

Resident Aggression in a Long-Term Care Setting:
Concerns and Meanings from the Perspectives of Other Residents

By

Daniel S. Lapuk

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of the requirements for the degree of

Master of Nursing

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MASTER OF NURSING

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Abstract

Aggression in long term care is a common occurrence, but most research has examined staff reactions and solutions, based on resident behaviour. Aggression has rarely been examined from the long term care resident's perspective. This exploratory, descriptive, cross-sectional study used a convenience sample of eight Second World War veterans (average age of 85 years) who live in a personal care home in Winnipeg, Canada. General health and sociodemographic information was collected, and the residents were interviewed with a series of open-ended questions to elicit their perspectives on what concerns they have with aggression; what meaning they attribute to aggression in their 'home' setting; and how they relate aggression to their sense of 'home' in long term care. Analysis of the interviews revealed 'men of few words' who were concerned for the safety and privacy of not only themselves, but also staff, other residents, and even aggressive residents. The residents' coping strategies included calling for help, avoiding the situation, or handling it themselves; strategies learned from a combination of familial, occupational, educational, and military experiences. The study offers the basis for further research into possible differing perceptions of aggression related to gender; whether residents maintain a network of concern over aggressive incidents; and maintenance of their sense of 'home' in relation to resident aggression in long term care.

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Dedicated to my father, Jacob Lapuk

Yet this too is a beginning

(Thomas Merton)

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Chapter One: Introduction

This thesis research addresses questions about older adults living in long-term care settings—often called nursing homes or personal care homes—who have experienced, either as victims or observers, the aggressive behaviour of other residents. This chapter provides a statement of the problem, the purpose, research questions, the investigator's assumptions, a section outlining the significance of the research, and a summary of the chapter.

Statement of the Problem

Aggressive behaviour emanating from residents is not uncommon in long-term care settings (Gibson, 2003). The vast majority of residents who exhibit violent or aggressive behaviours are those with sensory or cognitive limitations (most often dementia or other neurological diseases) (Gates, Fitzwater, & Deets, 2005; Ryden et al., 1999). Residents with dementia tend to be perceived as lacking the intent to harm. Although intent to harm another person may be absent, staff and other residents still experience physical and psychological injury from aggressive events (Souder, Heithoff, O'Sullivan, Lancaster, & Beck, 1999). In the preface of his book, *Psychology of Aggression*, Morgan (2005) stated that "all people are in some way affected by aggression, whether they are targets of it, engage in it themselves, or are charged with observing or controlling it in others" (p. vii).

Much of the research on resident aggression has focused on describing their aggressive behaviour toward nursing staff, and designing and evaluating interventions to prevent and manage such behavior. Long-term care staff experience high levels of stress when dealing with aggressive behaviour (Shah, Chiu, & Ames, 2000) and might consequently avoid unnecessary contact with residents who have been aggressive (Slone

& Gleason, 1999). This in turn, may isolate the aggressive resident and decrease social interaction, communication, and quality of life.

In contrast to research on resident aggression in relation to staff, very little research has examined the impact of resident aggression on other residents, and in particular, how (non-aggressive) residents experience and perceive aggressive behaviour in their living environment (Jackson, Templeton, & Whyte, 1999). The quality of life of residents is likely affected by witnessing or personally experiencing aggression from another resident (Buhr & White, 2006) but little is known about this situation. From time to time, there are newspaper reports on incidents of resident aggression toward other residents with consequential injuries and harm (Coulter, 1989; Zambito, 2000, Christoffersen, 2004; Priest, 2004a; Priest, 2004c; Ferenc, 2005a; Ferenc, 2005b; Matas, 2005). Zambito interviewed Karl Pillemer, a Cornell University gerontologist who has studied abuse in nursing homes. Pillemer was quoted in the *New York Daily News* as saying, "Resident-to-resident violence and aggression is extremely common". Shinoda-Tagawa et al. (2004) stated that "resident-to-resident violence in nursing homes is virtually unstudied, with little information available on the frequencies of violence with associate risk factors or potential effective interventions" (pp. 595-596). Indeed, a review of the research literature uncovered only one empirical study that presented residents' perspectives, and it concerned their perspectives of the cause of resident aggression in long-term care (Fagan-Pryor, Haber, Dunlap, Nall, Stanley, & Wolpert, 2003).

This thesis research was conducted in the Winnipeg Regional Health Authority (WRHA), one of 11 regional health authorities in the province of Manitoba, Canada. It is also the largest region in the province and serves the health care needs of about 700,000 citizens of Winnipeg plus the specialized care needs of other Manitobans. Reporting is

centralized for each region, and during a three month period (January to March, 2004) a total of 45 occurrences of resident aggression or abuse were reported in the WRHA Personal Care Home Program. More than half of these occurrences were directed toward other residents.

In 2000, the government of Manitoba ratified *The Protection for Persons in Care Act*. This law mandates the protection of adults from abuse in personal care homes, hospitals, and other health facilities, through the collection and reporting of data, and investigation of incidents related to abuse and neglect. It also provides legal mechanisms to protect persons—whether staff, family members, or patients—who report abuse. As a result, data on resident and patient abuse is collected across the province.

The Protection for Persons in Care Act (2000) has stimulated regional health authorities and facilities such as Deer Lodge Centre (where this thesis research was conducted) to establish ongoing education for staff. Programming at Deer Lodge Centre includes the *Nonviolent Crisis Intervention®* program, and another educational program entitled *Prevention is 9/10s of the Law*. These programs are intended to educate staff on the definition of abuse and their responsibilities in relation to *The Protection for Persons in Care Act*. The training includes ways to prevent and manage resident aggression.

Resident-to-resident aggression does take place, but it has not been widely studied. This thesis research addresses this knowledge gap by describing and examining the concerns and meanings of aggression through interviews with residents who have witnessed or been a victim of other residents' aggressive behaviour.

Purpose and Research Questions

The purpose of this research is to learn more about resident aggression in long-term care from the perspective of residents who have observed or been a victim of other

residents' aggressive behaviours. This research intends to shed light on the lived experience of residents whose home setting (a personal care unit) includes occurrences of aggression, and to share this information with decision-makers who can make changes to provide a better and safer quality of life for residents and staff.

The following research questions guided the research:

1. *What are the concerns of residents who have been observers or victims of other residents' aggressive behaviour?*
2. *What meaning do residents, who have been observers or victims of aggression, assign to this behaviour?*
3. *How do residents who have been observers or victims of aggression perceive their "home" setting in relation to their experience with aggressive behaviour?*

Eight male residents (Second World War veterans) of Deer Lodge Centre, a long-term care setting in Winnipeg, Canada, participated in open-ended interviews that addressed these three research questions. Their responses add considerably more to what is currently known about the impact (concerns and meanings) of resident aggression on other residents.

Assumptions

The investigator undertook this thesis research with awareness of both the compelling anecdotal evidence pertaining to aggression by residents in personal care settings and the current lack of research in this area. The investigator had previous experience with residents in long-term care as a student nurse, and later as a clinical nurse specialist in a facility similar to Deer Lodge Centre. In addition, the investigator's father, a Second World War veteran, partially reflected the inclusion criteria that were used to choose the research subjects. Finally, the investigator is an associate member (through his

father) of the Royal Canadian Legion, and thus came into contact with men of that age cohort with war service experience.

The investigator assumed that the research subjects would be similar to his father and the men he knew through the Legion in their forthrightness and veracity, yet not overly sentimental or dwelling on emotional aspects. The subjects, during interviews, were cooperative, eager to assist, and most often replied directly to questions in a matter-of-fact way. What was not anticipated was the brevity of responses to questions, leading the investigator to describe these residents as 'men of few words'.

Significance of the Research

This research is highly significant because it addresses a gap in the literature on aggression in long-term care from the perspectives of residents. It presents the perspectives of a particular group of residents—males who constitute the 'old-old' category of aging (85 years and older) and who are Second World War veterans. Much more research is needed in order to understand the perspectives of residents, and this thesis research is a beginning step.

Summary

This chapter presented background material on the need for research on the perspectives of long-term care residents who have been victims or observers of the aggressive behaviour of other residents. The three research questions address the concerns, meanings, and relation to 'home' that aggressive behaviour holds for these residents. This is significant research because it begins to address a gap in our knowledge. The subsequent chapters provide a review of the literature, describe the research methods, present the findings, and finally, provide a discussion of findings in relation to recommendations for practice, policy, and future research.

Chapter Two: Literature Review

Given the limitations of published research, and specifically on resident aggression in long-term care and the perspectives of residents who have experienced this aggression either as observers or as victims, this chapter reports on related literature pertaining to: the definition of aggression; prevalence of resident aggression in long-term care settings; types of aggression in long-term care; factors associated with resident aggression in long-term care; theoretical models of resident aggression; and the meaning of “home” in long-term care. This literature review chapter provides the foundation for the three research questions, and ends with a summary.

Definition of Aggression in Long-Term Care

Aggression has been associated with violence and abuse. Hillman, Flicker, LeGendre, and Traczuk (2005) have suggested that compared to other groups and settings, aggression among older adults in long-term care settings has not been given sufficient attention. They have noted that:

much of the public’s fascination with violence and aggression centers around children and young adults. The majority of literature within the field of psychology itself focuses upon aggressive perpetrators, including those who engage in domestic abuse, child abuse, murder, and rape.

However, significantly less attention is given to the aggressive acts committed by older adults, including nursing home and other institutionalized, elderly residents. (p. 70)

‘Aggression’ is etymologically related to similar ancient French and Latin nouns for “unprovoked assault” (Onions, 1966). The *Canadian Oxford Dictionary* (Barber, 2004) defined aggression as “the act or practice of attacking without provocation; an

unprovoked attack; a hostile or destructive tendency or behaviour". Berkowitz (1993) defined aggression as "any form of behavior that is intended to injure someone physically or psychologically" (p. 3). Baron and Richardson (1994) stated that aggression is "any form of behavior directed toward the goal of harming another living being who is motivated to avoid such treatment" (p. 5). According to Geen (1998) aggression is not a scientific term, but is used to describe different behaviours that inflict harm upon another person.

Liu (2004) provided an insightful exegesis in a concept analysis of aggression, and stated that "aggressive behaviour during early childhood is considered a part of the normal development process" (p. 699). Aggression may be appropriate (self-defense) or destructive to self and others. Liu noted that Freud and Lorenz, two prominent early psychologists who pioneered the study of aggression, determined that aggression was an innate, genetic encoding. Others since have generally concluded that various aspects of cultural learning—whether through television, family violence, abuse, neglect—and organic disorders, such as hormonal and neurotransmitter imbalances, have important roles in human aggression. Aggression as a behaviour has not been immune to the nature versus nurture debate.

Liu (2004) stated that the implications of aggression for professional nursing "cannot be overemphasized [because] it links person, environment, health/illness, and health outcome" (p. 694). Although violence and aggression are often considered synonymous, violence implies greater destruction and intensity and is usually related to human, rather than animal activity. Liu considered violence to be an "excessive negative aggression" (p. 707). Geen (1998) claimed that "the literature on human aggression has become so large that truly comprehensive overviews are no longer feasible".

This thesis research on resident aggression in long-term care and the perspectives of residents who have experienced aggression as observers or victims, defined aggression based on Liu (2004). Liu considers aggression to be an act that harms another person, either physically or psychologically, and is synonymous with an act of aggressive behaviour.

