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# The Effect of Playback Theatre on Managing Elderly Bullying in Senior Communities

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The Effect of Playback Theatre on Managing Elderly Bullying in Senior  
Communities

by

Jennifer E. Rooney, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. The project is neither a Master's thesis nor a dissertation.

# THE EFFECT OF PLAYBACK THEATRE ON ELDERLY BULLYING

## Abstract

This qualitative research project explores the long established social problem of bullying among the expanding population of adults over 65. One of the main goals is to identify effective interventions in addressing the problem, specifically Playback Theatre.

Grounded theory was implemented in data analysis. The social work theory of Person in Environment (PIE) and Systems Theory were used as the theoretical framework for formulating questions and interpreting answers. Seven professionals working in assisted living and senior public housing were questioned regarding their observations and experiences of elderly bullying within their facilities. Data analysis occurred within a three-month period. The main theme that emerged is the lack of evidence-based interventions. Other prominent themes include: (a) what bullying looks like in the studied population, (b) where bullying most often occurs, (c) reasons for bullying among older adults, (d) what interventions are currently being used, (e) Playback Theatre, (f) use and attitudes towards art-based interventions, (g) what type of training professionals have in dealing with bullying, and (h) messages communities can use to address bullying.

*Keywords:* Older adults, bullying in elder populations, interventions, elder victims, Playback Theatre

# THE EFFECT OF PLAYBACK THEATRE ON ELDERLY BULLYING

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My love and interest in geriatric social work is rooted in my experience of being raised next door to my grandmother. She was impatient, opinionated, and very bright. I watched the way my parents cared for her and how she cared for us. She was 104 years old when she died. She would have loved this research project!

# THE EFFECT OF PLAYBACK THEATRE ON ELDERLY BULLYING

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### The Effect of Playback Theatre on Managing Elderly Bullying in Senior Communities

Bullying is a societal problem that has risen to a place of high importance over the past decade. The word “bullying” generally triggers images of kids being teased in the halls at school. The media has given significant attention to teen suicides apparently linked to bullying around the young person’s sexual identity. Another type of bullying with which most people are familiar is workplace bullying. It is less publicized, but widely recognized as a problem in recent decades.

Bullying is a well-established problem with a newly recognized population: the elderly living in community. The most recently identified social group affected by bullying is people older than 60 years of age (Hone-McMahan, 2010). For the purpose of this qualitative study, “elderly bullying” will refer to intentional peer victimization among adults over 60 years of age occurring in senior high-rises and assisted living communities. Elderly bullying will not include resident-on-resident aggression in nursing home facilities because, as the Alzheimer’s Association states, 50% of all residents in nursing homes and assisted living facilities have some form of dementia or cognitive impairment (Alzheimer's Association, 2006). The difference in regular aggression and bullying behavior in this study is intent.

The reasons for the increased bullying among the elderly are both simple and complex. The most obvious reason is that people are living longer. “The number of Americans aged 65 and older increased tenfold during the twentieth century” (Richardson & Barusch, 2006). Therefore, there is a large population of elderly people in this country and the number is growing; social problems often grow statistically with population growth.

In correlation with the increase in elderly people, there is an increase of elderly housing. Many seniors decide to downsize their homes and enter a community living residence so they

have fewer building maintenance and transportation problems. They are often looking for a home that provides help with health care, meal preparation and cleaning.

Some of the causes of elderly bullying are more complex. They include, but are not limited to: racism, the fear of limited resources, and a need for attention or status. No matter the cause, the impact can be serious. Residents may begin skipping meals to eliminate interaction with bullies in the dining areas. Victims may isolate themselves from group activities or social situations in an attempt to evade confrontation. These avoidant behaviors can cause both physical and emotional damage. Families are affected when they see their matriarchs and/or patriarchs becoming less fully engaged, especially when the digression is not organic.

While participating in a foundational field placement at Jewish Family Service of St. Paul (JFS), this author was made aware of the elderly bullying problem in the greater Twin Cities area. Managers of both public housing and assisted living facilities were reaching out to JFS searching for advice and interventions. The social work profession is being called upon to identify the behaviors and causes associated with this phenomenon and help create interventions. This paper will use interviews to identify the effectiveness of one such intervention, the use of Playback Theatre training on public housing staff in managing elderly bullying behaviors.

## Literature Review

### **Bullying: The problem**

The first step in identifying the problem of bullying is defining it. Academics differ in the key words they use to define bullying. The U.S. Department of Health & Human Services describes bullying as “unwanted, aggressive behavior that involves a real or perceived power imbalance” (U.S. Department of Health & Human Services, 2013). Bonifas and Frankel (2012) rely on the definition created by the Hazelden Foundation (2008). They also use the term “imbalance of power,” but add that it is intentional and repetitive aggression.

Just as people behave differently, bullying behavior manifests itself in myriad ways. These behaviors are generally categorized as direct or indirect. Direct bullying is considered more overt and often physical. Hitting, punching, and slapping are behaviors associated with direct bullying. Direct bullying does not necessarily have to be physical. Name-calling, making threats, and stealing belongings from others are also forms of direct bullying. Indirect bullying uses exclusion as the fulcrum of the power shift. By excluding someone, bullies increase their own feeling of power by usurping some of the power of the victim, the excluded person(s). Bullying with indirect behavior may include something as basic as not acknowledging the bullied person’s presence to gossiping or talking maliciously about the victim (McGrath, Jones, & Hastings, 2010).

Both men and women bully and both men and women are victims of bullies. Direct physical bullying is not completely a problem of males, but Bonifas and Frankel (2012) state that physical bullying is more often associated with men. Women are more likely to bully in indirect means or non-physical direct means, like name-calling.

Crick and Bigbee (1998) identify this direct and indirect bullying behavior as overt and relational. Like the previously cited research, Crick and Bigbee acknowledge overt bullying as more often occurring between males. Relational, or indirect bullying, is more often associated with female behavior. However, Crick and Bigbee propose a reason for this gender-related difference in bullying behavior. Males usually base their self-esteem on their own accomplishments, physical stature, or perceived intellect—how they view themselves. Females frequently value themselves by the quality and/or quantity of their relationships—how others see them. With that value system in mind, one can understand why women would generally bully by exclusion, while men bully by more overt means (Crick & Bigbee, 1998).

### **Victims**

Just as bullying behavior is divided into two separate categories, so is victim behavior. Most victim behavior is considered passive or provocative. An example of provocative behavior is intruding in others' personal spaces or conversation. Although this provocation behavior is generally sparked by genuine interest, those being intruded upon may consider this behavior nose-y or pushy. Those demonstrating provocative behavior may appear “deserving” of overt or relational behavior by bullies.

The more common type of victim behavior is identified as passive. These victims are targeted because of *who* they are, not *what* they do. Bonfias and Frankel (2012) note that this group is often comprised of minorities—racial, ethnic, or perceived sexual orientation. Another recent study lists social class as a factor as important as race and gender when targeting passive victims (Jette, 2013). One reason that it is difficult to break out of the role of victim is that victims are often targeted because of their obvious lack of self esteem. The low self-confidence

and self-esteem leads to a lack of self-efficacy, making it even harder to stop the bullying (Popp, 2012).

