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Resident-to-Resident Violence Triggers in Nursing Homes

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Abstract

Certified nurses' assistants (CNAs) employed by a rural nursing home in Northeast Arkansas described their perceptions of resident-to-resident violence in order to provide insight on factors, including unmet needs, that may trigger the phenomenon. Semistructured interviews were conducted with 11 CNAs. Data were analyzed using content analysis and constant comparison. Two categories of triggers emerged from the data—active and passive. Active triggers involved the actions of other residents that were intrusive in nature, such as wandering into a residents' personal space, taking a resident's belongings, and so forth. Passive triggers did not involve the actions of residents but related to the internal and external environment of the residents. Examples were factors such as boredom, competition for attention and communication difficulties. Results indicate that there are factors, including unmet needs within the nursing home environment that may be identified and altered to prevent violence between residents.

Keywords

resident-to-resident violence; nursing homes; triggers

Resident-to-resident violence (RRV) is a commonly occurring phenomenon (Rosen et al., 2008) in nursing homes (NHs) that threatens the emotional physical health of residents (Lachs, Bachman, Williams, O'Leary, 2007; Rosen et al., 2008; Shinoda-Tagawa et al., 2004). Of the projected 10 million NH residents with dementia in 2030, up to 57% (5.7 million) may become violent at some point in the course of their illness (Dettmore, Kolanowski, & Boustani, 2009).

Resident-to-resident violence, the delivery of noxious stimuli by one resident to others that is clearly not accidental (Patel & Hope, 1992), is not confined strictly to individuals with dementia, and is particularly problematic for residents of NHs (Bharucha et al., 2008; Lachs et al., 2007; Rosen et al., 2008; Shinoda-Tagawa et al., 2004). Studies suggest that

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approximately 36% of all violence occurring in NHs is between residents (Allin et al., 2003; Bharucha et al., 2008), resulting in physical and emotional problems for all parties involved. Studies also suggest that unmet needs of the residents may have a significant effect on the development of RRV and other types of dementia-compromised behaviors (Algase et al., 1996; Dettmore et al., 2009). Predicting and preventing RRV is important because of its consequences, including physical and/or chemical restraints and physical and/or emotional harm.

To date, few studies have been published on RRV despite the preliminary evidence that it is a common problem in NHs (Bharucha et al., 2008; Lachs et al., 2007; Rosen, et al., 2008; Shinoda-Tagawa et al., 2004). Recent studies have identified specific triggers, such as calling out, territoriality, roommate incompatibility, impatience, loneliness, abandonment, jealousy, disinhibition, competition for material resources, intrusion into private spaces, and dementia (Lachs et al., 2007; Rosen et al., 2008). These triggers have been cursorily described in the literature, but the perceptions of unmet needs of the residents from the perspective of those closest to the residents, the certified nurses' assistants (CNAs), have not been described. Though informative, the methodologies used in previous studies did not allow for in-depth exploration of the unmet needs of the residents and contextual influences that may trigger the phenomenon. Therefore, the purpose of this study was to explore CNAs' perceptions of RRV in order to provide insight on the factors, including unmet needs of the residents that trigger the phenomenon.

The literature to date has overwhelmingly focused on violence that is directed by residents towards caregivers during intimate care in resident rooms (Hoeffler et al., 2006). Emerging evidence from direct observation studies (Allin et al., 2003; Bharucha et al., 2008) emphasizes unique circumstances in which RRV occurs and how it is different from resident-to-care-giver violence. These studies indicate that RRV is unique in the times of day it is committed, the locations in which it is committed, and the circumstances under which it is committed (Allin et al., 2003; Bharucha et al., 2008; Rosen et al., 2008). Additionally, the triggers for the two types of violence appear to be different (Bharucha et al., 2008; Lachs et al., 2007).

In the only previously reported qualitative investigation of RRV, Rosen and colleagues (2008) focus groups identified 29 total triggers. The most common triggers included calling out or making noise, territoriality or challenges with communal living, roommate inability to compromise preferences, impatience, loneliness, abandonment, jealousy, and cognitive impairment disinhibition or dementia.

