to increase the staff's focus on collecting information about residents' self-interests, individual needs, and goals. The training at Solar mirrors

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the focus of many other group homes in Euro-America, which have turned to knowledge and tools from the field of psychology to ensure the autonomy of residents better (see Levinson 2010; Munson 2020).

Our initial fieldwork suggested that Solar's increased focus on autonomy – and the tools developed to support it – did not immediately resolve the challenges at Solar as autonomy was not the only ideal that caregivers were obligated to uphold. Another legally mandated duty was to protect residents from the risk of neglect and harm, a duty described as *omsorgspligten* (the duty of care) in the Danish Social Services Act, Guidance No. 10,148. Caregivers explained that in some situations – e.g., when residents expressed an unwillingness to go to work, eat healthily, or go to the dentist – it was unclear to them how they should weigh the value of autonomy against the value of residents' health and safety.

This moral dilemma has also been identified in other countries (see Hawkins et al. 2011; Pols et al. 2017), and the tension between autonomy and care has been debated for decades both in anthropological discussions (e.g., Kittay and Carlson 2010; McKearney 2021b) and elsewhere (e.g., Hawkins et al.; Levinson 2010; Redley and Weinberg 2007). Ethnographic and anthropological studies on long-term care for people with ID have, for instance, examined whether "good" care is a precondition for enabling autonomous decision-making and action among adults with ID (e.g., Kittay 2011:2019; Pols et al.; Juhila et al. 2021), or whether care objectives may at times contradict or constrain residents' agentive choices (e.g., McKearney). These debates also highlight the polyvalent and sometimes conflicting meanings attributed to the notions of autonomy and care. Contributing to this discussion, the manager at Solar, Tom, brings into focus an additional dimension of the practical difficulties produced by the pursuit of autonomy – particularly interactional challenges – a dimension that has received comparatively little attention in the literature:

> A fundamental challenge concerning our increased emphasis on autonomy at Solar is that many of our residents don't have the prerequisites to make decisions on their own. Reason and the ability to choose and form an opinion simply do not exist for some. Many things become abstract when it comes to future goals. It can be difficult to imagine or reflect on them. Many of our residents may be driven by instinct rather than reason. The concept of autonomy, as I see it, is based on a very cognitive approach, which assumes that residents' words should be taken at face value. This does not always provide an accurate picture of reality. Should we simply give a resident who wants to get drunk the "permission" to do so? Should a resident's "yes" or "no" always be taken literally, or should we engage in dialogue? (Tom,[1] manager at Solar)

Tom links autonomy to what he calls a "cognitive approach": the assumption that autonomy rests on abstract reasoning and that residents' verbal expressions should always be understood literally. In doing so, he implicitly situates autonomy within what Post (1995) calls "hyper-cognitive" Euro-American traditions that privilege reason – following enlightenment legacies such as Cartesian mind – body dualism – as the highest human capacity. Tom, however, questions whether this framework fits the everyday realities at Solar, where residents often act on what he calls "instinct." His reflections foreground the uncertainty that caregivers face when interpreting residents' autonomy and intentions. This uncertainty moves us beyond a purely binary discussion of whether care enables or restricts autonomy, and resonates with McKearney's (2021b) notion of the "challenge of opacity," which highlights the limits of knowing another person's mind – particularly in the context of ID. Tom's reflections also align with arguments made by scholars such as Mattingly (2014), who describe care as marked by radical uncertainty, where moral action emerges through practical experimentation. In relation to care, such scholars argue that decisions are guided by context, shifting temporal circumstances, competing values, and what Pols (2005) has conceptualized as "enacted appreciations," encompassing the verbal, nonverbal, and performative aspects of communication in care. Taken together, these insights point to a central puzzle raised both by Tom and elsewhere in the literature: How can caregivers interpret and navigate what we refer to as residents' "expressions of autonomy?"

Building on previous literature, we elaborate on the unsettled and uncertain nature and dimensions of expressions of autonomy and the interpretation troubles and ethical concerns that accompany this uncertainty at Solar. We explore how caregivers, in their complex (verbal and non-verbal) interactions with residents at Solar and among themselves, struggle to identify and interpret individual residents'

(expressions of) autonomy in everyday life. Furthermore, we investigate how the inherent challenge of opacity and uncertainty is navigated practically in a context where both care and autonomy are mandated goals.

Reviewing the literature: the relationship between autonomy and care in ID studies

The ideals of, and ethical concerns about, autonomy in group homes for adults with ID are part of a broader discussion about care and caring relations (e.g., Hochschild 1983; Mol 2008; Tronto 1993). This research shows that abstract assumptions about what care is and how it ought to be provided are structured by power (Tronto) and are deeply "embedded in public debates, government policies, and institutional forms of support" (McKearney and Amrith 2023). It further demonstrates how everyday practices of care are entangled in political, relational, economic, gendered, emotional, and moral dimensions (Hochschild; McKearney and Amrith; Mol; Tronto; Kittay 2019), thereby highlighting not only the fluid and multidimensional nature of care but also its context-dependent nature – what counts as care depends on the setting. Care provision in settings for adults with ID has been examined outside anthropology (e.g., Levinson 2010; Redley and Weinberg 2007) and is an emerging field in anthropological research (e.g., Kulick and Rydström 2015; McKearney 2021a, 2021b; Pols et al. 2017). However, as we will demonstrate, even within this specific domain care appears as a polyvalent and fluid concept rather than a single, stable practice.

