Document Version
Peer reviewed version

Interactional perspectives on the mistreatment of older and vulnerable people in long-term care settings

Authors:

Martin Stevens, Social Care Workforce Research Unit, King's College London, Strand, London, WC2R 2LS, martin.stevens@kcl.ac.uk (Lead Author for correspondence)

Simon Biggs, School of Social and Political Sciences, University of Melbourne, Melbourne Victoria, Australia, biggss@unimelb.edu.au.

Josie Dixon, Josie Dixon, Personal Social Services Research Unit (PSSRU), London School of Economics j.e.dixon@lse.ac.uk

Anthea Tinker, Institute of Gerontology, King's College London, Strand, London WC2R 2LS, anthea.tinker@kcl.ac.uk

Jill Manthorpe, Social Care Workforce Research Unit, King's College London, Strand, London WC2R 2LS, jill.manthorpe@kcl.ac.uk

Interactional perspectives on the mistreatment of older and vulnerable people in long-term care settings

Abstract

290 Words

This article draws on a study aimed at developing theoretical and methodological understanding of the abuse and neglect (mistreatment) of older people in long-term care settings such as care homes and hospitals. It presents an interactionist account of mistreatment of older people in such establishments. Starting with an outline of definitional issues surrounding the topic, the allied concept of dignity is also briefly explored, and one important model described; we present dignity as the converse of mistreatment. The article argues for the potential of a positioning theory analysis of mistreatment. Positioning theory proposes that interactions are based on taking of 'positions', clusters of rights and duties to act in certain ways and impose particular meanings, which enable or prohibit access to certain storylines. It is argued that 'malignant' positioning can contribute to the creation of a climate that allows mistreatment to take place, or fails to prohibit its development. Mistreatment of people with dementia is used as an illustration, and it is argued that this is potentially generated by negative feedback loops of behaviour patterns, interpretations and malignant positioning by staff or family carers and subsequent response to these interpretations by the person with dementia. Positioning theory also allows for an explanation of the importance and impact of organisational cultures and social factors such as ageism. Individual staff members take positions, use meanings and develop storylines imbued with such factors. This understanding therefore overcomes some of the potential

confusions created by concepts such as organisational or institutional abuse, removing the need to ascribe intentions and personal responsibility to such constructs. The article concludes with some suggestions for further research to develop an understanding of the kinds of cultures that allow mistreatment and consequently to inform the development of protective measures.

Introduction

Awareness of elder mistreatment[i] in long-term care settings such as care homes and hospitals has increased greatly over the past 20 years (Biggs and Haapala 2010). This article explores the potential value of using interactionist approaches to understand the mistreatment of older people in long-term care settings. Following Dennis and Martin's (2005) review of symbolic interactionist approaches, the article suggests that interactive elements create and reproduce meso features such as organisational culture and macro social phenomena such as ageism. This analysis offers a new way of conceptualising the phenomena that may be helpful in minimising risks and developing responses.

The article draws on part of a study funded by the (Funders to be inserted), which explored definitional issues in relation to developing approaches to measure prevalence of mistreatment of older people in long-term care settings (authors: 2011 a b), This research followed the *UK Study of Abuse and Neglect of Older People* (O'Keeffe et al 2007) and the complementary qualitative study (Mowlam et al. 2007), which focused on mistreatment in the community settings such as people's own homes. Mowlam et al (2007) also had the aim of considering to what degree measuring the prevalence or incidence of mistreatment in

long-term care settings requires a different conceptual approach to that applicable to family and community settings.

In exploring this subject we accept that 'Not all adverse conditions are social problems' (Best 2010: 73). Negative situations become publicly debated in terms of causes and effects and claims are made that some kind of societal response is required (Manthorpe 1997). Biggs (1996) outlines how elder mistreatment was initially identified in the United Kingdom (UK) in the early 1990s as a problem primarily within domestic settings, emerging from a historical concern with self neglect and was linked to a move towards family care rather than a reliance on public services. Consequently, much focus has been placed in individualistic explanations involving carer stress, about which there is little evidence of increased risk or pathology, about which there is a fair amount of evidence in relation to family carers (Lachs and Pillemer 2004), rather than issues connected with organisations or the impact of ageism, which are likely to be of more importance as factors in long term care settings.

Protecting the rights of residents of long-term care services has become a high profile policy goal within the UK and internationally, thereby confirming elder abuse's current status as a social problem. For example, the Elder Justice Act (EJA), passed in 2010 by the United States Congress, formed part of a 'focused agenda for identifying, treating, and preventing all of its [mistreatment] subtypes' (Price et al. 2011: 354). A long line of scandals concerning mistreatment of older people in UK long-term care settings keeps the issue in sharp focus (Stanley and Manthorpe 2004). For example, the media coverage of the hospital care of older people by the Mid Staffordshire NHS Trust (Francis 2010) has highlighted individual

4

stories of 'victims' (older people as hospital patients) and focused further attention on

potentially contributory factors such as the quality and amount of inspection of such

establishments (Action on Elder Abuse 2011). These concerns highlight the nesting of this

issue within broader concerns relating to ageing societies and long-term care and treatment

(Commission on Funding of Care and Support 2011). Thus elder mistreatment in long term

care settings has been constructed as a social problem ascribed to a mix of social and

individual causes. Amongst a variety of solutions proposed, are responses to individual staff

members, such as the Protection of Vulnerable Adults (POVA) List and Independent

Safeguarding Authority (Stevens et al 2010) and social policy responses, such as new forms

of regulation of hospitals, care homes the professions and care workers (Stanley et al. 2011).

Several factors might be thought to affect the likelihood of mistreatment in long-term care.