Prevalence of Aggression in Long-Term Care Settings

The prevalence of aggression in long-term care has been estimated in several studies, but the definition of aggression has not been standardized across these studies. Furthermore, much of the research relies on staff reports. Prevalence is therefore likely under-reported because of definitional differences, and because staff were likely not consistently completing a formal incident report each time it occurs (Goodridge, Johnson, & Thomson, 1996; Gates et al., 2003; Ferns, 2006).

Fagan-Pryor et al. (2003) interviewed 92 patients in a United States Veterans Administration medical centre for their views on the causes of aggression. Although the range of ages is from 20 to 65 years of age, the authors found that 57% reported they were witnesses to either patient-to-patient aggression, or staff-to-patient aggression during their time as patients in the centre. The study does not indicate their average length of stay in the centre.

An Associated Press report (Christoffersen, 2004) on long-term care residents claimed that "resident-on-resident violence is sparking a growing number of complaints, studies and conferences. In the United States, more than 3,700 complaints about such abuse were lodged with state ombudsman programs in 2002, up from about 2,500 in 1997". Åström et al. (2004) found that 11.4% of their study sample of Swedish institutionalized older adults (n=848) were exposed to aggression during the one year

period of their study. Zuidema, Derksen, Verhey, and Koopmans (2007) reported from The Netherlands on their research in 59 dementia special care units, and found a prevalence rate of 30% for verbal aggression, and a 13% rate for physical aggression, including hitting, kicking, and biting.

Utilizing data from 2002, Shinoda-Tagawa et al. (2004) reported that 6.8% or about 88,000 nursing home residents in the United States had exhibited physically aggressive behaviour in the week prior to their assessment with the *Minimum Data Set* (MDS) (see also Williams, 2004; Lachs, 2006). The MDS is a mandated process of assessment for each nursing home resident based on their functional capabilities, thereby assisting staff to identify health problems. Information collected in each state is eventually forwarded to a national information database for further evaluation. Using the MDS in five American states as a source, Leonard, Tinetti, Allore, and Drickamer (2006) similarly reported that 6.9% of residents had been physically aggressive in a one week period. Shinoda-Tagawa et al. cited a 2000 Massachusetts Department of Public Health Report that found, through a one year period from January to December 2000, there were 1,132 resident reports classified as having received "physical harm" inflicted by other nursing home residents. They also noted that as many as 20% of residents with dementia in Massachusetts assisted living facilities are physically violent each year.

Estimates from these studies suggest a higher prevalence of resident verbal aggression compared to physical aggression, and a wide band of prevalence ranging from 6.8% to 57%. The link between residents with cognitive limitations, most commonly described as dementia or Alzheimer's Disease, and displays of aggressive behaviour is also presented in these studies. Considering that between 67% and 78% of personal care

home residents have dementia (Buhr & White, 2006) cognition is an important aspect of aggression in the institutionalized elderly.

Types of Aggression in Long-Term Care

Generally speaking, aggression in long-term care consists of several types including: staff-to-resident; resident-to-staff; family-to-staff; and resident-to-resident. Nelson and Cox (2004), who considered nursing homes a “virtual hotbed of conflict”, found that the literature on nursing home violence was focused primarily on staff-to-resident aggression (p. 86). However, it is not clear how staff and resident interactions during caregiving give rise to aggression and from whom the first action emanates. Nelson and Cox denote the significance of dementia and its relationship to aggression, although in the context of resident-to-staff aggression: “Some patient-to-staff abuse is not technically conflicted in nature. Some of it reflects the combativeness of demented residents. Still, a significant residual conflict escalates from the mild resistance that rational residents commonly give their caregiver to avoid unwanted handling” (p. 86). Sandvide, Fahlgren, Norberg, and Saveman (2006) examined staff-to-resident and resident-to-staff aggression. They claimed that “the field of knowledge about violence and elderly persons in institutional care facilities has so far focused on violence towards an elderly person, a phenomenon called elder abuse, or on violence towards staff” (p. 194).

The next largest literature focuses on resident-to-staff aggression. A mixed methodology of in-depth interviews and questionnaires were used to study aggression against long-term care staff in England (Mullan & Badger, 2007). Compared to occupational and physical therapists, nurses were more often the victims. This suggested that it is the frequency of contact or the type of contact (caregiving) that is germane here.

Resident-to-staff aggression was also examined by Brazil, Hasler, McAiney, Sturdy-Smith, and Tettman (2003) in their Canadian study of 15 key informants from long term care facilities housing 1,928 residents. Their study examined behaviours that staff considered most disruptive, which turned out to be screaming, physical aggression, and sexually inappropriate behaviours.

Aggressive resident-to-staff behaviour (in this case, nursing assistants) was studied by Gates et al. in 2003. They found that nursing assistants “experience frequent, sometimes daily harassment, threats, and assaults” (p. 38). Åström et al. (2004) examined staff’s emotional reactions to providing care for elderly institutionalized residents over the course of one year. Those staff who reported violent incidents toward themselves (97 or 11.4%; n=848) were followed up with a telephone interview. Åström et al. found that staff often felt aggressive, astonished, and antagonistic against the individuals who were aggressive towards them. They claim that “violence towards staff is increasingly recognized as problematic in various types of health care settings and in community residential settings” (p. 410).

Very little research has been conducted on family-to-staff aggression and resident-to-resident aggression. Only one study has reported on family aggression. Vinton and Mazza (1994) studied 70 Florida nursing homes during a six month period and reported 1,193 occurrences of verbal aggression and 13 occurrences of physical aggression from family members towards staff. Only two studies have focused on resident-to-resident aggression and these studies tended to report on the occurrence of resident injuries from resident aggression or the resident’s perceptions of the causes of aggression rather than exploring residents’ feelings or perceptions of this experience (Fagan-Pryor et al., 2003; Shinoda-Tagawa et al., 2004).

Fagan-Pryor et al. (2003) interviewed 92 patients in a United States Veterans Administration medical centre and 57% stated they were witnesses to either patient-to-patient aggression or staff-to-patient aggression. Their study, however, only determined if the patients were witnesses; what they considered the causes of aggression; and what they considered preventive measures. Non-aggressive patients indicated that internal factors such as personality conflicts and abrasive words relate to patient aggression toward staff or other patients. The patients also suggested that aggressive patients and staff play important roles in causing and intervening to prevent violence. Fagan-Pryor et al. note, "in few studies, however, have patients been asked about their perceptions related to aggression" (p. 549).

A study by Shinoda-Tagawa et al. (2004) examined resident-to-resident injuries in long term care from a medical perspective. Their case-control study examined Massachusetts nursing home residents who were injured by another resident during a 12 month period (n=1,994). The most typical injuries were lacerations, while the least typical injuries were dislocations. Most injuries were located on the head, face, nose, or neck. The areas of the facility where injuries most commonly occurred were the injured residents' room, followed by the hall, dining room, and the other residents' room. Shinoda-Tagawa et al.'s study also found that behavioural problems associated with resident-to-resident injuries include wandering, verbal abuse, and inappropriate social interaction on the part of resident-victims. In other words, a resident with cognitive limitations who presents others with inappropriate language and behaviours in a communal space or in another resident's room is at increased risk of becoming a victim of aggression and subsequently requiring medical attention. Most of the injured residents were either moderately or severely cognitively impaired. Shinoda-Tagawa et al. noted

that “although many incidents appeared to have been unprovoked, some of the residents allegedly injured by other residents may have provoked the aggressive physical contact—whether unintentionally, unknowingly, or otherwise” (p. 594). They suggest that cognitively impaired residents who are physically independent are at risk for incurring an assault.

Overall, most research on aggression focuses on staff-to-resident aggression, also known as elder abuse, and there is also a substantial literature on resident-to-staff aggression. Much less research has been conducted on family-to-staff aggression and resident-to-resident aggression. Of major interest for this thesis research is that residents who have observed or been victims of other residents’ aggressive behaviours have not been asked about their concerns, the meaning assigned to this behaviour, and how it affects their perception of home.

Factors Associated with Resident Aggression in Long-term Care

Several studies have attempted to identify common factors associated with resident aggression, with the ultimate goal of developing interventions to prevent or manage aggressive behaviour. Prevention and management of aggression would decrease the burden for staff and residents that is often associated with this behaviour (Leonard et al., 2006). These burdens or costs include: using physical and chemical restraints with aggressive residents; increased health care costs due to staff turnover and absenteeism (Voyer et al., 2005).

Resident aggression has often been perceived as being associated with, or as a consequence of many factors. Unmet needs, including unresolved pain and infections, inadequate exercise and sleep, and poor nutrition and dehydration have been linked to aggression. Vision, hearing, and speaking deficits, the side effects associated with some

medications, long-term alcohol abuse, and a history of aggressive behaviour have been related to aggression in institutionalized elderly. Compared with females, males are more likely to behave in an aggressive manner (Shah et al., 2000). Mental health problems such as depression and dementia have also been linked (Algase et al., 1996; Cox, 1993; Ferguson & Smith, 1996; Hall, & O'Connor, 2004; Soreff & Siddle, 2004). The overlap or links among these factors is difficult to separate. For example, Hall and O'Connor suggested that the association between aggressive behaviour and cognitive impairment may be caused by the communication deficiencies that accompany this impairment. Similarly, Cipher, Clifford, and Roper (2005) indicated from their research on behavioural disturbances and pain among long-term care residents that the likely link between aggression behaviour and dementia is unresolved pain.

Olson (2002) discriminated between internal and external stimuli related to aggressive behaviour. Examples of individual or "internal" stimuli that might stimulate an aggressive event include: hunger, fatigue, pain, lack of sleep, dehydration, constipation, loneliness, fear, and dysphasia. "External" stimuli include: noise, shadows, mirrors, and staff behaviours such as lack of consistent caregivers (that is, a rotation of caregivers rather than permanent assignment), abruptness, and hurriedness. Intimate care that includes toileting and bathing have also been identified as precipitating factors for aggression (Baker, Hanley, & Mathews, 2006; Keene et al., 1999; Olson, 2002).

Two recent studies have emphasized that factors associated with aggression might vary according to the manifestations of aggression, that is, either verbal or physical aggression. In other words, the two manifestations may differ in terms of associated factors, making interventions for one inappropriate or even unusable for the other. Using MDS information from five states (California, New York, Ohio, Pennsylvania, and

Texas), Leonard et al. (2006) attempted to determine whether a set of potentially modifiable resident characteristics was associated with physical aggression. Their secondary aim was to determine whether or not these same characteristics were associated with verbal aggression. Findings indicated that physical aggression was significantly associated with depressive symptoms, delusions, hallucinations and constipation. Verbal aggression was associated with mental health characteristics (depression, delusions and hallucinations) but not with constipation. They conclude that attention to mental health characteristics and attention to constipation will reduce physical aggression.

In a study of residents in long-term care facilities in the Quebec City area, Voyer et al. (2005) used secondary data to identify factors associated with verbal aggression and with physical aggression. Their findings indicated that 21% of residents displayed verbal or physical aggression. Almost half of these aggressive residents were both verbally and physically aggressive, and for this group, male gender, chemical (neuroleptic medications) and physical restraints, mild and severe cognitive impairment, insomnia, and psychological distress were common factors. Factors associated with physical aggression only were male gender, older age (85 years and older), chemical restraints (neuroleptic medications), mild or severe cognitive impairment, insomnia, and psychological distress. Factors associated with verbal aggression only were chemical restraints (benzodiazepine and neuroleptic medications), functional dependency, mild or severe cognitive impairment, and insomnia. This study demonstrated a commonality among factors associated with both verbal and physical aggression, but also some differences, adding strength to the notion that the manifestations of aggression (physical or verbal) might best be examined separately in order develop effective interventions.

