Published in final edited form as:

Res Gerontol Nurs. 2012 January ; 5(1): 55–63. doi:10.3928/19404921-20110603-01.

Victim or Initiator? Certified Nursing Assistants' Perceptions of Resident Characteristics that Contribute to Resident-to-Resident Violence in Nursing Homes

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Abstract

The purpose of this portion of a larger qualitative study was to explore certified nursing assistants' (CNA) perceptions of the characteristics of both the victims and initiators of resident-to-resident violence (RRV) in order to identify resident characteristics that influence the development of RRV. Data were collected using a demographic form and semi-structured interviews. Demographic data were analyzed using descriptive statistics and interview data were analyzed using content analysis and constant comparison. The results revealed that CNAs perceive initiators of RRV to be "more with it," to have "stronger personalities," "shorter fuses," and "life history" that makes them prone to inflict harm on other residents. Certified nursing assistants described victims of RRV using phrases such as, "they don't know," "can't communicate," and "gets around good." These results indicate that there are resident characteristics that may indicate whether a resident is likely to commit, or become involved as a victim in, RRV. The results also revealed that, in some situations, residents who were normally easy going and even tempered might strike out with violence if exposed to a large number of triggers over time. This study provides the first detailed description of nursing home residents who initiate violence against other residents. Knowledge gained from this study may be useful in developing models of RRV, a precursor to developing interventions for the prevention of RRV.

In the year 2030, it is projected that 10 million people with dementia will reside in nursing homes, and that 57% (5.7)million of those residents will become violent at some point (Dettmore, Kolanowski, & Boustani, 2009). Recent studies have shown that approximately 36% of nursing home violence is between residents (Allin, et al., 2003; Bharucha, et al., 2008). Resident-to-resident violence (RRV) is defined as the delivery of noxious stimuli by one resident to others that is clearly not accidental (Patel & Hope, 1992). Predicting and preventing (RRV) is important because of its potential to negatively affect the quality of life and safety of nursing home residents.

Studies suggest that RRV is very likely under-reported (Allin, et al., 2003; Bharucha, et al., 2008), and results in physical, psychological, and resource utilization consequences for all parties involved. The consequences include physical harm, emotional harm, the use of interventions known to be detrimental to the care of the older people (such as physical and chemical restraints), and the use of resources (nursing time, law enforcement resources) spent reacting to violence that could be better spent implementing proactive strategies for its prediction and prevention. This indicates that predicting and preventing RRV is important to nursing, not only from a policy and monetary standpoint, but also because of the dire consequences that often results.

In recent years, studies of RRV have revealed some insight into the characteristics of the victims, but have provided little information regarding the characteristics of the initiators (Shinoda-Tagawa, et al., 2004). To effectively predict the phenomenon, a comprehensive description of the characteristics of both victims and initiators is necessary. As those most intimately involved in the care of residents in nursing homes, certified nurses' assistants can provide valuable insight into their characteristics. Therefore, the purpose of this study was to explore the certified nursing assistants' (CNA) perceptions of the characteristics of both the victims and initiators of RRV episodes in order to identify resident characteristics that influence the development of RRV.

Literature Review

The study of RRV is in its infancy. To date, only six studies have been identified that explore the phenomenon (Allin, et al., 2003; Shinoda-Tagawa, et al., 2004; Lachs, Bachman, Williams, O'Leary, 2007; Bharucha, et al., 2008; Rosen, et al., 2008; Sifford, Beck, Green, & McSweeney, [in review]). (See Table 1). Though informative, these studies did not allow for in-depth exploration of the characteristics that residents who become involved in RRV as victims and initiators, share.

Victims

Shinoda-Tagawa, et al. (2004), conducted a case control study of nursing home residents who had sustained a visible injury from an incident with another resident and had therefore been reported to the Massachusetts Department of Public Health's Complaint and Incident Reporting System in 2000. The investigators examined injured residents' characteristics as part of the study and found that injured residents were more likely to be cognitively impaired, exhibit symptoms of wandering, be verbally abusive, have socially inappropriate behavior, and be re-victimized than the controls. These findings show that the cognitive

status of the victims of RRV is important in predicting its development. Though the study provided valuable information about the victims of RRV, Shinoda-Tagawa, et al., (2004) stated that, “we were unable to characterize or quantify the circumstances of the incidents due to insufficient reporting details that were almost always devoid of information about the alleged aggressors” (p. 594).

