Once They Get the Notion. Impacts on interaction of how residential support staff characterise residents.

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Abstract: As a feature of familiarity, and as a help factor for decision making in situations that arise in the course of daily life in supported living, staff create and maintain characterisations of the individual residents. The pictures they create are embedded in widely held representations of people with intellectual disabilities, but are individualised and cast in the local context. On the one hand, such characterisations focus either on difference or on similarity in regards to people with intellectual disabilities and others. On the other hand, characterisation is orientated either toward what is a problem for the resident, or on what creates problems and pressure for staff. From the possible combinations of focus and orientation, four styles of institutionalised practice emerge; therapeutics, disciplining, cooperation and service. Each style affects interactions in a typically different way.

A new type of group solution

Toward the new Millennium, major reforms in health and social services were implemented in Norway. In our debates, like in the other Nordic countries, questions were raised as to how we are to meet the challenges of the future. Were the solutions we had chosen appropriate and acceptable any longer? This debate on social policy was taking place in a climate of ideological change. The ideals of the Welfare State: equality, standardising and public, generic solutions, were starting to change toward more weight being placed on freedom of choice and variation in the welfare services. Within care for the elderly, psychiatry, and services for people with intellectual disabilities there was a development involving the minimising and closing of institutions, replacing them with decentralised and municipalized care systems. Services were constructed in the local environments and directed toward people's own homes (Alvsvåg and Tanche-Nilssen 1999; Sandvin 1992b). The new policies underlined that "*people with a need for care shall have the possibility for a private and independent life, with security and dignity in their own home*" (NOU1992:1, my translation)

When the institutions for people with intellectual disabilities all were closed early in the 1990s, a new living arrangement was created – for lack of a better term, and to distinguish them from the former group homes, I've called them grouped homes. These grouped homes

are buildings or row houses containing several - most often 3-6 – separate apartments, some common space, and facilities for the staff who provide services for the residents. This kind of arrangement has become the most typical living arrangement since the reform in Norway for adults with intellectual disabilities not living with their families. The people with intellectual disabilities who live like this have their own apartment, but their relationship to their neighbours is rather special. In many ways they have a tighter connection to the others living in the building than other neighbours have, and most often more distance than members of a single household would have. They pay rent for the apartment that has been administratively provided for them. At all times, at least while the residents are at home, there is a staff in the building who have a responsibility for services. These residents have little or no choice in whom they come to live close to, or in who is hired as staff. Such apartments are then still, everything taken into account, a "place" in the system (Tøssebro and Lundeby 2002).

When we speak of "people with intellectual disabilities" in the Norwegian context, we are restrictive in our categorisation. People who live in the grouped homes arrangements I am talking about, are among the 0.4% of the total population in our country that were registered as people with intellectual disabilities. This percentage is what one generally would expect to find of persons who have moderate to severe cognitive impairment within a population. Accordingly, we are speaking of a smaller population than what often is the case in e.g. Anglo-American literature, and of a group of people in which all are in need of help and services on a daily basis. As for staff, Handegård (2002) found an equivalent of 16 full-time positions for staff on average within these grouped homes arrangements: typically 6 are without relevant education, 7 have one year education and training at the baccalaureate level, 3 have college education for this field, and 2 have other types of educational background – but only 3-4 of these people hold full-time positions.

The background for this paper is my doctoral work (Folkestad 2003), a study that built on fieldwork and interviews with staff in residents in such arrangements. My focus was on the interactions between residents and staff, and the goal was to gain a research-based understanding of this particular form of everyday life, and to provide input for reflective practice. I am going to talk a part of this work, namely about how the way staff characterise residents influences the way staff choose to relate to these same residents.

Characterisation

When Susan[1] experienced what she regarded as inappropriate sexual behaviour from one of the male residents where she works, she did nothing more about it than handle it in the actual situation. She said:[2]

> *Maybe they're like that. I thought maybe it comes with the job. It isn't normal, but I thought I didn't need to make any fuss. I didn't report it either.*

The man who behaved inappropriately is seen as "like that", the focus is on difference, and what she said is an example of what I have called "characterisation".

There is a basic binary at the root of interactions within the grouped homes arrangement - residents are people with intellectual disability who live here because they require help on a daily basis, staff is hired to provide that help. When staff was telling me about how they made Randal's place cosy, I remarked that they were taking all the initiatives and making the decisions. "*Of course*", they said. It is their conceptions that staff generally are needed to discover needs and problems – and to deal with them, and that the residents are different.

