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Bullying in Senior Living Facilities: Resident Perspectives

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Bullying in Senior Living Facilities: Resident Perspectives

By

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Abstract

Research associated with resident-to-resident bullying in senior living facilities (i.e., senior bullying), has been growing in recent years due to anecdotal stories in the popular press. Few studies, however, have assessed resident-to-resident bullying from the perspective of residents. Therefore, the purpose of the current study was to better understand the phenomenon of senior bullying as observed by residents in senior living facilities. Nineteen individuals residing in senior living facilities were interviewed about their observations and opinions related to senior bullying at their facility. Results indicated that 52.9% of residents had observed senior bullying at least once. Verbal and social bullying were equally observed by participants, with the majority of bullying being observed in common areas. Perpetrators and victims were reported to be mostly female. Approximately half of participants who endorsed resident-to-resident bullying stated they had observed staff and residents intervene during instances of bullying. Only 10.5% of the sample felt that bullying was a problem at their facility, and that staff does not take the necessary steps to prevent bullying. Although previous research suggests senior living facilities typically have a bullying policy, implications for the current study suggest that policies could be improved by incorporating resident awareness and education.

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Introduction

Overview of Bullying

Bullying has been an area of interest in research for the last 30 years. Despite the extent of research on bullying, there is still debate around its definition (Monks et al., 2009). In general, the definition accepted by most researchers is a repeated action that is intended to cause harm, usually with an imbalance of power (Monks et al., 2009). This definition was broken down even further by Volk, Dane, & Marini (2014), who explain that rather than intended harm the perpetrator's actions are "goal-directed." This is what separates bullying, or proactive aggression, from reactive aggression, which is behavior that is more impulsive or a self-protective instinct to a trigger. The imbalance of power component of bullying is important because it suggests that the victims are unable to defend themselves, resulting in the repetition of bullying. Once again, Volk et al. (2014) suggest that rather than focusing on the number of occurrences, researchers look at both the frequency of the behavior and the intensity. By examining both pieces it reveals more about the level of harm that is directed at the victim, which ultimately is the most important part. This means that an individual could be bullied one time at a very high intensity, and other individual bullied several times at a lower intensity, but both have been harmed to a similar degree.

With this definition in mind, some researchers report that bullying is different from "relational aggression" (RA) because bullying includes overt behaviors, e.g., teasing or hitting (Golmaryami & Barry, 2010). Whereas relational aggression is covert and involves harming someone's reputation or socially excluding them. Because relational aggression has the potential to inflict harm it would qualify as bullying (Volk et al., 2014). Once it is understood that bullying occurs both overtly and covertly it can then be divided into three categories: physical, verbal and

social (Cardinal, 2015; Centers for Disease Control and Prevention [CDC], 2016). According to the CDC (2016), aggressive behaviors that qualify as bullying include: hitting, tripping, teasing, name calling and spreading rumors.

While research on bullying in various settings such as schools, (Crick & Grotpeter, 1995; Golmaryami & Barry, 2010; Tackett, Kushner, Herzhoff, Smack, & Reardon, 2014) the workplace, and prisons (Monks et al., 2009) has made significant progress; research directed toward bullying in senior living facilities has not received as much attention.

Senior Bullying

Research on bullying in senior living facilities (i.e., senior bullying) is split to ways: aggression directed at caregivers and aggression directed at other residents (Pillemer et al., 2011). Bullying or aggression between residents appears to have the least amount of research dedicated to it, and one reason for this may be the variety of target behaviors that are being investigated (McDonald et al., 2015). Within the literature on bullying in senior living facilities a variety of terms are used, including: bullying (Goodridge, Heal-Salahub, PausJenssen, James, & Lidington, 2017), resident-to-resident aggression (Bonifas, 2015; Ferrah et al., 2015; Pillemer et al., 2011; Rosen, Pillemer, & Lachs, 2008), elder mistreatment (Ellis et al., 2014; Lachs et al., 2016), aggressive behavior (Voyer et al., 2005), and relational aggression (Bonifas, 2015; Cardinal, 2015, Tackett et al., 2014; Trompetter, Scholte, & Westerhof, 2011). Each term encompasses a slightly different set of target behaviors, overt or covert; however, the purpose of this body of research is to identify the intentional harmful behaviors between residents (Cardinal, 2015; Ferrah et al., 2015).

Given the variation of bullying behaviors being investigated, there is discrepancy in prevalence rates for senior bullying. In a study using secondary analysis of aggressive behavior

(AB) in senior living facilities, Voyer et al., (2005) found that 21% of residents (n= 2,332) displayed either physical or verbal aggression and 11.2% displayed both. However, the researchers did not take into consideration who the behaviors were being directed at, staff or residents. A similar exploratory study addressed RRA in nursing homes and found that within the last 2 weeks there were 122 events that met the criteria for RRA, as previously defined (Pillemer et al., 2011). The researchers then categorized the events and created five major forms of RRA: "invasion of privacy or personal integrity, roommate problems, hostile interpersonal interactions, unprovoked actions, and inappropriate sexual behavior" (Pillemer et al., 2011, p. 27). Suggesting that RRA is not just one behavior but encompasses a large range of behaviors is important for future research attempting to establish the prevalence of these behaviors. Rosen et al. (2008), found that over a 2-week period, 2.4% of resident's experienced physical RRA and 7.3% had experienced verbal RRA (n=82).