Other studies have identified a relationship between impaired cognitive status and the development of violent behaviors. A qualitative focus group study on RRV by Rosen and colleagues (2008) found that intolerance of cognitively impaired residents and wandering behaviors often led to RRV. Lachs and colleagues (2007) also found cognitive impairment to be more prevalent in nursing home residents who experience RRV as victims in their retrospective study of police contact and RRV.

Further support regarding wandering behaviors and functional status as factors preceding RRV was gained from the Shinoda-Tagawa study (2004). The study found that residents who were classified as needing extensive assistance with activities of daily living (adjusted odds ratio [AOR], 0.3; 95% confidence interval [CI], 0.2–0.6) and as being severely dependent (AOR, 0.12; 95% CI, 0.5–0.27) had a significant reduction in being injured. This suggests that as dementia advances and functional status and mobility are limited, the likelihood that a nursing home resident will be a victim of RRV is decreased—probably because they are no longer capable of intruding on other residents’ private space.

Initiators

Lachs and colleagues (2007) found that residents with moderate functional dependency were more likely to be aggressive. Rosen and colleagues (2008) also cited impatience with physical limitations or barriers to mobility as factors preceding RRV. Bharucha and colleagues (2008) also identified frustration with a physical limitation as an antecedent to RRV in the initiators.

Demographic factors have been examined for their impact on the development of RRV. Male gender was found by Lachs and colleagues (2007) to be a significant factor in residents who commit RRV, especially in the context of “male unbonding.” Lachs and colleagues (2007) defined male unbonding as “incidents involving two males known previously to be individually argumentative and engaging in fistcuffs over what appear to be insubstantial issues (e.g., who enters an elevator first).”

The RRV literature indicates that premorbid personality characteristics and premorbid prejudices may influence the development of violent episodes. Rosen and colleagues (2008) found that racism, stereotyping, and perceived religious superiority of the initiators played a role in contributing to RRV.

Conceptual Framework

This study was guided by the Need-driven Dementia-compromised Behavior (NDB) Model (Algase et al, 1996). The primary purpose of theory in qualitative studies is to provide an approach by which to frame questions and gather data to maximize description of the

phenomenon under study (Crane, 2000). By guiding the literature review and the development of the interview guide, the NDB Model influenced the conduct of the study rather than being tested by the investigation.

The NDB Model conceptualizes RRV as a response to unmet needs. People with dementia lose the ability to effectively communicate through verbal channels as the disease progresses. Without the ability to verbally communicate unmet needs, residents with dementia residing in nursing homes may use any means available to them to communicate these needs, including what others may perceive as disruptive behaviors, such as RRV.

Though research on resident characteristics that influence the development of RRV is in its infancy, the previous studies have revealed some incidental findings, primarily about victims. Little information regarding the characteristics of initiators has been collected to date. Knowledge of the characteristics of both victims and initiators is necessary in order to predict which individuals are likely to become involved in RRV episodes. Therefore, findings from this study provide the most comprehensive portrait, to date, of all parties involved in RRV and the first thorough description of the initiators of this violence.

Objectives

The objectives for this portion of the study were (1) to describe the characteristics of the victims and initiators of RRV that occurs in nursing homes; and (2) to identify resident characteristics that influence the development of RRV.

Methods

Design

This is part of a larger qualitative study, parts of which have been submitted for publication elsewhere (Sifford et al., [in review]). A qualitative design permitted in-depth exploration of caregiver perceptions of resident characteristics that lead to RRV (Munhall, 2001). This exploratory design was necessary because little is known about nursing home residents who initiate and experience RRV (Shinoda-Tagawa, et al., 2004).

Sample

After obtaining Institutional Review Board approval, CNAs were recruited on the basis of self-reporting that they had witnessed at least one episode of RRV during their tenure at the nursing home. Eleven racially diverse CNAs participated in the study. The mean age of participants was 33 years and ages ranged from 21 to 60 with NH experience with residents with dementia ranging from 1 to 10.5 (mean = 5.25) years. The sample was comprised of six African Americans and five Caucasians. A high school education had been obtained by 10 of the CNAs. All participants stated that they had received some informal training in the management of violent residents in the form of advice from nurses and other CNAs.

