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BULLYING AMONG OLDER ADULTS IN RETIREMENT HOMES AN UNKNOWN EPIDEMIC

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BULLYING AMONG OLDER ADULTS IN RETIREMENT HOMES

AN UNKNOWN EPIDEMIC

A Project

Presented to the

Faculty of

California State University,

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In Partial Fulfillment

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by

Claudia Ferreira Sepe

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ABSTRACT

This study used an explorative quantitative survey method for the purpose of examining bullying among older adults in retirement homes and the consequences of bullying among this population. The study also explored the type of bullying that occurs in the community. Senior community centers were the significant domains in which to research bullying among older adults because it involved immersion of the researcher into an environment of older adults who knew one another and have witnessed or have been victims of bullying in their retirement home communities. The primary purpose of this investigation was to enhance research on bullying among older adults in retirement homes. Another purpose of this research was to address the consequences of bullying in older adults and to address mental and physical consequences of bullying addressed in previous research. Currently there is not much research done on bullying among older adults. This study found that many older adults living in retirement homes are being bullied and many of them are not speaking up and isolating themselves for the purpose of avoiding their bullies. Moreover, this study shows that staff members of the retirement communities are lacking the knowledge of the bullying problem in their community. The study suggests that future studies on bullying among older adults include qualitative research to determine if older adults understand the difference of bullying and “just being grumpy” and also explore a qualitative research regarding the perpetrator of bullying and not the victims of bullying.

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CHAPTER ONE

INTRODUCTION

The study of bullying among older adults in retirement communities is very important because there are many older adults who are being victimized and not speaking up. There are many older adults needing mental health care due to bullying. Education on how older adults are affected by bullying can help health care providers prevent the effects of bullying among this population. It will improve health care providers' assessments by education on what questions should be included during older adults' visits to their office for the purpose of identifying the problem. Supplementary research will help social workers identify new interventions in order to prevent bullying among older adults.

Problem Statement

The problem studied was bullying among older adults living in retirement communities. People are living longer because there are less child deaths due to new technology, more doctors and new medications and not because aging process has been reversed or slowed (Duke University, 2010). Between 2000 and 2010 the rate of adults living past their 65th birthday increased from 9.7 percent to 15.1 percent in the U.S. population (Werner, 2011). Because there are more adults living longer, many of them are moving

into retirement communities due to lack of social network, role changes (becoming widowed), retirement, and health problems (Benson, n.d.). Since there is an increase of older adults living in retirement communities, there is also an increase of bullying among older adults.

There are many health care providers, community members, and medical agencies that are concerned about the effects of bullying such as depression, PTSD, isolation, and suicide. However, there is not much research done regarding older adults as victims of bullying and the consequences of bullying against their health. Unfortunately, the public is not aware of the physical and emotional effect of bullying among older adults in retirement communities. The public has become more and more aware of bullying among children and adolescents due to news coverage. However, there is not much news coverage related to bullying among older adults in retirement homes.

Furthermore, there have been few studies conducted to identify the outcomes of bullying in retirement homes. According to Parker (2011), residents of retirement communities, older adults residing in assisted living, retirement communities, long-term care facilities, and senior centers around the country are being terrorized by bullies. Some of the retirement homes have lowered the age of older adults' admission to the facility from 62 to 55. Due to this change older adults are not accepting new members below 62 years old.

Some older adults “reserve” tables for their older friends and make loud negative comments so others can hear it. Moreover, older adult bullies ridicule, criticize, and lie about others that do not meet their approval standards regarding sexual orientation, race, economic background, ethnicity, and any other benchmark they allow. Furthermore, bullies in this community, destroy property and steal to proclaim their power and intimidate victims. Bullies physically abuse other older adults by hitting, punching, pushing, or kicking them, giving excuses that it was an accident (Parker, 2011).

Studies have shown that children and adolescent victims of bullying suffered from isolation, depression, PTSD, and/or suicide (Dobry, Braquehasis, and Sher, 2013). Due to little research done regarding older adults victims of bullying, there is no data regarding the effects of bullying among older adults.

Purpose of the Study

The purpose of this research was to investigate the effects of bullying among older adults living in retirement homes. This study was important to identify if bullying experienced by older adults in retirement homes are linked to depression, PTSD, isolation, and suicide. Moreover, it helped identify the quantity of older adults who are suffering from any mental health problems due to bullying. Furthermore, it investigated the average age of bullying in

retirement homes and what intervention needs to be done to stop bullying among older adults.

When individuals discuss bullying, it is easy to think about children and adolescents in school bullying their peers. There are many health care providers and social workers who are not aware of the epidemic among older adults bullying another adult in retirement homes, assisted living, and senior centers. According to Mary Andrada (personal communication, October 2, 2014), older adults do not like to share this information because they think it will create a bigger problem in the retirement community. Moreover, older adults do not share the problem they encounter in the community with their families because they do not want to burden their family members. Also, there are many older adults who isolate themselves in order to escape from being victims of bullying because they do not know where to seek help. Some older adults in retirement homes, assisted living, and senior centers are very fragile and do not have the mental and physical strength to deal with their bullies.

Retirement homes, senior centers, and assisted living facilities have contracts that the residents have to sign before they move in, which state that they will respect other adults in the community. However, according to Andrada (personal communication, October 2, 2014), a social worker from a retirement home who has worked with the same community for about fifteen years, bullying is one of the major problems in that facility. One example given

by Andrada is that one of the older adult residents does not like other older adult residents using the elevator more than three times a day, so most of the time, he stays in front of the elevator counting how many times some of the residents use the elevator. When he encounters residents that had used the elevator too many times, he then bullies other residents and complains to the social worker from the administration department (personal communication, October 2, 2014). Unfortunately, there is not a lot of support from staff members for older adult victims of bullying because many times the perpetrator will say that it was an accident, or state the other person (victim) is lying, or just ignore what staff has to say (Andrada, personal communication, October 2, 2014). A lot of victims of bullying in retirement homes, assisted living, and senior centers do not have a lot of resources, do not know how to resolve the issue, or do not speak up. This study provides more information to individuals working with older adults in assisted living facilities, senior centers, and retirement homes about the severity of the problem. Furthermore, it helps staff members from older adult communities, social workers, and health care providers develop interventions in order to diminish bullying and provide a safer home for older adults.

A quantitative research design was used with an exploratory approach. A survey using close-ended questionnaire was used for data collection. Participants' responses were important in the process of gaining knowledge regarding older adult bullying among older adult living in retirement homes. All

participants lived in a retirement community and their age was 55 years of age or older.

Significance of the Project for Social Work

This research will help social workers and health care providers, at a micro level, develop interventions in order to protect and help older adult victims of bullying. Individuals working with older adults should educate perpetrators and victims of bullying for the purpose of minimizing bullying behaviors at older adult community centers, retirement homes, and assisted facilities. It will demonstrate the severity of the problems and educate health care providers and social workers on the effects of bullying among older adults living in retirement homes, senior centers, and assisted living. Individuals need to understand the adverse effects of bullying such as depression, suicidal ideations, isolation, and PTSD.

Studies have shown that individual victims of bullying can develop depression (Hertz, Donato, & Wright, 2013) and if the illness is not treated, it can cause future outcomes. One of these outcomes can be severe major depressive disorder with suicide ideations (Hertz, Donato, & Wright, 2013). Unfortunately, there are many older adults who tried or had committed suicide due to major depressive disorder. As reported by many studies, there are a large number of older adults who visit the emergency department due to suicide attempt (Carter and Reymann, 2014). Sadly, many of these older

adults do not survive and many suffered severe consequences due to their attempt, such as cognitive impairment (Carter & Reymann, 2014). According to Carter and Reymann (2014), older adults who tried or had committed suicide used drugs or alcohol in order to alleviate their suffering. Moreover, older individuals living in retirement homes isolate themselves in order to hide from bullies (Andrada, personal communication, 2014). Isolation can lead to depression and subsequently to suicide (Fukunaga, et. al., 2012). Many analyses have been done to study the consequences of isolation and most of them show the same result; isolation leads to depression. Bullying also causes PTSD because victims have recurrent reminders of their bullying experience and they live in fear or worry about coming in the presence of their bullies.