Though studies of RRV are few, the Rosen (2008) findings have been supported by others. Competition for material sources was identified as a trigger in two observational studies (Allin et al., 2003; Bharucha et al., 2008). This competition may be related to the territoriality or jealousy identified as a trigger by Rosen and colleagues (2008). Shinoda-Tagawa and colleagues (2004) concluded that wandering behavior may be integral to the study of RRV, because wanderers often invade the personal space of others in the NH and "put themselves in harm's way." Wandering may be a factor in several of the triggers identified by Rosen and colleagues such as territoriality, impatience, dementia, cognitive impairment or disinhibition.

Although studies are limited, the evidence suggests that RRV is a common phenomenon that threatens the safety and quality of life of NH residents. An understanding of RRV and its triggers are requisite to the development of interventions by which to decrease or manage it. Findings from this study provide an important view of the triggers of RRV from the perspective of the CNAs who are the individuals in most intimate contact with the residents.

Method

Design

This study was conducted utilizing a descriptive, qualitative design. This approach was used in order to capture the caregivers' viewpoint regarding triggers to RRV in NHs. In-depth, face-to-face interviews and a demographic form were used for data collection.

Setting

After obtaining Institutional Review Board approval and a letter of support from the participating NH, the Principal Investigator (PI) recruited CNAs employed at a rural county-owned (not for profit) NH in the Mississippi Delta region of Arkansas with a capacity of 125 residents. Purposive sampling was used to increase the likelihood of obtaining a sample diverse in ethnicity, age, and length of time employed at the NH. Inclusion criteria included employment at the facility and verbalization that CNAs had witnessed RRV first hand. No exclusion criteria were employed.

The PI held an informational meeting during regularly scheduled CNA staff meetings. Permission to contact forms were completed by CNAs who met the inclusion criteria and who were willing to be contacted by the investigator. The PI then met individually with those willing to participate to describe the study, answer questions, and to obtain informed consent and Health Insurance Portability and Accountability Act authorization.

Measures

Demographic form—Following the informed consent process, participants completed a demographic questionnaire that provided background information such as age, gender, marital status, years of experience, education level, and a description of any training that the CNA might have had regarding the management or prevention of RRV. The demographic form was researcher-developed and was based on a demographic form previously utilized by Gates and colleagues in a study of resident-to-caregiver violence (Gates, Fitzwater, & Succop, 1999).

Semistructured interview guide—There were no previously developed interview guides designed to elicit CNA knowledge of the triggers of RRV. However, Gates and colleagues (1999) developed an interview guide to elicit CNA perceptions of resident-to-caregiver violence upon which the interview guide developed for this study was based. Additional questions were added that probed specifically for triggers of RRV. After questions were developed, the interview guide (see Table 1) was reviewed by a panel of nurse researchers with expertise in dementia research and qualitative interviewing to assess the utility of the questions.

Procedure

The semistructured interviews were scheduled on the basis of the CNAs' preferences. The structure allowed CNAs to tell their stories in the manner they chose. Nine were conducted at the NH in a private conference room and two were conducted in another private location. The PI, a gerontological advanced practice nurse with 25+ years of experience in caring for older adults, conducted all interviews to provide consistency. The PI began by asking each CNA to describe RRV occurrences that they had witnessed. In the course of each interview, CNAs were asked whether they believed that unmet needs of the residents influenced the development of RRV. The interviews lasted from 30 mins to 1.5 hrs. All interviews were digitally recorded and transcribed verbatim.