In conversations and exchanges in the course of day-to-day work, staff comment about residents in ways that is a characterising of these residents. This characterising is passed on as an oral report among staff, and when characterisations are repeated regularly, they come to create and sustain a social construction of the resident in focus. Such constructions may be an expression of close knowledge of the person, but, on the other hand, it may also have a conservative effect in that it creates a locked picture of that person. There is a risk then, of also cementing practice toward this same person. Characterisation can be part of what is set forth as causal explanations of events - in this way it also helps calibrate expectations. To some extent, characterisations give an insight into the kind of readiness that staff has towards particular residents. Characterisations are sort of shorthand images that are built from observations, local folklore, moral evaluations and attribution. However, it is important to note that the characterisations of a particular resident may be both diverse and inconsistent.

Given the focus on difference, it is not surprising the some of the characterisations involve terms that associate with diagnoses. E.g., Rebecca, it is said, "*has kleptomaniac*

[1] For the sake of information, in the examples that are used in this paper, I have given members of staff names that begin with *S*, and residents' assigned names start with *R*.
[2] The staff, of course, spoke Norwegian. I have translated meanings in as close to word-by-word possible.

tendencies". The backgrounds for this were some episodes where she had removed things from Richard's apartment after a visit. Staff say she has "*psychiatric problems*", but they do not (or can't) elaborate on this. Robert is said to be "*psychotic*", or rather "*is in a psychotic phase*". Among staff there are those who find this particularly interesting, and who would like to know more about "*this irrationality*". Then again, such a characterisation of Robert is neither the only one, nor even the one most frequently used. The idea of phases, however, is often brought up in remarks when his behaviour is seen as problematic.

Diagnostic terms provide a causal explanation; at the same time they also provide "excuses" by referring to illness rather than to intentionality. Actions in singular episodes may be characterised in terms that remind us of *The Diagnostic Culture* (Løchen 1976). E.g., where residents show anger, it may be reported that someone has been "*hysterical*". In the report and discussion following such an event, staff wondered whether Ruth's behaviour was the sign of "*something psychiatric*". Maybe she could "*use a pill to quiet down on*"?

Characterisations that reflect a focus on problems do not always use diagnostic terms that implicitly at least in part focus on problems for the resident. Characterising may be rooted in an experience of the workload certain behaviours create. Ruth "*isn't easy, won't budge*". Robert is "*pestering and demanding*" and "*always needs someone close by*". This kind of characterisation puts more of the responsibility on the resident, the acting person who by her/his behaviour creates demands on staff.

In an almost opposite way of characterising, the focus on what might be problematic is toned down. Sally described a man who has one-to-one follow-up at all times as "*an active fellow*", using a kind of characterisation that usually has positive connotations. Sally did however add, "*you have to be very alert when you are with him*". In general she characterises the residents where she works as "*well functioning*", elaborating that "*they are comparatively good at communicating, and they can all walk*". This brings our attention to what I would call a comparison-based characterising.

Even though Rebecca and Randy are said to "*have no language*", staff also say that "*all the residents here understand …not like some other people with intellectual disabilities*". What they are saying is that, more than in other places they assume of, one can rely on verbal communication here. At the same time, based on this same locality for comparison, though Rick has quite a vocabulary they say, "*he's the one who understands the least*". This relative characterising finds its basis for comparison in other residents within a grouped homes arrangement, or in more general assumptions. "*Some residents are more demanding than others,*" says Stella, "*Ronald is the easiest, not much work or demand*". The ones who live

upstairs are "higher functioning" than those who have their apartment on the ground floor. Though, upstairs, they protest and are "*just like kids*".

Much characterisation is assumptions about, or attribution of, personal qualities or traits. E.g., Rebecca "*learns quickly*" but is also said to be "*curious and demanding*" and at the same time "*sort of lazy*". Robert is "*intelligent*" and "*understands more than one would suspect*". Some say that he is "*really charming*". It is also said that he can "*read staff so well*", that he "*senses the situation so quickly*" and that he then quickly can bring things to a boil.

A danger

Reminding us of Asplund's concept of *concrete sociality*, Wærness points out how important it is that the systems of care are organised in ways that create possibility for staff and service recipients to experience each other as individuals, as fellow human beings. "*People in need of care may easily become a grey mass to busy staff who aren't able to see them as persons*" (Wærness 1999, my translation), then the danger of abuse increases.