This research will help social workers and health care providers to have a better understanding about the problem and develop new interventions in order to help adults in retirement communities. Once new interventions are developed, they can be implemented in assisted living facilities, retirement homes, and senior centers. The implementation of these interventions can help victims of bullying to deal with the perpetrator. Subsequently, they will be able to get help for their depression, isolation, and PTSD. Moreover, these new interventions will prevent bullying from happening among older adults in retirement communities.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter will provide a comprehensive insight into how bullying among older adults in retirement homes is increasing and why it is an unknown epidemic problem in our society. Additionally, it explains how bullying behaviors can affect individuals mentally and physically.

Brief Overview of Bullying and its Consequences

Bullying in retirement homes is increasing as the population grows. According to Dobry, Braquehasis, and Sher (2013), bullying can affect the perpetrator and also the victim. It can have financial costs, medical problems, and social problems. One medical problem that affects older adult victims of bullying is PTSD. According to Ogle, Rubin and Siegler (2013), the impact of trauma can last decades. Although there are many studies that concentrate in childhood trauma, research has demonstrated the trauma that happened in adulthood could also have the same effect on older adults (Ogle, Rubin and Siegler, 2013). Many older adults suffer from PTSD; however, because they do not meet the entire requirement from the Diagnostic Statistic of Mental Disorder IV, they are diagnosed with partial PTSD. According to studies, individuals with partial PTSD symptoms are more inclined to drink alcohol. Both, PTSD and partial PTSD have negative consequences on the individual

(Chopra, et.al., 2012). PTSD caused by the trauma of bullying can also affect individuals in their social life, causing them to isolate themselves. There are a large number of older adults isolating themselves because of bullying. Isolation can affect older adults' feelings of loneliness, which can decrease their quality of life (Heylen, 2010).

According to Benson (n.d.), victims of bullying have lower life satisfaction and they feel lonely. Isolation leads to severe depression, elevated moods (sadness, anxious, anger, etc.) and risk-taking behavior (Teo, 2012). Older adults living in retirement homes have a high risk of suffering from social isolation and it can lead to many health problems (Nicholson, 2012) and risk behaviors. Living alone is an important aspect of depression and suicide among older adults (Fukunaga, et. al., 2012).

Suicide can occur even in older adults over 80 years old but many older adults do not seek help even though there are treatments for depression (National Alliance on Mental Illness, 2009). An older victim of bullying can hide their depression and without treatment, they can commit suicide. According to Carter and Reymann (2014), many older adults are visiting the emergency department due to suicide attempts and many do not go home. Older adults of bullying have a higher chance of suffering from depression and suicidality afterwards (Hertz, Donato, & Wright, 2013). Unfortunately, there are many older adults who do not display their suicidal ideations and when they do, primary health care providers do not intervene. Many older adults with suicidal

ideations reveal them to their primary care days before their death (Cukrowicz, et. al., 2014).

Bullying

Dobry, Braquehasis, and Sher (2013), discussed bullying behaviors that can lead to medical, social, and financial costs for the perpetrator and the victims, with social and psychological impact. Furthermore, for both perpetrators and victims, bullying increases psychiatric disorders such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, personality disorder, suicidal behavior, and substance abuse. Suicidal behaviors (suicidal ideations, suicidal attempts, and completed suicide) are the most alarming consequence of bullying (Dobry, Braquehasis, & Sher, 2013). According to Dobry, Braquehasis, and Sher (2013), “bullying behavior in the absence of depression or suicidality is not an independent risk factor, but rather amplifies inherent risk of suicidal behavior associated with depression” (p.296).

Studies have shown that there is an interrelationship between symptoms of PTSD and bullying, which leads to serious deterioration in social functioning (Dobry, Braquehasis, & Sher, 2013). Individuals who experience bullying also demonstrate anxiety disorders besides PTSD and symptoms of social phobia, panic disorder, and obsessive-compulsive disorder are present (Dobry, Braquehasis, & Sher, 2013). Dobry, Braquehasis, and Sher (2013) explained that bullying is not always basically pathological (motivated by mental disorders) but sometimes is a human phenomenon associated with the

nature of our situation and only legal authority not related to psychological or psychiatric interventions may prevent humans from bullying.

Posttraumatic Stress Disorder

Ogle, Rubin, and Siegler (2013), studied the “impact of the developmental timing of trauma exposure on posttraumatic stress disorder (PTSD) symptoms of psychosocial functioning in a large sample of community dwelling older adults” (p. 2191). Studies had shown that individuals exposed to traumatic events have long-term effects of their experiences and it can last for decades. However, most of the studies had concentrated on traumatic events that occurred during childhood or during adulthood (e.g. veterans). There are not many studies done on traumas that have happened later in life amid older adult communities.

Depression, low sense of meaning in life, and poor physical health are indications of adults who were exposed to trauma during young adulthood and middle age, compared with collective trauma experienced during earlier and late times of the life course (Ogle, Rubin, & Siegler, 2013). However, according to Ogle, Rubin, and Siegler (2013), negative events that occur after age 50 are “strongly associated with late-life depressive symptoms” in comparison with “childhood-adolescence and early middle adulthood” (p. 2192). Usually, recent events tend to be the individual’s most traumatic or saddest time. The death of a loved one tends to be the most negative event in older adults, which links to a higher severity of PTSD and if they lack support,

it would be detrimental to their health. Older adults who have health problems such as sleeping disturbance and who are suffering from PTSD may have exacerbated symptoms (Ogle, Rubin, and Siegler, 2013). According to Ogle, Rubin, and Siegler (2013), “individuals who are exposed to traumatic events in older adulthood may be more vulnerable to negative posttraumatic outcomes compared with those who experience trauma early in life” (p. 2193).

Research done by the University of North Caroline Alumni Heart Study focused on individuals that suffered from partial PTSD and individuals with PTSD in adults 65 years and older. Data were collected from the 12th wave of the University of North Caroline Alumni Hearth Study. The participants were born between 1940 and 1949 and were exposed to traumatic events. Most were male (69.42%) and Caucasian (99.30%). Participants were divided into five groups by their currently most distressing event: Childhood (3-12), adolescence (13-19), young adulthood (20-34), midlife (35-54), and the young-old phase of older adulthood (55 and older). The measures used were the Traumatic Life Events Questionnaire (TLEQ), PTSD Check List-Stressor Specific Version, Subject Happiness Scale, and questions about social support and coping ability. Participants received instructions online and if they did not respond identical instructions were mailed (three times).

The results showed that PTSD, lower support and coping ability were related to female gender and lower income. Also, the research shows that witnessing family violence was the most common trauma in childhood and the

unexpected death of a loved one was the most common trauma for adolescence, young adult, midlife, and older adult groups.

The purpose of this article was to examine individuals who did not have the entire requirement for a diagnosis of Posttraumatic Stress Disorder using the *Diagnostic and Statistical Manual, Fourth Edition (*DSM-IV). “DSM-IV requires that in addition to traumatic experience (criterion A), the person has at least one re-experiencing (criterion B), three avoidance and or numbing symptoms (criterion C), and two hyperarousal (criterion D) symptoms for a duration of at least one month (criterion E) with significant distress and/or impairment (criterion F)” (Chopra, et al., 2012, p. 87). Individuals who did not have the entire requirement for PTSD were described as having a partial or subsyndromal PTSD. Subsyndromal PTSD refers to individuals who have all criterion of PTSD but do not have the numbers required to be diagnosed with PTSD (Chopra, et al., 2012). There are not many studies about the long-term development of PTSD, especially in older adult veterans. However, the little research done found that individuals who experience trauma earlier in life have exacerbation or resurgence of symptoms of PTSD later in life even though they did not meet the entire criterion for PTSD.

