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Bullying in Senior Living Facilities: A Qualitative Study

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Abstract

Resident-to resident bullying has attracted some attention in the popular press and is well-known to many who work with seniors in long-term care facilities. However, this is very little empirical literature that has address the topic of "senior bullying". The aim of the proposed qualitative study is to better understand the phenomenon of resident-to-resident bullying from the perspective of staff who work in long-term care facilities. Staff members (n=45) responded to a combination of open- and close-ended interview questions regarding their observations of senior-to-senior bullying. Results indicate that the majority of staff members (98%) have observed resident-to-resident bullying within senior care facilities. Verbal bullying was the most observed type of bullying, but social bullying is also prevalent among the elderly population. Both victims and perpetrators were reported to commonly have cognitive and physical disabilities such as dementia or limited mobility. Bullying was reported to most often occur in dining rooms and other common areas. Over half of the participants had not received formal training (58%) and only 21% of participants reported their facility had a formal policy to address deliberate acts of bullying. The implications of the current study support the need for detailed policies and training programs for staff members to effectively intervene in bullying situations among the elderly population.

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Introduction

Overview of Bullying

Bullying is typically defined as a type of aggressive behavior that is repeated over time and involves an inequity of power (Einarsen & Skogstad, 1996). These aggressive behaviors fall into two primary categories: direct versus indirect. Direct bullying includes verbal and/or physical aggression and the victim knows who the perpetrator is as the bullying behavior is explicit and easier to observe. On the other hand, indirect bullying involves social aggression (i.e., gossip), so the victim may not know who the perpetrator is, making indirect bullying more covert and difficult to observe (Cardinal, 2015).

Those who bully target specific individuals through various methods. Bonifas (2014) classifies bullying into three types: 1) verbal, 2) physical, and 3) social. Verbal bullying includes, but is not limited to, teasing, name calling, inappropriate sexual comments, taunting, and threatening to cause harm. Physical bullying involves hitting, kicking, pinching, spitting, tripping, pushing, and taking or breaking someone's personal belongings. Finally, social bullying includes excluding someone on purpose, shunning, spreading rumors, gossiping, and embarrassing someone in public. Bullying, particularly social bullying, may be difficult to detect because perpetrators often attempt to victimize others in private to avoid being observed.

Bullying commonly occurs in contexts such as schools, places of work, or prisons (Hoel et al., 2004; Ireland & Ireland, 2000; Olweus, 2002). In school settings, there is a greater likelihood for bullying to occur in crowded areas, often across multiple settings, where adult supervision is limited (Black & Jackson, 2007). For example, bullying occurs most frequently in the following settings: playground (76%), classroom (40%), hallway (24%), gym (19%), cafeteria (8%), and restrooms (4%; Fekkes, Pijpers, & Verloove-Vanhorick, 2005). Although

prevalence rates vary depending on the measurement procedures, a 2013 nationwide survey indicated that 20% of high school students reported being bullied during the last 12 months (Centers for Disease Control and Prevention, 2011). In addition, children in higher socioeconomic classes experienced lower rates of bullying. Conversely, children with at least two childhood adversities (i.e., childhood maltreatment) experienced higher rates of bullying (Strickland, 2015; Yager, 2014).

Regarding bullying in the workplace, approximately 11 percent of employees experience bullying in their workplace at some point in their career (Sansone & Sansone, 2015). Certain factors may contribute to bullying in the workplace. For example, it has been found that a lack of policies regarding bullying can facilitate higher rates of bullying behavior and absent or unenforced bullying policies can imply limited management supervision or a lack of punishment for bullying behaviors (Samnani, 2012). Furthermore, passive leadership within an organization has been identified as a predictor of bullying (Skogstad, Einarsen, Torsheim, Shanke, & Hetland, 2007). Further, certain job and employee types pose a greater risk of being bullied, such as blue-collar jobs and unskilled workers.

The prevalence rate for bullying in prison settings are much greater compared to other settings, such as schools. For instance, about 80% of prisoners report victimization and about 70% report perpetration with the last 30 days (Ireland & Ireland, 2008). In prison settings, resources are limited and dominance hierarchies are typically found (Ireland, 2010). As a result, institutional environments are at a greater risk for fostering bullying behavior (Ireland & Archer, 1996).

Empirical literature with populations such as children and adolescents has documented the adverse effects that bullying can have on victims. For example, bullying is associated with

psychosocial maladjustment, adverse health responses, and stress in adolescents (Delfabbro et al., 2006). A number of studies have indicated that bullying negatively effects many aspects of psychological or mental health, which is expressed through depression, anxiety, poor self-esteem, self-harm, and suicide (Hawker & Boulton, 2000; Rigby, 2003; Strickland, 2015). Data from a 50-year longitudinal study indicated there may be adverse effects of childhood bullying that persist well into adulthood (Yager, 2014). For example, when compared to individuals who did not experience bullying, victims reported increased psychological distress at age 23 and endorsed higher rates of depression, anxiety, and suicidality at age 45. Additionally, victims experienced the following adverse effects at age 50: greater psychological distress, lower socioeconomic status, lower levels of social support, decreased quality of life, poorer general health, and decreased cognitive functioning.

Senior Bullying

Although the word "bullying" is commonly associated with school children or adolescents, bullying also occurs in senior living communities amongst older adults. Although this phenomenon of "senior bullying" is less known to the general public, it is a topic that has received some attention, primarily in the popular press (Creno, 2010; Frankel, 2011; Mapes, 2011; Span, 2011; Weiner, 2015). The senior care facilities were often described as having a type of caste system among the residents, which is a similar occurrence in high school. In the dining room, for example, if an impaired individual tried to sit at the same table as the "elite residents", they would be ignored or berated (Mapes, 2011). It has also been reported that residents try to turn public areas or activities into private possessions. For instance, a resident may command control of the TV room and dictate who can be in the room, where they can sit, and what shows are being watched (Creno, 2010; Span, 2011).