A more recent prevalence study used various methods such as direct observation, staff and resident interviews, and chart review to assess the rate of resident-to-resident elder mistreatment (R-REM). The results indicated that over a 4-week period 20.2% (95% CI, 18.1% to 22.5%) of 2,011 residents experienced R-REM. However, this statistic appears to include residents who were either a perpetrator, victim or both. They also found that based on the whole sample, subtypes of R-REM were verbal (9.1%), physical (5.2%), sexual (0.6%) or other (5.3%; Lachs et al., 2016).

Research provides evidence that senior bullying is taking place, but who are the victims and what risk factors are associated with being a victim of senior bullying? Some research suggests that victims of senior bullying are typically male, show cognitive decline and undefined behavioral disturbances (Ellis et al., 2014). Voyer et al. (2005) and McDonald et al. (2015) found

similar factors for perpetrators of aggressive behavior, which included being male, mild to moderate cognitive decline, and undefined psychological distress. Rosen and colleagues (2008) support this claim and suggest that because 80 to 90% of residents living in senior care facilities display some form of cognitive decline that it is likely the reason bullying behaviors are observed. They go on to explain that research shows verbal aggression is more often associated with cognitively intact persons, and physical aggression with individuals showing cognitive decline (Rosen et al., 2008).

However, the gender of senior bullying victims and perpetrators still appears unclear. In a systematic review by Ferrah et al. (2015), of the 12 quantitative and six qualitative studies, victims of RRA were typically female, cognitively impaired and required more staff assistance. They also found that perpetrators were more cognitively intact, less dependent and displayed more aggressive behaviors. A review by McDonald et al. (2015) made the same conclusions regarding victim and perpetrator characteristics and added that characteristics such as personality may also play a role. Theses reviews provide evidence of just how varied the research is on senior bullying.

This leads to an important question, what is it about bullying in senior living facilities that makes it so difficult to research? Shinoda-Tagawa and colleagues (2004) found in their investigation of RRA that resident rooms were the most common area for RRA to occur, which would make it difficult for other residents, staff, and researchers to observe; however, some evidence suggests that RRA may occur in public spaces nearly as often (Ferrah et al., 2015). Additionally, policy on incident reporting varies across facilities, which leads to a lack of incidents that are reported to state departments, lowering the observed prevalence rates (Lachs et al., 2016). It is also difficult to collect data on prevalence from residents, who may have hearing,

visual or cognitive impairments, making them less reliable witnesses to such occurrences. Even then, residents may not respond honestly about the occurrence of bullying in their facilities, as an attempt to appear better off than they really are (Rosen et al., 2008). Furthermore, Rosen and colleagues (2008) explained that family members are not always reliable sources either, because they are not at the facilities all the time and residents could behave differently when family members are visiting. There are similar limitations with staff informants, who only observe a percentage of resident interactions and residents can potentially act different when staff is present compared to when they are absent. It appears the best way to investigate resident-to-resident bullying is by attempting to collect data using a variety of methods (e.g., observation, interviews) and from a variety of sources (e.g., staff, administrators, residents). This can be achieved by researchers doing in-person observation of a facility, or by video surveillance of common areas (Rosen et al., 2008). However, as mentioned previously, approximately 56% of RRA occurs in residents' bedrooms and would not allow researchers to observe these occurrences (Shinoda-Tagawa et al., 2004). Despite the methodological difficulties of conducting research on senior bullying, qualitative studies have collected data by obtaining both staff and resident perspectives.

Staff Perspective

A qualitative study by Bonifas (2015) employed semi-structured interviews to examine how nursing home social workers address instance of RRA and how nursing home staff (e.g., directors of nursing, nurses, and nursing assistants) cooperate in these situations (n=90). In general, the researcher found that social workers assess the RRA event by examining what happened before and after the event, and by assessing the psychosocial well-being of all persons involved. Interventions were developed for specific residents, focusing on person-centered care

and resident strengths. Interventions were primarily developed on an interdisciplinary level, between nursing and social work staff. The author suggested that to more effectively manage RRA, social workers should communicate directly with nursing assistants, who spend the most time with residents (Bonifas, 2015).

As discussed, nursing assistants can serve as valuable informants for understanding senior bullying because they provide approximately 80% of the direct care to residents in senior living facilities (Bonifas, 2015; Castle, 2012). Castle (2012) conducted a survey of 3,821 nursing assistants across the United States and found that within the last three months participants had witnessed yelling (97%), cursing (97%), humiliating remarks (96%) and pushing, grabbing, or pinching (94%), all forms of resident-to-resident abuse. These results provide evidence regarding the prevalence of senior bullying; however, the researcher also asked nursing aids if they agreed senior bullying "created an unpleasant atmosphere" (Castle, 2012, p. 345). For verbal abuse 85.8% of nursing assistants strongly agreed, and similar results were found for physical abuse (75.2%) and psychological abuse (71.8%; Castle, 2012). This is the first known study that addressed staff perceptions on the negative implications of bullying.