The research done by Chopra was evaluated at baseline, three months, and six months. The participants were over 65 years of age and showed symptoms of PTSD according to DSM-IV. For the study, the Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)

“compared two different forms of mental health care (not disclosed) delivered to older adults with common problems of depression, and “at-risk” drinking, attending primary care clinics” (Chopra, et al., 2012, p. 87). PRISM-E illustrated the negative symptoms of PTSD and partial PTSD such as poor general health, death wish, and mental distress. Chopra, et al. “hypothesized that partial PTSD would often be observed during the naturalistic course of PTSD and that both PTSD and partial PTSD would have independent negative effects on participants’ distress and the mental health quality of life” (p. 87).

The study’s prospective follow-up shows that at the third month, of the 1,185 baseline participants evaluated for trauma, only 308 were reevaluated for PTSD and trauma. At the sixth month follow-up, only 293 participants were assessed for PTSD had the highest combined medical problems, no social support, and anxiety and the group with lowest PTSD symptoms had the risk of becoming alcoholics (at-risk drinking), compared with the no trauma group (Chopra, et al., 2012).

PTSD in older adults is often a chronic disorder, with fluctuations in the number and severity of symptoms (Chopra et al., 2012). Regarding to the treatment of PTSD “especially in older adults, there is an emergency need to study therapeutic options to treat a disorder that has very likely been present for a longer period of time than when observed earlier in life” (Chopra, et al., 2012, p. 96).

Isolation

Heylen (2010) discussed the risk factors associated with social loneliness in the older population. According to Heylen (2010), there is a difference in social loneliness and emotional loneliness. The absence of feelings of social integration is referred to social loneliness and when a person feels the absence of a loved one, it is referred to emotional loneliness (Heylen, 2010).

To analyze social loneliness, a sample data of 1,414 participants aged 55 or older were collected from the Panel Study of Belgian Households. The research used quantitative and qualitative measures. The quantities of social relationships were measured by the frequency of visits with friends, families, and acquaintances living outside the home and the number of friends. The qualitative measures were the satisfaction of social relationships (the visitor was loving and caring). Participants were classified on a five-point Likert scale and to measure social loneliness, researches used the Jong-Gieveld loneliness scale (Heylen, 2010). Results confirmed that social relationships directly affect their feelings of social loneliness. People's expectations are based on their situations and if the expectations are low, they will have lower quantity or quality of social relations. However, they are prone to feel lonely due to having lowered their expectations to fight feelings of loneliness (Heylen, 2010).

Individuals who have health problems or have age-related losses are attributed in the loss of social contacts, resulting in the increase of loneliness (Heylen, 2010). According to Heylen (2010), individuals “need social contacts” (p. 1179) even if their desired contacts with social relationships are not satisfied, in order to prevent loneliness and if individuals do not socialize they will suffer feelings of loneliness. People’s social life changes when they become older, whether negatively or positively (Heylen, 2010). “One of the first theoretical perspectives on the social ageing process was disengagement theory, which related the shrinking social network in old age to consciousness of approaching death” (Heylen, 2010, p. 1181). Older adults select their contacts to receive social support, instead of attempting to preserve all their contacts.

Benson explored the problem of older adults who isolate themselves due to bullying behaviors of other older adult in retirement homes. Previous research has shown that approximately one out of five residents of an assisted living facility were aggressive towards another resident in their community. Individuals who experience relational aggression also suffered from anxiety, depression, lower satisfaction with life, and social loneliness (Benson, n.d.).

Benson conducted a study where she explored the relational aggression in three independent senior living facilities in the Chicago area. Her research was based on qualitative data collected from “one-on-one interviews

with four senior living community executive directors with more than 30 years shared experience in the senior living industry" (Benson, n.d., p. 4).

The data shows that individuals who use assistive advice, or health aids (e.g., walker, cane, oxygen tank), or have a personal caregiver may be a victim of relational aggression in the senior living communities. Older adults in assisted living facilities are decreasing the use of personal caregiver and assistive devices due to stigma and fear of being judged. Older adults who reported being victims of relational aggression also stated that they have lower life satisfaction, loneliness, and anxiety. Moreover, many older adult victims of relational aggression were more likely to suffer from depression (Benson, n.d.).

Individuals who have better social interaction with others are healthier and happier compared to those who isolate themselves. Studies have shown that social relationships are important for our physical and mental health (Benson, n.d.). As individuals grow older, their social networks change due to marriage, motherhood, role changes, widowhood, or retirement. Many older adults choose to live in senior communities to prevent isolation or due to health problems. However, adapting to life in a senior community can be very challenging because of their living style structure. Tension or territorial conflict may emerge between residents because older residents might have problems with new individuals in their community (Benson, n.d.). Tenants who do not have mental or physical problems may state their apprehension about sharing

their common space and time with other tenants who display vulnerabilities and health problems (Benson, n.d.). According to Benson (n.d.), “resident-to-resident aggression was an understudied and potentially significant public health problem” (p. 3).

Teo (2012) explains how mortality and mobility is highly associated with social isolation and a severe form of social isolation called hikikomori. According to Teo (2012), “social isolation is as deadly as excessive alcohol consumption and smoking” (p. 339). Socially isolated individuals are at a higher risk to develop mental illness because it increases the risk of major depressive disorder, social anxiety disorder, generalized anxiety disorder, and dysthymia (Teo, 2012). A severe form of isolation called hikikomori has been identified mostly in Japan. Hikikomori’s definition is not leaving home, not communicating with other individuals besides family member, and not going to school or work for at least six months.

In the United States, there is only one case reported of hikikomori. The patient did not leave his apartment for three years and continuously lived in isolation. He lived in a walk in closet, defecated and urinated in jars and bottles, ate ready-to-eat food, and he did not bathe. Due to his isolation he developed severe depression. Right after his depression episodes, he had long periods of elevated moods, decreased sleep, grandiosity, risk taking behavior, bipolar disorder, and increased goal directed activity. The patient went through diagnostic assessment using validated research instruments and

clinical interviews, and collateral corroborated his information. The patient declined pharmacotherapy but accepted cognitive behavioral therapy (CBT). Cognitive behavioral therapy focused on the social withdrawal and included cognitive restructuring, psychoeducation, goal setting, exposure and response prevention, and coping skills. The results of this study suggested that this patient's social isolation was associated with major depressive disorder (Teo, 2012).

Residents of elder communities are in extreme danger of suffering from social isolation, which leads to health deterioration (Nicholson, 2012). According to Nicholson (2012), "social isolation is defined as a state, which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling a quality relationship" (p. 137). Some health effects from social isolation in older adults impact their psychological behavior and physiological health. Psychologically, older adults who do not have a healthy network suffer from depression, and they are at a higher risk of cognitive deterioration. Moreover, men are at a higher risk of committing suicide. Older adults change their behavioral habits by smoking, drinking, and increasing their unhealthy eating habits. Physiologically, older adults who do not socialize are at risk of getting colds often, and dying from coronary heart disease/stroke. Social isolation in older adults also increases the number of institutionalizations, all-cause mortality, re-hospitalizations, and falls (Nicholson, 2012). According to

Nicholson (2012), the risk factors of social isolation include: economic, physical, work/family changes, psychological issues, and environmental.