There have been a variety of terms used to describe senior bullying such as: “relational aggression” (Crick & Grotpeter, 1995), “resident-to-resident relational aggression” (Bonifas, 2015; Cardinal, 2015; Wood, 2007), “social aggression” (Cardinal, 2015), “resident-to-resident elder mistreatment” (Rosen, Pillemer, & Lachs, 2008), and “resident-to-resident elder bullying” (Cardinal, 2015). Many of these terms (e.g., “relational aggression” and “social aggression”) place greater emphasis on social and verbal aspects of bullying based on the assumption that physical bullying occurs less frequently amongst the elderly. Interestingly, Trumpetter, Scholte, and Westerhof (2010) found that older adults reject “bullying” terminology because it is associated with behaviors exhibited by children, not adults.

Just as it is important to understand what is meant by senior bullying, it is equally important to distinguish this phenomenon from other similar constructs. Although they can appear similar, bullying differs from dementia-associated agitation and aggression because bullying, by definition, is intentional and involves deliberate acts of aggression and inequity of power. Persons with dementia may engage in behavior that looks like bullying, but may be caused by impairments in impulse control and social cognition as opposed to being deliberate and intentional. Further, senior bullying may be confused with elder abuse. Senior bullying, however, involves acts perpetrated by older adults against other older adults does not include staff-to-resident aggression or resident-to-staff aggression.

Several authors have speculated about the possible causes or functions of bullying among older adults, although these speculations appear to be based on anecdotal reports as opposed to empirical data. Bullying behaviors, such as social manipulation, appear to be related to feelings of powerlessness and the need to gain more control in one’s life (Span, 2011). Residents living in senior living communities may lose their sense of identity, security, and belonging. In turn,

they may resort to aggressive and controlling behaviors as they try to regain some control in their lives. Further, perpetrators seem to have few positive social relationships, lack empathy, and are unaccepting of individual differences (Bonifas & Frankel, 2012). Such characteristics would only exacerbate their malicious and controlling behaviors. Bullying behaviors have also been described as a function of lifelong personality traits and pathology—not of aging (Mapes, 2011). In addition, transitioning to community living requires many life changes and adjustments. For instance, community housing involves shared quarters, limited space, and set schedules. As a result, impatience and jealousy can develop as residents attempt to retain some sense of control and independence (Bonifas & Frankel, 2012).

Alternatively, bullying victims may have difficulty defending themselves against perpetrators. In their blog, Bonifas and Frankel (2012) describe victims as being 1) passive or 2) provocative. Passive victims are perceived as shy, quiet, anxious, and insecure. On the other hand, victims who are described as annoying, irritating, quick-tempered, and intrusive are labeled as provocative. Both types of victims might have cognitive impairments, but the impairment may be more advanced among provocative victims. Victims might also be targeted if they are considered a minority (e.g., race, ethnicity, sexual orientation).

As discussed previously, bullying has been identified as being prevalent in schools, in the workplace, and in prisons (Hoel et al., 2004; Ireland & Ireland, 2000; Olweus, 2002). There is, however, a very limited amount of scholarly work that examines bullying behaviors among the elderly population. For example, a doctoral dissertation by Wood (2007) suggests that nearly one half of competent nursing-home residents report some experience with being bullied. It was also identified that victims of bullying experienced significantly higher rates of adverse psychological consequences. Wood (2007) concluded that social policy change is necessary and can be

accomplished by adopting policies and procedures to specifically address bullying behaviors. Increasing awareness, providing resources for victims, and improving training and education will help produce “bully-free” nursing-homes. Cardinal (2015) also gathered survey data from one nursing home administrator that confirmed that resident-to-resident senior bullying does occur in long-term care facilities. The author also concluded that improvements in policy and training are likely necessary in many senior living facilities.

Purpose of the Current Study

Although much has been written about senior bullying in newspaper articles and blogs, the studies by Wood (2007) and Cardinal (2015) discussed above represent the entire known scholarly literature on senior bullying, although neither study is published. Cardinal (2015) thoroughly reviewed the existing literature on bullying and concluded that further investigation into the phenomenon of senior bullying was necessary. Therefore, the immediate goal of the proposed study is to better understand the phenomenon of senior bullying in order to confirm and/or disconfirm the existing information available on this topic. Data concerning bullying was gathered from the perspective of staff who work in long-term care facilities. Staff, as opposed to elderly residents, served as participants because staff have the opportunity to observe many residents across many settings within a facility (e.g., in the dining room, during activities). Therefore, it was believed that staff would have greater access to bullying behaviors as they occur in an entire facility whereas residents would have a more limited sample of these behaviors based on their own individual experience. More specifically, staff were asked to report on the frequency of bullying, characteristics of victims and perpetrators, common responses to bullying by facility staff, and staff training programs and facility policies regarding bullying that guide staff as to how to address bullying when it occurs.

Method

Participants

A total of 45 individuals participated in the current study. Professions of the participants included nurses, administrators, activity directors, maintenance staff, and dietary aides. The mean age of participants was 42.89 years (SD = 14.23). The sample was 75.5% female and 24.4% male. Regarding ethnicity, 75.5% of the sample identified as Caucasian, 15.5% as African American, 2.2% as Asian, and 2.2% as Czechoslovakian. On average, participants reported having worked in a senior care facility for 10.47 years (SD = 9.91) with 77.7% employed full-time and 22.2% part-time. The primary unit in which participants worked include: 42.2% assisted living, 35.5% memory care, 33.3% skilled nursing, and 6.6% independent living. The participants' reported level of education include 20% completed high school, 26.6% had an Associate's degree, 33.3% obtained a Bachelor's degree or beyond, and 20% reported "other". Table 1 summarizes the demographic characteristics of the sample.