Setting

The county-owned (not-for-profit) nursing home that served as the study site is located in the rural, Mississippi delta region of Northeast Arkansas. It was selected based on

established relationships between the researcher and the facility and through verbalization by nursing staff that RRV is one of the major problems facing the CNAs and that it occurs on a daily basis. The facility has a 125 bed capacity and employed 61 CNAs at the time of the study with 10 vacancies. Of the 61 CNAs employed at the time of the study, two-thirds were African American and one-third was Caucasian. The facility's CNA turnover rate is comparable to the national average of 71%, but most of the administrative staff and licensed nurses have been employed at the facility for many years.

Data Collection

After informed consent was provided, the CNAs completed a demographic form. A semi-structured interview guide (see Table 2), designed to provide the CNAs with the freedom to tell their stories in their own way, was developed by the research team. Prior to conducting the interviews, the interview guide was reviewed for content and suitability by six experts including the director of nursing at the facility, author XXXX, who is a geriatric nurse researcher specializing in disruptive behaviors, a nurse researcher specialized in resident violence, a geriatric psychiatrist specialized in RRV, and two nurse researchers with qualitative expertise, authors Green and McSweeney. Revisions were made to the interview guide according to suggestions made by the expert panel.

To provide consistency, all interviews were conducted by the Principal Investigator (PI). All interviews occurred at a time and location of the participants' choice, in a private conference room in the nursing home or another private location. Although all participants addressed the topics on the interview guide, the semi structured format provided the CNAs with the opportunity to tell their stories in their own way. Therefore, questions were not necessarily asked in sequential order. Interviews lasted from 30 minutes to 1.5 hours. All interviews were digitally recorded and transcribed verbatim.

Data Analysis

Each interview transcript was checked for accuracy before entering it into Ethnograph 6.0 (Seidel, 1998), a data management program. Data analysis and collection were concurrent as is expected in qualitative studies (Morse & Field, 1995). Content analysis was used to identify raw data clusters in the interviews followed by constant comparison to compare each raw data cluster with all other data clusters. Through this iterative process, data clusters were combined based upon similar meanings to yield factors. The factors with similar meanings were then combined to yield more abstract themes. Two experienced qualitative researchers reviewed coding and analysis decisions to enhance trustworthiness, the qualitative equivalent of reliability and validity.

Results

Resident characteristics

Eleven global factors that CNAs perceived as resident characteristics affecting the development of RRV emerged in response to the interview questions (see Table 3). The factors were then collapsed based on similarities in meaning into two broad categories: victim characteristics and initiator characteristics.

In response to the two interview questions, “Why do you think that RRV occurs?” and “Can you think of any characteristics that the residents who become violent share?” as well as in their descriptions of the episodes of RRV, the CNAs provided a wealth of knowledge regarding the characteristics of both victims and initiators. Resident characteristics will now be described as perceived by the participants.

Initiator Characteristics

Initiators of violence were identified as those who were physically, verbally, or emotionally abusive to other residents. Using the words of the CNAs, initiators were described as being “more with it,” as having “strong personalities,” as having “short fuses,” and as being influenced by events or teachings from their “earlier lives.”

More with it—Participants described most initiators as being “more with it.” They described initiators using phrases such as, “they have a pretty good memory” and “she knows a little bit more.” They were also described as having little patience with those who are more confused. In addition, CNA # 7 described behavior that may be compared to social clique or group behavior that may be related to the social environment that exists in the nursing home and includes initiators and victims. An example of this phenomenon as related by CNA #7 follows:

Like I said, there are a few ladies that if they were in high school, you would call them the cheerleaders. They instigate and they nit pick at all the other residents as they sit in their chairs in the sun room. They will sit there and talk about everybody. “She just thinks she’s pretty, look at her, she hasn’t brushed her hair all day.” Well, that hurts a lot of residents’ feelings. One resident won’t sit near them. She doesn’t want to be near them. She says she doesn’t want to be talked about. When we walk her we have to walk her in between the kitchen and us because she doesn’t want those particular residents to see her walk because they will make fun of her. They are more alert and their attitudes are different. They will say, “Get that woman away from here. She doesn’t need to watch TV. She doesn’t even know what’s going on.” It hurts. Just because you have Alzheimer’s doesn’t mean that you don’t have feelings. They know they’re being talked about.

In several instances the CNAs stated that the initiators of RRV believe that the victims intentionally irritate them to the point of violence. The CNAs stated that the initiators often do not understand that the victims are confused, but believe that their actions are intentional attempts to irritate them. The CNAs stated that they spend a lot of time trying to explain to the residents who have higher cognitive functioning that the more confused residents do not understand that they are irritating them by their vocalizations or actions.

