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"He Wanted to Talk and I Gave Him a Shower": A Qualitative Interview Study in Three Nursing Homes in Carinthia (Austria) about Violent Behaviour in Elderly Care and Its Causes

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Abstract:
Abuse and neglect in elderly care remain serious topics, but nursing home residents are considered highly vulnerable because many of them are affected by dementing illnesses and are care-dependent. We performed qualitative content analysis to evaluate interview data obtained from the nursing staff (8 nurses and 30 care assistants) of three nursing homes in Carinthia (Austria) to identify key aspects of work-related stress and violent behaviours in the daily nursing home routine. The findings revealed that their work experiences were highly burdensome. The nursing staff perceived themselves to be exposed to excessive demands, conflicts with colleagues, under-staffing, and a lack of support. Our participants openly discussed their violent behaviours against the elderly, and nearly all types of abuse and neglect were reported. Our results provide information about violent behaviours in the daily nursing home routine. A broad social and political discussion is required to develop prevention strategies within the setting of nursing care.

Keywords: *violence, neglect, elderly care, nursing home, work-related stress*

1. Introduction

Many residents of nursing homes have several co-existing diseases and depend on receiving care from nursing staff, who are often overwhelmed; however, this is not necessarily the reason for their violent behaviours. Nevertheless, empirical evidence shows that abuse of elderly people in Western societies is highly prevalent in long-term institutional settings, such as nursing homes (Phelan, 2008; WHO, 2002a). Although violence against the elderly still seems to be scientifically under-studied, this phenomenon is currently recognised as a broad social problem that occurs in different situations. Violence against the elderly was first described by Baker (1975). Recently, the World Health Organisation (WHO, 2002b) broadly characterised elder abuse as "...a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. It can be of various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect."

In the current research paper, we focus on causes and expressions of violent behaviour towards elderly people in nursing homes. In particular, we argue that dehumanising treatment of nursing home residents is a result of the highly stressful workplace demands in healthcare settings.

1.1. Different Types of Violence against Elderly People

Using the "violence triangle," Galtung (1993) described three forms of violence, namely human, structural, and cultural violence, which are interdependent and influence each other. Direct violence is actively directed against a person via physical and psychological abuse, financial exploitation or restriction of free will. Personal violence in the form of failure to act includes various forms of neglect, such as malnutrition, denial of care and hygiene, separation, and isolation (Henderson, Varble, & Buchanan, 2003; Hoerl, 2006). In a study conducted by Pillemer and Moore (1989), 36% of surveyed nurses (N = 577) observed that 81% of nursing home residents experienced physical and psychological abuse from other employees. Regarding their own violent acts, 40% reported perpetrating mental and 10% reported perpetrating physical abuse. In addition to the actions that are clearly classified as maltreatment, a variety of restrictive measures can be abusive, such as physical restraint using belly straps or tables affixed to wheelchairs and administration of

sedative drugs. Dissent regarding residents' needs and potentials for experiencing violence need to be resolved on an individual basis (Hoerl, 2006; Lindbloom, Brandt, Hough, & Meadows, 2007).

Violence without a perpetrator is called structural or indirect violence. This form of violence is invisible because it is hidden behind standards and regulations, and it has consequences on living and working environments. In passive implementation, the privacy of residents is ignored and disrespected, and autonomous lifestyles are not permitted (Hirsch &Kranzhoff, 2002).

Cultural violence involves a society's values and prejudices against certain populations (Galtung, 1993). In youth-centred societies, negative attitudes towards older people are prevalent. Some authors have highlighted the existence of ageist stereotypes that portray older people as less attractive, active, or competent compared with younger people (Butler, 1980; Kite, Stockdale, Whitley, & Johnson, 2005). There are persistent age-related beliefs about men and women, including the belief that women age more rapidly and that they are more affected by negative feedback (Kite et al., 2005; Krings& Kluge, 2008).

1.2. Theoretical Approaches Explaining Violent Behaviour against Elderly People

In initial research, violence against older people was found to be similar to child abuse: aged and disabled persons are considered to have the same level of dependency as children, and both groups are at the mercy of their caregivers (Steinmetz, 1981). In contrast, elder abuse is more difficult to identify due to the social isolation of elderly individuals, and the effects of disease and their diminished credibility are problematic (Miller &Zylstra, 2003).