Staff work very intimately with residents of long-stay settings often carrying out tasks in

residents' private spaces, particularly bedrooms and bathrooms. Such opportunities are

more pronounced given the increased level of dependence or disability of most long-term

care residents. However, staff working in care homes may be subject to greater levels of

monitoring than staff or family in people's own homes, who often interact with older people

without supervision. Levels of surveillance may therefore differ. Indeed, in their study of

referrals to the Protection of Vulnerable Adults (POVA) List[ii], Hussein et al (2009) found care

home staff were more likely to be referred for physical abuse whereas paid home care staff

were more likely to be referred for financial abuse,

While long-term care settings have been closely linked with mistreatment in the media

(Hussein et al. 2007), there is 'almost no scientifically credible empirical research about

abuse in institutions' (Lachs and Pillemer 2004: p1264). One key early study undertaken by Pillemer and Moore (1989), involved a random sample survey of nursing home staff. This study found that staff who: were intending to leave their jobs; scored highly on the Maslach burnout scale; had stressful lives; and viewed nursing home patients as child-like, were more likely to mistreat older people in nursing homes. These risk factors place more importance on staff characteristics and behaviours rather than the levels of dependence or disability of older people. In addition, this study found that high levels of patient to staff aggression and a lack of training on how this could be dealt with influenced the prevalence of abuse (Pillemer and Moore 1990). Pavez et al (1992), also found that aggression of older people increased their risk of being mistreated in community settings, although this study was limited to older people with Alzheimer's disease. These findings suggest an interactive element to mistreatment, which we explore further below.

Lachs and Pillemer (2004), in their review of elder abuse literature, which focused mainly on community settings, cited evidence for a set of risk factors for mistreatment. Shared living situations (eg living with adult children); having dementia; social isolation; psychological problems or substance abuse of perpetrators; and dependence of perpetrators on the older people they mistreat were all found to increase the risk of mistreatment. All of these factors also suggest the importance of dynamics between older people and family carers or paid care workers in explaining mistreatment.

While policy and awareness of the problem have been developing, a recent overview of conceptual development argued that knowledge has spread, rather than grown, and developments are taking place without apprehension of the models underlying them (Biggs

and Haapala 2010). This is particularly applicable when considering the impact of specific contexts, such as long-term care settings on interpersonal relationships. Consequently, understanding how mistreatment emerges and is sustained may inform the development of explanatory models that address individual and societal responsibilities and can inform approaches to reduce its incidence and impact. The definitional study (Authors 2011a;b) from which this current article has emerged, examined these conceptual issues. Authors (2011b) explored issues in operationalising key concepts and Authors (2011a) proposed elements of an explanatory model of mistreatment in long-term care settings.

In this article an interactionist approach to explaining mistreatment in long-term care settings is proposed. We argue that a series of interactions create and reproduce aspects of working culture that facilitate or inhibit mistreatment. The article will explore how interpersonal factors interact with institutional or organisational characteristics, through a positioning theory analysis, which has been applied in a number of allied areas, (e.g. in services for older people with dementia: Sabat 2001; Sabat 2007; Kelly 2010). The article starts with an exploration of definitions in relation to mistreatment, focusing on the concept of 'position of trust' within long-term care settings. Mistreatment may arise from the loss or lack of respect for an older person's dignity, and so we move on to discuss different aspects of dignity and how this may be maintained or diminished in long term care settings. We subsequently focus on positioning theory as a valuable approach to linking interpersonal explanations of mistreatment with organisational characteristics. The final section focuses on how such organisational characteristics may be considered a necessary part of any explanation of mistreatment.

Defining mistreatment

Definitional issues abound in the study of elder mistreatment (Dixon et al 2010; Authors 2011b) and have become increasingly inclusive in terms of setting, identity or intent (Johnson 2011). However, for our purposes, a broad definition may be sufficient, such as the one used in the US National Research Council Panel on Elder Mistreatment (NRC) (Bonnie & Wallace 2003):

(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)

Common to many definitions, this has an individualistic focus, in which abuse is seen as primarily, if not exclusively, an interpersonal phenomenon. This definition is also typical in that it excludes crimes committed by strangers and structural issues, such as poverty and the possible impact of ageism. This definition, again along with others, stresses the idea of a 'trust relationship', as a defining characteristic of abuse. However, Dixon et al. (2010) drew upon data from the *UK Study of Abuse and Neglect of Older People* (O'Keeffe et al 2007; Mowlam et al, 2007) to argue that establishing whether the general concept of trust could always be expected from certain relationships and never from others was difficult. In secondary analysis of the national survey data, Biggs et al (2009) proposed a categorisation

of relationships according to the level of trust expected, using 'circles of trust'(p16) as a metaphor: care workers would be placed in an inner circle, indicating a high expectation of trust.

Critically, Dixon et al. (2010) argued that the idea of 'position of trust', whilst not authoritatively legally defined, was a clearer criterion for identifying whether behaviour constitutes abuse than a more generalised trust relationship. This characterisation perhaps typifies relationships between care workers (e.g. care aides) and the people they work with, given the position of social care at the 'intersection of public and private' (Daly and Lewis 2000: 282). It is perhaps easier to operationalise and use the idea of a position of trust in long-term care settings, where most relationships, particularly involving staff, are underpinned by formal obligations, contracts and rights. Further, *all* harm caused by the actions of someone who has a well established position of trust or formal obligations to a resident, or through the failure to meet such obligations, might be identified as mistreatment. However, for a family member, for example, there would perhaps be mitigating circumstances of lack of intent or knowledge.

This is important for the current purpose of examining ways of linking individual interactions with broader institutional factors, which are reflected in the formal and informal rights and obligations built into certain kinds of relationships, particularly those between care workers and residents of long-term care services. This kind of limitation creates a social space or 'system of relations' (Bourdieu 1989: 16), which enables the establishment of groups with clearly defined and different rights and responsibilities. Without limiting the application of 'mistreatment', it becomes hard to distinguish it from generalised harm, losing the

concept's value in distinguishing a particular set of phenomena, and thereby facilitating prevention and response. We are interested here in restricting the applicability of mistreatment in terms of a social space, which includes the aspects identified by Biggs and Haapala (2010): interpersonal relationships, the adult-to-adult nature of mistreatment and age related factors of elder abuse.