Strong personality—Seven participants identified a strong personality as a common initiator characteristic. Phrases used by participants to describe initiators included “overly motherly” and “overly helpful.” Initiators were also described as “having to have things their way,” “thinking they know everything,” and being “strong-headed.” An excerpt of a description of these characteristics by CNA # 1 follows:

We had this one resident and she can't seem to get along with anybody. Every time she gets a roommate they are gone like that, because "that's her home" and "both of those beds are hers" and she is going to rule it the way that she wants to. She is overly helpful. She will try to help the residents in bed and out of the wheelchair. They don't want her help and get hurt.

Short fuse—Of the 11 CNAs, 10 described initiators of RRV as being "short-tempered," as being "impatient," or as having a "short fuse." The participants stated that they believed that residents maintain the same personality traits throughout life and that if a resident was short-tempered or irritable earlier in life, they will remain so following the onset of dementia. They stated that they gather this information from family and visitors. One participant (CNA # 4) described residents who initiate RRV:

That's people that aren't happy and never have been happy. I figure they were like that all of their lives. Like I said, they started out that way and they will die that way. They try to pick on people to feel better about their self.

Life history—Of the 11 CNAs, nine talked extensively about the influence of the initiators' earlier life and teachings on their potential for striking out at other residents. They stated that in some cases, the residents who were initiators seemed to associate residents at whom they strike out to people that they knew in their life before dementia or before they entered the nursing home. They perceived the victims as someone who they did not like or who had "done them wrong" at a previous time in their lives. One resident repeatedly told the CNAs that she hits and pushes another resident because she "stole my husband." Another resident told the CNAs that he was violent toward another resident because he was "the enemy." This particular resident was retired from the military. Premorbid racial prejudices and teachings were also identified by four CNAs as influencing the violent behaviors of initiators. The four participants described a situation in which a black man dumped a white man out of his wheelchair. One CNA (# 4) stated that "that is in their generation. It was in their day and time. That is what they were taught—not to like or respect each other—only to hurt each other."

Victim Characteristics

The CNAs described victims as having distinct characteristics that made them particularly vulnerable to RRV. The characteristics mentioned unanimously by CNAs and which emerged as sub-themes during data analysis (see Table 3) were factors related to confusion, impaired communication, and good mobility status. Using the words of the participants, victim factors were "they don't know," "can't communicate," and "physically mobile."

They don't know—When describing the victims of RRV, the CNAs repeatedly used the words, "they just don't know." They believed that the victims were more confused than the initiators in most cases. In one situation, a resident who was severely confused repeatedly walked into another resident's room and urinated in her trashcan. The episodes were described as follows by CNA # 4:

That lady threatens the other lady and has been sent to Oasis (inpatient geropsychiatric unit) for that. She will say, “The next time she comes in here I am going to turn that trash can over on her head and she is going to be wearing it as a hat.” It’s kind of weird, the lady that it’s her trash can, she knows a little bit more and we try to explain to her that the other lady doesn’t really understand. It is kind of hard for them to understand that the other person doesn’t know what they are doing. Sometimes, I think it is just people just being sick of being around people, but a lot of the ones that we can’t really fix is because of their mind. The person doesn’t know what they are doing and they can’t help it. A lot of it is that they don’t understand that the other person doesn’t know what they are doing.

Can’t communicate—At some point in each interview, CNAs mentioned that many victims of RRV have problems with either the sending or receiving of verbal messages. The CNAs described victims as having repetitive verbal communication patterns, as being unable to use the appropriate words to express a thought, as mumbling or “stuttering” in their speech, or as being extremely hard of hearing. Each of these communication problems were said to cause “aggravation” in residents and increase the potential for RRV. This factor appeared to be related to the factor of *can’t communicate* to several of the participants. An example, as related by CNA # 2, of how they linked the two factors together follows:

I don’t know—her dementia is really advanced. She speaks, but a lot of her words...she may say “dog” but she means “car” sometimes. But other times she speaks just fine. No one can really understand and they want to help but just get aggravated and sometimes strike out at her.

Physically mobile—Another important victim characteristic identified by CNAs pertained to being physically mobile. The CNAs stated that victims who were mobile and wandered into the private or intimate spaces of other residents were identified as being particularly vulnerable to RRV. One victim was perceived as “having no boundaries.” Certified nursing assistant #2 stated that even having a facility with all private rooms would not decrease the incidence of RRV because “you would still have the wanderers” and they would go places where they shouldn’t and “get into trouble.”