Literature related to elder abuse indicates that there is likely not just one cause of violence against elderly people. In fact, various theoretical approaches exist to gain understanding of elder abuse, such as the psychopathology of the abuser theory, the dependency hypothesis and the stressed caregiver hypothesis (Phelan, 2008; Quinn & Tomita, 1997).

In particular, caregiver stress has been discussed as a main factor for emotional and physical abuse resulting from nurses who are overworked and underappreciated (Pillemer& Wolf, 1986). In the Effort-Reward Imbalance model, Siegrist (1996a) discusses the disproportion between effort exerted at work and rewards received. Some authors have identified nursing as the occupation that is most affected by stress (Alfredsson, Karasek, & Theorell, 1982) because nurses work in an environment in which they receive a low level of appreciation and inappropriate salary and have few career opportunities (Bishop, Squillace, Meagher, Anderson, & Wiener, 2009). Another assumption of the Effort-Reward Imbalance model is that over-commitment leads to sustained stress reactions (Siegrist, 1996b). Over-committed people exaggerate their efforts beyond a level that is usually considered to be appropriate, and such behaviour is also addressed in the personality-centred approaches to burnout (e.g., Burisch, 2006). Over-committed people frequently endure sacrifice and disregard their own needs. Care is an ideal profession for receiving thanks, appreciation and affection, but it can quickly become a source of frustration if those dependent on care no longer show gratitude or appreciation. Studies have reported that nurses in the elderly care profession experience higher rates of burnout, depression, and low job satisfaction compared with those working in other areas (De Jonge, Janssen, & van Breukelen, 1996; Fronteira&Ferrinho, 2011). Social support at work plays an important protective role and decreases the prevalences of physical and mental illnesses (Rösler, Jacobi, & Rau, 2006; Van Vegchel, De Jonge, Bosma, &Schaufeli, 2005). Violent behaviour may occur due to work-related stress and institutional constraints (Hirsch &Vollhardt, 2001). The multifactorial model of Schwerdt (1994) describes acts of violence and abuse by caregivers as malignant decompensation and assigns such behaviours to the last of five stages in the process of burnout.

In addition to institutional and personal risk factors, residents´ behaviours and attitudes are also relevant. The interest in victim dependency arose from the observation that nursing home residents with chronic diseases and dementia have all the prerequisites for becoming ideal victims of neglect and emotional and physical violence (Quinn & Tomita, 1997). Nursing home residents are dependent on nursing staff and cannot escape or fight back, and their ability to complain is limited (Lindbloom et al., 2007). Confused elderly individuals are depicted as egoistic, hostile, uncooperative, and discontent (Jenull, Salem, & Brunner, 2010). Most nurses have little training in understanding the cognitive and behavioural aspects of dementia, and few can handle the emotional expressions associated with this disease (Magai, Cohen, &Gomber, 2002). Studies have shown that the recognition of happy faces is relatively unimpaired in patients suffering from dementia, but the recognition of negative emotions, such as sadness and anger, is poor (Lough et al., 2006; Rosen et al., 2006). The behavioural patterns and nonverbal emotional communication that occur in the process of dementia might be misinterpreted by nursing staff and thus perceived as personally offensive (Inhester, 2005). An important aspect of social interaction is the ability to perceive the emotional state of the other person. Nursing home residents with dementia cannot recognise negative emotions and adapt their behaviour accordingly, and therefore, they offend social norms. Explicitly acknowledged punishments, such as limiting communication and sarcastic remarks, can thus be seen as comprehensible coping strategies (Jenull et al., 2010).

Abuse and aggression within the nurse-patient relationship are primarily unintentional (Bojak, 2001) and result from a chain of events that cannot be reduced to a simple victim-offender interaction (Ostermann, 1999). In most cases, institutional violence is an aggressive, dynamic process that occurs between residents and nurses who have experienced structural violence in their work environment (Hirsch &Vollhardt, 2001). The probability that this situation escalates to elder abuse is higher when residents believe that they are powerless and dependent. Minichiello, Browne, and Kendig (2000) have described this phenomenon in the context of normalising and internalising ageist care practices.