A further consideration in the search for modifiable factors associated with aggression and subsequent interventions comes from a review of the literature on aggressive behaviour by residents with dementia in long-term care undertaken by Pulsford and Duxbury (2006). They conclude that while certain interventions “appear to reflect good and common sense practice, there is no clear evidence for the general effectiveness of any one management approach, and each approach has drawbacks of a practical or ethical nature. There is also very little empirical information about how professional carers actually manage aggressive behaviour in practice” (p. 616).

Current Theoretical Models of Resident Aggression

Two conceptual models have been developed that are useful to ‘frame’ aggressive behaviour in the context of residents in long-term care settings: the Progressively Lowered Stress Threshold model (Hall & Buckwalter, 1987), and the Need-Driven Dementia-Compromised Behaviour Model (Algase et al., 1996; Smith & Buckwalter, 2005).

The first model to be developed was the Progressively Lowered Stress Threshold (PLST) model, which came out of the work of Hall and Buckwalter (1987). The PLST model built generally upon Selye’s stress model (General Adaptation Syndrome) and in particular, on Lawton’s (1980) work on the relationship between environmental ‘press’ and physical or cognitive competence. His ‘environmental docility hypothesis’ posited that as competence decreases, environmental factors become increasingly important determinants of behaviour and affect. Residents with diminished competency because of dementia-based cognitive limitations may experience an environment that is overwhelming, demanding, and far too complicated to understand in relation to their abilities. Resultant behaviours such as aggression, vocalizations, and wandering were

attributed to confusion, frustration, and even fear of an increasingly complex environment that was “pressing” the limits of their abilities as elderly residents. These suppositions formed the basis for Lawton’s drive to develop ‘special care units’ for residents with dementia-based cognitive limitations. Such units were intended to provide social and physical stimulation, but not overwhelm the competence of residents with dementia.

The PLST model suggests that as the dementia disease progresses, individuals are less able to receive and process stimuli and information, and there is a progressive decline in the stress threshold (Hall & Buckwalter, 1987; Gerdner, Hall, & Buckwalter, 1996). Thus, although environmental circumstances might not be necessarily changing, the threshold of environmental stress that is tolerable to residents with dementia becomes progressively lower. Hall and Buckwalter suggested that stress-producing factors could be modified with a consequential decrease in stress reactions such as wandering, night wakening, agitation, and combativeness. They identified these potentially modifiable factors as including: fatigue; change of environment, caregiver, or routine; acute illness; discomfort; and medication reaction. From this PLST model, six principles to guide nursing practice were developed. The six principles advocate: maximizing individual function; providing unconditional positive regard; observing behaviour cues to limit stimuli; teaching caregivers to ‘listen’; modifying the environment to fit ability; and providing education and support to caregivers.

The second conceptual model that is often used to understand resident aggression is the “Need-Driven Dementia-Compromised Behavior” (NDB) model (Whall & Kolanowski, 2004). This model emphasizes that disruptive behaviours such as aggression reflect the caregiver’s view more than the aggressive resident’s perspective (Algase et al.,

1996). From the caregiver staff perspective, aggressive behaviour disrupts care and disturbs staff and others, and the NDB model attempts to reframe aggressive behaviour as a resident's attempt to convey meaning (Whall, 1999). Specifically, aggression is seen as an outcome of unmet needs (such as fatigue, pain, and hunger) and residents with dementia convey their needs not through clearly articulated requests for help that might be beyond their current abilities, but through verbal and physical aggression. Continued unmet needs result in an "escalation" of behaviours, for example, "verbally agitated behaviour may progress from repeating a word to screaming" (Woods, Rapp, & Beck, 2004, p. 126).

According to Whall and Kolanowski (2004), the NDB model "views behaviors as indicating needs that, if responded to appropriately, will enhance quality of life" (p. 106). For nursing staff, if the "meaning" of the aggressive behaviour becomes grounded in an understanding of unmet needs, then interventions to meet needs consequently will defuse and change the behaviour in a positive direction. As a result, behaviour will "de-escalate" (Woods et al., 2004). The model posits that background factors (neurological disease changes, current cognitive abilities, general health status, and psychosocial history) and proximal factors (physiological and psychological need states, and the physical and social environment) lead to need-driven dementia-compromised behaviours (aggressive behaviour, non-aggressive behaviour, problematic vocalizations, and passivity) (Kovach, Noonan, Schlidt, & Wells, 2005). Through educational sessions, nursing staff can learn about modifying some of these factors, such as decreasing noise in the physical environment, and assessing for pain and intervening with pain medications and comfort measures. Other factors are not modifiable (for example neurological disease changes)

and still other factors require policy directives such as determining an appropriate staff mix.

The NDB model does not focus on aggressive behaviours alone but also emphasizes “passive behaviour” as an outcome of unmet need, indicating that passivity tends to be disregarded in clinical settings because it is not disruptive to caregivers (Colling, 1999). The model also stresses that a situation of unmet need is primarily a communication problem between the resident and the staff, that interventions to meet needs should be based on respectful care, and that a positive approach might be to categorize aggressive behaviour as ‘challenging’ rather than ‘disruptive’ (Woods et al., 2004; Algase et al., 1996).

While the PLST model emphasizes difficulties dealing with stress and the NDB emphasizes situations of unmet need, these two models share some common features. First, both models assume dementia-based limitations as key factors in either dealing with stress or communicating need, and this perspective takes ‘blame’ away from residents who are aggressive in their behaviour. In connection with this, there is a concomitant emphasis on staff responsibility to modify factors that either decrease stress levels or attend to unmet needs. Modifiable factors are similar for both models, for example, fatigue, pain, and environmental change. Second, both models take a positive approach and stress the importance of good communication and having respectful or unconditionally positive regard for residents. Third, both models emphasize the important role of nursing to make changes that decrease stress and meet needs through the process of staff development and education.

While these models are clearly directed toward a better understanding of aggression by staff in order to promote positive interventions that decrease challenging

behaviour and improve quality of life, the elements of the models might be or might not have been appropriate frameworks for examining the meaning that residents, who have observed or been a victim of aggression, attribute to the aggressive behaviour of other residents. Therefore, these similar models may have limited applicability in understanding the impact of resident aggression on other residents and the meaning that is assigned to such behavior.

The Meaning of 'Home' in Long-Term Care

One of the thesis research questions asked, *How do residents who have been victims or observers of aggression perceive their 'home' setting in relation to their experience with aggressive behaviour?* This question assumed that residents of long-term care settings see their accommodation as a home, or perhaps a new or different home, at the very least. The underlying assumption of a home in our society speaks to permanency compared with a transitory or temporary abode, and this is true for long-term care settings.

Generally speaking, the concept of 'home' embodies several meanings. It is considered a sanctuary (for rest, peace, quiet, comfort, and security). Home may be a focus of personal expression and social interaction (for intimacy, family life, and activities). It may serve as a place for personal development and socialization (a place to learn values). Home may also provide a private site where individual control is at its height (Imrie, 2004; Angus, Kontos, Dyck, McKeever, & Poland, 2005). The interface between health status and home (and in particular to changes in health status) can affect the meaning of home. Imrie reported on how development of disability challenges the meaning of home as comfortable, safe, and private to those with limitations on their abilities. 'Home' becomes a place less private, holding obstacles and barriers to a

previous lifestyle. Similarly, Angus et al. examined the provision of long-term health care in the homes of 16 rural families in Ontario. Their findings suggest that “illness and home-care service disrupted the intimate, co-constitutive relationship between self and home” (p. 182).

The literature on personal care homes as ‘home’ is scant, with a few notable contributions, particularly some early work from Gubrium (1993). Gubrium used narratives or a ‘story of life’ for “uncovering the subjective meaning of the nursing home experience in relation to life as a whole” (p. 7). In-depth interviews were conducted with 58 residents, primarily women whose functional limitations precluded living in their community homes, and who had moved to nursing homes in Florida. Gubrium asked these residents, among other things, about the meaning of home. Two questions were, “Now that you’ve been here for ----, does it feel like home? What would it have to be like for it to be like home?”

Gubrium (1993) presented three case studies to illustrate the meaning of home for these nursing home residents. The themes that appeared are several, some of which depicted the attitude of “making the best of it [as a home]” and accepting one’s circumstances rather dwelling on change or loss. Another theme related to fellow residents and roommates as “family-like”, as people who help, care about, and matter to each other. One resident’s reference to female residents as “a bunch of sisters” seemed to fit with the notion of the nursing home as a place where “family” live (p.48). Another resident described helping an older woman whom she sees as an adopted grandmother. Gubrium’s narratives suggested that when asked about the nursing home as ‘home’, these three residents described feelings of acceptance that could be interpreted as either positive or negative, but there was also a truly positive context of family and mutual

caring or concern as part of the meaning of home. Similarly, in their research with nursing home staff and the creation of a home-like environment, McIntyre and Freeman (2003) referred to feelings of attachment to others as the “root of our capacity to feel ‘at-home’ [in a nursing home]” (p. 4).

In contrast to Gubrium’s (1993) findings, Hammer’s (1999) research with 10 relocated older men and women in three settings (one life-care and two long-term care locations) suggests that some older adults experience great difficulty in establishing a sense of home in these alternative settings. Her study asked two questions: “What meaning does the experience of being at home have for older adults? Is there an essence (i.e., a core of invariant features) to the idea of being at home?” (p. 11). The majority of residents (six of the ten) indicated that they did not feel at home in their relocated home, and they were, “for the most part, reluctant to engage new friends, participate in social activities within the home, and engage in any type of future planning” (p. 16). This seems to fit with McIntyre and Freeman’s (2003) speculation on a direct association between feelings of attachment and feeling at home.

Referring to the perspective of humanistic geographers, Hammer (1999) describes those who see themselves as being at home are also engaged in a “journey away from [previous] home”, that is, making new friends and engaging in social activities in a new, relocated home. Furthermore, she cautions that the ‘essence’ of being at home varies on an individual basis, and that nursing home personnel should not assume that all older adults will adjust to long-term care facilities simply because some have adjusted.

Summary

The literature on residents' perspectives on their concerns and meanings in relation to observing or being a victim of another resident's physical or verbal aggression is sparse and consists of two studies. One of the studies examined injuries incurred during resident-to-resident aggression. Much of the research on aggression in long-term care has focused on staff abuse of residents or resident aggression toward staff. The reported prevalence of resident aggression ranges between 6.8% and 57% and the factors associated with resident aggression have been multiple and more than likely interrelated. Unmet needs, sensory and cognitive deficits, medication side effects, mental health problems, alcoholism, communication deficits, gender (male), and negative affect (for example, frustration and fear) as well as environmental and caregiving factors have been linked with aggression.

Two models, the Progressively Lowered Stress Threshold Model (Hall & Buckwalter, 1987) and the Need-Driven Dementia-Compromised Behaviour Model (Whall & Kolanowski, 2004)—while untested—are intuitively appealing, and seem to fit with the factors known to be associated with aggression. The models focus on aggressive behaviour as an expression of unmet need or the inability to deal with stress. Finally, our understanding of how residents view their residence in a personal care home as a 'home' is in its infancy, but suggests that the concept of "home" is associated with attachments with people and that some but not all residents will adjust to life in a personal care home.

The next chapter describes the methodology of this thesis research.

Chapter Three: Methods

This thesis research is an exploratory, descriptive, and cross-sectional study of residents' concerns and meanings of aggression from their perspectives as observers and victims of aggressive behaviour from other residents. The research is exploratory because, other than two studies, there is no extant literature on the subject. This chapter informs and describes the logic-in-use in planning, collecting and analyzing data for this thesis research. Information is provided under the following sections: setting; sample; procedure for access and ethical approval; data collection; and data analysis. The final section is a summary.