Characterising is always invoking some abstract category, but as long as the focus is still on Ruth, Richard and Robert – people with names – we are still seeing concrete individuals. However, when Sally comments, "*it's that they are so strong*", then it isn't Richard who is the main reference any longer. It is rather that Sally worries about a situation where she might have to deal with one of the "retarded and aggressive". The focus is shifted, from Richard's situational reactions, to being about the security of staff in meeting with "one of them". Should the general concerns be about the staff's well being, then other priorities and solutions are both thinkable and acceptable, compared to how we must act when the concern is decent care and the relationship we can foster with a person called Robert. If we allow ourselves only to see him as "one of them", we abandon his concrete sociality in favour of an abstract sociality. Then a personal relationship is no longer possible – neglect or abuse may result from this.

Characterisation and choice of action

The pictures that are drawn of individual residents by characterisation are multi-facetted and diverse, sometimes even inconsistent. Characterisation may function more or less as social constructions. It may have its roots in a focus on residents' status as people with disabilities, or this may - to a varied degree – rather be overlooked. This of course raises questions about how characterisations influence action.

Ambivalence and dilemma arise when staff have to balance ideas about self-determination and conceptions of needs due to intellectual impairment. As manager, Sally pointed out to her staff that they at all times should "*ring the doorbell and recognise and respect the apartment as the person's own home*". When, however, doubt arose about whether or not Rebecca had remembered to get things out of the freezer in the morning for her dinner later, Sally unlocked the door and entered the apartment while Rebecca was at her work centre, and saw to it. She "*saved the day*", as she put it, solving a potential problem in the afternoon by overstepping the private boundaries she had pointed out to staff. By making this choice, she underlined a specific way of characterising Rebecca – namely that she is forgetful and in need of help in a way that makes it necessary for them to take over responsibilities. This characterisation thus took the fore at the expense of seeing Rebecca as a tenant of her own apartment. There is a complex interplay between how situations are defined, how residents are characterised, and how staff chooses to act and react. The point I am trying to make is that characterising has implications for choice of action, and choice of action validates certain ways of characterising residents.

Although residents actively take part in interactions with staff, and thus influence them through demands, participation, and/or countermeasures to staff's demands and proposals, staff is advantaged when it comes to power. Staff's conceptions of residents and staff's way of interpreting situations have the strongest influence because they have more power of definition and they act more as a collective.

Characterising, in the way I have pointed it out, is the action of staff drawing a shorthand image of individual residents. To the extent that such images become commonly accepted and maintained by being repeated, they become constructions with bearing on how staff act and react toward a given resident. Though characterisations are made of individual residents, they are embedded in more generalised conceptions about people with intellectual disabilities.

Social representations

The larger frameworks for characterising are *social representations* (Chaib and Orfali 1995; Moscovici 1981; Moscovici 2000).

> *By social representations, we mean a set of concepts, statements and explanations originating in daily life in the course of inter-individual communications. They are equivalent, in our society, of the myths and belief systems in traditional societies; they might even said to be the contemporary version of common sense* (Moscovici 1981, 181).

Social representations are part of the worldview that influences actions and reactions from members of the group that holds such a view. Social representations form the backdrop for stories and observations staff share, and are the frame of reference in which problems and tasks are formulated. In this way social representations are helpful in interpreting the surrounding world, they provide group members with a common identity and make them more secure in their interpretations and choices of action. The ways staff characterise individual residents are embedded in representations that contain contradictory 'truths' - people with intellectual disabilities should have their own homes, but we have to build in common space so as to avoid isolation and loneliness; the ambition is individual services, but the living arrangement has a group(ed) format; we stress self determination, but expect staff input.

Characterising is not only tied to the individual. Even when a resident is characterised in positive terms, there is an implicit comparison that basically points back to difference. E.g., Susan has discovered that Richard likes it when she speaks to him in a usual everyday fashion. Highlighting that it is possible to speak to him the same way she normally speaks to people, points out that he is different from those people she, without a second thought about the matter, would speak to in that way.

How characterising typically influence interactions

The figure below is an illustration of the interplay between characterising and choice of action, and is presented as a point of reference for the remarks to follow.

