From Social Bullying in Schools to Bullying in Senior Housing
A New Narrative & Holistic Approach to Maintaining Residents’ Dignity

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Dr. Evelyn J. Eddy, a respected and dedicated pediatrician, was an innovative thinker in her work with Dr. Julius Richmond and Dr. Bettye Caldwell, thought leaders behind what became known as the Head Start program for less advantaged children in the United States. Evelyn, following retirement, was left partially paralyzed from a stroke and suffered for years in two different nursing homes. Evelyn’s sister-in-law, Hazel Eddy, following a fall which broke her leg at age 90, suffered as well in both assisted living and two nursing homes until she died at age 94. While the people and places that cared for them may have done their best at the time, memories of visiting both relatives in their last years of life serve as reminders that continued changes are needed in long-term care and communal senior living environments. While this work cannot undo their painful experiences, it is dedicated to their memories and serves to better inform the current workforce of aging service professionals charged with providing our nation’s older adults with the very best in person-centered care.
I met an elderly couple in an assisted living facility. They told me their story of social rejection. When they went for their first meal at their new place, they walked into the dining room to eat breakfast. They went from table to table to join in with others where there appeared to be open seating. After multiple rejections, they took their breakfast trays, returned to their room and never went back to eat in the dining room again. By the time they told me this story they had spent two years eating alone in their room.

- Alyse November, Social Worker

A woman who entered a nursing home and was fully accepted by peers eventually made the decision to identify herself to her friends as a lesbian. For years the friends had thought of her as straight. The staff began to notice changes in her demeanor and she began to isolate and show signs of depression. Staff initially thought that the changes were due to a new diagnosis of Parkinson’s disease and symptoms associated with that. However, it eventually was identified by nursing staff that the woman’s friend group began to reject her based on her newly disclosed sexual orientation. They refused to let her play bingo with them anymore. They would no longer let her join them for meals.

- Anonymous

We have to realize that bullying, at its base, is about abuse of power, discrimination and bigotry.

-Rosalind Wiseman, Thought Leader & School Bullying Expert

The Granby Oak is an important symbol in town so it served as a nice backdrop for notes recognizing individuals in the school community for Random Acts of Kindness. It encourages students and everyone to be good to one another.

- Dr. Mary H. Gadd, Principal
Granby Memorial High School
Granby, CT

“Mrs. Balkun’s Buddy Bench” was given to the school in honor of Principal Edie Balkun’s dedication to the pillars of character program. She wanted the children to let others know if they felt lonely or left out. Children were instructed by Edie to join their fellow classmate by sitting next to them on the buddy bench.

Central Elementary School
Simsbury, CT
Introduction

Bullying is a hot topic today in the United States, a problem typically associated with our nation’s youth. More than four decades of research has informed the thinking and strategies used by educators to identify and attempt to prevent tragedies associated with the maladaptive cluster of behaviors that comprise “bullying.” More recently, another segment of the population has emerged with the same problem: senior citizens. Elderly people residing in assisted living, nursing homes, memory care, and other senior housing environments are now on the radar of healthcare professionals for bullying behavior, often resulting in social isolation, depression or circumstances that may lead to more tragic consequences. While intuitive, experienced healthcare workers may identify problems and prevent or de-escalate social aggression and while a culture of dignity may be the norm in many senior living environments, lack of regulations and universal specialized staff training for social bullying means inconsistent emotional safety for seniors in these environments. Elder resident-to-resident relational aggression or bullying which is social in nature, (unlike physical bullying) is an emotional safety and human dignity concern with few laws or regulations in place. Policies, procedures, and training for youth educators and school children on social and physical bullying have been developed over the past few decades. Now the same is needed to protect elders who rely on aging and healthcare service providers for their care.

Clinical psychologist and long-term care specialist Dr. Eleanor Barbera from New York, NY; social welfare researcher and professor Dr. Robin Bonifas in Phoenix, Arizona; gerontologist and dementia expert and trainer, Pamela Atwood in Connecticut; and Florida social worker and school bully program developer Alyse November are all hearing heartbreaking stories from seniors on how they prefer “not to make waves” and feel trapped living with social bullying. Problems are reported by seniors themselves and nursing staff or social workers can piece together the evidence that social aggression is occurring. In organizations where social aggression is more commonplace, direct care workers may ignore what they see and hear. Others either do not know how to respond, or have come to expect this kind of behavior as the norm. Some staff may not even label these behaviors as problematic.

Without staff education, training and a comprehensive cultural shift that recognizes elder-to-elder bullying as an important psychological health problem, older adults in nursing homes, assisted living and other communal housing will continue to suffer. There is ultimately no emotional safety in an environment where social aggression is not addressed with effective preventive measures and thoughtful intervention. Residents who are objects of ridicule are left feeling trapped and unsafe in a place that is supposed to feel like home.

Physical aggression is written up as incident or accident reports, which fall under state regulations and are addressed with policies and mandated reporting protocols. However, very little protects a senior from social bullying, unless the offense involves discrimination, harassment or violations associated with people in protected classes. In nursing homes where more cognitively intact residents are sometimes living alongside peers living with Alzheimer’s disease or other forms of dementia, intentional cruelty creates a negative environment that may then escalate into violence. “Incidents may not necessarily be remembered by dementia patients,” says social worker Alyse November, “but we know that discomfort can be felt and can affect a person with Alzheimer’s entire day.”
Seniors in assisted living, skilled nursing, and memory care are vulnerable to resident-to-resident social bullying in ways that can make their living situations uncomfortable and, in some instances, intolerable. Oftentimes they are unable to remove themselves from situations, and may not even be able to communicate how they feel toward others in their community, causing great anguish. Not all nursing homes and senior housing are over-run by this kind of negative environment, but some are. Others have isolated pockets of problem residents. Programming that promotes civility and empathy can help in either situation. The scope of a social bullying problem in elders is yet to be determined due to lack of research. However, researchers and clinicians are curious if resident-to-resident aggression, which studies show is a pervasive problem, can be seen as one of the symptoms of an underlying problem of social bullying. (Lake, 2014)

It is critical that staff differentiate aggressive behaviors symptomatic of other problems from bullying behaviors, which can appear similar. All staffing levels, from upper management to front line workers, need specialized training on relational aggression and bullying to help differentiate hallmark features from other forms of aggression due to mental illness, memory impairment, or other medical conditions. Dr. Robin Bonifas notes that while, “all bullying is relational aggression, not all relational aggression is bullying.” (R. Bonifas, personal communication, April 7, 2015)

Specialized training based on evidence-based practices are not yet available due to lack of research, but Bonifas and social work colleague Marsha Frankel, Clinical Director of Senior Services at Jewish Family & Children’s Services in Boston, have teamed up to offer workshops that present their current thinking on the subject. Information can be found on Dr. Eleanor Barbera’s website, www.betternursinghome.com, which posts a blog from Bonifas and Frankel. Bonifas suggests learning about bullying by looking to experts in other populations that already have an understanding of intervention and prevention from evidence-based research. As with school children, group dynamics play a vital role with multiple individuals playing different roles over time. The problem might manifest in a one-time incident between only two or three residents when witnessed by staff. It is then up to the staff to realize that the incident could be evidence of a pattern of bullying that has been building up. Nursing and social work staff members need to be good detectives, which is difficult because staff shift changes occur frequently. Unless nursing staff thoroughly notate even seemingly minor events that affect a resident’s emotions, much can go unnoticed and unreported. While there is an entire body of research designed to respond to bullying in school children, staff caring for nursing home residents and seniors in other communal housing need the same type of training and support to protect elders in terms of human rights and dignity. While some aging industry professionals have developed pilot prevention and intervention programs in an attempt to help, further research needs to validate their work.

This project makes the case for funding to support much-needed research, along with scientific evaluation of pilot programs that can contribute to the development of evidence-based best practices. In addition, this work offers a new narrative that industry leaders can use to educate workers in the aging services field and the public. If the belief that “we don’t have anything like that here” or, “this is just part of senior housing,” continues to dominate, and if attempts are made to minimize the problem for public relations purposes, the aging services industry will not be able to come together to find solutions. Social, relational bullying is a lifelong phenomenon found in every socioeconomic class, ethnicity, and culture. It must be identified as a significant problem worthy of funding and research toward solutions for elderly in various types of senior housing. Adult daycare and senior centers may also benefit from programming, so the research may have far-reaching effects.

The following pages present an analysis of the emerging problem of elderly resident-to-resident bullying as a systemic issue. What is needed is a comprehensive, holistic approach that includes a new aging service provider narrative more consistent with what experts on school bullying promote. Supporting this premise are first hand reports from experts obtained through personal interviews, attending live webinars and presentations from professionals in the fields of gerontology, psychology, long-term and memory care, social work, and legal counsel for nursing homes and assisted living communities. It includes an overview of peer-reviewed journal articles along with supportive thinking
from organizations such as AARP, respected as valid sources on senior topics. In nearly every personal interview, there was concern that solutions to this problem, now more than ever, must be found in anticipation of the baby boomers’ generation entering senior housing. Rosalind Wiseman, in the study of childhood bullying, has found that discrimination and bigotry, albeit covert, are at the base of much bullying—if this is true for elder bullying, how can messages of inclusion and acceptance be integrated into programming for seniors? The main question to be answered here is simply: what can be done to reverse trends of relational aggression and social bullying in senior living communities, both for today and tomorrow’s elderly? The scope of the problem for seniors is still yet to be defined. Given new focus on person centered care, aging services professionals and researchers can glean starting points for social bullying research, prevention and intervention from the following narratives, and expert opinions, and begin the task of developing solutions for future generations in senior housing. Keys to managing problems of social aggression among residents are found in the education, training and modeling of health care workers. Without accountability found in organizational policies and without training on how to intervene to improve the quality of communication between residents, little can be done that impacts residents industry-wide. Just as parents and teachers require coaching from experts on childhood bullying, so do employees on all organizational levels within senior housing communities.

Social/Relational Aggression – A Form of Bullying Defined

An individual is considered a target of bullying when he/she is exposed repeatedly over time to negative actions with intent to harm on the part of one or more other people. These actions can be physical, verbal, or relational in nature. (Bonifas & Frankel, 2012, Olweus, 2015) Cyber bullying is considered the same but occurs via technology through texts, emails or in online social networks. (Dilmac, 2009, msisac.cisecurity.org, 2015) Social, relational aggression, also called social bullying, occurs when a person intentionally inflicts, or attempts to inflict, injury or discomfort on someone else through negative actions or aggressive behaviors with direct words, indirect words to others, making mean faces or gestures, spreading rumors or untruths, or intentionally excluding someone from a social group. (Olweus, 2003)
Above is a schematic representation that shows how a bully drama can play out in the context of a social hierarchy in a senior living community. It was developed both from referencing the Bullying Circle, developed by Dan Olweus, the work of Rosalind Wiseman and from interviews with aging service professionals and research included within this study.

Dr. Robin Bonifas classifies bullying as follows:

- **Verbal:** name calling, teasing, insults, taunts, threats, sarcasm, or pointed jokes targeting specific individuals.
- **Physical:** pushing, hitting, destroying property, or stealing.
- **Socially aggressive:** shunning/excluding, gossiping, spreading rumors and using negative nonverbal body language, such as mimicking or offensive gestures. (Bonifas, 2014)

Bonifas makes the point that the, “necessity of repetition is questionable: one-time incidents can have significant negative impact.” (Bonifas, 2014) She also maintains it is important to keep in mind that some people exhibit verbal or physical aggression when they are frustrated or upset as a way of communicating their feelings. These cases would not be considered bullying. Attacks from bullies can be classified as direct or indirect attacks. In direct attacks, the target is aware of the source of aggression. In indirect attacks, a victim may be hurt by gossip, shunning, or isolation but not know who the culprit is. Kathleen Stassen Berger puts it best when saying, “…if no one sits near a particular child in the school cafeteria, all the classmates are the bullies yet the victim cannot confront the ringleader.” (K. Berger, 2007)

In terms of the impact bullying has on everyone in the environment, the points listed in the visual below were compiled from a personal interview with Dr. Bonifas and information presented both in Dr. Eleanor Barbera’s live webinar on elder bullying and on her website, mybetternursinghome.com. (Bonifas, et. al. 2012; R. Bonifas, personal communication, April 7, 2015, E. Barbera, personal communication, March 25, 2015) It is important to note that staff who witness bullying report experiencing negative emotions, just as victims do. As targets or victims could benefit from bullying prevention and intervention, so too could the bully themselves along with witnesses, including staff.
History of Bullying - Problem Typically Associated with Youth

Early research on school bullying by Dan Olweus, considered the founding father of research on bullying, first described behaviors as “mobbing” where a group or an individual harassed another, focusing on the physical aspect. (Polanin, 2012) Similarly, much research thus far in elderly has focused on resident-to-resident aggression, an umbrella term under which the category of bullying falls.

A review of the history of bullying in schools and the work of Dan Olweus provides important insights into how social bullying, which is essentially witnessed as taking place between two individuals, is really played out in front of an audience of multiple people. There is typically a constellation of individuals involved, sometimes with shifting roles. Unlike one-time incidents of aggression, there is a growing escalation to social bullying that may take place covertly making life for the target, and allies of targets, more and more difficult over time. Individuals who socially bully are clever at concealing their words, glances, and gossip from those who would challenge them or threaten their ability to continue. Thus, detection of bullying among residents by staff is complicated, and must be methodical, looking and listening for patterns of behavior, in addition to ruling out other explanations for the behavior over weeks or months. Those inclined to bully may not do so when new to a social system – many months or years may go by before they emerge, having honed relationships in their favor, as a social bully.