Setting

The setting is Deer Lodge Centre, a large long-term care and rehabilitation centre in Winnipeg, Canada. It has more than 497 temporary and permanent personal care and chronic care beds. Historically beginning with the First World War, Deer Lodge Centre was a veteran's hospital. Although this is no longer the case, a residual aspect is that 80% of residential beds (in personal care) are initially allocated to veterans (Second World War and Korean War). An outcome is that the proportion of males to females in residential care at Deer Lodge Centre is the opposite of what might be found in other personal care homes or long-term care settings. At Deer Lodge Centre, males compose approximately 2/3 of all residents—females are about 1/3 of the resident population.

A notable feature of Deer Lodge Centre is the establishment of the Collaborative Research Unit in 1992. This unit fosters research relationships between the Centre and researchers from provincially-based universities and other research institutions across Canada and internationally. The application for permission to access potential research subjects goes through the Manager of the Collaborative Research Unit.

Sample

A convenience sample of eight residents was selected from the personal care units of Deer Lodge Centre. Given the exploratory nature of the topic and the lack of specific literature on residents' perspectives of aggression, it was decided to maintain the homogeneity of the sample as much as possible. Inclusion criteria were: residence in a personal care unit for at least three months (to allow for 'settling-in' and to increase the likelihood of experiencing aggression as an observer or a victim); being male (because male and female perspectives on aggression may differ); being a Second World War veteran (with corresponding similar wartime experience and a similar age cohort grouping); and the ability to speak English and respond to simple interview questions.

Procedure for Access and Ethical Approval

As indicated earlier, access to residents was granted through an application to the Manager of the Deer Lodge Centre Collaborative Research Unit. An application for ethical approval was also made to the Education/Nursing Research Ethics Board at the University of Manitoba (ENREB).

Once access was approved, a Deer Lodge Centre staff liaison was assigned to the thesis research investigator. This liaison contacted the resident care managers of all of the personal care units, providing them with the list of inclusion criteria (Appendix A) and a script (Appendix B) with which to introduce residents to the thesis research. Those residents who were interested in participating and who agreed to have their names forwarded to the investigator were contacted by the investigator, who then provided more information and obtained written consent (Appendix C), as appropriate. Interviews were scheduled at the mutual convenience of residents and the investigator who carried out all of the interviews.

Ethical approval was in place before the Deer Lodge Centre liaison contacted resident care managers about potential residents for the project. Ethical approval policy and procedures at the University of Manitoba are governed by the *Tri-Council Policy on Research on Human Subjects* (2001). The faculty affiliation of the principal investigator determines which of the five Research Ethics Boards will review the application for ethical approval. For this thesis research, approval was granted through the ENREB.

The two major concerns from the ENREB were based on subjects' rights to privacy, and the potential risks of being interviewed for a study that asked about aggressive behaviour from residents who had been observers or victims of aggression from other residents. First, the ENREB emphasized the right of privacy in relation to confidentiality, but there was an additional risk identified. This risk was whether or not the aggressive residents who were being described might retaliate against those who were 'reporting' these aggressive behaviours to the investigator. The ENREB wording spoke about concerns of 'ratting-out'. Confidentiality was maintained and interviews were held in private areas, most often the resident's private room.

Second, the ENREB was also concerned that the subject matter of aggressive behaviour might lead to a re-living of the experience for those being interviewed, and subsequent distress. During the interview, the investigator indicated that if questions were upsetting then the interview would be stopped, and after reflection, a decision would be made to terminate the interview, continue the interview, or call someone to provide support to the resident (a social worker or a pastoral care worker). In fact, the occurrence of distress did not take place during any of the interviews, but nevertheless, assurances were provided. A copy of the ENREB approval certificate is contained in Appendix D.

Data Collection

All of the eight residents were interviewed only once. Fatigue that might have necessitated a second interview did not occur. The interviews ranged from 20 minutes to about 70 minutes, but overall, most were less than 30 minutes. All of the interviews were conducted during a three week period in March, 2007.

Initial discussion with each participating resident ensued informally for a few minutes, providing time to set up audio-taping equipment, provide further information on the nature of the study, and establish rapport. The investigator would share with the residents his associate membership with the Royal Canadian Legion and the fact that his father was a veteran. This provided some common ground between the investigator and the resident and invariably led to the resident talking about his Legion membership prior to the beginning of the formal interview. All of the residents who were interviewed seemed friendly, interested in the study, and graciously gave of their time and their thoughts.

Prior to questions on residents' experience as observers or victims of other residents' aggression, some sociodemographic (Appendix E) and health-based questions (Appendix F) were asked in order to develop a profile of the group as a whole (Appendixes G and H). Sociodemographic questions included: age; marital and family status; ethnic identity; religious affiliation; military service; and length of residence at Deer Lodge Centre. Data on health characteristics include: identifying chronic illnesses and functional status (ability to perform selected activities of daily living); self-rated health (single item); self-rated quality of life (single item); and self-rated depression (single item). Given that this was a small convenience sample, the sociodemographic and

health characteristic data were not intended for analysis other than as descriptive qualitative or univariate quantitative descriptors of the group of eight residents.

In relation to the open-ended questions that pertained to residents' concerns and meanings of aggressive behaviour, the interviews began by first asking the resident to describe an aggressive situation of which he had observed or been a victim. This was done intentionally in order to provide a concrete basis upon which to ask the remaining questions on concerns, meanings, and affect pertaining to their "home" environment. The questions are contained in Appendix I and flow from the concrete example to *concerns* (research question #1), *meanings* (research question #2), and *effect on home environment* (research question #3). Probes were used throughout the interview to add context, to allow the resident to fully explain his perspective, and for clarification. Two follow-up questions related to the experience of resident aggression in relation to other experiences, plus a general closing question: "*Is there anything else you would like to tell me?*"

Data Analysis

All of the interviews were audio-taped and later transcribed into text by a professional transcriptionist. This thesis research was funded by the Fort Garry Legion Poppy Trust Fund in Winnipeg, and funds were allocated to hire a professional transcriptionist. The investigator reviewed each transcript by simultaneously listening to the audiotape and reading the transcript to ensure the accuracy of each transcribed interview. Each interview was identified by resident number (i.e., Resident #1, Resident #2, and so on, to Resident #8) and each line of text for each interview was numbered to facilitate analysis that was conducted by the investigator and his thesis advisor. Given the short length of the transcripts, qualitative analysis software was not needed for data management.

The length of transcripts varied from two to six single-spaced pages of text, and this indicates the brevity of responses. Generally speaking, these residents answered the questions as phrased, and even with probes, they tended not to elaborate on their answers. The phrase, 'these are men of few words' rings true for this group of residents. Throughout the interviews and at the end of each interview, the investigator reviewed what the resident had said and asked about accuracy and any further comments.

In order to ensure the trustworthiness of the data, it was evaluated on four characteristics: credibility; dependability; confirmability; and transferability (Graneheim & Lundman, 2004). Four actions relate to data credibility. The first action is "prolonged and sufficient time to conduct interviews", and this was the case for interviews which, although relatively brief, were sufficient to have all the questions answered. The second action is 'member check', which included feedback from residents on the content of the interview during and after each interview. The third action is 'monitoring saturation of findings', and this occurred as the interviews proceeded. For example, during the fourth interview, the resident mentioned his easy going approach to aggressive behaviour, saying that he has the "same nature as my father, easy-going". In subsequent interviews, the investigator added a question that asked about other factors (including family) that might be reflected in a resident's approach to aggressive behaviour. One other resident similarly mentioned his father as an influence in his approach to aggressiveness. The fourth factor is peer debriefing and a review and discussion of findings occurred between the investigator and the thesis advisor.

In terms of data dependability and confirmability, the actions include a 'member check'; creating a paper trail beginning with raw data; and developing a document of personal reflections. 'Member checking' took place during and at the end of each

interview. The investigator maintained a personal journal throughout the data collection process which summarized his feelings about each interview immediately after it occurred. After each interview the investigator would try to capture any impressions gained from the resident, which were then summarized into a 'title' for each session. These journal entries provided context but were not formally analyzed as part of this thesis research.

For the fourth characteristic, data transferability, the action by the investigator was to note the presence of context, or the physical and social environment of the research. This thesis research and the subsequent findings do not suggest wide transferability, but findings are presented in the context of eight male Second World War veterans who are residents of a personal care unit in a large Canadian long-term care facility.

As indicated earlier, the sociodemographic and health characteristics of the eight residents were analyzed purely to provide a description of the group. The findings from this analysis are presented in the subsequent chapter. In terms of the open-ended questions that were designed to address the three research questions, the analytical technique used was content analysis, with the overall goal of identifying manifest and latent content of the data. In qualitative analysis, the investigators search for patterns and categories in the data (Burnard, 1998). The thesis research data were analyzed separately by the investigator and the thesis advisor for all interviews. They met on a regular and sustained basis during a one month period.

The first piece of work involved analyzing the example of the aggressive incident that the resident had been asked describe. This included what, when, and where it happened, the resident's reactions and feelings, and how it was handled. This led to the

specific question on 'concerns' that directly attended to research question #1 (*"What are the concerns of residents who have been observers or victims of other residents' aggressive behaviour?"*). Some of the residents described more than one aggressive incident. The investigator and thesis advisor decided to categorize these incidents into physical or verbal aggression, to individually record and count the 'terms' used by the residents, and then compare these categories and counts. For example, the investigator and thesis advisor counted the number of times "swear" or a form of that word was used to describe verbal aggression. Given that little is known about residents' perceptions of aggression, this analysis would produce a listing of words commonly used by this sample of residents. Whenever possible, the analysis of the aggressive incident also identified and counted the location of the incident and the time of day the incident occurred.

This type of analysis corresponds to manifest content or the "visible, obvious components [of the text]" as described by Graneheim and Lundman (2003). The words used by residents such as "swear" are evident, and can be counted. The interpretation of which words are used or chosen by residents and which words are not chosen is not possible. But findings may suggest that some words used to describe aggression may indeed occur more often from this group of residents.

The analysis of the first research question on 'concerns' was based on its latent content, that is, where the text of the interview suggested underlying themes or types of concerns. It had been expected that a major concern of residents would be their own safety, and this certainly emerged from the text. In addition, concern for the safety of others also emerged. Similarly, in relation to concerns for safety, there were concerns expressed for privacy and for 'peace and quiet'. Once the investigator and the thesis advisor had agreed on the theme of concern with two sub-themes of the essence of

concern (safety, privacy, and 'peace and quiet'), and the focus of concern (concern for self or others), it was possible to revisit the transcripts for the number of residents who reported the essence and foci of these concerns, and when possible, to count the number of times (manifest) each was mentioned. A similar process was undertaken in relation to research question #2 ('meanings') and research question #3 (impact on 'home').

As an analytical technique, content analysis is well-known and often used. Sandelowski (2000) emphasized that "qualitative content analysis is the analysis strategy of choice in qualitative descriptive studies" (p. 338). The investigator and thesis advisor followed Sandelowski in the process of analysis. Sandelowski noted that "qualitative content analysis is data-derived; that is, codes [also] are systematically applied, but they are generated from the data themselves in the course of the study" (p. 338).

A paper trail from the raw data of the transcripts to the development of themes for each research question was put in place, and after each meeting between the investigator and the thesis advisor, a document was prepared by the investigator that outlined the thinking and analysis decisions.

