Bullying: Not Just an Adolescent Issue

Bullying doesn’t end with high school. It is common in older adult communities, where there should be a protocol for addressing and alleviating the problem.

*By Jill Shutes, DNP, APRN, GNP-BC*
Bullying doesn’t end with high school. It is common in older adult communities, where there should be a protocol for addressing and alleviating the problem.

BY JILL M. SHUTES, DNP, APRN, GNP-BC

Suzanne was excited about moving into her new apartment. This was the first time she would be living on her own and was looking forward to this next chapter in her life. She picked out new furniture and had professionals cover the interior with fresh paint. Moving day arrived, and she had a lot of help from her family. After everything was unpacked and her family had departed, it was time for dinner. She dressed for the occasion and made her way to the dining hall. As she entered, her excitement quickly turned to anxiety. Each table she approached denied her a chair. “This seat is taken,” she heard over and over. Devastated, she decided to take her dinner back to her apartment and eat alone. She would not go back to the dining hall.
One may assume when reading the above scenario that Suzanne is at college. But Suzanne is a 78-year-old, recently widowed woman, and the apartment is at an assisted living community in Anytown, USA. This is what bullying looks like in the older adult community. Goodridge (2017) reported that 39 percent of tenants in a community senior living dwelling had witnessed bullying and 29 percent had experienced bullying themselves. The most prevalent forms of peer bullying were “deliberate social exclusion and hurtful comments” like Suzanne experienced (Goodridge, 2017). This is not just an adolescent concern.

“Epidemic” of Bullying
Bonifas (2012) reported that “elderly bullying” research is dragging its feet compared to related topics of youth bullying and elder abuse. Prior to 2015, there was little discussed in the literature about bullying in the senior community. Except for experts like Bonifas (2012), Wood (2007), Rex-Lear (2011), and Trumpetter (2010), little has been written about this phenomenon until recently. According to Alyse November, creator of the “Different Like Me” program, bullying among older adults is a hidden, unseen epidemic (Lade, 2014). Bonifas (2014) classified bullying into three categories: physical, verbal, and social. Bullying is defined by the National Center for Assisted Living (NCAL) with the following core elements: unwanted aggressive behavior; observed or perceived power imbalance; and repetition of behaviors or high likelihood of repetition (2017). Studies suggest that most senior-to-senior aggression in assisted living communities is verbal abuse (Positive Aging Sourcebook, 2015).

Jennifer Weiner, American writer, producer, and journalist, recently penned an editorial in The New York Times (2015) titled, “Mean Girls in the Retirement Home.” She discusses quite poignantly the experiences her 97-year-old grandmother endured at an independent living facility. When Jennifer asked her grandmother, “How is it going?” her grandmother cried, “They won’t let me sit at their table. You try to sit and they say, ‘That seat is taken!’ And just try to get into a bridge game,” her grandmother continued. “They’ll talk about bridge, and you’ll say, ‘Oh, I play,’ and they’ll tell you, ‘Sorry, we’re not looking for anyone.’” Weiner stated that the idea that the threat to seniors is their peers, and not the employees, shocked her. She writes that it goes against the long-time belief that “mean girls are not girls, or mean, forever.”

So how do we address this issue? Acknowledge. Identify. Intervene.

Acknowledge
First, we need to acknowledge that this is a legitimate concern. NCAL created a resource as a prevention and surveillance support for assisted living providers (2017). The organization states that even though assisted living communities provide a great service for older adults to socialize with others, it’s impossible to expect that everyone will be compatible with each other. This resource is designed to support assisted living providers when thinking globally and strategically about this issue, according to NCAL (2017).

In one study, the prevalence of staff witnessing bullying was as high as 28 percent, with most of this bullying being verbal or social in nature (Jeffries, 2018). Another study reported that most staff members had witnessed resident-on-resident bullying in the two weeks prior and that again, verbal and social bullying were the most prominent types witnessed (Andresen & Buchanan, 2017). One would think that with this amount of witnessed bullying there would be some specific training pertaining to this issue. However, a 2017 study found that more than 50 percent of the employees had not received formal training on the matter and only 21 percent reported that the facility had a formal policy to address bullying, even though most staff observed bullying among the residents of the facility (Andresen & Buchanan, 2017).

Identify
Once the concern is acknowledged as an actual threat, how do we identify and categorize typical traits of individuals who bully, and the victims’ risk factors? Bonifas and Frankel (2012) made inroads on this issue. They found that, while men and women have some specific traits that will be discussed later, the following characteristics are identifiable in either gender.

Typically, the “bully”:

• lacks empathy,
• has few friends,
• needs power and control,
• struggles with individual differences,
• uses power and control at the expense of others,
• suffers from low self-esteem, and
• is empowered by causing conflict, or making others feel threatened, fearful, or hurt.

Andresen & Buchanan (2017) interviewed staff at a long-term care facility about the incidents of bullying that staff had witnessed. The researchers found that those who bullied were more often male (42 percent vs. 18 percent). Men seemed to be more prone to
use verbal bullying (46 percent), followed by physical bullying (26 percent). Typical traits of men who bully are direct, spontaneous, verbally or physically aggressive, have a superiority complex, and are overly protective (Goodridge, 2017). In an assisted living facility where the author once worked, there was an incident with two men involving the television remote control in the community room. One of them punched the other in the face. This was not the first time they had argued over channel selection, but it had never escalated to this extent before.