Most important, in terms of defining any form of bullying, is the social aspect. Dan Olweus, identified what he calls “the bullying circle” (Olweus, 2015) A target of bullying is in the center; surrounding the target are the various participants who play various roles in a bully drama. The bully role can be played by one or more individuals.

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Dan Olweus was the first to begin studying bullying in a systematic way. In 1983, when three teenage boys took their lives likely attributed to peer bullying, the Ministry of Education in Norway initiated a national campaign against bullying in schools. The Norwegian government commissioned Olweus to investigate, and from there the first version of the Olweus Bullying Prevention Program was developed. The program claimed 50–70% reductions in student self-reports of bullying. In both 8 and 20 month follow-up evaluations, reductions in self-reports of anti-social behavior such as vandalism, fighting, theft, alcohol use, and truancy occurred and “social climate” was improved. The program involved 40,000 students from 42 schools, followed over a period of two and a half years. The program has since evolved and has been implemented in elementary and lower secondary schools throughout Norway. Thousands of schools around the world including in the U.S. use the Olweus’ model and programming.

- The Hazelden Foundation, 2007

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Enabling the bully to have power are “followers” or “henchmen” who take an active part in but don’t start the bullying. There are then multiple roles for various “supporters”: those who support the bully but do not take an active part, others who appear to like the bully but do not display open support and then “disengaged onlookers,” who watch what happens but do not take a stand. On the other side of the circle are two categories: “possible defenders,” who dislike the bullying and think they ought to help but do not, and then “defenders of the victim,” who dislike the bullying and make attempts to help the victim. The bullying circle illustrates the complex dynamics behind bullying, both social and physical.


**Literature Review / Under-Recognized, Under-Reported & Under-Researched**

In the literature review process, the search for scholarly articles on resident-to-resident social aggression and/or bullying in seniors, using a substantial variety of search terms, yielded little. Dr. Margaret Wylde produced the most recent study of seniors in independent living settings; her report came out in 2014. Dr. Wylde identifies trends and performs market studies for the senior housing industry. The seniors in her study, independent living residents, reported that it was difficult to make friends, they were lonely, felt as if they did not fit in, lacked common interests with other residents, were bullied by cliques and missed their friends. Opposite these are optimal responses—what we would hope to hear from seniors about where they live.

The principal study on the subject in terms of custodial care is a study in the Netherlands entitled, “Resident-to-resident relational aggression and subjective well-being in assisted living facilities” (Trumpetter, Scholte and Westerhof, 2010). Findings included a link between residents who were victimized by relational aggression and higher levels of depression, anxiety, more social loneliness, and lower satisfaction with life. Nothing causal was decided; researchers suggested a longitudinal study be done in the future. Most important to note was that “nurse reports of relational aggression were not related to any of the measures of resident’s subjective well-being. The study went on to say, “…apparently nurses have difficulty discerning incidences of aggression that are perceived as hurtful by residents.” (Trumpetter et al., 2010) The difference between what nurses perceived and what residents experienced differed greatly from facility to facility. When researchers attempted to explain why nurses’ perception of residents’ experiences were so incorrect, they posed two possible scenarios. It could be the “use of indirect aggression tactics by older adults”; essentially, stealth on the part of the bully, and/or “possible non-transparency of groups of residents making systematic relational aggression hard to detect for nurses.” Another important finding was that residents in the study emphatically rejected the term bullying – saying that only children were “bullies”, even though behaviors were consistent with the definition. (Trumpetter et. al., 2010)

Frank Wood’s 2007 study, “Bullying in nursing homes: prevalence and consequences to psychological health,” extrapolated the notion from bullying in schools, work, and prison settings that nursing homes may test positive for the same social problem. Wood’s study was, “…based on a theoretical foundation that understands bullying as aggressive behavior that is repeated over time and involves an inequity of power, and that psychological consequences from bullying adversely impact the victim’s capacity to adaptively cope with stress and with stressful situations.” (Wood, 2007) In his study, nearly 50% of the residents reported at least some bullying (“bullied-- now and then”). Victims reported significantly higher scores on negative psychological health consequences. Wood concluded that social policy change is necessary and programs need to be implemented that will result in, “a bully-free nursing home culture.” (Wood, 2007)

**Nearly 50% of the residents reported at least some bullying (“bullied-- now and then”). The group reporting being bullied reported significantly higher scores on negative psychological health consequences. The results from this study lay a foundation for future research on bullying in nursing homes and the development of programs that increase awareness, provide tools for victims, and enhance training and education. The implications for social change include the recognition of the impact of bullying in nursing homes, and social policy change will result in the implementation of programs that will result in a bully-free nursing home culture.** (Wood, 2007)
In addition to these three main studies that refer to resident-to-resident social aggression in older adult communal living, other relevant, yet tangentially related academic articles are informative in terms of how we look at elderly bullying within the context of the health care workplace and the aging services industry as a whole. In nursing, senior or more socially powerful nurses’ bully younger, more vulnerable, nurses. (Briles, 2009) In the workforce employees with more social power or other hierarchical status, even in terms of length of time on the job, can wreak havoc in departments or throughout an organization. Since aging service industries are, like any other company, administered by human beings, and since social aggression is observed in humans across the lifespan, it will be necessary to look at the role healthcare workers play in contributing to or decreasing incidents of bullying among residents.

EXPERT OPINIONS

From Resident-to-Resident Aggression to Bullying – Dr. Robin Bonifas

The study of bullying in elders is in its infancy and, in part, according to Dr. Robin Bonifas, is emerging from research done on resident-to-resident aggression (RRA). In an interview with Bonifas, who has been studying RRA for a long time, she stated that a few years ago she began getting calls from newspaper and other media reporters to interview her on bullying seen in nursing homes. The reporters themselves were essentially identifying and labeling the problem. Bonifas began offering her opinion on the topic because her research on resident-to-resident aggression was the best “expert opinion” on the subject. According to Bonifas there are no real experts yet on bullying in the elderly, since no evidence-based programming has been tested and put into practice.

Her attention began to shift from resident-to-resident aggression to relational or social aggression. She then saw how social aggression, a form of bullying, should be distinguished from resident-to-resident aggression: incidents which may or may not overlap with bullying. (To reiterate, all bullying falls into the category of resident-to-resident aggression, but not all resident-to-resident aggression can be considered bullying.) Bonifas, researcher and assistant professor at Arizona State University School of Social Work, reported that from her own research it seems that somewhere between 10 and 20 percent of residents may be victims of bullying or relational aggression. These numbers may be low, because a lot of social aggression is not recognized and therefore goes unreported. Because the problem is under-reported, under-recognized and under-researched, many healthcare and social workers remain unaware that this is a serious issue. (R. Bonifas, personal communication, April 7, 2015)

To understand bullying, it first must be distinguished from resident-to-resident aggression that may not be related socially to others at all. Cornell University gerontologist and researcher Karl Pillemer and Dr. Mark Lachs, a geriatrician, have conducted research highlighting what they call “resident-to-resident elder mistreatment” and it constitutes verbal, physical or sexual aggression in nursing homes. (Rosen, 2008) A New York Times article from November 25, 2014, cites how extensive the problem is and the “…harm ripples beyond either party, frightening other residents and staff members.”(New York Times, 2014) Pillemer and colleagues witnessed numerous aggressive or assultive behaviors in their study. Pillemer says staff members need to understand the “root of the problem” in caring for aging individuals. Questions should be asked, such as, is aggression due to pain, hunger, boredom, or other underlying reasons that may be uncovered in the patient’s history? For instance, a former police officer patient had worked the night shift for decades and had challenging behavior in the evenings. Nurse’s aides ultimately, “…gave him a clipboard and allowed him to wander around his unit at night. His frustration and challenging behaviors eased.” (Lake, 2014) Although in this instance bullying was not specifically labeled, the strategy the nurse’s aides employed helped foster an
environment in which bullying would be less likely, especially during evening hours. Environmental factors can also be critical. Dementia expert, Pamela Atwood, uses a decibel meter to detect noise volume on a unit where too much noise could be agitating to residents. (P. Atwood, personal communication, March 13, 2015)

Laura Mosqueda, geriatrician and director of the National Center on Elder Abuse, re-frames the problem as a continuum. She speaks in terms of “looking at causes and prevention—by improving care” and also talks in terms of “easing aggression” because people in the study conducted by Pillemer and those in nursing homes today, “…are some of the most vulnerable members of our society. Even if they’re the ones who are ‘perpetrating’ some of this, they’re not the ones who should be held accountable.” (Lake, 2014) Other clinicians note that it is the cognitively intact nursing home patients and ones undiagnosed but starting to show earlier stages of dementia that are most challenging in terms of aggression within groups. Of course, if residents begin to exhibit signs of dementia, their behaviors slowly transition from intentional acts to symptoms of a progressive condition. This in turn means the same resident could gradually transition from qualifying as a perpetrator of bullying into becoming a victim of physical decline from dementia with an overlap of the same types of behaviors being exhibited. This is a gray area for staff. It gets tricky because there is no clear demarcation in time when one goes from cognitively capable to having dementia or other memory impairments. But it is recognized that many victims of bullying may tend to be further along in dementia.

Dr. Bonifas believes that, “we cannot wait for research, which could take a number of years, to help with this problem.” She is pending publication on research that she has done on resident-to-resident aggression and has written several grants to research resident-to-resident elder bullying which have been denied funding. Alleged ‘higher priority’ aging issues have been cited as the reason for non-acceptance. Bonifas has carried on with un-funded research using her own resources. She is currently preparing to launch two studies, including one that examines bullying in an east coast nursing home. The other will address the issue from more of a macro view. She is also writing a book dedicated to elder bullying, which is designed to offer her own and other elder care experts’ best thinking on the subject. Bonifas and others believe that there is a four part strategy in terms of prevention and intervention for bullying in elderly housing: it begins on the organizational level with comprehensive polices and programming, then must be addressed on a staff level with training; individually it is addressed with those who bully and also victims. “If you intervene at the organization level, the staff level, the bully level, and the victim level, everyone will work together to improve the situation as a whole, but if you intervene only on one level, it won’t be effective.” says Bonifas. One chapter will be written by a licensed clinical social worker, Alyse November, who has taken a student-based anti-bullying curriculum that was utilized in Florida schools and has turned it into a program for residents and staff in nursing homes. (R. Bonifas, personal communication, April 7, 2015)

“A Hidden, Unseen Epidemic” – Alyse November

“There’s a hidden, unseen epidemic,” according to Alyse November, who is asked to speak regularly to different groups about bullying. November, a social worker in private practice, also hosts her own radio show and helps those who call in to handle common problems. An advocate for elders,
she has developed programming to enhance the social spirit in any aging community, whether or not they have a bullying problem. Some places she has seen have their challenges. “There’s a “white picket fence syndrome going on”, she says, “where if a place looks great on the outside with grand rooms and a great deal of events on the activities calendar then it’s automatically seen as great place, despite passive staff who may fail to intervene on behalf of residents who are vulnerable.”  (A. November, personal communication, April 13, 2015)

November worked on social issues and bullying in Palm Beach, Florida schools where she wrote and received a grant to develop and implement programming. Her work was considered successful, and she was contacted by the nursing home community. November spent the better part of a year adapting her school bullying program to older adults in nursing homes and aging communities. She implemented her approach and did her own independent surveys, before and after her programming. While her results are inconclusive, due to small sample size and lack of peer review, she reports anecdotally that participants were given a much-needed vocabulary for social issues and bullying, and became more aware of what it means to be tolerant of others. Residents, according to November, seemed to enjoy her interactive workshops and were reportedly less likely to “say mean things” to one another afterwards. Without seeing the surveys, research methodology, and results of November’s nursing home bullying programs, it is difficult to comment on her success. However, her initiative to move in the direction of pilot programming for bullying and troubleshoot this problem across the lifespan is progressive. See November’s website, www.differentlikeme.com for further information.

When asked to recollect specific incidents of social aggression in seniors that November has seen in her counseling practice, she told an anecdote of an elderly couple.

I met an elderly couple in an assisted living facility. They told me their story of social rejection. When they went for their first meal at their new place, they walked into the dining room to eat breakfast. They went from table to table to join in with others where there appeared to be open seating. After multiple rejections, they took their breakfast trays, returned to their room and never went back to eat in the dining room again. By the time they told me this story they had spent two years eating alone in their room.

- Alyse November, Social Worker

November finds that the dining room is where a lot of the problems occur. She says that activity rooms, where bingo and card games are held, are also “hot spots”. In a post-program survey, even though she cautions that her sample size is rather small, November found that her program had a positive effect by the residents’ own reports. She acknowledges further research and testing must be done.

