Institutional Mistreatment and Dignity: toward a conceptual understanding.

Simon Biggs *, Martin Stevens *, Anthea Tinker *, Josie Dixon**
and Lucy Lee**

***Kings College London**
****National Centre for Social Research**

A paper for the Department of Health and Comic Relief
December 2009

Institutional Mistreatment and Dignity: toward a conceptual understanding.

Introduction

The purpose of this paper is to explore conceptual and theoretical positions that pertain to mistreatment and loss of dignity in institutional settings. While the use of the term 'institution' is imperfect, it does allow coverage of a wide variety of settings, typically care or nursing homes but including long stay hospitals, and is commonly used in this literature. The phrase is specified down to 'organisational culture' as a conceptual analysis is developed. Also, we keep to the convention established in the UK prevalence study on community settings (O'Keefe et al, 2007; Biggs et al 2009) that elder mistreatment is used as an umbrella term covering instances of abuse and neglect. Abuse refers primarily to active and intentional acts of commission and neglect refers to 'passive acts' of omission, the absence of a response to identified need. The paper is inevitably tentative, yet hopefully has a bearing on the development of measures in institutional/organisational contexts.

The paper has been divided into a number of sections. First there is a discussion of dignity and how this might contextualise mistreatment in institutions. This examination is mostly focussed on mistreatment when compared to dignity and for operational purposes they often appear as two sides of the same coin. Second, trends in existing research are outlined and loss of dignity and mistreatment are examined as an interpersonal phenomenon. As part of this, some factors that affect prevalence studies in the community are compared with those proposed for institutional settings. Third, mistreatment and loss of dignity are examined from the perspective of a relationship within an organisational system. The paper concludes with a preliminary model that arises from this analysis. A number of existing questionnaires are also identified that might be drawn on in later parts of the programme.

The main conclusion of the conceptual analysis undertaken here is that organisational culture needs to be recognised as a core element, both conceptually and operationally and a distinctive feature of an institutional study. The value of this 'fourth set of variables' when added to the characteristics of actors, nominated separately as victims and as perpetrators, and types of mistreatment (Financial, physical, psychological/emotional, sexual

abuse, plus neglect) is outlined as a means of including contextual and interpersonal elements in the consideration of risk. Focusing on this fourth set of variables also moves debate away from the identification of 'good' and 'bad' homes and toward an analysis of combinations of factors at different levels of analysis that make mistreatment more or less likely to happen.

Dignity and mistreatment

Dignity, while often used in everyday speech to refer to personal character; whether an individual behaves 'with dignity' or 'has dignity', frequently in situations that cause forms of stress; is, in policy discourse, more commonly used to describe an other's conduct towards that person. Thus, a behaviour or context arising from a combination of behaviours over time may increase or decrease the likelihood of that person being 'treated with dignity'. The two understandings are underpinned by the idea that dignity is based on a belief in the universal worth of persons, (or 'Menschenwürde'), which provides the ultimate basis for respect (Cass *et al*. 2008; DH, 2006; 2005; Griffin-Heslin, 2005; Dignity and Older European Study, 2001; Haddock, 1996). Autonomy has been placed as one of the identifying characteristics of what it is to be a person (Chan, 2004), and as such plays a central role in many analyses of dignity (Barnes,2006; Bayer *et al*. 2005; Griffin-Heslin, 2005; Chan, 2004).

The Dignity in Older Europeans Study (2001) developed an 'Operational model', which articulated how different forms of dignity were threatened by certain kinds of treatment. This is of particular importance for the relationship between dignity and mistreatment. The operational model proposed by the European Study suggested that Menschenwürde generates dignities of merit, moral stature and identity, which in turn produce self respect:

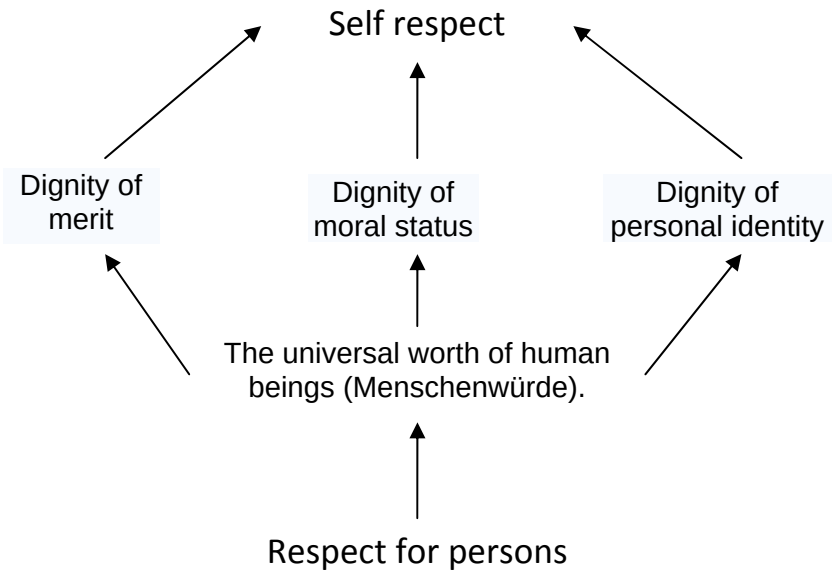


Figure One: Dignity and Older Europeans (2001: 7)

Thus 'Dignity of merit', earned through competence and achievement, can be threatened by loss of occupation and decreasing skill. Such threats are heightened by treatment which ignores past achievements, which in turn diminishes the personhood of the individual. People are also accorded respect according to their moral stature, ('Dignity of moral stature'), which arises from the moral behaviour of the individual and the ability to live according to personal beliefs and principles. Such stature is seen to vary depending on behaviour and context. Consequently, as people have reduced opportunities and resources to behave morally their moral stature can become devalued, which tends to reduce the relevant level of dignity in a particular context. In terms of institutional care, a number of points are worth making. Treatment in care services can enhance or limit opportunities for older people to show caring attitudes and engage in interaction, through which moral stature can become evident. Chan (2004) argues that people living without positive and meaningful relationships, which are more difficult to maintain in institutional settings, 'cannot be accountable and will not be granted rights' (231). Being held accountable is an essential element of moral behaviour and consequently people living in institutional settings are likely to be accorded less dignity of moral stature, which can increase or decrease according to context and behaviour (Dignity and Older Europeans (2001).

Perhaps of more direct relevance for the care of older people is 'Dignity of identity', which is bound up closely with self respect and autonomy. Identity is threatened by some of the consequences of old age, such as retirement and

increasing need for help with intimate caring duties, which can change self perceived identity and reduce autonomy. The degree to which residents are able to: create their own space using familiar objects and furnishing, maintain relationships with family members, staff and other residents that involve 'positive mutuality' and understanding of personal history (Help the Aged, 2006), and the style of care offered, particularly over intimate care and toileting; can all serve to enhance or diminish dignity of personal identity (Chan, 2004). The European model would predict that self respect is affected by individual treatment which enhances or diminishes dignity in each of the three dignity areas, plus the organisational contexts associated with different patterns of individual treatment.

Dignity is commonly used in contemporary policy documents to refer to a positive atmosphere that enhances the well-being and protects the human rights of a vulnerable individual. In the model proposed above, this would involve ensuring that maximising the potential for older people to be treated with the respect, is the same as that accorded to all people, with due regard for their past achievements and competence, moral stature and identity.