Many studies on bullying behavior focus on children and adolescents. One such study on peer victimization identifies victims as generally being physically weaker, visibly more anxious, and timid in stature. In contrast, bullies are often physically bigger, stronger, more assertive, and more impulsive than their peers. The study also reports 10% to 20% of participants identified as both victims and bullies. Those who are both victim and bully are described as aggressive victims (Mishna, 2003).

### **The Magnitude of the Problem**

The societal problem of bullying has been around for a long time, but was researched scientifically beginning in the 1970s (McGrath, Jones, & Hastings, 2010). The issue of bullying has received a lot of media attention in recent years, largely due to its implication in numerous school-based shootings (Harlow & Roberts, 2010). While acknowledging gun violence as an extreme and exceptional reaction to bullying, statistics illustrate the problem is large and widespread. A study conducted in 2001 showed 29.9% of students in the sixth through the tenth grade reported being involved in bullying as either a bully (13%) or as a victim of bullying (16.9%) on a moderate to frequent basis (Harlow & Roberts, 2010). The Kaiser Family Foundation worked with CNN on a study in 2001 that reported students ages 8-15 ranked bullying a bigger problem than racism, AIDS, or peer pressure to use drugs or alcohol (Mouttapa, Valente, Gallaher, Rohrbach, and Unger, 2004). Starting a young age, bullying is a problem with wide-reaching tentacles into many facets of society.

### **Aging and Assisted Living**

Currently, about one of out every eight people in the U.S. is 65 years of age or older. The U.S. Census Bureau predicts that number to be one in five by the year 2050 (Scharlack, 2011). With the increase in the population of those 65 and older, comes the need for both housing and care which accommodate the growing needs.

In 1999, the United States Supreme Court held in *Olmstead v. L.C.* “that states have an obligation to administer services in the most integrated setting appropriate to the individual’s needs” (Grabowski, Stevenson, and Cornell, 2012). People with mental health diagnoses were to be included in society as much as possible, not isolated. That same year Surgeon General Dr. David Satcher addressed the importance of psychological well-being in relation to the health and functioning of the elderly. He emphasized the problem of depression (U.S. Department of Health and Human Services [DHHS], 1999, p. 342).

It is during this same time period of the late 1990s when “aging in place” became a popular care model. Unlike the pre-existing, medically-orientated model, aging in place emphasizes the person as a resident, not a patient. The focus of this model is for facilities to “adjust service provision and level of care criteria to meet residents’ changing needs” (Chapin & Dobbs-Kepper, 2001). The concept is at the heart of the assisted living facility (ALF) boom. In 2009, \$450 billion was spent on care for older individuals (Brandl, 2012). Forty-five percent of all state Medicaid costs are long term care (LTC) expenditures (Cummings, 2002). LTC, commonly referred to as nursing home care, is very expensive. Although it varies with the facilities and amenities, ALFs have become a popular and generally less expensive means of residential care. In 2010, a study by MetLife Mature Market Institute reported the national

average for the cost of a private room in a nursing home was \$79,935 a year. The average cost of an assisted living placement for the same year was \$37,572 (Grabowski et al., 2012).

The goal of ALFs is to help frail elderly people live independently in a home-like environment as long as possible. Nearly all ALFs provide 24-hour staffing, meals, and housekeeping assistance. Ninety percent also provide assistance for those who need help bath, dressing, and/or taking medication (Cummings, 2002). In 2002, Cummings reported that the assisted-living industry was growing at an annual rate of 15-20 percent (Cummings, 2002).

The theory of aging in place is evolving into “aging in community.” Having social capital in a community can create positive feelings for individuals. Those positive feelings are often connected with a decrease in health risks (Eilers, Lucey, & Stein, 2007). That would suggest that the converse may be true: low social capital in community may correlate to negative feelings and possible increased health risks. Trompetter, Scholte, and Westerhof (2010) claim that although they found no studies dedicated to the association between “negative interaction and well-being in older persons,” there are so many studies linking positive social interaction with increase in overall well-being, that they conclude the association “is likely to exist” (p. 60).

### **Limited History of Elderly Bullying**

The problem of elderly bullying came into the public light on November 9, 2010 (Hone-McMahan, 2010). Nationally-publicized school shootings and heart-wrenching suicide stories associated with bullying prompted the *Akron Beacon Journal* to host a call-in event. They expected to hear a lot from school age children and their parents. They were shocked to discover the high number of senior citizens that were responding. Numerous older adults reported bullying within their assisted living or elderly high-rise communities (Hone-McMahan, 2010). This local event gained the attention of a number of national sources, including the American

Association of Retired People (AARP), *The Huffington Post*, and ABC News (Kreimer, 2012; Praetorius, 2010; Reese, 2012).

When the national news started to present the social problem of elderly bullying, it got a lot of attention in states with a high population of retired and elderly citizens. Since Arizona is one of those states, *The Arizona Republic* decided to write a story. They reached out to the Arizona State University School of Social Work to find an expert on bullying among the elderly. Robin Bonifas, PhD, MSW, was studying resident-to-resident aggression in nursing homes and assisted living facilities. She had not been focusing on bullying, simply aggression. She discussed her insights with the reporter (Creno, 2010) and unintentionally became the “expert” on elderly bullying. Since that time, she has made bullying an important part of her studies. She has frequently partnered with Marsha Frankel, Clinical Director of Senior Services at Jewish Family & Children’s Service of Boston. These social workers lecture, write, and teach on the topic of elderly bullying and possible intervention. Dr. Eleanore Feldman Barbera, PhD hosts an online resource called *My Better Nursing Home*. She had Bonifas and Frankel write a six-part blog on elderly bullying that provides a very clear picture on the basics of this newly identified issue (Bonifas & Frankel, 2012).

As previously mentioned, elderly bullying is such a recently recognized phenomenon that it is difficult to track the magnitude of the problem. Without intervention, bullying has potentially detrimental side effects for both the bullies and victims (Mishna, 2003). Research identifies childhood bullying as being an underreported problem. If that same trend of underreporting is occurring in the geriatric community, the results may be really dangerous for victims. Exclusion and avoidance can lead to depression, weight loss, and other forms of physical deterioration among older adults.

**Effects: Mental and Physical**

Richardson and Barusch (2006) state that depression symptoms increase with age. The anxiety of avoiding bullying behavior or the stress of enduring it would only exacerbate any pre-existing depressive symptoms. For example, if a resident withdraws from the dining room to avoid bullying at meal time, the effects on that resident's diet and health can become problematic in a short amount of time.