Settings

Participants were recruited from five senior care facilities in southern Minnesota. Facility A is a for-profit organization and includes independent living, assisted living, memory care, and skilled nursing. Furthermore, Facility B is a for-profit organization, which provides assisted living services. Facility C is a for-profit organization provides independent living, assisted living, and memory care services to male and female residents. Facility D is a governmental organization that serves the veteran population. The services provided at this facility include assisted living, memory care, and skilled nursing. Finally, Facility E is a for-profit institution and includes both male and female residents.

Procedures and Instruments

Participants were recruited by making announcements at facility staff meeting. Individuals interested in participating were asked to put their name and contact information (phone number or email) on a sign-up sheet. Participants were then contacted in order to arrange a time to complete data collection. Prior to starting data collection, informed consent was obtained and the purpose of the study was reiterated.

Data collection first involved having participants complete a demographic form that asked for the following information: gender, age, level of education, ethnicity, length of time in their profession, official job title, full- or part-time employment, and primary unit or floor on which they worked. Participants were then provided with a detailed definition and examples of bullying in order to ensure that all participants had an understanding of what bullying entailed. Participants then were administered one of two different interviews, depending on the participant's job title (i.e., direct care staff vs. administrators). The direct care staff interview consisted of 5 sections with questions regarding: 1) the characteristics of bullying behavior, 2) the characteristics of victims and perpetrators, 3) training and education, 4) typical responses to instances of bullying, and 5) institutional policy with regard to bullying behaviors. The administrator interview consisted of three sections with questions regarding: 1) the characteristics of bullying behavior, 2) the characteristics of victims and those who bully, and 3) training, education, and policy related to bullying behaviors. Unlike the direct care staff interview, the administrator interview did not include questions about typical responses to instances of bullying as it was expected that administrators would have less direct contact with residents on a day-to-day basis. However, it was anticipated that administrators would be more

knowledgeable about training program, institutional policy regarding bullying, and would likely be knowledgeable about bullying via written or verbal reports from the direct care staff.

The interviews were semi-structured with a combination of close- and open-ended questions. This semi-structured interviewing strategy was chosen to keep the interview focused on bullying and obtain specific information about bullying while also allowing participants to expound upon answers and provide spontaneous responses that may have deviated from the questions being asked, but that were still relevant to the topic of bullying. Although participants were asked specific questions, interviewers were provided with prompts (e.g., "tell me more about that", "can you give me some examples of what you mean?", or "can you think of anything else?") as a means for encouraging participants to expand upon and clarify answers. Participants were also encouraged to share examples, opinions, and to deviate from the topic of a given question provided that responses were related to resident-to-resident altercations. This data collection strategy allowed for accumulation of both quantitative as well as qualitative data. Interviews lasted approximately 15-20 minutes.

Interviews were audio recorded (with the participant's consent) using Audacity which is free downloadable software designed to provide high-quality recordings of live audio. Audio recordings were then sent to a professional transcription service. When necessary, any identifying information, such as names and place of work, were omitted from the audiotapes.

Data Analysis

For closed ended questions, data analysis simply involved tabulating frequency counts of responses. For open-ended questions data analysis first involved having the primary researcher identify common themes among the responses. This type of coding system helped standardize the data analysis process. When a response matched one of the identified themes, the specific

response was recorded. For example, when participants were asked, “In your observations, are there other common characteristics of persons who engage in bullying?”, their responses were categorized into the following themes: perpetrators typically have a physical disability, perpetrators typically are physically capable, perpetrators typically have a cognitive impairment, perpetrators typically are cognitively intact, and perpetrators have certain personality traits that make them more likely to bully. If a participant’s response encompassed more than one theme, each identified theme within their response was coded. Individual responses that did not correspond with any distinct theme were not interpreted for analysis.

Coding data in this manner required some level of judgement as to whether a response was indicative of an identified theme. For example, when explaining bullying behaviors of the verbal type, one participant might describe the behavior in a broad manner by simply stating they observed “verbal bullying”. Another participant might provide more specific descriptions of the verbal type of bullying behavior by stating they observed “teasing” or “one resident made threatening comments to another resident”. Although different, each of these responses would be coded as the “verbal” type of bullying.

The themes for the open-ended questions were defined by the researchers based on the review of a small sample (n = 5) of interview responses. To ensure the responses were coded in an objective and consistent manner, interobserver agreement (IOA) data was independently collected for the open-ended responses. Detailed descriptions of the coding themes and a list of different possible responses indicative of each theme were provided to a research assistant. IOA was calculated using a random sample of 20% (n = 9) of the interviews. Reliability between coders was determined by comparing the two coders’ data sheets to one another and recording how often each response theme was recorded by both. If both coders recorded a response theme,

it was counted as an agreement. However, if one coder identified a response as matching a possible theme and the other coder did not, it was counted as a disagreement. The overall reliability was determined by dividing the total number of agreements for each transcript by the total number of agreements plus disagreements and then multiplying that number by 100. The mean reliability coefficient was 98%, which indicates that the coding system for the current study was used consistently across both independent coders.