The Department of Health's 'Dignity in Care'[1] website gives a number of examples of situations liable to maintain or diminish dignity, which can be mapped onto the European model in the following way, suggesting that the greatest threats to dignity within institutional care services do indeed lie in removing threats to identity:

Box 1: Mapping undignified treatment to the European Operational Model

Treatment – Dignity in Care website	Lack of Dignity of... (Dignity and Older Europeans Study)
Feeling neglected or ignored whilst receiving care	Identity
Being made to feel worthless or a nuisance	Merit
Being treated more as an object than a person	*Menschenwürde*
Feeling their privacy was not being respected during intimate care, eg, being forced to use a commode in	Identity

[1] http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/DH_4134922

hospital rather than being provided with a wheelchair and supported to use the bathroom	
A disrespectful attitude from staff or being addressed in ways they find disrespectful, eg, by first names	Identity
Being provided with bibs intended for babies rather than a napkin whilst being helped to eat	Identity
Having to eat with their fingers rather than being helped to eat with a knife and fork	Identity
Generally being rushed and not listened to.	*Menschenwürde*

Taken individually, each of these areas of lack of dignity represents relatively minor harms. However two further points need to be made to connect loss of dignity with the identification of mistreatment. The first, links to thresholds of behaviours and when they might reasonably be considered mistreatment. Thus, repeated or ongoing undignified treatment of this kind could be characterised as mistreatment, although the amount and length of any episode would require further specification. Consequently any survey aiming to establish the prevalence of elder abuse in institutional settings may need to include of relative minor but repeated acts, with only high levels of repetition or duration counting towards prevalence rates. The second links to organisational culture, in so far as it is plausible to propose that more extreme kinds of elder mistreatment may be more likely in institutions in which lack of dignity is commonly accepted practice. Exploring relationships between these kinds of practices and prevalence rates may therefore be of value in developing a 'fourth set of variables' relating to organisational culture. In this context, dignity or lack of dignity might be thought of as a contextualising factor, part of an embedding culture of care that informs specific organisational contexts.

Trends in existing research on mistreatment and prevalence

Existing research on the prevalence of mistreatment is subject to a number of paradoxes. First, while residential institutions are more likely to be associated in the public mind with abuse and neglect of older people (Eurobarometer,

2008; Hussein et al, 2007), most of the evidence on the prevalence of abuse has been based on samples of people living in community settings (Hirsch & Vollhardt, 2008; Tinker et al 2010). A second factor affecting our understanding of institutional mistreatment is that almost all studies have relied on staff report, whereas community based studies have directly interviewed older adults (Hawes, 2003, Goergen 2002). Third, while there is a longstanding literature on institutional care, ranging from qualitative studies of resident-staff interaction (Hubbard et al, 2003, Lee et al 2002), to public inquiries into institutional failure (Glendenning, 1999), there is very little that specifically addresses the likelihood of mistreatment taking place. Finally, but not exhaustively, there has been very little use of a parallel literature on the role of organisational culture in creating and perpetuating certain forms of conduct (McKie et al, 2008). This would include the ways in which the context or climate of an institution interacts with the behaviour of individuals and groups within it to produce positive or negative outcomes. Unlike work on mental health and child care, there is a negligible tradition of consultation and supervision examining the processes at work when older clients/patients and younger workers interact (Foster & Roberts, 1999; McClusky and Hooper, 2000).

Taking these limitations into account, we will first examine interpersonal interactions as a factor in institutional care, then examine the need for specific variables covering organisational culture.

Interpersonal elements of mistreatment and loss of dignity

Elder mistreatment has most commonly been defined as the product of social interaction between a nominated carer and a person who is vulnerable and dependent on that care. For example, the US National Research Council Panel on Elder Mistreatment (NRC) (Bonnie & Wallace, 2003) states that:

> *'elder mistreatment is defined to refer to (a)intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or by (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm. 'Mistreatment' conveys two ideas: that some injury, deprivation, or dangerous condition has occurred to the elder person and that someone else bears responsibility for causing the condition or failing to prevent it'. (Bonnie & Wallace, 2003: 40)*

The Panel noted that this definition has a number of advantages in so far as it excludes behaviour between strangers- and thus excludes a large number of criminal acts. It is also intended to capture behaviours and treatment which would typically not be treated as criminal. In addition, it excludes structural inequalities, allowing a distinction to be made between general attitudes toward older people, including social ageism, and specific forms of interpersonal harm (Bonnie & Wallace 2003).

However, this tendency to see mistreatment exclusively in terms of a victim and a perpetrator has been paralleled by a conceptual desire to re-embed individual acts of abuse and neglect in their wider social context and networks of power relations. It is a question that is particularly acute when institutional forms are the principal focus of attention, where the boundaries between individual acts and acceptable micro-cultural practices are most blurred.

The NRC Panel's report itself includes such a model or 'theoretical sketch' (61). This model draws on two pre existing approaches. The first is Engel's (1977) 'bio-psycho-social' model, which the report's editors describe as 'encompassing psychological and social factors in explaining bio-physiological conditions, such as disease or ageing processes'(Bonnie & Wallace 2003: 61). The second approach comes from Schiamberg and Gans' (2000) 'ecological' model of family caring. This involves a successive embedding of feedback relations from the dyadic caring relationship upwards, through a meso-system including categories of interaction (which can extend to degree of dependency or characteristics of relationships such as familial bonds or duties of care), an exo-system (employment status, financial resources, service availability) to include macro-structural factors (cultural norms toward age, gender, disability, violence). The core of the model examines the 'interaction between the characteristics of the potential victim of mistreatment and those of the responsible actor', which are seen to be at the centre of a series of 'contextual risk factors' encompassing different types of social relationship, social location and socio-cultural context in which the two actors are embedded. The model refers, however, only to familial mistreatment and is not extended to cover institutional contexts.

The NRC model, acknowledges mistreatment as 'a transactional process unfolding over time among the elder person, his or her trusted other and other interested parties'… and attempts …'a risk model of elder mistreatment in

domestic settings' (61-2) later expanded to include a model for institutional care.

The model is structured so that the characteristics of two separate actors come together to generate a particular series of 'power and exchange dynamics' which include the 'negotiation of care-giving scripts (eg complete, moderate or limited dependency and need for assistance in performing daily living routines)' (63). Which, in combination with wider social and individual level factors produce a series of outcomes that include the physical and emotional health/happiness of each party, a form of mistreatment, the durability of the caring relationship and a sense of security and trust.

The NRC model is driven very much by concern to make the phenomenon manageable and distinctive, thus rendering it measurable. The sections of the model fall out directly from definitional concerns. Thus separate players (the victim and perpetrator) are placed on opposite sides of the model which imbues each party with a separate set of characteristics or individual level factors. These come together in a particular context, marked by status inequalities, relationship types and power and exchange dynamics which then lead to certain outcomes (forms of mistreatment). It underplays the mutual construction of meaning around events, which may be critical in understanding why abuse occurs, is maintained or declines, and why disclosure does or does not take place. It does, however, identify the question of context and of how that might affect the likelihood of mistreatment occurring.

The introduction of power and exchange dynamics and the negotiation of scripts is a distinct forward movement of the modelling process. It opens up the question of degrees of choice, interpretation, entrapment that may be experienced in mistreatment situations. And while the term 'actor' is generally reserved for the trusted other, opens the possibility of an active role for the older adult subject. Socio-structural factors take the form of sources of status inequality- such as gender, age, race and education, which are treated, within the terms of reference of the model, as demographic categories.