November is developing her program into a web-based learning series that could be a part of the solution for bullying among elders. It will now feature a new title that does not contain the word “bullying” because, in her experience, management in some nursing homes sees the word in programming as a public relations concern. Consumers can wrongly see such programming as an indicator of a bullying problem. She acknowledges that change in public perception and how organizations explain programming to prospective residents and the general public needs to be considered. In this context, November hopes these obstacles will vanish. Her vision is that one day consumers and management of aging service organizations will see anti-bullying programming

One day consumers and management of aging service organizations will see anti-bullying programs as proactive, necessary and gold standard indicators of the best organizations.
as proactive, necessary and gold standard indicators of the best organizations in terms of combating a common problem that exists across the lifespan.

November’s product has a ten part series for residents, with a substantial focus on empathy. The training is interactive, including vignettes about peer pressure, and takes on bullying in all forms by addressing issues that typically, she says, go unnamed and unnoticed. In one of her role-play interactions designed to elicit empathy, she uses signs with language associated with different functions that people in nursing homes typically lose. The signs say things like, “I am incontinent”, “I have a dysfunctional family”, “I lost my spouse or best friend” and “I don’t get many visitors”. An interesting result of the exercise is that she will hang one of the signs around her neck and motion for others to join her. She reports that no one in the groups ever agrees to wear a sign. However, at the end of the exercise they can report understanding on a visceral level how someone in any of these situations may feel. “This is the point of the exercise,” says November. “They don’t have to wear the sign and do the role-play, but I need them to put themselves in another person’s shoes and feel how they feel for them to understand empathy.” Some clinicians may steer clear of exercises of this nature that may embarrass certain residents who actually have challenging issues. However, it may be the case that residents lacking empathy can only understand their impact on others through such experiential means.

November also addresses distinctions in the role of active and passive bystanders. She is aware that subtle forms of bullying that are not physical, but relational in nature, and can, “… cause a great deal of harm and damage.” Aware of staff’s role in contributing to emotional climate, November is working on a four-part series for staff. Stressing the fact that bullying can be pervasive throughout an organization, she believes that addressing the issue from the top-down and bottom-up in the hierarchy of an organization is critical. She likened the need for both staff and residents to be involved in changing nursing home culture to her family counseling practice, where she finds it beneficial to counsel both children and parents when dealing with issues that involve the whole family system.

In terms of prevention of bullying, November offered an opinion in favor of specialty housing for residents with Alzheimer’s disease and other types of memory impairment. While many aging service organizations place cognitively intact and memory impaired residents together, November believes it may perpetuate some problems. When a nursing home setting merges cognitively intact residents with skilled nursing needs with individuals suffering from various forms of behavioral health problems or dementia (with behaviors like, wandering, calling out, or neuro-psychiatric symptoms of Lewy Body dementia, which can include hallucinations and other behavioral difficulties), it can be challenging to explain to residents why other residents with these challenges are treated with more leniency. Cognitively intact residents can be confused as to why it is not okay for them to exhibit certain behaviors, such as raising their voice, while others with psychiatric issues or certain forms of memory impairment have disruptive behaviors that affect others in the community just as much and are not addressed in the same way. In instances where these populations do have to live together, November suggests resident trainings designed to help cognitively intact residents understand and empathize with the struggles of their disadvantaged peers. When people are educated she finds them to be less fearful and more compassionate. (A. November, personal communication, April 13, 2015)

Inventing Programming out of Necessity in HUD Housing—Diana Benson

Diana Benson, service coordinator for an 80-resident HUD housing complex in Ohio with independent living seniors and physically disabled residents, has been working on just that--education, less fear, and compassion among residents in her building. A couple of years ago she set out on a mission to improve the spirit in the building. Having worked in social services for thirty years, Benson has a lot of experience with people. Her first job was at MRDD in Ohio with individuals struggling with both mental and developmental challenges. She then became a geriatric case manager for community mental health and was an executive director of a senior center funded by the United Way prior to her
current job. As the point person for people receiving certain services, like ride share programs and other community resources, Benson felt that certain residents were fearful of not getting their needs met. She felt they were being overly aggressive toward one another with the goal of “jockeying into position to access scarce services and resources.”

Benson felt the need to develop her own program out of necessity because she was discouraged with how poorly the residents treated one another. There were various cliques. One group of seven women was at the top of the social hierarchy. “The group would come walking down the hall and everybody moved out of the way,” she reported. Benson confirmed no knowledge of Rosalind Wiseman’s book entitled, Queen Bees and Wannabes but called the ringleader of the most problematic group, “the queen bee”. She would tell lies about other residents that would make others avoid them. She mocked a person with poor hygiene, would say incredibly mean things and call people awful names behind their backs. Other residents allowed the behavior and some joined in by laughing. The effect of this social bullying was damaging for many residents. “I had my fill of it,” reported Benson. Over two years ago, on her own time at home in the evenings; she went to work on the internet to figure out how she could change some of the group dynamics. She read the work of Dr. P. M. Forni at Johns Hopkins University on civility. She took ideas and information from The Civility Project in Duluth, Minnesota. Benson said at first, “I began plastering kindness quotes on the walls all around the building. People started asking me what I was up to and I didn’t tell them.” Once she had gathered enough information from what was already out there about bullying and civility, she developed her own educational program. She reported, “…not doing any finger pointing” and even avoided the truth with people who wondered out loud to her if they were culprits.

Benson said it was at least six months before she saw any changes. But now after two years, she finally feels that there is no longer a serious problem. She reports that the destructive cliques are gone. Other positives came out of Benson’s programming. She and the residents developed a neighbor-to-neighbor program to solve the fear of not obtaining seemingly scarce resources. It became a barter system where people offered services and then got some of their needs met from others in the building: people now cook meals for one another, provide rides to appointments or help one another with something they are able to do. “It’s all about meeting the underlying needs, inclusion and just being civil to one another.” Benson concluded.

While Benson was able to be effective in her approach through her own programming, there are drawbacks to developing and implementing untested programs and interventions. Benson worked as service coordinator for almost nine years before beginning her culture change efforts. As a new comer she may not have had the social power within the building or the skill set to accomplish what she eventually did. Without Benson’s vision and determination, the residents in her housing complex may still be doing active damage. A digital or manualized evidence-based program specifically designed for a particular population, like hers, would be ideal.

Psychologist & LTC Expert Presents Webinars & Bullying Blog – Dr. Eleanor Barbera

Dr. Eleanor Barbera, an author, speaker, clinical psychologist and consultant with over two decades of experience with long term care residents draws similar conclusions to Benson’s assessment of resident’s who feel the need to socially bully out of fear. From Barbera’s work in both long-term care and mental health, she has much experience providing health care workers with support as they assist elderly in senior housing. In a live webinar on March 25, 2015, Barbera spoke to an audience of nursing home administrators, directors of nursing, adult day health providers, and other aging service professionals. She cited a recent New York Times article which asserted the issue of bullying in elderly is widespread and worthy of attention. Barbera characterizes people who bully as individuals seeking to control others, noting that there is something that the person is gaining as a bully. She likened a relationship with a bully to a relationship with someone involved in active alcoholism. In terms of
specific traits people who bully tend to embody, Barbera noted that difficulty tolerating differences is a key feature, along with an inability to empathize. Bullies, while they may appear popular, seem to have few positive social relationships, and the relationships they have are often based on power imbalances. Many of these traits can overlap with personality disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, and can require psychological or psychiatric treatment.

Bullying among seniors, Barbera says, can also be associated with loss. In other words, the person who is bullying may feel out of control with an inordinate amount of loss in their world, and unconsciously may attempt to regain control by controlling others. This could include a loss of valued roles and loss of a sense of belonging in a community. Barbera encouraged her webinar audience, many of whom are nurses, staff or managers in elderly housing, to see a bully’s underlying needs for belonging and attempt to re-direct them into a healthier way to meet the need.

Gender differences were also discussed with Barbera noting that women are more inclined to partake in passive aggressive gossip and rumor spreading, while men tend to shout and or threaten when bullying or act duplicitously behind the scenes. A lot of what Barbera called “snubbing” can be involved with comments like, “this seat is taken.” The impact of bullying, over time, could be significant for the less socially powerful target. Results can involve any number of reactions including anger, annoyance, frustration, fear, anxiety, tension or some form of retaliation followed by shame and self-isolation. She emphasized that a social worker or other professionally trained staff must properly intervene on behalf of elders who cannot defend themselves, doing so in a way that supports the elder and is ultimately effective. (E. Barbera, elder bullying live webinar, March 25, 2015)

Expert Dementia Trainer Seeks Evidence-Based Best Practices – Pamela Atwood

An interview with Pamela Atwood, Director of Dementia Care Services at Hebrew Healthcare, in West Hartford, Connecticut, revealed real life challenges that demand more research. Atwood trains staff for her own and other organizations. Her goal is to have her organization be an industry leader, and she will only use new programs that are properly researched and have evidence to support them as “best practices.” This is difficult, since there are no evidence-based best practices yet for elder bullying. In reviewing the work of Bonifas and others to inform her work, Atwood says she is not able to teach many targets of bullying how to stand up for themselves, since targets often have challenges with cognitive processing abilities. De-escalation techniques and learning use of “I” statements and other behavior-based ways of responding cannot be utilized by residents who have dementia. This puts the burden squarely on healthcare staff to recognize signs of bullying and implement strategies to prevent or de-escalate problems. Bystanders feel badly as well when witnessing bullying incidents. Bullies do much of the damage when nursing home staff is not present. This requires staff to become detectives to rule out other causes for an individual’s symptoms, including social withdrawal, depression, and functional decline.

Atwood says that since targets of resident social aggression suffering from Alzheimer’s disease or other memory challenges cannot defend or protect themselves we need to know how to effectively train staff to respond. Without specialized staff training on how to redirect and decrease social aggression and without policies to handle such issues, staff does their best to redirect relational aggression and soothe targeted clients in ways that are restorative.

In addition to her role as director of dementia care services for the past thirteen years, Atwood has been a member of the Connecticut Chapter Education Conference Committee of The Alzheimer’s Association. These roles have prompted her into doing some of her own preliminary qualitative research on the subject of resident-to-resident bullying to ascertain if there is a more widespread problem. Atwood conducted a survey of a small sample of nursing homes and memory care facilities; all survey respondents reported that resident-to-resident social aggression, not physical in nature and not warranting an incident report, is emerging as a real problem. This survey identified the presence of
bullying among residents within a small sample of facilities, validating the need for more research. Six out of seven respondents in her initial survey saw bullying among dementia care residents as a significant problem. The seventh respondent answered “yes” that various behaviors on the survey were present but did not define these behaviors as “bullying” even though the descriptions of the behaviors would indeed be termed as such by definition. Thus, a gap in knowledge of what constitutes “bullying” for professionals in the healthcare field may also exist.

“It makes sense to research and develop practices to respond to behaviors that contribute to emotional distress, in the same way that we respond to physical aggression and violence,” says Atwood. Without evidence-based best practices, both in response to the target and the offending individuals, staff end up inventing their own ways to handle it: sometimes successful, and sometimes not. Atwood thinks that individual workshops are not doing justice to the subject of resident-to-resident social aggression and discrimination. She hopes that advocacy groups and others who have interest in quality of care for elders could start grass roots efforts that educate and communicate the need for funding and research. However, with so many competing demands in healthcare services right now, she says funding is a real problem. Right now, Atwood reports, Medicaid only pays 70 cents on the dollar for nursing home care, and even this amount toward services is in danger of being cut. She sees funding and increasing healthcare costs as a big obstacle. She hopes that a large philanthropic entity or other powerful senior industry group, like AARP, will take resident-to-resident bullying on in a serious way as a worthy cause.

Atwood teaches that planned activities, structure and controlling the environment are excellent ways to prevent and counteract many unwanted behaviors in memory care. Music, art and pet therapy are all utilized to help individuals with dementia. It is possible that these soothing, complimentary alternative medicine (CAM) approaches may also help soothe both those inclined to bully and their targets. It can be difficult to manage bullying in places where memory care and general skilled nursing residents are merged.

Another aspect is the role of pharmaceutical interventions, which have been falling out of favor, but have been traditionally used for managing aggressive behaviors. Ms. Atwood sees medication as a last resort in both behavioral health and memory care. A judicious use of medication can help certain individuals (if the right medication is given in the right dose at the right time). Certainly, controlling pain with medication sometimes addresses behavioral challenges that are expressed as agitation or aggression. (P. Atwood, personal communication, February 27, 2015) Nursing staff must attempt to identify symptoms of bullying while eliminating all other reasons why a person with dementia could act out with aggression or a change in behavior. For bullies, behaviors can be a life-long pattern: a person who is inclined to bully may have been bullying since childhood. The person is just older now and is forced to join others in communal living. A problem of bullying doesn’t go away. Both the person and the community need strategies to deal with the situation. (P. Atwood, Personal Communications, Jan.19, Feb 27, Apr. 30, 2015; P. Atwood Dementia Training Event, February 27, 2015)

**Thought Leader on Teen Bullying- Can School Lessons Apply? – Rosalind Wiseman**

Widely known for her expertise on school bullying and social aggression, cliques and social hierarchies is best-selling author Rosalind Wiseman. An internationally recognized presenter on children, parenting, bullying, social justice and ethical leadership, Wiseman serves as an advisor to the U.S. Department of Health and Human Services. Wiseman’s own work *Creating Cultures of Dignity* and contributions to the *Speak-Up Stop Bullying Campaign*, along with her books on social competence are meaningful references for aging services professionals. Wiseman’s approach to social/relational aggression can be highly beneficial if modified in ways that would suit seniors in communal living. For instance, her classification on “teasing” (below) can address people at any age. (R.Wiseman, Personal Communication, April 8, 2015) In a brief one-to-one discussion with Wiseman following her lecture to parents of high school students at Avon High School on April 8, 2015, she was eager to learn more
about the work of Dr. Robin Bonifas on bullying in elderly. Her initial thinking was that one of the strategies she employs for female youth, “girls circle” could be helpful for older women. Further follow up with Wiseman would add value to the creative thought on elder bullying.

