Living in hospital and hostel: the pattern of interactions of people with learning difficulties

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ABSTRACT. This study compared interactions between the staff and residents living in hospital wards and in community-based hostels. Twenty-four people with moderate to severe learning difficulties participated in this study. Interactions were categorized according to who was the initiator and recipient, their purpose, attitude of the recipient, duration, and place. It was found that the hospital and hotel residents had virtually no interactions with people outwith the establishment in which they lived. The hostel appeared to offer the residents a sociable environment with more interpersonal inter-actions and more positive attitudes towards the interactants than the hospital. Interactions in both kinds of setting were very short, thus giving residents little chance to develop communicative skills. It is suggested that a more personal approach, such as joint activities between residents and staff, and living in small groups in ordinary hous-ing, should be the first priorities in the effort to improve the pattern of social interactions of people with moderate to severe learning difficulties.

INTRODUCTION

Previous research has consistently shown that the quality and quantity of interactions between people with learning difficulties living in long-term hospitals and the staff attending to their needs are usually very impoverished. Several studies have reported no interactions between residents and staff for the majority of the time they spend together (Poole *et al.*, 1981; Wright *et al.*, 1974). Other studies have found that staff are to a great extent unresponsive to any communicative initiatives on the part of persons with learning difficulties (Warren & Monday, 1971; Cullen *et al.*, 1983; Beail, 1985). Prior *et al.* (1979) showed that in one mental handicap hospital communica-tions between staff and young people with learning difficulties were based mostly on staff instructions and only to a very small extent on conversations with the residents. Oswin (1978) presented a disturbing picture of inadequate interactions between staff and children with multiple handicaps living in long-stay hospitals. Thus, she observed that children were trained in a single activity; namely, that of behaving well at the dining table. However, this training was totally meaningless for these children because it was devoid of any interpersonal bonds, whether between the children and staff or amongst the children themselves, and was unrelated to any other of the children's activities. Moreover, interactions of any kind between staff and children only occurred less than 10% of the time they spent together. Similar results have been reported by Felce *et al.* (1984), who found that hospital staff were unattentive to

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certain undesirable kinds of behaviour of people with learning difficulties and left people to their own devices.

It is now well recognized by the professionals that the quality of interpersonal interactions of people with learning difficulties forms a fundamental feature of good quality care (Calculator, 1988; Bedrosian, 1988). To develop and maintain satisfactory interpersonal interactions is particularly important for those people with learning difficulties whose speech is impaired. This is often difficult to achieve for two reasons. Firstly, they do not communicate their needs and wishes effectively because of their impairment. Secondly, equally important, many recipients of their communicative messages themselves rarely have the skills and sensitivity necessary to interact adequately with someone who has little or no speech at all.

The present authors' own research (Cattermole *et al.*, 1988, 1990) has shown that people with mild learning difficulties are acutely aware of not having adequate interactions with other people and of being treated as second class citizens, or 'like a school bairn' (Jahoda *et al.*, 1989); of getting sympathy from others because of being handicapped rather than treated as a person in his or her own right (Jahoda *et al.*, 1987). Moreover, other research findings have shown that the opportunities for social interactions of people with learning difficulties and their degree of satisfaction with their lives is central to their sense of personal identity and feeling that they belong somewhere (Jahoda *et al.*, 1990).

With the change of policies and the establishment of community-based residences such as hostels with very few residents one would expect that the quality of social interactions of people with learning difficulties would have considerably improved. A more personal approach is possible between the residents and staff in a small community-based residence, and its whole ethos should differ from that of a hospital in terms of the recognition of people's individual needs and of their rights. Moreover, one would expect that living in community hostels would enhance the possibilities for a person with learning difficulties to meet people outwith the residence, and thus, to enjoy a broader spectrum of interpersonal interactions and relationships.

Therefore, the main aims of the present study have been, firstly, to identify the patterns of interactions between the staff and residents living in hospital wards and in community-based hostels and among the residents themselves, and secondly, to compare these patterns of interactions in hospital and hostel settings. The findings of such a study would contribute to the understanding of the social environment experienced by people with moderate to severe learning difficulties who live in community residences services. In addition, such findings would also lead to suggestions as to the ways in which the patterns of social interactions could be changed so that the quality of life in residences can be improved.