The NRC model reflects a tension in interpersonal approaches to dignity and mistreatment between separating out different elements of a model, to make them intelligible and ultimately capable of being measured; and retaining the phenomenological integrity of the events as experienced, that they seek to describe. This may be at the core of the complaint that somehow models are 'not real', although they can help practitioners and others 'make sense' of a

particular form of mistreatment or loss of dignity. The model, the categories used and their relative primacy therefore take on a particular mediating function between the events as experienced (for example, as relationships of trust) and ones that are measured. The value of models to prevalence measurement is perhaps at a macro level of analysis here, in the sense of understanding how different elements are connected to overall levels of abuse. To explain individual episodes, in depth and narrative approaches may capture individual experience. As Layder notes:

> *… social reality should not be and cannot be understood as a unitary whole which is susceptible only to one kind of explanatory principle, theoretical assumption, or methodological approach. (1998, p.86).*

Reviewing the NRC model draws attention to a group of factors that are particular to the study of elder mistreatment as a form of interpersonal behaviour. One such factor recognises that the key actors in situations of elder mistreatment are both adults, even if one is perhaps dependent upon or more vulnerable than the other. This demonstrates a somewhat obvious, yet often overlooked difference between elder abuse and child abuse and has an important influence on the quality of the relationship, expectations of behaviour, power, responsibility and the ability to take decisions. Children are increasingly seen as having human rights and input to decision-making processes, not in other words, to be treated as 'minors', which arguably represents the spread of 'adult' forms of relating into the domain of childhood. The situation with vulnerable adults, and older people who are vulnerable in particular, is rather the reverse, as infantilising processes are seen as diluting and inhibiting 'normal' adult rights and responsibilities (Coupland, 2004). Thus, while children have increasingly been positioned as adults for the purposes of decision-making, older adults have been positioned as children, with accompanying consequences for empowerment and loss of dignity.

One approach that may be helpful in locating interpersonal behaviour within institutional settings is positioning theory (Harrè and Modhaddam, 2003) Positioning theory views adult to adult interaction and relationships as typically involving taking and ascribing of positions, which Harrè and Modhaddam (2003) define as:

> *A cluster of rights and duties to perform certain actions with a certain significance as acts, but which may also include*

> *prohibitions or denials of access to some of the local repertoire of meaningful acts (5-6)*

Positions, combined with the interpretation of speech acts and developing story lines provide a means of interpreting much interaction. Positions can be negotiated and dynamic, but individuals and groups can also be ascribed more fixed positions which can be more or less advantageous in the expression of individuality and autonomy.

If the adult to adult nature of interactions between older people and care workers is accepted, it has certain implications for institutional care. To begin with, such interactions need a mutual positioning as valued persons (in the menschenwurde sense), which involves recognising (although not always respecting) the others' autonomy, identity and moral status. Second, relations, rights and responsibilities need to be negotiated, within pre-existing formal and informal power relationships, through positioning (as 'care worker' and 'resident', for example). Relations that compromise independence, autonomy and identity are likely to give rise to negative affect. Third, behaviour is a 'two way street' and that the meaning of a relationship is co-created. Positive adult to adult relationships will foster mutual dignity, which, as outlined above, will require respect for persons, in terms of autonomy, respect for identity, moral stature and merit. However, adult to adult relationships can also create a lack of dignity. Harrè and Moghaddam (2003) describe how dignity and the possibility of living a full life can be diminished through what they describe as 'malevolent positioning', which involves positioning a person as incapable of making decisions, based, for example, on different levels of cognitive capacity.

Recognising power imbalance raises the question of how positive, mutually dignifying interactions can be maintained if the balance of power between parties is uneven. This has, in residential care often been structured as a balance between 'rights and risk' and is a key concern with respect to mental, but also physical capacity. In such situations older people are positioned as incapable of making decisions, on the basis of different kinds of impairment. The degree to which age and generational differences mediate social relations would also be an important factor (Antonucci, Jackson & Biggs, 2007). This would influence the development of interpersonal scripts in institutions and how an older-younger dimension affects wider attitudes and expectations of age- related behaviour. Such expectations may involve positive elements such as respect for wisdom in addition to negative stereotypes.

A Positioning approach raises questions about the degree to which co-creation of meaning requires a sharp distinction between victims and perpetrators and perhaps means that events should be thought of in terms of different actors with different access to a variety of forms of power. It may, for example, be relatively difficult to identify individual 'perpetrators' in institutional settings, because of the impact of organisational culture and the role of formal lines of accountability. It is perhaps easier to identify individuals who experience mistreatment. Further, the adult-adult nature of relationships begs the question of whether research on mistreatment should include measures of resident-resident and resident on staff mistreatment in its attempt to understand complex interactions.

Recognising the interpersonal nature of mistreatment and loss of dignity, however, encounters a specific problem in the case of older adults in institutional settings, and that is the question of 'voice'. The few studies that have attempted to put a prevalence figure on institutional abuse (Goergen, 2001, 2002; Lachs et al on resident–resident abuse (2009) have drawn heavily on the original Pillemer and Moore (1989) research in using staff report as the means for assessing frequency of mistreatment. There are qualitative studies that report the experiences of residents in residential care, and at least one reporting on residents views on what abuse or neglect might be like (Furness, 2006), but almost none on residents actual experience of abuse. To date the authors know of no prevalence studies that use victims' own reports of institutional mistreatment. The absence of a resident voice is also reflected in the predominantly 'professional' discourse around abuse and neglect in general. Unlike areas such as disability, mental health or domestic violence, there are no voices 'by' older victims, as compared to NGOs or concerned professionals working 'for' them. This is understandable in so far as it reflects the vulnerability and capacities of the group of older people in question, however it does lead to a number of problems for research. The first is that there can be a confusion of voices such that it not always clear which actor's perspective is being heard. It also raises the question of the degree to which the recognition of abuse should take into account multiple perspectives. A consequence of accepting this is that a decision would need to be made on the degree to which the understandings of different actors should be used in coming to a judgement of whether an act contains mistreatment.

In explaining the relationship between interpersonal relations and context, it is also possible to examine an approach arising from criminology. This work represents a shift of focus, building on the positioning of key actors outlined

above, while expanding how mistreatment might become more or less likely to occur. Goergen and Beaulieu (2010) have recently applied two criminological theories; *Routine Activity Theory* (Felson, 2002) and *Situational Action Theory of Crime Causation* (Wikström, 2005; 2008) to mistreatment behaviours.

Routine Activity Theory (RAT) is based on the idea that routine everyday behaviour creates opportunities for criminal activity. Certain routines require more and others less effort in order to commit a crime and the risk of being associated with it. Goergen and Beaulieu state that 'Intentional crime requires a motivated offender, a suitable target, the absence of capable guardians, and the possibility of these three elements to intersect in time and space'. Where activity spaces overlap (Felson, 2002) for example, through *personal ties* (ie a resident's bedroom being a personal space and site for intimate and family interaction) or *specialized work roles* (care work needing to take place in a resident's bedroom and overlapping private and work environments), crimes of specialized access might occur. The latter are defined as "a criminal act committed by abusing one's job or profession to gain specific access to a crime target" (p.95) . Routine Activity Theory has been used by Harris & Benson (2006) to examine nursing homes as contexts in which overlapping activity spaces do occur, often under conditions of weak external guardianship (such as supervision and monitoring). Contextual factors such as caregiving strain, low job satisfaction, perceived unfairness of working conditions, absence of regular supervision and low self-control contribute to the likelihood that opportunities for mistreatment will be taken.

Wikström's *Situational action theory* (SAT) adds to RAT in so far as it is argued that moral rule breaking has to be explained by the interaction of personal and environmental factors. The two are linked by situational mechanisms that determine the moral perceptions and choices available to social actors. These include temptations and provocations (that Goergen and Beaulieu refer to as opportunities and frictions), and the moral context in which both occur. For SAT, moral context includes a setting's perceived rules, how they are monitored and sanctions that might apply. In Wikström's view:

"temptation, defined as a perceived option to satisfy a particular desire (need, want) in an unlawful way, and provocation, defined as a perceived attack on the person's (or his or her significant others) property, security or self-respect encouraging an unlawful response. Temptation occurs in response to opportunity, while provocation occurs in response to frictions'. (Wikström, 2005, p. 88).

Goergen and Beaulieu (2010) apply this criminological understanding to financial abuse, stranger 'its-me' crimes of deception, and institutional care.