Summary

This chapter provided information on the research setting (a large long-term care setting), inclusion criteria for the convenience sample of residents, and described the process and some of the issues related to ethical and access approval. In relation to ethical approval, major concerns were confidentiality and sensitivity to the feelings of residents who had observed or been victims of the aggressive behaviour of other residents. The chapter also outlined the process of data collection and analysis which formed the foundation for the subsequent chapter that presents findings.

Chapter Four: Findings

This chapter presents findings from the analysis of interviews with eight residents who described their perspectives (concerns and meanings of resident aggression and relationship to 'home') as observers and victims of aggressive behaviour of other residents. The chapter is presented in the following sections: sociodemographic characteristics; health-based characteristics; residents' descriptions of aggressive behaviour; research question #1; research question #2; research question #3; additional questions; and summary.

Sociodemographic characteristics

The eight residents who participated in this research ranged in age from 81 to 92 years of age (average age of 85). All of them were married and five of them were currently widowed. All of the eight residents reported having children (range from one to six children). They had resided at Deer Lodge Centre for an average of two years and four months, with a range of length-of-stay from four months to five years. Their background presented a variety of careers and vocations, but given the small number of residents who participated in the research, only their categorization as white collar workers (n=4) and blue collar workers (n=4) is reported here.

Because it was an inclusion criterion, all of the residents were in military service during Second World War, and all but one was active in service in Europe. Their war time service took place in three armed services branches: four were in the army; two were in the navy; and two were in the air force. Their average length of service was four years and four months (range of three months to six years).

Health-based characteristics

The residents were asked several questions about their health. In relation to the question on chronic illness: three residents reported having arthritis; two residents reported diabetes; two residents stated having congestive heart failure; and one resident each reported having cancer and obesity.

The residents' reports of chronic illness seemed not to translate into high levels of functional disability. In terms of activities of daily living (grooming, bathing, dressing, walking, eating) all of the residents reported complete independence with eating. A similar level of independence was reported with walking, although one resident who was sitting in a wheelchair during the interview stated that he required "a little help". Five residents were independent with grooming, and three stated they required a little help. One resident explained that assistance with grooming related to his limited range of motion in his arms, restricting his ability to brush and comb his hair. All of the residents stated they needed either a little help or a lot of help with bathing. For dressing, five residents stated they required a little help, and three residents indicated that they required a lot of help.

Despite their experience of chronic illness and functional disability, primarily in relation to bathing and dressing, there is a demonstrated optimism regarding self-rated health and quality of life among these residents. Most of the residents rated their health as fair or good, and one stated that his health was "very good". None of the residents rated their health as excellent or poor. Similarly, the question asking residents to rate their quality of life elicited "fair" or "good" responses, with no one stating their quality of life was "poor". Further corroboration of this overall optimism is found in responses to the single item self-rated depression scale (i.e., "During the past week, have you felt sad or

lonely?"). Six residents stated they were not sad or lonely, while only two stated "yes".

No further information was gathered on depression.

Residents' Descriptions of Aggressive Behaviour

In order to explore their concerns and meanings attached to aggressive behaviour, residents were asked to describe aggressive situations of which they had observed or been a victim. The request was stated in this way: "I would like you to describe a situation that you experienced (heard or saw) when another resident behaved aggressively either towards you or another person." All of the residents described at least one situation and some described two or more situations. Residents described the targets of aggression as themselves, staff members, and other residents, and in situations where the verbal aggression was overheard, there was no observable target. Examples of aggressive situations varied from very physically aggressive (e.g., a resident who "hauled" another resident off his wheelchair and pounded the "the hell out of [him]"); to physical intrusion (e.g., a resident who would push his way into another resident's room or bathroom); to non-specific verbal aggression (e.g., a resident who would get angry and could be heard shouting abusive words); to directed verbal aggression (e.g., a resident yelling at another resident).

The words that residents used to describe aggression varied widely, but can be categorized as verbal aggression or physical aggression. Six terms for verbal aggression were used 16 times by six different residents. Two residents did not mention witnessing verbal aggression but heard it from a distance. The term 'yell' is mentioned seven times by five different residents. Less commonly used terms are 'scream' and 'swear' (used three times by two different residents), and 'shout', 'loud', and 'aggressive', each used once. In terms of physical aggression, five different residents used 13 descriptors 21

times. The most common term used was 'push' (used four times), followed by 'pound' (used three times), 'punch', 'fight', and 'hurt' are used twice each, while terms used once include 'haul', 'roll', 'whip', 'slam', 'noise', 'attack', 'violence', and 'angry'.

When residents described where the aggressive incidents occurred, six locations in the personal care unit were mentioned. The most common locations were the hall and the aggressive resident's room, accounting for six incidents each. Residents indicated that their own rooms accounted for four incidents, while another resident's room and the dining room accounted for two incidents each. One resident said the aggressive acts occurred "anywhere". It should be noted that when residents described locations of aggression, some situations were described *in transit*. For example, an incident may have started in the dining room, moved into the hall, and then into the resident's bathroom. Therefore, the number of locations does not reflect the number of incidents of aggression.

Six residents noted the approximate time of day that aggressive incidents occurred. The most common time, "anytime", was mentioned four times. Other times of the day, including "morning", "day", "evening", and "night" were each mentioned twice in the interviews.

Research Question #1: Concerns about Aggression

Research question #1 asks, "*What are the concerns of residents who have been observers or victims of other residents' aggressive behaviour?*" After initial descriptions of incidents of aggression, including location and time, residents were asked more personal information about the incidents, in particular, how they reacted, and what concerns, if any, they had about the incidents being discussed. Two major themes: concerns about aggression and coping strategies to deal with aggression emerged from the responses given by residents.

The first theme, “concerns about aggression” had two sub-themes that related to: 1) the ‘essence’ of the concern about aggression (safety, privacy, and “peace and quiet”) and 2) the ‘focus’ of the concern about aggression (self, others including staff, other residents, and the aggressive resident).

The second theme was “coping strategies to deal with aggression” and the two sub-themes were (a) ‘types of coping strategies’ (calling for help, avoidance, and ‘handle it myself’); and (b) the ‘sources of coping strategies’ (learned from family, military service, work, and education).

Theme of Concerns about Aggression and Sub-theme of Essence

The theme of residents’ concerns about aggressive incidents consisted of two sub-themes, one of which related to the ‘essence’ of these concerns.

The essence of concerns about aggressive behaviour can be classified into the concern for safety, the concern for privacy, and the concern for peace and quiet.

Residents most often reported being concerned with safety, and it was mentioned eight times in three of the interviews (Resident #1, #3, and #7). For example, a resident known for being loud, aggressive, and forgetful pushed his way into Resident #3’s room and punched him in the shoulder. Resident #3 stated, “I was angry, fearful, he was bigger than me”. This incident is notable because it includes the rare mention of a resident feeling bothered by the incident: “I wasn’t bothered by it beyond that few hours”. The only other mention of being bothered by an aggressive incident was verbal aggression when Resident #5 noted, “I didn’t feel anything” [and] ...as soon as I left his room I forgot about it”.

Resident #1 spoke about his general concern for safety when he described witnessing a situation where an aggressive resident physically harmed another resident.

Resident #1 stated, "This particular fellow was the only one that I thought someone was going to get hurt if they [staff] didn't do something about him". Resident #7 also describes aggressive residents in general, indicating, "...well, depending where you are, you can often see messy situations building up and in which case, you are better off somewhere else".

Another concern expressed six times by three residents (Residents #1, #3, and #6) was the concern for privacy. Resident #1 described a situation where an aggressive resident was "just nosy...no violence". Resident #1 was enjoying a visit with his son when it was interrupted, "He [the aggressive resident] came in...and I just said, 'Hey, you're in the wrong room', and then away he'd go". There was no further interaction with the intruder after this admonishment, and he left the room.

Resident #3 described a situation occurring during evening care, saying that "...two of the nurse's aides were preparing me for bed around 8:30 in the evening and this fellow who is very aggressive followed them into my room. I said so look I don't mind two of you helping me but I don't need him watching the whole process. So one of the nurses who is quite tall and pretty healthy edged him out. He began to swear and push her, she handled it OK". In another situation, Resident #3 indicated concerns for both privacy and safety. He noted that he found a resident known to be aggressive in his bed, and when he tried to get him to leave, concern for his own safety became apparent:

"...when I told him to get out as this was my room he would argue with me that this was his room and one time he pushed me and actually punched me on [*sic*] the shoulder."

Resident #3 added, "He was going out and then turned around to come back in and I guess I foolishly was closing the door so he wouldn't come back in. He pushed his way in

and punched me in the shoulder.” In this situation, what was first a concern for privacy escalated to a concern for safety.

Resident #6 reported feeling that his privacy had been violated by an aggressive resident. He describes a situation in this way, “sometimes you come from the dining room to your bathroom and you ask what they [aggressive resident] are doing there and they can’t answer you, they don’t even know...[but] you feel like your privacy has been invaded”.

The third essence of concern was the desire for peace and quiet in the living environment. This notion is mentioned three times in two interviews (Resident #2 and #4). When asked if yelling, screaming, and crying out was disruptive to his lifestyle in personal care, Resident #4 replied, “Well, sure it could be a bit more peaceful, but our floor is a pretty good one”. When asked if he would like his unit more peaceful, he replied, “I guess so. As long as it is quiet at night and everyone can get a good night sleep at night would be good”.

In terms of the literature, these three concerns (safety, privacy, and ‘peace and quiet’) have been identified to a relatively lesser or greater degree, with safety being the most prominent. Because most of the literature on resident aggression focuses on resident-to-staff aggression, the emphasis tends to be on the impact of the aggressive act on staff, other health professionals, and sometimes to ‘others’ without always an explicit reference to other residents. Buhr and White (2006) referred to difficult behaviours as challenging to staff, and distressing to staff and the aggressive resident. In fact, the impact of resident aggression is often measured in relation to staff distress, injury, and subsequent lost work days (Martin & Boucher, 2005).

Voyer, Verreault, Azizah, Desrosiers, Champoux, and Bedard (2005) highlighted the consequences of aggressive behaviour in long-term care facilities as pertaining to the aggressive resident, family members and friends, and health care providers, with no mention of other residents. Leonard, Tinetti, Allore, and Drickamer (2006) conclude that resident aggression is a major cause of distress among staff, aggressive residents, and injured residents, but their study used secondary data (Minimum Data Set) to examine correlates of resident aggression. It seems that concern for safety and prevention of injury to non-aggressive residents is extrapolated from concern for safety and prevention of injury and distress for staff, and there is very little information on resident injuries. The exception is the secondary data analysis study by Shinoda-Tagawa, Leonard, Pontikas, McDonough, Allen, and Dreyer (2004) where Minimum Data Set information was analyzed to identify and count the resident injuries that were inflicted by other residents.

Much less research exists on aggression and concerns for privacy, and what is known seems to come serendipitously from research not focusing on resident concerns. For example, Ryden et al. (1999) suggested that placing several residents with cognitive limitations in the same hallway might exacerbate their aggressive behaviour. This is a tenuous link to the concern for privacy but Ryden et al. go on to state, "The density of residents in common areas resulted in a highly stimulating environment where frequent interactions occurred among volatile residents who were likely to invade each other's personal space" (p. 175). In the literature reviewed for this thesis research, there was no mention of resident's need or concern for 'peace and quiet'.

Theme of Concerns about Aggression and Sub-theme of Focus

The second sub-theme under the theme of concerns about aggression was 'focus', and the residents' focus of concern during the aggressive incident might be: self; others

including staff; other residents; and the aggressive resident. It should be noted that when residents were concerned about themselves, it was a concern for physical harm. They did not at any time suggest any concerns for themselves in relation to emotional or psychological insult.