Results

Characteristics of Bullying Behavior

The first set of interview questions concerned staff observations of bullying to get a better understanding of how often bullying occurs and what specific bullying behaviors have been observed. The first question on both the staff and administrator interviews asked whether participants had observed bullying behaviors in senior care facilities as well as to provide an example of bullying they had observed. This question allowed researchers to determine whether the participant had enough knowledge of resident-to-resident bullying to respond to the rest of the interview questions. The question also allowed participants to provide detailed examples of bullying. All but one participant (98%) reported having some experience with bullying behaviors, suggesting that most staff have experience witnessing bullying. When examining examples of bullying that were described, there were three general themes that emerged from the responses that corresponded to the three different types of bullying (i.e., verbal, physical, and social). The percentage of interviews in which each theme was conveyed were as follows: verbal (78%), physical (33%), and social (19%). Percentages do not add up to 100 because some responses included examples of multiple types of bullying. An example from a participant whose response included more than one theme is described below:

"I have seen residents intentionally exclude people from their table in the dining room. I've seen residents gossiping about each other (social bullying), *name calling* (verbal bullying)*..."*

When participants estimated how many different residents they have observed engage in bullying behaviors at their current facility, the most common response was 5 different residents with a range of 0-50 residents. These data indicate that there are often several different perpetrators of bullying within a facility.

Participants were also asked how often they believed bullying occurs. Participants were given a rating scale in order to provide an estimate of frequency of bullying. The percentage of participants endorsing each response choice were: 1-2 times a year (3%), 3-4 times a year (5%), about once a month (11%), about twice a month (13%), about once a week (21%), multiple times per week (24%), about once a day (8%), and multiple times a day (16%). These data indicate that staff frequently observe bullying, typically several times a week.

There were four primary responses identified when participants were asked the most common setting for which bullying behaviors occur. The most common responses included: the dining room (n = 30), common areas (n = 23), during activities (n = 8), and in an individual's room (n = 4). It should be noted that participants often stated that bullying occurs in multiple settings.

Regarding the question concerning the time of day bullying most often occurs, there were four common responses. The percentage of interviews in which each response was provided are as follows: morning (26%), afternoon (41%), evening (19%), and during meal times (30%). Given that the dining room was the most commonly endorsed location for bullying behaviors, it is not surprising that bullying was often reported to occur during meals.

Based on the participants' observations, the prevalence of each form of bullying between residents were as follows: verbal (95%), physical (5%), and social (24%). Several participants reported multiple types of bullying as being equally prevalent. A quote consistent with these trends is provided below:

"I see both the social and the verbal quite frequently. I've never witnessed any physical bullying, but the embarrassing someone in public and the teasing and name calling are very prominent."

Characteristics of Victims and Perpetrators

The purpose of the next set of questions was to better understand common characteristics of persons who engage in bullying and those who are victims of bullying. Questions inquired about gender differences related to bullying as well as physical or psychological characteristics of perpetrators and victims.

Characteristics of perpetrators. Participants indicated that perpetrators were more likely to be male (42%) rather than female (18%). However, 39% of participants stated that perpetrators had an equal likelihood of being male or female. Further, participants were asked whether residents tend to bully in different ways. For example, when examining common bullying behaviors among male perpetrators, the participants stated that verbal (46%) was most prevalent, followed by physical (23%) and social (0%). Conversely, female perpetrators were reported to most likely engage in the following forms of bullying: social (42%), verbal (31%), and physical (8%).

Participants were then asked about common characteristics of perpetrators. Responses to this question fell into a number of categories. First, 47% of respondents indicated that perpetrators were more likely to have some kind of cognitive impairment while 9% indicated that perpetrators were more likely to be cognitively intact. Second, 26% of respondents reported that

perpetrators were more likely to have physical disabilities while only 6% were described as being physically able. Finally, 38% of responses included descriptions of various personality traits common to perpetrators of bullying. These personality traits included feeling entitled, controlling, loud or outspoken, independent, and attention seeking. A quote is provided below to illustrate the staff perspective on perpetrators:

"They just kind of feel like they're entitled to more and feel like…they're higher up and, you know, can look down on certain people."

Characteristics of victims. Participants were then asked questions regarding common characteristics of victims. It was reported that victims were more likely to be male (42%) rather than female (16%). However, 42% of participants also stated that perpetrators had an equal likelihood to be male or female.

Participants were also asked about common characteristics of victims. Participant responses fell into several categories. First, 60% of respondents stated that victims were more likely to have some kind of cognitive impairment while none of the respondents reported that victims were likely to be cognitively intact. Second, 50% of respondents indicated that victims were likely to have some kind of physical disability while none of the respondents reported that victims were likely to be physically able. Finally, 60% of respondents stated that victims were likely to exhibit various personality traits. These personality traits included being shy, quiet, submissive, dependent, and are less likely to stand up for themselves. A quote is provided below to demonstrate the staff perspective on victims:

"They are more dependent; they really don't talk that much or they are slow at talking. If the individual has a memory impairment…they are more likely targets."

Training and education

The next set of questions address whether staff received formal training about how to respond to bullying situations and, if so, what the training entailed. To diffuse bullying situations, the majority of participants had not received formal training (58%) compared to those who reportedly had received training (37%). Another 5% of participants were unsure whether they had received formal training.

For the participants who had received formal training (37% of respondents), there was a series of follow-up questions. The most common mode of staff training involved the following: informational videos (57%), classes (57%), and discussions (50%). The most common intervention strategies and concerns were redirection (62%), separation (62%), de-escalation (23%), and protecting the safety of each individual (15%). It should be noted that participants often reported more than one form of training and intervention strategy. Lastly, 93% of staff reported feeling confident in their abilities to intervene effectively based on their training. None of the staff doubted their ability to intervene based on their training and 7% were unsure of their intervention abilities. A quote is included below to outline common intervention strategies:

"I guess just trying to redirect the residents when a resident is having a behavior…you're trained in that kind of sense to redirect them. So it's kind of the same with bullying to say: let's go for a walk, or let's talk to me about it. It's a get it off your chest kind of thing."