The abuse and neglect of elderly individuals is a serious but under-recognised problem. Elderly individuals comprise a group that is highly vulnerable to violence because many of them are affected by dementing illnesses and are dependent on the care of others (Lindbloom et al., 2007). The present study aimed to examine violent behaviours within the daily nursing home routine and to gain better understanding of this taboo topic in elderly care.

2. Methods

2.1. Study Design

The research design was guided by naturalistic inquiry (Lincoln &Guba, 1985), which is a qualitative method that is well suited for understanding the views and attitudes of nursing staff regarding violence against elderly individuals living in nursing homes.

2.2. Recruitment and Participants

We employed a purposive sampling strategy to select three nursing homes in Carinthia, Austria. Carinthia is a rural area with approximately 560,000 citizens. The participating nursing homes differed in size, with capacities of 50, 65, and 90 beds, respectively. Two of these homes are publicly run, and the third is denominational. Seven care levels exist in Austria, and the majority of nursing home residents have co-existing diseases and meet the criteria for level 5 (e.g., extraordinary care duties, incontinence, and more than 180 hours of care duties) (https://www.help.gv.at/Portal.Node/hlpd/public/content/36/Seite.360516.html).

In continuation of previous collaboration between the first author and the Carinthian nursing homes (Jenull et al., 2010; Jenull & Wiedermann, 2013), the nursing directors were asked to participate in this study. The study procedure was discussed one-on-one and then as part of a team meeting, during which the nursing staff received complete information about the aims, methods, and expected benefits of the study. The nursing staff was informed that participation was voluntary and that the information provided would be treated confidentially. The approach followed the Ethical Principles of the APA (American Psychological Association, 2010) and conformed our institution´s human subject protection policy (http://www.uni-klu.ac.at/rechtabt/downloads/mbl3b1_08_09.pdf). Appointments with nursing staff were agreed upon individually. The study participants were selected according to the following criteria: professional group (nurses and care assistants), job experience (more than 3 years), sex, and nationality. We aimed to evaluate experienced nursing staff and to determine any differences in education levels, gender and nationality.

Ultimately, approximately 36% of the nursing staff participated (N = 38). The study participants were approximately 39 years of age (range: 20-58 years) and had an average of 11 years of professional experience (range: 3 to 38 years). All of the participants were female. The sample consisted of 8 nurses and 30 care assistants. In Austria, care duties and nursing responsibilities are regulated by law under the "Gesundheits- und Krankenpflegegesetz, GuKG." Registered nurses are responsible for the diagnosis, planning, organisation, implementation and evaluation of all nursing care duties, as well as for psychosocial support. Care assistants are mainly responsible for basic care, personal hygiene, and nutrition, and these duties must be carried out under the supervision of higher-ranked healthcare and nursing staff (http://www.jusline.at/Gesundheits-_und_Krankenpflegegesetz_%28GuKG%29.htm). The nationality of the entire sample was Austrian, which is very common for rural areas (Jenull & Wiedermann, 2013).

2.3. Data Collection

The participants were recruited from three nursing homes over a 4-month period, and the data were collected using qualitative interviews. The interviews were conducted in the workplace so that the familiar background would be conducive to the provision of natural answers. The interview questions aimed to explore general views of work-related stress. Our theoretical points of reference were studies that reported high levels of work-related stress in elderly care (e.g., Bishop et al., 2009; Fronteira&Ferrinho, 2011; Jenull & Wiedermann, 2013). Stress and underappreciationare discussed as main factors for the expression of violent behaviour towards elderly people (Hirsch &Vollhardt, 2001; Pillemer& Wolf, 1986). Specific questions were asked to determine how the participants viewed the causes and expression of violent behaviours towards elderly people in their nursing home. Nursing home residents are dependent on nursing staff, dehumanising treatments are difficult to detect, and the credibility of old and disabled individuals is often questioned (Miller &Zylstra, 2003; Pillemer& Moore, 1989). The interview included the following two questions: 1. "Please tell me something about your professional life"; and 2. "Do you experience situations in your daily routine a) that lead to restrictions of the residents' needs and wishes? and b) in which you act against the residents' wishes?" After the first narrative sequence, we asked the participants about work-related stress (e.g., time pressure, staff shortages, conflicts at the workplace, and management style) and the expression of violent behaviours towards nursing home residents (e.g., dehumanising treatments in terms of personal care, food, and administering medication) if these topics were not already addressed. Finally, the completeness of the interview was evaluated.