In a similar study, Andresen & Buchanan (2017) interviewed forty-five nursing home staff (e.g., nurses, administrators and activity directors) in order to assess the prevalence of senior bullying, characteristics of victims and perpetrators, staff intervention strategies and training, and policy related to senior bullying. The researchers found that of the three types of bullying, verbal was the most observed (95%), followed by social (24%) and physical (5%), with the majority of staff reporting bullying taking place in the dining room (n=30) and common areas (n=23). Perpetrators were reported to be 42% male, 18% female, and 39% both male and female. Male perpetrators were usually observed engaging is verbal (46%) and physical bullying (23%),

whereas females were typically observed engaging in social (42%), verbal (31%) and physical (8%) bullying. Staff reported that perpetrators were more likely to show cognitive decline, have a physical disability and "entitled, controlling and attention seeking" personalities (Andresen & Buchanan, 2017, p. 37). Comparably, victims were usually observed as being 42% male, 16% female, and 42% both male and female. Staff identified victims as typically having some cognitive impairment (60%), physical disability (50%) and specific personality traits (60%) such as "being shy, quiet, submissive, dependent" and less likely to stand up for themselves (Andresen & Buchanan, 2017, p. 37). Interventions during bullying typically involved talking to the perpetrator during the event (41%) and talking to the victim during the event (27%). Staff indicated some residents intervene during bullying (59%) while others do not (38%). Regarding facility policy, 58% of staff said they were unsure if there was a bullying policy, 21% said yes, and 21% said no. This study suggests that senior living facilities could benefit from comprehensive bullying policies and intervention strategies (Andresen & Buchanan, 2017).

Resident Perspective

Just as there is little research from the perspective of staff working in long-term care facilities, there is also little research examining bullying from the perspective of residents. Trompetter et al. (2011) examined the prevalence of relation aggression and subjective well-being in assisted living facilities through interviews with residents and staff. Of the 121 residents who participated, 19% indicted they had been a victim of RA. However, nurses indicated that 41% of residents had been victims of RA. These findings suggest that residents and nurses perceive RA differently; perhaps having different opinions on what qualifies a behavior as RA or that nurses are not as mindful of the intent of resident behaviors. Residents who reported being victims of RA indicated higher levels of "depression, anxiety, social loneliness and lower

satisfaction with life" (Trompetter et al., 2011, p. 64). Further supporting the idea that bullying is a "life-long human phenomenon" (Trompetter et al., 2011, p. 66).

Unique to the literature on senior bullying, a qualitative study done by Goodridge and colleagues (2017) surveyed and interviewed tenants from two senior housing locations in Canada. From the forty-nine survey cards they received, 39% of respondents stated that within the last 12-months they had witnessed bullying and 29% stated that they had also been bullied. Thirteen residents participated in a follow-up interview and reported that most of the bullying occurred in common areas. The most common types of bullying were verbal and social, such as, mean comments, threats, gossip and "deliberate social exclusion" to name only a few (Goodridge et al., 2017, p. 1443). Respondents felt that perpetrators enjoyed being in control and that victims may have difficulty defending themselves. Finally, based on the resident interviews, there was little evidence that bystanders and apartment staff intervened during a bullying incident (Goodridge et al., 2017).

Purpose of the Current Study

The literature on senior bullying not only provides evidence for substantial prevalence rates, but the negative implications associated with it, such as: injury, depression, anxiety, post-traumatic stress and decreased quality of life (Bonifas, 2015; Ellis et al., 2014). However, there is still limited scholarly work examining bullying from the perspective of elderly individuals. Therefore, the purpose of the current study was to investigate bullying behaviors in senior living facilities by interviewing residents about their opinions and observations of instances of resident-to-resident bullying. More specifically residents were asked questions related to: types of bullying, characteristics of perpetrators and victims, interventions by staff and residents, and whether they felt bullying is a problem at their facility. The goal was to further understand the

occurrence of resident-to-resident bullying and how residents' perspectives can guide future research on how to implement educational and policy changes in senior living facilities.

Method

Participants

A total of 21 participants were recruited for the study. Two participants' interviews were excluded from the sample because they misunderstood the purpose of the study. For example, one individual thought the study was about bullying between staff members and another volunteered because they thought the researcher could help them with a personal matter. Of the remaining 19 participants, two couples requested to be interviewed together; therefore, the number of interviews conducted was 17; however, demographic data will be provided for the 19 individuals who participated. Most of the participants were female (73.7%). The average age of participants was 83.79 years old (SD = 6.41), with ages ranging from 67 to 90 years old. In regard to ethnicity, 100% of the sample identified as Caucasian. Participants were asked how long they had resided in their current dwelling. The average duration of residence for the sample was 26.11 months (SD = 24.04), with residency ranging from two months to 84 months (7 years). Finally, participants lived in both independent living (52.6%) and assisted living (47.4%) communities. Table 1 provides a summary of participants' demographic data (see Appendix A).

Settings

Participants were recruited from four senior living facilities in the southern Minnesota area. Facility A is a for-profit organization and provides independent and assisted living options. Facility B is a for-profit organization and provides independent living, assisted living, and memory care. Facility C is a for-profit organization and offers independent living, assisted living, and memory care. Although Facility B and C have memory care units on site, participants were

not recruited from those units. Finally, Facility D is a nonprofit organization; however, participants recruited from this location were not included in the sample.

Procedures and Instruments

Participant recruitment was completed in one of two ways. At three of the facilities, researchers were able to recruit during monthly resident meetings. During these meetings, the researchers discussed the purpose and procedures of the study, and interested residents provided their name and contact information on a sign-up sheet. One facility chose to recruit for the study themselves and then provide the researchers with participants' contact information. The researcher then contacted the participants to arrange a time to complete an interview. Interviews were completed in a location of the participant's preference (i.e., a commons area in the facility that provided adequate privacy or in the individual's room).