CHARACTERISING

Focus ➔	**Difference**		**Toning down difference**	
➘ ***Orientation*** (*Whose problem preoccupies staff?*)	**Resident**	**Staff**	**Resident**	**Staff**
Staff's actions in connection to resident's practical tasks:	steering	taking over	sharing	non-involvement
Space given to residents' initiative:	situational, moderate - little	generally little	situational, moderate - ample	generally ample
Reluctance/ resistance seen as:	confirming difference	threat to discipline	demonstrating self-determination	expressing opposition
Style of practice	**Therapeutics**	**Disciplining**	**Cooperation**	**Service**

On the one hand, characterisations focus on difference of people with intellectual disabilities compared to others. This is what characterisations that point to diagnoses do. On the other hand, characterisation can tone down this focus – readers will remember the man with a close follow-up due to behaviour, that was characterised as an active fellow. The first line of the table is based on these two options. Staff have to create an understanding of the actual situation in order to have a basis from which to decide what sort of and what amount of help they should provide the resident with. The decisions made are not, however, based only on unique situational qualities. A wider background is needed, and characterisations provide some of this. Not that characterising is necessary in it self, but a definition of the situation includes the *who, what,* and *where*, and characterisations represent first off a simplification as to "who".

The next line in the table is about *orientation*. It may well be that there really is a continuum here, but the poles at least are an orientation toward *what is a problem for the resident* or, *what creates problems for/pressure on staff*. Orientation impacts on what kind of characterisation is formulated and passed on. For example, Ruth, who had recently moved into her apartment, was very persistent in gaining contact with staff. This could be read as both "a need for contact and comfort in a new life situation" and as "unlimited demand on staffs' time". Even though some comments made by staff indicate the first of these understandings, the latter was the most prominent one. Staff were preoccupied with the workload Ruth represented, and this became the basis for the characterisations they shared of her. They implemented rules about contact with her, among other things wanting to teach her to wait her turn. The kinds of characterisations in use show orientation. In this way, characterising also influences the "what" in situational definitions.

The mechanism is that a standardised image of the resident also activates a standardised response. So, characterisation activated in a given situation will through its focus influence the conception of "who", and via orientation of "what". This is how characterising plays a role in defining the actual situation, and thus influences how staff choose act and react. Characterising becomes important – critical, but not causal – to how the situation is handled.

The focus on difference implicitly insists that the root of the problem is in the individual. In this perspective staff formulate problems in terms of *lack of skills* or about *challenging behaviour* on the part of residents. Where, in terms of orientation, the weight is put on how this creates problems for the resident; training and therapy are the chosen

response. A problematic implication stemming from this is the risk that the activities of daily living are referred to in a special vocabulary and thus changes character. Meals become situations where training takes place. This potentially social situation is invaded by a secondary instrumental undertaking. Similarly, also in other activities staff become concerned with steering what goes on and how, and this work legitimises their competence as therapists (see also Sandvin 1992a). An instrumental practice is developed with staff in a pedagogical role that demands professional distance. The underlying principle is paternalism, taking for granted that staff must be in charge. The debates aren't about whether to intervene or not, but about how it should be done and about what the outcome should be – what the resident should be brought to do. Activities are planned out; the day follows schedules and routines that are enforced cooperatively by staff. The activities themselves may easily become the centre of attention rather than the resident. Staff do not expect the resident to be able to manage the activities in question, and invitations – if any – tend to be put out in negotiative terms ("..and then we can do *x* afterwards"). Staff report "how it went while I had him". There is generally a declared goal that the person should experience self-determination, but in this style of practice there is little space made available for initiatives on the part of the resident. Finally, signs of reluctance or resistance to suggestions from staff are seen as confirmation of the difference that essentially is at the root of the resident's problems. The style of institutionalised practice that emerges from this combination of focus and orientation, I have called this *therapeutics*.

On the other hand, lack of skills or challenging behaviour can be understood as a strain on staff. Here the focus on difference is still dominant, but the orientation of staff has shifted toward themselves. Immersing oneself in practical business is a way of avoiding the inconveniences of having to interact with the resident (see e.g. Christensen and Nilssen 2002). Taking over the mundane tasks occurs from this alternative. Discontinuous contact, for example because of part-time positions, may also have this effect. Comments made by staff that some "*are here so seldom that they'd rather just stick with the cleaning*", illustrates this point. To the extent that the resident is allowed to participate in the chores of maintaining the apartment etc., staff keep the initiative and provide only imperatives as guidance. Positive remarks after such participation are about how good the resident is at helping out. Staff decide how things are done and what is a good enough result. There is little room for any initiative from the resident. Stern rules about behaviour are enforced, and there is a demand for consequent reactions among staff. This is seen as an appropriate response to what is understood as challenging behaviour. Staff are on guard toward the resident, they observe and

are ready to intervene and to enforce prior agreed procedures. This alert toward a possible need for procedures has the effect that there is less of other kinds of interaction with the resident, and more inter-personal distance between staff and resident. This is in part a result of the fact that procedures are strenuous in them selves and that they inhibit other kinds of interaction afterwards, and in part that staff keep clear in order not to provoke confrontations. The style of practice might here be called *disciplining*.