Similarly, autonomy – both as a theoretical concept and a practical ideal – has spread as an abstract political trope, both outside (see, e.g., Mol 2008) and within ID care. The notion often emerges with a range of related meanings, including independence, freedom, self-reliance, choice, self-regulation, self-determination, and citizenship. In the CRPD framework, autonomy explicitly incorporates several of these terms (e.g., freedom, choice, and independence). Theoretically, autonomy is also frequently approached as an overarching "ethic of autonomy," a historically situated concept that gained prominence in the latter half of the twentieth century and gathers these related meanings under its umbrella (Levinson 2010; Van der Weele et al. 2021). Nevertheless, some studies (e.g., Van der Weele et al.) illuminate the tensions and divergences among the sub-concepts.

Given this conceptual plasticity, providing fixed definitions of autonomy and care lies beyond the scope of this article. Instead, we outline three analytical angles developed in previous ethnographic and anthropological studies to explore how the autonomy of people with ID in long-term care has been understood and approached in different ways.

A body of work (e.g., Juhila et al. 2021; Kittay 2011, 2019; Pols et al. 2017) conceptualizes autonomy in care settings as inherently relational, drawing on the notion of "relational autonomy," which holds that choices are never made independently but rather in social and interactional contexts (Juhila et al.:170). These studies often critique traditional ethical and political theories for centering libertarian, masculine ideals of the autonomous, rational, self-sufficient subject – frameworks that treat autonomy as separable from social forces, including caring relations (Kittay; Kittay and Carlson 2010). While rejecting paternalistic or coercive care, they argue that care cannot be reduced to paternalism and that traditional autonomy models overlook the needs of people with impaired decision-making capacity who depend on others for support. Instead, by treating autonomy as embedded in social institutions and relationships, this literature emphasizes how individuals' choices and actions take on meaning through mutual dependencies and contextual interactions (Munson 2020; Kittay). Kittay (55) highlights the relational dimension of "good" care as involving cooperative, respectful, and attentive relationships with those who depend on us. This "ethic of care," grounded in responsiveness and connection, also challenges the tendency to sideline caregivers when autonomy becomes the overriding aim of care (Pols et al.).

Emphasizing the relevance of "good" care, Pols et al. (2017) study examines situations in a Dutch group home where residents with ID do not view certain issues – such as drug abuse – as problematic but caregivers feel compelled to intervene. The study shows how caregivers guide residents toward more meaningful lives by building and maintaining resident-centered networks and infrastructures

that reduce the appeal of drug use. Pols and colleagues (781) argue that these guiding practices do not limit autonomy but enable a co-constructed process of trying, testing, and adapting practices to support a "good life." In related work on the ability of caring practices to enable autonomy, Juhila and Löfstrand (2023) show how the autonomy agenda generates new dialogs between clients with mental illness and caregivers, producing empowered client subjectivities that challenge dominant and oppressive forms of subjectification in group homes.

A different body of research (e.g., Levinson 2010; McKearney 2021a; Van der Weele et al. 2021) challenges the idea that guided, co-constructed decision-making – often based on psychological expertise and tools – represents unequivocally "good" or "non-oppressive" care. McKearney (230) argues, for example, that relational autonomy studies risk reproducing a therapeutic ideology by endorsing one particular vision of "good care." This perspective, he suggests, obscures how seemingly transparent guiding practices may operate as subtle forms of persuasion and social control that cultivate dependency by removing conflict from the caring relationship. Within such dynamics, caregivers often invite recipients to "work on themselves" or to become autonomous in normatively sanctioned ways – for example by valuing self-reliance in line with Western moral assumptions (see also Levinson; McKearney; Munson 2020; Van der Weele et al.). Accordingly, in this body of research autonomy is often examined through the lens of resident resistance, illustrating how it can be overridden by care.

McKearney (2021a:163), for example, uses the case of Martha, a resident with ID who "remains resistant to many forms of caring," to illustrate how her refusals – whether verbal or physical – are interpreted by staff in a group home not as expressions of agency but as behaviors requiring persuasion or motivation "for her own good," such as efforts to bathe her. He argues that people with ID, like Martha, may not "fit" into care relations because they can be "agentive, insubordinate, and unruly" rather than because of their dependency on caregivers (McKearney164–165). A related critique appears in Van der Weele et al. (2021), who examine how staff at a Dutch group home navigate (in)dependence among young adults with "mild" ID who have verbal language. Adopting a Foucauldian framework, they describe care-guiding activities as techniques of governance and show how staff often equate independence with self-reliance, thereby shaping interventions to produce self-reliant residents. Yet, drawing on Mattingly's notion of the moral laboratory (Mattingly 2014), Van der Weele and colleagues also argue that using a lens that focuses solely on oppressive forms of subjectification is insufficient; in practice, ideals of independence are continually negotiated and experimented with by both staff and residents, rather than simply being imposed. While relational and resistance-oriented approaches offer important insights into autonomy in care settings, they can nevertheless lean toward framing care either as either enabling or as disciplinary and hindering autonomy.