Throughout Wiseman’s work with young people, she speaks about the “cultural scripts” of the different sexes and the social hierarchies, also known as “cliques”, which are the primary mechanism, she says, for enforcing the norms of the feminine and masculine “boxes” for students. Wiseman maintains throughout her work that, “boys who fit well within the box of masculinity are more likely to perpetrate violence (against both girls and boys), whereas boys who do not fit within the box (e.g., gay youth, smaller and weaker boys) are more often the targets of violence. In a small but growing number of situations, boys outside the box of masculinity perpetrate violence in protest of their “outsider” status. Such was the case with the Columbine massacre where female students and jocks were targeted as a result of the aggressors’ “outsider” status. (Katz 1999 as cited in Weisman, 2001)

In the 2009 revision of her best seller, Queen Bees and Wannabes: Helping Your Daughter Survive Cliques, Gossip, Boyfriends, and the New Realities of Girl World, Wiseman decodes female cliques and the power struggles in “girl world” that are every bit as disruptive on a social/relational level as physical aggression and violence that occurs more among males. Just as Wiseman sees differences in social and physical aggression among boys and girls, there are similar disruptive social behaviors in the elderly population. Even if “girls circle” and other interventions Wiseman uses for the younger set are not directly adaptable to elders, there is certainly much to gain from her macro view of how social hierarchies inhibit or promote bullying.

In much the same way, Dr. Robin Bonifas suggested that sometimes seniors will easily dismiss or reject other seniors by the way they dress or by the way they speak, related to a medical condition, e.g., a stroke. Wiseman cautions upper-middle class parents of high school students not to think they could avoid problems of bullying because of the socioeconomic status of their neighborhood. Similarly, seniors, their children and other caregivers cannot presume that social bullying occurs only in less expensive aging communities that draw from a lower socioeconomic class. While certain factors such as overcrowding and lower staff-to-resident ratios may contribute to agitation and conflict, Wiseman’s message can be applied to aging service professionals not to ignore hard-to-detect social strife among residents in higher end communities. Wiseman indicated that social aggression is everywhere despite class or societal rank. Management in organizations who cater to individuals with high socio-economic means cannot think of their residents and themselves as somehow exempt. Alyse November echoed these sentiments relative to senior housing.

Wiseman also points out another nuance in the problem of social bullying—the difference between the rights of people to socialize and spend time with those whom they choose to spend time with versus outright cruelty and group social snubbing which sets out to ostracize or harm another. There is a fine line and it can be difficult, said Wiseman, for people to distinguish bullying from normal gravitation of people into social groups. Her example was illustrated to parents when she said, “it is not bullying for a group of teens to go out and then post a group photo of their time together on social media if other children are left out.” That in itself is not bullying. Wiseman cautions that everyone will not be
invited to everything in high school. However, it is the cruelty and mocking at another’s expense or in a group behaving in a way that does not allow someone to join in something meant for everyone, that is the problem to be addressed. “At its base, bullying is about abuse of power, discrimination and bigotry,”
(Rosalind Wiseman, April 9, 2015 Avon High School Lecture)

This is the key for nursing homes, elderly and the aging population. With members of the baby-boomer generation now seeking elder housing for both their parents and ultimately themselves, new norms will need to emerge to establish peaceful ways for more numbers of people from diverse backgrounds, cultures and socio-economic classes who look and act more outwardly different from one another to somehow join one another peacefully to co-exist. Baby boomers and younger generations that are accustomed to demanding civility, safety and dignity for children within schools will, no doubt, demand the same for their parents, grandparents, and themselves.

“Civility” Model – Independent High School Arts Department Chair, Megan Eddy

Sage Hill School in Newport Beach California was distinguished in 2015 in the Washington Post’s list of “America’s Most Challenging High Schools”. While it is known for academics and the arts, the purpose of presenting it in this study is not to focus on its academic success, but rather its character education program. The state-of-the-art character program is strong in the way that it intentionally involves students to influence the rest of the student body in matters of civility. The honor code and honor committee, pillars of the program, were customized by the school’s original administration and are based upon the honor codes of colleges and universities that uphold the highest standards of practice in the area of character, integrity and leadership. While many of the strategies used in the school will not apply directly to elderly housing, some could. More applicable may be lessons for administrators and human resource departments regarding hiring practices and staff training in an effort to foster norms of civility in the healthcare workforce. Ideally, human resource hiring practices and staff training can influence civility among healthcare workers and may, in turn, provide better guidance for residents on issues of civility.

The overarching message from this narrative has to do with the dominant feeling of inclusion and comradery that the students and staff reportedly experience at Sage Hill School. Sage has embedded into its community a sense of emotional safety for students that allows them to thrive and significantly reduces incidents of social aggression and bullying. Thus, it has been included in this study so that aging service providers can begin to understand and internalize why some communities have strong cultural norms against bullying and others do not.

Megan Eddy, Chair of the Arts Department, has been at Sage Hill School almost since its inception. Developing the honor program was an organic process that she witnessed whereby the original administration researched what other academic communities did well. The founders of the honor program discussed at length how the faculty and staff can engender a sense of social etiquette in students in a way that manifests in how they conduct themselves. “Each year,” Eddy says “we have to start from nothing and have conversations with incoming freshman about honor, integrity and treating each other with dignity.” Peers and faculty choose influential students to be members of the honor committee. Senior honor committee students interview new applicants each year along with Eddy, who has been acting as an honor committee advisor for the past 15 years along with one other teacher advisor.

The honor committee, with faculty representation, functions similarly to a jury of peers. The committee reviews violations of the honor code. If anyone acts dishonorably whether it is related to cheating on a test, bullying, or anything in between, the person’s peers along with faculty representatives, deliberate as to how the person will repair the damage within the community. When looking into cases that come before the committee, faculty knows that they are only seeing the tip of the iceberg when it comes to violations. Due to this understanding, they take very strong measures when it
comes to handling provable infractions that occur. There is buy in among the student body because an administrator is not saying “here’s how you need to repair”. The members of the actual student body are, in part, deciding for their peers what will happen.

“We also have a group of students given the position of peer counselor,” says Eddy. Peer counselors function as a shoulder to lean on and someone to talk to for younger students. They are junior and senior students who are considered a different body of leadership from honor committee students. They have different advisors and a different agenda. There are more students assigned to this committee and they influence students in similar ways to that of supportive older siblings.

“It is a very delicate balance creating an honor system that works,” according to Eddy. If the student body thinks that any of the kids on the honor committee should not be there due to their own behavior, the structure breaks down. Therefore, honor students cannot make serious mistakes in the greater population because they will be called out on their behavior by other students. Freshmen learn this interactive accountability early on in their first semester. A lot of time is spent on learning teenage vernacular and understanding what students mean when using certain language. Incoming freshman are educated to the norms of the culture within the first weeks and months of school. For example, Eddy says that new ninth graders who make discriminating comments such as saying to another student, “that’s so gay” are immediately responded to by juniors and seniors with clear messages such as “hey, that’s not cool.” Older students might even go as far as to say “we don’t say that kind of thing here.”

Strong cultural norms around dignity and acceptance of others’ differences are enforced by students themselves and become self-reinforcing. The message given at Sage regarding social hierarchy seems unique for high school students-- seniors are considered no better than freshmen. All students have something to offer. There is no teasing or hazing, even in sports. Any act of this nature is brought before the honor committee, “… so fast your head would spin.” Eddy jokingly reported.

The huge drawback is the expense of this model. The school exists in one of the two most affluent areas in California – there’s an inherent problem in terms of using the approach in other schools with less resources. A lot of investment is put into training teachers and staff. “We do a lot of education on diversity at Sage,” says Eddy. “As a department chair, I am the first resource for students and faculty if there is a harassment issue. Sage provides me with on-going training which addresses details of law with respect to discrimination and harassment,” says Eddy. The training is geared specifically toward students in the school. It incorporates legal information by which the faculty needs to abide.

We have a diversity leader at the school who works with faculty on topics of inclusion and cultural competence. A lot of the training is experiential in a “lecture followed by group discussion format” says Eddy. A topic will be presented to the faculty and then discussed in small groups which return at the end of a workshop to share insight from exercises. Eddy believes that the students in their four years at Sage become well versed in cultural diversity issues because the staff is well trained on these topics. It is one of the strategies instituted that inhibits bullying. However, success in this area is very difficult to quantify. Each year, Eddy says, there is only a small group of kids who seem to have not learned to embrace the principles of personal integrity and value of accepting the differences of others. There is no way to know how many there would be without the character education program.

Typical offenses to the honor code are very subtle because the kids are so bright. Eddy acknowledges that once students realize what they can and cannot say, they attempt to find ways around it. “Exclusion,” Eddy admits, “is a problem in all schools. If a kid is not liked, others will avoid them. However, at Sage, students do not get away with being overtly mean and socially aggressive without consequence. They know that is not acceptable.” Eddy hopes that her students will not, in 70 years when they are seniors in life (not in school), have any problems with social aggression because of the social skills they learned in high school.

“Cost is a huge factor,” Eddy believes. Roughly ninety percent of the spending budget is spent on faculty. Teachers in this particular school are well paid and well-educated both in the subject matter on which they teach and on issues around cultural diversity and human dignity. Faculty members that stay are people that tend to fit the culture. In her training to become a choir director, Eddy was not
taught how to advise students on issues of diversity and human dignity— she gleaned these lessons from life experience. She had coaches and fabulous mentors who helped her on life’s journey to learn much of what she now does with the honor committee at Sage. With a master’s degree in choral music, Eddy states that while her teacher training did not include much in terms of how to support students with social skills, her continuing education at Sage does. The supportive environment and on-going workshops for faculty arms her with what she needs to be an effective leader.

One of the community’s primary goals is to be proactive in terms of influencing the student body to behave with integrity. The school’s philosophy is to assume people are inherently good, but need reminders and guidance along the way. “What we’re looking to do is to send a whole, balanced healthy community member into the world and that’s bigger than math and science. It’s about global perspective and human empathy.” claims Eddy. “Young people,” according to Eddy, “are able to learn empathy. We as teachers who work with students don’t give up on people in terms of learning empathy.” Hopefully this is true for our elders. In any case, we have to try to teach it, or at the very least, we need to, as aging services providers, educate on civility and have expectations that are in line with human rights and dignity. “We have to continue helping our students become educated” Eddy says. People continue to thrive when they are educated – and we now look at people as life-long learners. We are constantly in professional development as teachers, and seniors who are lifelong learners are better off as well. (M. Eddy, personal communication, April 22, 2015)

“Dignity” Model, Green House Project– Joanne Thomas

In the same way that Sage is considered a model of excellence among schools with regard to civility, the Green House Model, inspired by Robert Wood Johnson is progressive in this area in terms of promoting person-centered care and excellence in terms of civility. A group tour through the a model green house at the Leonard Florence Center for Living in Chelsea, Massachusetts provides visitors with a peek into what state-of-the-art person centered care looks like at its best. While the model is more expensive than traditional skilled nursing homes and rehabilitation centers, the environment inherently inhibits social aggression and promotes civility according to Joanne Thomas. Thomas is the executive assistant to Barry Berman, CEO of the Chelsea Jewish Foundation, which supports the Leonard Florence Center for Living. In her thirty years with the organization she has not once known an instance of resident-to-resident aggression. In fact, Thomas reports that long-term care residents think of each other as family and actually become very upset with the loss of one of their fellow residents.

In the green house model, a patient is seen at the top of the hierarchy and residents are chosen to be on committees which weigh in on all aspects of living at the center. The “shahbazim”, who goes through additional training well beyond what personal care aides receive in nursing homes, are paid accordingly for their knowledge from additional training. They are the first in line to support the resident, and are respected for intimately knowing what the residents in their care need on a daily basis. Doctors and nurses are seen in the hierarchy as supportive in their role to provide adequate information to the shahbazim so that they may deliver the very best care to their client. In this social system, the resident and shahbazim (equivalent to a nurse’s aide) are at the top of the hierarchy.

The environment, unlike that of a hospital-style nursing home, has the look and feel of a four-star hotel. There are no visible nursing stations with dividers that separate nursing staff and aides from their resident clients. The building is seen as the residents’ home and provides utter dignity in terms of respecting residents’ personal space. “Residents have their own rooms, which helps with privacy,” notes Thomas. “Social events are times when people eat together and enjoy one another’s company. Residents who suffer from multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS) initiate field trips with one another and support one another in remarkable ways,” says Thomas. The residents take ownership over their environment and staff members need to inquire with residents as to what time they wish to wake up, eat a meal, bathe and get dressed for the day or prepare for bed. Another way the
center demonstrates respect toward residents is in how they show prospective residents and guests the property. The residents often provide tours themselves regardless of their need for wheelchairs and computer-based assistive technologies which allow them to communicate electronically with visitors if they are unable to vocalize. When Thomas wants to schedule a resident-led tour, she phones or emails the resident to see if they are available. Residents keep their own social calendars and the staff structures tours around them and their personal needs. A resident’s room would never be entered without permission, and no resident shares a room, which cuts down on conflict a great deal.