In the provision of social care in the UK, a classification of a particular incident or situation as mistreatment will trigger a particular set of responses within a recognisable set of institutional practices, policy and legislation, in addition to possible criminal proceedings. For example, a care worker or nurse in England found to have abused a vulnerable resident or patient will face disciplinary action from their employer, referral to the Independent Safeguarding Authority, who will consider whether to bar him or her from employment in the care of vulnerable adults; they may also face a loss of licence to practise as a professional (as a nurse, for example). Before moving on to a positioning theory analysis of mistreatment, we briefly explore the allied concept of dignity, which we argue represents the converse of mistreatment.

Dignity

Dignity is often used in everyday speech to refer to personal character; whether an individual consistently behaves 'with dignity' or 'has dignity' in stressful situations. However, in policy discourse, dignity is more commonly used to describe the treatment or care people receive. The English Department of Health (DH) has identified the need to improve dignity in care as a policy priority (Manthorpe et al. 2010), supported by champions and web-based resources (DH 2009). This leads to a focus on the kinds of practices and contexts that may

increase or decrease the likelihood of a person being 'treated with dignity'. Underpinning

both of these perspectives is a conception of dignity as 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). The

Dignity in Older Europeans Study (2001) developed an 'Operational model' (p7) which

articulated how different forms of dignity were threatened by certain kinds of treatment,

which can thereby become mistreatment, at the extreme. The model proposes that

Menschenwürde generates dignities of merit, moral stature and identity, which in turn

produce self respect.

'Dignity of merit', earned through competence and achievement, may 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 status, ('Dignity of moral status'), which

arises from the moral behaviour of the individual and the ability to live according to

personal beliefs and principles. Such status is seen to vary depending on behaviour and

context. Consequently, as people have reduced opportunities and resources to behave

morally, their moral status can become devalued, which tends to reduce the relevant level

of dignity in a particular context.

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 personal

care, 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 treatment which either enhances or diminishes dignity in each of the three dignity areas. The model has been used later by the same team to investigate dignity in NHS treatment of older people (Tadd et al 2011).

Repeated or ongoing treatment that diminishes dignity in different ways can become mistreatment, although the amount and length of any episode would require further specification. Furthermore, the kind of behaviour that threatened dignity and potentially become mistreatment changes according to culture and expectations. As Nandlal and Wood (1997) found, much mistreatment rests on interpretation of speech acts within particular contacts. Such an analysis can be made of respecting dignities of merit, moral stature and identity. Organisational culture also has a role. Particular long term care settings where dignity is typically not respected, create the climate where mistreatment can be made more socially acceptable.

Much of this debate about respecting dignity, or not, rests on the analysis of interactions. We now turn to an interactional perspective to understanding how mistreatment practices

may become accepted in long-term care settings and how these may be linked to wider organisational and cultural factors.

Mistreatment and positioning theory

Positioning theory (Van Langenhove and Harré 1999) potentially offers some useful insights into the link between micro-interaction, institutional or organisational characteristics and macro elements such as ageism. This theory is based on an interactional perspective, which places paramount importance on the 'assignments and appropriations of rights and duties' (Harré 2008: 29). Approaches to elder mistreatment are increasingly focused on interpersonal relations within particular contexts (eg Bonnie and Wallace 2003), which makes positioning theory a potentially valuable approach.

Positioning theory is based on the connections between social interaction, individual understanding and actions. The theory takes as its starting point the idea that language is the 'prime instrument of thought and social action' (p29). Harré's (2008) understanding of language brings in a wealth of social factors that determine the way it is used and understood. This places importance on the kinds of social factors identified in the US National Research Council Panel on Elder Mistreatment (NRC) model, which focuses attention on the interaction between the older person and the 'trusted other', set within a nested set of risk factors that include relative status, rights and duties. In positioning theory these are expressed through the taking of 'positions', defined by Harré and Modhaddam (2003) 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.

Language is seen as the primary, but not the only, form of symbolic interaction. For

example, eye contact, which is a subtle form of symbolic interaction, which can lead to

varying interpretations of meaning (Bakker 2011). Indeed such subtle nuances of

communication can lead to misunderstandings between care workers and older people,

especially where care workers are from difference cultures (Stevens et al 2012). Such

misunderstandings could contribute to experiences of loss of dignity or mistreatment.

Consequently, positions can be taken and ascribed through a variety communication forms,

behaviours, gestures, tone of voice, or even badges and uniforms. It is these aspects that

establish workers as formally being in a position of trust in their daily interactions with

residents and relatives. Furthermore, particular phrases and utterances change their

meaning according to the social space within which they operate. Harré (2008) uses the

example of the phrase 'I'm sorry' (p30), which can be an apology or a request to repeat

something one has not heard properly. Indeed, for the older people taking part in Nandlal

and Wood's (1997) study, verbal abuse was understood to be constituted through the

'relationships, responsibilities, rights and violations' (28), which generated particular

meanings of utterances. Furthermore, Nandlal and Wood (1997) found that verbal abuse,

was present in most if not all abuse, thus placing emphasis on the interactions through which abuse or mistreatment is accomplished.

Care workers and older people are adults. Consequently, interactions between them carry a particular set of expectations, rights and responsibilities, compared with adult-child interactions. First, such interactions involve a mutual positioning as persons (in the *Menschenwürde* sense), which involves recognising (although not always respecting) the other's 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' or 'resident', for example). Consequently, a 'position of trust' is taken by staff members in their interactions with residents and confers the right to give certain kinds of support in certain places in the home and to undertake bodily intimate care, for example. Third, behaviour is a 'two way street', implying 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 compromise dignity, which may represent a precursor to mistreatment. Further, interactions between care staff and people with dementia are frequently not in adult-to-adult mode, sometimes being 'infantilising' of the person with dementia (Kitwood 1997), thereby discounting their personhood.