METHOD

Participants

Twenty-four people with moderate to severe learning difficulties participated in this study. Twelve people, six men and six women came from three wards, two single-sex and one mixed, in a large mental handicap hospital in Scotland. The other 12

participants, again six men and six women, came from 10 urban community hostels. The age-range of the hospital group was 29–53 years with a mean age of 43 years; the age-range of the hostel group was 24–48 years with a mean age of 37 years. The cause of learning difficulty for the hospital group was unknown for eight people, three people had Down's syndrome and one suffered from temporal lobe epilepsy. The cause of learning difficulty for the hostel group was unknown in five people, four had Down's syndrome, two had brain damage and one phenylketonuria.

Hospital and hostel residents were assessed by the Wessex Case Register Schedule (Dickens, 1985). It was intended to confine the study to those who were continent, ambulant, had no severe behaviour problems, had limited self-help skills, but little or no speech. However, there were considerable difficulties in finding residents of such a description living in the community. The majority of the hostel residents had a mild learning difficulty and, with one exception, in each hostel there were no more than one or two residents fulfilling these criteria. In order to find enough participants for our hostel group it was necessary to search for such residents in three Scottish Regions. Despite the search, the criteria for hostel residents had to be lowered. Although they had the same level of self-help skills, four persons with severe behaviour disorders and one incontinent person were included in the hostel group. The number of severely disabled individuals who benefit from local authority hostel care is still very small.

Permission from the health and local authorities to carry out the study was attained and those individuals who fulfilled the selection criteria were approached personally. It was explained to them that the researchers wished to be in their presence in order to see how they spent their time. All selected individuals who could express a view agreed to take part in this project. The remainder of the residents appeared quite happy with the researcher's presence.

Environments in which participants lived

Hospital residents lived in wards of 30–44 persons. The chosen wards represented a range of residences on the hospital site and accommodated people of differing levels of learning difficulties. Two of the wards were traditional single-sex hospital villas, accommodating 44 and 37 people, respectively. The third ward was a newer villa for 30 men and women. Residents slept in dormitories accommodating up to 20 beds, and the residents' private possessions, if any, were kept in their bed-side cabinets. Meals were served in a common dining room. Some residents attended therapy during the day while others spent most of the day in the ward living room.

The 10 hostels included in this study were located in three Scottish Regions. They represented a range of residential provision, some being purpose-built while others had been converted from large town houses or groups of modern council houses. The smallest hostel consisted of three council dwellings housing eight people, with three living semi-independently. The largest hostel was a large privately built town house, which had been purchased by the local authority, and which accommodated 25 people, 10 of whom had their own bedsits or flats. During the day all residents attended a local adult training centre (ATC) and they returned home between 1600 and 1700 h.

Procedure

Data were collected on the basis of participant observation. It was considered very important that the researcher's presence in the establishment did not disturb participants and that they easily interact with the researcher. Therefore, researchers made preliminary visits to the establishment lasting 10–15 h to familiarize themselves with the participants' home and work environment.

The formal observation sessions consisted of four 3-h periods, covering a weekday morning, afternoon and evening and one weekend session. In addition, there were two 7–8 h observation periods covering the time the participant was woken up in the morning until he or she went to bed at night. The researcher, whenever present, participated in the activities of the group or otherwise in which the observed individual was involved. Thus, the researcher either accompanied the participant to various events (e.g. shopping trips), or was in his or her close environment for the whole time of the scheduled observation period.

All *interpersonal interactions*, in which the observed individual was involved, were recorded. The researchers made discreet field notes during the observation periods. These notes were then written up comprehensively as soon as possible after the observation took place, usually on the same day. 'Interactions' were defined as verbal and non-verbal exchanges between two or more people, *and* as interactional initiatives even if they were not responded to by the intended recipient. Therefore, the minimum 'interaction' included at least one verbal or non-verbal gestural or verbal initiative. The maximum single interaction could last theoretically as long as its original purpose was maintained by the participants (see below). Therefore, interactions did not necessarily involve speaking and, of course, one of our selection criteria was that participants should have little or no speech. Thus, receiving a meal from a staff member at a serving hatch counted as an interaction just as much as having a discussion of the football results.