Nicholson (2012) examined past studies of isolation among the elderly. The results showed that because of psychological, physiological, and behavioral changes, it is important that older adults be educated about social isolation and participate in “social activity interventions targeting specific groups” (p. 149). These interventions will help decrease social isolation among older adults (Nicholson, 2012).

Fukunaga, et al. (2012) focused on factors that are linked with depression in a rural community located in Japan. Older adults suffering from depression are at a higher risk of committing suicide or having suicide ideations. There were over 30,000 suicides in Japan since 1998. Relating to the size and population of Japan, in 2010, suicide was the fifth cause of death in the world. Although Japan has high longevity among older adults, it also has a high mortality rate. Most individuals who committed suicide had mental disorders, major depression, or largely mood disorders. Living alone was also an important aspect of depression and suicide among older adults (Fukunaga, et. al., 2012). In addition to living alone, researchers also include other factors such as social support, disability, income and financial strain, insomnia, smoking, and alcohol drinking. Participants in this study were selected from a rural community in Asagiri because the older population was 30.2 percent. Older adults who lived in this town (1552) received a survey questionnaire by

mail. Out of 1,552 participants, 964 supplied complete answers for all questions.

According to Fukunaga (2012), suicidal ideation has a strong link with depression, so “it was not an independent variable” (p. 181). Suicidal ideation was studied in affiliation with living alone (Fukunaga, 2012). The social support scale was measured by five “yes” or “no” answers and the Geriatric Depression Scale (GDS) was used to assess depression. The results demonstrated that the lack of family living together was related to depression. Other factors that were related to depression in this research were low levels of social support, long-term care insurance, suicidal ideation, loss of appetite, worries in life, and financial strain (Fukunaga, 2012).

Depression

The National Alliance on Mental Illness (NAMI) (2009) explains that depression can occur late in life, even in older adults in their 80s and over. It affects 35 million Americans but 6.5 million of them are older adults aged 65 or older. Many older adults suffering from depression are untreated because they have the perception that depression is normal in older adults due to their social transition, loss, and chronic illness. Moreover, many individuals who suffer from depression think that it is a sign of arthritis, cancer, dementia, Alzheimer’s disease, stroke, thyroid disorders, or Parkinson’s so they do not seek help (National Association of Mental Illness, 2009). According to the National Alliance on Mental Illness (2009), other reasons why individuals with

depression do not seek help is because they think that the treatment will be costly, they are ashamed of sharing the information, they think it is a flaw, or are worried about being humiliated or made fun of.

Unfortunately, older adults who suffer from depression have a higher risk of cognitive deterioration and medical illness. Furthermore, depression can lead to mortality that is not related to suicide. “Depression is the single most significant risk factor for suicide in older adults” (National Alliance on Mental Illness, 2009), even though many of them looked for help before their death. According to NAMI (2009), 20 percent of people with depression saw a primary health care provider the day before their death, 40 percent the week of their death, and 70 percent in the month of their death. Older adults are more inclined to see their primary doctor for physical illness than they are for depression.

Sometimes, depression in older adults is characterized by memory problems, weight loss, irritability, confusion, social withdrawal, hallucinations, delusions, loss of appetite, inability to sleep, and vague complaints. Sadness is one of the feelings often experienced by individuals with depression but sometimes they hide this information and when asked if they are depressed, they sometimes answer no (National Alliance on Mental Illness, 2009). Many depressed individuals do not distinguish normal sadness from depression. However, depression does not go away and it can last for months if not treated. Depression can be caused by environment, medication, genetics

(from parents to children), substance abuse, and alcohol. Although depression is common in older adults, there are many treatments that can decrease symptoms of depression such as psychotherapy, medications, and electroconvulsive therapy (ECT) (National Alliance on Mental Illness, 2009).

Suicide

Carter and Reymann exposed the number of visits to emergency departments by older adults due to suicide related injuries and self-harm. In 2010, the estimated suicide rate of older adults, aged 65 or older, was approximately 16 percent and for adults aged 85 or older was more than 42 percent (Carter & Reymann, 2014). Some of the factors that contribute to suicide rates among older adults include depression, terminal illness, loneliness, grief, and isolation. Although, many older adults do not report being suicidal or look for mental health care services, many of them (75%) visited a medical care provider within 30 days of their suicide attempt (Carter & Reymann, 2014). According to Carter and Reymann (2014), studies allege that one-fourth of older adults admitted to the emergency room after a suicide attempt, will try it again.

Data were collected from the 2006 Nationwide Emergency Department Sample (NEDS) to illustrate older adults' use of emergency departments and what happened after they attempted to commit suicide. Using a stratified probability sample, NEDS captured all visits to the emergency room, despite the admission status. In 2006, there were approximately 26 million emergency

department visits gathered from more than 950 hospitals across 24 participant states. “The sample inclusion was restricted to patients’ visits by adults aged 65 or older for attempted suicide” (Carter & Reymann, 2014, p. 536). Measurement was divided into three categories: age, gender, and nonrural vs. rural residents. The outcome variable was characterized by variables indicating death, routine discharge from the emergency department, admitted to the hospital, and all other discharges such as transfer to another hospital and discharge against medical advice (Carter & Reymann, 2014).

The study indicated that 49.2 percent of older adult suicide-related patients’ visits used some drug and/or alcohol. Poisoning is the number one suicide-related injury among older adults (62.6%), followed by piercing/cutting (12.1%), unspecified mechanism (7.1%), firearms (5.1%), and strangulation/hanging (1.7%) (Cater & Reymann, 2014). According to Carter & Reymann (2006), suicide-related emergency department visits by older adults exceeded $353.9 million. According to research, adults from 75 to 84 years of age are at greater risk of not surviving from their suicide attempt compared to older adults age 65 to 74. Moreover, adults aged 85 years and older are more than 117% at a greater risk of not surviving from suicide-related visits to the emergency department compared to adults aged 65 to 74 (Carter & Reymann, 2014).

Hertz, Donato, and Wright (2013) discussed the relationship between bullying, depression, and suicide. There is a powerful connection between

suicide and bullying associated behaviors; however, delinquency and depression is also connected with those behaviors (Hertz, Donato, & Wright, 2013, p. S1). Verbal bullying is more common than physical and is likely to happen over a lengthy period of time. Moreover, victims of bullying have a higher chance of suffering from depression and suicidality afterwards (Hertz, Donato, & Wright, 2013). According to Hertz, Donato, & Wright (2013), the relationship between suicide and bullying can be explained by the relationship between depression and bullying (p. S2). Furthermore, “depression is a significant risk factor for bullying and suicide involvement, as well as a host of other health-risk behaviors” (Hertz, Donato, & Wright, 2013, p. S3). Therefore, Hertz, Donato, and Wright recommended that clinical practitioners start evaluating and implementing strategies that are effective at decreasing risk factors correlated with suicide and bullying, and start executing and assessing protective elements of bullying.

Cukrowicz et al. (2014), discussed if older consumers reveal their suicidal ideation to a health care provider. According to Cukrowicz et al. (2014), out of 107 patients 60 years of age and older that had thoughts of suicide, only 53 of them disclosed their thoughts of suicide to a health care or mental health care provider. “Approximately 75% of adults who died by suicide had seen a primary care physician and approximately 33% had seen a mental health provider in the year prior to death by suicide” (Cukrowicz et. al., 2014, p. 331). Compared to younger adults, older adults are less likely to reveal their

thoughts of suicide, even though they are more likely to die because of it (Cukrowicz et. al, 2014).