While the Leonard Florence Center can be very expensive to replicate, instituting ways for residents to feel engaged can in many instances cost very little. Residents, who may struggle with loss and a sense of belonging, can be encouraged to give tours with staff or in other ways be involved on committees to regain a sense of control over their lives. Residents could have more say in their daily care. If investments in models, like the Green House Project which promotes better resident directed care, appear to have very low incidents of bullying, researchers need to study the reason why. Perhaps when residents feel valued and worthy of customized care there is less social aggression because underlying needs are met. As important to investigate is how placing a higher value on the important work of direct care workers and offering them added training may promote healthier interactions among staff. To this point, Thomas cannot recount instances of social aggression among staff members either. She says, “It is a very unique place to work and staff happily remain here for many years.” (J. Thomas, personal communication May 2, 2015)

Bullying in Corporate America, Certified Rehabilitation Counselor & LPC - Eric Campion

Addressing the problem of bullying in elders forces us to look at bullying throughout the lifespan and realize that today’s workers are tomorrow’s seniors. While bullying in the healthcare workforce is beyond the scope of this research, it is important to recognize that a pervasive problem exists. (Briles, 2009) If we do not look for ways to help our workers both in and out of the healthcare industry, problems become cyclical. In addition, bullying in any human arena produces side effects in other areas of life. Bullying exists in the workforce, and affects a worker’s home life. Bullying takes place in families, and affects children in schools. Bullying is in nursing homes and affects residents, their families, and staff. Social bullying is in prisons, boardrooms and on playgrounds. Directly from corporate America, an interview with licensed professional counselor, Eric Campion reveals that social aggression is alive in the American workforce and in society. Campion says,

Social bullying is an extremely pervasive problem within today’s society. It is an important issue that has certainly been under-identified or ignored by many. As a licensed clinician, I have worked with many individuals of all ages who have been subjected to the adverse consequences of social bullying by peers, family members, and even service providers. Having worked in corporate America for many years, I have also witnessed firsthand the devastating effects of social bullying on individuals by their co-workers, supervisors, and others. Some of these adverse effects include depression, anxiety, low self-esteem, decreased self-worth, hopelessness, helplessness, social avoidance and withdrawal, decreased motivation, and reduced work productivity (among others). Lacking a true voice and appropriate levels of support, many of these individuals remain powerless to adequately cope with or make the necessary steps to overcome social bullying. While there are no easy solutions to this problem, dramatic reform is certainly needed in this area.

(E. Campion, Personal Communication, April 24, 2015)
Virginia-based attorney, Martin Donlan, who has provided legal counsel for nursing homes and assisted living organizations for the past 35 years, does not see a lot in terms of social issues and social aggression in his practice. Because laws do not specifically address this aspect of trouble between residents, Donlan is rarely involved in incidents of this nature. He typically deals with issues such as physically aggressive behaviors that cause injury to other residents or staff related to mental health issues. “Unless there are physical injuries or risk of injury, verbal abuse is generally seen as a management issue for caregivers to address,” says Donlan. Regulating these issues is difficult because the rights of residents are conflicting on this issue in most states. For instance, in his state of Virginia, the statutes establish resident rights which would be conflicting when viewed from the perspective of the “bullying” and the “bullied” resident. Virginia law assures residents in nursing homes certain rights while residing in state licensed facilities. Donlan delineated the resident rights below directly from legal code to illustrate the challenges inherent within the law with regard to social bullying. He stated that the administrator of the nursing home is obligated by law to provide policies and procedures which, in part, ensure a resident:

- Is free from mental and physical abuse and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time or when necessary to protect the patient from injury to himself or to others;
- Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;
- May associate and communicate privately with persons of his choice and send and receive his personal mail unopened, unless medically contraindicated as documented by his physician in his medical record;
- May meet with and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated as documented by his physician, physician assistant, or nurse practitioner in his medical record;

Thus, a bullied resident may claim to be mentally abused or not treated with respect by their rejection from participation in a group of some residents while the rejecting group would claim the right to associate with only the residents of their choice. Donlan therefore maintains that social civility would be difficult to mandate and really requires programs which encourage it. “What is clear,” Donlan says, “is that there is a duty on the facility to foster an environment in which abusive resident-to-resident behaviors are minimized without limiting the rights of residents to choose the residents with whom they associate.” Donlan admits this is a difficult task and one which requires a balancing of interests among the facilities residents.

From another perspective, even dealing with physical bullying is difficult to manage in nursing homes. Residents have the right not to be discharged or even moved to a different room in a facility without notice and appeal rights. Another related resident right is to be free from chemical and physical restraints, and the right to consent to their treatment under both state and federal law. Thus, the use of psychotropic drugs, even for a mentally ill and physically aggressive resident, can require lengthy processes and ultimately court ordered mandatory treatment to overcome a residents’ right to be free from chemical restraints. “Even then,” Donlan reports, “most nursing homes are not equipped to deal with mentally ill residents who refuse to take the medications that will allow them to better control their own behaviors.”

In Virginia, the state operates two nursing homes for mentally ill elderly patients that specialize in such care. According to Donlan, both are continuously full with waiting lists. Nursing homes that admit residents who have significant mental health issues are faced with very complex and difficult resident care issues. Donlan, therefore, believes that development of programs that improve civility
between residents is clearly needed and that specialized care programs for residents with mental illness, including the enhanced funding to pay for this care, are critically important to both residents and nursing homes. (M. Donlan, personal communication, May 1, 2015)

EMERGING THEMES

SOCIAL BULLYING OCCURS ACROSS THE LIFESPAN

ONE POPULATION MAY INFLUENCE ANOTHER WITHIN A COMMUNITY’S CULTURE

Teachers who are not interested in addressing bullying who say it, “isn’t their job” are contributing to the problem by their inaction. (Berger, 2007) Their “hands off” approach sends the message to targeted students that they aren’t worth stepping up for, and the message to bullies is that their behavior is okay. School bullying research has taught us that ignoring the problem makes teachers part of the problem. Students cannot focus on learning if emotional safety is an issue. Social behavior that is effectively controlled allows teachers to do the necessary work of teaching. (Berger, 2007) We can extrapolate and assume that staff and management in all types of senior housing who witness or obtain evidence of bullying between residents are actually part of the problem if they have taken no effective action. When responsibility for creating a safe environment moves from the principal’s office to the classroom students became safer and more learning occurs. In the same way nurses and personal care workers must be trained to “take ownership” of what happens on the floor of a nursing home. If nurses and aides ignore how residents treat each other or say that monitoring residents’ social interactions “isn’t my job or my business,” bullying has fertile ground in which to take root. Addressing bullying is difficult and complex. Not addressing bullying leads to even greater problems.

Bystander interventions in school bullying indicated that “when bystanders intervene on behalf of the victim, they successfully abate victimization more than 50% of the time.” (Craig, Pepler, & Atlas, 2000; O’Connell et al., 1999 as cited in Polanin, 2012) School bystander education programs are comprehensive and are based on Olweus’ bullying circle. One such program, The Safe School Ambassadors (SSA) program is a year-round bystander education program implemented in schools that reduces emotional and physical bullying in elementary, middle, and high schools. The program recruits influential students from different cliques and groups to act as "ambassadors" against bullying, while influencing cultural norms throughout the school. A specific percentage of students are required for the program so that the threshold of students who are trained is high enough to be able to effectively influence other students. Students who know right from wrong are chosen for these leadership positions and adult mentors are highly involved. This program is included in SAMHSA’s National Registry of Evidence Based Programs and Practices (community-matters.org, 2015)

By elicit the effect that bystander interventions have on school bullying in nursing homes, memory care, and assisted living facilities, nursing staff, nurse’s aides, activities staff and other workers would need to learn effective bystander interventions. Staff would need to model to higher functioning residents how to assert themselves without harming another. They also need to be the voice for
residents unable to stand up for themselves. Front line workers, who are most apt to witness incidents of bullying, are not trained nor do they inherently have social work skills. Amanda Aaron, Director of Life Enrichment at Hebrew Healthcare, West Hartford, Connecticut shares the concern that one social worker can be assigned to numerous residents in a nursing home. They must rely significantly on reports and assistance from nurses and personal care aides in order to address all of the psychosocial issues that arise. Social workers do not even have evidence-based training and tools to present, nor do they have a set of evidence-based best practices. (A. Aaron, personal communication, May 1, 2015)

Managing social hierarchies and bullying situations is a specialized social work skill. “Training,” Aaron says, “would have to include methods of coaching residents to avoid aggression with peers in a way that is neither punitive nor infringes on a resident’s right for self-expression.” Also workers would not be able to intercede with their own moral views and judgement but would rather need to protect targeted residents by providing good limits and boundaries on behalf of those who cannot provide them for themselves. All of this would have to be done in such a way that does not further anger or incite a bully to retaliate either against staff or a target/victim of bullying. Staff would not be attempting to change a bully’s particular views, but would intend to impact how a resident’s individual views manifest in behavior that infringes on someone else’s right to live in an emotionally and physically safe environment. Managing all of these factors is even a challenge for highly trained social workers. (A. Aaron, personal communication, April 30, 2015)

**NEED FOR BOTH ORGANIZATION WIDE CULTURE CHANGE & INDIVIDUAL APPROACH**

From Olweus and Wiseman on children to Bonifas and Barbera on elders, all professional opinions recommend a comprehensive organizational approach, while at the same time educating and intervening on an individual level with bullies, victims and bystanders. Without an intensive, systematic approach that eventually becomes second nature to a significant number of individuals in the community (an unknown ideal threshold) bullying will find fertile ground in which to root itself and grow. Organizations with pervasive problems will need, in most instances, to hire on-going outside help. Bullies and victims should not, for the most part, be brought together to work things out, but both in their own individual ways need different supports and therapeutic intervention. Allies of victims and those who, on the surface, appear to align with bullies need help independently as well.

Relative to social aggression in the workforce, it is short-sighted to invest money on hiring, training, and integrating new staff, if they soon move on because of an underlying bullying problem. If the bullies remain, and if behaviors associated with bullying go unchecked, problems will continue. In work places drowning in a problem of this nature trust among colleagues is low. Allies, protectors of victims who put themselves at risk, learn their mistake very quickly if they do not have social power in the hierarchy. Furthermore, some of the bully’s closest comrades may look and act like friends, but may not be friends at all. New employees who enter into the environment over-run with bullying start out as onlookers and bystanders. They may, out of fear, befriend the bully out of a need for self-preservation. In doing so, they bolster bullying behavior and contribute to a culture of mistrust and betrayal. Any person in a climate like this can then miss-step and become a target. Unless it is in a person’s nature to be a loner, withdrawal from social group activities can be a sign of a problem. For an employee, this could mean a new behavior of eating alone at their desk, or avoiding social functions. Translating into
reactions on the part of elderly victims or allies of victims, this can explain why residents may isolate themselves in their rooms.

ZERO TOLERANCE POLICIES DO NOT WORK

Dan Olweus, Robin Bonifas, Rosalind Wiseman and numerous other sources confirm that zero tolerance policies, while they may sound good to consumers and marketing departments, are virtually irrelevant in terms of solving social bullying. It is the comprehensive multi-level approach suggested by Bonifas, and detailed in the work of Dan Olweus that is anticipated as the heart of change for social bullying in elderly.

AGING SERVICE ORGANIZATIONS FORCED TO INVENT AD HOC PROGRAMMING

Research needs to be done and programming needs to be tested because organizations that invent their own ad hoc programming may not fully comprehend the complexity of the problem. While “necessity is the mother of invention,” many new inventions don’t work as planned the first time around. This is why funding for research is imperative. One well-meaning worker could decide to bring the victim and perpetrator together to “solve the problem,” which could aggravate the problem ten-fold. Without understanding that bullying is not helped with conflict resolution or mediation methods, an innocent worker could, with good intention, make matters far worse for a victim.

Kathleen Stassen Berger’s literature review on school bullying says that, “when science leaves a vacuum, superstition rushes in – sometimes with cruel consequences.” (Berger, 2007) She cautions that there are many bad guides and untested suggestions that hurt children when implemented. These cautionary words should be taken seriously. Implementing recommendations should only be done as part of training programs endorsed by a real expert in the subject.

GROUP WORK WITH THOSE WHO BULLY – NOT ADVISED

The Olweus Bullying Prevention website is one of the best in terms of explaining why bullying cannot be addressed with mediation or conflict resolution. “Not a conflict of equals,” it is a power play that mediation cannot solve. (Olweus, 2015) Group treatment for children who bully is counterproductive, because individuals in a group reinforce one another’s behavior. Anger management programs that lack expertise could seem to help but can actually make bully’s behavior more subtle, sophisticated and manipulative. In this respect transforming behavior of others who hold the bully accountable to a new standard and do not enable their behavior makes more sense. This has to come from the top down. Without adequate support from those above the bully in the hierarchy, lower ranking individuals who stand up to the bully are at risk for becoming targets. Social workers and psychotherapists would liken this to family systems work, whereby lessening enabling behaviors of one spouse and other family members may have a greater effect on the overtly problematic partner than attempting to change the partner directly.