Before data collection began, informed consent was obtained (see Appendix C) and the participant was reminded of the purpose of the study. The researcher had precautions in place in the event that participants experienced emotional discomfort due to the recollection of bullying incidents. Therefore, all participants were informed that they may chose not to answer a question/s, stop recording, or withdrawal from the study at any time. Additionally, the researcher had contact information for local county human service agencies if a participant disclosed they were experiencing emotional distress due to bullying. If a participant were to disclose an incident that met criteria for elder abuse (e.g., reporting having been physically bullied or that bodily harm has been threatened) the participant (as well as the facility in which they lived) would be informed that confidentiality would need to be broken and a report would be made to the Minnesota Adult Abuse Reporting Center. During data collection, all participants were able to complete the interview and no participant disclosed experiencing emotional distress or elder

abuse.

The interview began by collecting participants' demographic information, including: gender, age, ethnicity, duration of residence in their current dwelling, and the type of facility in which they lived. Participants were then provided a detailed definition of bullying, with examples of the three types of bullying. This helped to ensure that participants knew exactly what behaviors to which the interview would be referring. The interview consisted of four sections pertaining to: 1) characteristics of bullying, 2) characteristics of victims and perpetrators, 3) staff and resident interventions, and 4) resident opinions on bullying.

The interview was a modified version of the interview used in the study by Andresen & Buchanan (2017), and questions were modified to accommodate a sample of older adults. Like the Andresen & Buchanan (2017) interview, the current interview was semi-structured and included both closed- and open-ended questions. Open-ended questions were included to allow participants the opportunity to expand upon some of the closed-ended questions. Prompts were provided if the responses were vague (e.g. "what to do you mean by that?", "would you care to elaborate more?", and "do you have any examples of things that are said?"). Participants were encouraged to provide examples, opinions and to talk about anything related to bullying, even if not specifically asked by the researcher. The length of interviews varied between five and thirty minutes, with shorter interviews being a result of the participant never having observed bullying. In other words, if a participant indicated at the beginning of the interview that they had never observed bullying, the interview was terminated because all remaining questions concerned details about observations of bullying. Interviews were audio recorded (with the participant's consent) using QuickTime Player, an application that records and plays audio recordings. Audio recordings were then transcribed by the researcher. See Appendix B for the interview questions.

Data Analysis

Closed-ended questions were analyzed by calculating frequency counts for responses. Open-ended questions were transcribed by the researcher. A simplified version of a theme analysis was employed to find common themes in participants responses. The theme analysis involved having the researcher identify common responses to open-ended questions (e.g., looking for common phrases or words used in responses) across participants and calculating how frequently each theme occurred in the entire sample. Due to the small sample size, and limited number of participants who reported observing bullying, interobserver agreement for the theme analysis was not obtained. Additionally, two couples requested to be interviewed together and their interviews were counted as one. Although demographic data is provided for 19 participants, only 17 interviews were analyzed.

Results

Characteristics of Bullying Behavior

The first part of the interview included questions related to observations of bullying behavior. Participants were first asked if they had ever observed bullying at their current residence. The researcher was able to use this question to then determine if it was appropriate to continue the interview, such that participants who indicated they had observed bullying behavior continued the interview. Of the 17 participants, nine said they had observed bullying (52.9%). Due to the ability of participants to provide multiple responses to several interview questions, the percentages may not equal 100. Forms of bullying that were observed were verbal (n=5, 55.6%) and social (n=5, 55.6%). No participants indicated that they had observed physical bullying. Common examples of bullying included: gossiping or spreading rumors, teasing other residents,

and saving seats in the dining room. An example from a participant who reported social bullying is below:

"In the dining room, saving seats at a table. Some telling others they are not allowed to sit there, saying 'You'd be happier someplace else…'"

The majority of participants indicated that the bullying behaviors were observed 1 to 5 times a year (n=3, 33.3%), about twice a month (n=2, 22.2%), about once a week (n=2, 22.2%), about once a month (n=1, 11.1%), and about once a day (n=1, 11.1%). These results suggest that although bullying was observed by slightly more than half of participants, bullying occurred relatively infrequently. Furthermore, bullying behaviors were reported to occur most often in the dining room (n=6, 66.7%) and common areas (n=6, 66.7%), followed by hallways (n=4, 44.4%) and residents' rooms (n=2, 22.2%).

Characteristics of Victims and Perpetrators

The purpose of the next interview section was to further understand common characteristics of perpetrators and victims of bullying. These questions were related to gender differences, cognitive, physical, personality and ethnic characteristics of perpetrators and victims.

Characteristics of Perpetrators. Participants reported that perpetrators were more commonly female (n=8, 88.9%) rather than male (n=1, 11.1%). Participants also reported that perpetrators had specific personality traits or characteristics (n=8, 88.9%). Some examples of these personality traits and characteristics included: "above everyone else," selfish, not happy for others, "know-it-all," judgmental, and controlling. Four participants (44.4%) reported that perpetrators had physical disabilities, such as hearing impairments and mobility problems. Two participants (22.2%) indicated that perpetrators were generally healthy and one participant

(11.1%) reported that perpetrators had cognitive/memory impairments. None of the participants indicated that perpetrators identified as an ethnic minority.

Characteristics of Victims. Participants reported that victims were mostly female (n=6, 66.7%), with two participants reporting victims were equally male and female (22.2%) and one participant reporting victims were male (11.1%). Four participants (44.4%) indicated that victims had specific personality traits or characteristics, such as: loner, friendly, "not able to stand up for themselves," and loud. Three participants (33.3%) reported that victims were generally healthy. Two participants (22.2%) indicated that victims had physical disabilities (i.e., mobility problems) and one participant (11.1%) reported that victims had cognitive/memory impairments. Finally, none of the participants indicated that victims identified as an ethnic minority.