Scheetz, Martin, and Poon (2012) report that although depression is not necessarily part of the aging process, older people are more vulnerable to depression. This may be due to age-related biochemical changes or the compilation of loss and change that comes simply from living longer and experiencing more. The same report states perception of health may be the link between one's physical and mental health. That means feeling good about one's self and one's health may act as a means of maintaining that high level of mental and physical function (Scheetz et al., 2012).

A study by Knack, Gomez, and Jensen-Campbell (2011) describes bullying as the cause of chronic social pain for some. Their research shows that "chronic social pain does indeed lead to increased sensitivity to future experiences of social pain as well as a plethora of physical and mental health problems" (p. 228).

Another study which focused on the link between physical activity and depression found, "Depressive symptoms are associated with decline in physical performance in older adults" (Matthews et al., 2011, p. 495). The same study identifies physical activity as having antidepressive benefits (Matthews et al., 2011). This information illuminates how the mental/physical link can become cyclical. For example, a person may become depressed about losing physical abilities. That depression is difficult to treat without physical activity as a form

of intervention. If the same person is not being physically active, he or she is probably not getting as much social interaction. A decline in one area of the person's being can quickly cause a decline in another. Scheetz et al. (2012) describes this withdrawal as a form of depletion syndrome that occurs among the elderly.

Friedman, Delavan, Sheeran, and Bruce (2009) identify depression among the elderly as a significant public health problem. They state that an increasing amount of research indicates that "depression is often associated with greater healthcare utilization and costs for older persons" (Friedman et al, 2009, p. 669). The Centers for Medicare & Medicaid Services report that, "Total U.S. health-care expenditures will surpass \$3 trillion in 2014 and reach \$4.8 trillion in 2021" (Walters, 2013, p. 38). Elderly bullying has significant social, emotional, physical, and financial ramifications.

### **Playback Theatre: The Intervention**

In her autobiographical experience of Playback Theatre, founder Jo Salas describes it as "artistic, healing, community-building, and visionary." She follows that up by saying it is really a "synthesis of these functions" (Salas, 1996, p.1). Salas and Jonathon Fox founded Playback Theatre in Mid-Hudson Valley of New York in 1975. The concept of Playback Theatre is simple. An audience member tells a story or offers a scenario of a problem and a small group of actors play the scene back for the audience. It offers the audience a chance to witness a problem or story from the outside-in, allowing them a different perspective. Salas has now performed Playback Theatre in more than 20 countries and groups have formed in approximately 60 countries (Salas, 1996). Although it was originally designed to help the story of any oppressed group, currently it is frequently being utilized in school settings and communities with high immigrant populations.

Theatre is frequently used as an intervention with the elderly. A similar organization in Canada, Senior Action Theatre Troupes, is based on the methodology of Augusto Boal, creator of Theatre of the Oppressed. The concept of both companies is to act out a form of oppression to help audience members identify an imbalance of power. The group in Canada focuses on the issues that impact the lives of elderly people. They perform for the public, but cater to educating both seniors and professionals who work in gerontological professions (Palmar & Nascimento, 2002).

The added benefit of theatre as intervention is that it requires people to gather. It is a social event in which the elderly attendees participate even if their role is that of audience member. Community building is a benefit highlighted Diana Halperin's 2008 study of utilizing theatre with the geriatric clients. She describes her group's experience and concludes, "Social workers need to work toward building the creation of community with their clients" (p. 45).

The literature illustrates that bullying is a societal problem at all ages. The new phenomenon of senior bullying is linked to an increase in the senior population and related growth in elderly community living residences. Victimization can cause seclusion as seniors avoid community events and locations that are ripe for bullying. This seclusion can lead to depression and other serious health problems. The emotional, physical, and financial ramifications make this a problem that affects everyone. Finding solutions is the next step and is dependent on a strong conceptual framework.

### **Conceptual Framework**

This paper is written utilizing two different conceptual frameworks. The first is a social work theory called Person-In-Environment (PIE). The second framework in use for this paper is the Systems Perspective, which is rooted in numerous disciplines. While these two are separate

theories, they have a number of similarities in their approaches. The most significant difference is PIE's focus on individuals and System Theory's focus on groups.

Because PIE focuses on the interaction between the individual and his/her environment, it is a useful lens from which to observe the problem of elderly bullying in community living. The aim of PIE is to understand how elderly bullying affects human behavior (Hutchison, 2008). For many elderly people, the ability to travel out of their residential living community is either physically or logistically challenging. For some, the residential community is almost exclusively their only environment. This is another reason PIE offers an appropriate conceptual framework for the problem of elderly bullying within assisted living or elderly high-rise facilities.

The PIE classification system helps to evaluate a person's ability to cope with stress. This system utilizes four factors to gauge the individual's coping capacity: social functioning problems, environmental problems, mental health problems, and physical health problems (Hutchison, 2008). All of these areas are important when considering the population being studied and the limitations on their ability to change their environment.

From the Systems Theory perspective, "human behavior [is] the outcome of reciprocal interactions of person operating within linked social systems" (Hutchison, 2008, p. 43). Social systems are firmly linked when people share common dining space, mailbox areas, and scheduled social events, as they do in assisted living facilities. Moreover, the feeling of competition for resources that residents believe to be scarce, whether factual or imagined, can spark aggressive behavior.

Systems Theory also applies when considering gender differences and appropriate behaviors to resource availability. "Resource controlling may have coevolved with men's competitive strategies, resulting in the cross-cultural tendency for men to have more control over

resources” (Kruger & Fisher, 2014, p. 5). This may explain why men have been reported to demonstrate more aggressive and physical bullying behavior than women (Bonifas & Frankel, 2012; Crick & Bigbee, 1998).

Although systems evolve from different environments for myriad reasons, there are certain basic theoretical similarities in all groups of people known as isomorphism (Forte, 2007). In a residential living community, those similarities are covered by Maslow’s Hierarchy of Needs. The largest and most basic needs, according to Maslow, are physiological and include food and water. The next most significant need is safety, followed by a need to belong and love. Being respected, a so-called esteem need, is the next component on the hierarchy. The pinnacle of Maslow’s pyramid is self-actualization, to be fully the person one wants to be (Hutchison, 2008).

It is important to consider Maslow’s Hierarchy of Needs when utilizing the systems framework. As mentioned above residents may revert to a competitive view of their resources in a contained environment, such as an assisted living facility. An overarching goal of many successful systems is fulfillment of the greatest amount of needs for the largest number of individuals with the least amount of resistance.

In conclusion, the PIE and Systems Theory approach are beneficial tools to assist in analyzing the relationship between bullies and victims in elderly residential facilities. These two frameworks provide important background in understanding the social phenomena and possible clinical solutions for communities.

## **Methods**

### **Research Design**

This research study utilized qualitative research methods to explore the impact that Playback Theatre has on decreasing elderly bullying in senior living communities. Since this is a new intervention being applied to the new social phenomenon of elderly bullying, a qualitative study was most appropriate. The key objective of qualitative research is “exploring a topic about which little is known—especially from the ‘inside’ perspective” (Padgett, 2008. p.15).