A third emerging body of research approaches autonomy in disability care through the lens of interactional and interpretation troubles generated by the uncertain nature of care (e.g., McKearney 2021b; Pols 2005; Redley and Weinberg 2007). In line with the manager, Tom – quoted in the introduction – some of these studies highlight how policy initiatives and involvement models rely on clearly articulated "patient perspectives," which assume an ability to represent oneself verbally as an individual (Pols), and thus that "transparent" information about residents can be collected with a view to responding to their desires (McKearney). The studies (McKearney 2021a; Redley and Weinberg:767; Friedner 2018) question whether such assumptions make sense in ID care, where residents' entitlement to state-sponsored support is justified by early and enduring intellectual impairments that affect mental capacities essential for everyday functioning. The impairments that they demonstrate may result in "non-standardized," and often non-verbal, forms of communication, e.g., "stimming" and other repetitive movements that may generate "interactional troubles."

McKearney (2021b), for example, explores the challenges of opacity that carers at the group home L'Arche face when providing care to residents who communicate non-verbally only. He describes how long-term caregivers gradually attune to what initially appears, to new caregivers, as residents' incomprehensible expressions. However, newcomers are deliberately left to grapple with this

uncertainty rather than relying on codified behavioral interpretations. Based on these findings, McKearney argues that "knowing" another person rests on long-term relational engagement, not on information per se. Other studies show that such opacity is not limited to caregivers or caregivers' interpretations of residents with little or no verbal language. Pols (2005:203), for instance, introduces the concepts "patient position" and "enacted appreciations" after her own struggles with identifying a voiced client perspective among residents in a long-stay psychiatric ward. She demonstrates how a resident who did not respond when addressed directly nonetheless displayed enjoyment when participating in activities that did not single him out, enabling him to participate in the way he preferred. These subtle forms of participation, she argues, are enacted appreciations – expressions of likes and dislikes conveyed through situated, embodied interaction. Appreciations, Pols further contends, must be understood as co-produced in specific contexts, emerging through both verbal and non-verbal means.

Mattingly (2013, 2014) extends this focus on uncertainty by situating caregivers' interpretive struggles within broader moral processes. With her notions of "moral laboratories" and "moral scenes," she argues that care is always rooted in moral judgment about how a person ought to be, act, or live. These judgments unfold in the "vagaries of everyday life" (2013:304), creating situations characterized by "radical uncertainty" (2014:16). In such spaces, people continually experiment with what counts as "the good" and "how life might or should be lived" (2014:15). These experiments are revised, adapted, and sometimes collapse. Our analysis of the unsettled and uncertain ways in which autonomy is expressed, experimented with, and navigated at Solar builds on this body of work.

The study

Solar is a large Danish housing facility for adults with ID, comprising 26 supported group homes, each with 4–12 residents (aged 20–76). Residents have various cognitive and physical disabilities and communicate by verbal and/or non-verbal means. The majority of caregivers at Solar hold a professional bachelor's degree in "social education" (Danish: *socialpædagogik*), earned through a three-and-a-half-year degree program. Like most Euro-American care organizations, Solar is a highly regulated workplace: Local authorities assign legal guardians, who determine the level of support to which each resident is entitled, and the national authorities (*Socialtilsynet*) routinely inspect Solar's compliance with legal standards, including those rooted in the CRPD, which Denmark ratified in 2009. In 2019, just before our fieldwork started, Solar received several regulatory injunctions for insufficient attention to residents' autonomy.

In response to this, Solar intensified its organizational focus on residents' needs and autonomy, adopting two central tools: Goal and Behavior (GB) plans and Low Arousal 2 (LA2) plans. Both required caregivers to conduct interview-based functional behavior assessments of residents. The GB plans aimed to identify positive everyday goals, while LA2 plans were adapted – having originally been designed to reduce coercion in social psychiatry – to strengthen autonomy and collaboration by constructing "well-being plans," designed to designate residents' warning signs, stressors, resources, and coping strategies. These tools presupposed residents' motivation and their ability to verbalize their perspective – a presupposition that soon proved problematic.

Our main field sites were two of Solar's group homes. Between April 2019 and September 2024, we[2] conducted semi-structured interviews with managers, staff, and residents to understand Solar's autonomy practices. We also carried out participant observation during daily activities (including staff and resident meetings), shadowed residents at their workplaces and during leisure activities, and held staff workshops to discuss preliminary findings. In total, we engaged with 14 residents, 16 staff members, and 5 managers through interviews or extended informal conversations.

From the outset, we focused on the dilemmas generated by Solar's intensified emphasis on autonomy. As described earlier, staff frequently faced moral tensions when balancing autonomy and health risks. Another challenge concerned their attempts to access residents' internal worlds and use the LA2 and GB plans in meaningful ways. As researchers, we confronted

similar uncertainties in our own data collection. Because of concerns about residents' cognitive abilities, we followed principles of process consent (Dewing 2008), repeatedly confirming informed consent throughout the study. Despite efforts to make interviews less abstract – using posters, pictograms, and images – interviews rarely produced the dialogue we anticipated. We also realized that formal interviews unintentionally excluded residents without verbal language. However, caregivers often succeeded in creating meaningful exchanges from residents' expressive behaviors that initially appeared incomprehensible to us.

Recognizing these limitations, we redesigned the study midway through our fieldwork. Rather than collecting general information about caregivers' efforts to enact regimes of autonomy, we shifted toward a more person-centered ethnography, inspired by Pols's (2005) notion of patient positions. We focused on eight residents: four who used verbal language and four who did not, and examined how caregivers interpreted and responded to each resident's expressions of autonomy in everyday life. The notion of moral scenes (Mattingly 2014) proved helpful in capturing the uncertainty involved in interpreting such patient positions.