For participants that did not receive formal training (58% of respondents), 76% reported that bullying behavior had been informally addressed in other contexts (e.g., speaking with co-workers). There were two themes identified when participants were asked to provide an example for what was specifically discussed with co-workers: potential solutions (53%) and specific

situations in which bullying behaviors occurred (47%). Overall, of the participants that did not receive formal training, 96% believed that formal training or education was necessary.

Typical Responses to Instances of Bullying

The next section of the interview was intended to gather information to determine how staff members and other residents or bystanders intervene in bullying situations. In their experience, 87% of participants believed that staff typically intervene in bullying situations compared to 13% that stated staff did not typically intervene. Participants were also asked what the most common method of intervention was. Participants were given six intervention options in order to quantify their responses. The percentage of participants endorsing each response choice were: intervene while the event is happening by talking to the perpetrator (41%), intervene while the event is happening by talking to the victim (27%), intervene after the event by talking with a supervisor or administrator (14%), intervene after the event by talking to the perpetrator (9%), and intervene after the event by talking to the victim (9%). Included below is a quote to describe a participant's perspective prior to the intervention:

"You want to intervene immediately if there is a threat of harm, but you also want privacy later so that you are able to talk to the people."

In addition, 59% of participants believed that other residents or bystanders intervene in bullying situations compared to 38% that stated others did not typically intervene. Similar to the question above, participants were given six intervention options to describe various intervention strategies. The percentage of participants endorsing each response choice were: intervene while the event is happening by talking to the perpetrator (38%), intervene while the event is happening by talking to the victim (24%), intervene after the event by talking with a supervisor or administrator (22%), intervene after the event by talking to the perpetrator (8%), and intervene

after the event by talking to the victim (8%). Below is a good example of how residents will sometimes intervene in bullying situations:

"They might stick up for the victim or they might just be saying to the bully to shut up and get out of here."

Institutional Policy with Regard to Bullying

The following information was intended to determine whether staff members were provided with a policy to guide how they should intervene in bullying situations. When participants were asked whether their facility has a formal policy describing how to deal with bullying, 58% were unsure, 21% said yes, and 21% said no. Of the participants that endorsed the facility not having a bullying policy, 83% believed one would be necessary or helpful. Provided below is a good example of why formal policy is necessary:

"We've got groups of ladies that will sit at tables and talk about residents as they enter the dining room. They all want to sit at the same tables to intentionally keep those residents from sitting with them. They're all adults, so there's really only so much you can do about it."

For the participants that stated their facility had a policy for bullying, 60% reported that the policy specified how staff should intervene if bullying is observed, 30% were unsure, and 10% reported no intervention specifications. There were four options provided to participants when they were asked what staff are specifically required to do if bullying is observed. The response options included: report incidents to supervisors or administrators (n=13), talk to the perpetrator (n=7), and talk to the victim (n=7). Furthermore, when formal reports are made, the majority consist of written reports (n=13) compared to verbal reports (n=7).

There were six themes identified when participants were asked whether there were any other actions staff are required to take if bullying is observed. The frequency of the themes

included: documentation of the event (n=4), filing a formal report (n=3), separation of the individuals involved (n=3), safety (n=2), redirection (n=1), and de-escalation (n=1). It should be noted that participants often provided more than one required action.

Of the participants that endorsed having a formal policy at their facility to address bullying, the following percentage of participants found the policy helpful: yes (64%), no (14%), and unknown (21%). Participants were also asked about family notification if a resident is involved in a bullying situation. When asked whether the perpetrator's family was notified, the participants reported the following percentages: yes (58%), unknown (27%), and no (15%). In addition, participants were asked whether the victim's family was notified. Participants' responses and percentage in which each response was endorsed are as follows: yes (45%), unknown (45%), and no (9%).

Administrator Interview

A total of six interviews were conducted with facility administrators. As mentioned previously the administrator interview differed slightly from the one administered to other staff members. The researchers chose to administer two separate interviews to assess two different populations of staff working within senior care facilities. Staff members, such as nurses or dieticians, were identified as those who work closely with residents on a day-to-day basis. It was expected that these staff members were likely to experience resident-to-resident bullying firsthand and, therefore, would have the most detailed information regarding bullying. Alternatively, administrators, such as directors of nursing, were viewed as those who manage the senior care facility and would have less direct experience observing bullying, but would have more knowledge concerning training opportunities and institutional policies related to bullying.

The following section will include data related to interview questions that were specific to administrators.

Characteristics of bullying behavior. There were three themes identified when administrators were asked to provide an example of their experience with resident-to-resident bullying (i.e., verbal, physical, and social). The percentage of interviews in which each theme was communicated are as follows: social (67%), verbal (50%), and physical (17%). It should be noted that some of the provided examples encompassed more than one theme. Two quotes consistent with this information are included below:

"Not too much name calling, more just ignoring, kind of leaving people out. You see it in the dining room a lot."

"There's a couple residents that we have, one in particular would be in the more social category, that does embarrass people in public and makes up stories."

When administrators were asked how often they received a report of bullying behavior during the last six months, the frequency of each response included the following: once (n=3), daily (n=1), 3 times (n=1), and 5 times (n=1). In regards to weekly occurrence, administrators were given a rating scale in order to provide an estimate of frequency: about once a day (n=2), multiple times per week (n=1), about once a week (n=1), and about once a month (n=1). A quote consistent with the information provided is included below:

"We have a gentleman who will not sit next to or associate with another gentleman, just because he has dentures. And he bullies him for it. This happens multiple times a day."