In 2013, the St. Paul Public Housing Agency (SPHA) had two mandatory training sessions for their site managers utilizing Playback Theatre. This researcher’s initial plan was to interview at least eight of the more than 20 participants from these trainings. Although SPHA had originally shown interest in participating in this study, they chose not to endorse participation because of the scheduling and time commitment it would require of their employees. This researcher developed an alternate sampling method design.

Qualitative research requires data collection, data analysis and coding, and drawing conclusions. The data for this project was ultimately collected through semi-structured interviews and questionnaires completed by professionals working in assisted living and elderly high rise communities. Those professionals included social workers, RNs and LPNs. The goal of these interviews was to determine if Playback Theatre training was effective in enabling staff to reduce or eliminate bullying behavior among residents.

### **Sample**

The researcher conducted seven semi-structured interviews with professionals working in assisted living and public housing for seniors. In this case “semi-structured” refers to utilizing eight standard questions, while allowing for follow-up questions if there was a lack of clarity on

the part of the researcher. The professionals were all Caucasian women ranging in age from 23-66. These professionals were recruited through flyers and by word of mouth (see Appendix A). Colleagues were enlisted to help recruit and invite this snowball sampling. They passed on the researcher's contact information to possible participants. Potential participants contacted the researcher via phone or email.

Once the researcher established contact with potential participants, the researcher explained the nature of the study and emailed or mailed an information sheet (see Appendix B). Interview questions were listed on this information sheet so potential participants were fully aware of the subject and nature of the interview. Potential participants were notified that interviews would be audio recorded face-to-face; audio recorded via speaker phone; or audio recorded utilizing Skype. Potential participants were also given the option of writing out their responses to the questions and mailing or emailing them back to the researcher.

Once participants agreed to take part in the study, the researcher asked the participant which method of response they would prefer to utilize. Three of the interviews were audio recorded face-to-face. The procedure by which the interviews were conducted, audio recorded, transcribed, and stored was explained in the research information sheet (see Appendix B). Four participants responded via email. The researcher explained confidentiality to all participants before beginning each verbal interview or accepting the email responses.

To assure convenience and comfort on the part of the interviewee, the researcher allowed all face-to-face participants to choose their own interview sites. The researcher stipulated that the location had to be private enough to ensure the confidentiality of the participants. The researcher transcribed each of the face-to-face interviews to identify themes for data compilation.

The researcher used a structured interview guide (Appendix C) to ask questions of the interviewees. These questions included identifying what bullying behavior looked like in the participant's facility. Questions also addressed which interventions were being utilized to eliminate/decrease the problem of bullying, specifically the use of Playback Theatre. These interviews were semi-structured as it was important to have the ability to ask follow-up questions or encourage participants to elaborate if answers were not comprehensible or complete.

### **Protection of Human Subjects**

In order to protect human subjects, this study was reviewed and approved by the St. Catherine University Institutional Review Board (IRB) before research began. The day of face-to-face interview, each participant was asked to read and sign a consent form for research participation. The forms were locked in a filing cabinet at the researcher's home (see Appendix D). The transcripts of the audio files were kept on the researcher's private computer, which is password protected. Only the researcher and research assistant have had access to the transcripts of the audio files for data analysis. The researcher will destroy the original tape and the transcripts after the completion of the research project.

The researcher had originally submitted a proposal to the IRB with the face-to-face interview methods as the only data collection option, which was approved. The researcher then discovered that many professionals who were potential participants had difficulty committing to the research project because of scheduling conflicts. Potential participants requested the ability to interview via telephone and/or email. The researcher submitted an amendment to the original IRB proposal, asking for permission to utilize Skype or speaker phone for audio interviews. The amendment also asked permission to accept written responses to interview questions, utilizing mail, email, or fax. That amendment was approved by the IRB.

Participants who indicated they were going to submit written responses were sent consent forms (see Appendix D). They were informed these consent forms must be signed and submitted to the researcher prior to the submission of the interview responses.

### **Data Collection and Data Analysis**

The face-to-face, semi-structured interviews were audio recorded on a digital audio recorder. Those participating had access to the interview questions prior to the actual recorded interview. Face-to-face interviews were recorded for data transcription and coding. Written responses were coded as well. The interview questions explored the problem of bullying in senior living facilities and interventions being utilized. Each participant was asked if she was familiar and/or utilized one specific intervention, Playback Theatre. The researcher applied grounded theory and content analysis to analyze the data gathered in the interviews. Grounded theory was an appropriate approach due to the moderate size of this particular sample, and this type of qualitative study (Padgett, 2008). Content analysis was useful when analyzing texts or other materials for the study. The researcher performed open coding of the interview transcripts, as is the norm with grounded theory research (Padgett, 2008).

### **Strengths and Limitations**

Since elderly bullying has only recently been identified as a social problem, there is very little research on the issue and even less on intervention. This study provided the social work community with some descriptive information on the how bullying manifests itself in senior living facilities. It also identified possible interventions and focused on one, Playback Theatre. Social workers can access this research to explore possible interventions, including Playback Theatre, if they are working in communities that might be experiencing bullying. Because the interviews are from individuals dealing with the issue of elderly bullying, concrete examples are

accessible to social workers and other helping professionals accessing the research. This initial intervention exploration may act as a catalyst for other investigative studies.

A limitation to this research was the small sample size. Because all interviewees were of the same gender and race, the results are limited in scope. As this is a new focus of research, there are not extensive literature or intervention results from which to base hypotheses for this research study.

### **Findings**

The purpose of these questionnaires and interviews was to explore the reality of resident-on-resident bullying among older adults in residential community. Seven professionals, currently or previously employed in assisted living or public high-rise communities for the elderly, responded and shared their insight. Respondents were all female ranging in age from 23-66 years. Three participants were licensed social workers, two were registered nurses, and two were licensed practical nurses. Five reside in Minnesota, one in Wisconsin, and one in Texas. I will refer to these participants as participants 1-7.

### **Themes**

The professional responses illuminated eight themes associate with their knowledge and treatment of elderly bullying. These themes are: (a) what bullying looks like in the studied population, (b) where bullying most often occurs, (c) reasons for bullying among older adults, (d) what interventions are currently being used, (e) Playback Theatre, (f) use and attitudes towards art-based interventions, (g) what type of training professionals have in dealing with bullying, (h) messages communities can use to address bullying.

### **What Bullying Looks Like**

All seven participants were asked what bullying looks like among residents in their places of employment. Participant #7 responded, “Elderly bullying is defined as abuse: physically, verbally, emotionally, and spiritually.” She has witnessed all of these types of bullying. She is the only respondent who mentioned spiritual abuse. All other residents responded with examples that would fall under one of the three other categories of physical, verbal, or emotional bullying.

**Physical abuse.** Physical abuse is extreme and only mentioned by three participants. Two mentioned witnessing residents hitting one another, but reported this was a rarity, nothing they witnessed regularly. Participant #7 reported:

There was one resident that deliberately bumped into the walker [of another] resident which caused the person to fracture her wrist—and then the bully told the resident she better get out of peoples’ way or there would be more trouble.