Moral scenes at Solar

We present three "moral scenes" at Solar, focusing on three residents – Benedicte and Hans, who communicate verbally, and Carl, who uses non-verbal language – and their caregivers' challenges in identifying and interpreting these (non-)verbal expressions of autonomy while attempting to discern what might constitute morally appropriate care. The moral scenes help us focus on how the uncertainty that surrounds expressions of autonomy is deeply engrained in caregivers' challenges with navigating plural (non-)verbal expressions and competing values of moral good (autonomy and care).

Hans: "a bit of a 'no' man"

In our first moral scene, we meet 40-year-old Hans, who has ID. Hans has no physical disability or language issues. Caregivers describe Hans's ability to reflect and concentrate as quite low. Furthermore, he has a temper and is categorized as "outwardly reactive" and, as the staff tend to put it, he is "a bit of a 'no' man." This label arose from Hans's habitual, contrary response of "no" to most questions. For example, when staff try to motivate or persuade him to get involved in everyday activities, such as carrying groceries, if he is in a bad mood he often responds with "mind your own business" or "you sure as hell can't tell me what to do." In this way, Hans often expresses "resistant" responses (McKearney 2021a) to caregivers' guiding activities aimed at keeping him active and involved in everyday life.

The staff describe Hans's resistant responses as having increased after the aforementioned autonomy course for residents and find that his resistance is counter-productive to their efforts to involve him in conversations about how they can support him in pursuing his goals concerning everyday activities (including household duties, recreational activities, and employment activities). When staff try to engage Hans in the goal-setting conversations guided by the GB plans, he simply says "no." In an interview with Hans, his resistance to talking about (healthy) everyday activities becomes apparent:

Interviewer [I]: Can you explain to me which activities you like to do?

Hans [H]: Hmmm . . . [long pause]

I: When do you like to be active?

H: [Long pause] Well, I don't really like being at work [sheltered employment].

I: What do you like?

H: It's kind of boring.

I: What would be fun for you to do?

H: Well . . . [pause]

I: Is it hard to think of anything?

H: [Laughs a little] Yes, it is. I am not very active. I am just calm and relaxed. I don't really enjoy going for walks.

I: Do you have to go for a walk on Mondays?

H: Yes, but I told them I don't want to. (. . .). They [the staff] want to walk all the time.

I: Do you get to stay behind then?

H: Yes, they allow me not to go.

I: What do you do instead?

H: I watch TV a lot. I decide myself. I have my own TV – therefore I can decide for myself.

During this interview, we learn why staff find it challenging to have a dialogue with Hans about the type of (healthy) everyday activities he likes. Hans simply tends to not answer such questions. However, although Hans does not mention specific healthy activities he likes he quite clearly states that he likes watching television and that he dislikes healthy activities (e.g., going for a walk or doing sheltered work), describing them as "boring." It seems that Hans directly associates the activities he likes with something he can decide himself, while he designates activities the staff encourage him to do as boring. If Hans's utterances are analyzed in the context of what McKearney (2021a) calls "voiced agency," the staff's ongoing focus on motivating Hans to go for a walk may be interpreted as "masked" attempts to discipline what they perceive as his unruly behavior. Staff (and we as researchers) might find Hans's voiced

expression of autonomy difficult to accept because what he wants (to watch television all day) does not fit the ideals and norms regarding living healthily that the staff feel obliged to uphold (McKearney; Munson 2020; Van der Weele et al. 2021). However, in contrast to McKearney's resistant resident Martha, where the staff did not take no for an answer (continuing to insist that Martha bathed everyday), Hans recounts that the staff at Solar accept his refusal to go for walks, though they do continue to invite him. To consider an alternative interpretation of the staff's continuing efforts to motivate and invite Hans to do things he usually does not want to do, we return to the interview:

I: What else do you like doing? Going out on trips and experiencing things?

H: Naaah. I don't really like that.

I: But you often go along anyway, right?

H: Yes.

I: How do you feel about that?

H: Then it's okay. It's okay sometimes.

I: Which trip has been the most fun?

H: I can't quite remember.

I: The aquarium or the zoo?

H: The aquarium. I'm looking forward to that.

Hans explains that he, despite the fact that he dislikes the walks and trips, sometimes goes along anyway. He also says that he feels "okay" about that, and when the trip to the aquarium is mentioned he expresses excitement about going. When the staff explain why they continue to invite Hans, they not only highlight that getting him to go for a walk (instead of watching television) holds the possibility of increasing his capacity to participate in everyday activities in the future (see also McKearney 2020), they also describe a discrepancy between the desires Hans *voices* in one situation and the ways he *enacts* appreciations in other situations (see Pols 2005). Over several years, staff have noted that when Hans takes part in activities (after persuasion/motivation), he is often engaged, watching with interest, laughing, and talking enthusiastically about the event afterward. Similarly, staff experience that when they manage to "persuade" Hans to join the daily walks, he enacts appreciation during the walks. As one member of staff explained: "He actually chooses to walk right at the front at a fast pace by himself and he seems to feel good and enjoy the time to himself and the fresh air."