They argue that mistreatment arising from institutional or domestic care-giving can be conceptualized as a *crime of specialized access* with care recipients being regarded as *suitable targets* for abuse. Within institutional contexts, *capable guardians* against an attempted act of abuse by a motivated offender are seen to include adequate supervision, management and monitoring processes. However, they also state that:

'Contrary to many other aspects of everyday life, the perception of opportunities as such and the intention to make use of opportunities cannot be taken for granted in family or professional care-giving. We have pointed to the tension between care-giving's general underlying motive and its pervasive "offender-friendly" opportunity structure and to the conditions under which the altruistic motive may give way to more deviant ones' (p 6).

What they are saying here is that caring contexts are not generally ones that provoke negative behaviours, a point supported by Hawes' (2009) research that showed paid carers to be highly motivated and positively engaged with older residents, often in spite of stressful working conditions.

While Goergen and Beaulieu's (2010) criminological modelling is primarily concerned with the behaviour of potential perpetrators it gives further evidence of the need to engage with the interaction between individuals, relationships and context.

Taken together conceptual models that attempt to address mistreatment and loss of dignity at the level of interpersonal interaction, draw attention to the role of negotiated relationships in the context of unequal power. They suggest the need to find a balance between rights, risks and factors that might facilitate mistreatment, but also to the role of multiple perspectives in the construction and recognition of abusive and neglectful behaviour. While the definition of mistreatment tends to restrict its scope to the relationship between nominated victims and perpetrators, modelling appears to require, almost without exception, the re-introduction of context and wider systems to fully explain mistreatment phenomena. This leads to the second section of this discussion, which centres on the nature of institutional abuse and the role of organisational culture in explaining risk.

A relationship in a system

Mistreatment that takes place in an institution, has to be seen, perhaps more so than in other contexts, as a relationship within a system. It involves social

actors who in the normal running of the institution are categorised as 'resident', 'care staff' or 'manager' to name but three, which tends to make certain patterns of behaviour and positions commonplace in interactions, each category carrying different sets of rights and duties. The way that the system is organised may be thought to generate the possibility of respect or depersonalisation of older people. The study of mistreatment has traditionally divided actors into, categories such as victim and perpetrator, which is attractive to researchers because it allows for the identification of individual actors' characteristics that can then be treated as if they were independent variables. When they are compared, they provide an indication of risk and likelihood of abuse. Looking at institutional mistreatment draws sharper attention to an understanding based on context. This would be a strong argument for the elaboration of organisational culture as a specific form of contextual variable in the study of institutional mistreatment. This would go beyond simply classifying where abuse took place, to an elaboration of the different attributes of situations and would allow different combinations of institutional characteristics to be included in the identification of prevalence and therefore risk.

Organisational Factors as a 'Fourth set of variables' in prevalence research

That the majority of prevalence studies on elder mistreatment have relied upon community sampling, raises questions about the degree to which the categories, questionnaire material and operational factors used in this research will fully represent the range of issues occurring in institutional settings. Those few researchers (Pillemer & Moore, 1989; Pillemer & Hudson, 1992; Goergen, 2001 ,2002) who have looked for prevalence data in hospitals, residential and nursing homes, have used staff report and staff characteristics data, which often refers to the embedding organisational culture as an important determining factor when assessing risk. Further, related work on institutional abuse (Garner & Evans, 2000) workplace bullying (Salin, 2003) and organisational 'care-scapes' (McKie et al 2008) focus on institutional context as a key variable in an organisation's capacity to care and/or the likelihood of mistreatment taking place. 'Care-scapes' refer to attempts to map the overall caring structures in any one organisation as a means of capturing its caring capacity in relation to work, organisational supports and culture.

If it is accepted that institutions and communities have particular as well as shared characteristics when considering the likelihood of abuse, then

organisational factors would form an important fourth set of variables in prevalence research. The first three sets of variables are common to both institutional and community studies and include: the characteristics of actors such as (1) nominated victims and (2) perpetrators and (3) different types of mistreatment. An advantage of this ' fourth set of variables' approach is that it not only separates out organisational from staff and resident characteristics, in a way that relying exclusively on staff attitudes and responses (Pillemer and Moore, 1989) does not, it allows a continuum of organisational risk to take shape. By turning organisational characteristics into a continuum, one escapes from labelling a particular institution as being either abusive or not abusive. It allows different risk factors to be isolated and o that they can be compared to risks arising from the characteristics of the victim and perpetrator populations for any one form of mistreatment. It is therefore analytically possible to cross correlate each set of factors (organisation, victim, perpetrator, type of mistreatment) at see whether certain forms of mistreatment occur within a particular set of circumstances.

Such an approach takes the focus away from identifying 'bad' and 'good' homes and onto the risk that a certain combination of factors are associated with mistreatment of various kinds. Identifying organisational culture as a 'fourth set of variables' alongside victim, perpetrator and type of mistreatment allows the analysis of how far a particular combination of characteristics occurs and how these are connected to risk of mistreatment. This would help target particular risky circumstances in addition to how commonly risk occurs.

Relationships within formal systems

One of the issues specific to institutional care is that, unlike family forms, care takes place within a relatively formal set of boundaries. These boundaries may refer to physical structures, such as a specifically designed and designated building, role expectations on formal carers, or quality criteria and forms of monitoring. It could be argued that families and communities also undertake care in systemic ways. The more formal and defined roles of paid carers in the community blurs this difference, as do relations between the institution itself, friends and families. However, unlike families or friends, relationships within institutional settings exist in a system with relatively speaking, clearly designated roles and responsibilities. In formal systems, such as institutional settings, the degrees of freedom around issues such as the balance between 'rights and risk' are themselves often explicitly constituted in a way that they are not between informal carers and people being cared for in the community.

The relationship between a worker and a resident/consumer/customer is less negotiable, more clearly defined and more subject to external constraints than informal caring arrangements and this is particularly so in bounded settings such as institutions. Life based in a residential or nursing home still includes an element of a combination of different worlds, what Willcocks et al (1987) referred to 'private lives in public places'. It is a workplace as well as a dwelling place (Biggs, 1989) and includes different sources of motivation, concerning attitudes to work, working life and everyday life that- mediate intergenerational relations and the care of others. It is also a space marked by non-familial co-residence, which includes within its boundaries relations between residents. Instances of resident on resident mistreatment and to resident mistreatment of staff can therefore contribute to an assessment of organisational culture (Lachs et al 2009).

Goergen (2009) reports that, in comparison to other settings it can be more difficult to distinguish a single perpetrator, or responsibility that lies behind a form of mistreatment in institutions. This is a paradox given the fact that the system is more explicitly drawn, but arises from the possibility that institutional cultures 'permit' certain actions or include routines that inhibit dignity. A system, in other words, sustains group assumptions about quality of care and dignity and what would be considered appropriate behaviour or mistreatment, beyond the judgement of any one individual. That there are a number of people directly involved in formal care also means that it can be difficult to distinguish between a single person, engaging in repeated acts of abuse across a number of individuals, or a culture that permits a number of people to behave in an abusive manner or that does not respect dignity . This is particularly the case for neglect, where not doing things can be difficult to assign to individual carers. Placing neglect in a formal context helps a move beyond the restricted definition often used in community studies, of seeing neglect as a perceived absence of support from someone who used to give it but no longer does so. In institutional settings, acts of omission can be related to clearer expectations of the kinds of care that should be expected, while the formal context itself may make it difficult to carry out care to an expected standard, creating a further complexity in attributing responsibility. The key point here is that dignity and mistreatment in institutional settings is dominated to a much higher degree than relations in community settings by aspects of care outlined above: boundaried space, clearer role expectations and quality criteria, local cultures of acceptable practice and a larger number of individuals providing care.

What are the measurable characteristics of organisations?