Coding

For each interaction, the following information was recorded: who initiated it and to whom it was directed; what was its purpose and what was the attitude of the recipient towards his or her interactant; the duration and place of interaction. The reasons for choosing to record this particular information were pragmatic rather than theoretical: it was considered important to record basic data, describing the kinds and number of interactions in the two establishments.

Who was the initiator and recipient. All interactions were categorized according to whether the initiator was a resident, a member of staff or someone else. In addition, it was recorded whether the interaction was directed towards a single recipient or more recipients.

The purpose of interactions. All interactions were categorized as either *functional* or *social* according to their intentions (as perceived by the researcher). *Functional interactions* were those that were assumed (intended) to be concerned with the basic

necessities of everyday life and with the rules and routines of the environment in which the participants lived. These interactions included the following sub-categories: *physical needs* (e.g. meals, having a bath, medication, toileting); *living skills* (e.g. cooking, crossing the road, cashing one's pension at the post office); *routines* (e.g. a call 'dinner's ready' or 'the minibus has arrived'); and *rules* (e.g. a staff member saying 'let's go' when he or she has decided to let the participants know that it was time to go home from the pub; or a staff member saying 'now it's time to do this' when instructing the participant to start another activity at therapy).

Social interactions were those that were perceived as *not intended* for any particular purpose, but only to address, socially, the resident or the group of residents as fellow human beings. Therefore, these interactions were more spontaneous and personal than the former kind of interactions. *Social interactions* included the following sub-categories: *leisure and work interactions* (e.g. sharing sweets, holding hands on the way to the shops, or jointly putting records on the record player); *conversations; comments* (e.g. greetings or attempts to initiate interaction); *choices* (e.g. interactions that were concerned with choosing amongst possible activities, meals or other events or making enquiries about social activities, such as whether the participant would like to go to the pub).

Reliability of categorizations was carried out as follows: Six of the 24 participants were randomly selected and all of their interactions were independently categorized into the above sub-categories by the researcher and by a post-graduate student who was helping with the study. The proportions of mutual agreements of these sub-categorizations ranged from 63 to 90% per participant with a mean of 73·6%. The discrepancies in judgements were resolved by negotiation and the researcher took the sources of these discrepancies into consideration when coding the remaining interactions.

The attitude of the recipient towards his or her interactant. An attitude was defined as an expression of feeling towards or dominance over the interactant who initiated the interaction in question. Six kinds of attitude were identified in the data: *friendly, impersonal, ignoring the interactant, annoying/intimidating attitude, offering help* and *controlling. Reliability* of categorizations of the above attitudinal sub-categories was carried out as follows: Six out of the 24 participants were randomly selected and all the recipients' attitudes were categorized into the above sub-categories independently by the researcher and by a post-graduate student helping with the study. The proportions of mutually agreed sub-categories ranged from 62·1 to 85·5% per participant with a mean of 71·5%.

Place of interaction. Interactions were categorized according to the places where they occurred: living area, dining room, therapy/ATC, kitchen or laundry, outside, others (grounds of the establishment, corridor or hall, office or the establishment, bathroom, bedroom and transport).

Duration of interaction. All interactions were categorized according to their duration as follows: under 1 min, 1–4 min, 5–9 min, and over 10 min.

RESULTS

With whom did the residents interact?

Altogether 3130 interactions (1025 in hospital wards and 2105 in hostels) were recorded. Of those, 1971 (63%) were between staff and residents, 1096 (35%) amongst residents themselves, and 63 interactions (2%) were between residents and people not belonging to either hospital or hostel. There were very small differences in these proportions between hospital and hostel interactions, although of the 63 interactions (2%) that occurred between residents and people outwith the establishment, 51 were due to hostel residents and only 12 to hospital residents.

Of the total of 3130 interactions, 1943 (62%) were initiated by staff, 1152 (37%) by residents and 35 (1%) by outsiders. The majority of all interactions were between dyads, i.e. either between a member of staff and a resident or between two residents (2710; 87%), and 420 (13%) were group interactions. Of these, 392 (12%) were initiated by staff and 28 (less than 1%) were initiated by residents. However, only three group interactions were initiated by hospital residents while the remaining 25 interactions were initiated by hostel residents.