In this respect, the staff's continuing efforts to motivate and invite Hans to do something he typically says no to (daily walks, trips, work etc.) and their questions and curiosity about his verbal "no" could be interpreted as something other than persuasion, or denial of his agency. These efforts could instead be interpreted as a way of coping with the challenge of opacity (McKearney 2021b). When interpreted through the lens of Mattingly's (2013:304) moral laboratory concept, we suggest that the caregivers' efforts could reflect open-ended experiments that recognize that the good Hans wishes to pursue is not straightforward, given, or easy to discern. By observing and attempting to interpret Hans's multifaceted and sometimes even conflicting expressions of autonomy, the staff experiment to uncover what it is that Hans's "no" expresses; for example, "no" could represent a resistance to being asked, a preference for television, or something else entirely (see also McKearney 2020). Such experiments are related to the challenge for the staff of determining what is an appropriate response to Hans's answers. When Hans's expressions seem uncertain and conflicting (and do not seem to "act in concert" with each other), both responding to his yes and his no would involve a risk of not acting *with* him, i.e. of not providing "good care" (see also McKearney:227). Viewing caregivers' efforts as "experiments" becomes particularly interesting because, as noted above, caregivers generally label Hans as a "no man." The experiment view raises the question of whether the staff, by being open to Hans's verbal expressions of autonomy, may avoid reproducing their own habitualized categorizations of residents (e.g., as "no" people) and instead remain attentive to the multiple ways residents express themselves.

Benedicte: "it depends on my mood"

Benedicte is in her twenties and lives with her partner in an apartment in the same group home as Hans. She has Down's syndrome but is physically capable of doing most of the things she wants to. She loves being social and often expresses her emotions in words and poetry, and, in contrast to Hans, Benedicte's habitual way of responding to caregivers is positive. She actively asks caregivers for advice, and she engages in conversations with them. Benedicte has also welcomed the conversations guided by the GB plans, which Hans refused to have. During her first goal-setting conversation, Benedicte expressed that she was unhappy about being overweight, and the staff encouraged her to set a formal goal: "Benedicte wants to lose weight." To reach this goal, the staff and Benedicte discussed a set of subgoals, one of which included trying to avoid unhealthy food and enlisting the help of a dietician. However, staff have difficulties in determining how to support Benedicte in situations where she is tempted to abandon her diet and written GB plan. As two staff members describe:

> Benedicte is seeing a dietician because she wants to lose weight. She has requested this herself and approved the plan. But she also finds it frustrating when there is cake and she has to say no to it (. . .). If she doesn't, I have to remind her (. . .), so there is some work involved in helping her. It is in both my and her interest that she reaches her goal. She gets upset if she gains weight (. . .). She lives here for a reason, and I need to be ahead of things when it comes to her. (Louise, staff member)

> Sometimes Benedicte says, "I can decide for myself." And she does have that freedom, but it would also be like giving up if I just let her eat whatever she wants because of her right to autonomy. Then I wouldn't be doing my job well enough, because I need to support her in reaching her goal [of losing weight]. It's a limbo between respecting the residents' autonomy and also doing your job well. (Camilla, staff member)

As members of the staff explain, supporting Benedicte's diet is challenging because what she wants at different times can be contradictory; her expressions of autonomy differ depending on the situation she finds herself in. On the one hand, Benedicte has voiced and approved a long-term goal of losing weight in one situation. On the other hand, when she is offered cake, she enacts (by taking a piece of cake) another appreciation and desire (Pols 2005). This leaves the staff in a "limbo" between possible appropriate moral actions: to support Benedicte's long-term goal or to respect her immediate desires. In their reflections, the caregivers seem to emphasize Benedicte's long-term goal of losing weight. In one sense, this weight-loss goal creates a common project for Benedicte and her caregivers that allows

the caregivers to meet both the obligation of promoting autonomy (by facilitating Benedicte's wish to lose weight) and the obligation of promoting healthy life choices (see also Pols et al. 2017). However, situations of temptation (where cake is offered) seem to dismantle their common project and prospects of combining ideals of autonomy and care, which demonstrates the moral complexity of Benedicte's diet. In situations where Benedicte wants to abandon her diet, the caregivers explain that they often tend to encourage and advise her to stick to it. However, as Camilla explains, Benedicte has the freedom to decide for herself, and Camilla seems well aware that her advice potentially threatens Benedicte's right to autonomy.

In a similar way, staff member Louise seems compelled to justify her advising behavior. As we saw in the case of Hans, temporality plays an important role in this justification (see also Mattingly 2014; Munson 2020). Louise justifies her advice to Benedicte on maintaining her diet by highlighting the relevance of her advice for Benedicte's overall goal of losing weight in the future. In this way, Louise does not interpret the moment of temptation (in the present) as an isolated incident but frames it as embedded in what Mattingly (18) refers to as "temporal arcs" of past, present, and possible future situations. Thus, Louise being mindful of the future could be interpreted as an attempt to be mindful of these temporal arcs. Benedicte herself also adds an embodied dimension to the issue of how temporality affects her autonomy:

> I have started doing my own grocery shopping, but I just can't always decide for myself. That's when I need a staff member to help me decide. I want to lose weight, but it depends on my mood whether I can decide for myself. (Benedicte, resident)

Benedicte explains that she wants to lose weight. She also reflects on how, in some situations, she needs help from caregivers to prevent her "mood" from overriding her goal of losing weight. We propose that Benedicte's reflections on her autonomy illustrate that her cognitive expression of autonomy (her decision to lose weight) coexists and competes with another more embodied expression of her autonomy (her inner urge to eat cake). As in the case of Hans, the case of Benedicte directs our attention to how interpreting a verbal "no" or "yes" as a direct representation of autonomy might risk overlooking various performative and situated aspects of the goods that residents wish to pursue. This leaves an unanswered question: Which expression of autonomy should caregivers support, a resident's verbal or embodied expression?