Staff and Resident Intervention

The next part of the interview aimed to assess staff and resident interventions, as observed by residents. Of the nine participants who reported having observed bullying, four reported never having witnessed staff intervene (44.4%), three participants were unsure (33.3%), and two stated that they had witnessed staff intervene (22.2%). To assess frequency of staff intervention, participants were asked how often staff intervenes when someone is being bullied. four participants were unsure (44.4%), three stated never (33.3%), one stated occasionally (11.1%), and one always (11.1%). Of the two participants who endorsed that staff intervenes during bullying situations, both stated that they intervene "while the event is happening by talking to the perpetrator," and one answered, "after the event by talking to the victim." Two examples of how staff intervene by talking to the perpetrator are, telling them to be nice and saying, "you can't do that." Additionally, one participant who reported that staff do not intervene stated that staff reminds residents during resident meetings to not hold seats in the dining room.

The participants were then asked if they had ever witnessed a resident intervene when someone is being bullied. Five participants stated they had not (55.6%) and four participants stated yes (44.4%). They were then asked how often residents intervene when someone is being bullied. All four participants who endorsed resident interventions reported they "occasionally" see residents intervene. Ways that residents intervene include: "while the event is happening by talking to the perpetrator" (n=3, 75%) and "after the event by talking to the victim" (n=2, 50%). Examples of what residents have said to intervene include saying things such as: *"You're not supposed to do that,"* and *"button it up."* Of the five participants who indicated they have never observed residents intervene during a bullying incident, three explained to the researcher that they personally have intervened.

Opinions on Bullying

The interview was concluded by asking a few questions related to the participants opinions on bullying where they live, and if they had ever been bullied by another resident at their facility. Seven of the nine participants (77.8%) indicated that bullying is not a problem where they live. They were also asked if they believed staff takes the necessary action to prevent resident-to-resident bullying. Seven participants (77.8%) said "yes" staff take the necessary action. Finally, participants were asked if they had ever been a victim of bullying. Similar results were found, six participants (66.7%) responded "no," and three participants (33.3%) responded "yes." One participant provided an example of how they had been bullied and indicated that during activities (e.g. bingo) they are called names and "mocked" for losing. For the three participants who indicated being victims of bullying, the researcher further prompted the participants to determine if there was continued emotional distress from the incident(s) and/or if elder abuse had occurred. None of the three participants indicated lasting emotional distress or

incidents that met criteria for elder abuse.

Discussion

The current study investigated resident-to-resident bullying in senior living facilities by interviewing residents about their opinions and observations of instances of bullying. Some of the findings of this study are consistent with existing research on senior bullying. The researchers hypothesized that residents would report having observed bullying in their senior living facility and findings indicated that residents are in fact aware of resident-to-resident bullying. Previous research (Ferrah et al., 2015; McDonald et al., 2015) suggests that perpetrators and victims were more commonly female than male, which corresponds with findings of the current study. Additionally, results related to type of bullying are similar to that of Andresen & Buchanan (2017), such that verbal and social bullying occurred most often. However, our data indicate that verbal (55.6%) and social (55.6%) bullying occur equally, which may suggest that residents in senior living facilities are a more reliable source of information regarding social bullying. It appears as if previous research that included data from cognitively impaired individuals tends to find a higher prevalence of physical bullying (Pillemer et al., 2011; Voyer et al., 2005). Our results suggest physical bullying is not as prevalent in independent and assisted-living settings, where fewer residents typically have significant cognitive impairment. Furthermore, consistent with previous research, senior bullying was reported to occur most often in common areas (e.g., dining room, common areas, hallways; Andresen & Buchanan, 2017; Ferrah et al., 2015).

Although there is limited research to which we can compare our findings concerning perpetrator and victim personalities and characteristics, in the current study victims were reported to be less likely to stand up for themselves, whereas perpetrators were reported as being

more selfish, controlling and judgmental. Approximately half of the study's participants reported perpetrators and victims as having a physical disability. In comparison, past studies have indicated that victims were more likely to have a physical disability when compared to perpetrators (Ferrah et al., 2015). As previously discussed, much of the research on resident-to-resident bullying includes cognitively impaired populations. The current study excluded participants with potential cognitive impairments to maximize the accuracy of reports. As a result, our findings demonstrate that very few perpetrators and victims have cognitive/memory problems. These results may also be due to participants' lack of awareness of other residents' cognitive impairments.

The current study examined how staff and residents intervene during incidents of resident-to-resident bullying, which until recently has not been reported in the senior bullying research. Staff intervention was not found to be as frequent when compared to a similar study (Andresen & Buchanan, 2017), with less than half of participants reporting they had observed staff intervene. Similar results were found for resident intervention; however, three participants who reported never observing other residents intervene stated that they themselves occasionally intervene. These findings suggest that residents may not be as aware of staff or resident responses to senior bullying, possibly due to intervention occurring privately with the perpetrator or victim.

This is the first know study that asks participants if they believe senior bullying is a problem at their facility. Our sample indicated that 10.5% of the sample felt bullying was a problem and that staff do not take the necessary action to prevent bullying. Although only two participants endorsed these interview questions, it suggests that there is room for facilities to revise their policies and procedures related to senior bullying. Andresen & Buchanan (2017)

found that senior living facilities typically have a policy for physical and verbal bullying; however, it is less evident if residents are aware of these policies and if resident education would result in decreased senior bullying.