The interviews lasted from 20 to 35 minutes and were taped and transcribed verbatim.

2.4. Data Analysis

The transcribed interviews were assessed by qualitative content analysis, and structuring and deductive and inductive techniques were applied (Elo&Kyngäs, 2008). First, the interview answers were structured into meaningful units. Second, we formulated theory-driven main categories primarily via a deductive procedure. Third, we examined the interviews line by line to define inductive categories that were subsumed under the main categories. Development of the category system was accompanied by research team meetings, during which progress was discussed and intersubjective comprehensibility was assured (Steinke, 2004).

3. Results

We identified 13 categories that were subsumed under the two main categories of work-related stress (there were a total of 8 categories) and another 5 categories related to violent behaviours in elder care. Reliability was assessed by randomly selecting 11 interviews for independent coding by another researcher. Kappa values of between .86 and .91 were determined in the present study, which indicates sufficient interrater agreement according to Fleiss and Cohen (1973). Below, we present the results by defining the

main categories within each domain, separated by professional groups, and providing some typical examples. Table 1 presents categories of work-related stress.

	Category	Definition	Care attendants (N=30)	Nurses (N=8)	N=38
1	Conflicts at the work place	Disputes with colleagues, bad atmosphere, no respect or support	25	2	27
2	Management style	Excessive demands, deficiencies in communication and collaboration	16	1	17
3	Patient-staff ratio	Staff shortages, with emphasis on the time factor	16	1	17
4	Time pressure	Care duties, with emphasis on time pressures/being under time pressures	10	5	16
5	Care quality	Staff follows rules with minimal added effort, provides minimal care, acts blunt and unfeeling	15	2	17
6	Framework requirement	Economy is in the foreground, economic thinking	9	1	10
7	Family members	Scarce support and no appreciation for the various tasks of elder care	9	1	10
8	Nursing documentation	Nursing documentation is forged (e.g., eating and drinking protocols)	4	0	4

Table 1: Work-related stress

The main sources of burden for most of the participants were conflicts in the workplace. According to the statements, the colleagues were working against and not with each other.

"There is chaos and bullying among colleagues." (Category 1: CA12[1])

"Social support is often not available." (Category 1, CA3)

Another source of work-related stress that affected almost half of the nursing staff was managerial failures:

". . . by the executive staff, I often felt left alone . . . there is a lack of support and openness." (Category 2, CA11)

Lack of transparency and support increased the burden of the work and contributed significantly to the team climate. Additionally, institutional frameworks, staff shortages and economisation in everyday work became apparent and affected the quality of care, as illustrated in the following examples:

"Patients are dispatched as quickly as possible as in assembly line work." (Category 3, CA4)

"The worst thing is the ignorance. The patient is deprived of a personal way of thinking, you will not speak to them, they can be left. . ." (Category 3, N17)

"You have in a very short time to do a lot more work and are always at the limit." (Category 4, N6)

"He came into the room and asked how long ago was the patient still alive. Two hours after his death, the room was newly occupied."(Category 5,CA1)

"Actually, I've done a shit job, but it was technically correct." (Category 6,CA3)

"One is silent and simply tries to just finish." (Category 6, CA5)

Nearly one-third of the nursing staff reported that working with family members was exhausting. According to their statements, relatives were often very demanding and minimally cooperative with regard to the daily routine:

"They should have more tolerance regarding the age . . . they need to understand that their fathers or mothers are simply not as they were before." (Category 7, CA27)

Ten participants reported that the expansion of nursing documentation added to the already difficult work routine.