Organisational culture can include staff and resident characteristics, organisational milieux, structures and systems, all of which combine to give 'the feel of a place'. But how far can that 'feel' be pinned down and measured?

That institutional relations exist in relatively closed systems when compared to more 'open' community living allows them to be more closely monitored and supervised than community based staff or indeed family members. It has been argued by (Hussein *et al*. 2009) that this may help to explain the high proportion of residential care staff referred to the Protection of Vulnerable Adults List. A further factor is that the boundaries between the context of abuse and the wider environment are relatively well defined and formally designated in institutional abuse. There are hierarchies of power within institutional settings, with which some residents and their relatives will be able to engage directly, in the form of complaints. The degree to which monitoring and supervision of staff occurs, a potentially protective factor in care homes, may also reflect differences in organisational culture and generate data that can be measured and compared.

An 'Organisational Cultures' workshop, held as part of the project's 'Future-search' conference identified the following issues that were specific to developing an approach that takes institutional factors into account when measuring elder mistreatment:

- the tension between focussing on organisational culture and individual acts of mistreatment.

- the permissive role of culture- as allowing mistreatment or acts that are lacking in dignity to take place.

- the problem of longstanding staff who may be so immersed in a culture that is abusive or lacks dignity that they cannot distinguish between good and poor practice.

- institutional resistance to change

- the rigidity of some institutions and their tendency to perceive research as criticism

- the possibility of using staff burnout and stress as factors in 'poor' organisational culture
- sickness, staff turnover as indicators of quality of environment
- the presence or absence of recorded procedures as indicators of quality of environment
- the presence or absence of regular training and supervision as indicators of quality of environment
- there are not 'good' or 'bad' organisational cultures, rather there is a continuum of quality
- Residents will spend much of their time with other residents, so need to include questions about bullying
- It is important to consider the nature of the relationship between service user and staff member
- It is important to include a measure of the impact of the behaviour on the person
- Relationships between residents and staff are thought of as crucial
- There may be a difference between what is perceived by residents as abuse and what objectively may be thought of as abuse
- Dissatisfaction is neither necessary nor sufficient to warrant a judgement of mistreatment or loss of dignity

A suggested global question arising from the workshop was: 'would you be willing to live in a home like this one when you grow old'/ 'would you be willing for someone close to you to live in a home like this one'?

These observations point to a reasonably high correspondence between the research literature and the reports of key stakeholders on the characteristics and research issues that arise in institutional settings.

Unfortunately, the literature on abuse and neglect and that on organisational systems appear to have been travelling in parallel with little attempt to make links between the two. Observations on organisational culture are often based on qualitative studies or results of consultations to organisations (Scott, 2008). They are likely to be 'value-neutral' in so far as they describe system types that are 'open and closed' or 'team matrix or hierarchy' rather than identify dignity or mistreatment. There is also a tendency to draw on business models (Morgan, 2006) as that has been where organisations have funded interventions. A series of questionnaires have, however, been produced that attempt to specify elements of organisational climate, these, in addition to ones arising from literature on mistreatment or lack of dignity have been listed at the conclusion of this paper as a potential source of items for an institutional study.

Two existing studies that have produced prevalence figures for institutions have included the following data sources, which could be expanded to examine organisational culture.

Pillemer & Moore (1989) concentrated on Physical and Psychological abuse, based on the Conflict Tactics Scale (CTS). Their questions were prefaced by; 'sometimes when conflicts occur with patients, the staff may find it difficult to respond in ways that they are supposed to'. Staff were asked how frequently they had seen others or had themselves acted abusively on a scale of: never, once, 2-10 times, 10plus. Physical abuse was defined to include: excessive use of restraints; pushed, grabbed, shoved or pinched a patient; threw something at a patient; kicked a patient or hit with a fist; and hit or tried to hit a patient with an object'. Excessive restraint was described as: 'beyond what you would now really think was needed at that time'. Psychological abuse included: 'isolated a patient beyond what was needed to control him or her; insulted or swore at a patient; yelled at a patient in anger; denied a patient food or privileges as part of a punishment; and threatened to hit or throw something at a patient'. This study also used the Maslach Burnout Inventory (MBI) (1982), described later in this paper.

The study examined: Attitudes toward nursing home work, Stress and burn out, Staff attitudes, Conflict between staff and patients, Patient aggression toward staff. Abuse was associated with high scores on:

- Frequently thinks of quitting
- Believes patients are like children

- High burnout
- High conflict
- With psychological abuse including: personal life is stressful

Goergen's (2002) study also used the CTS and the MBI scales, but included a range of structural and material items. The study thus went beyond staff reports, but did not interview residents/patients. Organisational characteristics were assessed via:

1. An entry interview- with the head and administrator of the home.
2. An analysis of written documents and records. These included: organisational policies, supervision structures, documentation such as floor plans, standards, policies, contractual agreements. Plus staffing ratios, pay and recruitment practices.
3. If questions could not be answered from written documents (an adapted standards instrument was used), a more formal set of interviews were carried out.
4. A 'site visit' took place, looking at handrails, doors, recognisable locations, wider surroundings.
5. Front line staff were asked about the usage of documentation and any guidelines arising, in their daily work.
6. Staff characteristics

Staff characteristics included questions on the following topics:

1. Family, background, outside life.
2. How staff coped with stress; 'in order to cope with workplace stress I do'… frequency. Here, 'I use.. alcohol/ substances' had the greatest predictive value.
3. *Morale,* Using the Maslach Burnout Inventory, questions on satisfaction plus perceived strain.
4. Staff turnover, stability, education and training

Staff were also asked about which situations were: burdensome, lead to conflict, or lead to abuse or neglect. They were asked about: being possible perpetrators, possible victims of resident aggression, the behaviour of colleagues and others such as family members.

In Goergen's (2009) view dramatic events are rare, requiring a large sample if anything more than mild forms of mistreatment are to be identified. The study also suffered from restrictions that were a condition of access. He was not allowed to ask about financial information and was not allowed to trace questionnaires back to individual institutions. Staff were asked about their current professional situation, but also within 12 months which may not have been the current place of employment. He notes that policies were mediated by personal leadership styles in each home- this was, however very difficult to pin down behaviourally. Having said this, staff were not reported as being defensive and it has to be remembered that this was research undertaken via a Police Academy. Several studies have shown staff to be to be willing participants in discussing problems at work and incidents of abuse or neglect that they have observed or have been personally involved in when this is done in a neutral or problem solving research context (Juklestad, 2000; Iborra, 2008; Hawes 2009; Shinan-Altman & Cohen, 2009). Hawes' (2009) interviews with nursing staff raised specific factors that might reduce the likelihood of mistreatment occurring. These were largely compatible with the studies above and allow some insight into items that may be measurable. Specifically, they recommended:

- More initial or basic training, more continuing education, and a greater focus on dealing with dementia and behaviours;

- Improved staff/resident ratios, with no more than eight residents for each member of staff during the day and no more than 12 to 1 on the night shift, depending on resident case mix (which could lower the ratios); and

- An end to mandatory overtime.

Hawes comments that staff were typically motivated to take and retain the job because they cared deeply about the welfare of the residents. They had comprehensive views about what constituted abuse, including physical and verbal aspects of abuse. Some staff did not think certain types of physical or verbal aggression toward a resident was abuse if it was done for self-

protection or because the staff member was startled by a resident's physical aggression. Others while understanding these reactions felt such actions were nevertheless forms of mistreatment.