Harré and Moghaddam (2003) suggest that 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 on lack of cognitive capacity,

15

for example. Such a mechanism is particularly important in explaining the means by which interactions create and reproduce institutional characteristics, and we turn to examine this in more depth below.

We describe below two studies (Kelly 2010; Sabat et al. 2004), focusing on the mistreatment of older people, which use positioning theory as a conceptual framework. Both studies focus on analysing the way that individuals and real world interactions create and constrain possible positions, using observational and interview techniques. These research projects ascribe a key role to the language used by participants and draw broader conclusions from micro interactions. They focus mainly on older people with dementia, who make up a large proportion of the long-term care population (MacDonald and Cooper 2007) and who are reportedly at greater risk of mistreatment (Wiglesworth et al 2010). This focus serves to illustrate the value of positioning theory, although its application with other groups of older people is also identified.

Malignant or malevolent positioning

Harré (2008) describes malevolent or malignant positioning of people with dementia as operating by negatively characterising people, for example, as someone who has nothing to say and therefore is not worth talking to or, in a more extreme characterisation, as an incomplete person (Sabat 2007). Harré comments that this potentially excludes the person from the ebb and flow of conversation or 'the communal cognition, the thinking together that is such a feature of language-using beings like ourselves' (Harré 2008: 32). Such positioning can become commonplace owing to the amount of time and work needed to maintain conversation with some people who have cognitive impairments (Sabat 2007). For

people with severe dementia, the effort and skill needed to maintain a mutual interaction may mean that sometimes people are typically positioned as being difficult to interact with. Staff shortages and a high number of untrained, demotivated staff may also help to underline such positioning and perception (Kitwood 1990). Sabat's research (Sabat et al. 2004; Sabat 2007) described how it might be possible to reposition people by engaging them in purposeful activity and by providing opportunities for social exchange, in which contributions were sought and valued from people with dementia. Kitwood's (1993) notion of 'malignant social psychology' (p542) embodies a similar set of ideas, arguing that people with dementia tend to be treated in ways that ignore their personality and biography, which depersonalises and can demoralise people. Positioning theory provides a means of understanding the interactions through which such malignant social psychology unfolds.

Sabat et al (2004) identify three psycho-social factors that affect the social lives of people with dementia and can create negative feedback loops: the impairments caused by dementia; reactions of other people; and the reactions of people with dementia to those reactions (Sabat et al. 2004: 185). Similarly, Kelly (2010) describes a transactional process of interaction in which 'A presents a stimulus, which elicits a response from B, which elicits a further response from A, which elicits a further response from B' (p272), which can also characterise this kind of feedback. The interactive element in verbal abuse and other mistreatment, we noted above (Pillemer and Moore 1989; Lachs and Pillemer 2004), whereby older people who are aggressive are more likely to be mistreated, illustrates a potential feedback loop. Furthermore, as we describe below, such loops may be characterised in terms of malignant positioning and misinterpreted attempts to reject such positioning.

Sabat (2007) outlined the impact of negative positioning in terms that are similar to ignoring dignities of moral status, identity and merit, in terms of the Dignity and Older Europeans' study (2001) model, which can add to the impairments caused by the condition. For example, he describes how doctors can position people in such a way as to ignore their 'Intellectual and emotional characteristics' (dignity of merit) 'needs and social personae' (dignity of moral status) (Sabat 2007: 84) and indeed their right to be treated as a worthy human being (Menschenwürde). He argues that the commonly held understandings and blanket ascription of negative characteristics to those with dementia generate negative positioning and magnify problems in caring for people with dementia. This closely links to Kelly's (2010) research, in which negative positioning and lack of recognition of the various aspects of the self of people with dementia was found to lead to, or made possible, various kinds of mistreatment.

Simply being positioned as being 'old', can also be a malignant position, given the commonality of negative stereotyping of older people (Scholl and Sabat 2008). In contrast, Jones (2006) describes how particular positioning as 'old', can be combined with other positive positions, such as 'former nurse' (p.81), making particular storylines more available and helping to create more positive and meaningful interaction. This provides a way of preserving dignity of identity and of preventing malignant positioning.

Kelly's (2010) in-depth research in secure hospital wards for people with severe dementia identifies a pattern of beliefs amongst staff that often resulted in positioning people with dementia as having lost their personhood. She explores 'the transactional and institutional

drivers for abusive practice and their impact on those perpetrating and experiencing it' (p268). Like Sabat (2001), she places importance on the concept of selfhood and on how people with dementia are often characterised as losing their selves. She argues that this is connected with the persistence of a Cartesian view of the mind as separate and superior to the body. It is worth exploring this conceptualisation, which provides a slightly different application of positioning theory and helps in understanding how larger scale factors may influence individual episodes of abuse. The attacks on self described in the next section relate to the role of context in allowing serious mistreatment to develop, rather than being seen as serious mistreatment in their own right.

Mistreatment and attacks on the 'self'

In order to examine the idea that people negatively positioned in the ways described above are suffering an attack on the self, a brief outline of a social constructionist view of the self is valuable. From a social constructionist perspective, three aspects of 'selfhood' can be identified (Sabat 2001; 2007; Kelly, 2010), which are differently affected by dementia. This is known as the 'Selfs 1-3 framework'. Self 1 is the persistent sense of individuality, which allows people to use first person pronouns or 'indexicals' ('I', 'me' 'mine' etc.) meaningfully. This kind of self is often relatively unaffected, even by severe dementia. Sabat (2007) argues that someone who cannot remember any details about their earlier life may demonstrate an intact Self 1, simply in the act of saying 'I can't recall anything about who I am' (p.87). Self 2 relates to an understanding of one's physical, mental and emotional characteristics and abilities and how these have changed over time. While this can remain intact, it is more vulnerable to the perceptions of others and 'malignant positioning' as being 'unable'. Having a diagnosis of Alzheimer's disease becomes part of a person's Self 2 attributes (Sabat 2007).