In a conversation with the manager at Benedicte's (and Hans's) group home, Tom (quoted in the introduction), we ask how he responds to Benedicte's requests for advice in what we refer to as "situations of temptation." He hesitates for a moment, then says that Benedicte is sometimes "almost too easy to collaborate with" and tends to internalize the opinions and agendas of the staff. When Tom reflects on the contrast between Benedicte's ("too" collaborative) and Hans's ("resisting") verbal expressions, he explains that many residents have lived at Solar for most of their lives, which means that the staff have to be more reflexive regarding how institutionalization may have shaped residents' responses over time. This institutionalization adds to the challenge of opacity on which caregivers must reflect: Do residents' "yes" or "no" reflect expressions of autonomy or are they products of habituated behavior at Solar – that is, an institutionally shaped "yes" or "no**?"**

Carl's walks: A warning sign or a sign of well-being?

In our final moral scene, we elaborate on our meeting with 70-year-old Carl. Carl lives in a group home mainly populated by people with ID who require more intense care than Hans and Benedicte. Carl does not have a well-developed verbal language. He primarily communicates with a few words (and sounds) and non-verbally through small actions and bodily expressions: He smiles and laughs when he watches something he likes on television, and he reacts physically when he is frustrated (e.g., by hitting). His body (and balance) is marked by his age, and he shuffles slowly but steadily around in slippers inside the housing unit and outside (sometimes also in slippers). Since Carl (like many other residents) does not have a verbal language, the staff have not attempted to have conversations guided

by the GB plans. Instead, the staff try to gain a perspective on Carl's internal world by using LA2 plans. The caregivers explain that they, based on their experiences with using the "original" LA2 protocol, have redesigned the procedures in relation to residents with a non-verbal language. We familiarize ourselves with these changes during a LA2 meeting where Carl is on the agenda.

To begin with, it seems striking that the LA2 meeting is being held without Carl's participation. The manager of Carl's unit, Hanne, explains to us that they have experimented with finding alternative procedures at Solar to ensure that "an aspired-to inner-perspective" on Carl (and other residents who have non-standardized ways of communicating) is present at the meeting. Ensuring this perspective ideally includes intense observations of the resident by an appointed caregiver before a meeting and bringing together all staff members (to ensure multiple perspectives on the resident). Furthermore, caregivers are asked to change the way they talk about the residents at the meeting.

At Carl's LA2 meeting, the manager Hanne reminds the caregivers not to talk about how "Carl is" (third person) but to think and speak as if "you are Carl" (first person). The carer who has been appointed to observe Carl confesses that she has not been able to do her homework (i.e., observe Carl). Despite this, Hanne decides to proceed with Carl's LA2 plan. The plan is projected onto a screen and structured into several boxes labeled in accordance with the LA2 protocol (warning signs, signs of well-being, resources, network, stressors, and coping strategies), which Hanne endeavors to fill out dynamically during the meeting. A central topic at the meeting is Carl's walks. The caregivers are quite sure that he is trying to express "something" with the walks. However, they do not agree what:

Manager Hanne: Let us begin with Carl's warning signs.

Karen: When I [Carl] walk away, I feel lonely.

Manager Hanne: Walking alone can be categorized in two ways [in the LA2 plan], as a sign of well-being or as a warning sign. Is he feeling bad?

Anita: Is he feeling good when he goes for a little walk? And then when he goes for longer walks, he is feeling bad?

Karen: Today I [Carl] can manage to walk to the horticulture ground. [Shifts to third person perspective:] But he was starting to walk back on his own, and if he is not feeling well, he doesn't go back [home].

Ida: But is it a sign of dementia or well-being?

Maria: Sometimes he walks because he likes to walk – he probably knows it is good for his stomach. Ninety-five percent of the time he goes for a walk, he returns. It is only a small number of times that he doesn't return.

Manager Hanne: Okay, but we need to focus on the warning signs now [according to the LA2 plan].

Anita: When he says: "Henrik [other resident] needs to die," is not accompanied by anyone, pees his pants, has bad balance, or walks outside the unit.

Karen: Remember to talk as Carl [not about him]!

Anita: Okay, when I put jam in my coffee, am not attentive, or confused.

Maria: Hanne, I noticed that you have only noted going for a walk as a warning sign. But may I just say, he also goes for a walk when he is feeling good, he likes to go for a walk (. . .). Just so we are aware, and it is not only perceived as a warning sign.

Laura: Yes, you're right, walking is something he learned as a child.

Maria: Yes, enjoying the fresh air and nature.