When administrators were asked in which settings does bullying most often occur, they reported the dining room (n=4), common areas (n=3), and during activities (n=1). Some administrators stated more than one setting in their response. Regarding the question concerning

the time of day bullying most often occurs, there were two common responses. The percentage of interviews in which each response was provided are as follows: mealtimes (67%) and afternoon (33%).

Characteristics of victims and those who bully. The next set of questions were intended to gather information on gender differences between perpetrators and victims from the administrator perspective. In the experience of administrators, cognitive disabilities (n=2) were most common for victims of bullying behaviors. Furthermore, administrators indicated that both perpetrators and victims each had an equal likelihood to male or female (67%) compared to 33% of administrators that believed perpetrators and victims were more likely to be female.

According to administrators, the prevalence rate for each form of bullying include: verbal (83%), social (50%), and physical (17%). It should be noted that several administrators reported multiple types of bullying as being equally prevalent. Additionally, administrators reported that female perpetrators tend to bully verbally (75%) and socially (25%) whereas male perpetrators are most likely to bully verbally (75%).

Training, education, and policy related to bullying. The final set of questions concerned whether staff were provided with formal training for addressing bullying and if their institution had policies in place for addressing bullying. For instance, the following percentage of administrators indicated that new employees receive training for bullying situations during orientation: no (67%) or yes (33%). For administrators that endorsed staff training was available, the most common mode of staff training involved the following: classes (100%), videos (33%), and discussions (33%).

For administrators that indicated staff had not received training, 67% reported that bullying behavior had been informally addressed in other contexts. Further, participants were

asked to provide an example of such informal conversations surrounding bullying behavior. There were two main themes identified as common discussion points. First, 100% of respondents stated that possible solutions (i.e., redirection) had been discussed. Second, 33% of participants indicated discussions often surrounded specific events (i.e., what specifically occurred between the victim and perpetrator).

Additionally, 100% of administrators stated that staff typically intervene in bullying situations. Regarding whether other residents or bystanders intervene, 67% stated yes compared to the 17% that said no. Included below is a quote to describe the administrator perspective for how staff respond to bullying behaviors:

"I would assume if it was verbal or physical I know we have to. But the social part, I'm not sure…what they do. And I don't step in every single time I see it, because it literally happens every day."

When administrators were asked whether they receive reports of bullying behaviors from staff, 83% said yes and 17% said no. Of the received reports, 50% were considered formal (i.e., written) and 50% were informal (i.e., verbal report/description of the event). Administrator indicated that incidents were reported in the following ways: notify other nurses and family members (n=2), file an incident report (n=2), and record the event in the resident's progress note (n=1). A quote is included below to describe an administrator's response when they were asked to describe what incident report procedures entail for bullying behaviors:

"For bullying? We don't have one. We have an incident behavior report. We have not used that for bullying. We've used that more for sexually inappropriate behaviors of residents."

Similarly, when administrators were asked whether they receive reports of bullying behaviors from other residents or bystanders, 83% said yes and 17% said no. Administrators

were also asked about family notification if a resident is involved in a bullying situation. When asked whether the perpetrator's family was notified, administrators reported the following percentages: yes (33%), no (17%), and unknown (17%). In addition, administrators were asked whether the victim's family was notified, with 50% reporting yes (50%) and 33% reporting no.

When administrators were asked whether a formal policy was in place at their current facility for bullying behaviors, 33% said yes, 50% that said no and 17% were unsure. When administrators endorsed having a formal policy, they were asked to describe their policy. Administrators reported their policies had the following characteristics: a statement that bullying will not be tolerated (n=1), a requirement that behavioral interventions be applied (n=1), medications should be evaluated (n=1) and the possibility of eviction if safety of others has been compromised (n=1). Lastly, 67% of administrators indicated there are consequences for bullying, which included: eviction (50%), warning (33%), and returning the perpetrator to their room (17%). Included below is an example from an administrator, which demonstrates that there are protocols in place for severe bullying (e.g., physical bullying). However, it is unclear whether there are policies in place for social bullying:

"If resident to resident aggression is severe enough, a protocol is put into place to see if the resident is still qualified to stay here. But we first would have to look at non pharmacological interventions."

Discussion

Much has been written about senior bullying, although little of this information has been published in the scholarly literature. Therefore, the current study aimed to better understand the phenomenon of senior bullying from the perspective of staff who work in long-term care facilities. Several of the findings of this study confirm existing information found in popular press and is consistent with research studying bullying in other populations. For example, it was

expected that nursing staff would frequently be exposed to bullying behaviors among the elderly and the findings from the current study suggest that staff members and administrators are well aware of bullying behaviors in senior care facilities. Previous research also suggests that men were more often identified as being the perpetrator and the victim when compared to females (Nansel et al., 2001), which corresponds to the findings of the current study. There have also been gender differences identified for how perpetrators typically bully others. Particularly, males tend to use more direct forms of bullying, such as verbal insults, whereas females use more indirect or passive aggressive behaviors, such as gossiping and spreading rumors (Bonifas & Frankel, 2012; Zapf, Einarsen, Hoel, & Vartia, 2003). Our findings support this information, as males were most likely to engage in verbal bullying (46%) and females were most likely to engage in social bullying (42%).

It has been reported that resident-to-resident senior bullying receives less attention compared to other populations because it is generally verbal and social in nature rather than physical (Frankel, 2011). Consistent with those trends, the results of the current study indicate that verbal bullying (41%) was the most observed type, while it was also found that social bullying is prevalent among the elderly population as well. Cardinal (2015) indicates that verbal and social bullying are often precursors to physical aggression. Therefore, although physical bullying has been found to be a captivating topic within popular press, our data indicates that it is a relatively rare occurrence among the elderly population.