Finally, Self 3 relates to the ongoing roles and personae in the social world. Thus, we have multiple aspects of our Self 3, as a parent, friend, professional and so on. For people with dementia, it is hard to express valued personae because of patterns of positioning activities of staff and relatives (Sabat 2001). The positions ascribed to people with dementia, who are less able to reject ascribed positions, tend only to allow for a position of 'demanding' patient or resident with dementia and not someone who is worth engaging with on an adult to adult basis (Sabat 2001; 2007). This provides very few opportunities to engage in the kinds of interactions that are essential in maintaining these roles. For Kelly, such negative positioning leaves people with dementia particularly vulnerable, given that they:

> ...depend on the affirmation and co-operation of others to co-construct (Snyder, 2006) and support a valued Self 3. (Kelly 2010: 169)

Furthermore, such positioning, which undermines Self 2 and Self 3, can lead to conflict, as the person with dementia tries to reject the positioning and social personae others are ascribing to them. For example, Kelly (2010) interprets some of the conflicts she observed between staff and patients in the dementia ward as resulting from resistance to the positioning of residents as helpless and needing support, which she suggests was misinterpreted by staff as aggression. Similarly, Sabat (2007) gives an example of a woman who no longer identified her husband, who had dementia, as '"the man I knew"' (p88) and positioned him as helpless and in need of protection. Such a position was resented by her husband, and she too resented the change in him and in having (as she saw it) to 'take over his life completely' (p.88). This conflict involved negative or malignant positioning of the husband as someone who is unable to do anything and as someone whose identity has been

lost, therefore not able to engage in reciprocal interaction. Sabat (2007) argues that, in such situations, interactions become dominated by the impairments related to dementia, which undermines a sense of the person's Self 2 and Self 3, and generates resentment on both sides. Furthermore, the limited efforts of people with dementia to reject this negative positioning are easily misinterpreted (Sabat 2007; Kelly 2010) as being simply symptoms of dementia. Consistently negative positioning makes it harder to maintain the belief that people with dementia are able to evaluate and interpret situations and express agency (Sabat 2007), which leads to difficulties in responding more personally. It is in such a pattern that the feedback loop of reaction and counter reaction is expressed. This is not to deny the change in roles involved: in the example of the woman and her husband, she is doing much more for him compared with their lives before he developed dementia. However, such changes can come to dominate interactions and positioning in a way that diminishes the person with dementia's sense of self and the carer's sense of the person.

The 'Selfs 1-3' framework carries strong echoes of the model of dignity described above: dignity of identity can be mapped to self 1; dignity of merit to self 2; and dignity of moral status to self 3. This reinforces the importance of thinking about dignity in understanding mistreatment. Kelly (2010) concludes that it is through a lack of recognition of and support for the three kinds of self that practices emerge that may underpin mistreatment in long-term care settings. Such malignant positioning and attacks on the selfhood do not necessarily qualify as mistreatment, although may certainly be seen as a 'permissor' of mistreatment; a pattern of behaviour and practice that makes more serious episodes of mistreatment less unacceptable.

Kelly (2010) reports that such a dominant mindset within a staff group made it very difficult for her, as an observer in the setting, to interpret residents' behaviours differently and even more difficult to respond in alternative, more positive, ways. For example, she describes how she had had been kissed on the hand as a good bye by one of the residents, for which she had received 'sharp admonishments from particular care assistants' (Kelly 2010: 275). This had led to her changing the way she interacted with the resident subsequently, which she felt led to her 'denying him what really is just normal social contact . . .' (275). This is a good illustration of how institutional characteristics and cultures are created and reproduced through micro interactions, and therefore suggests an interactive mechanism. So, for example, as new members of staff start work in a particular care home they can both discover and recreate the local constructions and habits of positioning. While such patterns are not unbreakable, they can endure beyond immediate interactions (Harré 1998). Indeed it is likely to be difficult for a new member of staff to go against the culture of the nursing home (for example); it is much more likely that new workers will become socialised into 'the way we do things around here' (Brown 2011: p119).

Consequently, positioning creates and reproduces broader social factors and can be seen to illuminate the connection between individual characteristics, interactional elements and institutional, organisational or social factors. Understanding mistreatment through this kind of lens therefore provides a link with institutional and societal variables, which we have argued (Authors, 2011a; b) are needed in order to understand the development of mistreatment. It is these elements that we now turn more specifically, to establish their role in understanding mistreatment of older people in long-term care settings.

Interactions expressing organisational characteristics and social factors

Explanatory models of abuse have typically involved three sets of variables, covering the characteristics of nominated 'victims' and 'perpetrators' and kinds of mistreatment (Biggs et al. 2009), including relative degrees of power in situations. For example, the NRC model of risk factors for mistreatment (Bonnie and Wallace 2003: 62) and the 'Risk and Vulnerability model tested by Fulmer et al (2005) focus on the involvement of two actors in any incident, which emphasises the interactive element of mistreatment. The NRC model also emphasises the interpersonal and relational nature of mistreatment, as opposed to characteristics of individuals. In addition, both models introduce a broad range of external factors, such as status inequality, gender, age, ethnicity and education that need to be considered in order to explain mistreatment.

 The model allows some room for the role of institutional variables, although we would argue for a clearer prominence of such variables, which are not explicitly built into the model.

The strength of positioning theory is that it provides an explanation for the interplay of relatively fixed discourses such as ageism and attitudes towards disability and difference along with locally common perceptions and interaction styles or organisational culture, with individual interactions that make up episodes of mistreatment. This approach therefore can provide a link between institutional variables and the kinds of interpersonal factors described in the earlier section. Davies and Harré (1999) argue that interactions encompass position taking and ascribing, which 'incorporates a particular interpretation of cultural stereotypes' (Davies and Harré 1999: 39). Staff working in long-term care settings, of course, also bring with them the set of potential positions possible within wider society.

Consequently the impact of local sets of commonly held positions within a long-term care setting is not fixed and may be ameliorated or changed as a result of attitudes and positions from outside the local context.