This incident is not only physical in nature; it is both verbally abusive and emotionally threatening in nature.

**Verbal abuse.** All seven respondents mentioned exclusion as the most common form of bullying at their facilities. Participant 1 stated that bullying in her facility was “mostly verbal” and that it was “insidious.”

Participant 6 reported, “It generally takes the form of resident groups who choose a target victim and exclude them, make false statements about them or other nonverbal actions.”

Participant 7 described exclusion in her site and acknowledged it as being more prevalent among females. She observed, “Willful, destructive gossip or spreading of rumors to exclude people from their group. A nasty power game...especially women.”

**Non-Verbal Abuse.** Exclusion can be carried out by non-verbal means as well. Respondents all mentioned bullies who leave when a resident who is targeted for exclusions tries to join a conversation or group. Non-verbal bullying appears to be more prevalent in establishing power and territory with new residents.

Participant 7 identified this non-verbal attack style as “emotional” bullying. She described this display of power as “giving the silent, stare, glare treatment to some of the new residents.” She explained, “The bullies want to set the pecking order.”

Participant 2 stated that some residents may perceive exclusion, when other residents are simply fulfilling their own needs. She described a situation where a resident felt ignored when her dining companions left the table immediately after they finished eating. The companions liked to wash up and take short naps before afternoon activities began. The woman who remained at the table “felt they didn’t like her because they didn’t want to be by her.”

### **Location of Bullying**

Although participants were not asked directly, their responses identified two locations as most common for bullying: the dining room and any community recreation areas. While describing when she most often sees bullying, participant 1 stated: “in the dining room and...activity or therapeutic recreation situations is often when we see the bullying.” This makes sense as these areas are open shared space, unlike private living quarters which are acknowledged as being assigned to someone.

**Dining room.** Five out of seven participants named the dining area as the most problematic location for bullying in their facilities. The frequent exclusion and avoidance discussed above seems securely linked to the dining room. Participant 3 reported, “Most of the

issues revolve around food and meals.” She also observed residents trying to time their dining to avoid certain other residents.

Participant 5 stated, “We have some residents that will alienate others from certain tables and chairs because they are holding spots for their friends.”

Because of residents’ close proximity in the dining area, their behaviors and habits become more evident to one another. Since many older adults have physical limitations or established eating habits that may bother other residents, some bullying behaviors are unknowingly triggered by the victim. For example, Participant 2 described a resident who picks her teeth with her fork. A recent dining companion verbally lashed back saying, “Stop! I don’t want to see the inside of your throat. Stop picking your teeth.”

Although almost all participants listed the dining room as a problem zone for bullying, they seem rather divided on assigned seating or independent seating as a way of dealing with it. Participant 5 noted that her site does utilize assigned seating. They do this so residents “are placed with other residents that they will get along well with.”

Participant 1 stated, “It’s kind of an unwritten rule, but there are no assigned seats in the dining room.”

Participant 3 identified a third seating arrangement. She explained that each resident has a placemat and the staff places the placemats on the table before each meal. “We call it party planning and we try to mix up the groups,” she said.

**Activity/commons area.** Four of the seven participants noted that the community gaming/recreation areas are often sites for bullying. It may be linked to the power struggle that comes along with competition. Participant 4 recognized name calling and put downs “would also take place in the common areas generally during group activities.”

Participant 1 described the exclusion that often accompanies card games or board games as “not being welcoming.” Although etiquette dictates that people can take turns rotating in and out, new residents are sometimes not allowed in the rotation. “[A new resident] was told, ‘you can just watch,’” Participant 1 reported.

That information is confirmed by Participant 5, who stated “They bully one another during games.”

### **Reasons for Bullying**

Although participants seemed to concur on types and locations of bullying, their answers were extremely varied on what they viewed as the motivation and reasons for the bullying behavior.

Participant 1 attributed some of the bullying in her facility to differences in religious practices and orthodoxy. She said, “Even within their own faith community, if they are not strict enough in their religion that is sometimes a reason for bullying.”

Participant 1 also noted, “I often feel that some of the bullying might relate to boredom.”

Participant 2 responded, “It’s power.” She also credited the need for attention as a reason for bullying. She recognized this need for attention can also be a form of self preservation. She reported, “Attention can sometimes equal care.”

Participant 3 also recognized the need for attention as a cause of bullying. She acknowledged that she sometimes feels like a pawn in the residents’ competition for attention. She recalled an incident where she was caring for a resident, when another resident pushed her light for assistance. The first resident said, “Don’t you dare leave me for her!”

Participant 4 recognized more clinical reasons as the root of bullying behavior at her site. She identified, “memory/psychological impairments such as dementia as well as physical ailments or other stressors.”

Participant 5 also listed physical reasons for bullying. She stated, “They [bullies] are frustrated with their own health deteriorating and limited capabilities.” However, she acknowledged personality differences may also contribute to bullying.

Participant 6 has a completely different theory for bullying at her facility. She reported, “The residents do not have significant outside social/recreational outlets. This sort of closed environment, coupled with too much time on their hands, would be the reason...for inappropriate social behavior, including bullying.”

Participant 7 reported differences, like perceived economic levels, were sometimes highlighted by bullies to boost their own self-esteem. She added, “Generally bullies are sad and lonely but refuse to admit it and then they push people away so others are afraid of them.”

The seven participants also listed other possible reasons for bullying including: envy, resistance to change, anxiety, side effects of medication, and lack of independence.

### **Interventions**

After establishing how bullying manifests itself in residential living facilities, recognizing where bullying occurs, and identifying causes for bullying, the next logical question is, “What type of interventions are being used to decrease or eliminate the problem? All seven of the participants identified one-on-one discussions with the bullies as a common intervention.

**One-on-one interventions.** Participant 3 was very specific about her reasoning for choosing one-on-one interventions. She stated, “I don’t think you can shame somebody or try to

embarrass with a crowd...because usually bullies have been shamed, have been made to feel guilty, haven't been able to express themselves. That's part of the reason that they bully."

Participant 7 recommended doing a one-to-one intervention with the bully and also one with the victim. She advised:

The bully needs to be informed of their behavior and the consequences it holds.

During one-to-one meetings a person can sometimes get to the root cause and help the person set goals or learn better ways to deal with their behavior.

**Zero tolerance policy.** Five participants expressed the importance of establishing and enforcing a "no tolerance" policy for bullying. Participant 1 communicates to the bully, "We don't tolerate that."

Participant 3 identifies the specific bullying behavior and expresses, "We don't (whatever the behavior) here!"

Participant 7 recommended distributing the zero tolerance policy with residents' admissions packets. She also emphasized giving examples to "identify physical, verbal, emotional and spiritual abuse/bullying." That will limit confusion when conveying "abuse of any kind will not be tolerated."