Limitations and Future Research

Limitations associated with the sample. The current study aimed to understand senior bullying from the perspective of residents, which has rarely been done in the senior bullying literature. Although the purpose and method of the study was unique, it was not without limitations. In addition to the recruited facilities being located in southern Minnesota, the small, mostly female sample reduces the generalizability of the results. Furthermore, the researchers did their best to exclude participants with known cognitive impairments; however, residents were not screened prior to being interviewed and it is possible that participants were not as reliable sources as expected. Future research should consider screening participants to ensure the reliability of responses. Finally, several participants who reported never having observed senior bullying explained to the researcher that their level of social engagement was low. Because bullying was most commonly reported to occur in common areas, it is possible those participants have fewer opportunities to observe bullying. Therefore, it may be beneficial for researchers in the future to collect direct observation data in facility common areas to obtain a broader and more representative sample of bullying.

Limitations associated with recruitment. During the recruitment process, researchers used the term "bullying" to describe the study. It is possible that "bullying" is associated with a school setting and residents may have been deterred from participating. Additionally, recruitment for the current study was done simultaneously with another study. This may have been a reason why the sample size was small. It also appeared to confuse potential participants who believed

that both studies were the same.

Limitations associated with the interview. The interview was adapted from the Andresen & Buchanan (2017) study, and although the researchers did their best to adapt it for the target population, some questions appeared to be confusing for participants. Future research should consider piloting the interview with a small sample of older adults to assess the content validity of the interview and to ensure the interview questions were understandable. Another potential limitation of the interview was that participants were asked to recall any incidents of senior bullying while residing at their current facilities. Some participants had been at their facility for several years and others only a few months. Limiting the timeframe on the interview (i.e., the last year, the last two months) could have made it easier for participants to recall instances of bullying. Finally, when asking participants about resident interventions, three participants reported that they had never observed other residents intervening but that they themselves had intervened during a bullying event. Because the interview focused on participant observations rather than their own experience, future research may wish to ask participants if they have ever intervened.

References

Andresen, F. J., & Buchanan, J. A. (2017). Bullying in senior living facilities: Perspectives of long-term care staff. *Journal of Gerontological Nursing, 43*(7), 34-41. doi:10.3928/00989134-20170126-01

Bonifas, R. P. (2015). Resident-to-resident aggression in nursing homes: Social worker involvement and collaboration with nursing colleagues. *Health & Social Work, 40*(3), e101-e109. doi:10.1093/hsw/hlv040

Castle, N. G. (2012). Resident-to-resident abuse in nursing homes as reported by nurse aides. *Journal of Elder Abuse & Neglect, 24*, 340-356. doi:10.1080/08946566.2012.661685

Cardinal, K. (2015). *From social bullying in schools to bullying in senior housing: A new narrative & holistic approach to maintaining residents' dignity*. Retrieved from https://www.umb.edu/editor_uploads/images/mgs/mgs_gerontology/Cardinal.Katherine_Capstone_Gerontology_ May_2015.pdf

Centers for Disease Control and Prevention. (2016). Fact sheet: Understanding bullying. Retrieved March 29, 2018, from http://www.cdc.gov/violenceprevention/pdf/bullying_factsheet.pdf

Crick, N. R., & Grotpeter, J. K. (1995). Relational aggression, gender, and social-psychological adjustment. *Child Development, 66*(3), 710-722. Retrieved from http://ezproxy.mnsu.edu/login?url=http://search.proquest.com.ezproxy.mnsu.edu/docview/618684649?accountid=12259

Ellis, J. M., Teresi, J. A., Ramirez, M., Silver, S., Boratgis, G., Kong, J., Eimicke, J. P., Sukha, G., Lachs, M. S., & Pillemer, K. A. (2014). Managing resident-to-resident elder

mistreatment in nursing homes: The SEARCH approach. *Journal of Continuing Education in Nursing, 45*(3), 112-121. doi:10.3928/00220124-20140223-01

Ferrah, N., Murphy, B. J., Ibrahim, J. E., Bugeja, L. C., Winbolt, M., LoGiudice, D., Flicker, L., & Ranson, D. L. (2015). Resident-to-resident physical aggression leading to injury in nursing homes: A systematic review. *Age and Ageing, 44*, 356-364. doi:10.1093/ageing/afv004

Golmaryami, F. N., & Barry, C. T. (2010). The associations of self-reported and peer-reported relational aggression with narcissism and self-esteem among adolescents in a residential setting. *Journal of Clinical Child & Adolescent Psychology, 39*(11), 128-133. doi:10.1080/15374410903401203

Goodridge, D., Heal-Salahub, J., PausJenssen, E., James, G., & Lidington, J. (2017). Peer bullying in seniors' subsidised apartment communities in Saskatoon, Canada: Participatory study. Health and Social Care in the Community, 25(4), 1439-1447. doi: 10.1111/hsc.12444

Lachs, M. S., Teresi, J. A., Ramirez, M., van Haitsma, K., Silver, S., Eimicke, J. P., Boratgis, G., Sukha, G., Kong, J., Besas, A. M., Reyes Luna, M., & Pillemer, K. A. (2016). The prevalence of resident-to-resident elder mistreatment in nursing homes. *Annals of Internal Medicine, 165*(4), 229-236. doi:10.7326/M15-1209