However, the particular nature and relative isolation of most long-term care settings means that a set of local positions will be available and locally valued. Törrönen (2001) stresses the importance of 'the history embedded in social institutions and practices' (p319), which plays a key role in the kinds of positions and identities people adopt in different settings. This suggests also that socialisation into institutions must also be important in prescribing and proscribing positions and creating the social order (Tiradu and Gálvez 2007). Similarly, Kelly (2010) identifies the importance of institutional factors in inhibiting the kinds of positive interactional styles she deems necessary for good quality care that respects people's dignity. Such a theory provides a way of reconciling the role of the individual within a social structure that each individual plays some role in creating and reproducing.

For Tiradu and Gálvez (2007) the social order and rules governing any set of interactions do not exist outside the situated interaction, and are created and developed through it. However, as Harré (1998) argues, there is both a created and 'found' element inherent in such rules, which are recreated through interactions, but also discovered by newcomers as they witness the interactions of others. As a result of this, in order to understand mistreatment, it is necessary to understand the interactions between the individual actors involved and elements of the social space within which mistreatment is located, or in other words a fourth set of variables measuring organisational culture. It is only in relation to this fourth set of variables that characteristics of the perpetrators and the victims can be seen as

predictors of mistreatment (Authors 2011 a;b). For example, Jenkins and Braithwaite (1993) found that for profit rather than not-for-profit nursing homes were more likely to be non-compliant with rights based standard, thus arguably suggesting a greater potential for mistreatment.

In the same work, we proposed a model for explaining abuse, which involved four sets of interactions (Authors 2011 a;b). between: individual 'perpetrators' and 'victims'; individual perpetrators and organisations; organisations and 'victims'; and an interaction between all three, in which a permissive culture creates the opportunity for, and the acceptance of, bad practice and in which mistreatment may become socially acceptable or even the norm.

In summary, positioning theory provides a useful approach to explaining how organisational culture and societal factors may be created and reproduced by and feed back into individual interactions. Common patterns of positioning set limits on the available storylines and can represent attacks on different elements of the self. Such patterns reflect and create organisational level factors and can lead to practices that do or do not respect dignity, and which may make mistreatment more or less likely.

Conclusion

The article has explored definitions of mistreatment of older people and its emergence as a social problem, conceptualised as interpersonal interactions within a particular context. Upholding dignity was proposed as a key concept, being seen as the converse of mistreatment. Therefore, understanding what underpins practice that leads to loss of dignity may provide valuable insight into how mistreatment develops. One model was

discussed, which identified three types of dignity: dignities of identity, merit and moral status making up universal worth or *Menschenwürde* (The Dignity and European Study 2001). We argue that this model is reflected in debates about the impact of negative or malignant positioning (Sabat 2007) and attacks on various aspect of the self (Kelly 2010). The central argument of the article is that patterns of micro interactions, particularly positioning older people with care needs as less able, less worthy of interaction and not complete people (Sabat 2007) can lead to and form part of loss of dignity and give rise to risks of mistreatment. Such common patterns of positioning and interpretations of language, create and reproduce organisational culture and societal factors such as ageism and therefore provide a valuable insight into how more macro scale characteristics, such as routines of practice or management styles and social inequalities, can influence and be influenced by micro interactions that create the backdrop to the interactions of mistreatment. Thus, research focusing on interactions between individuals within long-term care settings is important in understanding and explaining mistreatment, and can indicate links with organisational culture and social factors. Such studies would need to take into account the roles of chief executives and proprietors of nursing or care homes, who influence the general climate of such establishments (Jenkins and Braithwaite 1993).

Positioning theory is associated with particular kinds of research methods that focus on analysing talk, especially conversations (Smith et al. 1995). Research using observational and conversation analysis techniques, along the lines that Kelly (2010) employed, would enable us to identify patterns of positioning common within long-term care settings. Such micro interactional work could be analysed alongside the organisational characteristics of long-

term care facilities in terms of policies and practice and other variables related to staff morale, for example.

Research that analyses interactional styles and explores how they create and reproduce organisational culture and societal attitudes, may identify means by which such factors can affect levels of mistreatment, without ascribing intentions and a moral status to 'organisational culture'. Much of the focus of this article has been on the types of positioning and interactions that form and reproduce organisational cultures that are likely to allow mistreatment to develop, or at least fail effectively to prohibit them. Studies involving analysis of interactions in situations of more serious mistreatment would develop this understanding.

Settings with generally high levels of aggression, for example from residents to staff, may well generate more mistreatment of vulnerable older people. Consequently, more investigation of how older people in long term care settings position staff and other residents and respond to the negative positioning that they are ascribed would provide a detailed understanding of the interactive element. In this way, it may be possible to identify the negative feedback loops suggested above, which would then open the way for development of practice interventions to reduce mistreatment. For example, interventions with groups of staff, aimed at raising awareness of the impact of particular interactional styles, as promoted by Sabat (2007) may therefore be of value. However, the article has perhaps more relevance in terms suggested directions for future research rather than direct practice implications.

Identifying organisational culture as a contributory factor (i.e. institutional abuse), creates problems in terms of identifying individual perpetrators (authors 2011a;b). For example, it raises the questions about the role of individual responsibility if the organisational culture is such that mistreatment and loss of dignity become acceptable and about the meaning of institutional abuse, given the predominance of interpersonal understandings of mistreatment. Positioning theory provides a way of helping to understand and address these dilemmas, which will influence the kind of social solutions identified. This is not to remove individual responsibility completely, but to acknowledge that mistreatment can arise from a dysfunctional alignment of context, culture and interpersonal behaviour.

References

Authors 2011a

Authors 2011b

Action on Elder Abuse 2011 News Release: *The care home sector is in crisis, the regulator is failing, and older people are increasingly at risk, new information demonstrates,* Action on Elder Abuse, London, press release dated 28/07/2011.

Bakker, J.I. 2011 '"The 'Semiotic Self"': From Peirce and Mead to Wiley and Singer', *American Sociologist*, 42(2-3) 187-206.