**Welcoming environment.** Two participants discussed taking a proactive approach to eliminating bullying by creating a welcoming environment. Participant 1 recognized her facility's efforts to welcome new residents and help them fit in. She reports, "Our social worker will hold a welcome lunch...and try to invite some people that might be a good peer link for them." The same participant establishes committees for different areas of the facilities, like menus and entertainment, so that residents feel that they have a voice in creating the environment.

Participant 3 reported her facility has minimal resident-to-resident bullying. She credits that to their emphasis on an “environment where they feel warm, safe, and welcome.”

**Removal.** Three participants listed physically removing the bully from the situation as an effective intervention. Participant 4 reported that if her facility feels that the bullying is related to any type of psychological deficit, they would “generally remove the person engaging in bullying from the situation.”

Participant 5 recalled a situation in their dining room when one resident hit another. She stated, “That resident was then told they must stay in their apartment and a family member had to come in and stay with the resident until they were able to move to another facility.”

Participant 6 stated that bullies are reminded that continued bullying behavior “can place a resident’s ongoing stay in housing or on the program services at risk.”

**Other interventions.** Other interventions identified by the participants included: monitoring, inclusion, redirection, identification/prevention of triggers, empathy awareness, and counseling.

### **Playback Theatre**

One of the goals of this research project was to explore the effectiveness of Playback Theatre as an intervention on decreasing/eliminating bullying between older adults. Unfortunately, none of the respondents were familiar with Playback Theatre. This lack of familiarity makes it impossible to measure the intervention’s effectiveness. Therefore, this finding is inconclusive.

**Arts Intervention.** Since none of this study's participants have utilized Playback Theatre, it was important to the researcher to identify what, if any, art-based interventions were being utilized in the participants' facilities. Although nearly all of the participants reported some form of artistic therapy being used, few applied it as an intervention to behaviors. They employed the arts as communication, relaxation, or physical therapy, not problem solving.

**Role play.** Three participants mentioned having used role play to try to increase awareness and empathy levels of their residents.

Participant 1 described an informal role play her staff prepared for a tenant meeting. She reported they reenacted a scene from the movie "Forest Gump." She stated:

We did the little role play with Forest getting on the bus and being told, "This seat is taken. You can't sit here. This seat is taken." We're trying to put that empathy component there. Showing the residents that they can be the new person or they can be part of the problem.

Participant 7 acknowledged the use of role play for the staff, but not for the residents. She reported, "Facility staff did a lot of role playing related to abuse scenarios in their training."

**Other artistic therapies.** Participant 3 reported residents being encouraged to paint and draw as forms of expression, communication, and relaxation.

Participants 1 and 6 identified dance as a therapeutic intervention at their facilities.

Participant 2 utilized a different form of theatre therapy called "Senior Focus." It was not meant as a problem solving intervention, but more as a form of narrative therapy. She reported, "It was an interactive thing where they might bring up a picture and then the residents would have to make up a story to explain the picture." This is an exercise in helping residents find meaning.

Participant 5 shared that her facility does have a resident chorus and reading groups. Overall, all participants seemed open to the idea arts-based therapy, just not overly experienced with it.

### **Training**

All of the participants were asked what type of education or training (if any) the staff at their site had in addressing elderly bullying. The majority of participants acknowledged receiving little to no training on the issue.

Participant 1 reported that most training occurs on a case-by-case basis, as needs arise. She said, “I think we could always do more with staff training.”

Participant 2 said their staff training does address how to prevent triggers. As for the focus of the training she responded, “Nothing specifically geared toward bullying.”

Participant 3 said that other than an in-service at the beginning of their term of employment, they really don’t address bullying.

Although participant 4 acknowledges her facility uses a computer program for training, she admitted that bullying is “not an issue that was strongly emphasized.”

Participant 5 reported receiving little training on bullying.

Participant 6 stated her facility has “done two presentations on bullying in the past two years.”

Participant 7 stated her facility requires “two to three hours of initial training.” They also follow up with “a yearly in-service related to abuse.”

### **Simple Messages**

Since consistent language helps staff and residents identify bullying behavior when it occurs,

participants were asked for a simple message they currently use, or could use in the future, to help the entire facility recognize and eliminate bullying.

Many participants chose broad general messages. Participant 1 recommended the general statement of “Be nice to one another.”

Participant 3 endorsed the message, “This is not o.k.”

Participant 5 chose “Show respect to one another.”

Participant 7 stated, “Treat people the way you want to be treated! It’s OK to be mad, but not OK to be mean to someone.”

Other participants felt it was important to identify the specific bullying behavior in the message. For example, Participant 2 suggested, “We don’t do (name the behavior) here.”

Participant 6 is similar with “I just saw/heard this happen. Are you aware that this probably hurt (name victim) feelings?”

## **Conclusion**

Data showed that most bullying occurring in residential facilities for seniors is not physical, but verbal or exclusionary in nature. It most often happens in the dining or community room. The most common forms of interventions currently being utilized are one-on-one meetings, zero tolerance policies, creating a welcoming environment and removal of the bullying from the situation and possibly the facility. Staff members are not adequately trained in dealing with the issue of resident-on-resident bullying. Facilities seem open; however, staff members are inexperienced with using arts-based therapy as a form of bullying intervention. None of the participants have used Playback Theatre. There are both broad and specific messages being employed to confront bullying in these facilities.

The next section will include a discussion on implications of these findings on society, the social work profession, and policy.

### **Discussion**

There were a number of similarities and differences found when comparing the findings of this research to the literature review. Not all themes of the findings were addressed in the literature, which is a point that this researcher believes is a testimony to the exploratory nature of the topic. The majority of studies published on bullying addresses bullying among young people; few studies address the plight of older adults facing the problem of bullying. There was a similarity between the literature about bullying with young people and the findings, including Popp's findings of self-esteem being linked to self-efficacy (2012). Among the themes addressed by both studies found in the literature review and the findings were: (a) what bullying behavior looks like among older adults, (b) who bullies, and (c) reasons for bullying.

#### **What Bullying Looks Like and Who Bullies**

Participants in this study witnessed physical, verbal, and non-verbal, and non-verbal forms of bullying. The participants' three bullying categories fit within the context of the two categories defined as direct and indirect bullying by McGrath et al. (2010). Crick and Bigbee (1998) categorized these same behaviors as overt and relational.

The exclusion, gossip, and malicious talk identified as indirect bullying were consistent with the reporting of the participants. Both the study participants and the literature identified this form of bullying occurring more frequently than other forms of bullying (Bonifas & Frankel, 2010; Crick & Bigbee, 1998; McGrath et al., 2010). All respondents also noted that this

behavior was far more prevalent among women than men. This finding also is in alignment with the research of McGrath et al. (2010).

Crick and Bigbee (1998) identify physical bullying as overt bullying. It is also more often perpetrated by men than women. The research findings of this study were also consistent with those listed in the literature review (Bonifas & Frankel, 2010; Crick & Bigbee, 1998; McGrath, et al., 2010). Participants expressed that physical bullying was uncommon and infrequent in their sites. Bonifas and Frankel (2012) also reported physical bullying to be much less common than other forms of bullying.