Concern for self was expressed in ten incidents noted by seven of the residents (all but Resident #2). Of the 10 aggressive incidents, six involved the residents as victims and four involved the residents as observers. The previous incident described by Resident #3 is one example. In this incident, the aggressive resident had entered Resident #3's room thinking that it was his own, and there was some pushing that took place as the aggressive resident was leaving the room. Resident #3 stated, "I was angry, fearful, he was bigger than me. As quickly as I could, I got to my alarm to call someone and they finally came to get him out of here".

Another example of self-concern was given by Resident #5. The situation is interesting because it involves Resident #5's accidental intrusion into the aggressive resident's room: "...I accidentally walked into his room and he became aggressive. There was no physical activity but it was in his voice." The resident added, "I walked into his room and apologized but he didn't take the apology and raised his voice." The uniqueness of this incident is that the resident's intrusion resulted in an aggressive action to himself, rather than the aggressive resident intruding into someone else's personal space.

A final example of self-concern is illustrated when Resident #8 observed another resident who was "...screaming and whipping things off the table...I was in there and he was yelling. He didn't know who I was. We've been together three years here and he didn't know". Resident #8 left the situation and proceeded to his room for safety.

Residents also indicated that their focus of concern could be others, including staff members. Resident #3 spoke generally of concern and sympathy for staff members: "I don't think that they [aggressive residents] are acceptable but they are understood and I feel for the staff because there is nothing they can do, they have to put up with it". He also described a specific situation where a resident was verbally and physically aggressive toward a staff member: "He began to swear and push her, she handled it okay. I was worried about her but she handled it okay".

Resident #2 described a situation where an aggressive resident became increasingly angry and was shouting. The staff took this aggressive resident to his room and Resident #2 stayed in the vicinity, saying "I wanted the opportunity to come to help them [staff]". Resident #2 remained outside the aggressive resident's room "just to listen, to see how he was behaving...I was there as protector of the staff. They wouldn't have known what he might do". This remarkable liaising was also extended to the aggressive resident. Acting as a "big brother", Resident #2 would say to staff, "...leave him alone and time will tell. If he is getting aggressive just go to his room or to the office because he will follow you because he still wants to be aggressive".

Resident #1 described an aggressive resident who used to be on his unit and his concerns are for both staff members and other residents: "There was one who was violent, he hurt nurses and he hurt other residents here...I used to holler at him to let the nurse go or the person that he was attacking".

The literature on resident aggression does not attend to resident concerns generally, nor in relation to the focus of concerns, be it themselves, staff members or other residents including the aggressive resident. However, it is reasonable to assume that residents would be concerned for their own safety. Residents in personal care homes do

not live in isolation of their caregivers and other residents, and that within that milieu, there may develop some fellowship, friendship, or acquaintanceship. Taunton, Coffland, Pedram, Piamjariyakul, and Bott (2006) speculated on the 'community' of a nursing home. Based on their resident satisfaction survey data, they have suggested that residents seem most satisfied in their community when, among other things, they shared an interest or a joke with staff members. So, it should not seem unlikely that residents who observe resident aggression toward staff members would sympathize and be concerned for the safety of the staff member. Similarly, residents would be concerned about the safety of fellow residents in their community.

An interesting 'non-concern' was voiced by several of the residents when they seemed to dismiss the severity of the aggression once the incident was over. After observing physical aggression, Resident #1 denied feeling embarrassed, sad, flustered, or shaken by the incident. Resident #6 claimed, "I have never been afraid". When the investigator asked about fear or feeling afraid, most residents' responded in the negative. It may be that these residents have developed ways of dealing with aggressive behaviour that has given them some level of comfort and self-assurance.

The finding of 'non-concern', that is, of dismissing the severity of the aggression once it was over, may provide an insight into the suspected under-reporting of aggression. Ferns (2006) speculated that the life experiences of individual nursing staff related to the likelihood of their reporting an aggressive incident. Almvik, Rasmussen and Woods (2006) suggested that when aggressive behaviour becomes intrinsic to care ('part of the job'), the result is an under-reporting of incidents. Perhaps residents' 'non-concern' is related to their current life experiences, and the frequency of aggressive incidents (on

the personal care unit) may lead to a dismissive attitude—because it is ‘part of the life’ of the community.

This finding of ‘non-concern’ or dismissiveness after the incident is over, deserves maximum attention because it suggested two possible and quite disparate explanations. The first explanation is that residents possess a kind of resilience in minimizing the aggressive incident. The second explanation, with more serious implications, suggests an acceptance, normalization, or event apathy toward aggressive incidents in residents’ home environment.

These speculations lead to discussion of the second theme for research question #1: *coping strategies to deal with aggression*.

The second theme was *coping strategies to deal with aggression*, and the two sub-themes are (a) *types of coping strategies* (call for help, avoidance, and ‘handle it myself’); and (b) *sources of coping strategies* (learned from family, notably their fathers; military service; work; and education).

Theme of Coping Strategies to Deal with Aggression and Sub-theme of Types of Coping Strategies

The questions on concerns emanating from being either an observer or a victim of aggression lead to questions about reaction and action. The types of coping strategies identified by residents fell into three groups: call staff for help; avoidance; and ‘handle it myself’.

Of the 34 times a post-incident strategy was found in the interviews, about a third of the comments related to the presence of staff members being prepared to handle any situation, on duty and ready, with a plan, ready to respond to a call for help. The

pervasiveness of this strategy, 'call for help', underscores the perception that residents have of staff as responsive and competent to handle the situation.

Resident #1 stated, "I know there is enough staff members to handle it and they have a plan. They have security here too if things get that violent". Resident #2 explained what he would do if he needed help, "I would press the call button, it is for help. You press it and they [staff] come to the door and they would know he [aggressive resident] was there...They know he shouldn't be there. So that's the answer right there". Resident #6, having discovered an aggressive resident in his room, described his coping strategies: "You don't know how bad that man [aggressive resident] is. What I do is just mind my own business and press my buzzer and a nurse comes in and tells him he's in the wrong room and out he goes".

Another strategy to deal with the aggressive behaviours of other residents was avoidance. The investigator asked Resident #4 how he reacted to other residents yelling during the day and night. He said, "I don't know because I don't even know who the people are". A more concrete example of avoidance is evident from the previous paragraph with Resident #6, who says he minds his own business and then asks the staff for help. Resident #7 attempted to avoid a situation that was in the making: "...Depending where you are, you can often see messy situations building up and in which case you are better off somewhere else". Resident #8 recalled a friend he had made on his personal care unit who had become aggressive. After observing an aggressive incident involving this friend, Resident #8 stated he did not feel sad or afraid: "No. I just left".

Residents listed a few of the strategies that they used to "handle it myself". A few residents spoke of staying calm and cool. Resident #8 noted his past experience dealing

with difficult situations saying, “You learned to keep your cool. A couple of times I had the daylights scared out of me but you learned”. Resident #7 stated, “...the more I’ve traveled the more I have learned to deal with minor incidents that happen”. Resident #2, who saw himself as a protector to staff, stated that he would just “listen”, presumably to discern whether his input was required to defuse a situation. Humour was noted as a strategy by resident #3 who stated, “I would try to humour him [the aggressive resident] or something, find some means to get through to him, such as, ‘Hey, you can’t go to my bathroom, your bathroom is four doors down to the left’”.

Although the literature on resident aggression emphasizes the coping strategies of staff caregivers and has not examined those of residents, some comparison can be made. Residents speak of calling for help, avoiding the situation, and handling it themselves. These first two strategies are clearly not relevant to staff members, and the literature emphasizes staff training to prevent and manage aggressive behaviour. The major interventions fall under the rubrics of behavioural, physical, and chemical interventions (Olson, 2002; Martin & Boucher, 2005). “Handling it myself”, the third resident-reported strategy, is what staff members do using prevention and behavioural management interventions (Fagan-Pryor et al., 2003). In addition, the literature emphasizes a broader perspective on prevention and management using a multifaceted approach incorporating policies on staffing, environmental modifications, and one-to-one interventions. Residents, by the nature of their roles on personal care units, focus their strategies at the individual level. The investigator did not ask if residents ever discussed incidents of aggression among themselves, that is, within their own social network.

The question was not asked—but it might have been useful to ask residents if there was any feedback or debriefing that occurred after the aggressive incident.

Education and training of staff focuses on the development and reinforcement of appropriate coping and intervention strategies. Similarly, it might be beneficial to provide informal education and support of residents who observe or are victims of aggression. This debriefing might reinforce a resident's appropriate coping strategies and encourage safe conduct, such as calling for help.

Theme of Coping Strategies to Deal with Aggression and Sub-theme of Sources of Coping Strategies

Although the investigator did not ask a specific question related to how residents had developed their coping strategies in relation to aggressive resident and incidents, several of the residents volunteered information on where and how they developed these strategies. Generally speaking, their coping strategies were learned from family, notably their fathers; military service; work; and education. Resident #5 talked about his father who was a "calm man" and how he learned patience from him: "Patience. No one seems to have patience anymore. Anger seems to play a large part". Resident #8 said that he learned to "keep his cool" during his service with the navy. Resident #7 indicated that he learned to stay calm and in control because of a number of experiences: "I probably learned it [calm, cool] from school, from my father, and from the services". Resident #3 attributed his calm approach in dealing with aggressive behaviour to his work in a helping profession: "So my background in [the helping profession] puts me in a position of not getting unduly excited or upset or angry. I've seen lots of this".

Research Question #2: Meaning of Aggression

Research question #2 asked, *What meaning do residents who have been observers or victims of aggression assign to this behaviour?* The theme that emerged from the data was 'the aggressor is not himself', and this person is not himself because the dementia

has taken over him or something else has burdened or stressed him (pain or sadness). References to dementia, confusion, or Alzheimer's Disease are common (mentioned 33 times) in relation to the meaning of aggression assigned by residents.

In describing an aggressive resident, Resident #1 states, "It's Alzheimer's eh, those are the worst. Guys with Alzheimer's are the worst. The average guy is pretty good...A lot of them have Alzheimer's so they are badly confused". Similarly, Resident #2 explained, "He [aggressive resident] is not a desperate man, or a cruel or hard man. He is just confused. Confusion, loneliness, sadness, aggression comes into the picture". Resident #3 stated that aggressive residents are "forgetful", and "mentally out of it".

Resident #4 described a verbally aggressive resident whose "mind had started to go": "They [aggressive resident] might want their pills and yet they've already had them and they don't think they did and they start swearing". Resident #6 described his frustration and anger with a situation of invasion of privacy but softened those feelings as he spoke: "There is always someone worse than you. Sometimes you come from the dining room to your bathroom and you ask what they [aggressive resident] are doing there and they can't answer you, they don't even know. A lot of them have Alzheimer's Disease. A lot of times, I think to myself I should get a cup of water and let him have it and then I think why would I do that? It gets you mad enough though when someone is using your toilet...but you have to see where it is coming from. The guy himself doesn't know what he is doing".

Although dementia or Alzheimer's Disease was frequently mentioned, there was a second explanation of 'meaning' for aggression—something had burdened or stressed the aggressive resident. Only two residents did not mention cognitive limitations in relation to the meaning of the aggression. Resident #7 spoke about aggression in relation to a

resident who slammed his cup on the table and suggested that it could simply be a situation of 'emphasizing a point'. Resident #8 attributed the aggressive resident's behaviour ("screaming and whipping things off the table") to being in a "lot of pain". According to Resident #8, this aggressive resident was given morphine for his pain and died three days later. Resident #1 also mentions pain as giving meaning to the aggressive behaviour: "We had one fellow in here who had a cane and had severe pains in his leg and whenever that happened, no matter what time of day or night, he was pounding on the bloody walls screaming for the nurses to come help him".