The purpose of interactions

In order to find out whether there were differences between hospital wards and hostels with respect to the purpose of interactions, 2×2 analysis of variance was performed, with hospital versus hostel as *between* variables and social versus functional interactions as *within* variables. There was a main effect due to institution [$F(1, 22)=12\cdot0$, $P<0\cdot002$], showing that there were more interactions in hostels, and an interaction between institution and the purpose of communication showing that
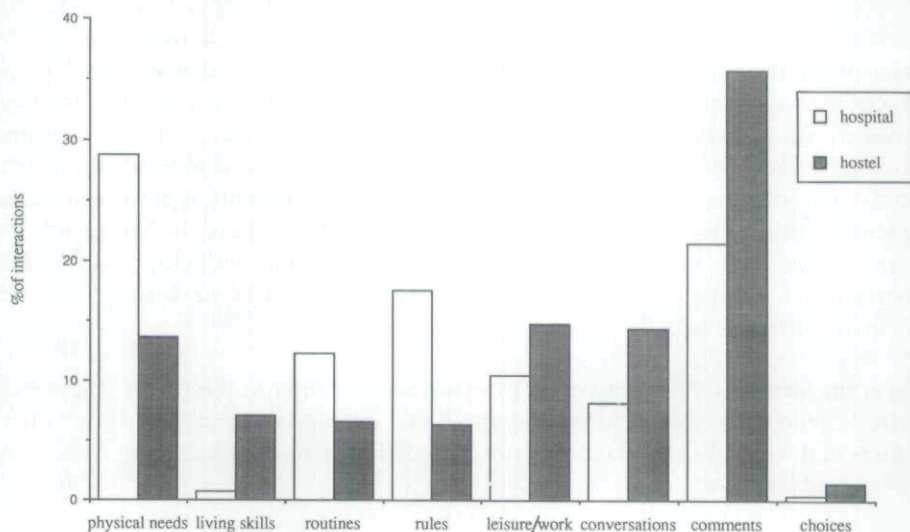

Figure 1.   The purpose of interactions.

there were more functional interactions in hospital wards than in hostels [F[1, 22)=14·5, P<0·001].

A descriptive analysis of the data showed (see Fig. 1), that of the functional interactions those concerned with physical needs were the most frequent in both settings, although they were particularly prevalent in hospital. Thus, in the hospital dining room there were nearly five times more functional than social interactions (Fig. 2). It is notable (see Fig. 1) that virtually no interactions in hospital were concerned with living skills.

Of social interactions, brief comments, such as greetings, were most common in both settings and these were followed by leisure and work interactions and conversations. There is lack of interactions concerned with social choices in either setting. Figure 2 shows that far fewer interactions occurred at hospital therapy than in ATCs attended by hostel residents and that those occurring there were equally likely to be of a functional and social nature. The far smaller number of social interactions in therapy sessions in the hospital setting was a reflection not only of the pitiful amount of time the participants were alloted to attend therapy (see Fig. 2), with some participants not going at all and others going only for a couple of hours in the afternoon, but also of the lack of purposeful activity expected there.