Victims or Initiators?

Of the 11 CNAs, five mentioned that sometimes it is impossible to know who will most likely commit RRV. They stated that, in some cases, a previously mild mannered, sweet-tempered individual can be driven to initiate RRV if the conditions are right. In these cases they believe that the lines blur between victim and initiator and the wrong resident is sent to the inpatient psychiatric unit for treatment. An example of this phenomenon as related by CNA # 5 follows:

Mr. C had been violent toward the CNAs all day long. His meds had been changed that morning. Mr. B had been watching Mr. C hit us and swing us around all day. He finally had enough. He broke his cane over Mr. C’s head. Mr. B (who hit the other man) has been here for about 3 months. He is as sweet as sugar. He is a really good guy. I have never heard him raise his voice. He has never had any altercations

with any other residents. It is completely out of his character. His daughter said that he never even spanked them as children. They sent the wrong man to Oasis.....Mr. B thought he was protecting us and couldn't take it anymore.

This situation described above is the only episode described by any of the CNAs in which a resident without a previous history or tendency toward violence committed a violent act toward another resident. It is significant because it was mentioned by five of the CNAs. They believed that the true initiator was the man who had committed violent acts toward the CNAs all day rather than the man who committed the violent act toward the other resident. This will be discussed further in the next section.

Discussion

The findings of this study emerged from a larger study focusing on the unmet needs that may trigger RRV in nursing homes. Initially, the participants were asked only one question regarding the characteristics that residents who experience RRV share. However, as the CNAs described episodes of RRV, they provided descriptions of both initiators and victims of the phenomenon. Therefore, probe questions were added to help us better understand the residents who were involved in RRV and how their characteristics may influence the development of the phenomenon. These findings are particularly important because they represent the first comprehensive description of the initiators of RRV and additional information regarding victims.

Though certain resident characteristics had been identified in the Rosen, et al., study (2008), they were not examined separately but were listed only as "triggers." (See Table 4) The results of this study reveal that resident characteristics may not be triggers, but instead inherent traits of the residents that may interact with triggers to influence the development of RRV. Though not designed to test theory, these results support the work of Algase, et al., (1996) who proposed through the Need-driven Dementia-compromised Behavior Model that background factors (resident characteristics) interact with proximal factors (unmet needs/triggers) to produce need-driven dementia-compromised behaviors (RRV).

The findings of this study represent the first in-depth view from the perspective of CNAs of the characteristics of residents who become involved in RRV. Though resident characteristics have been discussed previously in the literature (Rosen, et al., 2008), the findings regarding social behavior and the existence of social cliques in the nursing home were not previously mentioned. These findings may indicate that social (group) characteristics, as well as individual resident characteristics, may play a role in the production of RRV. If so, this further emphasizes the importance of the social environment in the development of RRV. This type of violence was identified as being particularly hurtful to residents and troublesome to CNAs even though no physical harm was inflicted.

The findings regarding shared characteristics indicate that residents who may be low risk for violence because of their inherent characteristics (sweet disposition) may be provoked to violence if exposed to enough triggers or to severe triggers. This indicates that the levels at which individual residents become provoked to commit RRV may be very different but that all residents may be at risk for becoming either an initiator or victim of RRV. The findings

indicate that the lines between initiator and victim are somewhat blurred because the victim may instigate the violence by “aggravating” the initiator past his/her level of tolerance.

The limitations of this study include a small sample size recruited from only one facility. Generalizability of the study is also limited by the characteristics of the nursing home itself. It is different from most other nursing homes in the region because of its reputation for exemplary care as evidenced by a waiting list of residents awaiting admission. Another limitation may be related to the characteristics of the sample. As stated earlier, the nursing home had a turnover rate comparable to the national average, but the CNAs included in this study had worked at this one nursing home for an average 5.25 years and may represent a core group of dedicated workers who provide better than average care. Registered nurses may also provide different views. Despite these limitations, this study provided the first real view into the lives of the initiators and the social interactions that produce RRV in nursing homes.

Application to Practice

Resident characteristics that may put residents at risk (such as, degree of cognitive impairment, ability to communicate effectively, mobility status, pre-admission personality type, tendency to lose temper, and pre-admission values and beliefs) should be assessed on admission to the nursing home and with any changes in the cognitive, functional, or health status of the residents. Simply asking the residents or families what makes them lose their temper or become aggravated may assist in developing strategies to decrease the aggravation level of residents. If possible, an assessment of premorbid personality characteristics (i.e., temperament), values, beliefs, prejudices, and history of violence (both emotional and physical) may shed light on the risk of the resident becoming involved in RRV.