A wider summary of the literature on residential care and mistreatment, including qualitative studies and reports (see mapping exercise) indicates the following indicators of organisational culture that may lend themselves to measurement:

- Staff Burn Out
- Conflict between staff and patients
- Negative attitudes toward nursing home work/older people
- High staff turnover/ sickness
- Bullying/ resentment/ poor staff cohesion
- Stifling of constructive criticism and whistle blowing
- Resident violence

- Lack of external monitoring
- Absence of procedural guidance
- Inadequate staffing levels
- Ad hoc staff training/supervision
- Lack of pastoral/spiritual care
- Rigid timetables
- No external advocates

It appears, then, that staff attitudes are only one element in determining institutional prevalence although they have historically been the main source of data. While relevant, staff reports need to be seen as part of a wider organisational context. This wider context would include group behaviours and

structural factors which could, when taken together, be used to operationalise organisational culture.

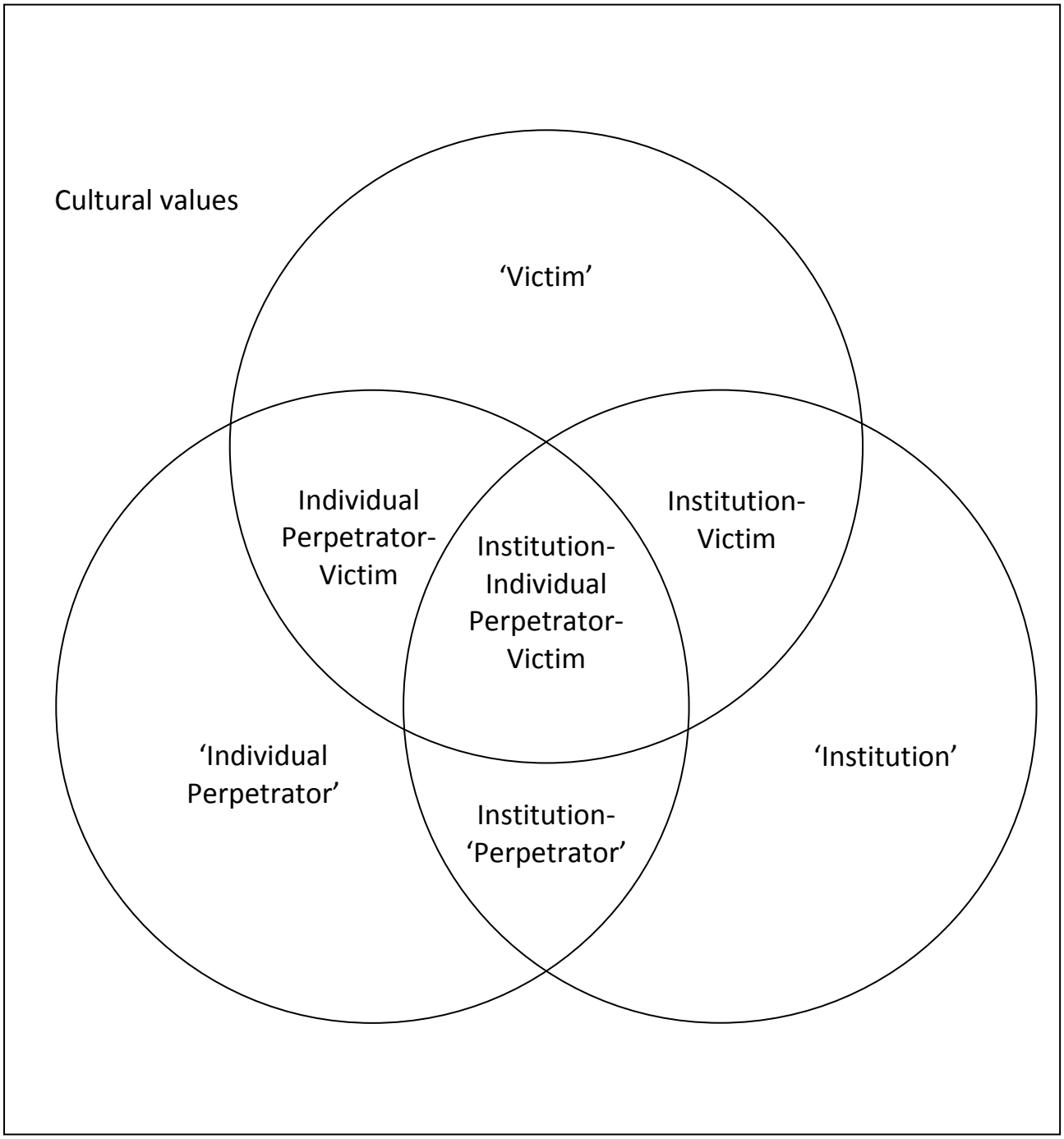
In conclusion, while factors associated with organisational culture remain under-developed, they constitute a rich source of information that may be particularly useful when engaging with the specificities of institutional mistreatment and loss of dignity. As such they open a means of addressing the operationalisation of prevalence in such settings. The implications for prevalence research include the development of a set of variables that specifically addresses institutional characteristics through culture and interactions between older people and potential perpetrators. These may include structural aspects, such as staffing ratios and absenteeism as well as staff attitudes and resident behaviour. An inclusion of a broader spectrum of actors than in community studies, that have traditionally dominated prevalence research should also be considered. These would include managers, staff groups and other residents, with managers forming important gate-keepers to certain forms of information.

There follows a preliminary integrative model which attempts a description of how different operational elements might fit together. This is followed by a list of existing questionnaires that may inform the operationalisation of organisational culture.

An integrative model

The integrative model shown in Figure two indicates a set of interactions between different levels affecting mistreatment and lack of dignity in institutional settings. As we have argued, mistreatment is a product of individual actions, interpersonal relations and organisational features that can directly lead to mistreatment or can indirectly influence staff and residents in ways that make mistreatment more or less likely. The model maintains the operational distinction between victims and perpetrators, even though this may be difficult to identify in some contexts, and adds institutional characteristics as an additional independent variable. The model can be applied to each type of mistreatment in turn.

Figure Two – Integrative model for Interactions in elder mistreatment



The Venn diagram presented here is intended to outline a generic model that could be applied to understand the combination of influences at different levels of analysis. Individual Venn diagrams can be applied to each type of mistreatment so that diagrams can be produced to show the dynamics of financial, physical, psychological/emotional, physical and sexual abuse and various forms of neglect. In principle, the same diagram could be used to chart forms of dignity, as outlined by the European study (2001).

Four interactions are identified in the model, which could be influential in an episode of mistreatment:

- 'Perpetrator to 'victim' - the direct, personal interactions that manifest the abusive episode or relationship

- Institution to 'victim' – Policies, accepted practices, common patterns of mutual positioning

- Institution to 'perpetrator' working conditions, rates of pay relationships between employers and staff/other residents and between the staff group, levels of support and supervision

- Institution-individual perpetrator-'victim' Interaction of three elements producing an organisational environment permissive of mistreatment or dignity.

The model therefore allows a separating out of each contributing source of risk, through identifying the attributes of victims, perpetrators and institutional culture and allows for complexity by examining interactions of these variables at different levels. These levels include personal interaction, accepted practices, working conditions and finally organisational environment.

These attributes and interactions are themselves situated within prevailing cultural values, which would include the perception of dignity and the influence of wider social issues, such as the influence of ageism, intergenerational relations, gender and those arising through ethnicity or cultural diversity.

Separating out institutional/organisational elements as a 'fourth set of variables' in this way allows different combinations of risk from different sources to be compared and combined to create a continuum of contextual vulnerability less available to previous models. It also moves the debate on from the identification of good and bad institutions to a consideration of degrees of risk of mistreatment.

As such the model presented here draws on the strengths of existing attempts to examine mistreatment and lack of dignity, while creating a flexible and easily understood way of operationalising what is becoming an increasingly

complex phenomenon. It is perhaps the role of such models to provide a framework or a tool for researchers, policy makers and practitioners alike, when trying to make sense of the issue at stake. Hopefully the integrative approach outlined above makes a contribution to that endeavour.