The recipients' attitudes

It was considered important to find out whether there were any overall differences between the recipients' expressed attitudes towards the interactant in hospital and hostel settings. Therefore, attitudes that were categorized (see coding) as impersonal, ignoring and annoyed/intimidating were grouped together and relabelled as negative
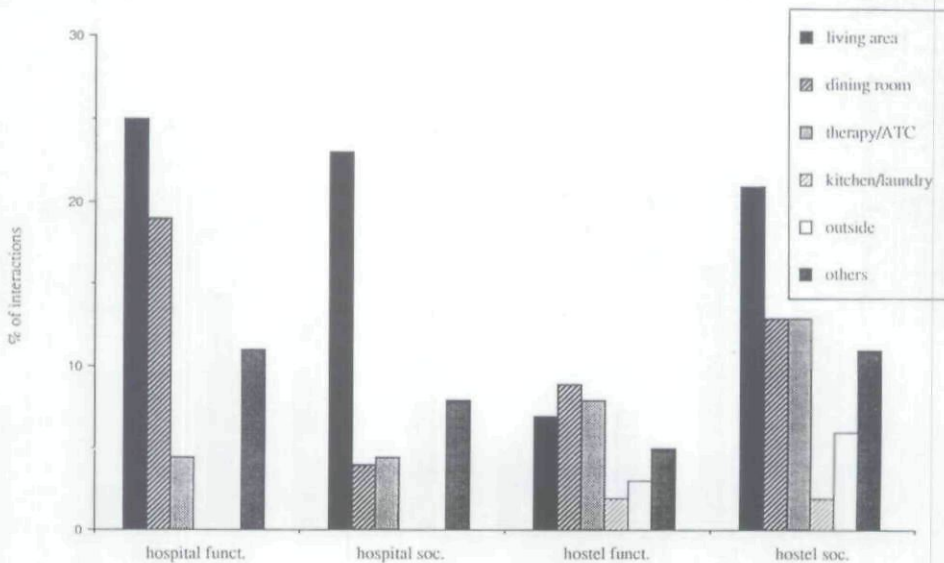

Figure 2. Functional and social interactions in different locations.

for the purpose of analysis of variance. The data were then subjected to a $2 \times 2 \times 4$ analysis of variance with hospital versus hostel, and staff versus residents as between factors, and attitudes as within factors. There was an interaction between the institution and attitude [$F(3, 66)=15 \cdot 32$, $P<0 \cdot 001$] and between the recipient of interaction and attitude [$F(3, 66)=4 \cdot 89$, $P<0 \cdot 04$]. There was also a three-way interaction between attitude, recipient of interaction and institution [$F(3, 66)=5 \cdot 94$, $P<0 \cdot 001$].

Figure 3 shows these differences and interactions graphically. One can see that there were considerably more friendly attitudes in a hostel than in the hospital setting, and that in the hospital setting there were more impersonal, ignoring and controlling attitudes. The figure shows that a high proportion of the impersonal and controlling attitudes in the hospital stemmed from staff responses. Hospital residents relatively often ignored the other interactant too or tended to express a controlling attitude. As for hostels, staff's attitudes were considerably more friendly and helpful than those in the hospital, although they were nearly as controlling as in the hospital. Residents' attitudes were largely friendly.

Where did interactions take place?

Table 1 shows the numbers and proportions of interactions in the six main locations in hospital and hostel settings. While the proportions of interactions in the hospital and hostel dining rooms were very similar, there were considerable differences between the two establishments in other locations. One can see that in hospital settings practically no interactions took place outside the establishment. During the whole period of the project, apart from one exception, residents participating in this study spent no time at all outside hospital. Moreover, in the hospital group, very few interactions took place in the kitchen, because hospital residents had very restricted
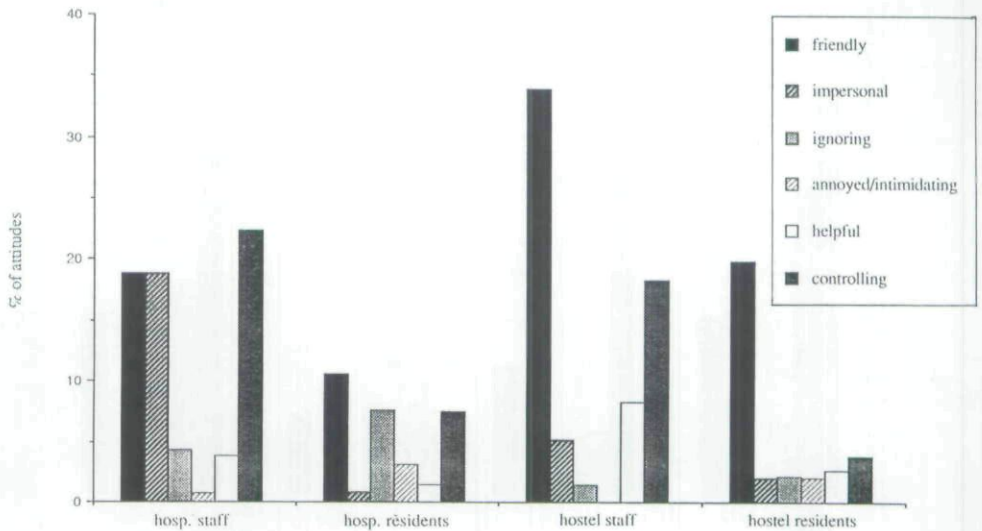

Figure 3.   Attitudes expressed in interactions.

access there and thus to training in self-help skills. Very few interactions occurred during therapy sessions and nearly half of all the interactions were recorded in the living room. In contrast, in the hostel group, interactions in therapy sessions and in ATCs and those outside the hostel accounted for 30·5% of all the interactions in which the residents were involved, but once again, very few interactions occured in the kitchen.