Manager Hanne: But it is difficult to know whether it [walking] should be put down as a warning sign or something else? (Fieldnote)

As the meeting unfolds, it becomes apparent that the "something" that Carl tries to express non-verbally with a rather simple behavior, his walks, may have a multiplicity of complex and rather contradictory interpretations among caregivers. They find it difficult to determine whether Carl's walks are enacted appreciations (Pols 2005) of well-being (feeling good), a warning sign (of loneliness, dementia), a coping strategy (to relieve stomach problems), a habit (learned in childhood), or something else entirely. They also struggle to interpret unequivocally Carl's long walks, short walks, his return to the house after a walk, and him not returning. As Van der Weele et al. (2021) argue, perceptions of autonomy emerge as diverging perspectives that are under constant (re)negotiation, which we also see in the group home. However, while they discuss how this (re)negotiation predominantly takes place between residents with ID with a verbal language and caregivers we suggest that such renegotiations can also take place *among* caregivers, each of whom may interpret a resident's expressions of autonomy differently.

At the LA2 meeting, the individual interpretations of the caregivers are brought into a collective space where care emerges as a collective effort to share and make visible the multiplicity of possible interpretations that coexist. The multiplicity of interpretations emphasizes, as argued by McKearney (2021b:16), that "whether and how we access one another's mind is not a cognitive question that can be separated from the ethical matter of how we stand in relation to people (. . .). It is in itself a relationship to another that constitutes the way of knowing them." However, in contrast to McKearney's description of care practices at L'Arche – where newcomers are left to grapple with the meaning of non-verbal expressions on their own to cultivate their capacity to relate to opacity – the LA2 meetings at Solar make it clear that the struggle to engage with opacity is not limited to newcomers but also challenges experienced workers.

In this respect, the LA2 meetings have the potential to become real-life moral laboratories (Mattingly 2014) where the moral complexity of residents' expression of autonomy is negotiated and the most appropriate interpretations and actions are debated. The "radical uncertainty" (Mattingly:16) of this experiment is illustrated by the number of hindrances at the LA2 meeting: Carl's absence, several breakdowns in the staff's efforts to speak as though they were Carl, and

difficulties in trying to interpret and categorize his behavior. Despite such hindrances and uncertainty, the staff seem adamant about discussing why Carl goes for walks and determining what the right interpretations and course of actions in these situations may be. In this respect, the LA2 meeting can thus be seen as one scene where caregivers enter into experimentation with their interpretations of residents' autonomy.

However, as we will show in the following, this attention to the challenge of opacity did not replace the urge to make collective decisions on how caregivers "should" behave. Some time after the LA2 meeting, we observed one of the situations where Carl walks away:

> While Maria (caregiver) is fixing breakfast, she is watching over Carl. During our conversation, she stops me [first author] and tells me that Carl is walking towards the hallway. "Phew, he can't usually get out that way," she proclaims and returns to our talk. Five minutes later, Carl is standing outside in the garden. Maria immediately walks across the room and opens the door. "Can you come inside?" she says, grinning. Carl laughs as well, his eyes lingering on Maria with affection as he shuffles along. They laugh together and almost have a kind of dance on their way back, while Maria hums a song. (Fieldnote)

At the LA2 meeting, Maria was one of the employees who framed Carl's walks as a sign of well-being, emphasizing that he returns ninety-five percent of the time. So as a researcher I (first researcher) cannot help feeling surprised by the scene. Why is Maria insisting on preventing Carl from walking? When asked, Maria tells of a recent incident where Carl had gone missing and was brought back to the facility in an ambulance. "He was ok," she ensured me, and "luckily no media reported the story." However, following this episode the staff had reached the consensus that efforts should be made to guide Carl away from walking outside, to avoid potential harm (see also Pols et al. 2017).

As demonstrated in the fieldnote, this coercive decision had not reduced Carl's attempts to walk away, almost the contrary. Maria also expressed ambivalence about her new, restricting behavior, explaining that she would prefer to accompany Carl on his walks, which she still felt were beneficial for him. But she explained that staff shortages made that impossible. Thereby, she addresses another inherent tension in group homes that emphasizes resident autonomy, namely that the needs are "potentially limitless," while service options and resources are limited (see also Juhila et al. 2021; Levinson 2010:93). Hence, Carl's walks remained a site where competing ethical goods intersected – autonomy, protection, well-being, resource allocation, institutional reputation, and regulation.

Finally, we highlight that, unlike what is described in other studies of resistant behavior (McKearney 2021a; Van der Weele et al. 2021), Carl's resistance to staff guidance (i.e., his continued attempts to walk away) is not accompanied by anger. Rather, when Maria persuades Carl to go inside again, he is chuckling, looking affectionately at Maria as they walk back inside while doing a little dance. This raises the question: Is he in fact enacting a positive appreciation (Pols 2005) in relation to Maria's guidance? At least, in this case, persuasive care does not seem to take a negative "claustrophobic" form (see Mckearney:164). An alternative interpretation could be that Carl may enjoy the care and attention his walks elicit. We do not suggest this as the definitive explanation for why Carl walks. Instead, we emphasize that Carl's expressions of autonomy remain multifaceted and open to interpretation.

Concluding discussion

In this article, we examine how caregivers at the Danish group home *Solar* enact Euro-American ideals of autonomy, generating moral dilemmas. By analyzing three residents' everyday activities – Carl's walks, Benedicte's diet, and Hans's routines – as "moral scenes" (Mattingly 2014), we illustrate that tensions arise not only from balancing autonomy with other care-related goods, but also from interpreting residents' complex and sometimes conflicting (non-)verbal expressions. These challenges make it difficult for caregivers to determine what constitutes an expression of autonomy and how to respond appropriately. In particular, we highlight two ways in which caregivers struggle to interpret and navigate residents' "expressions of autonomy" at *Solar*.