McDonald, L., Sheppard, C., Hitzig, S. L., Spalter, T., Mathur, A., & Singh Mukhi, J. (2015). Resident-to-resident abuse: A scoping review. Canadian Journal of Aging, 34(2), 215-236. doi:10.1017/S0714980815000094

Monks, C. P., Smith, P. K., Naylor, P., Barter, C., Ireland, J. L., & Coyne, I. (2009). Bullying in different contexts: Commonalities, differences and the role of theory. *Aggression and Violent Behavior, 14*, 146-156. doi:10.1016/j.avb.2009.01.004

Pillemer, K., Chen, E. K., Van Haitsma, K. S., Teresi, J., Ramirez, M., Silver, S., Sukha, G., & Lachs, M. S. (2011). Resident-to-resident aggression in nursing homes: Results from a qualitative event reconstruction study. *The Gerontologist, 52*(1), 24-33. doi:10.1093/geront/gnr107

Rosen, T., Pillemer, K., & Lachs, M. (2008). Resident-to-Resident Aggression in Long-Term Care Facilities: An Understudied Problem. *Aggression and Violent Behavior, 13*(2), 77-87. doi:10.1016/j.avb.2007.12.001

Shinoda-Tagawa, T., Leonard, R., Pontikas, J., McDonough, J. E., Allen, D., & Dreyer, P.I. (2004). Resident-to-resident violent incidents in nursing homes. *JAMA, 291*(5), 591-598. doi:10.1001/jama.291.5.591

Tackett, J. L., Kushner, S. C., Herzhoff, K., Smack, A. J., & Reardon, K. W. (2014). Viewing relational aggression through multiple lenses: Temperament, personality, and personality pathology. Development and Psychopathology, 26, 863-877. doi:10.1017/S0954579414000443

Trompetter, H., Scholte, R., & Westerhof, G. (2011). Resident-to-resident relational aggression and subjective well-being in assisted living facilities. *Aging & Mental Health, 15*, 59-67. doi:10.1080/13607863.2010.501059

U.S. Department of Health & Human Services. (n.d.) Bullying definition. Retrieved from https://www.stopbullying.gov/what-is-bullying/definition/

Volk, A. A., Dane, A. V., & Marini, Z. A. (2014). What is bullying? A theoretical redefinition. *Developmental Review, 34*, 327-343. doi:10.1016/j.dr.2014.09.001

Voyer, P., Verreault, R., Azizah, G., Desrosiers, J., Champoux, N., & Bédard, A. (2005). Prevalence of physical and verbal aggression and associated factors among older adults in long term care facilities. *BMC Geriatrics, 5*(13), 1–13. doi:10.1186/1471-2318-5-13

Appendix A

Table 1.
Participant Demographics

Variable	*n (%)*
Gender	
Male	5 (26.3)
Female	14 (73.7)
Age (years)	*M* = 83.79 (*SD* = 6.41)
	Range = 67-90
Ethnicity	
Caucasian	19 (100)
Residency (months)	*M* = 26.11 (*SD* = 24.04)
	Range = 2-84
Facility Type	
Independent	10 (52.6)
Assisted	9 (47.4)

Note. Residency is the length of time a participant had been living at their current residence.

Appendix B
Bullying Interview

Demographic Information:

1. Gender: M F
2. Age: _____
3. Ethnicity: _____
4. How long have you lived at your current residence: _____years_____months
5. What type of senior care facility do you live at?
   - ____ Independent living
   - ____Assisted living
   - ____Nursing home

Interview Instructions:

The purpose of this interview is to get your opinions on the occurrence of bullying between residents where you live. All your responses to the interview questions will remain anonymous and confidential. If you do not feel comfortable answering a question you many chose to refrain from answering and move on to the next question. In order for this interview to remain confidential, please do not provide names of people or the facility in your responses.

The act of bullying is characterized as an aggressive behavior in which someone deliberately and repeatedly causes another person injury or discomfort. Bullying, or relational aggression, can be seen in several forms. The following are some examples of physical, verbal and social bullying.

Physical:

1. Hitting/kicking
2. Tripping/pushing
3. Making hand gestures
4. Spitting.

Verbal:

1. Name-calling,
2. Taunting
3. Teasing
4. Inappropriate sexual comments
5. Threatening

Social:

1. Intentionally leaving someone out
2. Spreading rumors about someone
3. Embarrassing someone in public.

U.S. Department of Health & Human Services. (n.d.) Bullying definition. Retrieved from https://www.stopbullying.gov/what-is-bullying/definition/

Interview Questions

Questions about the characteristics of bullying behavior:

1.) Have you ever observed resident-to-resident bullying behavior?

Yes:____ No:____

a.) If yes, can you give me an example of what occurred?

(Note: Remind the interviewee to refrain from providing specific names.