The category 'other' in Table 1 included locations such as the groups of the establishment, corridors or halls, the offices of the establishment, bathrooms, bedrooms and transport. While, for the hostel group, of the 337 interactions in the category 'other', 90 (27%) occurred during transport to ATCs and during excursions and walks to various places in the community, for the hospital group only two such interactions were recorded because, as pointed out above, the participants did not, apart from one single occasion, leave hospital during the whole period of the study.

Although Table 1 shows that most interactions in both settings occurred in the living room, a different picture emerges if one considers the data with respect to density of interactions. One can see that the density of interactions was highest in the dining rooms of both settings while the density of interactions in the living room was rather low for the hospital group when compared with the hostel group. While interactions were relatively dense in all locations for the hostel group, the only other dense location was 'other' for the hospital group. The dense interactions in this location were due to interactions that took place in the office and corridor, and these were concerned with routines and the physical needs of residents. The reason for dense interaction in the location 'other' for the hostel group was mainly due to social interactions in transport.

The duration of interactions

Table 2 shows that the vast number of interactions were very brief and that it was unlikely for a participant to have an interaction with someone for longer than 4 min. There was a difference between hospital and hostel interactions in terms of their

Table 1. Locations of interactions

Location	Hospital				Hostel			
	Number of interactions	%	Time (h)	No. of interactions per hour	Number of interactions	%	Time (h)	No. of interactions per hour
Living area	489	47·7	8·5	58	575	27·3	3·5	164
Dining room	235	22·9	1	235	463	22·0	2	232
Therapy/ATC	91	8·9	3	30	445	21·1	5	89
Kitchen	9	0·9	—	—	90	4·3	0·5	180
Outside	2	0·2	—	—	195	9·3	1·5	130
Other	199	19·4	2	100	337	16·0	2	169
Total interactions	1025	100			2105	100		

Table 2.   Duration of interactions

Establishment	Time				Total interactions
	<1 min	1–4 min	5–9 min	>10 min	
Hospital	853 (83·2%)	138 (13·5%)	9 (0·9%)	25 (2·4%)	1025 (100%)
Hostel	1449 (68·8%)	560 (26·6%)	50 (2·4%)	46 (2·2%)	2105 (100%)

duration ($\chi^2=70\cdot5$, $P<0\cdot001$), and Table 2 indicates that hospital interactions were briefer than the hostel ones. Inspection of the data showed that the high proportion of brief hospital interactions (those lasting less than 1 min) was due to interactions concerning physical needs and to comments. Most hospital interactions lasting 1–4 min were due, again, to physical needs and to 14 conversations. The 25 hospital interactions lasting longer than 10 min were due to interactions concerning physical needs of the residents and to joint interactions (e.g. games). Interactions lasting longer than 10 min in hostels were due to conversations, and joint leisure and work activities.

DISCUSSION

The data show that the hospital and hostel residents with moderate to severe learning difficulties who participated in this study had virtually no interactions with people outwith the establishment in which they lived, showing that they had not become part of the wider community in any real sense. For hospital participants, the fact that they were living and working on a hospital site was an added obstacle to integration. Moreover, the low level of residents' integration into the wider community was not helped by a lack of staff both in the hospital and in the hostels. It is particularly disappointing that those living in the community-based hostels enjoyed only a few fleeting social contacts with others from the wider community. This finding shows that 'being there', i.e. living close to shops, banks and pubs, and making some use of those and other local services, is no guarantee of having interpersonal contacts with other people using these services and getting to know them.