Data Analysis

The PI entered descriptive quantitative data manually into Statistical Package for the Social Sciences 17.0 (SPSS Inc., Chicago, Illinois) for analysis. She checked interview transcripts for accuracy and then entered them into Ethnograph 6.0 (Qualis Research, Colorado Springs, CO), a data management program that facilitated data sorting. Qualitative data collection and initial data analysis were concurrent. Content analysis was used to identify specific triggers which were then grouped into trigger clusters. The researcher then compared these trigger clusters with other triggers, using the technique of constant comparison, and consolidated the groups of clusters to form the overarching global trigger categories of active and passive triggers. Active triggers were defined as any actions by another resident that precipitated RRV. Passive triggers were defined as irritants in the physical or social environment that influenced the development of RRV but did not necessarily involve an overt action by another resident. To provide auditability, the researcher recorded coding decisions used to guide data analysis. Examples of analyses are found in Table 2. Two experienced nurse researchers with expertise in qualitative methods reviewed and assisted with the analysis.

Results

Sample Description

Eleven CNAs participated in this study. Mean ages of participants were 33 years with ages ranging from 21 to 60. Nursing home experience caring for residents with dementia ranged from 1 to 10.5 years (mean = 5.25 years). All participants stated that they had received some on-the-job training in the management of violent residents, but all denied formal training.

Active Triggers

Active triggers were described by CNAs as precipitating factors of RRV a total of 359 times. Moreover, all eleven CNAs described active triggers in each of the categories during the course of the interviews. Specific active trigger categories and the number of times they were described included the following: Intrusion into personal space (208), environmental issues with roommates and others (75), taking/touching another resident's possessions (53), and another resident's act of violence (23). One participant described the active triggers that might precipitate RRV as often being "the least little things" and stated that actions by other residents that the CNAs considered to be insignificant were often highly irritating to the residents, especially if several triggers were experienced in a short period of time. A discussion of each of the active trigger categories follows.

Intrusion into personal space—All CNAs mentioned intrusion into personal space ($n = 208$) as the foremost trigger precipitating RRV. In some cases the intrusion occurred in resident rooms or outside resident rooms in areas which the residents claimed as their "territory." The CNAs described many instances of wanderers who entered another resident's room and used their restroom. One CNA quoted a resident as saying, "that whore be walking the street down here and she keeps coming into my house using my bathroom. I will kill her ass if she do it again." Climbing into another resident's bed was described by CNAs as being particularly "aggravating" to residents. One resident was described by CNAs as "Goldilocks" because he had "no boundaries" and wandered into other residents' rooms and "tried out" their beds before moving on to the next resident's bed. The CNAs stated that this man had been the victim of multiple episodes of RRV. The residents, understandably, did not want him in their beds.

Incidents of RRV were also described outside residents' rooms. The CNAs stated that they spend much of the day intervening between residents who claim the same seat in the dining

room or activities room. One CNA quoted a resident as saying just prior to an episode of RRV, “Get out of my chair! I have sat there for the last 20 years and you can’t have it!”

Environmental issues—The CNAs mentioned environmental triggers 75 times. Most often, RRV was thought to be caused by loud or repetitive noise produced by other residents. According to the CNAs, residents often state the following after episodes of RRV: “They are too loud; they stay up too late; I don’t like to watch TV!” One resident was bothered by the sound of her roommate’s oxygen so she turned it off. According to CNAs, residents also “came to blows” because one would constantly adjust the heat or air conditioning causing discomfort for another resident in the room. Other episodes of RRV involved disagreements between roommates about whether the door and/or curtains should be open or closed.

Taking/touching possessions—The CNAs stated that many times one resident would strike out at another resident when they perceived that their possessions had been taken or touched ($n = 55$). One CNA stated that food was often the focus and one resident would reach over and take food from another resident’s tray. Another CNA stated that a “fight” broke out when one resident took another resident’s stuffed animal. Other instances involved accusations of merely touching other residents’ possessions, “She got into it with her because she must have actually touched something of hers.”

Violence—Witnessing or experiencing acts of violence as a victim was described by the CNAs as a major trigger and one that almost always resulted in physical retaliation by the victim ($n = 23$). Five of the 11 CNAs described a situation in which one male resident watched another resident repeatedly hit, kick, and grab CNAs repeatedly over the course of a day. The man who witnessed the violence became so upset that he broke his walking cane over the head of the man who had been committing the resident-to-caregiver violence.