One challenge emerges in caregivers' need to interpret and prioritize often competing goods that regulate social institutions such as group homes (see also Levinson 2010). Legislation requires safeguarding autonomy while simultaneously promoting well-being and safety (Hawkins et al. 2011; Munson 2020; Pols et al. 2017). These aims may conflict. For example, prioritizing health and safety may undermine autonomy. This tension permeates everyday decisions – whether to allow unrestricted cake eating or whether to support or discourage solitary walks. Additionally, other goods, including scarce resources, shape the ways in which caregivers can support residents' autonomy.

Another struggle stems from caregivers' difficulty in identifying and interpreting residents' expressions of autonomy. The psychological expertise and tools used at *Solar* and similar institutions (see Levinson 2010; Munson 2020) – promote a "client perspective" (corresponding to Pols and colleagues' patient perspective) yet assume that residents can articulate their wishes verbally and cognitively (see Pols 2005; Redley and Weinberg 2007). In contexts where residents have IDs, the pitfalls of this assumption quickly become apparent. Staff cannot rely on these tools alone; they must continually adjust and supplement them, exposing how multiple – and sometimes contradictory – forms of expression become a central interpretive challenge. However, the difficulty of expressing autonomy and of accessing others' internal worlds (McKearney 2021b) is not unique to these institutions but rather is an inherent aspect of caregiving in private (e.g., Mattingly 2014) and other public domains of care (e.g., Mol 2008).

By examining the varied interpretations surrounding three residents' expressions, our analysis identifies a multiplicity of sublayers of interpretive challenges involved in discerning expressions of autonomy. In line with previous scholarship (Kittay 2011; Mattingly 2014; Munson 2020; Pols 2005), we show that temporality and context constitute one such layer, shaping both expressions and interpretations of autonomy. Hans and Benedicte express different preferences at different moments, embedded within shifting temporal arcs (Mattingly). Conflicting (non-)verbal appreciations form another layer. A "no" to walking or a "yes" to dieting in one moment may not align with later "enacted appreciations" (Pols). If taken too literally, caregivers may risk overriding future enjoyment or suppressing valued pleasures.

Further, our findings extend Pols's (2005) notion of "enacted appreciations" by underscoring the uncertainty involved in interpreting non-verbal enactments themselves. Carl's walks, for instance, may simultaneously be interpreted by staff as a warning sign (a negative appreciation) and a sign of well-being (a positive appreciation). Benedicte's reflections on the tension between her reasoning "mind" and her affective "mood" further highlight that these expressions cannot be reduced to conflicting temporal arcs or discrepancies between verbal and enacted behavior. Rather, they coexist as embodied tensions. These findings invite further inquiry into how caregivers interpret enacted appreciations and how they might weigh reason-based against mood-based appreciations.

By identifying these two interpretive challenges, we contribute to anthropological and ethnographic debates both within and outside ID care that emphasize the multidimensional and varied meanings attached to the notions of autonomy and care. Our findings further speak to discussions of the complex relationship between care and autonomy. In studies examining autonomy through the lens of resistance in care settings (e.g. McKearney 2021a; Van der Weele et al. 2021), resistance is often presented as the clearest expression of agency, understood as an autonomous reaction to persuasive care. Our empirical findings complicate this view. Hans's refusal to walk, Carl's insistence on walking, and Benedicte's desire for cake may be responses to care but treating them as *pure* agency risks oversimplification. Instead, we show that residents' expressions of autonomy – whether resistant or collaborative – are situated, relational, and co-produced in the everyday life in the group home. This aligns with relational autonomy scholarship (e.g. Kittay 2011; Pols et al. 2017), which highlights that autonomy is embedded in social and institutional contexts. At the same time, we share McKearney's critique of studies that frame care as inherently "good." Though Pols and colleagues present "good care" as an empirical question, they nonetheless reaffirm normative assumptions – for instance, when abstaining from drugs is implicitly equated with leading a good life.

To avoid normative closure while remaining open to autonomy as a notion that extends beyond resistance, we shift attention to caregivers' struggles to interpret autonomy and thus the challenge of opacity as formulated by McKearney (2021b). In line with McKearney, we suggest that rather than viewing opacity as a frustrating outcome of care or a problem to be resolved it can be approached with curiosity. While McKearney frames the capacity to cope with opacity primarily as an individual process for new caregivers, our analysis highlights the potential – and risks – of cultivating this capacity among both novice and experienced caregivers. Centering opacity and uncertainty in both caregivers' (and scholars') attempts to interpret and experiment with different dimensions of autonomy and competing goods may foster a more reflexive engagement with these dilemmas. We therefore propose bringing the dilemmas, uncertainties, and multifaceted expressions and interpretations of autonomy into the open, as part of a real-life moral laboratory, in which the temporal, embodied, and situational nature of autonomy becomes the subject of ongoing reflection and experimentation among caregivers and residents alike.

Notes

1. All names have been changed to protect the identity of our research participants.
2. Leif Olsen, Pernille Skovbo Rasmussen, Maria Røgeskov, and Nichlas Permin Berger.

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Ethical approval

In accordance with Danish law and research practice, this study has been approved by the Danish Research Ethics Committee, Region of Zealand: No. EMN-2024–04584.

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