One interesting finding that was not discussed in the literature was the identification of spiritual abuse. Only one of the seven participants in the study used this term. Since the researcher was unfamiliar with its specific meaning, the participant provided an example. She observed spiritual abuse as, “a Baptist and a Catholic trying to tell each other how they belong to the true church and the other was going to hell because of their beliefs.” In this case both the Baptist and the Catholic would be bullies and victims, what Mishna (2003) refers to as aggressive victims.

### **Reasons for Bullying**

Although the participants identified a far broader scope of reasons for elderly bullying than those recognized in the literature review, some of the information was confirmed. The participants acknowledged health problems, medications, and loss of independence as possible reasons for bullying. The connection between physical health, mental health, and isolating behaviors was recognized by findings in two studies (Matthews et al, 2011; Scheetz et al, 2012). The majority of studies addressing bullying

are found among the children and adolescent population. The focus on that age group makes comparisons to the results of this research not thoroughly applicable.

### **Themes Not Addressed**

Effective interventions in dealing with bullying among older adults were not found in the literature review. Again, it is this lack of information that motivated this researcher to explore the topic and gain insight.

One noticeable deficit in the literature corresponded to a deficit in findings: training. Two of the seven participants in the study listed specific and current training regarding bullying that was in place for their staff. The other five acknowledged a lack of training or expressed a need for more. Playback Theatre is a bullying intervention that can also be applied as training for staff.

Although Playback Theatre was specifically highlighted in the literature review, there was no literature highlighting other forms of art-based therapy as problem solving interventions. The research findings illustrated that forms of artistic expression are being utilized and appreciated within senior residential living facilities. However, none of the respondents were familiar with the intervention chosen as the focus of this study.

Every one of the study participants mentioned using one-on-one discussion as an intervention with bullies. That technique has proven merit with the participants. Even though one-on-one discussions are not meant for others to hear, bullies are often seen being pulled aside or their absence from community is noticed.

This researcher believes that there may be merit in bullies being part of an audience, instead of being singled out. Playback Theatre allows both the bully and the victim to see themselves and the conflict from the outside. This provides an opportunity for both parties

involved to recognize behaviors without being named or excluded. The founder of Playback Theatre uses the words “healing” and “community-building” in describing her vision (Salas, 1996, p.1). Healing and community-building resonate as positive goals for assisted living and public housing facilities confronted with bullying.

### **Strengths and Limitations**

Because the problem of elderly bullying has come to light so recently, there is very little academic data on the topic. In light of that shortage, descriptive data like this study is valuable. There were also similarities found in the existing literature and the research sample. Although the list of research questions was short, findings from the research tool identified which elderly residents bully, where the bullying occurs, and what interventions are being tried. The study also created a narrative of possible motivations behind bullying. The importance of staff training was also illuminated by this study, which this researcher views as a positive outcome.

This study was meant to measure the effectiveness of Playback Theatre as an intervention for decreasing and/or eliminating bullying. Because the St. Paul Public Housing Agency (SPHA) required their managers to attend two separate Playback Theatre trainings last year, this researcher expected more familiarity within the senior housing community of the St. Paul/Minneapolis area. SPHA opted to not endorse participation in this study with their managers. This lack of knowledge of Playback Theatre as an intervention among respondents is the greatest limitation of this study.

Other limitations include lack of diversity among respondents. Since all respondents were Caucasian females, the study lacked the depth in racial and gender perspective. Although one participant currently resides in Texas, her responses were

based on her recent experiences of working at an assisted living facility in Minneapolis. Therefore, all information gathered represented senior living facilities in the Midwestern region of the United States only.

The other obvious limitation was the small size of the study. It was extremely difficult to recruit participants with the limited time allotted after SPHA deferred participation.

### **Implications for Policy**

As the literature indicates, bullying is a problem most often associated with young people. Unfortunately, this problem has led to other social problems including violence in schools and increased suicide rates. Because of these compounding issues, communities around the United States are recognizing bullying as a social problem. School districts, local governments, and states are creating policies to try to help eliminate/decrease bullying. Minnesota recently enacted the Safe and Supportive Schools Act to address this problem and set standards for school districts around the state. These policies were created as a response to a crisis.

Bullying in senior living communities is not a crisis at this time; however, with the rapid growth of the aging population in the U.S., elderly residential communities are at risk to follow the bullying trend. As previously mentioned, the U.S. Census Bureau is predicting that by year 2050, one in five people in the U.S. will be 65 years of age or older (Scharlack, 2011). It is worth considering proactive measures that social workers and other helping professionals can utilize in this regard.

The literature emphasizes bullying behavior generally starts at a young age. However, this researcher is not aware of the age when bullying generally stops. As the

findings indicate, bullying may manifest itself differently as people age, but it does not disappear. Since the population of those over 65 years of age is growing exponentially (Scharlack, 2011), bullying is a problem that will be growing along with it. In addition to proactive measures, social workers can take; it is also an appropriate time for legislators to enact safe and secure policies for residential living facilities for senior citizens.

### **Implications for Social Work Practice**

Although this study describes bullying behavior, possible motivations, and interventions, it is just a small step toward unearthing the complete reality of bullying between older adults. One important action that can and should be performed by social workers is information sharing. Social workers who assist older adults need to ask questions, relay their experiences of bullying, and consult one another. Sharing information on the effectiveness of interventions is crucial to the elimination of the problem. It is important to note that sharing data regarding failed interventions is as educational as sharing data on successful interventions.

Information sharing is helpful on an individual or small group level, but agencies must support this effort, too. Collaboration between multiple geriatric centered agencies brings not only information, but credibility and possible financial and academic resources which can be utilized in intervention testing and development. This research study helps make evident the need for increased research on this topic.

### **Implications for Future Research**

As stated, the majority of current research on bullying is child-centered. The growing population of older adults not only brings an increase in geriatric behavioral issues, but an increased pool of possible study participants from which to learn. There

may be more people affected, but there are also more people to solicit for wisdom and research.

The fact that this interview showed females bully more frequently than males is consistent with the findings of the literature in younger populations (Crick & Bigbee, 1998; McGrath et al., 2010). However, this does not take into account mortality rates between genders. According to Kirkwood, “Women outlive men about five to six years. By age 85 there are roughly six women to every four men. At age 100 the ratio is more than two to one” (2010, p. 34). Quantitative research on the effects of the gender mortality rates on bullying among adults would be beneficial.

One area that came to this researcher’s attention during the study was the concept of “perceived” bullying. Seniors admitted feeling excluded while those who were walking away from them, to attend to personal needs, were unaware of and certainly unintentional about the message conveyed. This makes the idea of studying elderly bullying victims as important as studying the bullies themselves. This look at victimization may carry over to other age populations, as well.