Best, R. 2010 'Situation or Social Problem: The Influence of Events on Media Coverage of Homelessness', *Social Problems,* 57(1): 74–91.

Biggs, S. 1996 'A Family Concern: Elder Abuse in British Social Policy', *Critical Social Policy,* 16(47): 63–88.

Biggs, S., Doyle, M., Hall, J. and Sanchez, M. 2009 *Abuse and Neglect of Older People: Secondary Analysis of the UK Prevalence Survey,* London: NatCen.

Biggs, S. and Haapala, I. 2010 'Theoretical development and elder abuse; spreading awareness and conceptual complexity in examining the management of socio–emotional boundaries', *Ageing International* 35(3): 171–184.

Bonnie, R.J., & Wallace, R.B., 2003 *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America*. Washington D.C.: National Research Council. Available from: http://www.nap.edu/openbook.php?record_id=10406&page=1 (Accessed 21/02/2012).

Bourdieu, P. 1989 'Social Space and Symbolic Power', *Sociological Theory,* 7(1): 14–25 .

Brown, H. 2011 'Abuse in Care Homes for Older People: The Case for Safeguards', in **Dening, T. and Milne, A.** *Mental Health and Care Homes,* Oxford: Oxford University Press, 113-130.

Cass, E., Robbins, D. and Richardson, A. 2009 *Adults' Services SCIE Guide 15: Dignity in Care*.

London: Social Care Institute for Excellence. Available from:

http://www.scie.org.uk/publications/guides/guide15/index.asp (Accessed 21/02/2012).

Chan, C. 2004 'Placing dignity at the Centre of Welfare Policy'. *International Social Work*,

47(2): 227–39.

Commission on Funding of Care and Support 2011 *Fairer Care Funding,* London,

Department of Health. Available from:

http://www.dilnotcommission.dh.gov.uk/files/2011/07/Fairer-Care-Funding-Report.pdf

(Accessed 21/02/2012).

Daly, M. and Lewis, J. 2000 'The Concept of Social Care and the Analysis of Contemporary

Welfare States', *British Journal of Sociology,* 51(2): 281–298.

Davies, B. and Harré, R. 1999 'Positioning and Personhood' in **Harré, R. and Van**

Langenhove, L. 1999 *Positioning Theory: Moral contexts of intentional action,* Oxford:

Blackwell, 32–53.

Dennis, A. and Martin, P.J. 2005 'Symbolic Interactionism and the Concept of Power', *British*

Journal of Sociology, 56(2): 191–213.

Department of Health 2005 *Now I Feel Tall: What a Patient–Led NHS Feels Like,* London:

Department of Health. Available from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4124475 (Accessed 21/02/2012).

Department of Health 2006 *A new ambition for old age: Next steps in implementing the national service framework for older people*. London: Department of Health. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133941 (Accessed 21/02/2012).

Department of Health 2009 *Dignity in care*, London: DH (http://www.dignityincare.org.uk/. (Accessed 21/02/2012).

Dignity and Older Europeans Study 2001 *Operational Model of Human Dignity*, Deliverable 23, University of Cardiff.

Dixon, J., Manthorpe, J., Biggs, S., Tennant, R. and Mowlam, A. 2010 Defining elder abuse: Reflections on the United Kingdom study of the abuse and neglect of older people, *Ageing and Society*, 30: 3, 403 –420.

Francis, R. 2010 *The Mid Staffordshire NHS Foundation Trust Inquiry, Volume 1,* London, The Stationary Office, HC375–1.

Fulmer, T., Paveza, G., VandeWeerd, C., Fairchild, S., Guadango, L, Bolton-Blatt, M. and Norman, R. 2005 'Dyadic Vulnerability and Risk Profiling for Elder Neglect', *The Gerontologist,* 45(4) 525-534.

Griffin–Heslin, V. 2005 An analysis of the concept dignity. *Accident and Emergency Nursing*, 13(4): 251–257.

Haddock, J. 1996 'Towards a Further Clarification of Dignity', *Journal of Advanced Nursing,* 24(5): 924–931.

Harré, R. 1998 'When the Knower is also the Known', in: May, T. and Williams, M. (Eds. *Knowing the Social World,* Buckingham, Open University Press 37-49.

Harré, R. 2008 'Positioning Theory' *Self–Care and Dependent–Care Nursing,* 16(1): 28–32.

Harré, R. and Moghaddam, F. 2003 'Introduction: The Self and others in traditional psychology and in positioning theory' in **Harré, R. and Moghaddam, F.** *The Self and Others,* West Post, USA: Praeger Publishers 1-12.

Help the Aged 2006 *My Home Life: Quality of life in Care Homes,* London, Help the Aged. Available from: http://www.ageuk.org.uk/documents/en-gb/for-professionals/research/my%20home%20life%20report%20(2006)_pro.pdf?dtrk=true (Accessed 21/02/2012).

Hussein, S., Manthorpe, J. and 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.

Jenkins, A. and Braithwaite, J. 1993 'Profits, Pressure and Corporate Lawbreaking', *Crime, Law and Social Change,* 20(3) 221-232.

Johnson, F. 2011 'Problems with the Term and Concept of "Abuse" Critical Reflections on the Scottish Adult Support and Protection Study', *British Journal of Social Work,* doi:10.1093/bjsw/bcr115, First Published online 15 September 2011

Jones, R.L. 2006 '"Older people" talking as if they are not older people: Positioning theory as an explanation', *Journal of Aging Studies,* 20(1): 79–91.

Kelly, F. 2010 'Abusive Interactions: Research in Locked Wards for People with Dementia', *Social Policy and Society*, 9(2): 267–277.

Kitwood, T. 1990 'The Dialectics of Dementia: With Particular Reference to Alzheimer's Disease', *Ageing and Society,* 10(20) 177-196.

Kitwood, T. 1993 'Editorial: Person and Process in Dementia', *International Journal of Geriatric Psychiatry* 8(7): 541-545.