Concluding Points

As part of this exploration of the conceptual issues surrounding elder abuse, neglect and loss of dignity, a number of points have emerged that may contribute to future work on operationalising measures of institutional mistreatment.

First, many of the operational factors associated with community based prevalence research (the distinction between victim and perpetrator, clearly identified types of mistreatment) can be built on, with minor modification, in the study of institutional forms.

Second, degrees of dignity might best be thought of as an embedding feature which makes mistreatment more or less likely to occur. Thus, lack of dignity may act as permissive of institutional practices that approach abuse and neglect. The number and frequency of incidents lacking dignity will, at a certain threshold, constitute mistreatment.

Third, a clearly identified single perpetrator may be relatively difficult to identify in institutional settings due to the influence of common practices, chains of responsibility and multiple inputs from different carers and other professionals. The study and definition of mistreatment is emerging as multi-perspectival endeavour and the judgement of a range of social actors may need to be taken into account.

Fourth, separating out an 'organisational variable' that describes institutional practices at a number of levels; including staff attitudes, wider interactions occurring between social actors and structural elements; would help reflect operationally the special features of institutional contexts. The identification of this 'fourth set of variables' would allow more accurate assessments of risk and a continuum of dignity and mistreatment to be identified.

Potentially Relevant Questionnaires

In addition to the 'Map' there are a number of existing questionnaires that could be adopted, in full or in part, or adapted for a study of institutional mistreatment and dignity.

1. **Department of Health 'Dignity in Care'** website identifies examples of behaviours that reflect Dignity and Loss of dignity in social cares settings.

http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Dignityincare/DH_4134922

2**. 'The Atlanta Long Term Care Ombudsman Program Nursing Project facility Assessment Form' (2009)**

51 questions. Four that cover aspects of resident participation, rates of incontinence and pressure sores. 47 questions to residents that cover staff response times and attitudes in a number of situations, occurrence of neglectful and abusive actions, consequences of reporting poor practice, opinions on staff numbers and competence.

An appendix itemises respondents definitions of abusive and neglectful acts.

3. **Psycho-social risks at work (2009).**

Covers issues in the past year. Focus on factors preventing risks assessing quality of working environment. 150 items with an estimated total filling in time of 15 minutes. Consists of four parts. Part one- basic information on respondent and workplace. Part two- kind of work including quality of work-tasks, environment and relationships. Part three- degree of autonomy and ability, supervisor behaviour, team behaviour. Part four- feelings, satisfaction and attitudes toward work. Uses a 7 point scale for the majority of questions. The questionnaire is analysed into factors: information, resources, claims, emotions, positive responses and negative responses.
An accompanying article (Bresco et al, 2006) identifies exhaustion, cynicism and inefficacy as factors leading to burn-out.
http://www.wont.uji.es/web_formularis/index.php?option=com_facileforms&Itemid=30

4.Maslach Burnout Inventory (1981)

A 23-item inventory designed to measure three aspects of burnout: emotional exhaustion, depersonalization, and lack of personal accomplishment. Three questions are optional. Asks questions on a seven point lickert scale.

5. Karasek Job Demand Control (JD-C) Model (Karasek, 1979)
Asks questions on a four point scale about job characteristics and attitudes, supervisor attributes, attributes of 'people I work with' and about job security (26 questions). There are also 15 specific job satisfaction questions covering expectations, conditions, future intentions, bullying at work. Interesting questions include; 'would you advise a friend to take your job?'
Skill discretion
Decision authority
Decision latitude
Psychological job demands
Co-worker support
Supervisor support
Social support
Job insecurity
Customer relations
Self-identity through work

Used in the Longitudinal Care Workforce study (LOCS) – Hussein *et al.* unpublished research proposal), which will be using the questionnaire as part of a study aiming to increase understanding of the factors that facilitate or constrain recruitment and retention in the adult social care workforce in England and Wales. The Karasek questionnaire is to be used to gather information of staff satisfaction and perceptions of their job role. The KArasek was also used in the national evaluation of the Individual Budgets pilots (the , IBSEN study: Glendinning *et al.*, 2008).

5.Organisation Carescapes: researching organisations, work and care' (McKie et al, 2008)

'Policies and practices of work-related wellbeing' Questionnaire.
A series of 25 items, using a combination of lickert scales, multiple choice and open and closed questions. Estimated to take 20 minutes to complete.
Attempts to assess different aspects of organisational systems that contribute to a caring organisational culture.
Examines: Organisational Policies, Implementation of Policies.

References

Antonucci,T., Jackson,J. & Biggs, S. (2007). (eds) Intergenerational relations: theory, research and practice. *J. Social Issues.* 63:4. 679-903.

Atlanta Long Term Care Ombudsman Program. (2000). The silenced voice speaks out: A study of abuse and neglect of nursing home residents. Atlanta, GA: Atlanta Legal Aid Society and Washington, DC: National Citizens Coalition for Nursing Home Reform.

Banerjee, A., Daly,T., Armstrong, H., Lafrance, S. & Szebehely, M. (2008). *Out of control: violence against support workers in long term care*. York Canada: York University Press.

Barnes, M., Blom, A., Cox, K. & Lessof, C., and Walker, A., (2006) The Social Exclusion of Older People: Evidence from the first wave of the English Longitudinal Study of Ageing (ELSA) – Final Report. London: HMSO

Bayer, A., Tadd, A. & Krajick, S (2005) Dignity: the voices of older people. Quality in Ageing: policy, practice and research, 6(1), pp2-29

Biggs, S. (1989) Understanding Ageing: images, attitudes and professional practice. Bucks: Open University Press.

Biggs, S., Manthorpe, J., Tinker, A., Doyle, M., & Erens, B. (2009). Mistreatment of older people in the United Kingdom: finding from the first national prevalence study. *Journal of Elder Abuse and Neglect, 21*(1), 1-14.

Bonnie, R.J., & Wallace, R.B., (2003). *Elder Mistreatment: abuse, neglect and exploitation in an aging America*. Washington D.C.: National Research Council.

Cass, E., Robbins, D. and Richardson, A. (2008) Social Care Institute for Excellence (2008) *Dignity in Care: Practice Guide 9*, London, Social Care Institute for Excellence.

Chan, C. K. (2004) Placing dignity at the centre of welfare policy. International Social Work, 47(2), pp227–39.

Coupland, N. (2004) Age in social and sociolinguistic theory. (69-91) *n Nussbaum, J. & Coupland, J. Handbook of Communication & Aging Research. (2nd Edition) New Jersey: Lawrence Erlbaum.*

Department of Health (2005) *Now I feel tall: What a patient-led NHS feels like*. Department of Health: London

Department of Health (2006) *'Dignity in care' public survey, October 2006 Report of the survey Gateway number: 7213*

Engels, G. (1997). The need for a new medical model: a challenge for bio-medicine. Science 196; 129-136.

Eurobarrometer (2008) Health and long term care in the European Union. http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf.

Felson, M. (2002). *Crime and Everyday Life*, 3rd edition. New York: Sage.

Foster, A. & Roberts,V. (1999) Managing Mental Health in the Community: Chaos and Containment . London: Routledge.

Furness, S. (2006) Recognising and addressing elder abuse in care homes: views from residents and managers. *J. Adult Protection.* 8.1: 33-49.

Garner, J. & Evans, S. (2000) Institutional abuse of older adults. Council Report CR 84. London: Royal College of Psychiatrists.

Glendenning, F. *The Mistreatment of Elderly People.* London: Sage p1-34.

Glendenning, F., (1993). What is elder abuse and neglect/ in Decalmer, P., &

Glendinning, C. Challis, D., Fernandez, J., Jacobs, S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) *Evaluation of the Individual Budgets Pilot Programme: Final Report*, Social Policy Research Unit, University of York, York.