As a place to live, the hostel appeared to offer the residents quite a sociable environment with significantly more interpersonal interactions than in the hospital. In addition, the predominance of social interactions in the hostel contrasted sharply with that of functional interactions in the routine-based hospital settings. In the hospital dining room, many more people had to be managed during meal times and, since the dining room could not seat all residents at the same time, there were two sittings for meals. Therefore, a meal in the hospital dining room did not appear to have much of a social function but, rather, was a refuelling event, a function only of physical necessity but not an occasion to be enjoyed by the residents. The residents were often reminded to hurry up in order to make place for the next sitting. In contrast, hostels' smaller dining rooms where staff usually sat and ate with residents, social interactions at meal times were prevalent. In addition, small hostel dining rooms, living rooms, therapy

sessions and ATCs provided an environment conducive to joint activities, conversations and other kinds of social interactions. The data also showed that the more sociable nature of interactions in hostels was accompanied by more positive attitudes. Thus, although there was a proportion of negative and controlling attitudes in hostels, the predominance of interactions expressed friendly and helpful attitudes by residents and staff. In contrast, while nearly one-third of the recipients' attitudes in the hospital setting were friendly, it is very disturbing that impersonal, ignoring, intimidating and controlling attitudes figured most significantly in the hospital settings.

This study did not specifically explore the relationship between the nature of the establishment in which residents lived and the nature of interactions. However, it is apparent that the rigidity of hospital routines to a considerable extent predetermined the kinds of interactions that took place between the staff and residents, and amongst the residents themselves, in that a great many of the interactions were actually concerned with those routines. In other words, these data indicate that the routine nature of institutional life actually fosters impersonal functional interactions between people. Therefore, it is difficult to envisage whether, and to what extent, staff and resident training towards better communication, and a better physical environment, would be sufficient to allow the two parties to break out of the institutional constraints preventing more social and sociable patterns of interactions.

The lack of any longer interactions both in hospital and hostel settings meant that people with moderate to severe learning difficulties had little chance to develop communicative skills and strategies that would enable them to enjoy meaningful human interaction. Sustaining interaction with a person who is unable to hold conversation requires a great deal of sensitivity, skill and time on the part of staff. However, sustained interactions do not necessarily need to be conversations. They might well be achieved through participating in joint activities. Any joint activity, such as listening to records together, preparing a meal, going out or playing a game, is enjoyed by most residents and gives them the feeling of togetherness and of being wanted. Such joint activities could play a very important role in the lives of residents with very limited speech or with no speech.

Conclusions

The White Paper *Caring for People* (DHSS, 1989) specifically states the government commitment that people with disabilities should live independently in their own homes or in 'homely' settings in the community. Lack of integration into the community is a matter for concern in both hospital wards and hostels. In particular, the section in the White Paper on mental handicap services in Scotland suggests that more than 90% of residents in mental handicap hospitals could be accommodated into the community, depending on the availability of suitable places and personal support. However, the present study shows that living in the community does not in itself provide a guarantee for integration. The main two reasons for lack of integration were staff shortages, and the lack of importance that staff attached to the participants' social lives and their integration into the community. Thus, it is important that staff open up opportunities to people with learning difficulties to take part in ordinary daily

activities such as cooking and shopping, as well as in social pastimes. The importance of social life should be emphasized and it should be ensured that in residences weekends are sufficiently staffed to offer people with learning difficulties the opportunity to go out.

Training the residents in communicative skills has an important role in the effort to improve staff-resident communication. Indeed, the lack of interactions found in this study showed the need for greater emphasis on helping people with moderate to severe learning difficulties to acquire communicative skills. People with moderate to severe learning difficulties are always likely to require some support in the management of their daily living tasks. However, focusing solely on training blurs staff's sensitivity to individuals and maintains social distance.

A more personal approach on the part of staff is required if they are to participate in joint activities with residents. The present authors would like to suggest that the first priority must be that residents live in smaller groups of four to five in ordinary housing. The advantages of smaller groups are that they can give staff and residents a chance to develop intimate personal relationships in a flexible social environment. For example, there is little point in helping residents to buy their own food stuffs if they are not helped to prepare a snack outside the prescribed times by themselves. Improved communication and a flexible environment should in turn foster residents' interests and offer choice, and so opportunities for personal development.

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