The research conducted by Cukrowicz et. al. (2014), discovered that suicidal ideations were reported 20.9 percent more frequently when a physician interviewed the patient. Moreover, patients who report suicide ideation were found to have depressive symptoms severity. Participants in this research were part of the Improvement Mood-Promotion Access to Collaborative Treatment (IMPACT) trial. They were discovered "through referrals of depressed older adults from primary care clinics or by screening using a two-item depression screener" (p. 332). Furthermore, participants had to meet the criteria of having current major depression, dysthymia, or both and are 60 years of age or older. Participants with a history of bipolar disorder or psychosis, acute risk of suicide, current alcohol abuse, or had severe cognitive dysfunction were excluded from the research (Cukrowicz et al., 2014).

There were 1,801 participants that were randomly assigned to the IMPACT intervention after a 60 minutes baseline interview. Trained interviewer conducted the interview. "To assess suicide ideation, the IMPACT study utilized an item from the Hopkins Symptoms Checklist (HSCL-20: Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974; "In the past month, how much were you distressed by thoughts of ending your life?")" (p. 333). They also asked yes or no questions such as if they had shared those thoughts or feelings with a primary or mental health care provider (Cukrowicz et. al., 2014). Some of the

reasons individuals with suicide ideation do not share their thoughts is because they believe that providers might overreact and ask private and intrusive information about their lives that might result in undesirable outcomes (Cukrowicz et. al., 2014).

Theories Guiding Conceptualization

Social workers and health care practitioners working with older adults must be aware that elders' needs are very much like the needs of younger individuals (Jacobs, Masson, & Harvill, 2006). In analyzing research about bullying, it is important to realize that there is not much research done regarding older adults bullying older adults.

An important theory to consider when working with older adults is General Systems Theory, which focuses on wholeness, relationship, organization, order, and integration (What is General Systems Theory?, n.d.). Bullying behaviors among older adults need to be broken down into its elements in order to find interventions to decrease bullying behaviors among people in older adult communities such as retirement homes, assisted living facilities, and senior community centers.

Bullying is a deviant act so it is important to analyze Structural Theory and Processual Theory when dealing with bullying among older adults. Structural theories stress the relationship of deviance to structural conditions within a community (Clinard & Meier, 2008). Processual theories define the process by which people come to carry out deviant acts (Clinard & Meier,

2008). People do not become bullies simply by committing bullying behaviors, so it is very important to understand why individuals who commit deviant behaviors such as bullying, acquired such behaviors. To understand this process, social workers and health care professionals need to examine the social nature of people with empathy to be able to see the world the way they do.

Another theory to consider is the Bowen Family System Theory because individuals must be understood as part of their families and not in isolation. Family System Theory (FST) is a theory of human behavior that views the family as an emotional unit (Goldenberg and Goldenberg, 2013). There are eight basic concepts that need to be understood by social workers and health care providers that make up the FST which are: (1) Levels of Differentiation of Self – it represents the gravity of a person's emotional state that connects one person to another, (2) The Nuclear Family – individuals should have a relationship with family members and communicate with many relatives from different generations as possible. It is the quality of individuals within a family, (3) Family Projection Process – is how individuals project themselves in a nuclear family, (4) Mutigenerational Transmission Process – there are many generations within a family and they all have different general behaviors, (5) Sibling Position – family emotional system can be influenced by sibling behaviors, age and sex, (6) Triangle, (7) Emotional Cut Off – is when individuals distance themselves from their families (Hall, n.d.), and (8) Societal

Emotional Process –it is the strain between closeness and people. According to Hall (n.d.), it is a “theoretical system through its accounting for the impact of social influences on family processes and for the impact of family processes on wider society…The concept of societal emotional process describes how the emotional system governs behavior on a societal level, promoting both progressive and regressive periods in a society” (Emotional Process in Society section, para. 2). The importance of using FST is to understand what aspect of the family contributes to people being bullies and to help individual victims of bullying by using psychotherapy method. Bullying behaviors are tied to *Societal Emotional Process* because environmental stressors can contribute to an individual’s aggression.

Summary

There are many older adults who are being bullied by another older adult in retirement homes, assisted living facilities, and senior centers. Many of them suffer the effects of bullying, such as depression, PTSD, isolation, and suicide. This research will help health care providers and social workers to have a better understanding of the problem and eventually, develop interventions to better help the older adult population in assisted living facilities, retirement homes, and senior centers. It will also educate older adults regarding bullying in order to decrease the number of bullies and to increase the number of older adults willing to seek help before it is too late.

CHAPTER THREE

METHODS

Introduction

This chapter discusses the methods that were used in administering this research. In researching how older adults bullying older adults in retirement community can be detrimental to victims of bullying, researchers discussed how the research occurred. Researcher explained how data was collected, the design of the study, the type of instrument that was used, and the procedure of the research. Lastly, researcher explained how the participants involved were protected during and after research and how data was analyzed.

Study Design

The purpose of this study was focused on exploring the experiences and perspectives of older adults dealing with bullying in retirement communities. In order to gain knowledge about the problem of bullying in older adult communities such as retirement homes, assisted living facilities, and senior centers, this study utilized a quantitative research design with an exploratory approach. This study used a survey questionnaire composed of thirteen close-ended questions for data collection that was adapted using the Gatehouse Bullying Scale (GBS) and the Multidimensional Peer-Victimization Scale (MPS). The quantitative research was conducted in the participants'

natural environment. In administering this study, an anticipation of 20 participants was included. The inclusion criteria were that participants must live in retirement homes and be above age 55. They must have been victimized by bullying or had witnessed bullying among older adults in retirement communities. The materials that were used in this study consisted of yes/no and true/false questions survey.

Sampling

This study used non-probability sampling. The sample was obtained from the George M. Gibson Senior Center, located in Upland, CA and Ontario Senior Center, located in Ontario, CA. Participants were required to have experiences of living in retirement communities or assisted living. Participants who live in retirement communities or assisted living had to be 55 years of age or older who have been victims of bullying or witnessed bullying in the retirement community. Participants were from different ethnics background, religion, age (over 55) and sex.

Data Collection and Instruments

A semi-structured one-on-one interview was conducted to obtain a quantitative data regarding bullying among older adults living in retirement communities. A survey was used to examine the extent bullying among older adults in retirement communities and how victims of bullying among older adults in retirement communities were being affected by the problem. The

instrument that was utilized in conducting this study constituted of thirteen closed-ended questions adapted using the Gatehouse Bullying Scale and Multidimensional Peer-Victimization Scale. The survey constituted of three demographic questions such as gender, age, and race. It also included eight yes/no question and two true/false questions (see appendix A). Participants were asked about their experiences related to bullying in the retirement communities, senior center facilities, and/or assisted living facilities. Moreover, how they were affected by bullying in their community.

Procedures

The data was gathered through close-ended questionnaire survey given to residents of retirement communities who attended community senior centers. Participants were recruited with the help of Ontario Senior Center and George M. Gibson Senior Center staff members. Permission was given to the researcher to advertise the study through the use of fliers, which were displayed in the community centers. The researcher recruited participants by participating in senior's events in community centers, waiting outside the senior community center classrooms to speak with older adults once classes were over (computer and dance), and by speaking with older adults during lunch hours. Researcher spoke with each participant regarding his or her perspective on bullying. The director of the community centers gave date and time of the events. The fliers included the type, benefit and purpose of the study. Participants were given an informed consent (see Appendix B), which

provided expectations, explanations, and purpose of the survey. By signing the informed consent, participants agreed to complete the survey and agreed that information will be kept confidential. Participants were provided with information in how to obtain results of the research. Furthermore, participants were provided resources in case they needed assistance to deal with bullying and its consequences.

Protection of Human Subjects

Participants were provided with informed consent prior to the survey. No personal information or names were requested. Participants were given information about confidentiality and limits of privacy. The surveys were locked in a file cabinet until study was inputted into a computer. Once data was transferred to a computer, the survey was destroyed to protect research participants' anonymity and confidentiality.