Passive Triggers

Though not described with the frequency of active triggers, passive triggers were mentioned a significant number of times by all participating CNAs. Competition for attention and resources was mentioned 43 times as a trigger to RRV, communication difficulties were mentioned 40 times, and boredom was mentioned 30 times. Each of these will be described in more detail in the following section.

Competition—According to the CNAs, if a resident believed that another resident was receiving something that he/she was not, he/she might strike out physically at the resident who was perceived as more privileged ($n = 43$). The context of these episodes distinguished them from the active trigger of *taking possessions* described in the previous section because in these cases, residents verbalized to the CNAs that they were being slighted in some way. An example provided by one CNA involved a resident stating, “Why does she have a big sign with her name over the door and I don’t?” Another example involved a resident stating, “She is special and I’m not. I’ll get her!”

Communication difficulties—A variety of communication problems were described by the CNAs as causing “aggravation” with the potential for escalation to RRV ($n = 40$). These included difficulty with verbal expression which resulted in repetitive or inappropriate vocalizations and difficulty hearing which led to complete misunderstanding or loud vocalizations. According to the CNAs, both the senders and receivers of verbal communication became “aggravated” when understanding was not achieved through verbal communication. One CNA story involved a man, his wife, who had a severe hearing deficit, and another resident who was attempting to communicate with her. The wife became upset

when she couldn't hear what the other resident was saying and the man, believing that the resident was harming his wife, slapped the resident who was attempting communication.

Boredom—The CNAs stated that they believed boredom to be a major trigger to RRV ($n = 30$) in spite of an excellent restorative and recreational therapy program provided by the facility in which each resident receives an average of 5 mins per hour of one-on-one time with restorative therapists during the work week. According to one CNA, "You get more hand-to-hand action when they are in a group with nothing to do." Another CNA said, "They need something more to do. The best thing to do is to keep them busy and they don't get nearly as aggravated." All participants indicated that during Nursing Home Week and during the Christmas holiday when residents are occupied with additional activities, fewer episodes of RRV occur.

Findings Related to Unmet Needs of the Residents

Interestingly, when asked specifically whether they believed that unmet needs of the residents influenced the development of RRV, the CNAs unanimously denied it. Interpretation of this finding is included in the discussion section.

Additional Findings

The CNAs participating in this study had no difficulty describing active and passive triggers to most episodes of RRV. However, they also described episodes of RRV in which they could not identify a specific trigger. For example, CNAs made statements such as, "I don't know what caused it, but they really don't like each other" and "I don't know what ticks him because it could be anything." Situations in which the CNAs could not describe a specific trigger were mentioned only six times in the course of the interviews.

A large amount of data, in addition to that related to triggers, emerged from the interviews. These findings included the following: Characteristics of the victims and initiators that may influence the development and escalation of the phenomenon; strategies that the CNAs used to prevent and de-escalate RRV and; consequences of RRV. These findings will be presented in subsequent publications.

Discussion

The results of this study provide the most comprehensive and in-depth description of triggers of RRV to date, with insight into the context of the episodes. Previous studies identified triggers but did not examine them from the perspective of unmet needs of the residents. The depth of the previous findings may also have been limited by the methodologies used to explore RRV.

The CNAs in this study had no difficulty identifying a variety of triggers that they believed influenced the development of RRV. Though the CNAs did not view any of the triggers as unmet needs of the residents, when viewed objectively, each of the trigger categories may relate directly to one or more unmet needs of the residents (see Table 3). The disparity in recognizing triggers as unmet needs of the residents may be explained by the manner in which CNAs conceptualize them. They may view the existence of unmet needs of the residents as a failure on their part to sufficiently care for the residents with whose care they have been charged.