TARGETING THOSE WITH VISIBLE SIGNS OF WEAKNESS OR DISABILITY

Those inclined to bully, by nature, target those who are weaker in a social hierarchy. This automatically makes individuals with visible signs of weakness or disability perfect targets. The Pacer Center discusses this in terms of school children and notes that being bullied based on a student’s disability may be considered harassment. Since disability harassment is a civil rights issue based on both the Rehabilitation Act of 1973 (also referred to as ‘Section 504’) and Title II of the Americans with
Disabilities Act of 1990, clear acts of bullying toward disabled citizens can be brought to court. (Pacer Center, Inc. 2012) However, the problem being addressed here is one of covert discrimination and harassment. In fact, intelligent individuals who are older in years have learned over time what they can and cannot say. It is subtle, indirect comments, gestures and actions that, while inspired by feelings of bigotry, superiority or fear, are difficult to prove. This is why laws alone cannot address bullying. The behavior modification that must occur in a bully is difficult to impose and may be slow to change, if ever, from within. Yet in relation to the bully’s peers, the power of the social group for halting the bully’s behavior is necessary. Improvements in the system hinge largely on those at the same level or above the bully in the social hierarchy. Those in key positions cannot tolerate or enable bullying behavior at all and must send a clear top-down message. Without clarity from leaders, change efforts are futile.

MENTAL ILLNESS —MISSING A DIAGNOSIS

Bullying behaviors sometimes overlap with behaviors seen in mental illnesses. It is critical for psychotherapists, psychiatrists and clinical social workers to assess individual situations. Some conditions associated with mental illness result in hallucinations or bizarre aggressive behaviors. In addition to professionals weighing in on the subject, lay people can receive information from resources like the National Association for Mental Illness (NAMI). Marilyn Ricci, NAMI’s 2011 – 2017 Second Vice-president on the national board of directors was reached for comment on whether or not NAMI has resources and training with regard to bullying for elders or any population. Ricci stated that, “while NAMI does not have materials addressing this area, the organization can be used as a resource for issues with mental illness which may overlap.” NAMI is an organization that can assist family members and caregivers with a diagnosis of mental illness and can assist with supportive programming and resources. A free twelve-week course is available through NAMI for individuals who need more information to determine if mental illness is an underlying problem in a bullying situation. The NAMI website can also be referenced at www.nami.org. (M. Ricci, personal communication, March 12, 2015)

ACTIVE ADDICTION —METHODS OF NUMBING PAIN FOR EVERYONE IN BULLY CIRCLE

Active addiction, either to substances or other behaviors, may also interconnect and/or overlap with individuals caught in bullying situations. Substances may be used by bullies themselves or by victims of bullies and bystanders when feeling trapped in a bully drama. When victims feel powerless to endure pain from bullying, addictive substances provide immediate relief by numbing the pain for those who feel powerless in any system. In the bigger picture, it does nothing to solve the problem, and often makes matters worse. Michelle Bourque, nationally credentialed alcoholism and drug counselor, states that education and providing oneself with tools to become empowered is essential. Twelve-step programs, such as Al-Anon and Alcoholics Anonymous, are easily accessible and can provide a place to begin. Seeking professional help with certified alcohol, drug rehabilitation specialists is another option. A word of caution; there are just as many ineffective addiction treatment therapists and programs as there are ineffective anger management and bullying programs. Vetting professional help is always necessary. (M. Bourque, CAC, NCADC, personal communication, April 25, 2015)

IS THE PROGRESSION OF SCHOOL BULLYING RESEARCH A CRYSTAL BALL FOR ELDERLY?

Kathleen Stassen Berger, a professor who has done extensive research on adolescent identity, sibling relationships, and bullying, notes that interest on the subject and support for research over time is prone to “wax and wane in relation to incidents.”(Berger, 2007) Berger notes how the tragedy at Columbine High School in 1999 created a push for more research. It was the same in Norway following three teen suicides, when the work of Olweus was commissioned by the Norwegian government. And in
the case of Dr. Robin Bonifas, her interest in elder bullying was a direct result of requests from reporters for interviews on the subject.

The chart below is taken directly from Berger’s study regarding the progression of school bullying. If school bullying at all could predict what we would find in elderly bullying following more research, we would begin to focus more on the link between social bullying and resident-to-resident aggression in elders. Focus on the systems that engage to increase or decrease emotional and physical abuse and violence rather than sole focus on each individual incident is a lesson learned from school bullying that may apply to seniors. Attention to group dynamics and social systems is vital to the overall health and wellness of everyone within a greater system.

<table>
<thead>
<tr>
<th>Questions to Answer</th>
<th>Public Perception Media Attention</th>
<th>Scientific Method &amp; Developmental Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the problem?</td>
<td>Violence in schools</td>
<td>All forms of bullying, especially social forms</td>
</tr>
<tr>
<td>Evidence of the Problem</td>
<td>School shootings, suicide</td>
<td>Rejection, isolation, low achievement</td>
</tr>
<tr>
<td>Who are the culprits?</td>
<td>A few mean &amp; bad students</td>
<td>Entire peer group &amp; school staff</td>
</tr>
<tr>
<td>How common is bullying?</td>
<td>Rare, not in my neighborhood</td>
<td>In every school, some more than others</td>
</tr>
<tr>
<td>Origin of the Problem?</td>
<td>Probably in parents</td>
<td>Multivariate, including genes, peers, &amp; policies</td>
</tr>
<tr>
<td>How problem is solved?</td>
<td>School-wide policies e.g. zero tolerance</td>
<td>Whole school effort, teachers within each class</td>
</tr>
<tr>
<td>How does change occur?</td>
<td>Linear, dose-related</td>
<td>Sometimes, tipping, threshold needed</td>
</tr>
<tr>
<td>Time until solution?</td>
<td>A few weeks</td>
<td>Years of study, intervention &amp; evaluation</td>
</tr>
<tr>
<td>Measure of success?</td>
<td>Bullying eliminated</td>
<td>Fewer victims, better understanding</td>
</tr>
<tr>
<td>Relation to Academics?</td>
<td>Conflicts, choose one or other</td>
<td>Connected, choose both</td>
</tr>
</tbody>
</table>

Comparing initial public perception which became myths about school bullying to what became fact may be critical in understanding elder bullying. The problem with violence in nursing homes and elder housing may be, at least in part, due to social bullying. Culprits may not be just a few mean or bad residents, but entire peer groups and staff, as in schools. If school bullying is a crystal ball for senior bullying, policies of zero tolerance would be replaced by organization-wide programming. Nursing staff on every unit would receive specialized training. Finally years of study, intervention and evaluation is needed along with a re-framing of the problem as one that may be improved upon but not fully eliminated and may be dramatically decreased, but not eradicated. Part of the call to action for providers is to apply what has already been learned in other populations through scientific research.

**EARLY PROACTIVE INTERVENTION MAY HELP LESSON SOCIAL BULLYING – K. S. Berger**

Kathleen Stassen Berger writes that in terms of childhood bullying, “… it became widely accepted that early intervention was the key to preventing further tragedies.” (Berger, 2007) Diana Benson’s anecdotal experiences in HUD housing may well illustrate what could happen with early
proactive intervention versus allowing situations to grow and fester. When Benson let it be known that she would not stand by and watch people act hurtful toward one another, and when her message got around to a majority of the building’s residents, she saw a vast improvement. “We don’t really have much of a problem here anymore, and the second I see or hear something start, I just start doing my thing and it calms down again.” Once she consistently spread her message strengthening cultural norms of kindness, she saw results. (D. Benson, personal communication, April 15, 2015)

Clear boundaries and strong cultural norms are self-reinforcing. Early intervention sends messages to everyone in the environment what is acceptable and what is not. It may be important to point out that Benson was the main person responsible in her building. She was in charge and did not have to train numerous staff under her to have the same agenda around issues of social bullying. It becomes an entirely different management issue in facilities with multiple managers and staff members.

Autism, ADHD, Anxiety & Depression - Dr. Elizabeth Laugeson & Dr. Fred Frankel

The Peers Program developed at UCLA by Dr. Elizabeth Laugeson and Dr. Fred Frankel is an evidence-based social skills training program for teens and young adults on the autism spectrum, or who suffer from anxiety, depression or other socio-emotional challenges. The program comes in manual form and is used throughout the United States and around the world. Reviewing Laugeson and Frankel’s research in depth is beyond the scope of this project, but their work could be of benefit to those who wish to further pursue it. Short video clips are available on the internet of Laugeson demonstrating how teens can learn to handle social bullying based on the ecologically sound responses of their socially competent peers. Laugeson refutes advice parents and teachers have traditionally given children with respect to bullying. Having targets walk away, ignore bullying or tell an adult isn’t always seen as the best and it is not how socially competent teenagers naturally and successfully manage bullying. Laugeson posits that the old advice may in some instances further empower bullies.

This raises the possibility that seniors, in order to become effective in new communal living environments, may need to learn some new social skills. The support and training that Laugeson and her team provide to adolescents to develop skills for success in this area takes months to be effective and includes supportive instruction for parents who are taught to reinforce new skills at home over many months. (Laugeson, 2014) The cost of finding out if this approach can be adapted for seniors may be prohibitive. However, if this kind of training can be easily accessed via the internet, many could reap the benefits.

MIXED REVIEWS ON USE OF THE WORD “BULLY”

Re-framing the problem of bullying by using softer and more positive language such as "cultural competence" or “social wellness”; phrases and terms that engender civility, empathy and dignity, could, in some instances, be necessary according to Dr. Robin Bonifas. (Bonifas, 2014) Upon introducing the topic of elder bullying in an academic class setting to gerontology graduate students, there were mixed reviews on whether or not use of the word bullying was appropriate when referencing elderly in nursing home and assisted living settings. However, by the semester’s end, after demonstrating the problem through academic research, most students responded positively to the term. One graduate student, Rachel Lively, in gerontology study at University of Massachusetts, Boston noted that looking back on her many years working in nursing homes, bullying was something she did witness. It was not labeled or identified as such at the time, but new information prompted her to rethink the necessity of programming. Lively commented that, if she were ever to return to work in nursing homes, she would advocate for anti-bullying programs. (R. Lively, personal communication, April 19, 2015)

Alyse November hopes that nursing homes are able to see themselves as better equipped for bullying problems if they have programming in place. She would like nursing homes and aging communities to promote the idea that, “loved ones are safer because staff has training on how to handle
incidents, and residents are more likely to treat each other well directly because of educational, interactive workshops.” It is important, according to Pamela Atwood, that aging service professionals control the message given to the public so that it does not turn against them in a way that does a disservice to seniors.

**ORGANIZATIONS OFFER RELATED PROGRAMMING ON BULLYING & CULTURE CHANGE**

Certain organizations have been very successful at framing messages to others in terms of human rights and dignity in a way that benefits both the organization and those they serve. Below are organizations at the forefront of human rights issues. In different ways, stories of their organization’s struggles to promote inclusion, diversity and acceptance as part of their greater mission can help generate ideas for how providers in the field of aging services can progress with respect to inclusion, dignity and emotional safety for seniors—opposite discrimination and bigotry, which Rosalind Wiseman reminds, are at the base of bullying.

**Anti-Defamation League**

While the Anti-Defamation League was founded by Jewish Americans to defend the liberties of Jewish Americans, the organization, now over 100 years old, organizes on behalf of all people to fight anti-Semitism and all forms of bigotry, and to defend civil rights. The Connecticut Chapter was contacted and while they do not specifically speak to issues of “bullying” directly, they have programming for different segments of society that help in terms of education on civil rights and human dignity. Their “World of Difference” program is designed to help people recognize bias and the harm it inflicts on individuals and society. It builds understanding of the value and benefits of diversity, improves intergroup relations, confronts racism, anti-Semitism and all other forms of bigotry. More information can be obtained at www.adl.org. Below is the story of how the ADL began a century ago.

100 years ago, a visionary attorney named Sigmund Livingston brought together a group of prominent Jewish leaders to form a mechanism to fight back against the anti-Semitism and other forms of bigotry and discrimination then rampant in society. With a $200 budget and two desks in his Chicago law office, the Anti-Defamation League was born. ADL is dedicated to making our country a more inclusive home for all; where being different is not a liability, and diversity is a cherished strength.... Together, we will continue to change hearts and minds ...one student, one classroom, one family, one community at a time. (adl.org, 2015)

**Unitarian Universalist Welcoming Community**

Two true accounts of residents in nursing homes clearly illustrate the urgent need to address bullying in senior residential environments in relation to rights of residents who identify themselves as part of the lesbian, gay, bisexual, transgender and queer (LGBTQ) community. Preventative steps need to be taken in ways that make senior living environments both accessible and safe havens for those who identify themselves as such.

A gay man, with skilled nursing needs, was being admitted to a long-term care facility because he could no longer care for himself. The intake staff at the facility had a choice as to whether they would place him on a floor with other residents who were cognitively capable, but just had skilled nursing needs like himself or to put him onto a floor with residents who suffer from advanced stage Alzheimer’s disease and dementia. The intake staff made the choice to have the man placed on the memory care floor because of concern he would be rejected socially by cognitively intact residents because of his sexual orientation. After having no one to connect with for months, and being the only one who was mentally competent, he grew depressed and more withdrawn. He later died in the nursing home—he hanged himself.
A woman who entered a nursing home and was fully accepted by peers eventually made the decision to identify herself to her friends as a lesbian. For years the friends had known thought of her as straight. The staff began to notice changes in her demeanor and she began to isolate and show signs of depression. Staff initially thought that the changes were due to a new diagnosis of Parkinson’s disease and symptoms associated with that. However, it eventually was identified by nursing staff that the woman’s friend group began to reject her based on her newly disclosed sexual orientation. They refused to let her play bingo with them anymore. They would no longer let her join them for meals.