Goergen, T. & Beaulieu, M. (2010) Criminological theory and elder abuse research – fruitful relationship or worlds apart? Ageing International. 35.1. pp17.

Goergen, T. (2001) Stress, conflict, elderabuse and neglect in German nursing homes. Journal of Elder Abuse & neglect. 13.1: 1-23.

Goergen, T. (2009) Telephone interview with Thomas Goergen. Thursday August 13th 2009. Project expert interview.

Gorgen, T. (2002) Abuse & neglect of elderly people in residential care. Research in Legal Medicine 27: 367-392.

Griffin-Heslin, V. (2005) An analysis of the concept dignity. Accident and Emergency Nursing, 13(4), pp251-257.

Haddock, J. (1996) 'Towards a further clarification of the concept 'dignity', *Journal of Advanced Nursing,* 24(5) 924-931.

Harrè, R,. And and Moghaddam, F. (2003) 'Introduction: The Self and others in traditional psychology and in positioning theory' in Harrè, R,. And Moghaddam, F. *The Self and Others,* West Post (USA) Praeger Publishers.

Harré, R. and Slocum, N. (2002) 'Disputes as complex social events: On the uses of positioning theory', *Common Knowledge*, **9**(1), pp. 100–18.

Harris, D.K., & Benson, B. M.L. (2006). *Maltreatment of Patients in Nursing Homes: There is no Safe Place*. Binghamton, NY: Haworth Pastoral Press.

Hawes, C. (2003) Elder Abuse in residential long term care settings. (446-500) In Bonnie, R.J., & Wallace, R.B., (2003). *Elder Mistreatment: abuse, neglect and exploitation in an aging America*. Washington D.C.: National Research Council.

Hawes, C. (2009) Certified Nursing Assistants focus group interviews on abuse and neglect of older people. Research report to NIA Program of research on Elder Mistreatment. Texas: Health Science Center Texas A&M University.

Help the Aged (2006) *My Home Life: Quality of Life in Care Homes*, Help the Aged.

Hirsch,R. & Vollhardt, B. (2008) Elder Mistreatment. (731-745) In jacoby, R., Oppenheimer, C. Dening, T. & Thomas, A. (Eds) The Oxford Textbook of Old Age Psychiatry. OUP: Oxford

Hubbard, G., Tester, S. and Downs, M. (2003) 'Meaningful social interactions between older people in institutional care settings', *Ageing and Society*, vol. 23, pp. 99–114.

Hussein, S., Manthorpe, J. & Penhale, B. (2007). Public perceptions of the neglect and mistreatment of older people: findings of a UK survey. *Ageing & Society*. 27.6: 919-940.

Hussein, S., Stevens, M., Manthorpe, J., Rapaport, J., Martineau, S. And Harris, J. (2009) 'Banned from working in social care: a secondary analysis of staff characteristics and reasons for their referrals to the POVA list in England and Wales', *Health and Social Care in the Community* (2009) 17(5), 423-433.

Hussein, S., Manthorpe, J., Moriarty, J. and Stevens, M. (Unpublished) *Longitudinal Care Workforce Study (LoCS) Project manual*, London, Social Care Workforce Research Unit.

Iborra, I. (2008). *Elder Abuse in the Family in Spain.* Doc 14. Valencia: Centro Reina Sofia.

Juklestad, O. (2001). Institutional care of older people- the dark side. *J Adult protection*. 3.2: 32-41.

Karasek, R. (1979) Job demands, job decision latitude and mental strain: implications for job redesign, *Adminstrative Quarterly*, 24, 285-308.

Lachs, M., Bachman, R., Williams, C. & O'Leary, J. (2007) resident to resident elder mistreatment and police contact in nursing homes; findings from a population based cohort. Journal of the American Geriatrics Society. 55.6: 840-5

Layder, D. (1998) 'The Reality of Social Domains: Implications for Theory and Method', in: May, T. and Williams, M. (Eds.) (1998) *Knowing the Social World*: Buckingham: Open University Press.

Lee, D, Woo, J. and Mackenzie, A. (2002) 'A review of older people's experience with residential care placement', *Journal of Advanced Nursing*, vol. 37, no. 1, pp. 19–27.

Maslach, C. & Jackson, S. (1981) The measurement of experienced burn-out. Journal of Occupational Behaviour. 2. 99-113

McCluskey, U. & Hooper, C-A. (2000) *Psychodynamic perspectives on abuse*. London: Jessica Kingsley.

McKie,L., Hearne, J., Bowlby, S., Smith, A. & Hogg, J. (2008) Organisational carescapes; researching organisations, work and care. Meddelanden Working Paper 538. Helsinki : Hanken.

Morgan, G. (2006) Images of organisation. London: Sage.

O'Keeffe, M; Hills, A; Doyle, M; McCreadie, C; Scholes, S; Constantine, R; Tinker, A; Manthorpe, J; Biggs, S and Erens, B (2007) *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report*, London: NatCen

Phillips, D., Fawns, R. and Hayes, B. (2002) 'From personal reflection to social positioning: The development of a transformational model of professional education in midwifery', *Nursing Inquiry*, **9**(4), pp. 239–49.

Pillemer, K. and Hudson, B. (1993) A model abuse prevention program for nursing assistants The Gerontologist. 33: 128-131.

Pillemer, K. & Moore, D. (1989). Abuse of patients in nursing homes: findings from a survey of staff. The Gerontologist. 29.3: 314-320.

Rosen, T., Lachs,M., Bharucha, A., Stevens, S., Teresi, J. Nebres, F, Pillemer, K. (2008). Resident on resident abuse in LTC facilities. Journal of the American Geriatrics Society. 56.8: 1398-408.

Salin, D. (2003). Ways of explaining workplace bullying: a review of enabling, motivating and precipitating structures and processes in the work environment. *Human Relations* 56.10: 1213-1232.

Schiamberg, L.B. and Gans, D. (2000) Elderabuse by adult children;an applied ecological framework for understanding contextual risk factors and the intergenerational character of quality of life. *Int'l.J. Aging & Human Development*. 50.4. 329-359.

Scott, R. (2008) Institutions and organisations: ideas and interests. London: Sage.

Shinan-Altman, S. & Cohen, M. (2009) Nurses aides' attitudes to elder abuse in nursing homes; the effect of work stressors and burnout. The Gerontologist. 10. 1093

Straka, S.M. and Montminy, L. (2006) 'Responding to the Needs of Older Women Experiencing Domestic Violence', *Violence Against Women*, 12 (3) 251-267.

The Dignity and Older Europeans Study (2001) *Operational Model of Human Dignity (Deliverable 23)* Cardiff: Cardiff University.

Tinker,A., Biggs, S. & Manthorpe, J. (2010) Mistreatment and neglect of older people. (Pp 8) In Talliss, R., Fillitt, S. & Brocklehurst, T. (Eds) Brocklehurst's Textbook of Geriatric Medicine and Gerontology. Chennai India: Elsevier.

Törrönren, J. (2001) 'The concept of subject position in empirical social research', *Journal for the Theory of Social Behaviour*, **31**(3), pp. 313–28.

Wikström, P.O. (2005). The social origins of pathways in crime: Towards a developmental ecological action theory of crime involvement and its changes. In D.P. Farrington (Eds.). *Integrated Developmental and Life Course Theories of Offending. Advances in Criminological Theory, 14.* (p. 211-246) New Brunswick, NJ: Transaction.

Wikström, P.O. (2008). Deterrence and deterrence experiences: Preventing crime through the threat of punishment. In S.G. Shoham, O. Beck & M. Kett (Eds). *International Handbook of Penology and Criminal Justice* (p. 345-378) Boca Raton: CRC Press.

Willcocks, D., Peace, S. & Kellgaher, L. (1987) Private lives in public places. London: Tavistock.