The findings of this study support the work of previous researchers (Allin et al., 2003; Bharucha et al., 2008; Rosen et al., 2008). However, intrusion into private space emerged from the interviews as the single most prevalent trigger of RRV where calling-out behavior

was identified as most prevalent by Rosen and colleagues (2008). This discrepancy may be due to the fact that Rosen and colleagues relied on data provided by a variety of NH workers as focus group informants rather than the CNAs who are in most intimate contact with the residents.

Contextual information that emerged from the interviews indicates that the social environment may have a significant effect on the development of RRV. Especially significant may be the identification of intrusion into personal space as the primary trigger. The remaining factors (touching possessions, environmental issues, violence committed by others, boredom, and competition) all allude to the importance of the social environment in the development of RRV. However, boredom may also be influenced by geropsychiatric pathology, including depression. Particularly important may be the adjustment of residents from a lifetime of independence to institutionalization and communal living.

Conclusions and Implications for Clinical Practice

The findings of this study support previous studies that identified RRV as a common and serious problem in nursing homes (Bharucha et al., 2008; Lachs et al., 2007; Rosen et al., 2008; Shinoda-Tagawa et al., 2004). Knowledge of common triggers of RRV may assist CNAs and other nursing home workers to identify situations in which it is likely to occur.

The participants included in this study were CNAs caring for residents in a nursing home. It is likely that many of the residents for which they cared were cognitively impaired. However, conclusions regarding the impact of dementia on the development of RRV are not reported here.

The CNAs included in this study repeatedly discussed “aggravation” caused by intrusion into personal space as a catalyst of RRV. This finding implies that intrusion into personal space, as well as other triggers, may be linked to a need for control over their territory that residents lose in the transition from private living to the communal environment of the NH. Staff should be made aware that assisting residents in maintaining a maximum amount of control over their personal space, belongings, and environment may reduce the number of RRV episodes. This may be facilitated by providing residents who wander and are likely to invade the personal space of others with safe wandering paths away from resident rooms. Efforts to ease the transition from private living to communal living may also decrease the incidence of RRV.

The volume of evidence emerging from the interviews indicates that CNAs spend a significant amount of time intervening in potentially volatile situations between residents. Knowledge of triggers may assist CNAs in identifying situations that have the potential for violence and in intervening before escalation occurs. Effective prevention of RRV may drastically reduce the workload of both CNAs and licensed nurses, who are responsible for reporting and documenting RRV.

The findings also indicate that overstimulation in the form of loud noises, crowding, and perceived extreme temperatures may increase “aggravation” levels that lead to RRV. Allowing for adequate space in which residents may move around, spaces in which residents can escape from noise and adequate clothing for cold-natured residents or fans for hot-natured residents may decrease the incidence of RRV.

Although this study focused on a small sample of CNAs from a single NH, important information was obtained about factors that may trigger RRV. There is, however, much more to be learned. Further research is needed to explore additional factors that influence the development of RRV, using larger sample sizes and participants from multiple centers,

including metropolitan NHs. Following a thorough exploration of the factors that influence the development of RRV, a model for the prediction of the phenomenon may be developed. Finally, it is imperative that researchers develop and test interventions for the prevention of RRV involving residents in NHs to improve their safety and quality of life.