There are two other examples of stressed or burdened residents becoming aggressive. Resident #2 addressed the notion of events triggering and causing the behaviour: "It all depends on the circumstance. You have to know what started this, it may be a letter or someone said something to him...A letter, he got in the mail, maybe he doesn't like it. Any little thing can trip someone off". Resident #3 provided an example of an aggressive resident who had come to Deer Lodge Centre against his will: "She [his sister] brought him in and he wasn't happy about coming in. Now this same resident finally settled in but has been at times aggressive, forgetful". Speaking generally, Resident #3 went on to say, "I'm sure some of it [aggression] is related to their background, some of them are angry people, not just angry over this institution but angry in relation to their life, their upbringing. Like I said some of them are angry because they are brought in here by family".

The responses from residents seemed to fit with the two theoretical models of resident aggression: the Progressively Lowered Stress Threshold (PLST) model (Hall & Buckwalter, 1987) and the Need-Driven Dementia-Compromised Behaviour (NDB) model (Whall & Kolanowski, 2004). The models take into account the role of dementia-

based limitations, stress, and unmet needs, and take 'blame' away from the offender. Similarly, in attempting to attach meaning to aggressive behaviour, the eight residents demonstrated forbearance, understanding, and even perhaps an implicit forgiveness, by taking blame away from the aggressive resident.

The frustrated yet understanding attitude of the residents might be based in underlying feelings about their own situation and vulnerability. This is of course, pure speculation, but it may be that as residents have viewed the progression of dementia, pain or sadness in other residents, they have felt their own vulnerability to these forces, and have projected the kind of attitude that they themselves in a similar positions might wish to enjoy.

Research Question #3: Residents' Perception of Aggression in their 'Home'

Research question #3 asked, *How do residents who have been observers or victims of aggression perceive their 'home' setting in relation to their experience with aggressive behaviour?* Specifically, residents were asked if they considered Deer Lodge Centre to be their home and how the experience of aggression affected their home life. Six of the eight residents indicated that this was their home. Of these six, one described himself as being "stuck here for the rest of my life". Two other residents spoke more positively, saying "Well, it's [Deer Lodge Centre] the best place. I couldn't live by myself. I couldn't look after myself", and "I call it my residence. That's what they call it. That's what I call it. They take good care of me here and help me out".

Of the two residents who said that Deer Lodge Centre was not their home, one resident stated that he had two homes, the first was the one he left in the community and sometimes returned to for visits, and the second was at Deer Lodge Centre, but he refused

to call it 'home'. The other resident indicated that he did not consider Deer Lodge Centre to be his home, but rather, "This is just a place along my lifeline that I'm staying at".

The responses from residents to how the experience of aggression affected their home life were varied, and it is difficult to categorize them into themes or patterns. It may be that the question itself was not as clearly developed as it could have been, or it may be that near the end of the interview, residents were not as attentive.

The residents did not appear to make a connection between their home and aggressive incidents. A few residents seemed to take a practical or accepting approach, sometimes with a sense of resignation. Resident #4 seemed to want more peace and quiet in his home: "Well sure, it could be a bit more peaceful but our floor is a pretty good one. I guess [I would like it more peaceful]". The investigator asked Resident #6 how he would feel if he found another resident in his room—would it feel like his home was broken into? The resident replied, "No, because there are no locks on the room", and added, "I don't like it but that's the rules". When asked if he keeps his door closed, he replied, "No, there is no point".

Other residents seemed indifferent, indicating that aggression was part of life and had been part of their lives before coming to Deer Lodge Centre. Resident #1 referred back to his school days, saying, "We all got beat up at school". Resident #3 recalled his wartime experience and the acceptance of circumstances as they existed then and as they exist now.

The literature on personal care homes as 'home' is limited, and a better understanding of how and why residents do and do not view their residency in a long-term care 'home' is still to be captured. Although analysis of length of stay and feelings of home could not be stringently undertaken, the data suggested that this is not a strong

relationship. Residents who had lived in Deer Lodge Centre for a short period of time (less than 6 months) versus a longer period of time (more than 4 years) might indicate that this was or was not their home.

However, the literature suggested that adjustment to personal care home life is highly individual, and factors associated with adjustment are not well understood (Hammer, 1999). The literature also suggested that it may be attachments formed with others (other staff or residents) that contribute to a resident's feeling that this is 'home' (McIntyre & Freeman, 2003). The investigator did not ask questions about personal attachments (fellowship, friendship, and acquaintanceship) so it is not possible to speculate from the data. However, this remains an important topic for further examination.

Additional Questions

Two additional questions were asked at the end of the interview: (a) *As we have been talking about aggressive behaviour, have you been reminded or have you thought of something connected to your experience?*; and (b) *Is there anything else you would like to tell me?*

There were very few responses to the first question and none to the second question. Response to the first question included Resident #5, who indicated that he had been in charge of men during the war and had learned how to handle things. Resident #8 recalled being ill-treated by his father: "I had a brother who was Dad's favourite and anytime he did anything wrong, I would get blamed for it, I sure would get it".

Summary:

The residents who were interviewed were relatively independent on their unit once they received help with getting washed and dressed in the morning. They were

optimistic regarding their health and quality of life. The residents' concerns about aggression from other residents were based on their desire for safety, privacy, and peace and quiet. Major coping strategies include calling for help, avoiding the aggressive situation, or simply handling things on their own. The sources for these coping strategies include family upbringing, military training and experience, work experience, and educational pursuits. When asked about the meaning of aggression, most residents seemed to indicate that circumstances had affected the aggressive resident so that he 'was not himself'. These circumstances include several mentions of dementia and Alzheimer's Disease, and other stressors, such as receiving a letter, or being relocated from the community to Deer Lodge Centre. When asked about their experience of aggression and their sense of home, the residents responded with acceptance, and for some, a sense of resignation about their relocation to Deer Lodge Centre.

Chapter Five: Discussion and Recommendations

This thesis research was undertaken to answer three questions:

1. *What are the concerns of residents who have been observers or victims of other residents' aggressive behaviour?*
2. *What meaning do residents, who have been observers or victims of aggression, assign to this behaviour?*
3. *How do residents who have been observers or victims of aggression perceive their "home" setting in relation to their experience with aggressive behaviour?*

This chapter presents the limitations of the thesis research and provides a discussion of the findings that leads into recommendations for clinical practice, policy, and future research. The final section is a conclusion from the investigator.

Limitations

The limitations of the thesis research are several, and include considerations of sample selection and size, the type and length of the data collection, and the questions that were asked during the interviews. A major strength of this thesis research should also be noted and that is that it sought to explore a neglected area within the larger research area of resident aggression in long-term care. This thesis research asked older residents in personal care home units to speak about their personal experiences of resident aggression in terms of their concerns and the meaning assigned to these experiences, including the impact on their perceptions of home. This research therefore stands as a beginning step to further work that focuses on residents' perspectives.

The study included a small sample size that was limited to men—specifically to men who served in the Second World War—and their perspectives may be grounded in their gender and cohort ('old-old' and veterans). The residents who agreed to be

interviewed are clearly a self-selected group and form a convenience sample which naturally curtails generalizability.

The residents who were interviewed revealed themselves as 'men of few words'. The investigator found that all eight residents were eager and personable, willing to answer most questions, so their parsimony does not appear related to any reticence in taking part in the study. It connotes, however, the difficulty in eliciting detailed descriptions from 'men of few words'. The investigator has been an associate member of the Royal Canadian Legion for more than 25 years, related to a parent (father) who served six years overseas in Europe during the Second World War. This helped to establish rapport with the residents.

The investigator chose to do face-to-face interviews, and not to undertake a multi-method approach that might have included participant-observation or focus groups. In retrospect, follow-up focus groups might have contributed to the richness of the data. The data were collected during a three week period in March 2007, and this plan was based on discussion between the investigator and the thesis advisor. The investigator, who works full-time in community nursing, needed to be highly flexible in his availability to recruit and interview interested residents. This fairly compressed time period of data collection may not have allowed the time usually accorded in qualitative research to examine the data and maximize follow-up questions.

As with most research, a limitation lies in the questions that were not asked, questions that may have added to our understanding. For example, the concept of 'home' in personal care homes was not fully explored, specifically the relationship to feelings of 'home' and the development of personal attachments. Similarly, the idea of 'community' in personal care home units could have been further explored, including the idea of a

network of residents and whether or not aggression is ever discussed within these networks. As a final example, the 'non-concern' exhibited by some residents could have been followed-up with more questions.

Discussion

This section provides a brief summary and discussion of findings for the three research questions. This section is organized according to the questions.

Research Question #1

Research question #1 asked, "*What are the concerns of residents who have been observers or victims of other residents' aggressive behaviour?*" Residents responded with three concerns: safety, privacy, and 'peace and quiet'. In terms of safety, they went beyond thinking only of their own safety and included staff and other residents, including aggressive residents. It was expected that residents would talk about concern for their own safety, but it was not anticipated that privacy would also be a dominant issue. Although the concern for 'peace and quiet' was mentioned, it was not to the same extent as safety and privacy. The research on concerns about aggression in the literature is nearly all focused on the concerns of staff, and concerns for staff (safety, injury, and lost work). Concerns of residents and concerns for residents seems to be an extrapolation of staff concerns. We need to know much more about resident concerns for safety, but also concerns for privacy and 'peace and quiet'. Residents also indicated a concern for others in their environment, and if we knew more about the personal care community and meaning of 'home', we might gain a better understanding of the root and motivation of this concern.

Along with sharing their concerns, residents spoke of their coping strategies (call for help, avoidance, and 'handle it myself'). These strategies are all at an individual level,

and we do not know whether or not residents discuss their concerns with a network or community of residents or with members of staff—the question was not asked. Again, learning more about the community aspect of personal care home units and dealing with aggression might be quite enlightening. What was adamantly clear from residents' responses was their trust and confidence in the staff to step in, as needed, to protect their safety. Calling for help and knowing that help would be forthcoming was a common perspective.

Finally, the 'non-concern' exhibited by residents after the aggressive incident ended is of critical importance. The dismissal of the incident might be related to resilience and a lifetime of dealing with periodic difficult situations. Alternatively, it may be related to apathy, acceptance, and a normalization of aggression in the community of the personal care home resident. This has serious implications for residents' mental health and quality of life.

Research Question #2

Research question #2 asked, "*What meaning do residents, who have been observers or victims of aggression, assign to this behaviour?*"

The responses from residents indicated frustration, but also forbearance and an understanding that the aggressive resident 'was not himself'. The aggressive resident escaped blame because 'he was not himself'; instead, he was afflicted with dementia or Alzheimer's Disease, or he was under the stress of relocation or experiencing pain. The attitude of the residents seemed to reflect the two theoretical models of resident aggression: the Progressively Lowered Stress Threshold (PLST) model (Hall & Buckwalter, 1987) and the Need-Driven Dementia-Compromised Behaviour (NDB) model (Whall & Kolanowski, 2004). As indicated earlier, residents' frustration coupled

with an understanding attitude might be based in underlying feelings about their own situation and inherent vulnerability. They may have felt their own vulnerability to these forces (dementia, sadness, and pain) and have projected the kind of attitude that they themselves in a similar position might wish to enjoy. It may be that the old adage, 'do unto others as we would wish others to do to us', is evident here.