- Anonymous

In the same way that the Anti-Defamation League began to protect Jewish individuals in America, Unitarian Universalist congregations have sought to make their houses of worship safe and inclusive places for citizens who identify as LGBTQ. An interview with Reverend Jan Nielsen, senior minister at the West Hartford Universalist Congregation, highlights the process of culture change in detail for their church organization. Applications for how the church came to be considered a safe “spiritual home” for all is important in the context of this work because so many individuals who identify as lesbian, gay, bisexual, transgender or queer will be entering senior housing in the baby boomer generation. Better preparing senior healthcare providers to intentionally embrace and respect the needs of all individuals is necessary now, and for future generations. The process of decreasing discrimination, addressing human rights’ issues and encouraging the respect of all beings is interwoven in Nielsen’s story of how her church officially became a “welcoming community.” Being designated a welcoming congregation is a comprehensive process that looks at how the church as an organization intentionally displays in word and deed overt acceptance of individuals who identify as LGBTQ.

It considers the use of language that divides or unites and looks at every aspect of the church for evidence of inclusion for the LGBTQ community. From a welcoming message on the website to representation in decisions, it is a long, time consuming and involved endeavor. The process started before Nielsen arrived in the fall of 2001 and was very much inspired by a husband and wife who were looking for the church to be more openly accepting of their teenage son, who identified as gay. However, even before taking steps to reach the goal of officially earning the designation of a “welcoming community”, the congregation, democratically run, needed to be educated and then take a vote in order to proceed.

It was around this time that Nielsen entered the church as a new minister. The congregation was at the beginning stages of deciding whether or not to start into the endeavor and before a vote could be taken a committee began the process to educate the community on what becoming a “welcoming community” meant. A number of meetings, workshops, discussions, films related to the subject, presenters hired from outside the church community and once a month pot-luck suppers followed and took place over about a two-year period.

When asked about members of the community who had reservations about going through the process or out-right said “no”, Nielsen said that disagreement, though not overt, took the form of “polite resistance”. Comments such as, “why do we need to say that we are a welcoming community, we’re already welcoming of everyone.” Underneath Nielsen’s feeling was that there was an uneasiness and unspoken discomfort. In the same way that certain attempts to counter decade upon decade of oppression toward African Americans and other minorities who suffered long-term consequences, the congregation needed to be educated about how, similarly, people who identified as LGBTQ had been ridiculed, oppressed and denied basic human rights and a sense of belonging in families and churches over decades. Coming from a place that some people do not share the same freedoms as others to be themselves, it became understood by most why overt expression to welcome was necessary. Some discussions turned to exploring instances in history where biblical passages were misused and misinterpreted to justify horrible actions against individuals who were gay. At the end of the educational process, the congregation voted. A few still voted against the process of becoming
“welcoming”. She recollected at least four individuals who voted “no”. However, the overwhelming majority, Nielsen recalls, voted in favor of it—close to 99 percent. It was then that, according to Nielsen, the “real work” began. The formal work following the vote, as she recalls, was more subtle and behind the scenes.

Nielsen reported being very intentional about including at least one person or couple who identified as LGBTQ on every church committee. She did not do this as tokenism, but rather she did not want to see the church silently divide into two separate cultures. Nielsen’s time in the West Hartford congregation is ending in June of 2015. Part of her legacy is a unified welcoming church community. Explaining that the importance of social justice and inclusion in the West Hartford church pre-dated her and had an effect on institutions beyond the church, she relayed a story that she felt related to the topic. For 75 years the West Hartford church was used to host a Boy Scout troop that regularly met in one of the church halls.

When the controversial debate over allowing Boy Scouts who identified as openly gay was being debated and boys were rejected if they identified as such, the church board and members found they were in a compromising position. They valued all the good that came from the Boy Scouts meeting at the church. However, exclusionary practices were inconsistent with the stated values of the church and church members did not wish to look the other way. The church board asked the leaders of the Boy Scout troop at their location to sign a non-discrimination document stating that in order to use the church facilities they may not discriminate against any boy who wished to be a member for reasons of sexual orientation. Troop leaders signed the document and both the church and the Boy Scouts of the troop stood in solidarity for many years signing the non-discrimination document each year until the recent 2013 vote overturning of Boy Scout’s original policy of membership exclusion. When asked if bullying specifically was addressed in the welcoming curriculum at the church, Nielsen said that the process was specific to acceptance of individuals who identified as gay but inherent in the process were messages of inclusion, kindness and tolerance which all speak to discouraging bullying in any form. Nielsen reports that even though the “welcoming congregation” curriculum and process is designed to foster emotional safety, inclusion and maintain dignity specifically toward people who identify as LGBTQ, she believes that the process was beneficial in terms of honoring differences across the board. (J. Nielsen, personal communication, April 8, 2015)

COSTLY CONSEQUENCES OF BULLYING IN AGING SERVICES– A BUSINESS PROBLEM

Any forms of bullying, no matter how subtle, should be considered a “business problem.” While it is obvious that physical bullying falls into the category of mandated incident/accident reporting and receives nursing staff and management’s immediate attention, it is the more subtle forms of social bullying that are ignored, but become negative to the business and result in potential financial losses as well. Trouble with healthcare professionals bullying colleagues is expounded upon in various organizational behavior articles and by experts in the field. Dr. Judith Briles, an award winning author, columnist, consultant, researcher and international speaker holds both Masters and Doctorate of Business Administration degrees. She has consulted for nearly three decades on the subject of bullying and sabotage in the workplace.

In her book, Stabotage! How to Deal with the Pit Bulls, Skunks, Snakes, Scorpions, & Slugs in the Health Care Workplace (2009), Briles comments on financial losses attributed to social and hierarchical staff issues that involve bullying and other sabotaging behaviors. Whenever there are staffing changes, there are changes to social hierarchies. If staffing changes are caused by bullying where there is a large turnover in a certain department or throughout a company, Briles suggests it could be due to bullying issues or social issues where individuals are in conflict with one another.

“Organizations are collectively losing billions of dollars a year due to lost productivity. Stabotage, sabotage and conflict in the workplace isn’t a lightweight issue, nor should it be treated as one.
Unfortunately, it is. Every day, hospitals keep their losers and lose their keepers.” (Briles, 2009)

Workplace bullying has to be addressed alongside resident-to-resident bullying, if not before it. If employees are to successfully manage resident-to-resident aggression, they must first learn how to manage it for themselves and have buy-in to the concept of a community of social wellness.

**SUMMARY & NEED FOR A NEW NARRATIVE**

This project sought to educate on the psychosocial issue of resident-to-resident social/relational aggression, a form of bullying, and also advocate for research which in turn would inform best practices for prevention and intervention. Other populations that may influence research in the senior population were highlighted. The discussion of creative solutions contained within this study will hopefully galvanize the aging services industry to join elder advocacy groups and researchers like Dr. Robin Bonifas who wish to find promising solutions to the problem of elder bullying.

It was first important to distinguish between resident-to-resident aggression and bullying; to recap: while all bullying is resident-to-resident aggression, not all resident-to-resident aggression is bullying. While physical violence is addressed through laws and regulations, addressing the more subtle and covert aspects of social and relational aggression (with virtually no legislation around it) becomes an issue of motivating senior housing managers and administrators to solve the problem because of a responsibility to provide an emotionally safe environment, rather than a legal mandate. There is anticipation that consumers, the media and the baby-boomer generation will also drive forward progress in this area forcing all types of senior housing to become emotional and physical safe havens for our elders--places that feel like home. In this respect, creating policy and implementing programming will, in turn, be seen as good business practice.

Examining best practices in other population segments reveals that further research is needed to determine if elderly bullying has unique challenges not found in other populations. Yet, the aging services industry must not delay in its effort to start solving bullying problems now. Trends in how other populations deal with social, relational aggression were explored, namely among school children within the field of education. The need for a new narrative, with respect to bullying across the aging services industry was highlighted. The current narrative will need to dissolve once “person-centered care” ideals become further defined, developed and articulated in policy and regulations across the aging services spectrum. We need to reinforce the message to seniors just as we do to our young people, that their spirits, their feelings and their lives matter.

Denying that the problem exists is no longer acceptable. Instead of being fearful from a public relations perspective, organizations should emphasize their investment in programming to prevent potential problems and intervene early in existing ones. If industry leaders were to embrace and support research, and test promising pilot programs based on research in other populations, it would benefit the entire industry. Future research to identify the scope of the problem, how it is best managed, and the ongoing resources and funding that will be necessary to provide evidence-based best practices will hopefully manifest in the coming decade.

“Organizations are collectively losing billions of dollars a year due to lost productivity. Sabotage, sabotage and conflict in the workplace isn’t a lightweight issue, nor should it be treated as one. Unfortunately, it is. Every day, hospitals keep their losers and lose their keepers.”

- Dr. Judith Briles, 2009
President Obama convened the first ever White House Conference on bullying prevention in 2011. While its primary focus was on children, the President and First Lady called upon citizens to understand the issues of bullying as serious. The message from the conference was also that bullying is no longer considered a rite of passage, like it once was, but is considered abuse. (Shepherd, 2011) Dr. Robin Bonifas was invited to speak at the March 31, 2015 White House Conference on Aging where her work was part of the broader topic on how to protect older Americans from financial exploitation, abuse and neglect. Seniors in today’s nursing homes and assisted living facilities, some even younger, grew up in an era where children beat one another up on the playground and that was just how it was. In fact, stories told by older adults are often full of pride when they were the “bully” who came out on top. The narrative has changed for children. Hopefully continued national focus on bullying, as a children’s issue and as a newly discovered issue for older Americans, will result in great movement forward in terms of research and programming across the lifespan. Anecdotal evidence and effective anti-bullying strategies implemented in schools suggest organizations must implement multi-level comprehensive approaches in senior housing and aging services. Research from other populations can point social scientists in the right direction. Trailblazing efforts by those who have conducted school bullying research can shorten the timespan between hypothetical ideas and tested solutions for older adults. Legally it is clear that there are limits to imposing laws on social aggression and lack of civility. However, programming can do much to help and may even contribute to lessening physical aggression which is a serious issue.

In her work on social aggression among girls, Rosalind Wiseman addresses the fact that her reader may be upset or conflicted about the subject matter in her book. She invites her readers to reflect on where in the past each of us has stood in our own experiences as a victim, bystander or perpetrator. While the topic may create discomfort, Wiseman invites her reader to learn all that they can learn in order to help our daughters. (Wiseman, 2002) Similarly, aging service professionals need to be brave, and self-reflective. It is only in this way that we can be at our best, for the older adults we serve, and in the bigger picture, for ourselves, our families, and our greater communities. If we all have an impact on one another, why not have it be for the better?

If fixes for the problem of social bullying are interconnected to the environments and communities in which human beings live, we need to improve the environments. Once a threshold of health and wellness with regard to emotional safety exists within a community, it can be perceived on a visceral level by participants within the community as a place where they feel at home. This is the goal of every family and person – to live in a place where they are physically and emotionally safe enough to call it home.

**CALL TO ACTION**

- Now is the time for accountability in programming and policy which fosters civility and social wellness in aging services. All stakeholders in the aging services industry, including CEO’s, administrators of nursing homes and owners of assisted living and memory care organizations and others, must take note of reforms that are needed industry-wide.
- Movements toward accountability are in the infancy stages, but over time it is inevitable that consumers will demand progress. Center for Medicare and Medicaid (CMS) could require staff training and/or policies

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One key to successful leadership is continuous personal change. Personal change is a reflection of our inner growth and empowerment.

Robert E. Quinn, Organizational Change Thought Leader
“Dignity” models, such as Green House Projects, the Eden Alternative & Wellspring Model, part of the Pioneer Network which places focus on resident directed care, appear to have lower incidents of bullying. Studies that look at this link could lead to important discoveries in terms of what supports social wellness in senior housing.

State Ombudsman offices should have access to the latest research and findings on social bullying in senior housing and be responsive to those who inquire about the topic.

Administrators & management in positions of authority: use your influence in ways that maintain the dignity of those below you – the most respected leaders are successful at doing this. Become aware of ways you have contributed to the problem. Strong leaders are capable of reflecting on their own personal style and are open to feedback.

Surround yourself with others who can provide supportive suggestions for how you may grow as a leader.

Leaders in the aging services community must look at this problem regardless of perceived challenges to marketing and public relations departments.

Managers: Even if you are not seeing bullying in your senior community, assume that it is there somewhere. Start with a “listening campaign.”

Do not use “spy” technology to identify or prevent social aggression or bullying in your organization. While it may help you detect bullying, technology does nothing in terms of prevention or intervention and can be misused for these purposes. Use of technology for safety and security is far different ethically than utilizing technology to incriminate people in social conflict where it then becomes part of the problem as an unfair use of “big brother” power over subordinates. Put funds and time into comprehensive (not merely reactive or legally-protective) continuous programming that becomes embedded into the culture as part of cultural competency.