Cognitive functioning and confusion were the most important resident characteristics identified by participants. Awareness of resident intolerance of more confused residents may allow nursing staff to prevent episodes of RRV. Space for those who are more confused to move freely in the nursing home without irritating those who are more cognitively intact may positively impact the quality of life of both groups of residents.

The interviews revealed important information regarding behavior by residents who were more cognitively intact that produced “hurt feelings” in residents who were less cognitively intact. Awareness of this behavior by nursing staff may allow them to protect the feelings of the victims. Because this violence produces emotional harm rather than physical harm, facilities may need to propose guidelines for the management of emotional abuse.

Conclusions and Future Directions

Few studies have focused on the characteristics of residents who become involved in RRV episodes in nursing homes. This study provides a glimpse into the lives of the residents, as perceived by the individuals who are most intimately involved in their care, the CNAs. It provides direction for clinical intervention and future research. Particular attention is needed to allow for routine assessment of resident characteristics that may lead to RRV. The education of nursing staff in high risk resident characteristics and common resident

situations leading to RRV may be useful in the prevention of the phenomenon. Further exploration of resident characteristics and the social context that influence the development of RRV is needed in order to develop predictive and preventive strategies for the phenomenon.

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Table 1**What We Know**

Study	Victims	Initiators
Shinoda-Tagawa, et al., (2004) case control, retrospective study (n = 1994)	More likely to: <ol style="list-style-type: none"> 1 be cognitively impaired 2 exhibit signs of wandering 3 be verbally abusive 4 have socially inappropriate behavior 5 be re-victimized 	No data reported.
Lachs, et al., (2007) Reported on police contact (from 1985–1995) with 42 of 747 older adults placed in nursing homes who had been community dwelling.	More likely to: <ol style="list-style-type: none"> 1 have cognitive impairment 	More likely to: <ol style="list-style-type: none"> 1 have moderate functional dependency 2 be male
Bharucha, et al., (2008) Direct video surveillance study in a dementia special care unit. (n = 15)	No data reported.	More likely to: <ol style="list-style-type: none"> 1 be frustrated with a physical limitation
Rosen, et al., (2008) Qualitative focus group study. Sixteen focus groups included various nursing home workers and 7 cognitively intact residents.*	More likely to: <ol style="list-style-type: none"> 1 call out or make noise 2 be cognitively impaired 3 wander 	More likely to: <ol style="list-style-type: none"> 1 be intolerant of cognitively impaired residents 2 aggressive toward wanderers 3 be “impatient” 4 be racist, stereotype others, and have perceived religious superiority 5 be territorial

* This study focused on proximal antecedents to RRV, but did not always differentiate characteristics belonging to the victim or initiator.

Table 2

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 R-R 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 3

Over-Arching Theme: Resident Characteristics

Major Categories	Sub-Themes	Raw Data
Victim Characteristics	They don't know	Doesn't know what they are doing Dementia is really advanced Memory not so good
	Can't communicate	Can't really talk Say that about 300 times The same questions over & over Really hard of hearing
	Gets around good	Was really strong Can walk on a walker He walks to all the other stations
Initiator Characteristics	More with it	Pretty well with it Know a little bit more They don't forget
	Strong personality	She knows everything Overly helpful She's the boss
	Short fuse	Very impatient Short tempered her whole life Quicker to get angry
	Life history	Don't like blacks That is the way they were taught Get that "n word" away from me Reminds her of a woman who stole her husband

Table 4

Comparison with the Rosen Study

	Rosen and colleagues (2008)	XXXXXXX and colleagues (2010)
Methodology	Focus groups	In-depth interviews
Participants	Sixteen groups of various nursing home workers with varying degrees of resident contact and one group of seven residents	Eleven certified nurses' assistants in constant contact with residents
Objectives	To more fully characterize the spectrum of resident-to-resident aggression	To describe the characteristics of the victims and initiators of RRV and to identify resident characteristics which influence the development of RRV.
Findings	Grouped findings about residents as "triggers." Identified 29 contexts and circumstances in which aggressive episodes emerged.	Identified through thematic analysis eleven sub-themes that CNAs perceived as resident characteristics affecting the development of RRV. These factors were further aggregated into victim and initiator characteristics.