2.) **On average, how often do you observe bullying?**
____ Never
____ 1-5 times a year
____ About once a month
____ About twice a month
____ About once a week
____ About once a day
____ More than once a day

3.) **What form of bullying do you observe the most often?**
____ Physical
____ Verbal
____ Social

4.) **Where do you see bullying occur most often?**
Dining room: ____ Common areas: ____ Hallways: ____ Resident's room: ____

Questions about characteristics of victims and perpetrators:

5.) **In your observations, are the perpetrators (the one's doing the bullying) typically male or female?**
Male: ____ Female: ____ Equal: ____ Unsure: ____

a.) **Do male and female residents who engage in bullying behavior bully in different ways?** Yes: ____ No: ____

i. **If yes, please describe.** *If the interviewee needs examples, please refer to the three different types of bullying behavior – physical, verbal, social – and ask if males and females are more likely to engage in any of these three types of behaviors.*

j. **In your observations, are there are other common characteristics of persons who engage in bullying?** *The interviewee is encouraged to elaborate on the following characteristics.*
____Cognitive/memory impairments

____Physical disabilities

____Generally healthier than other residents

____Specific personality traits

____Ethnic minor/majority

6.) **In your observations, are the victims (the one's being bullied) typically male or female?**
Male: ____ Female: ____ Equal: ____ Unsure: ____

a.) **In your observations, are there are other common characteristics of persons who engage in bullying?** *The interviewee is encouraged to elaborate on the following characteristics.*

____Cognitive/memory impairments

____Physical disabilities

____Generally healthier than other residents

____Specific personality traits

____Ethnic minor/majority

Questions about staff and resident intervention

7.) **Have you ever witnessed staff intervene when someone is being bullied?**
Yes: ____ No: ____ Unsure: ____

a.) **In your observation, how often does staff intervene when someone is being bullied?**
Always: ____ Occasionally: ____ Never: ____ Unsure: ____

b.) **When and how do staff intervene?**
____ While the event is happening by talking to the victim
____ While the event is happening by talking to or reprimanding the perpetrator
____ After the event by talking to the perpetrator
____ After the event by talking to the victim
____ Unsure

i. **If yes to the above questions, can you give me an example of what a staff intervention might look like?**

8.) **Have you ever witnessed a resident intervene when someone is being bullied?**
Yes: ____ No: ____ Unsure: ____

a.) **In your observation, how often do residents intervene when someone is being bullied?**
Always: ____ Occasionally: ____ Never: ____ Unsure: ____

b.) **In what ways do staff intervene?**
____ While the event is happening by talking to or consoling the victim
____ While the event is happening by talking to or reprimanding the perpetrator
____ After the event by talking to the perpetrator
____ After the event by talking to the victim
____ Unsure

i. **If yes to the above questions, can you give me an example of what a resident intervention might look like>**

Questions about the resident opinions on bullying:

9.) **In your opinion, is bullying a problem where you live?**
Yes: ____ No: ____ Unsure: ____ Prefer not to answer: ____

10.) **In your opinion, does staff takes the necessary action to prevent resident-to-resident bullying?**
Yes: ____ No: ____ Unsure: ____ Prefer not to answer: ____

11.) **Have you ever been a victim of bullying?**

Yes: ____ No: ____ Prefer not to answer: ____

12.) If yes, do you have an example you would like to share?

(Note: Remind the interviewee to refrain from providing specific names.)

Appendix C
Informed Consent for Participation

Purpose
I understand that the purpose of the research study is to get my opinions on the occurrence of bullying in senior care facilities.

Participants
I understand that I have been asked to participate because I live in a senior living community.

Procedure
I understand the experimenter will ask me a series of questions to assess my general opinions about the occurrence of bullying in my senior care facility. The experimenter will first provide verbal instructions about the interview process and then I will be asked a series of questions. I also understand that this interview will be audio recorded and that no identifying information will be included on the audio recording. The total time commitment will be about 30 minutes.

Risks
It is possible that I may be uncomfortable answering some questions. If this occurs I may choose not to answer a question or end my participation at any time with no negative consequences. I may also request that the interview not be audio recorded. There is also the potential that discussing incidents of bullying may cause emotional discomfort. Should this be the case, I will be provided with information about mental health services I can utilize.

Benefits
I understand that no direct benefits will result from participation in this study. However, the results of this study may yield useful information about developing programs that increase awareness, provide resources for victims, and enhance the training and education to prevent bullying in senior care facilities.

Confidentiality
I understand that the findings of this study will be completely confidential. Confidentiality will be protected in that no identifying information will be included on any records collected during this study, including audio recordings. The only circumstance under which confidentiality will be broken is if I disclose that I have been physically assaulted or I have been threatened with bodily harm. In this situation, a report through the Minnesota Adult Abuse Reporting Center will be made and an investigation may occur if it is determined that the incident meets criteria for abuse.

All information collected during this study, including audio recordings, will be used for research purposes only and will only be accessible to the researcher and his research team. Audio recordings will be transcribed and then immediately destroyed. Transcriptions will be stored on a password protected computer and destroyed after three years. All other information will be kept in a locked cabinet in the principle investigator's office and will be destroyed after three years. Finally, the summarized findings, with no identifying information, may be published in an academic journal or presented at a scholarly conference.

Right to Refuse or Withdraw
I understand that participation is voluntary. I understand that I may withdraw from the study at any time without penalty. I understand that I will not be penalized or jeopardize my relationship with Minnesota State University as a result of withdrawal from the study.

Questions
I have been informed that if I have any questions, I am free to ask them. I understand that if I have any additional questions later, I may contact the office of the principal investigator, Jeffrey Buchanan, Ph.D. at (507) 389-5824 or the student investigator, Kathryn Ira at (563) 319-6203; or if you have questions or concerns about the treatment of human subjects, please contact the IRB Administrator and Associate Vice President of Research and Dean of Graduate Studies, Dr. Barry Ries at (507) 389-1242.

Closing Statement
My signature below indicates that I have decided to participate in a research study and that I have read this form, understand it, and have received a copy of this consent form.

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

IRB.net ID#: 987459