Be careful not to label every socially aggressive act as “bullying”. Consult with professionals to accurately identify repeated, intentional patterns of aggression. Some, as Dr. Bonifas reminds us, use raised voices, gestures and facial expressions when simply communicating feelings and emotions. This is very different from bullying.

Don’t be caught up in appearances or company mottos like “we’re welcoming here,” and “we don’t have that kind of problem here”. Listen to direct care workers and their direct supervisors. Revise the narrative to: “we see bullying as a life-long problem that every place struggles with. We need you and everyone associated with our organization, to model how to treat others with dignity. Will you be part of our solution team?”

Impressive décor and upper class residents do not always translate into an environment that receives gold stars for cultural norms of dignity and respect. Relationships and interactions in the environment are better indicators. Some environmental factors however, seem to promote a healthier emotional atmosphere. In other words, environmental factors do influence how people feel and can contribute to conflict or peace. Various conditions such as overcrowding or neglected properties could contribute to problems. Make efforts to have environments reflect a message that “you matter” to elderly residents.

Meet with other like-minded colleagues and compare notes on what you are doing to solve problems of social aggression and bullying. Seek out others in the industry that are ahead of you in this area.

Begin drafting a bullying policy that focuses on staff training and education of residents. A task force that focuses exclusively on the company’s strategic plan for creating a culture of dignity will put you ahead of the competition.

Make bullying and cultural competency education a priority in your organization.

All departments must be represented; bullying is an “equal opportunity” problem where no one, not even top management, is immune.

A new narrative must be written-- bullying exists across lifespan. Citizens of all ages need programs.
Those who bully need to be seen in the context of a social system that enables them to act out. The bully has to be held accountable. Others in the system do as well, especially those at the pinnacle of the hierarchy.

**Call to Action for More Research & Funding from Foundations, Philanthropists and Government Organizations**

It is short sighted for foundations, philanthropists, government grants and other funding sources to deny funding for social bullying in elders while supporting funding to study physical aggression. While the cost of healthcare is overwhelming, preventive measures may be far less costly. Putting effort into solutions that address the root cause of violence in nursing homes and elder care is critical to long-term management of the problem. Verbal and social aggression can be precursors to physical aggression and should be seen as interconnected. Intervention at the source, instead of where symptoms manifest can save time, money and unnecessary emotional and physical pain for victims of bullying and bystanders which in many instances are healthcare workers and suffer alongside victims.

While this study attempted to cover many important topics with respect to elder-to-elder social aggression and bullying, the primary focus was on education and a call for research to identify the scope of this psychosocial health problem as it relates to older adults. The wealth of information that could be considered relevant to the topic seems endless. For this reason this study should be considered an exploration of topics for future research on the subject of resident-to-resident elder bullying.

**RESOURCES**

Anti-Defamation League  
www.adl.org

Al-Anon Family Groups  
www.al-anon.org

Alcoholics Anonymous  
www.aa.org

Alzheimer’s Association  
www.alz.org

American Association of Retired Persons  
www.aarp.org

CDC Violence Prevention  
www.cdc.gov/violenceprevention

Character Matters  
www.charactermattersnc.com

Creating Cultures of Dignity  
www.rosalindwiseman.com

Cyber Bullying Resource Center  
www.cyberbullying.us
All is connected
... no one thing can change by itself.”

-Paul Hawken

Natural Capitalism
Yoga Journal
October 1994

Dr. Wendy Craig, PhD. Bully Lab
www.bullylab.com

Different Like Me – Alyse November
www.differentlikeme.com

My Better Nursing Home – Dr. Eleanor Barbera
www.mybetternursinghome.com

National Alliance on Mental Illness
www.nami.org

National Bullying Prevention Program
www.pacer.org

Olweus Bullying Prevention Program
www.violencepreventionworks.org

Peers Social Skills Training Intervention
www.semel.ucla.edu/peers

Professional Bully Prevention Alliance
www.bpindyinc.org

Prevent Bullying in Society
www.bullying.org

Safe School Ambassadors Program
www.community-matters.org

Words Can Change Your Brain Neuroscience
www.markrobertwaldman.com

Work Place Bullying
www.workplacebullying.org
How Can I Impact Older Adult Housing Right Away with Regard to Social Aggression?

- Message of caution: do not implement programs without professional guidance & ample support. Piecemeal efforts or haphazard programming can backfire
- Go to the Olweus Bullying Prevention website - www.violencepreventionworks.org and read the tips for administrators in schools. This is not yet proven but if bullying in schools is an indicator of bullying in senior housing, this guide may be adaptable to your setting.
- Get outside professionals to support change efforts – people become blind to cultural norms
- Learn all you can from scholarly articles on bullying
- Infuse Subtle Lessons into the culture (book club picks & movies with themes of personal triumph over discrimination, post signs with kindness quotes, begin random acts of kindness)
- Increased staff presence at resident meals – sit with various groups
- Impromptu discussions initiated by staff “discussing importance of positives & kindness”
- Info sessions to educate about common behaviors in dementia
- Info sessions on tolerance, empathy, civility & human dignity
- Be mindful of behavior in staff-to-staff interactions
- Practice empathy
- If staff are fearful of resident bullies, get outside professional advise

AARP SUGGESTIONS
- Begin drafting a resident code of conduct
- Begin assigning capable residents to a newcomer / welcome program

DEVELOP A 2-5 YEAR CULTURE CHANGE PLAN

- Add cultural competency to an organization’s strategic plan
- Look at how human resource hiring practices include or lack questions on diversity, inclusion, bullying, & awareness of factors that impact cultural competence
- Circulate and discuss codes of conduct for staff
- VP’s & managers need to know harassment & discrimination law – when there are social issues that are casually mentioned, dig deeper
- Establish an interdepartmental culture change team – meet regularly
- It is possible that resident-to-resident aggression is taking place in the context of a department-wide or organization-wide problem – outside professional advice is essential
- There are grass roots anti-bullying workforce groups & workshops to attend bring colleagues
- The AARP instructional piece below is what consumers are seeing. Make it a business priority to give consumers what they will come to expect.
- Call Dr. Robin Bonifas & Alyse November -ask to have your nursing home or assisted living participate in a study or pilot program
- Attend Dr. Eleanor Barbera’s live webinars on elder bullying
- Investigate the healthy workplace bill at www.healthyworkplacebill.org
- Per Dan Olweus, there is no end date to bullying prevention – it is woven into the culture
- Support grass roots efforts on civility, human rights and dignity across the life-span
If you’re sizing up a place, experts recommend asking whether it follows these practices: Residents are required to sign a code of conduct to treat peers with consideration and respect; resident "ambassadors” help newcomers transition into the community; staff members coach residents on how to handle snubs and aggression; staff members encourage bystanders to act in positive ways when they observe bullying, being respectful of possible physical or cognitive impairment; and offenders receive a written reprimand or, in the case of multiple complaints, stronger penalties.

AARP, March 2012
www.mybetternursinghome.com
Dr. Eleanor Barbera

Free Webinar 3/25 @ 2pm ET: 4 Steps to Preventing Senior Bullying in LTC
Dr. El - March 24, 2015 - Bullying/Senior bullying, Resident care, Talks/Radio shows
Join Dr. EL Wednesday, March 25th at 2pm Eastern Time (1pm Central Time) for a FREE Webinar on 4 Steps to Preventing Senior Bullying in Long Term Care sponsored by EmLogis To register: visit EmLogis Events About the Webinar: Senior living communities often experience problems with bullying among residents. Join psychologist Dr. Eleanor Feldman Barbera [...]

msisac.cisecurity.org

Keeping Senior Citizens Safe Online --

From the Desk of William F. Petris, Chair

Senior Citizens are online too
Senior citizens are embracing the digital age in greater numbers every year. Fifty-three percent of adults ages 65 and older now use the Internet and online tools such as email, according to the Pew Internet & American Life Project. Among those Internet users, seventy percent report going online daily.

Make a Decision to Be Part of a New Narrative
Don’t Let Social Aggression Take Root by Inaction
Start a Multi-Department Committee Today
Support Funding & Research Efforts
Put Social & Cultural Competency into Strategic Planning
Build a Vision of Tolerance & Inclusion for the Future
Put the People You Serve Above Profit
Treat One Another Kindly
You Are All Meant To Be On The Same Team
Do Right the Right Thing – Step Up.
Your Clients May Someday be YOU!

K. Cardinal 2015
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Addendum: Pilot Survey Given to Senior Management in Elder Housing & LTC

The following survey was developed and sent to one continuing care retirement community (CCRC) in New England as a test to determine its value and accuracy in terms of questions to be asked regarding resident-to-resident social aggression/social bullying toward disadvantaged peers in long-term care and senior housing. The responses given by a nursing home administrator are telling and indicate that further research and a survey of this nature conducted nationally may provide funding sources with enough evidence to warrant scientific study which in turn could inform policy and program development. While the answers provided in some instances are ambiguous and prompt further questions, this was an informative exercise and confirms that there is much work to be done on this topic.
Resident Social Aggression/Bullying toward Disadvantaged Peers

This survey is designed to specifically identify social, verbal or gesturing, behaviors by cognitively intact residents who intend to exclude, demean, belittle, criticize, isolate or reject another resident (a target/victim) with derogatory verbal expressions or body language at least one time or repeatedly in a nursing home setting. The target (victim) would carry a clinical diagnosis of dementia, memory impairment, Alzheimer’s diagnosis or mental/physical illness that would clearly put them at a disadvantage with less social power and on an unequal footing in a social group. This disadvantage would make them unable to be assertive or protect themselves from repeat offenses (even though they may display reactive or aggressive behavior, it would not resolve the power differential and would continue to keep them at a social disadvantage among nursing home peers). THIS QUESTIONNAIRE IS NOT ADDRESSING ANYTHING CURRENTLY ILLEGAL. It is also not addressing anything CURRENTLY at odds with REGULATORY GUIDELINES. Answers you provide will remain strictly anonymous and will be used only in a general sense to understand industry-wide challenges for best care practices for dementia patients and training needs of staff in efforts to best serve and meet the needs of all nursing home residents.

* Required

1. What healthcare services does your organization provide? *

   Check all that apply:
   - [x] hospital/acute rehab
   - [x] skilled nursing (snf)
   - [x] assisted living
   - [x] memory care / dementia
   - [ ] independent living
   - [ ] Other:

   ...
2. Please check behaviors you have witnessed by cognitively intact residents toward
dementia or otherwise cognitively impaired residents.

Check all that apply & add your own list: The key is that the cognitively intact resident is
knowingly intending social exclusion.
Check all that apply.

☐ Seems to refuse to let disadvantaged resident join table during meals by saving
seats or some other method

☒ Talks negatively or gossips about disadvantaged resident to other residents.

☐ Rolls eyes, huffs or makes other obvious negative gestures with regard to
disadvantaged resident.

☐ Intentionally withholds invitation or information about community events from
disadvantaged resident.

☐ Makes jokes about disadvantaged resident making fun at their expense

☒ Makes negative comments directly or indirectly toward resident

☒ Uses power in the group for exclusion and division rather than inclusion and uniting
regarding disadvantaged person.

☒ Doesn’t let certain staff ever hear or see negative comments or gestures being
made.

☒ Other: not observed

3. Direct care staff respond to the above behaviors by doing the following:

You may check more than one because multiple answers may apply depending on the
circumstances. Option to add your own.

Check all that apply.

☐ Ignore negative Resident to Resident issues if it is not physical or in violation of the
law or nursing home regulations

☒ Report accounts of social aggression to superior

☒ Express in a professional manner that the behavior is unacceptable (even in a
social setting where other residents and staff may hear staff’s response)

☐ Other: ...

4. Do you think some residents feel more comfortable & "at home" when resident
peers who engage in social aggression are not around.

Mark only one oval.

☐ yes

☒ no

☐ n/a

file:///C:/Users/User/Documents/Trina%20Cardinal,%20Masters... 4/11/2015
5. If you answered yes to the above question, please explain factors you believe may be fostering or feeding negative social interactions among residents. 

 depends on situation too many to list

6. Do you think policies around social aggression to protect and include those with dementia and other disadvantaged residents would benefit residents in your organization?

Mark only one oval:

☐ yes
☒ no
☐ unsure

7. Do you think staff training on this subject would be helpful at your organization?

Mark only one oval:

☐ yes
☒ no
☐ unsure

not really can't see a reason it would be

8. Do you find similar kinds of exclusionary and negative behaviors among staff at your organization?

could be in any area of the organization - strictly confidential

Mark only one oval:

☐ yes
☒ no
☐ unsure

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9. Do you have a policy specific to this topic?
(Addressing issues with resident-to-resident peer pressure, bullying, peer rejection or anything that describes the behaviors spoken of in this survey that are not currently considered illegal or against state nursing home regulations.)
Mark only one oval.
- [ ] yes
- [ ] no
- [ ] unsure

10. Do you train staff on this specific topic?
Mark only one oval.
- [ ] yes
- [ ] no
- [ ] unsure

11. Would you find a policy on resident to resident aggression/bullying helpful?
Mark only one oval.
- [ ] yes
- [ ] no

12. Would you find staff training helpful?
Mark only one oval.
- [ ] yes
- [ ] no