Data Analysis

Surveys from participants were gathered and data were inputted into the computer using the Statistical Program for Social Science (SPSS) to be analyzed. A nominal level of measurement was used. Nominal data had no logical; data was basic classification data, e.g., male, female, yes, or no answers. There was no order associated with male or female. Each category was assigned an arbitrary value (Male=0, Female=1). The Researcher tabulated her results from different variables in her data set. This process gave

the researcher a comprehensive picture of what her data looked like and assisted her in identifying patters. The best ways to do this were by constructing frequency and percent distribution. Frequency distribution is an organized tabulation of the number of individuals or score located in each category. This helped determine if the scores were entered correctly, if the scores were high or low, how many were in each category, and the spread of the score.

Summary

The objective of this study was to explore and identify bullying among older adults residing in assisted living communities, retirement homes, and senior centers. The participants were older adults aged 55 and older who lived in retirement communities and were victims of bullying or have witnessed bullying in their community. This study was a quantitative research and each participant completed a thirteen close-ended questionnaire survey. The result of this research provided evidence of bullying among older adults in retirement communities, senior centers, and assisted living communities. Moreover, it provided information about how bullying is affecting the older population.

CHAPTER FOUR

RESULTS

Introduction

This chapter presents frequency of graphics of the data collected for this study. It provides the demographic variables such as age, race, and gender. It looked at the independent t-test and the association between the question “have you been bullied this year” and the variable of age and gender. The results of this test will be discussed in the following chapter.

Presentation of the Findings

Table 1. Frequency Distribution of Gender

		Frequency	Percent
Valid	Male	11	55
	Female	9	45
	Total	20	100

Table one provides a description of the demographics collected from the 20 survey participants. Of the total, 55% were male and 45% were female. The survey results showed that there was not much difference related to men (N=11) and women (N=9) being bullied.

Table 2. Frequency Distribution of Age

		Frequency	Percent
Valid	55 - 65 = 5	5	25
	66 - 75 = 7	7	35
	76 - 85 = 8	8	40
Total		20	100

Table two provides an illustration of age (N=20), 5 from 55 – 65 (25%), seven from 66 – 75 (35%), eight from 76 – 85 (40%). The survey results demonstrates there are many older adults under the age of 65 residing in retirement homes, which is one of the reasons older adults of age 65 and over are bulling adults under age 65 living in retirement homes. Several members who are older, are openly rude to younger members by saving seats in the dining room for their friends, guaranteeing that the new, young individuals did not have any other place to sit but the undesirable, leftover seating, and isolating them from the older members from the community (Stringfellow, n.d.).

Table 3. Frequency Distribution of Race

			Race
		Frequency	Percent
Valid	White	12	60
	Latino/Hispanic	3	15
	Black/African American	2	10
	Asian American	2	10
	Other	1	5
	Total	20	100

Table three illustrates race of participants (N=20), 12 White (60%), three Latino/Hispanic (15%), two Black/African American (10%), two Asian American (10%), one other (5%). The survey demonstrates that bullying among older adults is not related to race/ethnicity since 60% of bullying was amongst the same race. It is very important that professionals working with older adults are extremely educated about other cultures. Our ethnicity dominates the way we think, feel, and perform, for that reason it is highly suggested that professionals educate themselves about diverse population. The difference on race was higher for Whites/Caucasians (60%) only because the availability from other races was limited.

Table 4. Mean and Standard Deviation of Age

	N	Mean	Std. Deviation	Std. Error Mean
Age	20	71.90	7.704	1.723

The statistics of mean and std. deviation of age were used to identify the hypothesis of the unknown amount of bullying among older adults occurring in retirement homes and assisted living communities. The survey demonstrates a high mean of 71.90 with a std. deviation of 7.704, which explains that bullying occurs in any age. This is very important because if bullying amongst older adults in retirement community homes and assisted living facilities continues to be ignored that will only get worse.

Table 5. Frequency of Yes and No Answers

	Number	Yes	No
Have members of the community spoilt activities on purpose to make you upset?	20	17	3
Have you been bullied this year?	20	15	5
Have members of the community not wanted to hang around with you to make you upset?	20	15	5
Did you witness bullying in your community?	20	13	7
Have members of the community called you nasty names?	20	12	8
Have members of the community told stories about you that were not true?	20	12	8
Is bullying a problem in your community	20	12	8
Did the staff know about the bullying you witnessed?	20	5	15

This analysis demonstrate that the amount of participants who witnessed or were victims of bullying in their community. Many older adults have their regular activities, with their regular friends, in their regular locations, and at regular times. In this study we asked members of retirement communities “have members of the community spoilt activities on purpose to make you upset?” and the result was surprising because 85% of participants said yes. The result of this question tells social workers to concentrate on the reason of why participants are avoiding activities in the community. Followed this question regarding activities in the community, we asked “have members of the community not wanted to hang around with you to make you upset?” and the results were that 75% of the participants said yes. The result of these questions shows that older adults are acting just like children if not worse. This

study shows that the bully older adult tries to gain control and power over the older adult just like popular kids in high school.

There are many ways a person can be bullied, such as name-calling, pushing, kicking, cyber bullying, and isolation. In this study, it was discovered that older adults also use many bullying activities that children use. There was a question “have members of the community called you nasty names?” and only 40% said no, which means that the other 60% were called names at one point or another while living in a retirement community or assistant living residence. Another question asked was “have members of the community told stories about you that were not true?” because false rumors is another form of bullying. Older adults tell lies about one another so they can create conflict and isolate the victim. More than half of participants agreed that people lied about them (12 out 20) causing them to be isolated because they did not want to confront those people who believed the lies.

Because of the lack of education regarding bullying among older adults and its consequences, when asked “is bullying a problem in your community?” 60% of participants said yes. This means that staff members and residents of retirement homes, assistance living, and participants in activities in the senior community centers should be educated about bullying. Since social workers are so busy trying to find activities for older adults in the community, they should create an activity to educate them.

The question “did you witness bullying in your community?” had a significantly high response of 65% older adults saying “yes.” This question did not count the answers from many staff members who reported seeing bullying in their community. This study found that older adults are bullying others by intimidation (not allowing them to go in the elevator), by ignoring others, by name calling, by stealing, and by shouting at others.

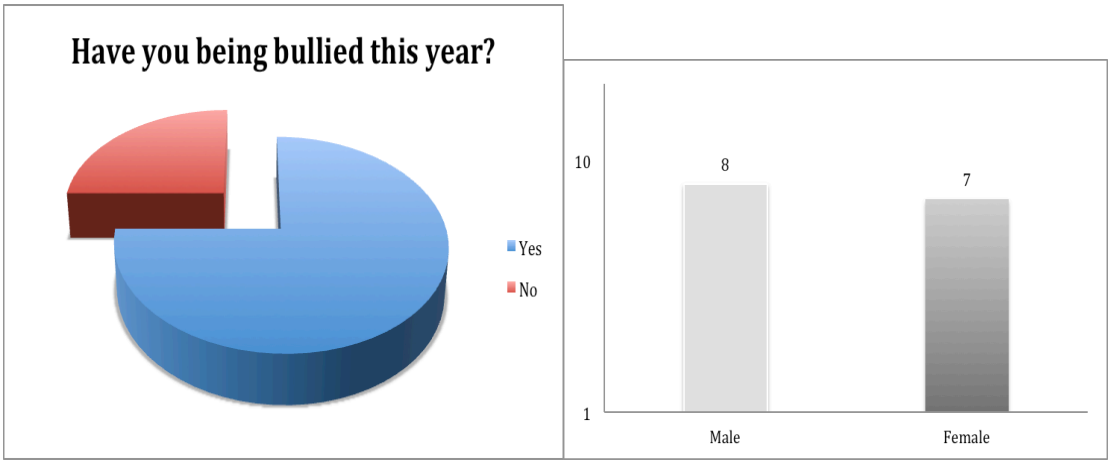

Figure 1. Frequency of “have you been bullied this year?”