Kitwood, T. 1997 'The concept of personhood and its relevance for a new culture of dementia care', in **Miesen, B.M.L. and Jones, G.M.M.** *Care-giving in dementia: research and applications,* London: Routledge, 3-13.

Lachs, M.S. and Pillemer, K. 2004 'Elder Abuse', *The Lancet,* 364(9441) 1263-1272.

MacDonald, A. and Cooper, B. 2007 'Long–term care and dementia services: an impending crisis', *Age and Ageing* 36(1): 16–22.

Manthorpe, J. 1997 Developing Social Work Practice in Protection and Assistance, in **Decalmer, P. and Glendenning, F. (eds)**: *The mistreatment of elderly people*, London Sage.

Manthorpe, J., Iliffe, S., Samsi, K., Cole, L., Goodman, C., Drennan, V. and Warner, J., 2010, 'Dementia, dignity and quality of life: Nursing practice and its dilemmas', *International Journal of Older People Nursing*, 5(3): 235–244.

Mowlam, A., Tennant, R., Dixon, J. and McCreadie, C. 2007 *UK Study of Abuse and Neglect of Older People: Qualitative Findings,* London: NatCen. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078333 (Accessed 21/02/2012)

Nandlal, J.M. and Wood, L.A. 1997 'Older People's Understandings of Verbal Abuse',
Journal of Elder Abuse and Neglect, 9(1) 17-31.

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 the Abuse and Neglect of Older People.* London: NatCen. Available from:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076197 (Accessed 21/02/2012)

Paveza, G.J, Cohen, D., Eisdorfer, C., Freels, S., Semla, T., Wesson, A., Gorelick, P., Hirschman, R., Luchins, D. and Levy, P. 1992 **'**Severe Family Violence and Alzheimer's Disease: Prevalence and Risk Factors, *The Gerontologist,* 32(4) 493-497.

Pillemer K. and Moore, D.W. 1989 'Abuse of Patients in Nursing Homes: Findings from a Survey of Staff', *The Gerontologist,* 29(3) 314-320.

Pillemer K. and Moore, D.W. 1990 'Highlights from a study of elder abuse in patients in nursing homes, *Journal of Elder Abuse and Neglect,* 2(1-2) 5-30.

Price, T., King, P.S., Dillard, R.L. and Bulot, J.L. 2011 'Elder Financial Exploitation: Implications for Future Policy and Research in Elder Mistreatment', *Western Journal of Emergency Medicine,* 12(3): 354–356.

Sabat, S. R. 2001 *The Experience of Alzheimer's*. Oxford: Blackwell.

Sabat, S.R. 2007 'Positioning and Conflict Involving a Person with Dementia: A Case Study', in **Moghaddam, F., Harré, R. and Lee, N**. (eds) *Global conflict resolution through positioning analysis*, London, Springer: 81–93.

Sabat S.R., Napolitano, L., Fath, H. 2004 'Barriers to the construction of a valued social identity: A case study of Alzheimer's disease', *American Journal of Alzheimer's Disease and Other Dementias,* 19(3): 177–185.

Scholl, J. and Sabat, S.R. 2008 'Stereotypes, stereotype threat and ageing: implications for the understanding and treatment of people with Alzheimer's disease', *Ageing and Society* 28(1): 103–130.

Smith, J.A., Harré, R. and Van Langenhove, L. 1995 Introduction, in **Smith, J.A., Harré, R. and Van Langenhove, L**. (Eds): *Rethinking Methods in Psychology,* London, Sage Publications Ltd 1–9.

Stanley, N. And Manthorpe, J. (eds): 2004 *The Age of the Inquiry,* Abingdon: Routledge.

Stanley, N. Ridley, J., Harris, J. and Manthorpe. J. 2011 'Disclosing disability in the context of professional regulation: a qualitative UK study,' *Disability and Society,* 26(1) 19-32.

Stevens, M., Manthorpe, J., Martineau, S., Hussein, S., Rapaport, J. and Harris, J. (2010) Making decisions about who should be barred from working with adults in vulnerable

situations: the need for social work understanding. *British Journal of Social Work.* 40(1):290-310.

Stevens, M., Hussein, S. and Manthorpe, J. 2012 'Experiences of racism and discrimination among migrant care workers in England: Findings from a mixed-methods research project', *Ethnic and Racial Studies,* 35(2) 259-280.

Tadd, W., Hillman, A., Calnanm S., Calnan, M., Bayer, T. and Read, S. 2011 *Dignity in Practice: An exploration of the care of older adults in acute NHS Trusts,* London, DH and Comic Relief. Available from: http://www.sdo.nihr.ac.uk/files/project/SDO_ES_08-1819-218_V01.pdf (Accessed 21/02/2012).

Tirado, F. and Gálvez, A. 2007 'Positioning Theory and Discourse Analysis: Some Tools for Social Interaction Analysis' *Qualitative Social Research,* 8(2): 28pp. Available from: http://www.qualitative-research.net/index.php/fqs/article/view/248/547 (Accessed 21/02/2102).

Törrönen, J. 2001 'The Concept of Subject Position in Empirical Social Research', *Journal for the Theory of Social Behaviour*, 31(3): 313–329.

Van Langenhove, L. and Harré, R. 1999 'Introducing Positioning Theory' in **Van Langenhove, L. and Harré, R.** (Eds): *Positioning Theory,* Oxford, Blackwell Publishers. 14–31.

Wiglesworth, A., Mosqueda, L., Mulnard, R., Liao, S., Gibbs, L. and Fitzgerald, W. 2010

'Screening for Abuse and Neglect of People with Dementia', *Journal of the American*

Geriatrics Society, 58(3): 493–500.

Notes

---

[i] We use mistreatment to mean elder abuse and neglect, following O'Keeffe et al, 2007)
[ii] The POVA List is a list of people barred from working with vulnerable adults. It has since been replaced by the Independent Safeguarding Authority Adults List