The focus isn't necessarily an underlining of difference, in fact, it may be that the focus instead tones down difference. Characterising that conveys this focus will carry positive descriptions of what the resident is able to do. The person's need for assistance is seen only as a difference of degree, not as an essential difference from the needs of most people. Where the orientation is toward the resident, staff try to assist in the activities of daily living by sharing the labour and doing things together with the resident. Staff try to find ways in which to help without taking charge. Initiatives from staff then tend to be invitations and suggestions, and there is ample room for initiatives by the resident. The resident experiences both help and accept, protest or reluctance is seen as appropriate reminders and gratifying signals of independence. This style of practice is labelled *cooperation*.

The final style of practice is what I have called *service*. Here the resident is not seen as different per se, but there is a distance due to insecurities of staff. It is not so much the level of functioning in it self that is the determinant, but that the resident sets boundaries for contact with staff without staff interpreting this as psychiatric problems or essential difference. Staff may express understanding when the resident "*doesn't like us to nag*", or that the resident "*likes to do things his/her own way*", but they feel uncomfortable when in contact. It seems that staff have trouble making and maintaining a relationship with the resident. And one way to handle problematic relationships it to maintain distance and legitimise this in the vernacular of service – providing only the services that are explicitly asked for. The resident may contact staff, and is otherwise left to his/her own resources. However, since this person is a resident in this living arrangement, staff still feel a responsibility. They answer to this by providing reminders about things that should be taken care of. Otherwise contact is limited as long as problems do not arise. Characterisations of the resident play down difference, but underline that this person is "difficult" – either to make contact with or to have dealings with. Reluctance and resistance is interpreted as opposition. The perceived independence is seen as a legitimate reason to limit contacts and to avoid the problematic relationship. The danger of neglect is imminent.

The four styles of practice that I have outlined here should be understood as ideal types or simplification. Residents may experience, and we may observe, that different members of staff use different styles towards them; that the same member of staff may use various styles in various situations with the same resident; and that a certain style may be the most typical toward some residents. The preparedness that characterisations bear signal to, influences how much room is given for initiatives on the part of residents. Characterisations also carry implications for the ways in which guidance is offered – in the form of invitations or imperatives. Whether a close follow-up is seen as helpful organising or as restriction depends on what kind of characterising is activated in a given situation. The same holds true for whether non-intervention and ample space for initiative is seen as an opportunity for self-determination or as neglect. Focus and orientation are implicit in the styles of practice that staff choose, and they are indicated in the characterisations they put forward in the actual situations. They are not, however, necessarily results of open discussions or explicit formulations. They might not even be subjects of conscious reflection or debate. But characterisations figure in the reasons given for choices of action where these become necessary. In situations like these, the characterisations of a resident or residents used among some, may meet upon challenging characterisations put forward by others. Then discussions may arise. To a large extent, characterisations are the tacit basis for defining situations and for choosing how to act in interactions with residents. In this way, characterising works "*for all practical purposes*" in creating a sufficient basis for decision-making.

The styles of practice that I have outlined here are of course liable to be affected by plays made by residents and their responses to the actions of staff. Using prior experiences and close knowledge of staff, residents may be able to provoke certain styles of practice. Residents may hold off staff and provoke, e.g., the style I have called 'service'. The important point I have been trying to make, is the insight provided by the Thomas' Theorem: "*If men define situations as real, they are real in their consequences*" (see Merton 1995) . Characterising very much determines how situations in daily practice are defined, and leads to choices of action that realises the implicit focus and orientation that characterisations implicitly hold.

Concluding Remarks

I have concluded that staff are trying to do their job by trying to solve the problems as they are locally formulated or tacitly understood more or less collectively. Through characterisation, implicitly, it is considered just how different residents are and whose

problems should be at the centre of attention. How interactions are played out depends upon whether effort is put into reducing the strains on staff or into assisting the resident deal with the issue creating problems for him or her. Characterising is a process for practical legitimising of the choice made in situations. Other characterisations may challenge the ones in use. Since a characterisation carries a certain focus and orientation, alternative characterisations that are agreed upon will cause change in style of practice.

As consequence, I propose that new standards or guidelines enforced from outside may not result in much change. Supervision or counselling can help staff formulate problems explicitly, steer their attention to the impact of characterisation, and draw attention to the input from residents. This has a potential for bringing focus and orientation to the fore in reflection and discussion, so that new and critical questions arise about current practice. New ways of looking at problems, agreed upon reformulations, have the potential for creating a new way of working as well.

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