"Documentation will be created but is partially just faked." (Category 8, CA4)

A comparison of the two professional groups showed that the care assistants primarily suffered from conflicts in the workplace, managerial failures and staff shortages. Time pressure was the main stress factor for nurses. Working conditions such as these have direct impacts on the quality of care. These results can serve as the foundation for educational training and tailored interventions and underline the need for investments in team building and leadership.

As illustrated in Table 2, abuse and neglect of elderly people occurred in all of the activities of daily living.

[1]Care assistant (CA) or nurse (N), number of interviews (11)

	Category	Definition	Care attendants (N=30)	Nurses (N=8)	N=38
1	Eating and Drinking	Food is not age-appropriate, eating preferences are not respected, all food must be eaten	18	4	22
		Ignoring of dysphagia, hydration under duress	7	1	8
2	Personal Hygiene	Defined procedures for bathing, showering, etc.	10	4	14
		Refusal of toilet access, residents must wear diapers although they are not incontinent	7	1	8
3	Way of Living	Restricted sleeping and waking hours, no support regarding individual interests and activities	13	5	18
		Sexual desires and needs are ignored or ridiculed	1	3	4
		Residents are persuaded and trivialised (baby talk)	11	2	13
4	No privacy	Open doors, no knocking	25	0	25
5	Restricted freedom	Involuntary medication use, drug immobilisation, sedation	16	3	19
		Use of physical restraints	10	1	11

Table 2: Violent behaviour in elderly care

The following examples illustrate how different aspects and various dimensions of eating and drinking can be experienced as violence.

"The pureed food is stuffed into the throat. There is no time for the patients to administer the food at their own pace." (Category 1, CA15)

"Every day the coffee was poured, the cup was pressed between her lips behind her cheek so that she had to swallow." (Category 1, CA1)

Nurses and care assistants are required to work under time pressure and institutional constraints that are detrimental to the quality of individual care, as illustrated in the following examples:

"Mrs. K is dragged into the shower, even though she doesn't want that." (Category 2, CA16)

"There is no time to take the people to the toilet, they have to wear diapers." (Category 2, N10)

In many cases, violence towards residents does not result from physical force but from deprivation of privacy and self-determination.

"Man is a commodity without self-determination." (Category 3,CA3)

"It is an involuntary renunciation of sexuality because it is still a taboo subject." (Category 3, N23)

"It´s demeaning, this nursery language: Open the mouth, good daddy, yam-yam." (Category 3, N14)

"Most of the time, the doors are wide open, anyone can watch as the naked person is washed." (Category 4, CA20)

"We have inhumane regulations, like 15-hour meal-breaks. (For example, dinnerat 4 p. m. andbreakfastat 7 a. m.)" (Category 4, CA10)

Another category was dedicated to restriction of freedom, and the administration of medication seemed to play a major role in this category.

"During night duty, the drugs are simply crushed and mixed in the food, and no information is provided, so that we have our peace during the day, so they do not run away." (Category 5, CA18)

". . . a few drops Psychopax, so they keep their mouths shut." (Category 5, N20)

"Fixations are part of the daily routine." (Category 5, CA15)

"People scream, we put them into their rooms, and the bell is switched off."(Category 5, CA20)

4. Discussion

There is little reliable data on violence against the elderly, but the number of unreported cases is estimated to be high (Hoerl, 2006). The present study did not seek to cause scandal or to assign blame; rather, it sought to direct attention towards nursing home residents and staff.

Nurses and care assistants work in a spiral of stress and overload. The findings of this study illustrate that the daily work routine of individuals who care for the elderly is characterised by multiple stressful experiences. Institutional work conditions were shown to be extremely burdensome, and this result is in agreement with those of other studies (Jenull & Wiedermann, 2013). Within the framework of the established Effort-Reward Imbalance model (Siegrist 1996a, 1996b), the available results suggest that nursing home employees comprise a group that is at high risk of burnout. Overwhelmed nursing staff commonly want to provide adequate care, but the demands of the job exceed their abilities. The experience of an imbalance between the care required and the inappropriate valuation of the efforts to provide that care was relevant to the participants interviewed in this study. They were highly engaged but had few appropriate problem-solving strategies and transferred their frustrations to the residents. Additionally, many residents would prefer to be cared for at home (Brogaard, Neergaard, Sokolowski, Olesen, & Jensen, 2013). These residents feel frustrated by their own frailty and disappointed and may react atypically due to dementia. Thus, both nursing home residents and employees can exhibit aggressive behaviour. However, in nursing homes, similar to daily life, the losers are determined from the outset, and they are the old men and women who are dependent and in need of help.