With regard to the characteristics of victims, our finding suggests that victims were commonly described as having cognitive and physical deficits. Much of this information is consistent with existing information available about senior bullying. For example, the current study also found that cognitive impairments are a common characteristic among victims of

bullying. The finding is consistent with anecdotal reports suggesting that cognitive impairments elicit bullying from those who are cognitively intact as those with cognitive impairments may be provocative (e.g., annoying, intrusive) or passive (Bonifas & Frankel, 2012). The finding that victims were also commonly reported to have physical disabilities and certain personality traits such as being shy, quiet, and submissive are also consistent with previous writings and suggest victims of senior bullying are often noticeably vulnerable, thus may be perceived as easier targets because they are unlikely or unable to defend themselves.

Concerning characteristics of perpetrators of bullying, the majority of respondents described perpetrators as also having cognitive and physical deficits. These results are consistent with existing information regarding what motivates perpetrators to bully. It has been suggested that perpetrators put others down in order to build themselves up, indicating that low self-esteem and feelings of vulnerability may be related to bullying. The fact that perpetrators were often described as having cognitive impairments was somewhat unexpected and the implications of this finding will be discussed later. The finding that perpetrators were commonly reported to have certain personality traits, such as being entitled, controlling, loud, independent, and attention seeking, is also consistent with existing information. Such personality traits support the belief that perpetrators are trying to gain more control in their life at a time when they feel exceptionally powerless (Bonifas & Frankel, 2012).

Based on research with other populations (i.e., schools, workplace, prisons), particular circumstances such as overcrowding and lower staff-to-resident ratios may intensify conflict (Cardinal, 2015). Our results are consistent with this research as it was found that bullying most often occurred in dining rooms and common areas. Therefore, crowded areas may mask bullying

behaviors more easily, which in turn, may make it more difficult for staff to promptly or effectively intervene.

Findings and implications regarding institutional policy. Although several findings of this study were consistent with existing information available about senior bullying, novel findings with regard to training and policy are worth noting because they have implications for staff in senior living facilities. Despite the fact that bulling is commonly observed by staff, results revealed that there are rarely formal policies in place to help staff navigate these situations. Our research indicates that facilities typically have a policy in place for severe verbal (e.g., threats of harm) and physical instances of bullying, and in fact staff are mandated to report these behaviors because they cause direct harm or threaten direct harm to residents. There is less guidance, however, for handling less extreme verbal bullying (e.g., insults, name calling) and social bullying that although less severe in nature, can cause significant stress and psychological harm to residents who experience them. In other words, some bullying behaviors are not really considered "incidents" that have to be reported, a sentiment that is summarized nicely by one participant who stated, “There aren't incident reports for bullying—just for disruptive behaviors.” Also, participants often divulged that some instances of bullying are quite ambiguous in terms of whether they should be reported or not.

This ambiguity in determining when bullying, particularly social and verbal bullying, crosses the line into being a “disruptive behavior” has potential implications for staff in terms of intervening when bullying occurs. Although it was reported that the majority of staff members intervene in bullying situations, it is suspected that they do so based on their own moral code rather than based on formal training or mandated by institutional policy. For example, one participant stated that *“It’s just common sense of telling the resident that their behavior is*

unacceptable, or you don't need to talk that way." Another example comes from a different participant stating *"I told [the perpetrator] her that what she was saying right now was not polite, or nice...I pretty much just say the things that I was raised off of."*

An additional factor that complicates the decision of whether or not to intervene and how to intervene when bullying occurs is that staff working in senior care facilities are often significantly younger than the residents, with the median age of nursing assistants being 37 (Squillace et al., 2009). Therefore, it is understandable that staff might feel uncomfortable confronting an elder or attempting to intervene in a bullying situation, particularly if no formal training or institutional policy is in place to guide intervention strategies.

Overall, it is clear staff would benefit immensely from increased training and education about how and when to intervene when bullying occurs. Based on our results, policies will need to address two issues that pose greater ambiguity for staff. First, policy that addresses more covert and less severe forms of bullying (i.e., social and verbal bullying) would be helpful so there is consistency across staff as to how or when to intervene. Second, policies will need to specify how bullying should be handled differently when it is perpetrated by a cognitively intact individual versus a cognitively impaired resident, as staff may be more unsure as well as less comfortable intervening in these situations. Unfortunately, evidence-based best practices have yet to be developed (Cardinal, 2015). For instance, Alyse November, a licensed clinical social worker, has adapted a school bullying program to be used on older adults in senior care facilities. The program educated participants on bullying behaviors and how to be more accepting of others. Although the interactive workshops were anecdotally reported as successful, the results and efficacy of the program are inconclusive, which is attributed to the limited sample size and lack of peer review.

It is believed that prevention and intervention techniques require a four-part strategy: organization level, the staff level, the bully level, and the victim level. First, comprehensive and prevention programs and policies need to be implemented at the organizational level. Second, staff should be trained on effective intervention strategies. Next, perpetrators and victims should both be educated on the "bully free" environment with in the facility. According to Bonifas, the program needs to encompass all four levels for it to be successful (as cited in Cardinal, 2015). Once these social policy changes have been implemented, the possibility of a bully-free culture within senior care facilities becomes more likely, although it is clear that empirical studies will be necessary to substantiate this claim (Wood, 2007).

Limitations and Future Research

Limitations associated with the sample. Although the current results offer some valuable information regarding resident-to-resident senior bullying, several limitations must be acknowledged. First, the sample size was relatively small and was predominately comprised of Caucasian females, which limits the generalizability of the results. Generalizability is also compromised due to the fact that the sample included individuals who lived and worked in the Midwestern region of the United States. There is a possibility that individuals from other regions or countries have a different perspective regarding bullying behaviors within the elderly population.