Research Question #3

Research question #3 asked, "*How do residents who have been observers or victims of aggression perceive their 'home' setting in relation to their experience with aggressive behaviour?*" Residents were equivocal in their feelings about 'home' in the personal care home unit, and a greater understanding of the meaning of home is needed before questions about aggression can be placed in context. We also need a better understanding of factors associated with adjustment to living in long-term care and how personal attachments are made and sustained in that environment.

Recommendations

The investigator's recommendations from this thesis research fall into three categories and are recommendations for: policy, clinical practice, and future research.

Policy Recommendations

At a broad level, policies in long-term care coupled with clear procedures and training can address the concerns and meanings expressed by residents in relation to aggression emanating from other residents. One recommendation is that debriefing and informal education of residents who have observed or been victims of aggression be embedded in a policy. The implementation of this policy will involve formal training of staff in the concerns expressed by residents not only for their safety, but also for their privacy and for 'peace and quiet' on the unit. Staff training will also involve education

and understanding the strategies expressed by residents (calling for help, avoidance, and taking care of it themselves). Debriefing and informal education would seem to be appropriate for visiting family and friends.

Second, if information on the prevalence of resident aggression—specifically resident aggression toward other residents—is not routinely collected, this should become a policy. The extent of resident aggression and the factors associated with it will assist decision-makers in pursuing changes in relation to staffing and the physical environment.

While it is not clear how this might be done, it is of great importance that staff hear what residents have to say about the trust placed in their hands, and the confidence they have for protection and care.

Clinical Recommendations

In relating aggressive incidents, residents expressed concern about their safety, privacy, and 'peace and quiet' on the unit. While the concern for safety seems obvious, the other two concerns may not be so obvious. On a day-to-day basis staff need to remember that privacy and 'peace and quiet' were also important concerns of residents. Similarly, staff might gain an appreciation that these residents can be quite resilient when dealing with aggression. This resilience might cover an underlying apathy or normalization of aggression in their home environment that has serious implications for residents' mental health and quality of life.

A major message for staff is that residents trust and have confidence in their forthcoming assistance when an aggressive incident occurs. Furthermore, residents are concerned about staff safety and the safety of other residents, including aggressive residents. There is little empirical support for the supposition that residents' feelings of home are related to the personal attachments that are developed in their personal care unit

or community. However, this seems intuitively sound, and staff are a major part of the social milieu of residents' home life in personal care units.

Finally, if the forbearance that residents exhibit toward aggressive residents is embedded in feelings of their own vulnerability, then staff must be careful whether or not blame is assigned to behaviour that occurs because an aggressive resident "is not himself". What is said by staff may be taken to heart by a non-aggressive resident who has concerns for his own behaviour at some time in the future.

Future Research

This exploratory research on aggression in long-term care and residents' concerns and perspectives on the meaning of this aggression, including the meaning of aggression in relation to 'home', has opened several avenues of future research. This research was limited to a small sample of self-selected male residents who served in the Second World War. Clearly, we could ask many more questions including questions that relate to gender and a younger cohort.

First, we need to know more about not only the prevalence of resident aggression but also the prevalence of resident aggression toward other residents. Second, we need to know more about residents' concerns, in particular concerns for privacy and 'peace and quiet', and about their strategies for coping with aggression. Third, we definitely need to know more about the apparent 'non-concern' that occurs after the aggressive incident ends.

Fourth, we need foundational research to be undertaken on the meaning of home for residents who live in long-term care and the factors associated with facilitating adjustment and feelings of home within a facility environment. Questions might be in relation to: with whom do personal attachments (fellowship, friendship, and

acquaintanceship) develop and sustain themselves; how comfortable are staff with the concept of personal attachment; is this a personal care home unit 'community' and how do social networks among resident grow and flourish?

Conclusion

This research was undertaken to answer three questions related to resident aggression in long-term care. After interviewing eight veterans of the Second World War, their thoughtfulness is expressed not only through concerns for themselves, but also for others. Despite limitations on the sample size and the extent of the interview process, the wisdom of the residents—men who have been through so much—provides us with uncommon insight into aggression in long-term care. Understanding residents' concerns for safety, privacy, and peacefulness needs to be understood. Just as importantly, non-concerns may connote an underlying apathy or a normalization of aggression in their 'home'.

By providing these insights, all of us are empowered to use the increased awareness of these important and often overlooked issues, to acknowledge their impact, and to work toward ways of making life in long term-care better.

Appendix A: Resident Inclusion Criteria

For this project, eight residents of personal care or chronic care are required for interviews. The interviews are expected last about one hour, possibly longer. A second interview may be scheduled if necessary.

The residents *must*:

- have lived on the unit for at least three months
- be male
- speak English and able to converse with the interviewer
- have observed or experienced aggressive behaviour from another resident

Aggressive residents will not be interviewed.

Appendix B: Nurse Manager Script

Hello Mr. _____

A nursing student in a Master's program from the University of Manitoba is doing a study of how a resident might feel when they see or hear another resident acting aggressively toward another person, maybe even yourself.

The student's name is Dan Lapuk and he would like to interview about 8 residents at Deer Lodge Centre who are willing to talk about other residents' aggressive behaviour and how it makes them feel. The interview might take about 60 to 90 minutes, but it could take place at different times and whenever and wherever you choose. The questions ask about your background, your health, and your perspective on other residents' aggressive behaviour.

You do not have to agree to participate but if you are interested in hearing more about it, I will let Dan know and he will contact you with further information and then you can decide if you want to participate or not. Feel free to speak with a family member about your participation in the project. A family member is welcome to be present during your interview with Dan.

Would you like me to contact Dan on your behalf? Are there any questions?

Appendix C: Resident Consent

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

I am a graduate student in the Master of Nursing program at the University of Manitoba. The purpose of this project is to provide a description of the experience of aggression from the perspective of residents who have observed or been victims of aggression and the impact of this experience on their perception of their "home" at Deer Lodge Centre. Your participation involves talking part in an interview that asks about your background (such as your age and family status) and health characteristics (such as illnesses and how you see your health), and about your concerns, your understanding of other residents' aggressive behaviour and how it makes you feel about your home here at Deer Lodge Centre. The interview might take about 60-90 minutes and we can break it into two or three meetings. We can meet wherever you choose to meet and at your convenience.

There are no known risks associated with participation in this project, however, this topic may cause you some discomfort. You may choose to answer some or all of the questions. If you find any of the questions about aggression to be upsetting, we can stop the interview and you can decide whether or not you want to continue. The interview will be audiotaped and later transcribed so that I can read about what you said. Once I have

Appendix C: Resident Consent (continued)

had an opportunity to read what you have said, I would like to ask you if I correctly understand what you have said. When I report my findings from this project, I will be reporting on what a group of residents like you have said. If I quote what you say in my report, I will not identify you by name or by any other identifier. All of the information that I collect will be kept confidential except if I discover any incident of abuse. The Protection for Persons in Care Act requires that I report any incident of abuse that might come to my attention during this project.

I will not disclose your participation in the project. My advisor, Dr. Guse, will have access to the transcription of your interview and the information from the background and health questions but she will not know who you are. About two years after my project is completed when the findings have been reported, then I will destroy all of the tapes, transcriptions and questionnaires. In the meantime, I will keep all this material safely in my home and Dr. Guse will keep the transcriptions and questionnaires safely in a locked cabinet in her Deer Lodge Centre office.

If you are interested in receiving a summary of the findings from this project, please indicate so at the end of this consent form. I will send or deliver a summary of findings.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from

Appendix C: Resident Consent (continued)

answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

This research has been approved by the Education Nursing Research Ethics Board of the University of Manitoba. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at 474-7122, or e-mail ethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

 Participant's Signature

Date

 Researcher and/or Delegate's Signature

Date

I would like to receive a summary of the findings. My name and contact information is given below:

Appendix D: Education/Nursing Research Ethics Board Approval Certificate

APPROVAL CERTIFICATE

06 November 2006

TO: Dan Lapuk (Advisor L. Guse)
Principal Investigator

FROM: Stan Straw, Chair
Education/Nursing Research Ethics Board (ENREB)

Re: Protocol #E2006:048
"Concerns and Meaning of Resident Aggression in Long-term Care:
Perspectives from other Residents"

Please be advised that your above-referenced protocol has received human ethics approval by the **Education/Nursing Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement. This approval is valid for one year only.

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

Please note:

- if you have funds pending human ethics approval, the auditor requires that you submit a copy of this Approval Certificate to Kathryn Bartmanovich, Research Grants & Contract Services (fax 261-0325), including the Sponsor name, before your account can be opened.
- if you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

Appendix E: Sociodemographic Questions

Before we get started on the questions related to aggressive behaviour by other residents, I have some questions about your background and health. The answers to these questions will be grouped together to describe the group of people who participated in this research.

In which year were you born (age):

Are you married?

Do you have children?

Do you consider yourself to be a member of an ethnic group? If so, which group?

Do you consider yourself to be a member of a church or religious group? If so, which group?

Have you ever been in the military?

In which year (or month) did you arrive at Deer Lodge Centre?

What kind of work have you done for most of your life?

Appendix F: Health Questions

Do you have any chronic illnesses? If so, what are they?

Are you able to do most things for yourself, do you need a little help, or a lot of help with:

Grooming

Bathing/washing

Dressing

Walking/Getting around

Eating

How would you rate your health? Excellent, Very good, Good, Fair, Poor?

Do you often feel sad or depressed?

How would you rate your quality of life? Excellent, Very good, Good, Fair, Poor?

Appendix G: Sociodemographic Summary

Table G1

Average age	85 years
Range of Age	81-92 years
Widowers	5/8 = 62.5%
Married	3/8 = 37.5%
Average number of children	3
Armed service	Army = 4/8 Navy = 2/8 Air Force = 2/8
Average length of armed service	4 years 4 months
Range: length of armed service	3 months to 6 years
Average length of stay	2 years 4 months
Range: Average length of stay	4 months to 5 years
Career	Blue collar = 4 White collar = 4

Appendix H: Health Questions Summary

Table H1: Self-Reported Chronic Conditions

Rheumatoid arthritis	3/8
Diabetes I	2/8
Congestive heart failure	2/8
Diabetes II	1/8
Cancer	1/8
Obesity	1/8

Table H2: Activities of Daily Living

	Self	Little help	Lot of help
Grooming	5/8	3/8	---
Bathing	---	4/8	4/8
Dressing	---	5/8	3/8
Walking	7/8	1/8	---
Eating	8/8	---	---

Table H3: Self-Rated Health

Excellent	Very Good	Good	Fair	Poor
---	1/8	4/8	2/8	1/8

Table H4: Self-Rated Quality of Life

Excellent	Very Good	Good	Fair	Poor
---	---	5/8	3/8	---

Appendix I: Research Questions

Research Question #1:

I would like you to describe a situation that you experienced (heard or saw) when another resident behaved aggressively either towards you or another person (staff, another resident or family)?

1. Can you tell me about what happened?
2. Where did it happen?
3. When did it happen? (time of day, activity)
4. How did you react?
5. How did this situation make you feel?
6. How did you handle your feelings? Did you talk to someone?
7. What were your concerns? (Probe: Safety, injury, anger or other concerns?)

Research Question #2:

8. Why do think that some residents act this way?
9. Is there a way to "understand" this kind of behaviour?
10. Do you think that sometimes or in some circumstance these behaviours are acceptable?

Research Question #3:

11. This is your "home". How does the experience of this kind of behaviour affect your home life?

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