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References

- Algate D, Beck C, Kolanowski A, Whall A, Berent S, Richards K, Beattie E. Need-driven dementia-compromised behaviour: An alternative view of disruptive behavior. *American Journal of Alzheimer's Disease*. 1996; 11(6):12–19.
- Allin, SJ.; Bharucha, A.; Zimmerman, J.; Wilson, D.; Roberson, MJ.; Stevens, S.; Atkeson, CG. Toward the automated assessment of behavioral disturbances of dementia. Paper presented at the meeting of the Fifth International Conference on Ubiquitous Computing and the Second International Conference on Ubiquitous Computing for Pervasive Healthcare Applications; Seattle, WA. 2003.
- Bharucha AJ, Vasilescu M, Dew MA, Begley A, Stevens S, Degenholtz H, Wactlar H. Prevalence of behavioral symptoms: Comparison of the Minimum Data Set assessments with research instruments. *Journal of the American Medical Directors Association*. 2008; 9:244–250. [PubMed: 18457799]
- Dettmore D, Kolanowski A, Boustani M. Aggression in persons with dementia: Use of nursing theory to guide clinical practice. *Geriatric Nursing*. 2009; 30(1):8–17. [PubMed: 19215808]
- Gates D, Fitzwater E, Succop P. Reducing assaults against nursing home caregivers. *Journal of Gerontological Nursing*. 1999; 25(4):12–22. [PubMed: 10426030]
- Hoeffler B, Talerico KA, Rasin J, Mitchell M, Stewart BJ, McKenzie D, Sloane PD. Assisting cognitively impaired nursing home residents with bathing: Effects of two bathing interventions on caregiving. *Gerontologist*. 2006; 46:524–532. [PubMed: 16921006]
- Lachs M, Bachman R, Williams CS, O'Leary JR. Resident-to-resident elder mistreatment and police contact in nursing homes: findings from a population-based cohort. *Journal of the American Geriatrics Society*. 2007; 55:840–845. [PubMed: 17537083]
- Patel V, Hope RA. A rating scale for aggressive behavior in the elderly: The RAGE. *Psychological Medicine*. 1992; 22:211–221. [PubMed: 1574558]
- Rosen T, Lachs M, Bharucha AJ, Stevens S, Teresi JA, Nebres F, Pillemer K. Describing resident-to-resident aggression in long term care facilities: Insights from focus groups of nursing home staff. *Journal of the American Geriatrics Society*. 2008; 56:1398–1408.
- Shinoda-Tagawa T, Leonard R, Pontikas J, McDonough JE, Allen D, Dreyer PI. Resident-to-resident violent incidents in nursing homes. *Journal of the American Medical Association*. 2004; 291:591–598. [PubMed: 14762038]

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Table 1**Interview Guide**

Lead in/global question	As you know, I'm interested in resident-to-resident violence. Tell me about your experiences with it.
Probe questions	Could you describe some of the occurrences that you have witnessed? Why do you think that resident-to-resident violence occurs? Can you think of any characteristics that the residents who become violent share? What do you think the most important triggers are? What do you think the residents who are violent are trying to communicate? One theory is that resident-to-resident violence is influenced by unmet needs of the residents. If so, what do you believe some of these needs might be? Is there anything else that you would like to add about resident-to-resident violence? If you could have one wish granted to solve the problem of resident-to-resident violence, what would most help you deal with the problem? Is there anything that you would like to add?

Table 2

Examples of Analysis Decisions.

Global trigger categories	Trigger categories	Frequency	Raw data
Active triggers	Intrusion	208	She said, "Get out of my room!" No boundaries for this guy. She is overly helpful.
	Environmental issues	75	Some are hot and some are cold. He said, "I don't like to watch TV." She said, "Turn that light off!"
	Taking/touching possessions	55	That is her stuff. Steals stuff out of her room. Touched something of hers.
	Violence	23	Tried to kick her in the head. Say they have been hit.
	Competition	43	She said, "You treat her special." She said, "They are more important than me."
Passive triggers	Communication	40	Can't understand her. She's not verbal anymore. Lots of them are hard of hearing.
	Boredom	30	They are waiting and anxious. They have nothing to do. They just stare at these ugly walls.
			There is nothing in front of them but another resident.

Table 3

Trigger Categories and Their Corresponding Unmet Needs.

Trigger category	Unmet need
Intrusion into private space	Personal space
Taking/touching possessions	Control over personal property
Environmental issues	Control over the environment (heating/cooling, quiet/tranquillity, etc.)
Violence	Personal safety
Competition	Attention and interaction
Boredom	Sensory stimulation
Communication	Safety, environmental control, and/or physiological needs (hunger, thirst, pain, elimination, etc.)