In regards to the question “have you been bullied this year?” there was a significant amount of older adults being bullied, which counted for 75% of participants. There was no significant difference related to gender, the number of males who said yes was eight out of eleven (N=20) and females was seven out of nine (N=20). The percentage of older adults being bullied would have increased if many older adults would have been educated about bullying because many of them are confusing bullying with the act of “just being old.”

Moreover, according to staff A, there were many older adults who complained about being bullied but when asked staff A more information for study purposes; staff A refused to participate (personal communication, February 2014). This study demonstrated that some of the bullies are bullying other older adults because they learned that it is their way of survival and the staff is not going to take any actions towards them.

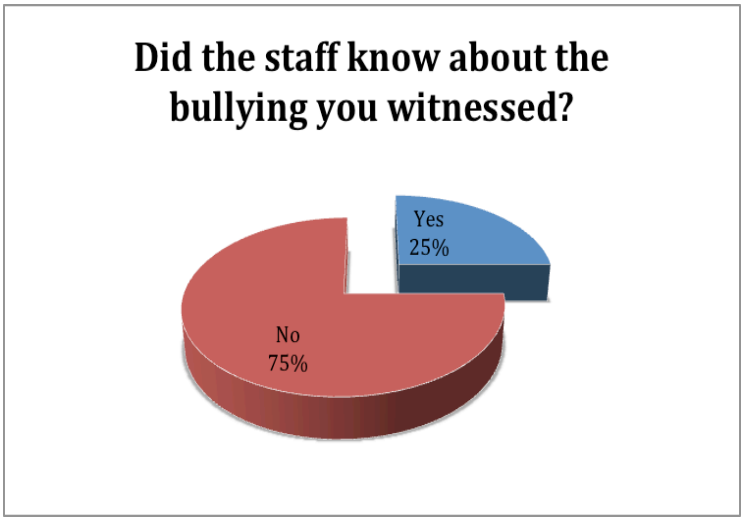

Figure 2. Frequency of "did the staff know about the bullying you witnessed?"

There is a large lack of staff knowledge regarding bullying in older adult's community. This study demonstrates that only 25% of the staff, according to older adult community members, knows about the problem of bullying in their community. Older adults are afraid of creating more problems in the retirement home if they share the fact that they are being bullied. Moreover, they do not realize that bullying also occurs among older adults.

Many staff members and older adults have the mentality that some older adults are just being “grumpy” and there is nothing they can do about it (personal communication, February 2015). This study revealed that many staff members are so busy with their own agenda that they ignore the problem of bullying in the community. Furthermore, many social workers from retirement communities are so busy trying to find activities for the elders to do that they do not realize that many of the residents do not participate because of the bullying problem in the community.

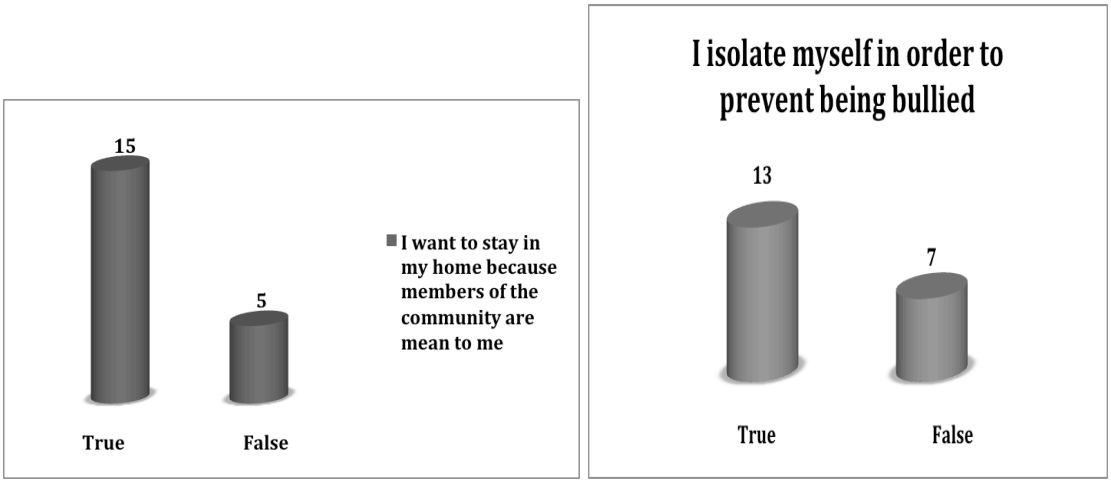

Figure 3. Frequency of true or false questions

This study also had two true or false statements to identify the actions of older adult victims of bullying. The first statement was “I want to stay in my home because members of the community are mean to me.” Unfortunately, there were 75% of older adults participants said it is true (15 out of 20). The other statement was “I isolate myself in order to prevent being bullied” and 65% said it is true (13 out of 20). This study confirms that older adults are

isolating themselves to avoid being bullied by other adults in their own community.

Summary

The results presented in the graphics above were the most important data for this study. The research used the descriptive frequencies variables to identify the demographic statistics of gender, age, race, and each close-ended questions. The statistics of the mean and std. deviation of age was discussed in order to demonstrate the amount of bullying amongst older adult populations living in retirement home communities.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will produce a more intense discussion of the results. Moreover, an examination of the limitations of the study will be discussed and suggestions for Social Work practice will be recommended.

Discussion

According to the Census Bureau's statistics, the older adult population is growing fast and by the year 2050, it will be more than double from now, about 80 million elders. Between the year of 2010 and 2030 the growth of older adult population will be about 2.8 percent annually (Sixty-Five Plus In The United States, 1995). This study shows that older adults are choosing to live in retirement communities or assistant homes because their lifestyle had changed, such as losing their partner, job, getting sick, retirement, and/or lack of network. When older adults move into a retirement community or assistance living community, they do not imagine that despite of all their life changes, they will face one more challenge, which is being bullied. The age of the participants for this study that chose to move to a retirement home varied from 58 to 84 years of age.

This study confirms that many older adults bully their peers. It confirms that many older adult victims of bullying are isolated, snubbed, shut out of

activities, called names, insulted, subjects of rumors and gossip, shouted at, and physically attacked. Many of the bullying behaviors are loud arguments, name-calling, bossy-behaviors, and physical violence that many times are not reported to staff. Moreover, it demonstrates that many older adults are intimidated by their bullies (not let them inside the elevator, not allowing them to sit at the dinner table, and isolating them from activities) because they hide themselves inside their homes in order to avoid confrontation. According to one of the participants (A), his bully had hit him on the leg with a cane that caused him to fall on his knees (personal communication, February 2015).

Many residents of older adult retirement homes are not immune to abuse as we think they are. It is very difficult for seniors to stand up for themselves and speak up about the problem. As the study shows, many isolate themselves because members of the community are mean to them or because they want to prevent being bullied.

There is no difference about bullying behaviors of older adults and younger individuals amongst peers. The only problem is that society is advocating for younger individual victims of bullying because they are aware of the problem among the younger population and are unaware of bullying amongst older adults in retirement home communities. Younger people have older adults to advocate for them, such as teachers, police, parents, and school counselors that they feel comfortable with. However, older adults feel a

burden to their family members, community, and friends so they prefer to become isolated.