Women, on the other hand, were inclined to social bullying (cliques, gossip) in 42 percent of instances and used verbal bullying nearly a third (31 percent) of the time. Goodridge (2017) reports that verbal bullying was the most commonly used type, with physical appearance as the target (being poor, homely, and/or not having clothing that is as nice as that of other people). Typical traits of women who bully are those who gossip, snipe, are members of a clique, exhibit passive-aggressive behavior, and manipulate others’ emotions.

We also need to identify those at risk for being bullied. Generally, residents in assisted living communities who become victims have one or more of the following characteristics (Bonifas & Frankel, 2012):

• is a new member of the community,
• is alone (widowed or divorced),
• has a passive demeanor,
• suffers from depression,
• suffers from other mental illness,
• is heavily dependent on others, and
• has a scattered support network.

In order to help those victims, it is important to clearly be able to define and identify bullying behaviors. Bonifas and Frankel (2012) have identified certain examples of bullying behaviors that staff and visitors to assisted living facilities can look for in their residents. Physical bullying may take the form of something as simple as a dirty look across the dining hall or in the elevator, or it may constitute an overbearing presence, or even be an actual assault. Verbal bullying ranges from passive-aggressive comments or negative critical comments about one’s appearance, to unsolicited sexual comments. Relational bullying is the most difficult to identify, as it is subtle in nature: ignoring a resident, gossiping, and/or participating in cliques that conspire to isolate another resident.

Those patients who are experiencing memory loss from a neurocognitive disorder such as Alzheimer’s may be at greater risk for bullying. This is because they may ask repetitive questions or invade personal space, and the bullying behavior surrounds getting power and control over others.

Intervene
What are the results of not intervening in the bullying behavior? Goodridge (2017) reported that some of the results of not intervening include loss of sleep, stress, anger, worry, and embarrassment. Another study found that bullying was associated with a decline in psychological health, reduced life satisfaction, and increased risk for depression, low self-esteem, and neglect (McDonald, Sheppard, Hitzig, Spalter, Mathur & Mukhi, 2015). If the victim internalizes the bullying, Bonifas (2015) found the victim may feel:

• helplessness,
• anger,
• fearfulness,
• depression,
• reduced self-esteem, and
• loneliness, as well as having
• increased physical complaints, and
• poor overall physical health.

Statistically speaking, it takes about sixteen years for best practice to translate from the typewritten word to actual “bedside” practice (White & Dudley, 2016). With that information, and the fact that the first authors of older adult bullying reportedly recorded their findings in 2007, we are approaching the golden hour of application at the bedside.

Andresen (2017) reported that there is ambiguity around when bullying (social and verbal) crosses the line to a reportable offense. It was noted in this study that staff intervene in bullying events based on their own moral code, rather than a specific policy or guideline. NCAL recommends that, when responding to potential incidents addressing bullying, communities have specific policies in place to address a bullying incident. Such policies ideally include staff education, reporting requirements, and a protocol to help define bullying. In the resource, the organization outlines a sample process for how to address bullying when it occurs (NCAL, 2015):

1. Staff member observes or is told about a situation involving bullying behavior.
2. Staff member assesses whether there is a potential for immediate or imminent physical danger to anyone, and if so, takes immediate steps to de-escalate the situation.
3. Staff member notifies the appropriate leadership.
4. Once notified of the situation, leadership/management also assesses the potential for physical danger, and if so, whether appropriate steps have been taken to safeguard the victim or if necessary, all within the community.
5. If the incident is less severe, staff may be able to help resolve the situation.
6. With the above information, brainstorm possible solutions, while still adhering to the residents’ rights.
7. Develop a corrective plan and communicate this plan to the impacted parties and staff.

In conclusion, bullying in the older adult community is an under-identified concern. As providers of care, we need to acknowledge that this is truly a problem, help staff and residents identify which actions constitute bullying, and intervene with policies and corrective action plans to eliminate this destructive pattern of behavior. The deserving population of older adults living in facilities merits our attention to this pervasive problem. • USA

Dr. Jill Shutes has been a gerontological nurse practitioner for over twenty years. She has worked in the areas of long-term care, assisted living, and home health care, focused on primary care of the older adult. She currently works at Jupiter Medical Center as the gerontological clinical coordinator for the NICHE (Nurses Improving Care for Health Systems Elders) program and teaches FNP-DNP students at Palm Beach Atlantic University. She has traveled extensively teaching hospital systems, ACOs, and long-term care facilities how to reduce acute care transfers utilizing the INTERACT program. She is currently a member of Sigma Theta Tau Nursing Honor Society and the Gerontological Advanced Practice Nurses Association.

RESOURCES
MyBetterNursingHome, six-part series on senior bullying in a blog by Eleanor Barbera, PhD:
http://www.mybetternursinghome.com/?s=bullying

REFERENCES