As previously stated, staff members served as participants for the current study because they have the opportunity to observe many residents across many different settings within a facility (e.g., in the dining room, during activities). Therefore, future research should interview residents in senior care facilities to gather their unique perspective on senior bullying. Gathering information from the perspective both direct care staff and residents would provide a more comprehensive understanding of the nature of bullying in senior living communities.

Limitations associated with the interview. Additional limitations were related to the data collection instrument. For instance, the open-ended interview questions relied on the ability of participants to carefully observe, accurately recall, and clearly articulate their experiences. Given this, it is possible that participant responses were limited to one or two personal experiences rather than their broader experience with senior bullying. For example, two separate participants working at the same facility both thoroughly described the same instance of bullying involving a chair being stolen and a "sergeant type" resident "interrogating" and verbally abusing those suspected of taking it. Therefore, the result may be that participant responses were often based on a limited sample of instances of bullying that were particularly severe, recent, and/or highly memorable as opposed to being based on more common or typical instances of bullying.

Prior to the interview, participants were provided instructions that included the definition and examples of different forms of bullying. It was considered necessary to provide a detailed definition of senior bullying to ensure that participants would have a thorough understanding of the construct and could provide answers relevant to the topic of senior bullying. Furthermore, the use of a standard definition of senior bullying based on existing literature made certain that all participants had a similar understanding of the construct. However, a potential limitation with this procedure is that the definition and examples may have biased and limited the participants' responses. For example, interview instructions included definitions of verbal, physical, and social types of bullying. Upon reading this definition, more severe acts of physical or verbal aggression may have been more likely to come to mind because they are more memorable.

Also, it is suspected that participants had difficulty differentiating between intentional acts of bullying and behaviors due to cognitive deficits associated with dementia that are less

clearly intentional in nature. For instance, when participants were asked whether there were common characteristics of perpetrators, one respondent stated, "*I think that there is a lot of memory issues in the [perpetrator] person that is being that way…a fair amount of them don't even know that they are doing it…"* In fact, 47% of participants reported that perpetrators commonly had cognitive impairments. Including aggression as part of the provided definitions and examples, although necessary to comprehensively define bullying, may have confined the examples participants recalled to acts of severe verbal or physical aggression perpetrated by persons with cognitive impairment. Acts committed by persons with cognitive impairment actually fail to meet the definition of bullying because they are typically not an intentional and conscious acts, but instead are the result of social cognition deficits related to dementia. Therefore, it appears as if an unknown number of responses to the interview concern dementia behaviors as opposed to "true" acts of bullying that are intentional and repeated.

As a result, future research should confine the definition of bullying to the more specific construct of "relational aggression", which comprises social bullying and some forms of verbal bullying that do not involve direct threats of harm. These behaviors appear to be relatively common, may cause harm to victims, and as mentioned previously are behaviors that staff find more challenging to deal with due to the general lack of formal policies related to these behaviors. Developing instructions and examples more specifically related to relational aggression will help gather information specifically about these less severe, yet very harmful forms of bullying that may go unaddressed by facility staff. Data from the current study does contain examples of relational aggression, but it is likely that many reports were related to more extreme forms of bullying. Gathering data from independent living facilities or assisted living

facilities where few (if any) residents have cognitive impairments would also likely produce more data about relational aggression.

Conclusions

The findings of the current study suggest that resident-to-resident senior bullying is a prevalent phenomenon, which warrants investigation of evidence-based prevention and intervention techniques. Although staff and administrators in senior care facilities are aware of bullying behaviors among the elderly, there are very few (if any) formal policies in place to help staff navigate through these situations. When policies were in place, they were limited to verbal and physical disruptions and did not address covert and deliberate bullying behaviors (i.e., social bullying). The participants in the current study often reported that bullying behaviors are quite ambiguous in terms of whether they should be reported or not. The uncertainty of such intervention practices demonstrates the need for comprehensive policies that address bullying behaviors within senior care facilities.

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Table 1. *Participant Demographics*

Variable	*n* (%)
Gender	
Female	34 (75.5)
Male	11 (24.4)
Average Age (years)	*M*= 42.89 (*SD*= 14.23) Range= 18-79
Ethnicity	
Caucasian	34 (75.5)
African American	7 (15.5)
Asian	1 (2.2)
Czechoslovakian	1 (2.2)
Education	
High school	9 (20)
Associate's degree	12 (26.6)
Bachelor's degree or beyond	15 (33.3)
Other	9 (20)
Official Job Title	CNA- 7 Human Services Technician- 6 Registered Nurse- 3 LPN- 3 Maintenance- 3 Care Manager- 2 Cook- 2 Activities Director- 1 Administrative Assistant- 1 Assisted Living Coordinator- 1 Behavioral Analyst- 1 Bus Driver- 1 Dietary Manager- 1 Dietician-1 Director of Life Enrichment- 1 Executive Director- 1 Health Unit Coordinator- 1 Lead Care Manager- 1 LPN Supervisor- 1 Marketing Director- 1 Psychologist- 1 Public Housing Manager- 1 Recreation Therapist- 1 Recreation Therapy Aid- 1 Director of Wellness- 1 Social Worker- 1 Other- 1

Length of time in profession (years)	*M*= 10.47 (*SD*= 9.91) Range= 6 months- 35 years
Primary Unit/Floor	
Assisted Living	19 (42.2)
Memory Care	16 (35.5)
Skilled Nursing	15 (33.3)
Independent Living	3 (6.6)
Employment Type	
Part-time	10 (22.2)
Full-time	35 (77.7)

Note: Percentages may not equal 100 due to rounding.