This study focused on assisted living and senior public housing. Just as the population expands, so may the models of care developed for older adults. Further research brings the opportunity to keep bullying and other behavioral issues in the forefront of thought and design as these models are developed.

### **Conclusion**

Technology and medical advances have helped create an environment where people are living longer. That extra gift of time should be embraced, encouraged, and celebrated. As a society and as a profession, social workers need to continue to research,

share information, and develop interventions so that bullying behavior does not act as an isolator. Keeping the person in environment theory as a professional focus will help social workers create and maintain environments that foster the enjoyment of life at all ages.

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**APPENDIX A  
Recruitment Flyer**

**Recruiting social workers and other professionals who work with seniors in community living facilities for a research study!!**

**Looking for professionals to be interviewed one time for one hour!**

**Study purpose: To help identify behaviors and interventions related to elderly bullying.**

Criteria for participation:

Professionals (Social Workers, Nurses, Household Coordinators, Psychologists)  
Who work in senior living facilities (Senior High Rise, Assisted Living)  
which are not long term nursing care facilities (nursing homes).

**Commitment: 1 tape recorded interview lasting no more than 1 hour.  
A \$5 Caribou Coffee gift card will be provided as a thank you!**

Please call MSW Candidate Jen Rooney at xxx-xxx-xxxx or email  
[xxxx@stthomas.edu](mailto:xxxx@stthomas.edu)  
to discuss participation!

If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through St. Catherine University at  
(651) 690-7739

**APPENDIX B**  
**Initial Information Sheet**  
**Phone and/or Email Script**

Dear Sir or Madam,

I am a graduate student working toward my Master's degree in the Social Work program at St. Catherine University and the University of St. Thomas. I am also an Area of Emphasis on Aging (AEA) scholar, which means I am specializing in geriatric studies and issues. Currently, I am examining the problem of elderly people bullying other elderly people in community living residences. This is focus of my clinical research project I am preparing under the supervisions of Dr. Catherine Marrs Fuchsel. I am asking for your assistance in my research.

Although bullying seems to be a problem starting in childhood, new emphasis on the prevalence of bullying in senior communities has acted as a catalyst for exploring interventions. The goal of this research is to find out if Playback Theatre is an effective intervention for bullying in senior communities.

As an AEA scholar, I have contacted my peers to help recruit professionals working at senior community living residences. My goal is to interview at least eight participants.

Each interview will ask eight semi-structured questions and will require approximately 45-60 minutes of your time. Interviews will be scheduled early next year, most likely January of 2014, after receiving approval from the St. Catherine's Institutional Review Board (IRB) to proceed with my research. These interviews will be audio recorded and transcribed.

A \$5 Caribou Coffee gift certificate will be given as appreciation for your participation. Risk to you is low and participants' names will not be released. Results will be presented to peers, professors and the general public in May of 2014.

The semi-structured questions that will be asked are the following:

1. What does resident-to-resident bullying look like at your site?
2. What do you see as the main cause(s) of bullying in your community?
3. What types of education or training (if any) have staff at your facility had addressing the problem of elderly bullying?
4. What types of interventions, if any, has your facility utilized to decrease/eliminate elderly bullying?
5. Are you familiar with Playback Theatre? If so, explain.
6. What, if any, form of artistic expression has your facility utilized in dealing with problem solving in the past? How was that received by residents?
7. What simple message or phrase would be most helpful for your staff to use when addressing bullying?
8. Can you think of other intervention plans for elderly bullying that you think might be more effective?

Participation is completely voluntary. Participants can terminate the interview and withdraw from the study at any time.

Thank you for your consideration. If you have questions please feel free to call me at xxx-xxx-xxxx or contact my research supervisor, Dr. Catherine Marrs Fuchsel at 651-690-6146.

Respectfully,

Jennifer E. Rooney,  
MSW Candidate

## APPENDIX C

### Qualitative Research Questions

1. What does resident-to-resident bullying look like at your site?
2. What do you see as the main cause(s) of bullying in your community?
3. What types of education or training (if any) have staff at your facility had addressing the problem of elderly bullying?
4. What types of interventions, if any, has your facility utilized to decrease/eliminate elderly bullying?
5. Are you familiar with Playback Theatre? If so, explain.
6. What, if any, form of artistic expression has your facility utilized in dealing with problem solving in the past? How was that received by residents?
7. What simple message or phrase would be most helpful for your staff to use when addressing bullying?
8. Can you think of other intervention plans for elderly bullying that you think might be more effective?

**APPENDIX D****CONSENT FORM****The Effect of Playback Theatre on Managing Elderly Bullying in Senior  
Communities**

I am conducting a study about Playback Theatre as an intervention on elderly bullying behavior in senior living communities. I invite you to participate in this research. You were recruited as a participant because of your professional work with seniors in community living facilities. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Jennifer Rooney, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. Catherine Marrs Fuchsel, Ph.D., LCSW, LISCW.

**Background Information:**

The purpose of this study is: to identify the effectiveness of Playback Theatre training as an intervention in curbing or eliminating bullying behavior between elderly residents in senior living communities.

**Procedures:**

If you agree to be in this study, I will ask you to do the following things: sign a written consent form; answer approximately eight questions in an audio recorded interview 45-60 minutes in length; share your experiences and insight of managing elderly bullying behavior for research purposes; and agree to the research being presented to the public in a non-identifying way. I will be presenting my findings to my GRSW682 research committee and a panel of my peers, professors, and members of the general public. The interview will be conducted in a private place of your choice. St. Catherine's University and the University of St. Thomas have private rooms available for interviews at the library if needed. A research assistant will be viewing my data for reliability.

**Risks and Benefits of Being in the Study:**

The study has minimal risks.

The only direct benefit to you is a \$5 Caribou Coffee gift card for participating. The benefits of this study are aimed at increasing the knowledge of bullying intervention for the field of social work and possibly the field of gerontology. On a broader level, it may benefit the community in general as bullying behaviors decrease between the elderly.

**Confidentiality:**

The records of this study will be kept confidential. Research records will be kept in a locked file in my home. I will also keep the electronic copy of the transcript in a password protected file on my computer. A research assistant and my research professor will see a transcript of the interview, but will not know who you are. I will delete any identifying information from the transcript. Findings from the transcript will be presented to my GRSW682 committee and a panel of my peers, and professors.. The audiotape and transcript will be destroyed by May 19, 2014.

**Voluntary Nature of the Study:**

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

**Contacts and Questions**

My name is Jennifer Rooney. You may ask any questions you have now. If you have questions later, you may contact me at xxx-xxx-xxxx. You may also reach my professor, Dr. Catherine Marrs Fuchsel at 651-690-6146. You may also contact the St. Catherine University Institutional Review Board at 651-690-6204 with any questions or concerns.

**You will be given a copy of this form to keep for your records.**

**Statement of Consent:**

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audio-taped.

\_\_\_\_\_  
**Signature of Study Participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Study Participant**

\_\_\_\_\_  
**Signature of Researcher**

\_\_\_\_\_  
**Date**