Social support, which is comprised of emotion- and problem-oriented aspects (Welbourne, Eggerth, Hartley, Andrew, & Sanchez, 2007), plays important roles in both job- and non-job-related areas of life. A high level of social support is correlated with a low level of stress. Mutual assistance among staff members in highly functional teams is assumed to be a good strategy for avoiding stress and

burnout in jobs that are related to elder care (LeSergent& Haney, 2005). The results of the present study showed that such highly functional teams were rare in the participating nursing homes. More than two-thirds of the participants reported conflicts in the workplace that involved insufficient team communication and cooperation.

Contrary to our expectations, the nursing staff discussed abuse openly, and all types of abuse and neglect were reported. They took responsibility for their behaviours and were therefore motivated to improve upon them. Nurses and care assistants have key roles in the care of seriously ill people and are important figures in their relatives' lives. The strength approach might work well for those who want to do a good job but lack the time and energy, and sometimes, the ability. Nursing staff members require supportive supervision, emotional support in difficult situations and coordination with other healthcare professionals (Spoor, De Jonge, &Hamers, 2010).

5. Limitations and Suggestions for Future Research

Although we are confident in our hypothesis and results, there are some shortcomings that should be addressed.

In the current study, we took a situational approach to violent behaviour in elder care. We could have shown that situational and institutional factors (such as poor working conditions, excessive work demands and poor communication structures), which are external to the dispositional features of people, may lead to maltreatment of the elderly. Nevertheless, the risk of elder abuse should not be solely attributed to caregivers' stress levels. We believe that a person-centred perspective on this topic is fruitful for future research to complement the complex picture of causal agents of nursing violence. Intrapersonal, psychological factors for the occurrence of elder abuse have received less attention than interpersonal, social factors. Elder abuse might also be influenced by various pathologies (e.g., alcoholism or chemical dependency). In fact, studies have shown that caregivers who behave violently and abusively against older people in domestic settings are more likely to have mental health problems than non-violent caregivers (Homer & Gilleard, 1990). However, little is known about the impact of the "inner moral compass" of nurses on their working behaviour, which would link elder abuse with relevant personality characteristics (e.g., a lack of awareness of wrongdoing or low internal pro-social standards). Our findings provide evidence that overwhelmed nurses and care assistants are aware of their abusive behaviours, but we cannot provide any explanation of the intrapersonal aspects that influence their behaviours.

Elder abuse is caused by multiple factors. Hence, future research should address the complexity of this problem by exploring individual, situational and systemic risk factors.

Furthermore, our results are based on a rural sample consisting of only female nursing staff. Due to the sample size and composition, a generalisation of the results would not be valid. Further research is needed to apply our findings in other areas with different living and working conditions.

It is assumed that there are also staff members who are not aware of how they treat residents. Reaching these people and investing in improving the quality of care and adequacy of nurse staffing should become major goals (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Aiken et al., 2012). In addition, abuse and neglect needs to be addressed on a broader level as a significant social and political issue. The implementation of abuse prevention strategies is a pressing and necessary requirement within the setting of nursing care. Even the most minor abuse should be alertly and attentively considered. Prevention is the best way to stop elder abuse, and strategies should focus on occupational and residential factors. In general, it is necessary to invest in the work environment through measures such as maintaining adequate staffing and allowing for staff to take sufficient breaks. Additionally, nurses and care assistants need to have sound knowledge about the care of people with dementia and need to be sensitive to nonverbal communication.

6. Conclusions

Mistreatment of older people who are nursing home residents is a topic of high societal relevance. A demographic change in future decades with an increase in elderly people will result in higher demands for care in institutional settings. Therefore, exploring causal factors for violence against the elderly seems to be highly necessary to prevent the abuse and neglect of nursing home residents.

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