This study also shows that older adults use some tools to protect themselves from being bullied. One participant (B) acknowledged that it is easy to become a bully because it is a survival tool (personal communication, February 2015), which implicates that he was once bullied. Some researchers had showed that when individuals feel vulnerable to a particular situation they either adjust to it or develop destructive behaviors (Creno, 2010). Another tool used by older adults living in retirement community is isolation because they do not want to face their bullies. One of the most extreme tools used by a participant (C) of this study was the destruction of his apartment. The participant (C) set fire in his apartment for the purpose of being relocated to a different community (personal communication, February 2015). The most extreme tool used to escape bullying is suicide. According to a study conducted by Yale University, there are a higher percentage of victims of bullying who consider suicide compared to non-victims (Bullying and Suicide, 2013).

Staff members of the retirement home, assisted living communities, and senior community centers described that bullying in the community is high and that they try to resolve the problem but all they can do is to remind older adult bullies the form they have signed before moving into the community (behavior contract), send them reprimand letters, or not allow them to be part of the

activity for the rest of the day. Staffs have disclosed their concerns to directors of the retirement communities but were afraid to go any further in fear of losing their jobs (personal communication, February 2015). Perhaps, that is one of the reasons many older adults do not go to staff members to discuss bullying in their community because they know that nothing is going to happen. Moreover, if nothing is going to be done by staff members, bullies might become aware of the complaints and the bullying behaviors might increase.

This study shows a significant amount of older adults bullying older adults in retirement communities, assisted living communities, and senior community services. It also confirms that older adult victims of bullying are isolating themselves to prevent being bullied, causing them to be depressed, have anxiety, and many other mental health conditions. According to one of the participants (D), “people in the retirement community isolate themselves to a point where you think that they are dead” (personal communication, February, 2014). Another participant (E) stated that her anxiety level was so high due to bullying in the community that she had problems going to sleep and she was depressed because she did not know where to turn but she is now taking medication that helps her “deal with it” (personal communication, February 2015).

Due to the small sample size, this study found no significant results on the independent t-test and the association between the question “have you been bullied this year” and the variables of age and gender. This study shows

that bullying is occurring in retirement homes, assisted living communities, and senior centers no matter what gender or age of older adults.

Limitations

Usually bullying occurs more in retirement homes than assisted living facilities or senior communities centers. However, staffs from retirement homes were not able to give an authorization to conduct the study due to fear of legal issues. There are many staffs and residents that want to speak up about bullying in the retirement homes but without authorization, their information could not be included in this survey.

There is much information regarding bullying that was provided by the bullies and the victims that could not be included in the survey because it was a quantitative survey. Due to the small sample size it was not possible to identify a correlation between bullying among older adults in retirement communities and age, race, and gender. There was also a limitation of ethnicity because the sample was primarily White/Caucasian, which limited the concerns on other ethnicities. Another limitation of this study is the lack of staffs' ability to complete the survey.

One variable that might play a role doing a quantitative survey with older adults is that older adults' cognitive ability to understand or define what bully means differs from one to another.

Future Studies

More research should be conducted related to bullying among older adults living in retirement communities and what interventions are being used to prevent bullying amongst this population. Due to legal issues, researchers should get additional time to get approval from the retirement homes' staff to conduct the study. Researchers should conduct quantitative and qualitative studies to gain in-depth knowledge about the issue of bullying among older adults and how it is affecting their mental and physical health, their friends, and family.

Conclusions

Much of the information we hear in the news is bullying amongst children/adolescents and how the problem implicates their growth. However, anyone at any age can be victims or perpetrators of bullying. It is easy for adults to protect their children by teaching them about bullying, have parent/child talk, and advocate for them. Even though there is no guarantee that bullying will be prevented, children have more freedom to express their struggles with bullying than older adult victims of bullying.

According to these study, bullying among older adults is high as 85% in the retirement homes, assistant living communities, and senior centers. Because of these figures, bullying amongst older adults should be treated as a problem that transcends in any cultural or racial differences among this population. Bullying intervention should not be focused only on

children/adolescence communities but also in older adult communities such as retirement homes, assisted living facilities, and senior centers.

APPENDIX A

QUESTIONNAIRE

Demographic Questions

1 – Gender: ☐ Female ☐ Male

2 – Age: _____

3 – Race:

☐ White ☐ Black/African American

☐ Latino/Hispanic ☐ Asian American

☐ Native American ☐ Middle Eastern

☐ Eastern European ☐ Asian

☐ Biracial (Please specify) ☐Other_____

_____

Yes/No Questions

1 – Have you been bullied this year?

☐ Yes ☐ No

2 – Did you witness bullying in your community?

☐ Yes ☐ No

3 – Did the staff know about the bullying you witnessed?

☐ Yes ☐ No

4 – Is bullying a problem in you community?

☐ Yes ☐ No

5 – Have members of the community called you nasty names?

☐ Yes ☐ No

6 – Have members of the community told stories about you that were not true?

☐ Yes ☐ No

7 – Have members of the community spoilt activities (e.g., group activities) on purpose to make you upset?

☐ Yes ☐ No

8 – Have members of the community not wanted to hang around with you to make you upset?

☐ Yes ☐ No

True/False Questions

1 – I want to stay in my home because members of the community are mean to me.

☐ True ☐ False

2 – I isolate myself in order to prevent being bullied.

☐ True ☐ False

Adaptation from Bond, L., Wolfe, S., Tollit, M., Butler, H., & Patton, G. (2007). A comparison of the Gatehouse Bullying Scale and the Peer Relations Questionnaire for students in secondary school. *Journal of School Health, 77,* 75–79.

Mynard, H., & Joseph, S. (2000). Development of the Multidimensional Peer-Victimization Scale. *Aggressive Behavior, 26,* 169–178.

APPENDIX B

INFORMED CONSENT

Informed Consent Form

My name is Claudia Sepe. I am a student from CSUSB. I am working with my professor Dr. McCaslin. We are currently doing a study regarding bullying among older adults in retirement homes, assisted living facilities, and senior center communities. The School of Social Work Sub-Committee of the Institutional Review Board (IRB) of California State University, San Bernardino has approved this study. An IRB is the group that makes sure that any studies done from the college protect the rights of individuals who participate in the study. The point of this study is to examine bullying among older adults living in retirement communities and in senior center communities. Additionally, this study seeks to identify older adults' coping skills to deal with bullying among older adults, who they speak with regarding the issues/concerns, and what they do to prevent from being bullied.

You will complete a bully survey composed of three demographic questions, nine yes/no questions and three true/false questions.

Your participation is voluntary. You will be able to skip any of the questions that you do not want to answer. There will be no consequences if you decided to stop the survey.

I acknowledge that I have been informed of, and that I understand the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am over 55 years of age.

Name:_____Date_____

APPENDIX C

FLYER

VOLUNTEERS NEED FOR

RESEARCH SURVEY ON

BULLYING AMONG OLDER ADULTS

California State University, San Bernardino (CSUSB) student is looking for volunteers to complete a survey on bullying among older adults. We will not be asking for your personal information (e.g., name). As a participant in this survey, you will be asked to answer 15 questions related to bullying. The survey will take approximately 10 minutes for you to complete. The purpose of this study is to help social workers to develop new interventions in order to help the older adult community living in retirement homes and assisted living.

If you are interested, please contact Claudia at (909) 767-7174.

Thank you!

This study has been reviewed and approved by the School of Social Work Sub-Committee of the Institutional Review Board of California State University, San Bernardino

APPENDIX D

DEBRIEFING STATEMENT

Debriefing Statement

The study by Claudia Sepe that will be completed is designed to investigate the epidemic problems of bullying among older adults residing in retirement homes and assisted living facilities. This study will measure the amount of bullying in the retirement community and the affects of bullying in the older adult communities.

The information that will be collected will help social workers or health care professionals to discover new interventions for the purpose of helping older adults in retirement homes and assisted living facilities.

Thank you for your participation. If you have any questions or concerns, please contact Dr. Rosemary McCaslin at (909) 537-5507. Thank you.

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